

POD Exercises

**ACLS Basic Training
2009**

Is This a Deficiency?

- During a routine visit to a FCH you determine that 3 of 5 residents did not receive their therapeutic diets as ordered.

YES

NO

Is This a Deficiency?

- During a routine monitoring of a 40 bed ACH it is determined that the residents' weights are not being documented monthly.

YES

NO

Is This a Deficiency?

- During a routine monitoring of a 12 bed ACH it is determined that a resident is transported to dialysis by his mother rather than the facility.

YES

NO

Record Review

- Revealed an order dated 01/21/08 for Lasix daily.
- Is this a complete order?

Regulatory Reference

- Part of the rule that was NOT met
- Medication Orders 10A NCAC 13F/G .1002
 - (a)(2) physician contact for clarification if orders not clear or complete
 - (c)(2)
 - The medication orders shall be complete and include the strength of the medication
 - Cite the rule that most clearly and specifically addresses the identified problem

Summary Statement

- Summary of problem
- Source from which evidence obtained (observation, record review, interview)
- Identifies scope & severity
 - Based on record reviews and interview with the medication aide, it was determined that 4 of 6 resident records did not have complete medication orders (#1, 2, 3 and 6).

Writing a Summary Statement

- During a probe visit of Nutrition and Food Service to a FCH you determine that 3 of 5 residents did not receive their NCS diet as ordered.
- What information would you include in your summary statement?

Summary Statement

- Based on record review, interview with the cook, and observation of the lunch meal, 3 of 5 residents did not receive their therapeutic diets as ordered by their physician(#2, 3 and 4).

ADULT CARE MONITORING REPORT

I. County:	Date of Visit:	Time of Visit:
Facility:	License #:	
Address:		
Administrator/ Designee:	II. Purpose of visit: Routine Monitor/TA/AS Deliver SOD/CAR CI (<i>Date of initial visit</i>) _____) Complete CI Death Investigation	

III. Census:

IV. Regulatory Areas Reviewed: (rule # and description)
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V. Visit Results:

VI. Facility's Response:

VII. Administrator/Designee Signature:	Date:
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VIII: Adult Home Specialist Signature:	Date:
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Adult Care Home Corrective Action Report (CAR)

I. Facility Name: _____
 Address: _____

County: _____
 License Number: _____
 Purpose of Visit(s): _____

II. Date(s) of Visit(s): _____

Exit/Report Date: _____

Instructions to the Provider (please read carefully):

In column **III (b)** please address *each of the rules* which were violated and cited in column **III (a)**. The plan of correction must also include a *system* to prevent recurrence of these rule violations. In column **III (c)**, for **Citations** you are to indicate a specific completion date for your plan of correction.

*If this CAR includes a **Type B violation**, a **directed date** by which the violation must be corrected is provided in column **III (c)**. The facility must submit an acceptable Plan of Correction for each Type B violation. Failure to meet compliance after that date could result in a civil penalty in an amount up to four hundred dollars for each day that the facility remains out of compliance.

*If this CAR includes a **Type A violation**, a directed plan of correction will be issued in Column **III (b)** and a directed date of completion specified in column **III (c)**. It is the intent of this agency to prepare an Administrative Penalty Proposal for this Type A violation(s). Please submit any additional information within **5 days** to be considered prior to the preparation of the penalty proposal. If on follow-up survey the violations are not corrected, a civil penalty of up to one thousand dollars for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified <i>For each citation/violation cited, document the following four components:</i>	III (b). Facility plans to correct/prevent: <i>(Each Corrective Action should be cross-referenced to the appropriate citation/violation)</i>	III (c). Date plan to be completed
<ul style="list-style-type: none"> Rule/Statute violated (rule/statute number cited) Rule/Statutory Reference (text of the rule/statute cited) Level of Non-compliance (Type A, Type B, Unabated Type B, Citation) Findings of non-compliance 	<input type="checkbox"/> POC Accepted _____ <i>DSS Initials</i>	
Rule/Statute Number:		
Rule/Statutory Reference:		
Level of Non-Compliance:		
Findings:		

IV. Delivered Via:		Date:
DSS Signature:		Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name):	Date:
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):
	Signature: _____ Date: _____

VII. Agency's Review of Facility's Plan of Correction (POC)		
<input type="checkbox"/> POC Not Accepted	By: _____	Date: _____
Comments:		
<input type="checkbox"/> POC Accepted	By: _____	Date: _____
Comments:		

Facility Name: ____

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VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Sent to ACLS:
Comments:		
<i>*For follow-up to CAR, attach Monitoring Report showing facility in compliance.</i>		



North Carolina Department of Health & Human Services
Division of Health Service Regulation
Adult Care Licensure Section

Electronic Adult Care Home Corrective Action Report (CAR) (DHSR Form # 4607)

Microsoft Word Document

Instructions for Using the Electronic CAR: Citing One Rule Area & When Multiple Rule Areas Are Cited

To complete the Corrective Action Report (CAR) form, follow these steps:

1. Open the document.

(If you experience problems opening the document, refer to "Troubleshooting the Electronic CAR: Enabling Macros" guide.)

**DO NOT unlock or unprotect this form. Unlocking or unprotecting the form will cause it not to work properly.*

2. Complete Section I

- Enter the Facility's Name, Address, County and License Number.

(Type into the shaded boxes. The shaded boxes will expand as you type allowing you to put as much information as needed in the space provided.)

3. Complete Section II

- Enter dates of your visits to the facility.
- Enter the purpose for the visit(s), i.e. Complaint Investigation, Death Investigation, Routine Monitoring, etc.
- Enter the Exit/Report Date. The Exit/Report Date is the date that the facility was made aware of the compliance decision.

4. Complete Section III

- Instructions to the Provider – Parts of this section no longer need to be deleted as on the previous version of the CAR. The contents of this section cannot (and should not) be deleted. This section instructs the provider on the procedure for responding to the citations and/or violations contained in the CAR.
- Section IIIa: Non-Compliance Identified – Document the following components of each citation/violation cited: *(Again, the shaded boxes will expand as you type into them. Also, you can cut and paste information from another document into the shaded boxes.)*
 - Rule/Statute Number violated *(rule/statute number cited)*
 - Rule/Statutory Reference *(this is the text of the rule/statute)*
 - Level of Non-Compliance *(Type A, Type B, Unabated Type B, Citation)*
 - Findings of Non-Compliance *(evidence obtained through observation, interview, and record review that supports the citation/violation being cited)*

****If more than one rule area was cited, refer to the next section "When Multiple Rule Areas Are Cited" for instructions on how to add another rule area to this form.**

- Section IIIb: Facility plans to correct/prevent – This section will be left blank for the facility to write their plan of correction on the printed hard copy of this form. Each corrective action should be cross-referenced to the appropriate citation. If a directed plan of correction is being given to the facility, type it in the previous section (Section IIIa) after your findings.
*Note: Once the plan of correction has been submitted by the facility and accepted, check the “POC Accepted” box and sign your initials next to it.
 - Section IIIc: Date plan to be completed – This section will be left blank for the facility to write their date of correction on the printed hard copy of this form. If a directed date of correction is being given to the facility, type it in the previous section (Section IIIa) after your findings and the directed plan of correction, stating that the directed date of correction is not to exceed the date of (give date) .
5. Do you have another rule to cite? – If more than one rule area was cited, refer to the next section “*When Multiple Rule Areas Are Cited*” for instructions on how to add another rule area to this form.
 6. Save the document on your computer.
 7. Print a hard copy of the CAR.
 8. Complete Section IV (this section and sections that follow are completed by hand as you are now working from the printed hard copy of the CAR)
 - Enter method the CAR was delivered, i.e. U.S. Mail, E-mail, Certified Mail, Hand delivered, etc.
 - Sign and date the CAR.
 - Enter the date the facility must return the CAR with a plan of correction to your agency.
 9. Section V: CAR Received By
 - When the CAR is received by the facility, the Administrator (or their designee) must sign and date the form. They should also print their name and provide their title.
 10. Scan the signed copy of the CAR, name the file according to the required naming format (below) and e-mail it to the DHSR Adult Care Licensure Section using the appropriate e-mail address for your region. *DO NOT WAIT until the plan of correction has been completed to send in the CAR to the ACLS. Please e-mail the original signed CAR first, then the CAR with the POC will be e-mailed at a later date.

Reminder: Email format is as follows:

<Facility Name as it appears on the license><Date of last visit YYYY-MM-DD><CAR>

For example, if you are e-mailing a Corrective Action Report from a complaint investigation that was conducted at Smith Family Care Home on 8-17-2010 the file name would be:

Smith Family Care Home 2010-08-17 CAR

11. Section VI: Plan of Correction Submitted By
 - When the facility has written their plan of correction, the Administrator should sign, print their name, and date this section of the form prior to submitting it to your agency.

12. Section VII: Agency's Review of Facility's Plan of Correction (POC)
- POC Not Accepted: If the facility's POC is not accepted, check the "POC Not Accepted" box, sign and date. Write any comments or reasons why it was not accepted in the "Comments" section. (Again, this section will be handwritten as you are now working off of a hard copy of the CAR with the POC written on it.)
 - POC Accepted: If the facility's POC is accepted, check the "POC Accepted" box, sign and date. Write any comments in the "Comments" section. (Again, this section will be handwritten as you are now working off of a hard copy of the CAR with the POC written on it.)
13. Section VIII: Agency's Follow-Up – In this section, document the agency's efforts to follow-up to ensure the facility is back in compliance in the rule area(s) cited.
- Check the 'Yes' or 'No' box indicating whether or not the facility is back in compliance.
 - Include any comments in the 'Comments' section. For example, if the Type A/B violation was abated, or if the facility is not back in compliance or violation is unabated, or the violation was abated but deficient practice continues in that rule area and a new CAR is being issued, etc. Be sure to write the corresponding rule number when referring to violations and citations.
 - Sign and date this section.
 - Write date CAR with POC is sent to ACLS.
14. Scan the signed copy of the CAR with the POC, name the file according to the required naming format (below) and e-mail it to the DHSR Adult Care Licensure Section using the appropriate e-mail address for your region. You may also attach the monitoring report in this email, showing the facility is back in compliance with the rule area cited.

E-mail format for a CAR containing the POC:

<Facility Name as it appears on license><Date POC signed by Administrator YYYY-MM-DD><CAR POC>

For example, if you are e-mailing a Corrective Action Report for Smith Family Care Home that contains a plan of correction signed by the Administrator on 9-1-2010 the file name would be:

Smith Family Care Home 2010-09-01 CAR POC

E-mail Format for Monitoring Report showing facility back in compliance:

<Facility Name as it appears on the license><Date of last visit YYYY-MM-DD><MON>

For example, if you are e-mailing a Monitoring Report from a visit on 9-10-2010 to show Smith Family Care Home is back in compliance with the rules cited on the CAR, the file name would be:

Smith Family Care Home 2010-09-10 MON

When Multiple Rule Areas Are Cited: Adding Citations/Violations to the CAR

A new feature on the electronic CAR form allows you to put all citations/violations of non-compliance on ONE Corrective Action Report form instead of completing a new form for each citation/violation. The form expands as you need it to and keeps all rule numbers, references, findings, etc. aligned for easy reading. It also saves you time by not having to re-enter all of the facility and visit information.

To add additional sections (Section III a, b, and c) in which to document citations and violations, simply follow these steps:

1. To add one rule area cited, click “Add Rule” from the Menu Bar (located at the top of the screen)
2. Click “Add Rule” for each additional rule that will be cited in the CAR.
3. Then, simply type your findings into the spaces provided. Each box will expand as you type and will keep your documentation aligned with the other columns.

The screenshot shows a Microsoft Word document titled "Electronic CAR-Draft - Microsoft Word". The "Add Rule" button in the menu bar is circled in red. The form is titled "Adult Care Home Corrective Action Report (CAR)" and contains the following sections:

I. Facility Name: [REDACTED]		County: [REDACTED]
Address: [REDACTED]		License Number: [REDACTED]
II. Date(s) of Visit(s): [REDACTED]		Purpose of Visit(s): [REDACTED]
Instructions to the Provider (please read carefully):		Exit/Report Date: [REDACTED]
In column III (b) please address each of the rules which were violated and cited in column III (a). The plan of correction must also include a system to prevent recurrence of these rule violations. In column III (c), for Standard Deficiencies you are to indicate a specific completion date for your plan of correction.		
*If this CAR includes a Type B violation, a directed date by which the violation must be corrected is provided in column III (c). The facility must submit an acceptable Plan of Correction for each Type B violation. Failure to meet compliance after that date could result in a civil penalty in an amount up to four hundred dollars for each day that the facility remains out of compliance.		
*If this CAR includes a Type A violation, a directed plan of correction will be issued in Column III (b) and a directed date of completion specified in column III (c). It is the intent of this agency to prepare an Administrative Penalty Proposal for this Type A violation(s). Please submit any additional information within 5 days to be considered prior to the preparation of the penalty proposal. If on follow-up survey the violations are not corrected, a civil penalty of up to one thousand dollars for each day that the facility remains out of compliance may also be assessed.		
III (a). Non-Compliance Identified For each citation/violation cited, document the following four components: <ul style="list-style-type: none">• Rule/Statute violated (rule/statute number cited)• Rule/Statutory Reference (text of the rule/statute cited)• Level of Non-compliance (Type A, Type B, Unabated Type B, Standard Deficiency)• Findings of non-compliance	III (b). Facility plans to correct/prevent. (Each Corrective Action should be cross-referenced to the appropriate deficiency)	III (c). Date plan to be completed
Rule/G.S. Number: [REDACTED]	<input type="checkbox"/> POC Accepted	[REDACTED]
Rule/Statutory Reference: [REDACTED]	[REDACTED]	DSS Initials
Level of Non-Compliance: [REDACTED]	[REDACTED]	[REDACTED]
Findings: [REDACTED]	[REDACTED]	[REDACTED]
IV. Delivered Via: [REDACTED]		Date: [REDACTED]
DSS Signature: [REDACTED]		Return to DSS By: [REDACTED]

****If it appears the form is not working properly, please refer to the troubleshooting guide titled, “Troubleshooting the Electronic CAR: Enabling Macros.” (DHSR Form #4652)**



North Carolina Department of Health & Human Services
Division of Health Service Regulation
Adult Care Licensure Section

Electronic Adult Care Home Corrective Action Report (CAR) (DHSR Form #4607)
Microsoft Word Document

Troubleshooting the Electronic CAR: Enabling Macros

1. Issue:

Before document loads you receive the following message:

“Macros may contain viruses. It is usually safe to disable macros, but if the macros are legitimate, you might lose some functionality.”



Solution:

In order for the **Electronic CAR** document to perform correctly you will need to click **“Enable Macros”**

2. Issue:

Upon Clicking “Add Rule” the following message appears:

“The macro cannot be found or has been disabled because of your Macro security settings.”

The screenshot shows a Microsoft Word document titled "Electronic CAR-Draft - Microsoft Word". The document contains a form titled "Adult Care Home Corrective Action Report (CAR)". The form is divided into several sections:

- I. Facility Information:** Fields for Facility Name, Address, County, and License Number.
- II. Visit Information:** Fields for Date(s) of Visit(s), Purpose of Visit(s), and Exit/Report Date.
- Instructions to the Provider (please read carefully):** A large text block providing detailed instructions on how to complete the report, including requirements for addressing violations and submitting plans of correction.
- III (a) Non-Compliance:** A section for listing violations, with a "Show Help >>" button.
- III (c) Date plan to be completed:** A section for providing a date for completion.
- Additional Fields:** Fields for Rule/G.S. Number, Rule/Statutory Reference, Level of Non-Compliance, Findings, and a checkbox for "POC Accepted".

An error message box titled "Microsoft Office Word" is overlaid on the form. The message reads: "The macro cannot be found or has been disabled because of your Macro security settings." The message box includes a "Show Help >>" button and an "OK" button.

Solution:

You will need to change your Macro security settings. The following directions will show how to set your Macro security settings to “**Medium**” (where you can choose whether or not to run potentially unsafe macros.)

In the case of the **Electronic CAR**, the highest Security Level it can be set to is “**Medium.**”

(**Warning:** it is **not** recommended to set your macro security settings to “Low” – doing so opens your computer to the risk of computer viruses. Only “Enable” macros from trusted macro developers.)

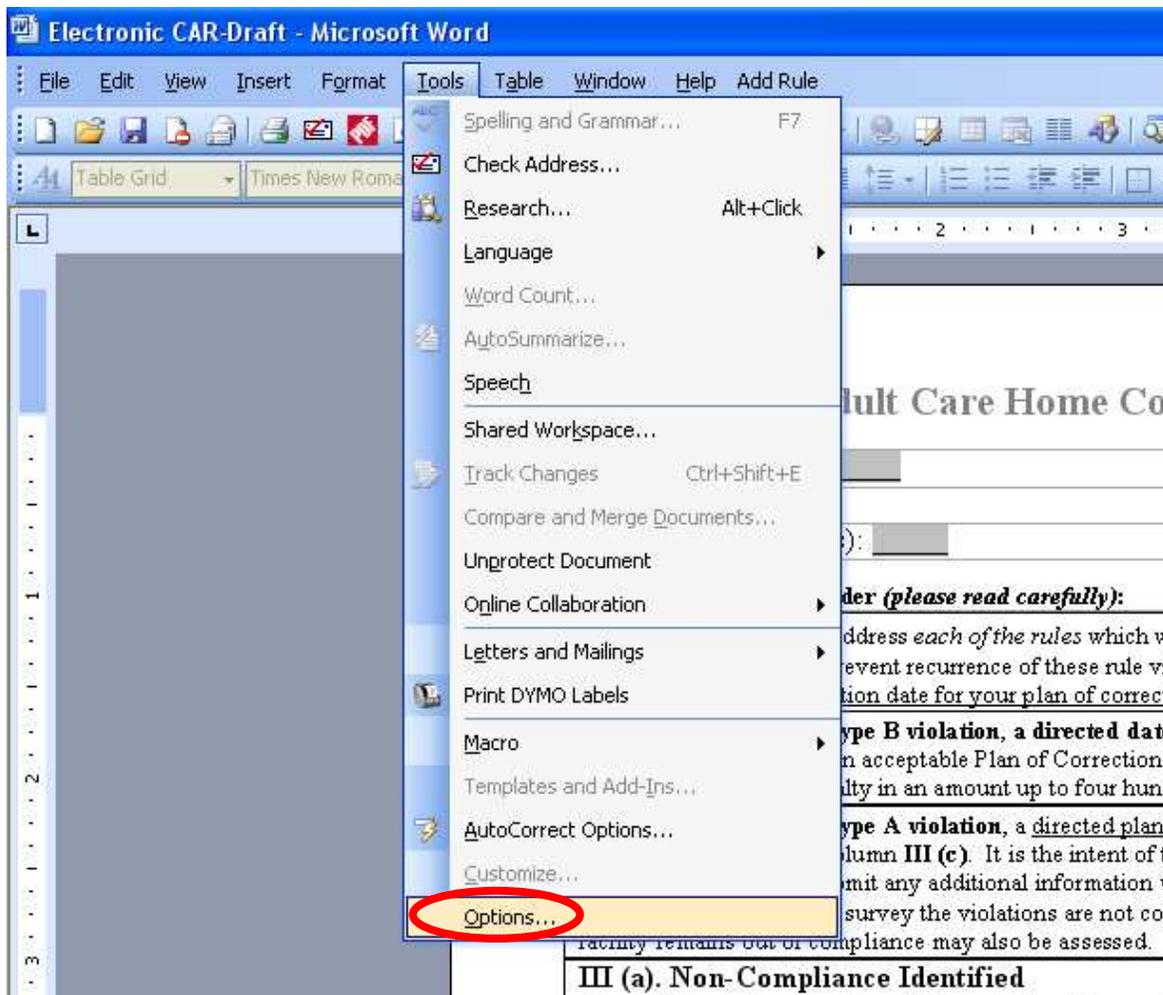
Click **OK** to close message box and continue to “**Steps to change your Macro Security Level**” – on the next page.

Steps to change your Macro Security Level:

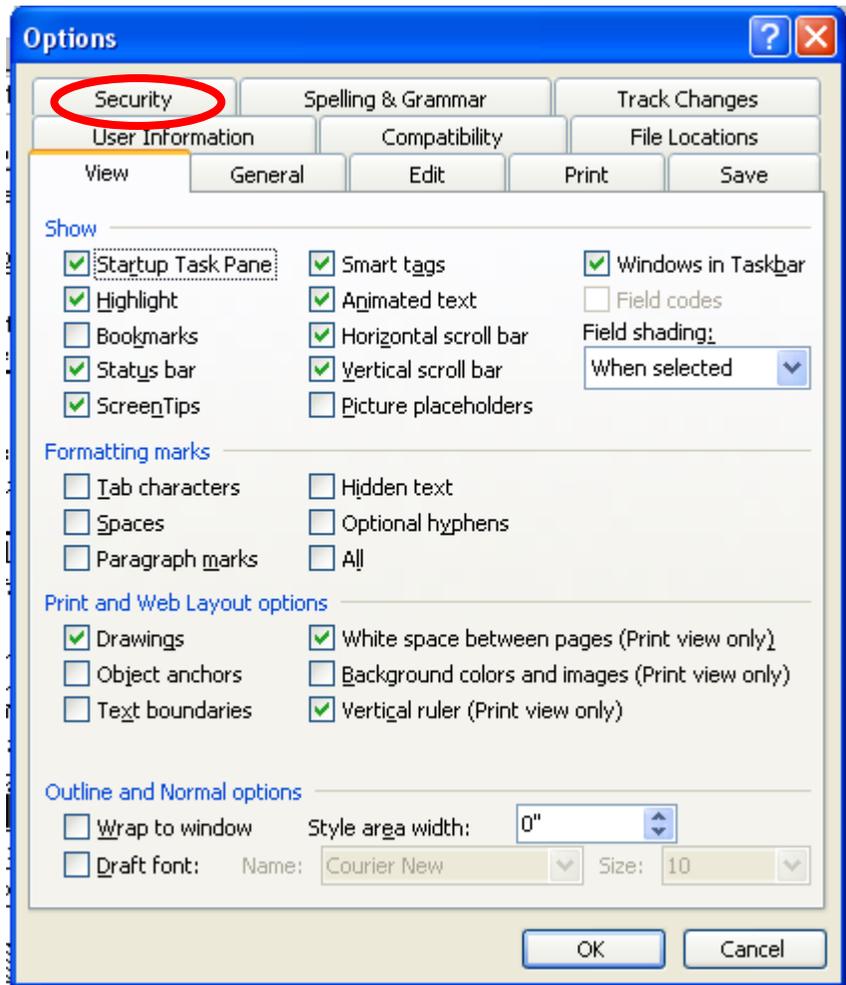
1. On the Standard toolbar click “Tools”



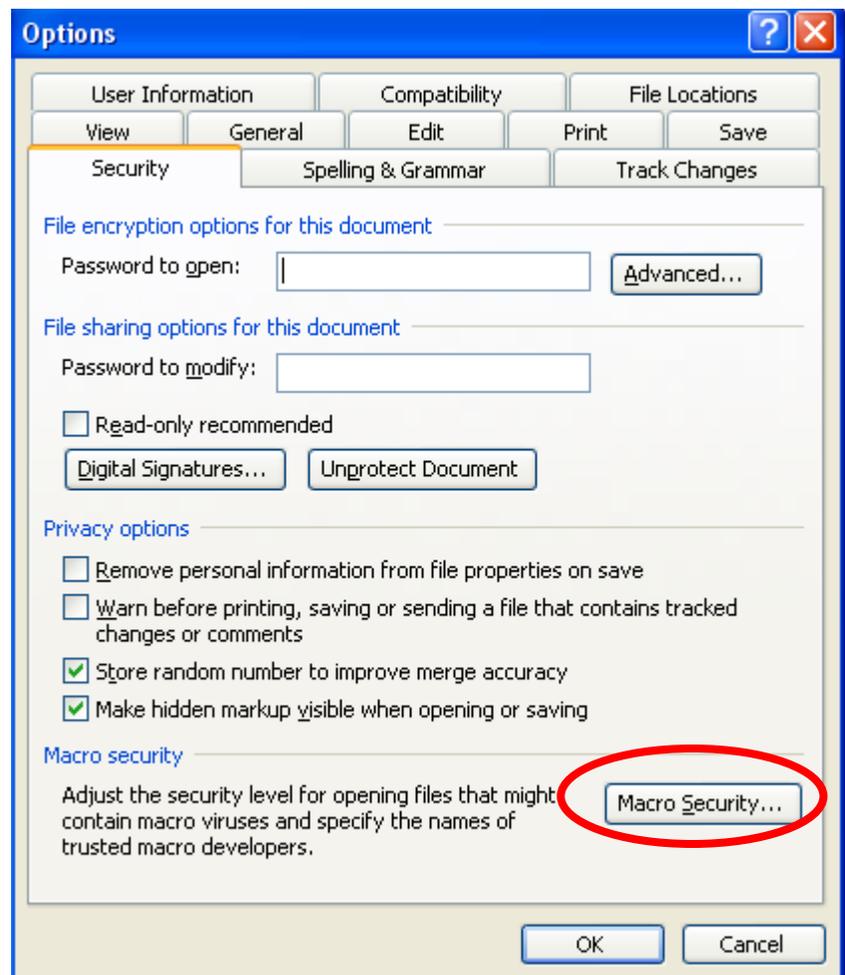
2. Click “Options”
 - a. (if “Options” is not visible click the bottommost portion of “Tools” to expand the choices)
 - b. Click “Options”



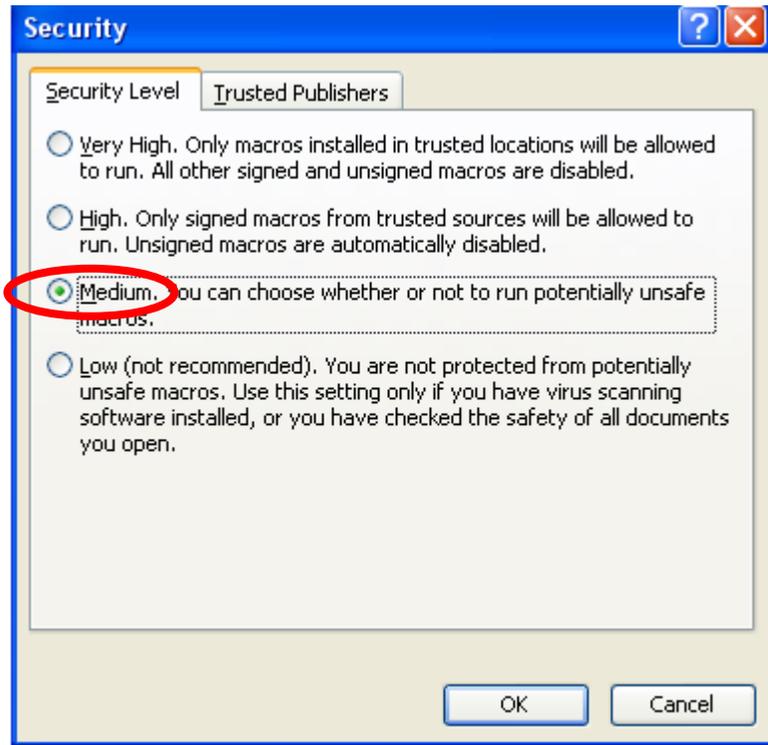
3. Click the “Security” tab in “Options”



4. From the “Security” tab click “Macro Security”



5. Set “Security Level” to “Medium”.
6. Click “OK” on the “Security” box and again on the “Options” box.



7. Finally, you will need to close the document and then re-open it for functionality. (Once you set your security level to “Medium,” this dialog will not happen again unless the security settings are changed to a higher level than “Medium.”)

Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>Section 1: Basic Medication Administration Information and Medical Terminology</p> <p>A. Match common medical abbreviations with their meaning</p> <p>B. List/Describe common dosage forms of medications and routes of administration</p> <p>C. List the 6 rights of medication administration</p> <p>D. Describe what constitutes a medication error and actions to take when a medication error is made or detected</p> <p>E. Describes resident's rights regarding medications, i.e., refusal, privacy, respect</p>	<p>Section 1: The employee must be knowledgeable of at least:</p> <p>A. The common abbreviations on ATTACHMENT A. The employee is to be familiar with the common medical abbreviations and be able to find a list when needed.</p> <p>B. The common dosage forms and routes of administration on ATTACHMENT A & B. The employee is to be familiar with the common dosage forms. Medications are available as different dosage forms, e.g., tablets, capsules, liquids, suppositories, topicals which include lotions, creams, ointments and patches, inhalants and injections. An order is to indicate the route of administration. Some medications may come in several dosage forms. An example is Phenergan. It is available in tablet, liquid, suppository and injectable.</p> <p>C. Six Rights of Medication Administration: 1.Right Resident 2.Right Medication 3.Right Dose 4.Right Route 5.Right Time 6.Right Documentation</p> <p>D. A medication error occurs when a medication is not administered as prescribed. Examples of medication errors include: omissions; administration of a medication not prescribed by the prescribing practitioner; wrong dosage; wrong time, wrong route; crushing a medication that shouldn't be crushed; and documentation errors. The employee must be able to explain the facility's medication error policy and procedure or at least be knowledgeable of where to find it. The procedure is to include who to notify, i.e., supervisor and health professional and forms to complete. The employee is to be able to recognize medication errors. The employee needs to understand that recognizing medication errors and acting quickly to correct them help prevent more serious problems.</p> <p>E. Medication administration can effect a resident's rights which include, but not limited to, the following: 1. Respect – How the resident is addressed; The resident should not be interrupted while eating for the administration of medications such as oral inhalers and eye drops. The resident should not be awakened to administer a medication that could be scheduled or administered at other times; Explain to the resident the procedure that the employee is about to perform; Answer questions the resident may have about the medication. 2. Refusal – The resident has a right to refuse medications. A resident should never be forced to take a medication. The facility should have a policy and procedure to be followed when residents refuse medications. The policy and procedure is to ensure the physician is notified timely (based on the resident's mental and physical condition and the medication). 3. Privacy – Knock on closed doors before entering; Do not administer medications when the resident is receiving personal care or in the bathroom; Administration of injections outside the resident's room is not acceptable if the resident receiving the injection or other residents present are offended by this; Administration of medications requiring privacy, e.g., vaginal and rectal administrations, dressing changes and treatments requiring removal of clothing. 4. Chemical Restraint Medications, especially psychotropics, are not to be administered for staff convenience.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>F. Define medication “allergy” and describe responsibility in relation to identified allergies and suspected allergic reactions</p> <p>G. Demonstrate the use of medication resources or references</p> <p>Section 2: Medication Orders</p> <p>A. List/Recognize the components of a complete medication order</p>	<p>F. Medication Allergy: a reaction occurring as the result of an unusual sensitivity to a medication or other substance. The reaction may be mild or life-threatening situation. These may include rashes, swelling, itching, significant discomfort or an undesirable change in mental status, which should be reported to the physician. A severe rash or life-threatening breathing difficulties require immediate emergency care. The employee should understand that information on allergies should be reported to the pharmacy and physician and this information is recorded in the resident’s record. Upon admission, it is important to document any known allergies. If there are no known allergies, this should be indicated also.</p> <p>G. The employee should be familiar with medication resources or references, including the facility’s policy and procedure manual, and be able to find information. Resources written for non-health professionals, including information sheets from the pharmacy, are recommended instead of references written for health professionals, such as the <u>PDR</u>.</p> <p>Section 2</p> <p>A. Components of a complete order:</p> <ol style="list-style-type: none"> 1. Medication name; 2. Strength of medication (if one is required); 3. Dosage of medication to be administered; 4. Route of administration; 5. Specific directions for use, including frequency of administration; and, 6. PRN or “as needed” orders must also clearly state the reason for administration <p>Orders for psychotropic medications prescribed for “PRN” administration must include symptoms that require the administration of the medication, exact dosage, exact time frame between dosages and maximum dosage to be administered in 24 hour period. Example: Ativan 0.5 mg. by mouth every 4 hours prn for pacing or agitation. Physician is to be contacted if more than 4 doses are needed in 24-hour period.</p> <p>For items B. through E. of this section: If the employee has any responsibility for transcription of orders and processing admissions, the employee is to describe and demonstrate the procedures involved in these areas. If the employee does not have any responsibility for transcription or processing orders, the employee still needs to have general knowledge of the procedures and be able to screen orders to determine correctness.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>B. Transcribe orders onto the MAR</p> <ol style="list-style-type: none"> 1. Use proper abbreviations 2. Calculate stop dates correctly 3. Transcribe PRN orders appropriately 4. Copy orders completely and legibly and/or checked computer sheets against orders and applied to the MAR 5. Discontinue orders properly <p>C. Describe responsibility in relation to telephone orders</p> <p>D. Describe responsibility in relation to admission and readmission orders and FL2 forms</p>	<p>B. Transcription of orders onto the medication administration record is to include:</p> <ol style="list-style-type: none"> 1. Orders are to be transcribed onto the medication administration record when obtained or written. The employee is to initial or sign and date orders written on the medication administration record. (Waiting until the medication arrives from the pharmacy before transcription of an order onto the medication administration record is not correct. The directions on the medication label from the pharmacy must be checked against the order on the medication administration record. If there is a discrepancy between the information on the medication administration record and the medication label, the order in the resident's record is to be checked. When there are discrepancies between the medication label and the order, the employee is to follow the facility's policy and procedure, which would address who to contact.) 2. Transcribe using proper abbreviations or written out completely. The order is to be complete. 3. When calculating stop dates for medication orders such as antibiotics that have been prescribed for a specific time period, the number of dosages to be administered should be counted instead of the number of days. 4. PRN orders are not scheduled for administration at specific times. PRN medications are given when the resident "needs" the medication for a certain circumstance. 5. Review medication administration records monthly at the beginning of the cycle to assure accuracy and the update the medication administration records as needed. 6. A discontinue order has to be obtained for an order to be discontinued, unless the prescribing practitioner has specified the number of days or dosages to be administered or indicates that a dosage is to be changed. For example, a prescription with "No Refills" does not automatically mean the order is to be discontinued. <p>C. Telephone or verbal orders may be accepted only by a licensed nurse, registered pharmacist or qualified staff responsible for medication administration. The order is to be dated and signed by the person receiving the order and signed by the prescribing practitioner within 15 days of when the order is received. It is important that the employee understands that a copy of an order, including a telephone order, is always kept in the resident's record.</p> <p>D. A FL2 form is required for new admissions. It is important that all the information on the FL-2 is reviewed for accuracy. If any clarification is needed, the prescribing practitioner is to be contacted. If the FL-2 has not been signed within 24 hours of admission, the orders are to be verified by the facility with the prescribing practitioner. Verification of orders may be by fax or telephone. There has to be documentation of this verification in the resident's record, e.g., a note in the progress notes or the orders may be rewritten as telephone orders and signed by the prescribing practitioner. The orders could also be faxed to the prescribing practitioner for review, signature and date.</p> <p>Readmission from the hospital requires a transfer form, discharge summary <u>or</u> FL-2 signed by the prescribing practitioner. Often, the facility may receive a discharge summary or transfer form and a FL-2. The employee must be able to describe the procedures for readmission, especially when two or more forms with orders are received. Orders are to be verified by facility staff with the prescribing practitioner if the orders have not been signed within 24 hours of admissions, if clarification is needed or if the prescribing practitioner has not signed the orders. If a</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>E. Describe or demonstrate the process for ordering medications and receiving medications from pharmacy</p> <p>F. Identify required information on the medication label</p> <p>Section 3 : Using appropriate technique to obtain and record the following:</p> <p>A. * Blood Pressure</p>	<p>prescribing practitioner does not sign orders, the orders are to be processed per facility policy and signed by the prescribing practitioner. This may be by telephone or facsimile.</p> <p>Medication orders are to be reviewed and signed by the physician at least every 6 months. When the orders are renewed and there are changes without any reason, the physician or prescribing practitioner should be contacted for clarification. A medication could have been accidentally left off or the wrong dosage could have been written.</p> <p>Clarification is obtained whenever orders are unclear, incomplete or conflicting. New orders will need to be written as necessary for these clarifications.</p> <p>“Continue previous medications” or “Same Medications” are not complete medication orders and are not to be accepted for medication orders.</p> <p>An order has to be obtained for any medication administered, i.e., over-the-counter or prescription. The employee is to understand the difference between a prescription and an order. The facility needs an order to administer a medication. The prescription may be used for the signed order.</p> <p>E. The employee should be knowledgeable of the facility’s procedures on ordering medications, including refills, procedures for emergency pharmaceutical services and on receiving medications when delivered from the pharmacy. The facility is to be able to account for medications administered by staff; therefore, the facility is to have procedures to ensure that dispensing information, i.e., date, name, strength and quantity of medication, can be readily available. For situations such as admissions when the resident or responsible party brings medications into the facility, the name, strength and quantity of medication brought in should be documented.</p> <p>F. The employee has to be able to identify the following information on the label: medication name and strength; quantity dispensed and dispensing date; directions for use; the pharmacy that dispensed the medication and the prescription number; and expiration date. The employee should understand the difference between generic and brand names and know that an equivalency statement should be on the medication label when the brand dispensed is different than the brand prescribed. The employee should also know labeling requirements for over-the-counter (OTC) medications, according to the regulation 10A NCAC 13F/13G .1004.</p> <p>Section 3</p> <p>A. Blood Pressure (B/P)– The employee is to know how to check a blood pressure by using the facility’s blood pressure device. If electronic machines are used, the employee should understand that the device needs to be checked for accuracy according to the manufacturer’s recommendations. The instructor needs to indicate on the checklist how the employee obtained the resident’s blood pressure, i.e., electronically or manually with a stethoscope and blood pressure cuff. The employee should know that blood pressure cuffs that are too small or large for the resident’s arm might result in an inaccurate reading. Ranges for high and low blood pressures that indicate the resident’s blood pressure should be reported are to be established by the facility’s policy or physician’s order.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>B. * Temperature</p> <p>C. * Pulse</p> <p>D. * Respirations</p> <p>E. Fingersticks/Glucose Monitoring (Only required to be validated if the employee will be performing this task.)</p> <p>Section 4: If medications are prepared in advance, procedures, including documentation, are in accordance with regulation 10A NCAC 13F/13G .1004. (only has to be completed if applicable to facility)</p> <p>Section 5: Administration of Medications</p> <p>A. Identify resident</p>	<p>B. Temperature (T or TEMP.)– The employee should know how to obtain the resident’s temperature using the facility’s thermometer: i.e., electronic, glass or tympanic. The employee should know the normal oral temperature and that temperature is measured using either the Fahrenheit or Celsius scale. Normal oral temperature is 36.5 – 37.5 degrees Celsius or 96.7 – 99.6 degrees Fahrenheit. The employee should know that activity, food, beverages and smoking all affect body temperature.</p> <p>C. Pulse – Number of heartbeats counted in one full minute. The employee should know how to take a radial (heart rate measured at the thumb side of the inner wrist) and apical pulse (heart rate measured directly over the heart using a stethoscope). A pulse may be obtained by using an electronic device. Normal range is 60 to 100 beats/minute.</p> <p>D. Respirations (R) – Number of breaths a person takes per minute. The normal range is 10 to 24 breaths per minute. One full breath is counted after the resident has inhaled and exhaled. The most accurate rate is taken when the resident is not aware that his/her respirations are being monitored.</p> <p>E. The employee is to know how to operate the facility’s glucose monitoring device, including calibrating and cleaning the machine. The range of the glucose-monitoring device should be posted with the MARs or available for staff for reference. Since ranges for the machines vary, the facility should have procedures developed for when the blood sugar reading is low or high. The employee is to be knowledgeable of the procedures and know where to locate the information if needed. The employee is to be knowledgeable of infection control measures such as wearing gloves, disposal of lancets in sharps container and the difference between multi-use machines and ones not for multi-use.</p> <p>Section 4</p> <p>The containers must be prepared and labeled according to regulation 10A NCAC 13F/13G .1004. If the medications are not dispensed in sealed packages, the container has to be capped or sealed and each medication prepared is to be identified on the container. The MAR is to be used when prepouring or preparing medications. If the person who prepares the medication is not the same person to administer the medication, the person preparing the medication must document each medication prepared. (This is in addition to documentation by the person who actually administers the medications. The administration of medications is not to be documented until after the resident is observed to take the medications.)</p> <p>Section 5</p> <p>A. The employee is to know the procedures for identifying residents. The most common method used is photographs of residents in the medication administration records. The photos should be kept updated and the photograph is to have the name of the resident on it. Relying on other staff to identify residents is not appropriate.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>B. Gathered appropriate equipment and keeps equipment clean</p> <p>C. Medication administration records utilized when medications are prepared and administered. They are also used when medications are prepoured, if prepouring is allowed.</p> <p>D. Read the label 3 times; Check label against order on the medication administration record.</p> <p>E. Use sanitary technique when pouring or preparing medications into the appropriate container</p> <p>F. Offer sufficient fluids with medications</p> <p>G. Observe resident taking medications and assures all medications have been swallowed.</p>	<p>B. This will depend on the medications to be administered. Supplies/equipment to have for medication administration need to include at least the following:</p> <ol style="list-style-type: none"> 1. Medication administration records 2. Medication cups for oral medications, i.e., liquids and tablets 3. Sufficient fluids available to administer medications 4. Food substance, i.e., applesauce or pudding, if needed. 5. If soap and water is not available for washing hands, an appropriate antiseptic is to be available for use. <p>Supplies and equipment used in the process of administering medications is to be kept clean and orderly, i.e., medication carts, trays and pill crusher.</p> <p>C. Employee is to use the medication administration record when administering medications.</p> <p>D. Reading the label - The employee should compare the label to the MAR 3 times:</p> <ol style="list-style-type: none"> 1. when selecting the medication from the storage area 2. prior to pouring the medication 3. after pouring and prior to returning the medication to the storage area. <p>The information on the MAR and the medication label should match, unless there has been a change in the directions. The employee is to be familiar with the facility's policy on direction changes. A medication label can only be changed or altered by the dispensing practitioner.</p> <p>E. Medications are not to be touched or handled by the employee's hands. Medications are to be poured from the medication container into an appropriate medication container or cup and given to the resident. It is not acceptable for the employee to use his/her hands to administer the medications or for the resident to have to use his/her hands to receive the medications. (This is referring to the facility not having adequate or appropriate supplies or the employee not using the supplies to administer medications. This is not referring to residents pouring the medication, e.g., tablet, or wanting the medication poured into their hands.)</p> <p>F. The resident should be offered sufficient fluids following the administration of medications even if the medication is administered in a food substance.</p> <p>G. The employee is to observe the resident taking the medication to assure the medication is swallowed. This must be before documenting the administration of the medications.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>Section 10 – Documentation of Medication Administration</p> <p>A. Initial the MAR immediately after the medications are administered and prior to the administration of medications to another resident. Equivalent signature for initials is documented.</p> <p>B. Document medications that are refused, held or not administered, appropriately</p> <p>C. Administer and document PRN medications appropriately</p> <p>D. Record information on other facility forms as required</p>	<p>should be with soap and water. When soap and water is not readily available, an antiseptic gel or product must be used in place of soap and water. Handwashing is required when there has been contact with the resident’s body or bodily fluids during the administration of medications. Gloves should be worn and handwashing must also be done when transdermal products, i.e., Nitroglycerin or Durgesic patches, are applied or removed.</p> <p>Section 10</p> <p>A. The employee is to sign the MAR only after observing the resident take the medications. Precharting is not permitted and this includes signing the MAR anytime prior to the medications being administered. The MAR is to be signed immediately after the medications are administered and prior to the administration of the next resident’s medications. The employee is also to document an equivalent signature to correspond with the initials used on the MAR.</p> <p>B. The facility is to have procedures to ensure that there is a consistent method of documenting why a medication was not administered. The employee is to be knowledgeable of the facility’s policy and procedures. If the facility uses abbreviations such as “R” or “H”, there is to be documentation on the medication administration records of the abbreviations and what the abbreviations mean. The facility may have staff circle their initials and document the reason a medication was not administered on the back of the MAR.</p> <p>The employee is also to be knowledgeable of the facility’s policy when a resident refuses medications, i.e., notifying the supervisor or physician.</p> <p>If the medications are not administered because the resident is out of the facility, i.e., leave of absence and workshops, there should also be documentation of the medications sent with the resident. (A medication release form is often used for leave of absence.)</p> <p>C. Documentation of PRN medications is to include the amount administered, the time of administration and the reason for administration. The reason a PRN medication is to be administered is to be indicated in the order. The effectiveness of the medication is to also be documented when determined. A different employee, depending on the time of administration and shift schedules may record the effectiveness of the medication. If a resident is requesting or requiring administration of a prn medication on a frequent or routine basis, the employee should report this to the supervisor or the physician. PRN medications are to be administered when a resident needs the medication but may not be administered more frequently than the physician has ordered. The need for medication may be based upon the resident’s request for the medication or observation by staff, i.e., resident exhibiting pain but does not request medications or may not be able to request the medication.</p> <p>D. The forms to be completed would depend on the facility’s policy and procedures. The employee is to be knowledgeable of forms to complete, i.e., administration of controlled substances and documentation of medications provided for leave of absence.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>E. Write a note in the resident's record when indicated</p> <p>Section 11: Completion of Medication Pass</p> <p>A. Store medications properly</p> <p>B. Dispose of contaminated or refused medications per policy</p> <p>C. Recheck medication administration records to make sure all medications are administered and documented</p> <p>Section 12: Medication Storage</p> <p>A. Maintain security of medications during medication administration</p> <p>B. Store controlled substances appropriately and count and sign controlled substances per facility policy</p>	<p>E. Any contact with the prescribing practitioner is documented in the resident's record. The employee needs to be knowledgeable of how to write a note in the resident's record appropriately, i.e., date and employee's signature. The employee also must be knowledgeable of the facility's procedures for documenting information that needs to be communicated to other staff or health professionals. This may be in the resident's record or on some other document used to communicate with staff or health professionals.</p> <p>Section 11</p> <p>A. External and internal medications are to be stored in separate designated areas. The employee should store refrigerated medications in the medication refrigerator or locked container. Medications requiring refrigeration are to be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C).</p> <p>A resident's oral solid medications should be stored together and separated from other residents' medications. It may not be possible for other medications, i.e., liquids and topical medications, to be separated by dividers for each resident. Medication storage areas need to be orderly so medications may be found easily.</p> <p>B. Dosages of medications that have been opened and prepared for administration and not administered for any reason should be disposed of promptly. The disposal of these medications should be in accordance with the facility's policy and procedures. Loose medications are not to be kept in the facility or returned to the pharmacy.</p> <p>C. When the medication pass is complete, the employee is to recheck the medication administration records to make sure all medications have been administered and documented appropriately. At the end of the medication pass if a medication is not signed off upon recheck of the medication administration record, and the employee is certain the medication was administered, it is acceptable for the employee to document the administration. This is acceptable when there are only a few, i.e., one or two, omissions. It is not acceptable for the employee to have omitted documentation of the administration of medications for multiple residents.</p> <p>Section 12</p> <p>A. Medications are to be stored in a locked area, unless the medications are under the direct supervision of staff. Direct supervision means the cart is in sight and the staff person can get to the cart quickly, if necessary.</p> <p>B. The storage of controlled substances is to be in accordance with the facility's policy and procedures. Controlled substances may be stored in one location in the medication cart or medication room. When Schedule II medications are stored in one location together or with other controlled substances, the controlled substances are to be under double lock. When controlled substances, including Schedule II, are stored with the resident's other medications,</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>C. Assure medication room/cart/cabinet is locked when not in use</p> <p>Section 13: Administer medication utilizing appropriate technique for dosage form/route and administer accurate amount</p> <p>A. Oral tablets and capsules B. Oral liquids</p>	<p>only a single lock is required. There has to be a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. The employee is to be knowledgeable of any forms to be completed.</p> <p>C. Medication room/cart/cabinet is locked when not in use. Unless the medication storage area is under the direct supervision of staff, the medication area including carts is to be locked. When the medication cart is not being used, it should be stored in a locked area or stored in an area where it is under the supervision of staff.</p> <p>Section 13</p> <p>The employee is to actually perform or at least be able to demonstrate to the instructor the proper technique for administering the different dosage forms and routes of administration for A through J prior to the employee being assigned to administer medications in the adult care home.</p> <p>Routes of administration for K through P only have to be validated if the employee will be responsible for administering these medications or medications by these routes.</p> <p>The information below does not provide step by step procedures for administering medications. It provides pertinent information on techniques and infection control that the employee is to know.</p> <p>A. & B. Oral Medications</p> <ul style="list-style-type: none"> • Appropriate positioning of resident, elevation of head. • The amount of medication to be administered, such as liquids, is never to be approximated. The amount ordered is to be the amount administered; therefore, a calibrated syringe is often necessary for measuring liquids in amounts less than 5 ml. and unequal amounts. • Liquid medications must be measured in a calibrated medication cup/device. • Measuring devices used for administering medications are to be calibrated and designed for measuring medications. Eating utensils or other household devices are not to be used for administering medications. • When measuring liquids, the medication cup should be placed on a flat surface, and measured at eye level to ensure accuracy. • For liquids, hold the medication container so that the medication flows from the side opposite the label so it doesn't run down the container and stain or obscure the label. • Powdered medications such as bulk laxatives need to be given with the amount of fluids indicated. • More than one capsule or tablet may be in the same medication cup, but liquid medications are not to be mixed together. • Special measuring devices for certain medications should only be used for that medication. (These measuring devices have increments marked off in "mgs." instead of "mls" and usually have the name of the medication on the measuring device.) • Liquids may have administration requirements such as Shake Well and Requires Dilution prior to administration. Examples of these liquids are Dilantin Suspension, which must be shaken thoroughly because the medication settles
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>C. Sublingual medications</p> <p>D. Oral Inhalers</p> <p>E. Eye drops and ointments</p> <p>F. Ear drops</p> <p>G. Nose drops</p> <p>H. Nasal Sprays/Inhalers</p> <p>I. Transdermal medications/Patches</p>	<p>after administration and gives inconsistent dosing; Liquid Potassium and bulk laxatives have to be mixed with sufficient fluids to decrease side effects.</p> <ul style="list-style-type: none"> • Refer to ATTACHMENT C for additional information. <p>C. Sublingual</p> <ul style="list-style-type: none"> • The medication is to be placed under the resident’s tongue. The resident should be instructed not to chew or swallow the medication. Do not follow with liquid, which might cause the tablet to be swallowed. <p>D. Oral Inhalers</p> <ul style="list-style-type: none"> • For information on technique for meter dose inhaler refer to ATTACHMENT D. • Spacing and proper sequence of the different inhalers is important for maximal drug effectiveness. • The prescribing practitioner may specifically order the sequence of administration if multiple inhalers are prescribed or the pharmacy may provide instruction on the medication label or MAR. • The use of spacer or other devices to aid with administration should be discussed with the employee. • Wait at least one minute between puffs for multiple inhalations <p>E. Eye drops and ointments</p> <ul style="list-style-type: none"> • Hands are to be washed prior to and after administration of eye drops and ointments. Gloves are to be worn as indicated. Gloves are to always be worn when there is redness, drainage or possibility of infection. • When two or more different eye drops must be administered at the same time, a 3 to 5-minute period should be allowed between each. • Dropper or medication container should not touch the resident’s eyes. <p>F. Ear Drops</p> <ul style="list-style-type: none"> • Wash hands before and after administration of medication. Gloves are to be worn as indicated. • By gently pulling on the ear, straighten the ear canal • The employee should request the resident to remain in same position for 5 minutes to allow medication to penetrate. It may be necessary to gently plug the ear with cotton to prevent excessive leakage. <p>G. & H. Nose Drops & Nasal Sprays/Inhalers</p> <ul style="list-style-type: none"> • Wash hands before and after. Gloves are to be worn as indicated. • For drops: Resident should lie down on his/her back with head tilted back and the employee should request the resident to remain in the position for about 2 minutes to allow sufficient contact of medication with nasal tissue. • For Sprays: Hold head erect and spray quickly and forcefully while resident “sniffs” quickly. It may be necessary to have the resident tilt head back to aid penetration of the medication into the nasal cavity. • The dropper or spray should be at least wiped with a tissue before replacing the cap. <p>I. Transdermal Products/Patches</p> <ul style="list-style-type: none"> • Application sites for transderm patches should be rotated to prevent irritation. The application sites should be documented on the MAR.
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ABBREVIATIONS

DOSES

gm = gram
mg = milligram
mcg = microgram
cc = cubic centimeter
ml = milliliter
tsp = teaspoonful
tbsp = tablespoonful
gtt = drop
ss = 1/2
oz = ounce
mEq = milliequivalent

ROUTES OF ADMINISTRATION

po = by mouth
pr = per rectum
OD = right eye
OS = left eye
OU = both eyes
AD = right ear
AS = left ear
AU = both ears
SL = sublingual (under the tongue)
SQ = subcutaneous (under the skin)
per GT = through gastrostomy tube

TIMES

QD = every day
BID = twice a day
TID = three times a day
QID = four times a day
q_h = every __ hours
qhs = at bedtime
ac = before meals
pc = after meals
PRN = as needed
QOD = every other day
ac/hs = before meals and at bedtime
pc/hs = after meals and at bedtime
stat = immediately

OTHER

MAR = medication administration record
OTC = over the counter
SIG = label or directions

COMMON DOSAGE FORMS

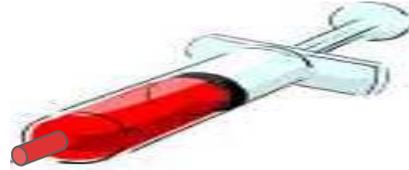
1. **Tablet** –Hard, compressed medication in round, oval, or square shape. Some have enteric coating or other types of coatings, which delay release of the drug and can not be crushed or chewed.
2. **Capsule** – Medication in a gelatin container. The capsule may be hard or soft and dissolves quickly in the stomach.
3. **Liquid** – There are different types of liquid medications:
 - A. Solution
 - B. Suspension
 - C. Syrup
 - D. Elixir
4. **Suppository** – small solid medicated mass, usually cone-shaped. Suppositories melt at body temperature. May be administered by rectum or vagina. Refrigerate as directed by manufacturer.
5. **Inhalant** – medication carried into the respiratory tract through the vehicles of air, oxygen or steam. There are inhalants used orally and nasally.
6. **Topical** – applied directly to the skin surface. Topical medications include the following:
 - A. Ointment
 - B. Lotion
 - C. Paste
 - D. Cream
 - E. Shampoo
 - F. Patches (Transdermal)
 - G. Powder
 - H. Paste
 - I. Aerosol Sprays

MEASURING TIPS



10cc = 10ml
20cc = 20ml

TIP: use an oral syringe for amounts less than 5ml



Reminder: 1cc = 1ml
A cubic centimeter is the same as a milliliter.

mg. ≠ ml.

A mg is NOT the same as a ml !!!

TIP: Always read the label carefully to be sure you are measuring the right thing.



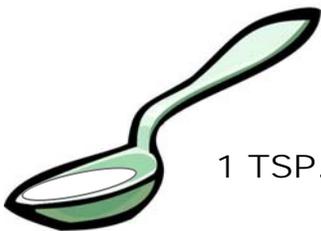
←20ml→



This 20ml cup contains 20mg of medication in it.

This 20ml cup contains 40mg of medication in it.

YOU CAN'T TELL THE DIFFERENCE BY LOOKING

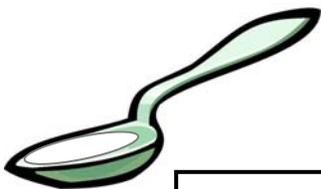


1 TSP. = 5ml.



TIP: Don't use household teaspoons. They are not accurate!

TIP: To be accurate, use the correct measuring tool. Ask your pharmacist. Some liquid medicines have special measuring tools.



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1 tbsp. = 3 tsp

3 tsp. = 15ml



TIP: When measuring liquids, hold the cup at eye level.

TECHNIQUE FOR PROPER USE OF METERED DOSE INHALERS

Equipment Required:

Prescribed Medication
Examination Gloves(optional)

Procedure:

1. Remove the cap and hold inhaler upright.
2. Shake the inhaler.
3. Ask the resident to tilt the head back slightly and breathe out.
4. Position the inhaler in one of the following ways:
 - Open mouth with inhaler one to two inches away.
 - Use spacer with inhaler; place spacer in mouth (Spacers are particularly beneficial for older adults & young children).
 - Position inhaler in mouth, close lips around inhaler.
5. Press down on inhaler to release medication as the resident starts to breathe in slowly.
6. Encourage the resident to breathe in slowly (over 3 to 5 seconds).
7. Ask the resident to hold breath for 10 seconds to allow medication to reach deeply into the lungs.
8. Repeat puffs as directed. (Waiting one minute between puffs may permit additional puffs to penetrate the lungs better).

SPACING AND PROPER SEQUENCE OF INHALED MEDICATIONS

Spacing and proper sequence of the different inhalers is important for maximal drug effectiveness. If more than one inhaler is used, following the sequence listed below provides the most benefit to the patient.

1. Bronchodilators / Beta-Agonists

albuterol - Ventolin[®], Proventil[®];
metaproterenol - Alupent[®];
pirbuterol - Maxair[®];
bitolterol - Tormalate[®]

- These agents work by promoting bronchodilation by relaxing bronchial smooth muscle.

2. Anticholinergic Agents

ipratropium - Atrovent[®]

- Antagonizes the action of acetylcholine with resulting bronchodilation.
- Minimal systemic activity.
- Is used for maintenance therapy only, not acute episodes.
- May be more useful than traditional bronchodilators in chronic bronchitis.

3. Miscellaneous Agents

cromolyn - Intal[®];
nedocromil - Tilade[®]

- Stabilizes mast cells and inhibits the release of histamine from these cells.
- Must be used on a regular basis, not useful on a PRN basis.
- May be used prophylactically prior to exercise.

4. Corticosteroids

triamcinolone – Azmacort[®];
flunisolide – Aerobid[®];
budesonide – Pulmicort[®]
fluticasone/salmeterol - Advair[®]

- Anti-inflammatory agents may have a variety of actions useful in management of COPD.
- Must be used on a regular basis, not PRN agents.
- Minimal systemic activity

All Inhalers Must Be Shaken Well Prior To Use !!

Bronchodilator: Proventil, Alupent, etc.

Wait one minute between “puffs” for multiple inhalations of the same drug



Wait five minutes before administering

Atrovent / Miscellaneous Agents

Wait one minute between “puffs” for multiple inhalations of the same drug



Wait five minutes before administering

Corticosteroids; Azmacort, Pulmicort, etc.

Wait one minute between “puffs” for multiple inhalations of the same drug

Rinse the mouth out following use (do not swallow the water) to help prevent oropharyngeal fungal infections. The use of a spacer device may also reduce these side effects.

Surveyor's Initials: _____

ADULT CARE LICENSURE RESIDENT RECORD REVIEW

Resident: _____

Date: _____

Facility: _____

Diagnoses: _____

Date of Birth: _____

Date of Adm: _____

Check appropriate: <input type="checkbox"/> POA <input type="checkbox"/> Guardian <input type="checkbox"/> Resp. Person			
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Date:		TB Testing	Diet Order		Health Care			
<i>ambulation:</i> <input type="checkbox"/> non-amb <input type="checkbox"/> semi-amb <input type="checkbox"/> ambulatory	<i>assistive device:</i> <input type="checkbox"/> none <input type="checkbox"/> cane <input type="checkbox"/> walker <input type="checkbox"/> w/c <input type="checkbox"/> other: _____	<i>bladder:</i> <input type="checkbox"/> continent <input type="checkbox"/> incontinent <input type="checkbox"/> int catheter <input type="checkbox"/> ext catheter	2-Step / Chest X-Ray <hr/> <i>STEP 1</i> given: _____ read as: _____ on: _____	Date: _____ Diet Order: _____	Date: _____ Orders / TX: <input type="checkbox"/> BS: <input type="checkbox"/> B/P: <input type="checkbox"/> HR: <input type="checkbox"/> WT: <input type="checkbox"/> O ₂ : <input type="checkbox"/> TED: <input type="checkbox"/> ROM: <input type="checkbox"/> DSG:	Date: _____	Referral / FU: <input type="checkbox"/> PT/OT/SLP: <input type="checkbox"/> HH: <input type="checkbox"/> POD: <input type="checkbox"/> MD: <input type="checkbox"/> LAB:	
<i>disorientation</i> <input type="checkbox"/> constant <input type="checkbox"/> intermittent <input type="checkbox"/> oriented <input type="checkbox"/> no info	<i>FL2</i>	<i>bowel:</i> <input type="checkbox"/> continent <input type="checkbox"/> incontinent <input type="checkbox"/> colostomy	<hr/> <i>STEP 2</i> given: _____ read as: _____ on: _____	supplements: <input type="checkbox"/> Y <input type="checkbox"/> N <hr/> thickener: <input type="checkbox"/> Y <input type="checkbox"/> N				

Medication Review		LHPS Review		Weight Management		Assessment & Care Plan			Mental Health
Quarterly: <input type="checkbox"/> Y <input type="checkbox"/> N Complete: <input type="checkbox"/> Y <input type="checkbox"/> N	<i>recommendations:</i> <input type="checkbox"/> none <input type="checkbox"/> yes: _____	Quarterly: <input type="checkbox"/> Y <input type="checkbox"/> N Complete: <input type="checkbox"/> Y <input type="checkbox"/> N	Date Task Ordered: _____ Tasks: _____ Phys. Assess: _____	Date: _____ Significant Δ: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> reassessment: <input type="checkbox"/> MD notified: <input type="checkbox"/> order: <input type="checkbox"/> wt. policy:	Assessment Date: _____ <input type="checkbox"/> MD signed <input type="checkbox"/> annual <input type="checkbox"/> significant Δ <input type="checkbox"/> 72-hour: (Res. Reg)	CP Date: _____	ADLs eating toileting ambulation bathing dressing grooming transfer	<input type="checkbox"/> seen by MH <input type="checkbox"/> behaviors documented <input type="checkbox"/> facility addressed:	
Date of Review: _____ Last date: _____	<i>follow-up:</i> <input type="checkbox"/> none <input type="checkbox"/> yes: _____	Date of Review: _____	<i>recommendations:</i> <input type="checkbox"/> none <input type="checkbox"/> yes: _____ <i>follow-up:</i> _____	weights: _____				<b style="background-color: #e0e0e0;">Restraints <input type="checkbox"/> Order: _____ <input type="checkbox"/> Assessment: _____ <input type="checkbox"/> Consent: _____	

Reviewer's Initials: _____

Resident's Name _____

Standing Orders: _____

FL-2 / DC Summary LOC _____ DATE _____	Medication Monitoring Form Subsequent Orders		Medication Administration Record		Medication Labeled Correctly?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					

Citation Confirmation/Documentation Tool

Purposes of the tool: Increases awareness of comprehensive data collecting/recording; draws focus and effort to suspected/known deficiencies for thorough analysis; and improves decision- making when citing deficiencies and improves strength of citation reports.

There may be or probably is a deficiency in _____ related to _____
because: ↓ *rule area*

Findings/Facts (who, what, when, where, how, outcome, sample size)	
Observations:	
O date O time O location	

Findings/Facts (who, what, when, where, how, outcome, sample size)	
Interviews:	
O date O time O who	

Findings/Facts (who, what, when, where, how, outcome, sample size)	
Record Reviews:	
O date(s) O source	

THE Good

DFS-4193
Rev 5/97

ADULT CARE MONITORING REPORT

MAY - 7 2007

County: [redacted] County Date of Visit: 04/24/2007 Time of Visit: 9:30 a.m.

I. Facility: [redacted] Rest Home License # [redacted]
Address: [redacted]

II. Purpose of visit: Monthly monitoring

III. Areas Reviewed: Medication Administration

IV. Improvements/POC Follow-Up:

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ADULT CARE
LICENSURE SECTION
DHS

MAY - 7 2006

ADULT CARE MONITORING REPORT

The home needs to ensure that a system is in place to ensure that all residents, including newly admitted residents to the facility are identified prior to the administration of any medication or treatment.

Resident [REDACTED] had an order that FSBS is to be completed two times a day at 7:00 a.m. and 4:00 p.m. This same resident also has an order stating that the resident's physician is to be called if the blood sugars fall below 60 or over 200. Record review revealed that the resident had a blood sugar of 204 on 04/09/2007. The blood sugar was re-checked at 8:30 and the blood sugar was then 196. The resident had a blood sugar reading of 203 on 04/16/2007 and of 234 on 04/19/2007. There was no documentation that the blood sugars had been re-checked or that the resident's physician had been contacted.

The prn medication, Darvocet for Resident RG had several prn documentation errors noted during the month of April 2007. The Darvocet had been documented as administered 1X on 04/01/2007, however, the prn documentation had been completed 2Xs. The Darvocet was documented as being administered as 2Xs on 04/02/2007, however, the prn documentation was completed 3Xs. Darvocet was documented as administered 4Xs on 04/08/2007, however, the prn documentation was only completed 3Xs. Darvocet was documented as given 2Xs on 04/12/1007, however, the prn documentation was only completed 1X. Darvocet was documented as administered 3Xs on 04/16/2007, however, there was no prn documentation. Darvocet was documented as administered 1X on 04/17/2007, however, there was no prn documentation. Darvocet was documented as administered 3Xs on 04/13/2007, however, the prn documentation was only completed 1X. Darvocet was documented as administered as 3Xs on 04/21/2007, however, the prn documentation was only completed 1X. Darvocet was documented as administered 3Xs on 04/22/2007, however, the prn documentation was only completed 2Xs.

Suggestion: SW noticed that Resident [REDACTED] received the prn medication, Darvocet 59 times between April 1-23, 2007. SW feels that the resident's physician needs to be made aware of the administration of the Darvocet to the resident.

Resident [REDACTED] had an order to have his blood pressure monitored weekly. SW was unable to locate this documentation. This was brought to the attention of the medication staff. This will be put into place immediately.

The medications for Resident [REDACTED] was circled as not administered on 04/08/2007, however, there was no documentation as to why. The client was on LOA from the home on 04/07/2007, therefore, SW feels certain that the resident was out with family at this time as well.

Resident [REDACTED] had an order for Dulcolax to be administered as a prn medication. The resident had prn documentation completed on 04/20/2007, however, the medication was not documented as administered.

MAY - 7 2007

ADULT CARE MONITORING REPORT

Comments:

SW entered the home with Ms. [REDACTED] to complete the monthly monitoring in the area of Medication Administration. The monitoring included record review, interview and SW observation.

SW observation revealed that the medications were stored appropriately under lock and key when medications were not being administered to the residents within the home.

SW observation revealed that the home was accountable for the controlled medications administered to the residents within the home. SW observation revealed that the controlled medications were stored under double lock and key.

SW observation, as well as, interview with staff revealed that there is no pre-pouring of medications within the home.

Pharmaceutical reviews had been completed on a quarterly basis by an appropriate health care professional. The pharmaceutical review for Resident [REDACTED] had a recommendation for the staff to clarify the Lantus, that there were no directions on the FL-2. This recommendation was made by pharmacist, [REDACTED] on 12/07/2006. This recommendation was sent to the resident's physician effective 12/08/2006 and directions for use were clarified. The pharmacy review for Resident [REDACTED] had a recommendation effective 12/07/2006 to have the frequency of the prn Dulcolax clarified. This was faxed to the physician and the Dulcolax was changed to 2 tablets daily for constipation. The pharmacy review for Resident [REDACTED] had a recommendation on 12/07/2006 to check off weight on the MAR since it was checked monthly on the FL-2. This recommendation was sent to the physician. The physician suggested that the staff continue to weigh the resident weekly due to her diagnosis of CHF.

Record review revealed no medications documented as unavailable, evidence of "borrowed medications", frequent refusals of medications, evidence of pre-charting or expired or discontinued medications.

Record review revealed that orders for medications to be administered are located in the residents' records and signed by a practitioner licensed by law to prescribe medications.

Record review revealed that 4 of 4 residents selected randomly for the SW's sample received their medications as ordered by their physicians.

VII. Facility's Comments:

VIII. Administrator/SIC Signatures:

[REDACTED SIGNATURE]

Date: 4/30/07

Adult Home Specialist Signatures

Paula Muckens

Date: 04/26/07

ADULT CARE HOME CORRECTIVE ACTION REPORT

County: [redacted] Date of Visit: January 9, 2003 Time of Visit: [redacted]
 Home: [redacted] Indicate: Adm/S.I.C. names/titles Administrator/Mr. J. H. [redacted]
 Address: [redacted] II. Purpose of Visit: Initiate a Complaint Investigation

To The Provider: The agency is preparing an Administrative Penalty Proposal for the following TYPE A VIOLATION. Included in this CAR is the directed plan that must be implemented as stated, within the specified time period to address the violations. If on follow up survey, violations are not corrected a civil penalty of up to five hundred dollars for each day that the facility remains out of compliance may also be assessed.

III a. Rule Violated and Reference	III b. Findings that confirmed violation	III c. How Adm/SIC plans to correct/prevent	III d. Date plan to be completed
10 NCAC 42C .2301 Personal Care -Responsible staff shall be on duty at all times to: (3) Assist residents, when necessary, on an individual basis with their bathing, dressing, eating, walking, going up and down steps, correspondence, shopping, and scheduling of medical and business appointments, as well as, attend to any personal needs residents may be incapable of or unable to attend for themselves.	Resident #1 was admitted to [redacted] Family Care Home on 06/13/1993. The current FL-2 dated 06/18/2002 diagnosed the resident with mental retardation and esophageal reflux disease. Resident #1 was admitted to [redacted] ER on January 8, 2003 for severe burns to her left lower leg. The resident was then transferred to the [redacted] Healthcare [redacted] Burn Center for the continued treatment of deep thickness burns to the anterior aspect of her left lower extremity, as well as, the dorsum of her left foot posteriorly with partial thickness burns. The resident also had a small first-degree burn to the medical aspect of her right lower extremity. The total body surface burn was approximately 9%. Staff and resident interviews revealed that these injuries were sustained while Resident #1 was left unattended near an area of hot smoldering ash. Resident #2 instructed Resident #3 to get water from the nearby flower bed where a bucket of water was kept for the watering of the household cats. Once the water was received, the resident was doused with the water by Resident #2 and the flames were extinguished. Resident #2 then instructed Resident #3 to go get the Administrator from inside the home. The Administrator and the PCA then came to the scene of the accident. Resident #1 was then transferred by facility vehicle to the nearest medical facility.	The facility shall develop a system/systems of supervision that shall be provided, at all times, for residents unable to make appropriate choices. <i>Our facility staff will provide supervision that is appropriate for [redacted] developmental capabilities</i> <i>Our facility staff will supervise [redacted] at all times when outside the facility</i> <i>Our facility staff will no longer be in leave on our property, we will call them</i>	March 18, 2003
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	Refer back to III b. Findings that confirmed violation under 10 NCAC 42C .2301 Personal Care	Refer back to III c. How the Adm/SIC plans to correct/prevent under 10 NCAC 42C .2301 Personal Care	March 18, 2003

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 DEPT. OF SOCIAL SERVICES

state laws and rules and regulations.

IV. Comments:

Return to me by March 17, 2003

IV. Signatures: [Redacted] Adm/SIC 3/5/03 Date 3/5/03 Other Authorized Representative Paul L. Muckens Date 03-03-03

V. Agency's Review: Disapproved By: _____ Date: _____

Comments: _____

VI. Agency's Review: Approved By: _____ Date: _____

Comments: _____

AHS Mailed to DFS: _____ Date _____ Facility in compliance: _____ Failed Corrective Action: _____

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BEAUFORT COUNTY
DEPT. OF SOCIAL SERVICES

ADULT CARE HOME CORRECTIVE ACTION REPORT

County: Cricket Date of Visit: March 25, 2006 Time of Visit: 8:30 AM

1. Home: Acme Assisted Living Indicate: Adm/S.I.C. names/titles Jane Smith, Administrator
 Address: 111 Roadrunner Lane, Somewhere, NC 22220 II. Purpose of Visit: Complaint Investigation

To The Provider: In column III c, please address *each of the rules* which were violated & cited in column III a (not just the findings in column III b). The plan of correction must also include a *system* to prevent recurrence of these rule violations. In column III d, indicate a specific completion date. Please respond with a plan of correction by (give a specific date)

III a. Rule Violated and Reference	III b. Findings that confirmed violation	III c. How Adm/SIC plans to correct/prevent	III d. Date plan to be completed
<p>10A NCAC 13F .0306 (a) Facilities shall: (6) have an adequate supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets and additional coverings on hand at all times.</p> <p style="text-align: center;">Regulatory Reference </p> <p>Based on observations and interviews with staff and residents, the facility failed to have an adequate supply of bath soap, clean towels, washcloths, sheets, and pillow cases on hand at all times in four of the four common bathrooms sampled (men's and women's bathrooms on Hall B, common bathrooms on Hall A and near the Activity room), five of the ten resident rooms sampled (A-17 & 20, B-4, 22 & 34).</p> <p style="text-align: center;">Scope </p> <p style="text-align: center;">Summary statement </p>	<p>A. Per observation on 10/18/05, during the facility tour at 8:40 AM and again at 1:50 PM, it was noted that four of the four common bathrooms (men and women's bathrooms on Hall B, common bathrooms on Hall A and near the Activity room) and five of the ten resident rooms sampled (A-17 & 20, B-4, 22 & 34) did not have soap, towels, paper towels or washcloths. Per interview of the Administrator on 10/18/05 at 2:30 PM, she stated that the residents "didn't come into the larger bathrooms unless aides brought them in" and also stated that she "guesses if someone does decide to use them, they should have towels and soap available." It should be noted that random residents were observed going in and out of the bathrooms throughout the monitoring visit. Per interview of housekeeping (Staff #32) on 10/18/05 at 9:10 AM, she thought the residents had their own personal soap.</p> <p>B. Five of five residents interviewed on 10/18/05 stated that they did not have clean linens when needed. Four of the five residents stated that they often bought their own hand soap to ensure they had some. One resident interviewed at 10:10 AM on 10/18/05 stated, "I usually take toilet paper and dry my hands."</p> <p>C. Per AHS count of the linen closet on 10/18/05 at 9:AM, there were 5 fitted sheets available, no flat sheets, no pillow cases, no towels, and 40 washcloths. Per interview of a staff member on 10/18/05 at 9:10 AM, there were no other clean linens, but there was washing to be done. The facility census was 63 on the days of survey.</p>	<p style="text-align: center;">Findings </p> <p style="text-align: center;">Identifier </p>	

IV. Comments:

Return to me by :

IV. Signatures: _____
 Adm/SIC _____ Date _____ Other Authorized Representative _____ Date _____ DSS Agency Representative _____ Date _____

V. Agency's Review: Disapproved By: _____ Date: _____

Comments: _____

III. Rule Violated and Reference	Findings that confirmed violation	How Adm/SIC plans to correct/prevent	Date plan to be completed
----------------------------------	-----------------------------------	--------------------------------------	---------------------------

VI. Agency's Review: Approved By: _____ Date: _____

Comments: _____

AHS Mailed to DFS: _____ *Facility in compliance:* _____ *Failed Corrective Action:* _____

OPTIONAL

This checklist has been developed as a tool to evaluate and monitor areas pertaining to the Health Care rule regarding Special Care Units for Alzheimer and Related Disorders in Adult Care and Family Care Homes. Licensure regulations for adult and family care homes have been referenced for the items that are specifically rule based.

SECTION .1300 SPECIAL CARE UNITS FOR ALZHEIMER AND RELATED DISORDERS

13F.1304 Special Care Units Building Requirements	Yes	No	Comments
1. Plans for new or renovated construction or conversion of existing building areas have been submitted to the Construction Section of DHSR for review and approval? <ul style="list-style-type: none"> • <i>Were plans submitted and approved prior to construction beginning?</i> • <i>Were residents in existing facilities given appropriate notice of room change or relocation during renovation/construction?</i> 			
2. Is the SCU separated from rest of facility by closed doors? (2)			
3. Are exit doors locked with special locking devices? (3) (See attachment * 1003.3.1.8.5 regarding locking devices) If additional information needed regarding the locking devices, call The Construction Section @ 919-855-3923.			
4. If no, is there a system of security monitoring? (4) <ul style="list-style-type: none"> • <i>What system does the facility have in place to monitor the unlocked doors?</i> • <i>Does the facility provide 24/7 visual supervision?</i> 			
5. Do other residents, staff, visitors have to routinely pass through the SCU to reach other areas of the building? (5)			
6. Is there a staff work area? (6)			

OPTIONAL

<p>7. Is there a nourishment station for preparation and provision of snacks? (6)</p> <p style="padding-left: 40px;"><i>•Are food and drinks for snacks available for independent residents and provided for all dependent residents?</i></p>			
<p>8. Is there lockable space for medication storage? (6)</p>			
<p>9. Is there storage space for residents' records? (6)</p>			
<p>10. Is living and dining space provided within the unit? (7) (30 sq. ft. per resident)</p>			
<p>11. Is there direct access from the unit to a secured outside area? (8)</p>			
<p>12. Is there a toilet/lavatory within the unit for every 5 residents? (9)</p>			
<p>13. Is there a tub and shower within the unit? (10)</p>			
<p>14. Is there minimization of potentially distracting, mechanical noises (eg., loud ice machines, window air conditioners, intercoms and alarm systems)? (11)</p> <p style="padding-left: 40px;"><i>•Does the SCU environment promote a calming, relaxed atmosphere, or does it provide excessive stimulation?</i></p>			

OPTIONAL

13F.1305 Policies and Procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments
<i>Do the policies and procedures address:</i>			
<p>1. In the facility’s philosophy, a mission statement and objectives regarding the special population to be served that includes</p> <p>-safe, secure , familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications ?(1)(a)</p> <p>-a structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each residents’ abilities? (1)(b)</p> <ul style="list-style-type: none"> •<i>Does the facility’s activity program involve community services, group and individual (one on one) activities?</i> <p>-individualized care plans that stress the maintenance of residents’ abilities and promote the highest possible level of physical and mental functioning? (1)(c)</p> <ul style="list-style-type: none"> •<i>Does the facility obtain personal information about each resident’s interests and capabilities, and then develop an individualized plan of care and activities based upon this information?</i> <p>-methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance? (1)(d)</p> <ul style="list-style-type: none"> •<i>Does the facility have appropriate space for a variety of activities, including indoor and outdoor activities?</i> 	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

OPTIONAL

2. The process and criteria for admission to and discharge from the unit? (2)			
3. A description of the special care services offered in the unit? (3)			
4. Resident assessment and care planning, including opportunity for family involvement? Implementation of the care plan, including responding to changes in the resident's condition? (4)			
5. Safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior? (5)			
6. Staffing in the unit? (6)			
7. Staff training based on special care needs of the residents? (7)			
8. Physical environment and design features that address the needs of the residents? (8)			
9. Activity plans based on personal preferences and needs of the residents? (9)			
10. Opportunity for involvement of families in resident care and the availability of family support programs? (10)			
11. Additional costs and fees for the special care provided? (11)			

OPTIONAL

13F.1306			
Admission to the Special Care Unit	Yes	No	Comments
1. Does a physician specify a diagnosis on the FL-2 that meets the conditions of the specific group of residents to be served? (1)			
2. Is there a documented pre-admission screening by the facility to evaluate the appropriateness of the individual's placement in the special care unit? (2)			
3. Are family members seeking admission of a resident to the special care unit provided disclosure information required by G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter ?	_____	_____	
Is this disclosure documented in the resident's record? (3)	_____	_____	
13F.1307			
Special Care Unit Resident Profile and Care Plan	Yes	No	Comments
1. Did the facility develop a written profile within 30 days of admission? (1)			
2. Does the facility review and update the profile quarterly ? (1)			
3. Does the profile contain assessment data that describes the resident's: -behavioral patterns? (1) -self-help abilities? (1) -level of daily living skills? (1) -special management needs? (1) -physical abilities and disabilities? (1) -degree of cognitive impairment? (1)			

OPTIONAL

4. Does the facility develop and revise the resident's care plan (13F.0802) based on the resident profile? (2)			
5. Does the care plan specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities? (2)			
13F.1308 Special Care Unit Staffing	Yes	No	Comments
1. Is staff present in the unit at all times in sufficient number to meet the needs of the residents? (a) (NOTE: At no time shall there be less than one staff person who meets the orientation and training requirements in Rule .1309 of this section, for up to eight residents on 1 ST and 2 ND shifts and one hour of staff time for each additional resident; and one staff person for up to 10 residents on 3 RD shift and .8 hours of staff time for each additional resident.)			
2. Is there a care coordinator on duty in the unit at least 8 hours a day, five days a week? (b) (NOTE: The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.)			
3. In units of 16 or more residents and any units that are freestanding facilities, is there a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule? (c)			

OPTIONAL

13F.1309 Special Care Unit Staff Orientation and Training	Yes	No	Comments
1. Prior to establishing a SCU, does the administrator document receipt of at least 20 hours of training specific to the population to be served for each SCU to be operated? (1)			
2. Does the administrator have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement? (1)			
3. Has each employee assigned to perform duties in the SCU completed 6 hours of orientation on the nature and needs of the residents within the first week of employment? (2)			
4. Has staff responsible for personal care and supervision within the unit completed 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule, within 6 months of employment? (3)			
5. Has staff responsible for personal care and supervision within the unit completed at least 12 hours of continuing education annually, with 6 hours being dementia specific? (4)			

13F.1310 Other Applicable Rule for Special Care Units

In addition to specific rules pertaining to special care units for residents in this Section, such units shall also meet all other applicable requirements governing the operation of adult care homes as set forth in this Subchapter.

OPTIONAL

This check list has been developed as a quality assurance tool to evaluate and monitor rules in Adult Care and Family Care Homes when Residents are demonstrating behavior issues. Licensure regulations for adult and family care homes have been referenced for the items that are rule based specific to behavior issues. All other licensure rules also apply, but this can be a ready reference for specific rules related to behavior issues. *Items on the checklist that are recommendations that may prevent problems from developing do not have a licensure regulation referenced.*

10A NCAC 13F/G Behavior Specific Rules

10 A NCAC 13 F/G .00305(h)(4) Physical Environment	Yes	No	Comments
In a home that has at least one resident who has been determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents is equipped with a sounding device that is activated when the door is opened?	_____	_____	
Is the sound at a sufficient volume to be heard by staff?	_____	_____	
If a central system of remote sounding devices is provided, is the control panel for the system located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel?	_____	_____	
10 A NCAC 13 F/G .0703(e) Tuberculosis Test, Medical Examination and Immunizations	Yes	No	Comments
(e)The facility has made arrangements for any resident, who has been an inpatient of a psychiatric facility within 12 months before entering the home and who does not have a current plan for psychiatric care, to be examined by a local physician or a physician in a mental health center within 30 days after admission and to have a plan for psychiatric follow-up care when indicated?	_____	_____	

OPTIONAL

10 A NCAC 13 F/G .0801 (C)(1)(D) Resident Assessment	Yes	No	Comments
<p>An assessment of a resident has been completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule</p> <p>(D) Significant change can include: deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic.</p> <p>(K) And, new onset of impaired decision-making.</p> <ul style="list-style-type: none"> • <i>What is the date the resident was admitted to the facility?</i> • <i>Does the facility have a copy of the discharge summary from a previous psychiatric facility?</i> • <i>Does the facility have copies of progress notes from a physician, psychiatrist, MH provider that address the resident's progress/lack of progress toward behavior goals?</i> 			
<p>Assessment Tool: Care Plan Form DMA 3050-R</p> <p>Has the facility utilized the DMA 3050-R to assess a resident's mood and behavior? Have they identified mood and behavior indicators such as:</p> <ul style="list-style-type: none"> • Constant pacing and restlessness • Increased confusion, disorientation • Refusing medications • Refusing meals • Refusing bathing, neglecting grooming, deterioration in personal hygiene • Increased anger, frustration • Increased loudness or tone of voice • Destructive behavior, throwing objects 			

OPTIONAL

<ul style="list-style-type: none"> • Verbal or physical threats toward staff or other residents • Sexually inappropriate behaviors • Delusions, hallucinations • Self-injurious behaviors • Talk or attempts of suicide • Sleep pattern disturbance • Changes in mood, indicated by increased crying, withdraw from normal activities, loss of appetite, flat/sad affect, making negative statements, increase in anxious complaints or concerns, etc. 			
---	--	--	--

10 NCAC 13F/G .0802 (a)(b)(f) Resident Care Plan	Yes	No	Comments
<p>A care plan has been developed for each resident in conjunction with the resident assessment to be completed <u>within 30 days</u> following admission according to Rule .0801 of this Section The care plan is an individualized, written program of personal care for each resident?(a)</p> <ul style="list-style-type: none"> • <i>Keyword: “Individualized” Is the care plan truly a reflection of the resident, including their psychosocial well-being state, cognitive status, physical functioning/ADL’s, mood and behavior?</i> • <i>Did the facility use the DMA 3050-R or a comparable facility form containing a minimum of the same information?</i> 			
<p>The care plan has been revised as needed based on further assessments of the resident according to Rule .0801 of this Section. (b)</p> <p>The facility has also assured that an assessment of a resident who has experienced a significant change is completed within 10 days following the significant change. (c)</p>			

OPTIONAL

<p>The care plan for each resident who is under the care of a provider of mental health, developmental disabilities or substance abuse services includes resident specific instructions regarding how to contact that provider, including an emergency contact when significant behavioral changes described in Rule .0801(c)(1)(D) of this Subchapter are identified, the facility has referred the resident to a provider of mental health, developmental disabilities or substance abuse services in accordance with Rule .0801(d) of this Subchapter? (f)</p> <ul style="list-style-type: none"> • <i>Where is the number listed to contact the resident’s MH service provider? In the chart? At the nurses station?</i> • <i>Is there a MH provider contact number for after-hours? A crisis hotline?</i> • <i>Have the staff been informed of how to find these numbers? Are the numbers accessible to the staff?</i> • <i>Has the staff been trained in the case of an emergency (resident-to-resident altercation, violent behavior, etc.) on how to protect the other residents until the situation is resolved?</i> 			
<p>10 NCAC 13F/G .0902 (b) Health Care</p>	Yes	No	Comments
<p>The facility has assured referral and follow-up to meet the routine and acute health care needs of the resident?</p> <ul style="list-style-type: none"> • <i>What is the facility’s system for monitoring and tracking appointments?</i> • <i>How does the facility reschedule cancelled/postponed appointments and document these schedule changes?</i> • <i>What is the facility’s system for implementing the new orders, if any, after the appointment?</i> 			

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL**

FACILITY INFORMATION

Facility Name: _____
Site Address: _____
County: _____
License Number: _____ FID Number: _____
Licensed Bed Capacity: _____ Census (At Time Of Violation): _____

LICENSEE INFORMATION

Licensee: _____
Executive Officer: _____ Title: _____
Licensee Address: _____

PENALTY INFORMATION

Proposal Submitted By: DSS DHSR
VIOLATION: (mark appropriate) Type A Unabated A Unabated B
Rule: _____ Correction Date: _____
Regulatory Area: _____
Rule: _____ Correction Date: _____
Regulatory Area: _____ Correction Date: _____
Statute(s): _____
Statutory Area: _____
Description Of Events: CAR attached SOD attached
Report Dated: (end date) _____

SCOPE

Residents Affected by Violation(s): _____
Potential Number of Residents Affected, Including Sample: _____
Staff Affected by Violation(s): _____ of _____

SEVERITY

Outcome to Affected Resident(s): _____

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL**

ATTACHMENTS

Attachment(s)

CAR / SOD With CITED VIOLATION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> n/a
Copy of NOTIFICATION to Licensee	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> n/a
Copy of Licensee's Receipt of Notification	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> n/a
Copy of Information Submitted by Facility	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> n/a
AFFECTED Residents' FL-2s	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> n/a
Specific Information Supporting Violation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> n/a
Other Documentation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> n/a

Submitted by: _____

_____ Date

Contact Information Obtained for Affected Resident(s): **YES** **NO** **n/a**



**North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section**

2708 Mail Service Center • Raleigh, North Carolina 27699-2708
<http://www.ncdhhs.gov/dhsr/>

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Barbara Ryan, Chief
Phone: 919-855-3765
Fax: 919-733-9379

CONTACT INFORMATION

Affected Resident Name:	CAR/SOD Resident Identifier Number:
Address:	
Date of Birth:	
Facility Name:	
Resident has POA/legal guardian (If applies, circle and complete next section)	

POWER OF ATTORNEY OR LEGAL GUARDIAN

Name:		
Street Address:		
City:	State:	Zip:
Phone #:		

Information is to be disclosed as required by Senate Bill 56 for **Type A Violations or Uncorrected Type A or B Violations**. The requirements include direct notification of the scheduled penalty review committee (PRC) meeting to **affected residents** and the **power of attorney or guardian of affected residents** of the penalties being considered by the PRC.

Date: _____ **Surveyor Signature:** _____



PLAN OF CORRECTION

Basic Training 2008

- The Facility's plan of correction should identify how the deficiency/violation has/will be corrected and how compliance will be maintained.
 1. Must address the rule(s) cited
 2. State the action already taken or action which will be taken to ensure correction and maintain compliance.
 3. Address methods that will be used to monitor and evaluate the corrective action (who, what, when)
 4. Give a date for facility to be in compliance if a violation cited, facility will give a date of compliance for deficiencies cited.

- The plan of correction should:
 1. Be legible
 2. Avoid vague words or terms
 3. Avoid excuses
 4. Correction plans and end results should be measurable
 5. Address the overall problem or rule violation(s) and not just the specific examples on the Corrective Action Report(CAR)/Statement of Deficiencies(SOD)
 6. Include the action already taken and/or action which will be taken to ensure correction and maintain compliance, i.e., monitoring, in services, staff validations etc.
 7. Include who (title of person) i.e., Administrator, SIC, Director of Resident Services, will be responsible for monitoring, what will be monitored, and how often the area will be monitored.
 8. Include any resources to be utilized, i.e., nurse, pharmacist, dietitian, ombudsman, etc.
 9. Have a realistic time frame for correction
 10. Alternative plans and possible sources of delay, if applicable, should be discussed with the facility upon reviewing the facility's' plan of correction.
 11. Failure to receive a POC or an acceptable POC does not delay your follow up to the facility.