

POD Exercises

ACLS Basic Training

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

CORRECT

- Three of 5 residents received regular foods rather than the no concentrated sweets diet as ordered.
- The three residents did not receive their therapeutic diets as required in **10A NCAC 13F/G .0904 (e)(4)**

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

CORRECT

- This is not a failure to comply with the licensing rules and is NOT a deficiency.
- Although monitoring of residents for a significant change in weight is a rule based issue. **10A NCAC 13F/G .0801(c)(1)(4)** A citation for significant change would be based on resident outcomes.

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

CORRECT

– This does not represent a failure to comply with rule and is NOT a deficiency.

10A NCAC 13F/G .0906 (A)

states that “the administrator must assure provision of transportation”

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).

correct or incorrect

- Scope is 3 of 5
- Severity may or may not be present.
- scope + severity concern



Deficiency

Deficiency

ADULT CARE MONITORING REPORT

Purpose of Visit:

- Monitoring**
 Complaint Investigation
 Complaint Investigation Summary (*see Attachment B*)
 Deliver CAR
 Follow Up to CAR issued on: _____
 Technical Assistance
 Deliver Correspondence
 Death Investigation
 Other: _____

Date Onsite: _____ **Time:** _____ **Previous Onsite Date:** _____

County:	Facility:	License #:
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Address:

Administrator/Designee:

Section A:	Current Census:	Sample Size:	<input type="checkbox"/> Unannounced Visit
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Section B: *Complete this section during onsite visit*

Rule Number:	<input type="checkbox"/> Observations <input type="checkbox"/> Interviews <input type="checkbox"/> Record Reviews
Description:	<input type="checkbox"/> No Deficiency <input type="checkbox"/> Deficiency <input type="checkbox"/> CAR to be Issued <input type="checkbox"/> Plan _____
Rule Number:	<input type="checkbox"/> Observations <input type="checkbox"/> Interviews <input type="checkbox"/> Record Reviews
Description:	<input type="checkbox"/> No Deficiency <input type="checkbox"/> Deficiency <input type="checkbox"/> CAR to be Issued <input type="checkbox"/> Plan _____
Rule Number:	<input type="checkbox"/> Observations <input type="checkbox"/> Interviews <input type="checkbox"/> Record Reviews
Description:	<input type="checkbox"/> No Deficiency <input type="checkbox"/> Deficiency <input type="checkbox"/> CAR to be Issued <input type="checkbox"/> Plan _____

Section C: *Brief Description of Visit/Discussion With Staff in Charge*

Section D: *Signatures*

ADULT CARE MONITORING REPORT

Administrator/Designee:	Date:
Adult Home Specialist:	Date:

County:		Facility:		License #:	
Address:					
Administrator/Designee:					
Section A:		<i>Complete this section upon initiating and when completing a Complaint Investigation</i>			
Date(s) onsite: _____					
Date Received: _____		Date Initiated: _____		Date Completed: _____	
Complaint #: _____		Rule(s)/Description:			
Section B:		<i>Upon Completion of a Complaint Investigation</i>			
Rule Number:		<input type="checkbox"/> Observations	<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews	
Description:		<input type="checkbox"/> Unsubstantiated	<input type="checkbox"/> Substantiated	<input type="checkbox"/> CAR to be Issued	
Rule Number:		<input type="checkbox"/> Observations	<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews	
Description:		<input type="checkbox"/> Unsubstantiated	<input type="checkbox"/> Substantiated	<input type="checkbox"/> CAR to be Issued	
Rule Number:		<input type="checkbox"/> Observations	<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews	
Description:		<input type="checkbox"/> Unsubstantiated	<input type="checkbox"/> Substantiated	<input type="checkbox"/> CAR to be Issued	
Section C:		<i>Complete this section when any Report of Abuse, Neglect or Exploitation of a Resident(s) has been made</i>			
Rule Number: 10A NCAC 13F .1205/G.1206		<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews		
Description: Investigation and Reporting Health Care Personnel		<input type="checkbox"/> No Deficiency	<input type="checkbox"/> Deficiency	<input type="checkbox"/> CAR to be Issued	
Section D:		<i>Complete with initial monitoring of facility, when new hire(s), and as appropriate</i>			
Rule Number: 13F .0407 (a)(5)/G.0406(a)(5)		<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews		
Description: Facility compliance with Health Care Personnel Registry for negative findings (G.S. 131E-256)		<input type="checkbox"/> No Deficiency	<input type="checkbox"/> Deficiency	<input type="checkbox"/> CAR to be Issued	
Rule Number: 13F.0407 (a)(7)/G.0406(a)(7)		<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews		
Description: Facility compliance with criminal history background checks (G.S. 114-19.3)		<input type="checkbox"/> No Deficiency	<input type="checkbox"/> Deficiency	<input type="checkbox"/> CAR to be Issued	
Rule Number(s):		<input type="checkbox"/> Observations	<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews	
Description: Rules in Sections .0400 Staff Qualifications & Section .0500 Staff Orientation, Training, and Competency		<input type="checkbox"/> No Deficiency	<input type="checkbox"/> Deficiency	<input type="checkbox"/> CAR to be Issued	
Adult Home Specialist:					Date:

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 provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c)**, indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to \$400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or Type A2 violation**, this agency may prepare an Administrative Penalty Proposal for the 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 \$1000.00 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:

- *Rule/Statute violated (rule/statute number cited)*
- *Rule/Statutory Reference (text of the rule/statute cited)*
- *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)*
- *Findings of non-compliance*

III (b). Facility plans to correct/prevent:

(Each Corrective Action should be cross-referenced to the appropriate citation/violation)

III (c). Date plan to be completed

Rule/Statute Number:

Rule/Statutory Reference:

Level of Non-Compliance:

Findings:

POC Accepted

DSS Initials

IV. Delivered Via:

Date:

DSS Signature:

Return to DSS By:

V. CAR Received by:

Administrator/Designee (print name):

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)

POC Not Accepted

By:

Date:

Comments:

POC Accepted

By:

Date:

Comments:

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	Name: _____ Address: _____ _____
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FL-2 Date: _____			TB Testing		Diet Order		Health Care			
ambulation: <input type="checkbox"/> non-amb <input type="checkbox"/> semi-amb <input type="checkbox"/> ambulatory	assistive device: <input type="checkbox"/> none <input type="checkbox"/> cane <input type="checkbox"/> walker <input type="checkbox"/> w/c <input type="checkbox"/> other: _____ _____	bladder: <input type="checkbox"/> continent <input type="checkbox"/> incontinent <input type="checkbox"/> int catheter <input type="checkbox"/> ext catheter bowel: <input type="checkbox"/> continent <input type="checkbox"/> incontinent <input type="checkbox"/> colostomy	2-Step / Chest X-Ray <hr/> STEP 1 given: _____ read as: _____ on: _____	Date: _____ Diet Order: _____ supplements: <input type="checkbox"/> Y <input type="checkbox"/> N thickener: <input type="checkbox"/> Y <input type="checkbox"/> N	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:				

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	recommendations: <input type="checkbox"/> none <input type="checkbox"/> yes: _____ _____ follow-up: <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: _____ weights: _____ _____ _____	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: Restraints <input type="checkbox"/> Order: _____ <input type="checkbox"/> Assessment: _____ <input type="checkbox"/> Consent: _____	

Reviewer's Initials: _____

Resident's Name _____

Medication Monitoring Form

Standing Orders: _____

FL-2 / DC Summary LOC _____ DATE _____		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.						

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? <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) <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> <ul style="list-style-type: none"> • <i>Are food and drinks for snacks available for independent residents and provided for all dependent residents?</i> 			
<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> <ul style="list-style-type: none"> • <i>Does the SCU environment promote a calming, relaxed atmosphere, or does it provide excessive stimulation?</i> 			

OPTIONAL

13F.1305 Policies and Procedures	Yes	No	Comments
<i>Do the policies and procedures address:</i>			
1. In the facility's philosophy, a mission statement and objectives regarding the special population to be served that includes			
-safe, secure , familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications ?(1)(a)	_____	_____	
-a structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each residents' abilities? (1)(b)	_____	_____	
<ul style="list-style-type: none"> •<i>Does the facility's activity program involve community services, group and individual (one on one) activities?</i> 			
-individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning? (1)(c)	_____	_____	
<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> 			
-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)	_____	_____	
<ul style="list-style-type: none"> •<i>Does the facility have appropriate space for a variety of activities, including indoor and outdoor activities?</i> 			

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. 			
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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> 			

PLAN OF CORRECTION

Basic Training

- 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.



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

Pat McCrory
 Governor

Richard O. Brajer
 Secretary

CONTACT INFORMATION

Affected Resident Name:	CAR/SOD Resident Identifier Number:
Address:	
Date of Birth:	
Facility Name:	
Resident has a Legal Representative?	
<input type="checkbox"/> No <input type="checkbox"/> Yes (check one and complete next section): <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Legal guardian	

POWER OF ATTORNEY OR LEGAL GUARDIAN CONTACT INFORMATION

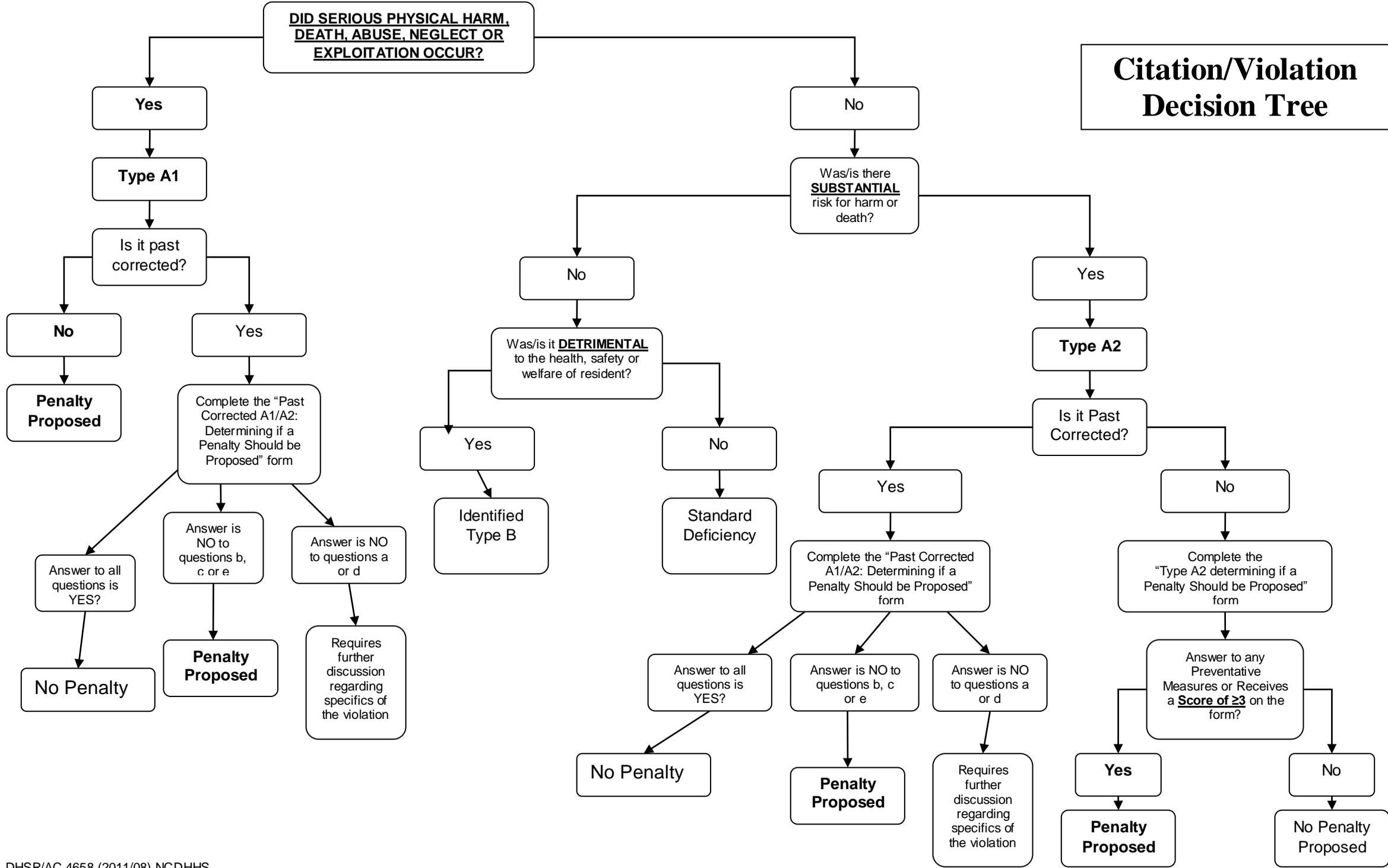
Name:		
Street Address:		
City:	State:	Zip:
Phone #:		

Information is to be disclosed as required by NC GS 131D-34 for **Type A1 and Type A2 Violations and Unabated Type A1, Type A2 and Type B Violations**. The requirements include direct notification of the scheduled penalty review committee (PRC) meeting to **affected residents** and their **powers of attorney or guardians** regarding the penalties to be considered by the PRC.

Date: _____ Surveyor Signature: _____



Citation/Violation Decision Tree



**NC Division of Health Service Regulation ---Adult Care Licensure Section
Plan of Protection**

To be completed by DHSR/DSS Staff

Facility Name: _____ License #: _____

Rule Violation Cited: _____

(Complete separate form for each Rule Violation)

PLAN OF PROTECTION

(To be completed by facility staff. Attach additional pages if needed)

What immediate action will the facility take to abate the violations?

Describe your plans to ensure residents are protected from further risk or additional harm?

Regarding A1 or A2 Violations - if you believe this to be a Past Corrected Violation, please answer the questions below.

Describe the preventative measures in place prior to the violation.

Describe how and when the violation was corrected.

Describe the corrective measures the facility implemented to achieve and maintain compliance.

Describe the facility's system to ensure compliance is maintained and how the system will continue to be implemented.

For Unabated Violations (Type A1, Type A2 and Unabated Type B) only:

Please provide a date by which the facility will be in compliance with the rule area cited (*required*). Date: _____

Facility staff completing this form:

Name/Title
DHSR/AC 4659 NCDHHS (2011/08)

Date

DHSR/DSS staff
Keep copy for facility file

Date

Adult Care Licensure Section
Past Corrected A1/A2: Determining if a Penalty Should be Proposed

Facility Name:

License #:

Survey Exit Date:

Rule Violation/Tag Number:

Efforts to Correct and Maintain Compliance

a. Provider had preventative measures in place <i>prior</i> to the violation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Justification:</i>	

b. Provider abated violation immediately.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Justification:</i>	

c. Provider implemented corrective measures that achieved and maintained compliance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Justification:</i>	

d. Provider continues to maintain and implement the system to ensure compliance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Justification:</i>	

e. The regulatory area remains in compliance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Justification:</i>	

If answer to all questions is yes then no penalty is proposed
If answer to question b, c, or e is no, then a penalty is proposed.

DHSR/DSS Staff completing this form:

Name: _____ Date: _____ Signature: _____

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Type A1 and Type A2 Violations**

FACILITY INFORMATION

Facility Name: _____
 Site Address: _____

 County: _____ License #: _____ FID #: _____ Facility Type: HA FCH
 Licensed Bed Capacity: _____ Census (at time of violation): _____
 Administrator: _____ Email Address: _____

LICENSEE INFORMATION

Licensee: _____ Email Address: _____
 Name of Officer: _____
 Correspondence Mailing Address: _____

PENALTY INFORMATION

Proposal Submitted by: DSS DHSR
 VIOLATION: Type A1 Type A2
 Rule: _____
 Regulatory Area: _____ Correction Date: _____
 Rule: _____
 Regulatory Area: _____ Correction Date: _____
 Statute(s): _____
 Statutory Area: _____ Correction Date: _____
 Description of Events: CAR Attached SOD Attached Supporting documents attached Exit Date: _____

SEVERITY *Select only one*

Outcome to Affected Resident(s)	
<input type="checkbox"/>	Substantial risk that serious harm, abuse, neglect, or exploitation will occur
<input type="checkbox"/>	Serious physical harm, abuse, neglect, or exploitation, without substantial risk for resident death, did occur
<input type="checkbox"/>	Serious physical harm, abuse, neglect, or exploitation, with substantial risk for resident death, did occur
<input type="checkbox"/>	Resident died
<input type="checkbox"/>	Resident died & there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation
<input type="checkbox"/>	Resident died, there is substantial risk further resident death

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Type A1 and Type A2 Violations**

COMPLIANCE STATUS

G.S. 131E-256 (d2) (HCPR Verification)	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G.S. 131E-256 (g) (HCPR Investigation of Allegations)	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NA
G.S. 131D-40 Criminal Record Check	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G.S. 131D-34.1 (a) Death Report to DHHS within 3 days of death of any resident resulting from violence, accident, suicide, or homicide	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NA
G.S. 131D-34.1 (a) Death Report to DHHS immediately when physical restraint or physical hold was used within seven days of resident death	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NA

FACILITY'S EFFORT TO CORRECT *Select only one*

<input type="checkbox"/>	Prior to the initiation of the survey, the facility identified and implemented corrective actions to correct the violation but the corrective action will not result in correcting the violation(s).
<input type="checkbox"/>	Prior to the initiation of the survey, the facility identified and implemented corrective actions to correct the violation but the corrective action did not result in correcting the violation(s) and/or furthered noncompliance and serious outcomes occurred.
<input type="checkbox"/>	Prior to the initiation of the survey, the facility had identified the specific violations but had not responded with corrective actions.
<input type="checkbox"/>	The facility was unaware or denies the existence of a violation(s). The survey team identified the violation(s).

COMPLIANCE HISTORY FOR THE PAST 36 MONTHS

Date	Rule Number Violation	Brief Rule Area Description	Select Appropriate Violation(s)			
	Rule	Rule Area	Type B	Unabated B	Type A	Unabated A

NUMBER OF RESIDENTS PUT AT RISK *Select Only One*

One More than one All

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Type A1 and Type A2 Violations**

INTERVENTION TIMELINE

Date(s) of Survey/Investigation	
Specified Time for Correction	
Dates(s) Follow-up/Revisit for Violation(s)	
Date Licensee Received Violation & Written Intent of Penalty Proposal	
Date Facility Received Violation & Written Intent of Penalty Proposal	
Date of Receipt of Additional Information	
Date of Penalty Proposal to Licensee	
Date of Penalty Conference/Additional Information Submitted	
Date Violation Abated	
Date Proposal Submitted to DHSR	

ATTACHMENTS

	Attachment(s)	Yes	No	NA
CAR/SOD With Signed Plan of Correction				
Copy of Notifications to Licensee				
Copy of Licensee's Receipts of Notifications				
Copy of Information Submitted by Facility (not POC)				
Affected Resident(s) FL-2s				
Specific Information Supporting Violations				
Other Documentation				

Completed by: _____
DHSR/DSS Staff Signature
Date

Submitted by: _____
DHSR/DSS Staff Signature
Date

Recommended Penalty Amount \$ _____

Branch Manager Signature
Date

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION - Unabated Violation**

FACILITY INFORMATION

Facility Name: _____

Site Address: _____

County: _____ License#: _____ FID#: _____ Facility Type: HA FCH

Licensed Bed Capacity: _____ Census (at time of violation): _____

Administrator: _____ Email Address: _____

LICENSEE INFORMATION

Licensee: _____ Email Address: _____

Name of Officer: _____

Corresponding Mailing Address: _____

PENALTY INFORMATION

Proposal Submitted by: DSS DHSR

VIOLATION: Unabated A1 Unabated A2 Unabated B

Rule: _____

Regulatory Area: _____ Correction Date: _____

Rule: _____

Regulatory Area: _____ Correction Date: _____

Statute(s): _____

Statutory Area: _____ Correction Date: _____

Description of Events: CAR Attached SOD Attached Supporting documents attached Exit Date: _____

Date Violation was Corrected: _____

Number of days Violation continued beyond date specified for correction: _____

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Unabated Violation**

INTERVENTION TIMELINE

Date(s) of Survey/Investigation	
Date(s) of Original Citation	
Specified Time for Correction	
Dates(s) Follow-up/Revisit for Violation(s)	
Date Licensee Received Violation & Written Intent of Penalty Proposal	
Date Facility Received Violation & Written Intent of Penalty Proposal	
Date of Receipt of Additional Information	
Date of Penalty Proposal to Licensee	
Date Violation Abated	
Date Proposal Submitted to DHSR	

ATTACHMENTS

	Attachment(s)	Yes	No	NA
CAR/SOD With Signed Plan of Correction				
Copy of Notifications to Licensee				
Copy of Licensee's Receipts of Notifications				
Copy of Information Submitted by Facility (not POC)				
Affected Resident(s) FL-2s				
Specific Information Supporting Violations				
Other Documentation				

Completed by: _____
DHSR/DSS Staff Signature
Date

Submitted by: _____
DHSR/DSS Staff Signature
Date

Recommended Penalty Amount \$ _____

Branch Manager Signature
Date

TYPE A2 - Determining if a Penalty Should be Proposed

Facility Name: _____ **License #:** _____

Date of Violation: _____ **Rule Area:** _____

PREVENTATIVE MEASURES

Did the facility have policies/procedures specific to the violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had staff been trained in the policies/procedures specific to the violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had staff implemented the policies/procedures specific to the violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>(If "No" is checked for any question above, a Penalty Proposal is to be completed)</i>		

COMPLIANCE HISTORY

Were there any previous violations in the past 36 months?				<input type="checkbox"/> Yes <i>(list below)</i>	<input type="checkbox"/> No
<i>Rule Area (number/brief description)</i>	Date	Type	Points		
			Subtotal =		

Were there standard deficiencies in the same rule area as the current violation in the past 36 months?				<input type="checkbox"/> Yes <i>(list below)</i>	<input type="checkbox"/> No
<i>Rule Area (number)</i>	Date	Type	Points		
			Subtotal =		

RESPONSE TO PREVIOUS VIOLATIONS BY THE FACILITY

Were there any unabated Type A or B Violations in the past 36 months?				<input type="checkbox"/> Yes <i>(list below)</i>	<input type="checkbox"/> No
<i>Rule Area (number)</i>	Date	Type	Points		
			Subtotal =		

Criteria to propose a penalty: 3 points or greater	Total Points =	
--	-----------------------	--

Points Assessed Per Citation/Violation

Standard Deficiency	Type B Violation	Unabated Type B Violation	Type A Violation	Unabated Type A Violation
.25	0.5	1	2	3

Completed by: _____

Date: _____

Bullet/Dash writing for Statement of Deficiencies

Effective June 1, 2013, staff will use bullet/dash writing for Statement of Deficiencies (SOD) to:

- Improve efficiency with writing and review of reports.
- Identify key issues and facts quickly for all readers, including providers.

Guidelines for Bullet/Dash Writing

1. Symbol that will be used for bullets:
 - Dash/Hyphen

Note: This symbol shows up more clearly in Aspen Central Office (ACO) and consistent throughout a report.

2. If findings typed in MicroSoft (MS) Word:
 - a. Type a dash/hyphen (-) for bullet symbol.
 - b. Do not add spaces or tabs to bullets, this may cause formatting problems when copied in Aspen Central Office (ACO).

Note: (When using bullets, do **not** type findings in Word Pad. ACO does not recognize the bullet format in WordPad.)

3. If findings typed in ACO:
 - a. Type a dash (-) for bullet symbol.
 - b. Do **not** use the feature in ACO for bullet format (black circle). The bullet format is not recognized when SOD printed.
4. The sentence preceding a bulleted list should be complete and end with a colon, and capitalize the initial letter of each bullet.
5. Place periods after independent clauses (complete sentences), dependent clauses, or long phrases that follow bullets.

Example: Review of Resident #1's FL-2 dated 02/14/13 revealed:

- Diagnoses included Alzheimer's disease and dementia.
- Medication orders for Aricept 10 mg. at bedtime (Aricept is prescribed to treat symptoms with Alzheimer's disease).

6. If a list consists of short phrases composed of two or three words only, do not place any punctuation (no comma, semicolon, or period) after the entries.

Example: Review of Resident # 1's FL-2 dated 02/14/13 revealed diagnoses of:

- Dementia and Alzheimer's disease
- Hypertension
- Diabetes
- Hypothyroidism

****Statement of Deficiencies for Jones Family Care Home provided as an example of how bullets will appear in the Statement of Deficiencies. The appearance of the bullets in the printed SOD will differ from the appearance in citation manager of ACO. This is formatting with ACO.**

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2012
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NAME OF PROVIDER OR SUPPLIER JONES FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3620 BARWELL ROAD RALEIGH, NC 27610
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 242	<p>10A NCAC 13G .0901(a) Personal Care and Supervision</p> <p>10A NCAC 13G .0901 Personal Care and Supervision (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.</p> <p>This Rule is not met as evidenced by: Type A2 Violation</p> <p>Based on observations, interviews and record reviews, the facility did not provide adequate supervision and personal care to 2 of 3 residents (Resident #1 and Resident #2) who exhibited behaviors of agitation, wandering and attempting to leave the facility, aggressiveness and inappropriate social behaviors (urinating and smearing feces).</p> <p>The findings are:</p> <p>1. Review of Resident #1 ' s FL2 dated 2/14/13 revealed: - " Skill Nursing Facility " was the current level of care; the recommended level of care was checked other. -Diagnoses included Alzheimer ' s disease and dementia. - A check had been documented beside intermittently disoriented, bathing, dressing, incontinent bladder and bowel.</p> <p>Review of Resident #1 ' s Care Plan dated 2/20/13 revealed: - Resident recently moved into Assisted Living Facility; will need assistance with ADLs; is forgetful and will need reminders</p>	C 242		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2012
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

JONES FAMILY CARE HOME **3620 BARWELL ROAD**
RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 242	<p>Continued From page 1</p> <p>Review of Resident #1 ' s Resident Register dated 02/15/13revealed:</p> <ul style="list-style-type: none"> - Resident needs assistance with dressing, bathing, nail care, shaving, hair groom, skin care, and scheduling appointment. - Resident #1 is forgetful and needs reminders. <p>Review of the Nurse ' s Notes for Resident #1 revealed:</p> <ul style="list-style-type: none"> - On 2/21/13, The resident became very agitated when it came time for his shower. - He tried multiple times to get out the doors and was going into other residents ' rooms and was very confused. - On 2/22/13, the resident had fallen under the front shelter, staff was delivering supplies and found front door open with Resident #1 lying under the shelter. - On same date, 2/22/13, the resident continued to try and get out of doors, setting the alarms off, waking other residents, urinating on floors and wiping bowel movement on floor and walls. - On 2/25/13, Resident #1 became very agitated and staff could not calm him down, he tried to leave, refused shower or bath, grabbed staff member ' s breast while she was trying to assist him, made suggestive remarks to staff, - Supervisor notified via email. - Resident #1 tries to leave, going into other resident ' s rooms, one resident has locked her doors so Resident #1 can not get into her room; - Resident # 1 refused to shower, urinated on floor and smeared bowel movement on floor, and got into another resident ' s room and urinated on her floor and her pull ups. - On 2/26/13 Resident #1 became very agitated trying to open facility doors to leave, urinating and defecating on the floor multiple 	C 242		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/27/2012
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NAME OF PROVIDER OR SUPPLIER JONES FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3620 BARWELL ROAD RALEIGH, NC 27610
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 242	<p>Continued From page 2</p> <p>times.</p> <ul style="list-style-type: none"> - On 2/26/13, Resident #1 went out the front door, while staff was using the bathroom, and walked down the ramp. - Staff got Resident #1 and notified supervisor. - Resident #1 defecated bowel movement on floor and Family Care Coordinator (FCC) showed up and saw this incident and helped staff clean up. - Resident # 1 continues to go into other residents ' rooms. - On 2/27/13, Resident #1 still trying to leave facility. <p>Interview with staff, Nurse Aide (NA)/Medication Aide on 3/1/13 at 11:15 am revealed:</p> <ul style="list-style-type: none"> - Resident #1 has never smeared feces anywhere during staff ' s shift, but staff witnessed Resident #1 entering another resident ' s bathroom and urinating on the floor. - Resident #1 wanders all the time. - Another staff member was working on 2/26/13 when Resident #1 smeared feces on the floor, bathroom, and walls and the staff member working reported this to the FCC. The FCC showed up and saw what happened and helped the other staff clean it up. - At this time, there is nothing in place to help staff or Resident #1 with the behavior exhibited by the resident. <p>Telephone interview with another staff, NA/Medication Aide, on 3/7/13 at 9:19 am revealed:</p> <ul style="list-style-type: none"> - Resident #1 came from a Memory Care facility, on 1/20/13. None of the staff were told whether this was long term or short term placement. - Resident #1 does try to get out and has to be redirected. 	C 242		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2012
NAME OF PROVIDER OR SUPPLIER JONES FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 BARWELL ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 242	<p>Continued From page 3</p> <ul style="list-style-type: none"> - Resident #1 has made vulgar remarks to her. - Their chain of command is to tell their FCC about any concerns or issues that go on in the facility with the residents. - The FCC is aware of Resident #1 ' s behavior but is not sure if FCC told administrator. - The administrator had a meeting on 3/6/13 about not knowing all the issues and concerns and she was very upset about it. - There was still nothing put in place to help staff or residents. - No physician has been called regarding the concerns of Resident #1 ' s behaviors. <p>Interview with Resident #1, on 3/1/13, at 11:45am revealed:</p> <ul style="list-style-type: none"> - Resident #1 had been at the facility 2 weeks and a family member placed him there. - Resident #1 was confused and did not seem to understand what was being asked of him during the interview. - Resident #1 made sexually inappropriate remarks, during the interview. (Resident #1 had to be redirected several times.) - During the interview, Resident #1 was observed to try to get out of the facility doors. The door alarm sounded. Staff was observed to redirect Resident #1. <p>Interview with a resident, on 3/1/13, at 11:30am revealed:</p> <ul style="list-style-type: none"> - The resident stated, in her opinion, neither Resident #1 nor another resident should be at this facility. - The resident has told the staff at the facility about her concerns regarding Resident #1 coming into her room, smearing feces in the facility and making vulgar comments, but nothing was done. 	C 242		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2012
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NAME OF PROVIDER OR SUPPLIER JONES FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3620 BARWELL ROAD RALEIGH, NC 27610
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 242	<p>Continued From page 4</p> <p>Telephone interview with a family member of Resident #1, on 3/19/13, at 3:54pm revealed:</p> <ul style="list-style-type: none"> - Resident #1 was only in the facility about 7 days, and this was only to be tried short term to see how Resident #1 fit in. - Staff from the Memory Unit called her and she was fine with them moving Resident #1 back to the Memory Unit. - The family member was aware of Resident #1 "pooping and urinating" as well as going into other residents' rooms bothering them. <p>Interview with Staff, NA/Med Aide, on 3/1/13, at 11:15 am revealed:</p> <ul style="list-style-type: none"> - Resident #1 talk was vulgar and has made vulgar comments to another resident. - The other resident will not come out and eat when Resident #1 is eating because she does not want to be around him. - The other resident also keeps her door locked so Resident #1 can not come in her room. - Staff stated Resident #1 tried to get out of the facility all the time. - In response to what action or intervention was implemented, " They have alarms on the doors plus they have locks on the doors at the facility, but this has always been in place. Nothing else put in place. " - FCC was notified of all incidents that occurred during the shift. - At this time, there is nothing in place to help staff or Resident #1 with behaviors exhibited by Resident #1. <p>Interview with Administrator, on 3/1/13 at 12:30pm revealed:</p> <ul style="list-style-type: none"> - Resident #1 was placed at the facility for a trial placement for 30 days to see how the resident would do in a family group home, which was smaller than his previous placement. 	C 242		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2012
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NAME OF PROVIDER OR SUPPLIER JONES FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3620 BARWELL ROAD RALEIGH, NC 27610
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 242	<p>Continued From page 5</p> <ul style="list-style-type: none"> - Resident #1 came from the Memory Care Unit at an affiliated facility. - Administrator knew Resident #1 tries to get out of the facility doors and she has told staff to redirect him but she did not feel the staff was doing that. <p>2. Review of Resident #2 ' s FL2 dated 1/25/13 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included dementia, fracture of 5& 6 left posterior ribs, and small left effusion. - Resident was intermittently disoriented, wanders, needs assistance with bathing and has an indwelling catheter. <p>Review of Resident #2 ' s Care Plan dated 1/25/13 revealed:</p> <ul style="list-style-type: none"> - Resident #2 had an indwelling catheter, was sometimes disoriented, forgetful-needs reminded. <p>Review of the Resident Register of Resident #2 revealed:</p> <ul style="list-style-type: none"> - Resident #2 was admitted to the facility on 1/25/13 and needed assistance with bathing and scheduling appointment. <p>Hospital records dated 1/22/13 for Resident #2 revealed:</p> <ul style="list-style-type: none"> - Resident #2 was admitted into local hospital for dementia, small left pleural effusion, acute left rib fracture on the 5th and 6th posterior ribs and small left side pneumothorax. Documentation noted that he is a resident from independent living. - Hospitalization was prolonged by the fact that the resident would become agitated and combative in the evenings, requiring Ativan every for his increased agitation. - Hospital upgraded the resident to a more 	C 242		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2012	
NAME OF PROVIDER OR SUPPLIER JONES FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 BARWELL ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 242	<p>Continued From page 6</p> <p>skilled monitoring nursing facility at time of discharged.</p> <ul style="list-style-type: none"> - Resident #2 was discharged on 1/25/13 with diagnosis of left pneumothorax, left posterior 5th and 6th rib fractures post blunt trauma to the chest and dementia. <p>Review of the Nurses Notes of Resident #2 revealed:</p> <ul style="list-style-type: none"> - On 1/25/13, the resident was agitated and refused to take medication. - The resident came into the kitchen, and before staff could stop him, grabbed knife and was trying to cut his catheter. The resident came at staff with the knife when staff tried to get the knife. The resident put the knife down and staff took knife. Staff then put knives in a " safe place " - On 1/26/13, Resident #2 woke up talking about taking out his catheter. - On 1/28/13, Resident #2 had taken all his clothes off, was very agitated, refused to take his medication, put his finger on a staff member ' s nose and said, " I better not get me any medication or water or I will blow my head off tonight. " - The resident was seen going from door to door, opening doors and activating the door alarms. - The resident is extremely confused and disoriented. - On 1/30/13, the resident had taken his catheter bag off and was trying to put it in the drawer beside the bed. - On 1/31/13, the resident was agitated, fell down and hit his head on the floor. As a result, the resident had a skin tear on forehead and was sent to the local Emergency Room. 	C 242		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2012
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NAME OF PROVIDER OR SUPPLIER JONES FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3620 BARWELL ROAD RALEIGH, NC 27610
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C 242	<p>Continued From page 7</p> <p>Hospital records on Resident #2 dated 1/31/13 revealed:</p> <ul style="list-style-type: none"> - Resident #2 came to emergency room due to fall, " A staff member from facility was escorting him and he fell. " <p>Review of the Nurse ' s Notes of Resident #2 revealed:</p> <ul style="list-style-type: none"> - On 2/1/13, the resident was agitated and very confused. - On 2/2/13, the resident was extremely agitated, yelled at staff, kicked a staff member in the shin and told staff member to get out of his room. The resident was using inappropriate language and struggling to put on his shoes. When staff offered to help, the resident started yelling at staff saying they deserted him and the he was just a child. - After being calmed down from the yelling incident, the resident suddenly grabbed the staff member by her throat and began yelling at her. After removing his hands from the staff member ' s throat, the resident tried to get out door. - On 2/3/13, the resident took his clothes off twice, was very confused and refused to be bathed. - On 2/5/13, the resident was very agitated and talking incoherently. He started yelling and popped staff in the back of the head. He was given medication to calm him and supervisor was notified. - On 2/7/13, the resident was admitted into hospital for broken ribs and pneumothorax. <p>Hospital records dated 2/6/13 for Resident #2 revealed:</p> <ul style="list-style-type: none"> - Resident #2 came into emergency room due to fall, the resident fell and struck the right side of his head. The resident was admitted to the hospital on 2/6/13 and discharged from hospital 	C 242		

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C 242	<p>Continued From page 8 on 2/8/13.</p> <p>Review of the Nurse ' s Notes of Resident #2 revealed:</p> <ul style="list-style-type: none"> - On 2/13/13, the resident was agitated and talking about killing someone. - On 2/14/13, the resident was in other resident ' s rooms with no clothes on. - On 2/16/13, the resident was wandering around in his room, taking all of his clothes off, removing straps to catheter bag, knocking large picture off the wall, and hitting and trying to bite staff. - On 2/17/13, the resident was found in his closet naked. - On 2/18/13, the resident was trying to bite and kick staff and refused to eat or drink. - On 2/19/13, the resident was hostile toward staff, refused to eat or drink and repeatedly slapped staff hands. He stripped down naked three times and was found sitting on the toilet naked and had removed his catheter. - On 2/25/13, the resident was sent out to Emergency Room because he pulled his catheter out. Notified the supervisor and family. <p>Hospital records on Resident #2 dated 2/25/13 revealed:</p> <ul style="list-style-type: none"> - Resident #2 was admitted for complaint of suprapubic catheter being accidentally pulled out. - The hospital was unable to replace the suprapubic catheter in the emergency department but an indwelling urinary catheter was replaced instead. - Resident #2 was discharged on 3/2/13 back to skilled nursing facility. <p>Interview with staff, NA/Med Aide, on 3/1/13, at 11:15 am revealed:</p> <ul style="list-style-type: none"> - On 1/26/13, Resident #2 got a butter knife 	C 242		

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C 242	<p>Continued From page 9</p> <p>and was trying to cut his catheter and when staff member tried to stop Resident #2, the resident went after staff member with knife. All sharp knives were put up after this incident.</p> <ul style="list-style-type: none"> - Resident #2 was agitated and would fight and try to go out the doors. The resident would fight all the staff if any of the tried to remove or redirect him away from the doors. - Staff stated Resident #2 would go into other residents ' rooms all of the time. Staff said Resident #2 grabbed another resident ' s arm. The incident occurred on another staff ' s shift on 2/9/13. Staff said Resident #2 has not grabbed another resident ' s arm since that incident. - Family Care Coordinator (FCC) was aware of Resident #2 ' s behaviors. There was nothing additional put in place to help the staff or Resident #2 with the concerning behaviors. - Resident #2 was in the local hospital in Critical Care. Staff said Resident #2 went into the hospital on 2/25/13 for pulling his catheter out which caused internal bleeding. <p>Interview with a resident on 3/1/13 at 11:30am revealed:</p> <ul style="list-style-type: none"> - Resident #2 would always make sexually inappropriate remarks towards her. - The resident stays in her room all the time because of Resident #2 and keeps her door locked now. - The resident has told the staff at the facility about all the concerns - Resident #2 used to bother her by coming into her room all the time; however, since he is not at the facility right now, he is not bothering her. <p>Based on record review, observations and interviews, the facility failed to provide supervision for 2 of 2 residents, with Dementia and</p>	C 242		

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C 242	Continued From page 10 wandering, exit seeking and aggressive behavior towards other residents, to assure the safety and well-being for all 3 residents in the facility. _____ INSERT PLAN OF PROTECTION INSERT: THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED <DATE>.	C 242		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the prescribing practitioner for 2 of 5 residents who were ordered insulin and pain medication (#2,#9) that were sampled for record review and 2 of 7 residents (#7, #8) observed during the medication pass who were administered insulin and metered dose inhaler. The findings are: A. Review of Resident # 2's current FL-2 dated	C 330		

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C 330	<p>Continued From page 11</p> <p>12/2/11 revealed the following:</p> <ul style="list-style-type: none"> - Diagnoses of end stage renal disease , type 2 diabetes mellitus and morbid obesity . - Medication orders for Lantus 45 units every morning (Lantus is a long acting insulin prescribed to help control blood sugars), Novolin R insulin 5 units twice a day (Novolin R is a short acting insulin used to help control blood sugars). - Resident #2 received dialysis three times a week. <p>Review of Resident # 2's record revealed an order dated 01/09/12 for Novolin R sliding scale insulin:</p> <ul style="list-style-type: none"> - Before breakfast, before supper and at bedtime. - Parameters for administration were: - 70-150= no insulin - 151-250= 2 units - 251-300= 4 units - 301-350=6 units - 351-400= 8 units - 401-450=10 units - Greater than 450 or less than 50 call MD. <p>Subsequent physician orders for insulin reviewed in Resident #2 ' s record included:</p> <ul style="list-style-type: none"> - Order dated 1/19/12 for Novolin insulin 5 units three times daily (breakfast, lunch and dinner) - Order dated 2/20/12 from the dialysis center to increase Lantus to 47 units every morning. <p>Review of the February 2012 Medication Administration Record (MAR) revealed the following:</p> <ul style="list-style-type: none"> - Hand written entry which read: "Lantus inject 77 units under the skin day 2/21/12" with documentation of administration from 2/22/12 at 8:00 am through 2/29/12. 	C 330		

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C 330	<p>Continued From page 12</p> <ul style="list-style-type: none"> - Resident's blood sugar ranged from 84 to 511. <p>Review of the March 2012 MAR revealed the following:</p> <ul style="list-style-type: none"> - Hand written entry which read: "Lantus 77 units inject under the skin each morning" with documentation of administration from 03/01/12 through 03/27/12 at 8:00 am. - Resident's blood sugar ranged from 63-319. <p>Interview with the medication aide on 3/27/12 at 11:55 am revealed the following:</p> <ul style="list-style-type: none"> - Resident #2 had been receiving Lantus 77 units for about 3 weeks. - Resident Care Coordinator (RCC) or the Director transcribes physician's orders to the MAR and the medication aides carry out what is written on the MAR. <p>Interview with the RCC on 3/27/12 at 12:35 pm revealed the following:</p> <ul style="list-style-type: none"> - When physician orders are received the former RCC was responsible for transcribing the order to the MAR and sending the order to the pharmacy. The RCC stated if the order was written by a different medical provider a copy of the order is faxed to the primary medical provider group. - Orders are transcribed to the MAR and faxed to the pharmacy by the RCC. A copy of the order is given to the Director for follow up of the order transcription and documentation on the MAR. <p>Interview with the Director on 3/27/12 at 3:40 pm revealed the following:</p> <ul style="list-style-type: none"> - RCC is responsible for transcribing new orders to the MAR and faxing the order to the pharmacy. - Director monitors new order transcriptions 	C 330		

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C 330	<p>Continued From page 13</p> <p>and documentation on the MAR and during the monitoring process orders are checked to see if the process of transcription was accurate.</p> <ul style="list-style-type: none"> - Previous RCC would make copies of new orders that had been transcribed. After receiving the copy of the new orders, the Director would go back to the MAR and resident 's record and check the orders that had been transcribed. - If the orders were unclear, incomplete or difficult to understand the RCC should have called the physician for order clarification prior to transcribing the order to the MAR. - When asked, the Director stated the order appeared to read as:"decrease Lantus to 47 units". <p>Review of the facility medication error report dated 3/27/12 revealed:</p> <ul style="list-style-type: none"> - Former RCC interpreted the order as 77 units everyday. - Documentation of "Clarification should be done immediately of any orders that are not obvious" and "The Director is supposed to receive copies of all orders to confirm". <p>Telephone interview with the Dialysis Center office nurse on 3/27/12 at 3:30 pm revealed:</p> <ul style="list-style-type: none"> - Orders dated 2/20/12 for Lantus was to increase to 47 units every morning. - The facility had not contacted the physician regarding the order and should have called for clarification if needed. - The nurse stated "the resident could have had a " huge problem" when asked, the nurse stated "the resident's blood sugar could have dropped and the resident could have gone into a coma or the blood sugar could have become so low the adverse effects could have killed the resident". 	C 330		

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C 330	<p>Continued From page 14</p> <p>Review of physician orders dated 3/27/12 from the Dialysis Center physician revealed "Lantus order on 2/20/12 Increase Lantus to 47 units subcutaneous everyday".</p> <p>B. The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 12:00 noon medication pass on 3/27/12 and the 8:00 am medication pass on 3/28/12.</p> <p>1. Review of Resident #8's current FL-2 dated 11/9/11 included:</p> <ul style="list-style-type: none"> - Diagnoses of psychosis, hypertension, history of cerebral vascular accident, and increased lipids. - Medication order for Pro Air 2 puffs four times a day. (Pro air is used to prevent breathing difficulties). <p>Observation of the 12:00 noon medication administration of Pro air revealed the medication aide:</p> <ul style="list-style-type: none"> - Shook the inhaler, then instructed the resident to take a deep breath and blow the air out while shaking the inhaler. - Asked the resident to open his mouth, placed the inhaler between the resident ' s lips, administered one puff and removed the inhaler from Resident #8's mouth. The medication vapor mist immediately expelled from the resident's mouth. - Did not wait before administering the second puff, placed the inhaler between the resident ' s lips and administered another puff and removed the inhaler from the Resident #8's mouth. The medication vapor mist immediately came out of the resident's mouth. - Did not tell the resident to breathe deeply and hold the inhalation of the medication after the 	C 330		

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C 330	<p>Continued From page 15</p> <p>puffs had been administered.</p> <p>The facility's policy for the administration of inhalation medications (metered dose inhalers) stated while breathing in, press down on the inhaler one time to release the medication, continue to breathe in slowly and as deeply as possible. Hold the breath for 10 seconds, to allow the medication to reach deeply into the lungs.</p> <p>During interview with the medication aide at 12:10 PM on 3/27/12, the medication aide stated:</p> <ul style="list-style-type: none"> - "This is how I always administered the inhaler". - She did not know she had administered the inhaler incorrectly. - " You are supposed to ask the resident to breathe in and blow out, then administer the inhaler. " <p>2. Review of Resident # 7's FL-2 dated 5/11/11 revealed diagnoses included diabetes mellitus..</p> <p>Review of resident's record revealed an order dated 1/19/12 for Humalog sliding scale (prescribed to lower blood sugar) with the following parameters:</p> <ul style="list-style-type: none"> - 70-150= 0 units - 151-250= 2 units - 251-300= 4 units - 301-350= 6 units - 351-400= 8 units - 401-450= 10 units - Greater than 450 or less than 70 call MD <p>Review of the March 2012 Medication Administration Record (MAR) revealed Resident #7's blood sugars ranged from 97-332.</p> <p>During observation and interview of the</p>	C 330		

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C 330	<p>Continued From page 16</p> <p>medication aide at 12:25 pm on 3/27/12:</p> <ul style="list-style-type: none"> - The medication aide retrieved the necessary supplies and insulin and began drawing up six units of insulin. The syringe had a large bubble located from the hub of the needle attachment at the top of the syringe that extended to the second line on the syringe. - The medication aide stated the insulin was ready to be administered to the resident and started towards the resident. - The medication aide stated the resident was to receive 6 units of insulin 4 units from the routine dose and 2 units for sliding scale coverage. The surveyor requested the medication aide not to administer the insulin as observed until the bubble had been expressed out of the syringe. - The medication aide approached Resident #7, asking the resident to hold up their sleeve, wipe the area with an alcohol swap and inserted the needle directly into the resident's left upper arm and pushed the plunger down then immediately withdrew the needle. <p>The facility's policy and procedure for insulin administration reviewed included the following:</p> <ul style="list-style-type: none"> - Pinch up a fold of skin and quickly insert the needle at a 90° angle. - Keep the skin pinched to avoid injecting insulin into the muscle. - Push the plunger down completely to inject the insulin. - Hold the syringe and needle in place for five seconds. - Release the skin fold then remove the needle from the skin. <p>_____</p> <p>—</p>	C 330		

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C 330	Continued From page 17 INSERT PLAN OF PROTECTION INSERT: THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED <DATE>.	C 330		