Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036035	A. BUILDING: ______ B. WING ______	R 03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OAKS ASSISTED LIVING	**916 S. MARIETTA STREET GASTONIA, NC 28054**

(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
D 000	Initial Comments The Adult Care Licensure Section and Gaston County DSS conducted an annual survey, follow-up survey, and complaint investigation on 3/7/17 to 3/10/17, and 3/13/17 with an exit conference via telephone on March 17, 2017. The complaint investigation was initiated by Gaston County Department of Social Services on January 30, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have walls, ceilings, and floors or floor coverings kept clean and in good repair for 1 common half bathroom, 1 common shower/bathroom, a small dining room on the 400 hall, a shared 1/2 bathroom, and all other common areas of the facility. The findings are: Observation of the half bath at the end of North Hall of the facility on 3/7/17 at 10:30am revealed: -A missing baseboard approximately 4 feet long running the length of the wall next to the toilet exposing unfinished wall covering. -An irregularly shaped area of damaged sheetrock approximately 2 x 2 inches with peeling paint and plaster on the bottom of the window	D 074		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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D 074	Continued From page 1 frame. -An irregularly shaped area of damaged sheetrock approximately 3 x 4 inches beside the entrance doorframe. -A scuffed area of the veneer approximately 18 inches long on entrance door to the bathroom. Observation of the shared half bath in resident room 110 at 11:25am on 3/7/17 revealed: -The bottom 6 inches of the wooden entrance doors to the bathroom were delaminated and splintered. -The entrances to the half bath had a heavy build up of dirt where the thresholds met the ceramic floor tiles. Observation of the door to resident room 108C on 3/7/17 at 11:40am revealed an area of delaminated splintering wood in the center door approximately 8 inches by 6 inches. Observation of the hallway outside of room 309 on 3/7/17 at 11:35am revealed: -Three broken 12 inch by 12 inch floor tiles. -The underlayment beneath the broken floor tiles sagged, causing the tiles to break. Observation of the ceiling tiles in the 200 hall on 3/9/17 at 10:28am revealed a 12 x 12 inch brown stain on one tile. Observation of the walls in all common areas throughout the facility on 3/9/17 at 10:31am and 10:41am revealed they were carpeted from the floor up to the handrails and had multiple brown and black stains. Observation of the walls in the hallways throughout the facility on 3/9/17 at 10:34am revealed they were wallpapered from the	D 074		

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D 074	Continued From page 2	D 074		

handrails to the ceiling and had multiple brown stains.

Observation on 3/9/17 at 10:35am of the common shower/bathroom on the 200 hall revealed:
-Molding had come loose at the base of an interior door frame and a 4x2 inch section of the frame was missing.
-Three pieces of 12x12 floor tile in the handwashing area that were cracked.

Observation on 3/9/17 at 10:38am of the floors throughout the facility revealed there was a 1/2 to 1 inch black substance at the edges of all baseboards.

Observation on 3/9/17 at 10:41am of the small dining room on the 400 hall revealed:
-Molding on a wall edge had come loose from the wall.
-Wallpaper near the vending machine was missing a 3x4 inch section.
-Wallpaper seams were taped together with clear packing tape from the chair railing to the ceiling.

Interview with a resident who used the common half bath at the end of the North Hall on 3/10/17 at 11:30am revealed:
-He had not noticed the scuffed baseboards in the bathroom or the splintered entrance doors to the bathroom.
-He had never complained to anyone about the baseboards or the entrance doors in the bathroom.

Interview on 3/10/17 at 10:30am with the Maintenance Manager revealed:
-He made a walk through every day and looked for things that needed repaired.
-When he saw items that needed to be repaired,

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D 074	Continued From page 3 he would fix them as soon as he could. -Sometimes repairs get slowed down because of the need to order items for repairs. -There was a maintenance log book in the medication room that anyone could document items that needed repair. -He looked at the book on a daily basis. -He felt like he needed an assistant to help him get everything done. -He was responsible for cleaning up litter on the outside grounds and checking for safety issues. -He cleaned the ramps and entries of the building. -He had "lots" of things to do. Review of the maintenance log book on 3/10/17 revealed there were items that had been signed off as repaired, but no current items documented as needing repaired.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 8 oxygen tanks were stored securely in storage holders.	D 079		

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D 079	Continued From page 4 The findings are: Observation of the oxygen tank storage room on 3/7/17 at 11:06am revealed: -At least 8 oxygen tanks were standing on the floor without benefit of a storage holder. -There was at least 8 empty places in the oxygen storage units. -The room had at least 20 oxygen tanks in storage holders. Interview with the Maintenance Manager on 3/7/17 at 11:10am revealed the medication aides were responsible for placing the oxygen tanks back in the storage holders. Interview with the Administrator on 3/7/17 at 11:15am revealed: -It was the responsibility of the Maintenance Manager to check the oxygen tank room every morning to assure the tanks were placed securely in the storage holders. -She talked to the Maintenance Manager "last week" and told him the monitoring of storage tanks was his responsibility and gave him a list of duties which described that responsibility. Review of the Maintenance Manager's responsibility list revealed duties included, "Check oxygen room for proper placement of oxygen in metal holders only. No O2 [oxygen] on floor."	D 079		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels,	D 080		

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D 080	Continued From page 5	D 080		

washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times;
This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure there was a supply of clean towels and washcloths for resident use on hand at all times.

The findings are:

Confidential interview with a resident revealed:
-He had not been in the facility very long, less than a year.
-They sometimes ran out of bath towels.
-He was supposed to get a bath three times a week.
-They ran out of towels "about once a week."
-Care staff told him they "just don't have enough towels."
-When they ran out of towels, "I don't get my shower."
-He needed assistance from staff to bathe.

Confidential interview with a second resident revealed:
-He did not need assistance with showers.
-They ran out of towels regularly and he has had to wait to take his shower.
-He had one towel of his own he tried to keep it clean "in case they ran out."

Confidential interview with a third resident revealed:
-He had to wait to take his showers due to the lack of bath towels.
-He could not recall how often this happened or

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D 080	Continued From page 6 how long he had to wait to take a shower. Confidential interview with six other residents revealed: -They sometimes had to wait for showers due to no clean washcloths and towels. -Staff often stated there were no towels and washcloths available for each shift to perform task timely. -Sometimes it took a while to get towels. -Sometimes they had to wait until the next day to get a towel or washcloth. Confidential interview with 3 Personal Care Aides (PCAs) revealed: -There were not enough towels and washcloths available daily for resident showers. -First shift PCAs assisted with 20-25 resident showers daily. -The soiled towels and washcloths from 2nd and 3rd shift were washed during first shift by the laundry staff. -Staff had to wait on towels to get washed and dried from laundry before all showers were conducted. -Residents had been known to hoard towels and washcloths in their room. -Residents that were independent with bathing received a towel and washcloth from their personal care aide, held it, and then did not take a shower. -When the next shift came on duty the same resident asked for another set of towels and washcloths and used that for their shower. -The residents eventually had several sets of towels and washcloths in their rooms. -There were not enough towels in the facility for residents to get showers timely. -There were extra towels and washcloths in a closet in the office.	D 080		

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D 080	Continued From page 7 -There were not enough towels and washcloths for the 80 residents in the facility. -There were sometimes no towels or washcloths in the linen closets on 1st shift. -The facility needed to have more extra towels and washcloths available. Observation on 3/8/17 at 10:20am revealed: -There was a linen closet for each shift. -There were 3-5 towels and 3-5 washcloths in each closet. -There were approximately 8-10 towels and washcloths in the laundry. -There were not a supply of towels or washcloths available for the 80 residents in the facility. Interview with Administrator on 3/8/17 at 4:40pm revealed: -There were towels and washcloths for each shift to give showers. -There were extra towels and washcloths in the office if needed by staff to give resident showers. -"We have plenty of towels." -"I buy towels every month, church groups donate towels." -"Staff should not be running out of towels and residents should not have to wait on their showers." -She was was not aware residents did not have towels for their showers. Interview with the laundry staff on 3/10/17 at 2:45pm revealed: -They had 3 washers and 3 dryers. -"It is hard to keep up the laundry" because of the washing machine issues. -Two washing machines were medium size and 1 was large. -If all 3 washing machines were on at the same time the large machine stopped several times	D 080		

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D 080	Continued From page 8 during the wash cycle. -"If the large machine was unplugged and plugged in again, the machine started washing again." -She stopped using the 2 medium machines and used only the large machine because it was a double washer and more clothes could be washed at once. -If all the machines "could run at the same time, washing clothes and other washable items would be quicker." -Two of the 3 dryers were out of order. -One dryer had been broken for over a year and the other one broke January 2017. -If all dryers worked, the laundry could be completed faster. Interview with the Administrator on 3/10/17 at 3:30pm revealed she was not aware any of the washers and dryers were out of order.	D 080		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all washers and dryers were maintained in a safe and operating condition resulting in residents not having a clean towel and washcloth available at all times. The findings are:	D 105		

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Interview with the laundry staff on 3/10/17 at 2:45pm revealed:
-They had 3 washers and 3 dryers.
-"It is hard to keep up the laundry" because of the washing machine issues.
-Two washing machines were medium size and 1 was large.
-If all 3 washing machines were on at the same time the large machine stopped several times during the wash cycle.
-"If the large machine was unplugged and plugged in again, the machine started washing again."
-She used the large machine because it was a double washer and more clothes could be washed at once.
-If all the washing machines "could run at the same time, washing clothes and other washable items would be quicker."
-Two of the 3 dryers were out of order.
-One dryer had been broken for over a year and the other one broke January 2017.
-If all dryers worked, the laundry could be completed faster.

Observation on 3/8/17 at 2:50pm revealed:
-There were three washing machines (two medium and one large) in the laundry room.
-There was no washing machines operating (i.e. washing clothes) at the time of the observation.
-There were three large dryers.
-One dryer was operating at the time of observation.
-One dryer was not operating and was empty.
-Another dryer was not operating but had wet bed covers in it.

Confidential interview with 3 Personal Care Aides (PCAs) revealed:
-The soiled towels and washcloths from 2nd and

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D 105	Continued From page 10 3rd shift were washed during first shift by the laundry staff. -Staff have to wait on towels to get washed and dried from laundry before all showers were conducted. -There were not enough towels in the facility for all the residents to get showers timely. -There were sometimes no towels or washcloths in the linen closets on 1st shift. -There were not enough towels and washcloths available for the 80 residents. -First shift PCAs assisted with 20-25 resident showers daily. Interview with the Business Office Manager (BOM) on 3/13/17 at 4:15pm revealed: -They have a contract, dated February 17, with a service and repair company to maintain and repair the washers and dryers. -He was not informed before the survey that the washing machines had a problem with staying on. -If a washing machine stopped during the cycle, the amps and voltage probably needed to be increased to power all three machines at once. -Before they signed the service and repair contract, the former Maintenance Manager was responsible for servicing and and repairing. -The BOM contacted the electrician "today" on 3/13/17 and there were now scheduled to increase the amps and voltage for the washing machines and dryers on 3/15/17. -The two dryers that were not working would be replaced, date not specified. -This repair company "will be removing" the non-working dryers on 3/14/17 at 8:30am. Interview on 3/13/17 at 4:55pm with the facility licensee revealed: -She had a contract with a service and repair company to lease and maintain washers and	D 105		

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D 105	Continued From page 11 dryers. -The washing machines and dryers would be in operable condition "as soon as possible." Telephone call to the service and repair company on 3/14/17 at 4:48pm revealed: -This facility was on the books to have the dryer replaced but there was no definite date scheduled at this time. -The facility was responsible for having the old dryers torn down and removed. Interview with the Administrator on 3/10/17 at 3:30pm revealed she was not aware all the washers and dryers were not in working order.	D 105		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of residents, related to notification of the Primary Care Provider regarding refusals of finger stick blood sugars (FSBS) and insulin injections, refusals and missed blood pressure readings, and labs not obtained, for 1 of 5 sampled residents (Resident #4). The findings are:	D 273		

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D 273	Continued From page 12 Review of Resident #4's current FL2 dated 6/4/16 revealed: -Diagnoses included diabetes mellitus, insomnia, major depression, bipolar disorder, schizophrenia, anxiety, deep vein thrombosis, and anemia. -Medications included Levemir (used to treat high blood sugar levels) 100 units/ml, inject 50 units subcutaneously (SQ) every morning and 60 units at bedtime; Novolog (used to treat high blood sugar levels) 100 units/ml inject 3 units SQ along with sliding scale insulin (SSI) dose three times daily before meals 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units, Cymbalta (for anxiety) 30mg daily, Lasix (a diuretic) 40mg daily, Imdur ER (for chest pain) 60mg daily, lisinopril/hydrochlorothiazide (for blood pressure) 20mg/12.5mg twice daily, Lopressor (for blood pressure) 100mg at bedtime, Seroquel XR (an antipsychotic) 250mg at bedtime, Oxycodone (for pain) 15mg 4 times daily, Xarelto (a blood thinner) 20mg daily, and Xanax 0.5mg twice daily as needed for anxiety. -An order to check FSBS levels at 7:30am, 11:30am, and 4:30pm. -An order to check blood pressure once daily and record. Interview with a Home Health nurse on 3/8/17 at 11:40am revealed: -Resident #4 was being treated for a Stage II pressure ulcer on the upper posterior thigh. -The Home Health nurse was performing wound care 2 times per week. Record review for Resident #4 revealed: -An order dated 9/8/16 to discontinue Xarelto. -A Physician's Order sheet signed 11/23/16 to	D 273		

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change Levemir 100units/ml to 60 units SQ twice daily and for Humalog 100units/ml (used to treat high blood sugar levels) inject 3 units SQ along with sliding scale insulin (SSI) dose three times daily before meals: 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units and call MD.
-A Physician's Order sheet signed 11/23/16 to start Symbicort 80-4.5mg inhale 2 puffs daily (for asthma and chronic obstructive pulmonary disorder), and Tamsulosin 0.4mg daily (to treat an enlarged prostate gland).
-A "Physician FYI" form dated 12/22/16 notifying the Primary Care Provider (PCP) that Resident #4 had been refusing injections for over 4 weeks.
-An order dated 12/26/16 to discontinue Humalog 100units/ml.
-There was no order to discontinue the FSBS checks before meals.
-An order dated 3/2/17 for warfarin 3.5mg daily (a blood thinner).

1. Review of Resident #4's Medication Administration Record (MAR) for December 2016 revealed:
-An entry for Humalog 100 units/ml inject 3 units SQ 3 times daily before meals along with dose per sliding scale insulin 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units and call PCP.
-An entry to check FSBS levels at 7:30am, 11:30am, and 4:30pm.
-From 12/01/16 to 12/25/16 there were 15 documented refusals at 7:30am for the FSBS and 18 refusals for the SQ injection of Humalog 3 units along with the sliding scale dose.
-From 12/01/16 to 12/25/16 there were 15 documented refusals at 11:30am for the FSBS

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and 18 refusals for the SQ injection of Humalog 3 units along with the sliding scale dose.
-From 12/01/16 to 12/25/16 there were 18 documented refusals at 4:30pm for the FSBS and 19 refusals for the SQ injection of Humalog 3 units along with the sliding scale dose.
-An entry for Levemir inject 60 units SQ twice daily.
-A Medication Note on the back of the MAR dated 12/21/16 at 4pm which documented the resident had refused the FSBS and the Humalog because "it made him feel faint/sick."
-No documentation of notification of the PCP for the refusal of FSBS readings and injections.

Review of Resident #4's Blood Sugar Documentation Sheet for December 2016 from 12/1/16 to 12/25/16 revealed:
-There were 15 empty blocks where the FSBS was not documented.
-There were 10 empty blocks where the dose of Humalog 3 units along with SSI given was not documented.
-FSBS was documented as refused 8 times.
-The resident's blood sugars ranged from 108-235.

Review of Resident #4's MAR for January 2017 revealed:
-There was no entry for FSBS.
-The entry for Humalog and SSI was crossed out and marked as "DC".
-An entry for Levemir inject 60 units SQ twice daily at 7:30am and 8:30pm.

Further record review for Resident #4 revealed:
-There was no Blood Sugar Documentation Sheet for January 2017.
-There was no request or documentation from the facility to clarify the frequency or discontinuation

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of the FSBS.
-A Consultant Pharmacist's Medication Regimen Review dated 1/18/17, that was sent to the PCP, and requested verification of how often FSBS were to be checked since the Humalog was discontinued in December.
-An order in response to the Consultant Pharmacist's Medication Review to check FSBS daily at 6:30am, which was to begin on 2/9/17.
-A hemoglobin A1c level of 6.6% (normal range 3.0 to 5.6) from a blood sample taken on 9/26/16.

Review of Resident #4's MAR for February 2017 revealed:
-There was no entry for FSBS.
-An entry for Levemir 100units/ml inject 60 units SQ twice daily at 7:30am and 8:30pm.

Review of Resident #4's Blood Sugar Documentation Sheet for February 2017 revealed:
-A note at the top of the form written by the MA to check FSBS before meals.
-There were 15 days from 2/1/17 to 2/28/17 where the FSBS was not documented at 7:30am.
-There were 7 days from 2/1/17 to 2/9/17 where the FSBS was not documented at 11:30am.
-There was no documentation of FSBS at 4:30pm from 2/1/17 to 2/9/17.
-The resident's blood sugars ranged from 140 to 567.

Review of Resident #4's MAR for March 2017 revealed:
-An entry dated 2/9/17 to check FSBS once daily before breakfast.
-An entry for Levemir 100units/ml inject 60 units SQ twice daily at 7:30am and 8:30pm.
-There was no documentation of FSBS readings for 3/1 and 3/3.

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-FSBS readings were obtained on 3/2, 3/4, 3/5, and 3/7.
-The FSBS on 3/6/17 was documented as refused.

Review of Resident #4's Blood Sugar Documentation Sheet for March 2017 revealed:
-FSBS readings were obtained 7 days from 3/1/17 to 3/9/17.
-There was no documentation of FSBS readings for 3/3 and 3/6.
-The resident's blood sugars ranged from 114 to 195.

Confidential interview with a Medication Aide (MA) revealed:
-The current order for FSBS was once daily before breakfast.
-The MA was unable to explain why Resident #4 had missed and refused FSBS and injections in December 2016.
-The MAs were responsible for notifying the PCP of FSBS or medication refusals after 3 consecutive times.
-The FSBS order was changed to once daily after the Humalog was discontinued in December.
-The MA was unable to explain why there were no FSBS done on the January or February MARs.

Interview with the Resident Care coordinator (RCC) on 3/9/17 at 9:40am revealed:
-She was responsible for checking the accuracy of the MARs.
-The blood sugars should be documented on the MAR or blood sugar documentation sheet.

Interview with the RCC on 3/10/17 at 10:00am revealed:
-There were no orders to discontinue or change FSBS from December 2016 to March 2017.

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-There was no January Blood Sugar Documentation Sheet for January 2017.
-She was unable to explain why the FSBS entry had dropped off the MAR in January and February 2017.

Interview with Resident #4 on 3/10/17 at 4:00pm revealed:
-He gets Levemir 60 units twice daily.
-Staff check his blood sugar 1-2 times daily.
-He had refused FSBS in the past.

Telephone interview with the facility's pharmacy provider on 3/13/17 at 2:09pm revealed:
-The FSBS order for three times daily before meals had "just dropped off" the MAR when the sliding scale insulin was discontinued on December 26, 2016.
-The facility should have requested a clarification order related to FSBS from the PCP.

Telephone interview with the PCP on 3/16/17 at 12:27pm revealed:
-She was made aware of the refusals on 12/22/16.
-After the Humalog was discontinued, the resident should have had FSBS checked at least twice daily.
-The facility should have been checking FSBS for January 2017.
-"That (not checking FSBS) should not have happened."

Interview with the Administrator on 3/13/17 at 3:40pm revealed:
-The RCC was responsible for ensuring all current orders were on the MAR.
-The RCC was responsible for order clarification.

Telephone interview with the RCC on 3/15/17 at

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10:34am revealed:
-She was not aware that Resident #4 had refused FSBS and injections "that many times."
-The MAs "should have let me know after 3 consecutive times, then I would notify the MD."
-She would not give insulin without checking a FSBS.
-She and another MA would compare the current MAR to the upcoming month's MAR, and not MAR to orders when a new month began.

Refer to interview with the Administrator on 3/13/17 at 3:40pm.

Refer to telephone interview with the RCC on 3/15/17 at 10:34am.

2. Record review for Resident #4 revealed:
-An order dated 9/21/16 for basic metabolic profile (BMP), complete blood count (CBC), and hemoglobin A1c to be done on the next lab day.
-An order dated 9/22/16 for CBC, thyroid stimulating hormone (TSH), and lipids.
-An order dated 1/12/17 for CBC, comprehensive metabolic profile (CMP), TSH and lipids.
-An order dated 2/9/17 for CBC, CMP, lipids and TSH.

Futher record review for Resident #4 revealed:
-On 9/26/16 a CBC, BMP and hemoglobin A1c were obtained and resulted.
-There was no documentation that the lab work had been collected.

Interview with the Administrator on 3/8/17 at 1:44pm revealed:
-Labs ordered on 9/22/16 and 1/12/17 were not in the resident's record.
-Labs ordered on 2/9/17 were not obtained due to the PCP not putting International Classification of

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D 273	Continued From page 19 Diseases (ICD) codes on the order. Review of documentation sent from the home health agency on 3/8/17 at 12:47pm revealed: -On 2/16/17 the Home Health RN had documented that she spoke to the Mental Heath provider's Nurse Practitioner regarding being unable to process the 2/9/17 lab order. -The home health agency needed ICD codes and frequency in order to obtain the labs. Interview with Resident #4 on 3/10/17 at 4:00pm revealed he was not aware that labs had not been obtained. Telephone interview with the RCC on 3/15/17 at 10:34am revealed: -A local home health agency normally obtained labs for Resident #4. -They had recently switched home health nurses and some labs were missed because of this. -She started working as the RCC at the end of December 2016. -Communication was a "big issue" in the facility. Telephone interview with a local home health agency on 3/15/17 at 10:53am revealed: -The only lab orders they had received were ordered on 9/21/16 and 2/9/17. -They had received an order to obtain a urinalysis on 10/26/16. -They had not received any lab orders for 9/22/16 and 1/12/17. -The 2/9/17 lab order was missing ICD codes and they were waiting for a clarification order from the PCP. Telephone interview with the Administrator on 3/15/17 at 2:49pm revealed: -New lab orders were placed in a box in the	D 273		

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medication room for the home health agency nurse to pick up.
-"They (the home health agency) dropped the ball."
-The home health box was located beside of a box for the Administrator, and if she noticed any orders in the home health box, she would make sure they were notified of the orders.

Telephone interview with the PCP on 3/16/17 at 12:27pm revealed:
-She was not aware that the ordered labs from 9/22/16, 1/12/17 and 2/9/17 had not been completed as ordered.
-They were just "routine labs."

Refer to interview with the Administrator on 3/13/17 at 3:40pm.

3. Review of Resident #4's MAR for December 2016 revealed:
-An entry to check blood pressures daily and record.
-There were 19 blood pressures (BPs) not documented from 12/5/16 to 12/31/16.
-There were 3 refusals on 12/2, 12/10 and 12/11.
-No documentation for the missed BP readings.

Review of Resident #4's Blood Pressure Documentation Sheet for December 2016 revealed:
-There were 19 BPs not documented from 12/5/16 to 12/31/16.
-There were 3 refusals on 12/2, 12/10 and 12/11.
-Blood pressures ranged from 89/68 to 148/109.

Review of Resident #4's MAR for January 2017 revealed:
-An entry to check blood pressures daily and record.

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D 273	Continued From page 21 -There were 4 consecutive BP refusals documented from 1/5/17 to 1/8/17. -No documentation of notification of the PCP for the refused BP readings. Review of Resident #4's Blood Pressure Documentation Sheet for January 2017 revealed: -There were 4 consecutive BP refusals documented from 1/5 to 1/8. -Blood pressures ranged from 99/71 to 182/76. Review of Resident #4's MAR for February 2017 revealed: -An entry to check blood pressures daily and record. -There were 6 BPs not documented on 2/4, 2/5, 2/9, 2/13, 2/14 and 2/23. -No documentation of notification of the PCP for the missed BP readings. -No documentation for the missed BP readings. Review of Resident #4's Blood Pressure Documentation Sheet for February 2017 revealed: -There were 2 refusals documented on 2/17 and 2/21. -Blood pressures ranged from 105/76 to 149/90. Review of Resident #4's MAR for March 2017 revealed: -An entry to check blood pressures daily and record. -On 3/4 and 3/5 the MA had signed that the BP was done, but did not document the results. -Blood pressures ranged from 105/68 to 144/126. Futher record review for Resident #4 revealed there was no Blood Pressure Documentation Sheet for March 2017.	D 273		

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Interview with Resident #4 on 3/10/17 at 4:00pm revealed his BPs were checked, but not daily.

Confidential interview with a MA revealed:
-The MAs were responsible for notifying the PCP of refusals after 3 consecutive times.
-The MA was unable to explain why Resident #4 had missed and refused blood pressures.

Telephone interview with the RCC on 3/15/17 at 10:34am revealed:
-She was not aware that Resident #4 had refused BP readings to be obtained.
-She was not aware of all the BP readings that were missing.

Telephone interview with the PCP on 3/16/17 at 12:27pm revealed she was not aware of the BP refusals or missed readings.

Refer to interview with the Administrator on 3/13/17 at 3:40pm.

Refer to telephone interview with the RCC on 3/15/17 at 10:34am.

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Interview with the Administrator on 3/13/17 at 3:40pm revealed the most recent chart audits were completed by the facility in November 2016.

Interview with the RCC on 3/15/17 at 10:34am revealed:
-She started working as the RCC at the end of December 2016.
-She could not recall any issues Resident #4 was having in December 2016.
-Communication was a "big issue" in the facility.
-The MAs "should have let me know (about refusals, missed medications and procedures)

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after 3 consecutive times, then I would notify the MD."

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The facility failed to assure referral and follow-up to meet the acute health care needs of Resident #4 with diagnoses of diabetes, Stage II pressure ulcer, anemia, deep vein thrombosis, major depression, insomnia, and polysubstance abuse. Failure to clarify FSBS orders resulted in the delay of implementing FSBS for 45 days. Failure to notify the physician for FSBS and BP refusals placed him at potential risks of high or low blood pressures, high or low blood sugars, and complications of inadequate treatment of diabetes, which include stroke, heart disease, kidney failure, permanent damage to the eyes, and death. Failure to obtain the ordered labs exposed the resident to the risk of failed monitoring of routine labs and the resident's general health that could lead to kidney and liver damage, worsening anemia, and failure to expose potential problems with thyroid function. These failures were detrimental to the health and safety of the affected resident and constitute a Type B Violation.

____

The Plan of Protection provided by the facility on 3/15/17 revealed:
- Charts will be audited to look for any lab orders that have not been completed, PCP will be made aware of new orders received and asked how to proceed.
- MD will be made aware of any refusals of medications and treatments per protocol/procedure.
-All lab orders will be faxed to home health agency and fax verifications will be kept.
-Meetings will be held weekly for home health

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D 273	Continued From page 24 agency to go over any refusals that occurred so PCP can be properly notified. -A record will be kept of labs drawn so RCC can look for results and document. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2017.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure documentation of the following in the resident's record: written procedures, treatments or orders from a licensed health professional; and implementation of procedures, treatments or orders for 3 of 5 sampled residents (Residents #1, #2, and #4) with orders for sliding scale insulin, blood sugar readings, daily blood pressures, and labs. The findings are: A. Review of Resident #4's current FL2 dated 6/4/16 revealed: -Diagnoses included diabetes mellitus, insomnia, major depression, bipolar disorder,	D 276		

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schizophrenia, anxiety, deep vein thrombosis, and anemia.
-Medications included Levemir (used to treat high blood sugar levels) 100 units/ml, inject 50 units subcutaneously (SQ) every morning and 60 units at bedtime; Novolog (used to treat high blood sugar levels) 100 units/ml inject 3 units SQ along with sliding scale insulin (SSI) dose three times daily before meals 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units, Cymbalta (for anxiety) 30mg daily, Lasix (a diuretic) 40mg daily, Imdur ER (for chest pain) 60mg daily, lisinopril/hydrochlorothiazide (for blood pressure) 20mg/12.5mg twice daily, Lopressor (for blood pressure) 100mg at bedtime, Seroquel XR (an antipsychotic) 250mg at bedtime, Oxycodone (for pain) 15mg 4 times daily, Xarelto (a blood thinner) 20mg daily, and Xanax 0.5mg twice daily as needed for anxiety.
-An order to check finger stick blood sugar (FSBS) levels at 7:30am, 11:30am, and 4:30pm.
-An order to check blood pressure once daily and record.

Interview with a Home Health nurse on 3/8/17 at 11:40am revealed:
-Resident #4 was being treated for a Stage II pressure ulcer on the upper posterior thigh.
-The Home Health nurse was performing wound care 2 times per week.

Record review for Resident #4 revealed:
-An order dated 9/8/16 to discontinue Xarelto.
-A Physician's Order sheet signed 11/23/16 to change Levemir 100 units/ml to 60 units SQ twice daily, Humalog 100 units/ml (used to treat high blood sugar levels) inject 3 units SQ along with sliding scale insulin (SSI) dose three times daily before meals: 150-200 = 2 units, 201-250 = 4

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D 276	Continued From page 26 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units and call MD. -A Physician's Order sheet signed 11/23/16 to start Symbicort 80-4.5mg inhale 2 puffs daily (for asthma and chronic obstructive pulmonary disorder), and Tamsulosin 0.4mg daily (to treat an enlarged prostate gland). -A "Physician FYI" form dated 12/22/16 notifying the Primary Care Provider (PCP) that Resident #4 had been refusing injections for over 4 weeks. -An order dated 12/26/16 to discontinue Humalog 100 units/ml. -There was no order to discontinue the FSBS checks before meals. -An order dated 3/2/17 for warfarin 3.5mg daily (a blood thinner). 1. Review of Resident #4's Medication Administration Record (MAR) for December 2016 revealed: -An entry for Humalog 100 units/ml inject 3 units SQ 3 times daily before meals along with dose per sliding scale insulin 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units and call PCP. -An entry to check FSBS levels at 7:30am, 11:30am, and 4:30pm. -From 12/01/16 to 12/25/16 there were 15 documented refusals at 7:30am for the FSBS and 18 refusals for the SQ injection of Humalog 3 units along with the sliding scale dose. -From 12/01/16 to 12/25/16 there were 15 documented refusals at 11:30am for the FSBS and 18 refusals for the SQ injection of Humalog 3 units along with the sliding scale dose. -From 12/01/16 to 12/25/16 there were 18 documented refusals at 4:30pm for the FSBS and 19 refusals for the SQ injection of Humalog 3	D 276		

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D 276	Continued From page 27 units along with the sliding scale dose. -An entry for Levemir inject 60 units SQ twice daily. -A Medication Note on the back of the MAR dated 12/21/16 at 4pm which documented the resident had refused the FSBS and the Humalog because "it made him feel faint/sick." -No documentation of notification of the Primary Care Provider (PCP) for the refusal of FSBS readings and injections. Review of Resident #4's Blood Sugar Documentation Sheet for December 2016 from 12/1/16 to 12/25/16 revealed: -There were 15 empty blocks where the FSBS was not documented. -There were 10 empty blocks where the dose of Humalog 3 units along with SSI given was not documented. -FSBS was documented as refused 8 times. -The resident's blood sugars ranged from 108-235. Review of Resident #4's MAR for January 2017 revealed: -There was no entry for FSBS. -The entry for Humalog and SSI was crossed out and marked as "DC". -An entry for Levemir inject 60 units SQ twice daily at 7:30am and 8:30pm. Further record review for Resident #4 revealed: -There was no Blood Sugar Documentation Sheet for January 2017. -There was no request or documentation from the facility to clarify the frequency or discontinuation of the FSBS. -A Consultant Pharmacist's Medication Regimen Review dated 1/18/17, that was sent to the PCP, and requested verification of how often FSBS	D 276		

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were to be checked since the Humalog was discontinued in December.
-An order in response to the Consultant Pharmacist's Medication Review to check FSBS daily at 6:30am, which was to begin on 2/9/17.
-A hemoglobin A1c level of 6.6% (normal range 3.0 to 5.6) from a blood sample taken on 9/26/16.

Review of Resident #4's MAR for February 2017 revealed:
-There was no entry for FSBS.
-An entry for Levemir 100 units/ml inject 60 units SQ twice daily at 7:30am and 8:30pm.

Review of Resident #4's Blood Sugar Documentation Sheet for February 2017 revealed:
-A note at the top of the form written by the Medication Aide (MA) to check FSBS before meals.
-There were 15 days from 2/1/17 to 2/28/17 where the FSBS was not documented at 7:30am.
-There were 7 days from 2/1/17 to 2/9/17 where the FSBS was not documented at 11:30am.
-There was no documentation of FSBS at 4:30pm from 2/1/17 to 2/9/17.
-The resident's blood sugars ranged from 140 to 567.

Review of Resident #4's MAR for March 2017 revealed:
-An entry dated 2/9/17 to check FSBS once daily before breakfast.
-An entry for Levemir 100 units/ml inject 60 units SQ twice daily at 7:30am and 8:30pm.
-There was no documentation of FSBS readings for 3/1 and 3/3.
-The FSBS on 3/6 was documented as refused.
-FSBS were documented on 3/2, 3/4, 3/5 and 3/7.

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D 276	Continued From page 29 Review of Resident #4's Blood Sugar Documentation Sheet for March 2017 revealed: -FSBS readings were obtained 7 days from 3/1/17 to 3/9/17. -There was no documentation of FSBS readings for 3/3 and 3/6. -The resident's blood sugars ranged from 114 to 195. Confidential interview with a Medication Aide (MA) revealed: -The current order for FSBS was once daily before breakfast. -The MA was unable to explain why Resident #4 had missed and refused FSBS and injections in December 2016. -The MAs were responsible for notifying the PCP of FSBS or medication refusals after 3 consecutive times. -The FSBS order was changed to once daily after the Humalog was discontinued in December. -The MA was unable to explain why there were no FSBS done on the January or February MARs. Interview with the Resident Care Coordinator (RCC) on 3/10/17 at 10:00am revealed: -There were no orders to discontinue or change FSBS from December 2016 to March 2017. -There was no January Blood Sugar Documentation Sheet for January 2017. -She could not explain why the FSBS entry had dropped off the MAR in January and February 2017. Interview with Resident #4 on 3/10/17 at 4:00pm revealed: -He gets Levemir 60 units twice daily. -Staff check his blood sugar 1-2 times daily. -He had refused FSBS in the past.	D 276		

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Telephone interview with the facility's pharmacy provider on 3/13/17 at 2:09pm revealed:
-The FSBS order for three times daily before meals had "just dropped off" the MAR when the sliding scale insulin was discontinued on December 26, 2016.
-The facility should have requested a clarification order related to FSBS from the PCP.

Telephone interview with the PCP on 3/16/17 at 12:27pm revealed:
-She was made aware of the refusals on 12/22/16.
-After the Humalog was discontinued, the resident should have had FSBS checked at least twice daily.
-The facility should have been checking FSBS for January 2017.
-"That (not checking FSBS) should not have happened."

Interview with the Administrator on 3/13/17 at 3:40pm revealed:
-The RCC was responsible for ensuring all current orders were on the MAR.
-The RCC was responsible for order clarification.

Telephone interview with the RCC on 3/15/17 at 10:34 am revealed:
-She was not aware that Resident #4 had refused FSBS and injections "that many times."
-She would not give insulin without checking a FSBS.
-She and another MA would compare the current MAR to the upcoming month's MAR, and not MAR to orders when a new month began.

Refer to interview with the RCC on 3/9/17 at 9:40am.

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D 276	Continued From page 31 Refer to interview with the Administrator on 3/13/17 at 3:40pm. Refer to telephone interview with the RCC on 3/15/17 at 10:34am. 2. Review of Resident #4's MAR for December 2016 revealed: -An entry to check blood pressures daily and record. -There were 19 blood pressures (BPs) not documented from 12/5/16 to 12/31/16. -There were 3 refusals on 12/2, 12/10 and 12/11. -No documentation for the missed BP readings. Review of Resident #4's Blood Pressure Documentation Sheet for December 2016 revealed: -There were 19 BPs not documented from 12/5/16 to 12/31/16. -There were 3 refusals on 12/2, 12/10 and 12/11. -Blood pressures ranged from 89/68 to 148/109. Review of Resident #4's MAR for January 2017 revealed: -An entry to check blood pressures daily and record. -There were 4 consecutive BP refusals documented from 1/5/17 to 1/8/17. -No documentation of notification of the PCP for the refused BP readings. Review of Resident #4's Blood Pressure Documentation Sheet for January 2017 revealed: -There were 4 consecutive BP refusals documented from 1/5 to 1/8. -Blood pressures ranged from 99/71 to 182/76. Review of Resident #4's MAR for February 2017 revealed:	D 276		

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D 276	Continued From page 32 -An entry to check blood pressures daily and record. -There were 6 BPs not documented on 2/4, 2/5, 2/9, 2/13, 2/14 and 2/23. -No documentation of notification of the PCP for the missed BP readings. -No documentation for the missed BP readings. Review of Resident #4's Blood Pressure Documentation Sheet for February 2017 revealed: -There were 2 refusals documented on 2/17 and 2/21. -Blood pressures ranged from 105/76 to 149/90. Review of Resident #4's MAR for March 2017 revealed: -An entry to check blood pressures daily and record. -On 3/4 and 3/5 the MA had signed that the BP was done, but did not document the results. -Blood pressures ranged from 105/68 to 144/126. Futher record review for Resident #4 revealed there was no Blood Pressure Documentation Sheet for March 2017. Interview with Resident #4 on 3/10/17 at 4:00pm revealed his BPs were checked, but not daily. Confidential interview with a MA revealed: -The MAs were responsible for notifying the PCP of refusals after 3 consecutive times. -The MA was unable to explain why Resident #4 had missed and refused blood pressures. Telephone interview with the RCC on 3/15/17 at 10:34am revealed: -She was not aware that Resident #4 had refused BP readings to be obtained.	D 276		

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-She was not aware of all the BP readings that were missing.

Telephone interview with the PCP on 3/16/17 at 12:27pm revealed she was not aware of the BP refusals or missed readings.

Refer to interview with the Administrator on 3/13/17 at 3:40pm.

Refer to telephone interview with the RCC on 3/15/17 at 10:34am.

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Interview with the Administrator on 3/13/17 at 3:40pm revealed the most recent chart audits were completed by the facility in November 2016.

Interview with the RCC on 3/15/17 at 10:34am revealed:
-She started working as the RCC at the end of December 2016.
-She could not recall any issues Resident #4 was having in December 2016.
-Communication was a "big issue" in the facility.
-The MAs "should have let me know (about refusals, missed medications and procedures) after 3 consecutive times, then I would notify the MD."

B. Review of Resident #1's current FL2 dated 11/8/16 revealed:
-Diagnoses included hypertension and diabetes type II.
-Physician orders for Lopressor 50 mg twice daily (used to lower blood pressure).
-Physician orders for Lantus inject 20 units daily, metformin 500 mg 2 tablets twice daily, Tradjenta 5 mg daily, and Tresiba inject 60 units at bedtime (all 3 medications used to lower blood glucose

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levels).
-Finger stick blood sugars three times per day.
-No blood pressures ordered.

1. Review of physician orders dated 11/9/16 for Novolog Sliding Scale Insulin (SSI) to be administered with the following protocol:
-150-200:2 units
-201-250-4 units
-251-300: 6 units
-301-350: 8 units
-351-400: 10 units
-401 and up: 12 units and call physician

Review of Resident #1's February 2017 MAR revealed:
-No documentation of 14 FSBSs on the 5th, 9th, 14th, 19th, 24th, 25th, and 26th for 7:30am and for 11:30am and no documentation of any SSI administered at those times.
-Other times which no FSBS and no SSI were documented was on 7th at 11:30am, 15th at 7:30am, 17th at 11:30am, 20th at 7:30am, and on the 21st at 7:30am.
-Times which FSBSs were completed without any documentation of insulin administered were on the 7th at 11:30 FSBS 216, 11th at 11:30am FSBS 203, 12th at 11:30am FSBS 205, 13th at 11:30am FSBS 157, 14th at 7:30am FSBS 175, 15th at 7:30am FSBS 261, 15th at 11:30am FSBS 227, 18th at 11:30am FSBS 216, 20th at 7:30am FSBS 223, 20th at 11:30am FSBS 188, 21st at 7:30am FSBS 242, 21st at 11:30am FSBS 178, 27th at 11:30 FSBS 159, and on the 28th at 11:30am FSBS 181.

Review of Resident #1's January and February 2017 MARs revealed:
-Entries for FSBS at 7:30, 11:30am, and 4:30pm with Novolog SSI.

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-Lantus at 7:00am.
-Tresiba 60 units at 8:00pm

Refer to interview with the RCC on 3/9/17 at 9:40am.

2. Review of a physician's order for Resident #1 dated 2/15/17 revealed blood pressures daily and record.

Review of Resident #1's February 2107 MAR revealed:
-An entry for blood pressures to be documented daily starting on 2/16/17.
-No blood pressures were documented on the 19th, 20th, 22th, 23th, 24th, 25th, and 26th.

Telephone interview on 3/10/17 at 2:15pm with the physician assistant revealed:
-She sees Resident #1 every two weeks.
-She asked staff for the last set of vital signs for the residents.
-She did not know Resident #1 was not having vitals (blood pressure) monitored daily as per the order.

Telephone interview on 3/17/17 at 4:40pm with the Administrator revealed:
-She did not know why Resident #1 was not having her blood pressure checked as ordered by her physician.
-She had not reviewed the MARs or blood pressure flow sheets to see if Resident #1's orders were implemented.
-The RCC was responsible for reviewing the MARs.

Telephone interview with the RCC on 3/17/17 at 11:30am revealed:
-She reviewed MARs once a week.

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-She checked for holes in the MARs and flow sheets.
-She did not know why the MAs were not documenting FSBS and blood pressures on the MARs and flow sheets.
-If there were corrections or documentation that needed to be made to the MAR or flow sheet ,she would post it on the board in the medication room.
-Some MAs would make corrections to their errors and other MAs would not.
-MAs would not listen to her when she told them there were problems with the MARs or with documentation.
-MAs stated to her they have always done things the way they did them and were not going to change.
-She informed the Administrator of the statements by the MAs.
-During a staff meeting the Administrator would bring up the MAs need to listen to the RCC to fix the problems.
-The Administrator never reviewed the MARs or any of the tasks the MAs were to complete.
-She could not fix the problems if staff were unwilling to listen and change the way they did things.

C. Review of Resident #2's current FL2 dated 3/2/17 revealed diagnoses included diabetes, respiratory failure, muscle wasting, and chronic obstructive pulmonary disease.

Review of Resident #2's Resident Register revealed a date of admission of 2/7/17.

Review of Resident #2's FL2 Medication Clarification orders dated 2/7/17 and 3/3/17 revealed:

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-Medication orders for Novolog insulin, 30 units subcutaneously before breakfast and supper and at bedtime, and 35 units before lunch. (Novolog is a quick acting insulin used to lower blood sugar levels around mealtimes.)
-A medication order for Tresiba, 100 units subcutaneously daily.(Tresiba is a long acting insulin used to control blood sugar levels around the clock.)

Review of Resident #2's record revealed:
-A verbal order from the facility's Nurse Practitioner (NP) dated 2/2/17 to check Resident #2's Accuchecks (finger stick blood sugars) 4 times a day before meals and at bedtime.
-An order from the facility's NP dated 3/8/17 for Accuchecks before meals and at bedtime, hold insulin if blood sugar less than 120.

Review of Resident #2's MAR for February 2017 revealed:
-A handwritten entry for blood sugars 4 times a day, scheduled at 7am, 11:30am, 4:30pm, and 8pm.
-No FSBS documented on 2/13/17 at 11:30am, 2/18/17 at 8pm, 2/23/17 at 4:30pm and 8pm, 2/24/17 at 7am and 11:30am, 2/25/17 at 7am and 11:30am, 2/26/17 at 7am, 11:30am, and 4:30pm, and 2/27/17 at 11:30am.

Resident #2's documented blood sugars ranged from 109 to 353 in February 2017.

Review of Resident #2's MAR and blood sugar documentation form for March 2017 revealed:
-A handwritten entry for blood sugars four times a day, scheduled at 7am, 11:30am, 4:30pm, and 8pm.
-No FSBS documented for 3/3/17 at 4:30pm, 3/4/17 at 4:30pm and 8pm, 3/5/17 at 11:30am,

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and 8pm, 3/6/17 at 4:30pm and 8pm, and 3/7/17 at 4:30pm.

Resident #2's documented blood sugars ranged from 114 to 383 in March 2017.

Review of Resident #2's blood glucose meter on 3/9/17 at 3:04pm revealed:
-There were 31 readings in the memory of Resident #2's glucose meter.
-The readings began on 3/9/17 at 11:59am, and ended on 2/23/17 at 5:33pm.
-From 3/9/17 at 11:59am to 2/23/17 at 5:33pm there should have been 47 blood sugar readings.
-One blood sugar reading on 2/28/17, and 2/23/17.
-Two blood sugars on 3/9/17, 3/6/17, 2/26/17, 2/25/17 and 2/24/17.
-Three blood sugars on 3/8/17, 3/7/17, 3/5/17, 3/4/17, and 3/3/17.
-Four blood sugars on 2/27/17.

Record review revealed Resident #2 was out of the facility in the hospital from the afternoon of 2/28/17 through the evening of 3/2/17 due to exacerabation of chronic obstructive pulmonary disease.

Interview with Resident #2 on 3/10/17 at 10:53am revealed:
-He had never refused his FSBS.
-As far as he knew, staff had always used the same glucose meter to obtain his FSBS.
-He was not aware of any change in his glucose meter after his last hospitalization.

Interview with a MA on 3/10/17 at 11:43am revealed:
-Resident #2 had not refused his insulin or FSBS while she was working.

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D 276	Continued From page 39 -She always checked his FSBS when she worked and documented it on the MAR. Telephone interview with the Administrator on 3/17/17 at 4:40pm revealed she did not know why staff were not documenting blood sugar readings properly on the MAR. Refer to interview with the RCC on 3/9/17 at 9:40am. ___________________________ Interview with the RCC on 3/9/17 at 9:40am revealed: -She was responsible for checking the accuracy of the MARs. -The blood sugars should be documented on the MAR or blood sugar documentation sheet.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 sampled resident (Resident #16) with a physician order for a puree diet was served as ordered. The findings are: Review of Resident #16's current FL2 dated	D 310		

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6/14/16 revealed:
-Diagnoses included Alzheimer's dementia, gastroesophageal reflux disorder, and B 12 deficiency.
-A physician's order for a puree diet.

Observation of the noon meal on 3/7/17 at 12:00pm revealed Resident #16 was served three pureed foods with tea and water.

Review of the pureed lunch menu for 3/7/17 revealed 5 items, pureed roast pork with gravy, macaroni and cheese, braised cabbage, cornbread, and applesauce cake were to be served.

Interview with the Dietary Manager on 3/7/17 at 9:47am revealed:
-The three pureed items served to Resident #16 were fish, pinto beans, and applesauce.
-They substituted the fish cake for pork and pinto beans for cabbage and Resident #16 had been served applesauce in place of pureed applesauce cake.
-They did not serve macaroni and cheese and bread to Resident #16.
-When he came to work there about 2 months ago he was taught to not serve bread to residents with a puree diet.
-Failing to serve Resident #16 the macaroni and cheese "was an oversight."

Observation of the breakfast meal on 3/8/17 at 8:00am revealed Resident #16 was served dry cereal soaked in milk, pureed scrambled eggs, pureed banana, and juice.

Review of the pureed breakfast menu for 3/817 revealed the item pureed sausage patty was also supposed to have been served.

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D 310	Continued From page 41 Interview with the Dietary Manager on 3/8/17 at 8:45am revealed Resident #16 did not like sausage and no other meat substitute was served to her. Telephone interview with the Administrator on 3/14/17 at 2:40pm revealed the activity director/business office manager was responsible for assisting the dietary manager with ordering food and for assuring all therapeutic menus were served appropriately. Telephone interview with the activity director/business office manager on 3/15/17 10:25am revealed: -She monitored the meals to assure the residents received pureed foods but she had not been comparing items served with the menu. -She had not monitored to assure all items were served as listed on the pureed menu. Review of documentation of weights for Resident #16 and observation of her weight on the scales on 3/8/17 at 2:30pm revealed no weight loss in the past 6 months. Based on observations and diagnoses, Resident #16 was determined to not be interviewable.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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	D 358		

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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 B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure medications (Forteo, simvastatin, and Novolog), were administered as ordered by a licensed prescribing practitioner for 3 of 6 residents (#2, #10, and #11) observed on a medication pass and failed to assure medications (Humalog, Klonopin, Oxycodone, Tradjenta, Tresiba, and lorazepam) were administered as ordered for 6 of 10 residents (#1, #4, #6, #12, #14, and #15) sampled.

The findings are:

A. Observation of the morning medication pass on 3/8/17 revealed 6 residents received 41 medications with 3 errors observed for a medication error rate of 7%.

1. Review of Resident #10's current FL2, hospital discharge summary, and FL2 clarification orders all dated 2/21/17 revealed:
-Diagnoses included generalized edema, elevated troponin level, and hepatitis C.
-Medication orders for Novolog, 18 units with breakfast and supper, and 15 units daily with lunch. (Novolog is a quick acting insulin used to lower blood sugar levels around mealtimes.)
-Novolog Sliding Scale Insulin (SSI) to be given with meals in addition to the fixed dose.
-The SSI was to be given as follows: A blood sugar reading of 120-149= 1 unit, 150-199=3

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units, 200-249=5 units, 250-299= 7 units, 300-349= 8 units, and > 349= 8 units, recheck after 2 hours, call physician if results >349.

Record review revealed a prior history and physical dated 8/15/15 with additional diagnoses of chronic obstructive pulmonary disease, diabetes, and congestive heart failure.

Observation of morning medication pass on 3/8/17 at 8:10am revealed:
-Resident #10 stood at the medication cart waiting to receive his morning dose of Novolog insulin.
-An unlabeled glucose meter was laying on top of the medication cart with a finger stick blood sugar (FSBS) reading of 221mg/dl.
-A empty glucose meter case was also laying on top of the medication cart with Resident #10's name written on the side of the case.
-The Medication Aide (MA) indicated the meter and case belonged to Resident #10, and he was to receive 24 units of Novolog insulin this morning.
-The MA stated the 24 units of Novolog insulin included 18 units of fixed dose insulin plus 6 units of SSI.
-The MA then drew up 24 units into an insulin syringe and administered it subcutaneously to Resident #10's right upper arm.

According to Resident #10's dose of SSI of 5 units for a FSBS of 221 and fixed dose 18 units, Resident #10 should have received 23 units.

Interview on 3/9/17 at 10:40am with the MA who administered Resident #10's morning medications on 3/8/17 revealed:
-Resident #10's FSBS was actually 128 on the morning of 3/8/17, not 221 as indicated on the

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meter, and he should have gotten 19 units, not 24 units.
-She could not explain the discrepancy with the reading on the glucose meter on the top of the medication cart on 3/8/17 at 8:10am, but they do not share glucose meters between residents.

Review of Resident #10's Medication Administration Record (MAR) for March 2017 revealed:
-A handwritten entry for SSI to be given at 8am, 12 noon, and 5pm.
-A computer generated entry for fixed dose Novolog insulin, 18 units to be given at 7am with breakfast, 15 units at 12 noon with lunch, and 18 units to be given at 5pm with supper.
-Initials for the SSI dose of Novolog given at 8am on 3/8/17 but no amount or FSBS documented.
-Initials for the fixed morning dose of Novolog on 3/8/17 with a blood sugar of 221 documented on the MAR below the MA initials.

Review of the facility's Blood Sugar Documentation form for March 2017 for Resident #10 revealed the documented FSBS for 3/8/17 at 7am was 128, with 0 units of SSI documented as given. (A FSBS of 128 should have triggered a SSI dose of 1 unit.)

Review of Resident #10's glucose meter readings on 3/9/17 at 10:54am revealed:
-The time stamp on the glucose meter read 11:14pm on 6/11.
-By deduction, the FSBS of 221 on 3/8/17 at 8:10am was correct.
-A reading of 128 did not occur until 11:57am on 3/8/17.

Interview with Resident #10 on 3/9/17 at 11:15am revealed:

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-He thought he received FSBS "about 4 times a day."
-He was not sure about his SSI or the dose he was supposed to receive.
-He believed he received his medications as ordered by his physician.

2. Review of Resident #2's current FL2 dated 3/2/17 revealed diagnoses included diabetes, respiratory failure, muscle wasting, and chronic obstructive pulmonary disease.

Review of Resident #2's Resident Register revealed a date of admission of 2/7/17.

Review of FL2 clarification orders dated 3/3/17 revealed a medication order for Forteo, 20mcg injected subcutaneously daily. (Forteo is a medication used to treat severe osteoporosis in patients with a high risk of bone fracture.)

Observation of the morning medication pass on 3/8/17 at 8:35am revealed:
-Resident #2 received 17 oral medications, 2 inhalers, 3 injections, and 1 nasal spray.
-One of the injections given was Forteo.
-The Forteo was given subcutaneously in the posterior region of the upper right arm by the MA.

Review of Resident #2's MAR for March 2017 revealed:
-An entry for Forteo, Inject 20mcg subcutaneously in the abdominal wall or thigh once daily with no scheduled administration time.
-An entry in the slot for the administration time stated "home health."
-The Forteo had not been initialed as administered for the entire month of March 2017.

Review of the manufacturer's recommendation

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for administration of the Forteo revealed it should be injected subcutaneously into the thigh or lower abdominal area for maximum effectiveness.

Interview on 3/8/17 at 11:44am with the MA who administered the Forteo to Resident #2 revealed:
-She had forgotten to document the administration of the Forteo on the MAR.
-She had not noticed the instructions on the MAR to administer the Forteo into the abdomen or thigh.
-She was not aware Forteo should be given in the thigh or abdomen.
-She had not noticed the entry of "Home Health" on the area of the MAR that contained the administration time.
-She administered the Forteo to Resident #2 daily when she worked.

Interview with Resident #2 on 3/10/17 at 10:57am revealed:
-He received his Forteo injection every day.
-He has gotten the Forteo injection in the abdomen and leg.
-He asked to have the Forteo injected into his arm "because it hurts if you given it in the thigh."
-He takes the Forteo injection because his spine was deteriorating and causing him back pain.

3. Review of Resident #11's current FL2 dated 6/14/16 revealed:
-Diagnoses included diabetes, hypertension, and elevated blood lipids.
-A medication order for Zocor 20mg daily in the evening. (Zocor is a medication used to treat elevated blood lipids.)

Observation of the morning medication pass on 3/8/17 at 8:18am revealed:
-The MA pulled all of Resident #11's medication

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packs from the medication cart including the Zocor 20mg.
-Resident #11 received 8 oral medications during the morning medication pass on 3/8/17 including her evening dose of Zocor 20mg.
-Resident #11 refused a nasal spray.

Review of Resident #11's MAR for March 2017 revealed an entry for simvastatin (generic Zocor) 20mg, 1 tablet each evening with a scheduled administration time of 5pm.

Interview on 3/9/17 at 10:40am with the MA who administered Resident #11's medications on the morning of 3/8/17 revealed:
-She stated the Zocor for Resident #11 was to be given in the evening.
-She did not recall administering Resident #11's Zocor on the morning of 3/8/17.

Interview with Resident #11 on 3/8/17 at 10:30am revealed she was not aware of what medications she took or what color they were.

Review of the manufacturer's recommendations revealed Zocor should be given in the evening to achieve maximum effectiveness.

Refer to telephone interview with the Administrator on 3/17/17 at 4:40pm.

Refer to review of the facility's policy and procedures for administration of medications.

B. Review of Resident #10's current FL2, hospital discharge summary, and FL2 clarification orders all dated 2/21/17 revealed:
-Diagnoses included generalized edema, elevated troponin level, and hepatitis C.
-Medication orders for Novolog, 18 units with

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breakfast and supper, and 15 units daily with lunch. (Novolog is a quick acting insulin used to lower blood sugar levels around mealtimes.)
-Novolog Sliding Scale Insulin (SSI) to be given with meals in addition to the fixed dose.
-The SSI was to be given as follows: A blood sugar reading of 120-149= 1 unit, 150-199=3 units, 200-249=5 units, 250-299= 7 units, 300-349= 8 units, and > 349= 8 units, recheck after 2 hours, call physician if results >349.

Record review revealed a prior history and physical dated 8/15/15 with additional diagnoses of chronic obstructive pulmonary disease, diabetes, and congestive heart failure.

Record review revealed prior FL2 clarification orders for Resident #10 dated 1/20/17 with the same dose of SSI and fixed dose Novolog.

Review of Resident #10's MAR and blood sugar documentation sheet for February 2017 revealed:
-20 documented errors in administration of sliding scale insulin (SSI) with either the wrong amount of SSI given, no SSI given but required, or no blood sugar or SSI documented.
-The resident's blood sugars ranged from 93 to 594.

Review of examples of SSI insulin errors from Resident #10's MAR and blood sugar documentation sheet for February 2017 revealed:
-An 8am blood sugar of 436 on 2/12/17 with no SSI documented as given and 8 units required.
-No blood sugars or SSI for 8am or 12 noon documented for 2/23/17.
-A 12 noon blood sugar of 479 on 2/24/17 with 15 units of SSI documented as given and 8 units required.
-A 12 noon blood sugar of 479 on 2/25/17 with 25

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units of SSI documented as given and 8 units required.

Review of Resident #10's MAR and blood sugar documentation sheet for March 2017 revealed:
-8 documented errors in administration of SSI with either the wrong amount of SSI given, or no SSI given but required.
-The resident's blood sugars ranged from 110 to 587.

Review of examples of SSI insulin errors from Resident #10's MAR and blood sugar documentation sheet for March 2017 revealed:
-An 8am blood sugar reading of 378 on 3/1/17 with 12 units of SSI documented as administered and 8 units required.
-An 8am blood sugar reading of 327 on 3/5/17 with no SSI documented as given and 8 units required.

Review of Resident #10's record revealed a hemoglobin A1c level of 14.2% (normal range 3.0 to 5.6) from a blood sample taken on 12/16/16.

Per the American Diabetic Association, the target hemoglobin A1c for diabetics is 7.0% to 8.0% depending on comorbidities and the resident's past medical history.

Interview with the Resident Care Coordinator (RCC) on 3/9/17 at 9:40am revealed:
-She was responsible for checking the accuracy of the MARs.
-The blood sugars and SSI should be documented on the MAR or blood sugar documentation sheet.

Interview with Resident #10 on 3/9/17 at 11:15am revealed:

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-He thought he received FSBS "about 4 times a day."
-He was not sure about his SSI or the dose he was supposed to receive.
-He believed he received his medications as ordered by his physician.

Interview with a MA on 3/10/17 at 11:43am revealed:
-"We contact the resident's physician after 3 consecutive refusals of medications."
-She "believed" this was the policy of the facility.
-She could not explain the discrepancy in the documentation of the SSI and blood sugars.
-She always documented the blood sugar and sliding scale insulin when she gave it.

Interview with the Nurse Practitioner on 3/10/17 at 2:03pm revealed:
-She was aware of Resident #10's blood sugars and refusal of medications.
-It was important for the resident to receive his insulin properly due to his multiple comorbidities.
-The hemoglobin A1c of 14.2% was taken when Resident #10 was not on insulin.
-The facility called and faxed when residents refused medications.

Telephone interview with the Administrator on 3/17/17 at 4:40pm revealed:
-She did not know why staff were not documenting blood sugar readings properly on the MAR.

Refer to telephone interview with the Administrator on 3/17/17 at 4:40pm.

Refer to review of the facility's policy and procedures for administration of medications.

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D 358	Continued From page 51 C. Review of Resident #14's current FL2 dated 2/15/17 revealed: -Diagnoses included bipolar disorder, personality disorder and schizoaffective disorder. -The medication Klonopin 0.5mg 1 tablet TID (three times per day) had been ordered (Klonopin is a medication used for the treatment of some mental health disorders). -There was no subsequent order changing the Klonopin dosage. Review of Resident #14's Resident Register dated 2/15/17 revealed an admission date of 2/15/17. Interview with Resident #14 on 3/10/17 at 4:15pm revealed: -He had not been getting his Klonopin the way he was supposed to. -When he first came to the facility in February he was getting the medication the way it had been ordered by his physician which was three times per day -In March 2017, the facility started giving it to him twice per day. -He had told the medication aides about not getting his Klonopin the way he was supposed to but they told him he was not supposed to get the Klonopin 3 times per day. -He had tried to talk with the Administrator. Review of Resident #14's February 2017 MAR revealed: -Handwritten instructions "Klonopin 0.5mg take one tab by mouth three times daily" and in the hour column was handwritten "8am, 2pm, 8pm". -The medication had been documented as administered three times per day from 8pm on 2/15/17 through 8pm on 2/28/17.	D 358		

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Review of Resident #14's March 2017 MAR revealed:
-An entry for "Clonazepam 0.5mg tablet take 1 tablet by mouth 3 times daily".
-In the hour column the times were typed and documented to be given as "9am, 9pm".
-The medication was documented as being given two times per day at 9am and 9pm.

Confidential interviews with 3 Medication Aides revealed:
-They had not noticed the discrepancy between the Klonopin instructions and the administration times.
-They had not "noticed" the change in number of times the Klonopin was administered from February 2017 to March 2017.
-The RCC checked the MARs for accuracy.

Interview with the RCC on 3/9/17 at 9:40am revealed:
-She was responsible for checking the accuracy of the MARs.
-There was not specific frequency for checking the MARs.

Interview with the Administrator on 3/13/17 at 2:45pm revealed:
-The error was because of the pharmacy printing the wrong times on the MAR.
-The RCC was responsible for assuring the MARs are correct.
-The Medication Aides should have caught the error.
-She did not recall Resident #14 ever addressing the medication issue with her.

Telephone interview on 3/15/17 at 4:00pm with the facility pharmacy revealed:
-A representative from the pharmacy did not know

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why the Klonopin printed on the MAR for just twice per day.
-The computer had the order for the Klonopin 0.5mg three times a day.
-It was a pharmacy error that the administration times were not correct.
-She always tried to emphasize with the facility the importance of checking the current MAR with the previous MAR to ensure errors like this does not occur.

Refer to telephone interview with the Administrator on 3/17/17 at 4:40pm.

Refer to review of the facility's policy and procedures for administration of medications.

D. Review of Resident #15's current FL2 dated 10/21/16 revealed:
-Diagnoses included chronic back pain, ileostomy, seizure disorder and insomnia.
-The medication Oxycodone 10mg tablet 1 every 6 hours as needed for breakthrough pain DNE (Do not exceed) 3 tablets per day.

Review of the Oxycodone 10mg controlled substance count down sheet for Resident #15 revealed:
-On 1/1/17 she was administered 4 tablets.
-On 1/3/17 she was administered 4 tablets.
-On 1/13/17 she was administered 4 tablets.
-On 1/14/17 she was administered 4 tablets.
-On 1/15/17 she was administered 4 tablets.
-On 2/2/17 she was administered 4 tablets.
-On 2/3/17 she was administered 4 tablets.
-On 2/4/17 she was administered 4 tablets.
-On 2/5/17 she was administered 4 tablets.
-On 2/6/17 she was administered 4 tablets.
-On 3/12/17 she was administered 4 tablets.

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Review of the February 2017 MAR for Resident #15 revealed:
-Four tablets administered on 2/7/17.
-Four tablets administered on 2/9/17.
-Four tablets administered on 2/14/17.

Review of the March 2017 MAR for Resident #15 revealed she had not received more than 3 doses on any day in March.

Confidential interviews with 3 MAs revealed:
-They had been told in the past, by a previous resident care coordinator, that the controlled substance count down sheet could be counted the same as the MAR.
-Sometimes they would sign both the MAR and the controlled substance sheet, but normally it was one or the other.
-The medication was never really effective with Resident #15.
-Resident #15 wanted the medication "all the time".
-Two of the MAs did not know the medication was not to be given more than three times per day.
-The RCC checks the MARs and controlled sheets for accuracy.

Interview with the Administrator on 3/13/17 at 2:45pm revealed:
-The RCC was responsible for assuring the MARs and controlled substance sheets are correct.
-The MAs should have been signing in both places and documenting the reason given and effectiveness.

Interview with Resident #15 on 3/13/17 at 3:15pm revealed:
-She received the medication every time she asked for it.

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-She could tell "a little" improvement but not much.
-She had never been told by a medication aide that she could not have the medication.
-She did not know that she was only supposed to get the medication only three times per day.

Refer to telephone interview with the Administrator on 3/17/17 at 4:40pm.

Refer to review of the facility's policy and procedures for administration of medications.

E. Review of Resident #1's current FL2 dated 11/8/16 revealed:
-Diagnoses included hypertension and diabetes type II.
-Physician orders for Novolog sliding scale insulin, Lantus inject 20 units daily, Metformin 500 mg 2 tablets twice daily, Tradjenta 5 mg daily, and Tresiba inject 60 units at bedtime (all used to control blood sugar levels).
-An order for FSBS three times per day.

Review of mental health provider notes dated 12/8/16 revealed Resident #1 had additional diagnoses of anxiety, chronic post traumatic stress disorder, and major depressive disorder.

Interview with Resident #1 on 3/9/17 at 2:45pm revealed she received all her medications and fingersticks.

Observations on 3/10/17 at 3:15pm of Resident #1's medications on hand revealed all were available for administration.

1. Review of physician orders dated 11/9/16 for Resident #1 revealed Novolog Sliding Scale Insulin to be administered with the following

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parameters:
-150-200: 2 units
-201-250: 4 units
-251-300: 6 units
-301-350: 8 units
-351-400: 10 units
-401 and up: 12 units and call physician

Review of Resident #1's January and February 2017 MARs revealed:
-Entries for FSBS to be taken at 7:30, 11:30am, and 4:30pm with coverage of Novolog sliding scale insulin.
-Entries for Lantus at 7:00am.
-FSBS documented in January for 7:30am ranged from 83 to 277, for 11:30am ranged from 121 to 339, for 4:30pm ranged from 80 to 377.
-FSBS documented in February for 7:30am ranged from 92 to 223, for 11:30am ranged from 117 to 227, for 4:30pm ranged from 160 to 298.

Review of Resident #1's February 2017 MAR revealed:
-No documentation of 14 FSBSs on the 5th, 9th, 14th, 19th, 24th, 25th, and 26th for 7:30am and for 11:30am and no documentation of any sliding scale insulin administered at those times.
-Other times which no FSBS and no sliding scale insulin were documented was on 7th at 11:30am, 15th at 7:30am, 17th at 11:30am, 20th at 7:30am, and on the 21st at 7:30am.
-Times which insulin should have been administered but not was documented was on the 7th at 11:30 FSBS 216, 11th at 11:30am FSBS 203, 12th at 11:30am FSBS 205, 13th at 11:30am FSBS 157, 14th at 7:30am FSBS 175, 15th at 7:30am FSBS 261, 15th at 11:30am FSBS 227, 18th at 11:30am FSBS 216, 20th at 7:30am FSBS 223, 20th at 11:30am FSBS 188, 21st at 7:30am FSBS 242, 21st at 11:30am FSBS 178,

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27th at 11:30 FSBS 159, and on the 28th at 11:30am FSBS 181.

Confidential interview with 2 MAs revealed they just forgot to document after they took the fingerstick and gave the insulin.

Interview with the Administrator on 3/9/17 at 3:31pm revealed:
-The RCC was responsible monitoring weekly to assure the MAs administered sliding scale insulin and FSBS as ordered.
-She "spot checked" occasionally to assure MARs were documented.

Telephone interview with the RCC on 3/17/17 at 11:30am revealed:
-She did not know why the FSBS and the insulin were not administered as ordered.
-She had reviewed MARs at the faciliy and tried to get the MAs to administer and document accurately but they had not.
-Some MAs would make corrections to their errors and other MAs would not.
-She had reported to the Administrator that the MAs were not documenting the administration of FSBS and insulin.

Telephone interview with the Administrator on 3/17/17 at 4:40pm revealed she did not know why staff were not documenting blood sugar readings properly on the MAR.

2. Review of Resident #1's January and February 2017 MARs revealed:
-Entry for Tradjenta to be administered at 9:00am.
-No documentation of any administration of Tradjenta on 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/1, 2/2, and 2/3.

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Review of delivery sheets for Resident #1's Tradjenta revealed:
-2/27/17 - 30 tablets
-2/1/17 - 17 tablets
-1/11/17 - 2 tablets
-1/9/17 - 2 tablets
-12/9/16 - 20 tablets
-11/15/16 - 30 tablets

Confidential interview with 2 MAs revealed they thought they ran out of Tradjenta but failed to document there was none in the facility.

Interview with the Administrator on 3/9/17 at 3:31pm revealed:
-The RCC was responsible monitoring weekly to assure the MAs administered medications as ordered.
-She "spot checked" occasionally to assure MARs were documented.

Telephone interview with the RCC on 3/17/17 at 11:30am revealed:
-She did not know why Resident #1's Tradjenta was not administered or not documented as ordered.
-She had reviewed MARs at the facility once a week and tried to get the MAs to administer and document accurately.
-Some MAs would make corrections to their errors and other MAs would not.
-She had reported to the Administrator that the MAs were not documenting the administration of medications.

3. Review of the front and back of Resident #1's February 2017 MAR revealed:
-Computer generated entry for Tresiba Flex Touch 200 units/ml, inject 60 units, 0.3ml,

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subcutaneously at bedtime at 8:00pm.
-No documentation of administration and no explanation that Tresiba was administered on the 25th, 26th, and 28th.

Review of delivery sheets for Resident #1's Tresiba revealed:
-Tresiba three 3 ml pens, 9 ml of 200 units per ml were delivered on 2/3/17, which would have been a 30 day supply with a physician order for 60 units nightly.
-Tresiba three 3 ml pens, 9 ml f 200 units per ml were delivered on 3/6/17.

Confidential interview with 2 MAs revealed they administered the Tresiba but forgot to document the administration and do not remember having none available.

Telephone with the RCC on 3/17/17 at 11:30am revealed:
-She was not aware Resident #1's Tresiba was not administered for three days.
-She did not know if Tresiba was not available, or if they did not administer it, or if they administered it and failed to document.
-She reviewed MAR once a week.
-She checked for holes in the MARs and flow sheets.
-If there were corrections or documentation that needed to be made to the MAR or flow sheet she would post it on the board in the medication room.
-Some MAs would make corrections to their errors and other MAs would not.
-The Administrator never reviewed the MARs or any of the task the MAs were to complete.

Telephone interview with the Administrator on 3/17/17 at 4:40pm revealed:

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-She did not know why Resident #1 had not been administered her Tresiba as ordered by the physician.
-She remembered that Resident #1 did not get one of the medications due to a mix-up with insurance benefits.
-The RCC was responsible for assuring all medications were available for administration.

Telephone interview with the prescribing physician assistant on 3/10/17 at 2:20pm revealed:
-Resident #1 was on more than 1 diabetes medication and if any were not administered, the other medications may have prevented her blood sugar from being exceptionally high.
-She did see documentation of Resident #1's blood sugar on her last visit on 3/8/17.

Refer to telephone interview with the Administrator on 3/17/17 at 4:40pm.

Refer to review of the facility's policy and procedures for administration of medications.

F. Review of Resident #6's current FL2 dated 6/13/16 revealed:
-Diagnoses included depressive disorder, delusional disorder, and mild neurological disorder "due to another medical condition."
-Physician orders for Lorazepam 1 mg every 8 hours as needed (an antianxiety medication).

Review of subsequent physician orders, dated 11/23/16 revealed Lorazepam was changed to routine, 1 mg at 9:00am and 5:00pm.

Interview with Resident #6 on 3/7/17 at 10:50am revealed;
-The medication aides did not administer the

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Lorazepam to her for several days recently, times not specific.
-She said when she missed the Lorazepam, she did not feel any differently.

Review of the February and March 2017 MARs revealed Lorazepam was documented as administered twice daily at 9:00am and 5:00pm from 2/1/17 through 3/8/17.

Review of the Controlled Drug Sheets on 3/8/17 at 11:00am for the Lorazepam which began with the dates of 2/12/17 and 2/24/17 revealed 11 doses Lorazepam out of 48 opportunities were not documented as administered at the following times:
-2/23/17 at 5:00pm
-2/24/17 at 8:00am
-2/28/17 at 5:00pm
-3/1/17 at 8:00am
-3/1/17 at 5:00pm
-3/2/17 at 5:00pm
-3/3/17 at 8:00am
-3/4/17 at 8:00am
-3/4/17 at 5:00pm
-3/5/17 st 5:00pm
-3/6/17 at 5:00pm

Review of the controlled drug count sheets revealed lorazepam available for administration for the dates of 2/23/17 through 3/6/17.

Observations of Resident #6's medications on hand on 3/13/17 at 11:35am revealed the number of lorazepam available for administration matched the count on the controlled drug count down sheet.

Confidential interview with one of the MAs who initialed the administration of the lorazepam on

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the MAR but did not document the administration on the controlled drug sheet, revealed she must have been distracted, forgot to administer the lorazepam, and just initialed all the "holes on the MAR."

Telephone interview with the prescribing physician assistant on 3/10/17 at 2:20pm revealed that Resident #6 "probably felt a little more anxious" when she did not have the routine lorazepam.

Interview with the Administrator on 3/9/17 at 3:31pm revealed:
-The RCC was responsible monitoring weekly to assure the MAs were documenting the MARs accurately
-"I also spot checked" to assure MAs were documenting.

Telephone interview with the RCC on 3/17/17 at 11:30am revealed:
-She reviewed Medication MARs once a week.
-She checked for holes in the MARs and flow sheets.
-She was not aware the MAs were not administering the lorazepam.

Refer to telephone interview with the Administrator on 3/17/17 at 4:40pm.

Refer to review of the facility's policy and procedures for administration of medications.

G. Review of Resident #12's current FL2 dated 11/9/16 revealed:
-Diagnoses included two part non displaced fracture of the right humerus and anterior displaced fracture left clavicle and muscle weakness.

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-A physician order for Oxycodone 10mg every 6 hours as needed.

Interview with Resident #12 on 3/10/17 at 11:20am revealed:
-He had constant pain in his right shoulder and left arm.
-He did not receive his oxycodone as ordered about "2 months ago because they ran out."
-He did not know specific dates and times that he did not get his oxycodone.

Review of the pharmacy delivery sheets for Resident #12's oxycodone revealed a quantity of 120 tablets were delivered on 2/27/17.

Observations of medications on hand on 3/13/17 at 11:35am revealed:
-One open bubble pack of oxycodone with 17 remaining out of 30 of the 120 dispensed on 2/27/17 which correlated to a controlled drug sheet with a matching prescription number.
-One unopened bubble pack of oxycodone with a quantity of 30 of the 120 dispensed on 2/27/17 which correlated to a controlled drug count sheet with a matching prescription number.

Review of the three controlled drug count sheets with the same prescription number as the oxycodone delivered on 2/27/17 revealed:
-Three controlled drug sheets accounted for 90 out of the 120 oxycodone dispensed.
-One controlled drug sheet had the number 30 handwritten in on the top line with no oxycodone documented as administered with label of 120 tablets dispensed on 2/27/17.
-One controlled drug sheet had 17 oxycodone remaining out of 30 which were administered from 3/7/17 at 2:00pm through 3/10/17 at 2:00pm and the label revealed 120 tablets were

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dispensed.
-One controlled drug sheet had 30 oxycodone documented as administered from 2/27/17 at 8:00pm through 3/7/17 at 8:00am with none remaining and label revealed 120 tablets were dispensed.

Review of filed controlled drug sheets and the controlled drug count sheets on the cart revealed no sheet for the 30 oxycodone which were unaccounted for.

Review of the pharmacy delivery sheets for Resident #12's revealed:
-60 oxycodone were dispensed but but someone had crossed it out and hand written in 120 tablets.
-The prescription number on the delivery sheet did not match the prescription number on the 3 oxycodone controlled drug sheets and the prescription number on the oxycodone available for administration.

Telephone interview with the pharmacist on 3/9/17 at 11:15am revealed the prescription number for the 120 oxycodone dispensed and delivered on 2/27/17 did not match because they at first had 60 oxycodone ready to send but changed it to 120 oxycodone, and then failed to change the prescription number on the delivery sheet.

Review of additional delivery sheets when compared to oxycodone documented as administered on the controlled drug sheets were correlated from 2/27/17 back to 1/2/17, but a delivery of oxycodone on 12/30/16 did not have a correlating controlled drug sheet.

Interview with the Administrator on 3/9/17 at 3:31pm revealed:

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-She was not aware of the missing Oxycodone in March 2017 discovered by surveyors and staff had not reported it.
-A MAs reported on 12/31/16 that a bubble pack of 30 Oxycodone were missing and her investigation revealed 30 Oxycodone delivered on 12/30/16 was not in the facility on 12/31/16 but she did not know the prescription number and did not have a delivery sheet avaialable.
-The 30 Oxycodone were never found and the pharmacy dispensed 30 more as replacement and charged them to the facility.
-When Resident #12's Oxycodone was identified as missing in December, 2016, she reported it to the pharmacy, but she did not request a controlled substance accountability assessment by by the pharmacist who provided medication reviews.
.-After 12/31/16, the facility changed the system by having the medication aides immediately lock up the controlled medications when delivered.
-The facility did not change their system for labeling the controlled drug sheets to correlate with the bubble packs when there more than 1 pack was delivered.

Review of the controlled drug sheets for Resident #12 for December 2016 and January 2017 revealed:
-The oxycodone controlled drug sheets had labels with prescription numbers but no dispense date.
-The controlled drug sheet which began with staff administering oxycodone on 12/25/16 had the last dose of oxycodone documented as administered on 1/1/17 at 6:00am.
-The next dose of oxycodone documented as administered on a controlled drug count sheet began on 1/2/17 at 11:00am.
-There was no documentation of administration of

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oxycodone from 1/1/17 at 6:00am until 1/2/17 at 11:00am, a total of 29 hours.
Review of the back of the January 2017 MAR had no documentation indicating Resident #12 requested oxycodone with no availability.

Review of the controlled drug count sheet revealed the last available Oxycodone was administered on 1/1/17 at 6:00am and review of the delivery sheet revealed the next oxycodone was delivered on 1/2/17 at 11:02am which was a total of at least 29 hours that no oxycodone was available for administration.

Review of December oxycodone controlled drug sheet which was first initialed on 12/25/16 revealed:
-For a 24 hour period, oxycodone was documented as administered 4 times on 12/25/16, 3 times on 12/26/17, 4 times on 12/27/16, 4 times on 12/28/16, 4 times on 12/29/16, 4 times on 12/30/16 and 3 times on 12/31/16.
-Resident #12 had requested the oxycodone 3-4 times in a 24 hour time frame.

Telephone interview with the RCC on 3/15/17 at 11:15am revealed:
-The MAs were supposed to have her lock up the back up controlled medications in the Administrator's office if there was one open card in the drawer.
-If a controlled drug sheet was not in the controlled drug notebook on the medication cart, the MAs would not know if a pack of medications were missing because if more than 1 card was dispensed, there were no identifiers on the control sheets which matched each the label on the bubble pack.

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D 358	Continued From page 67 Refer to telephone interview with the Administrator on 3/17/17 at 4:40pm. Refer to review of the facility's policy and procedures for administration of medications. H. Review of Resident #4's current FL2 dated 6/4/16 revealed: -Diagnosis of diabetes mellitus. -Medications included Levemir (used to treat high blood sugar levels) 100 units/ml, inject 50 units subcutaneously (SQ) every morning and 60 units at bedtime and Novolog (used to treat high blood sugar levels) 100units/ml inject 3 units SQ along with sliding scale insulin (SSI) dose three times daily before meals 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units. -An order to check blood sugar levels at 7:30am, 11:30am, and 4:30pm. Interview with a Home Health nurse on 3/8/17 at 11:40am revealed: -Resident #4 was being treated for a Stage II pressure ulcer on the upper posterior thigh. -The Home Health nurse was performing wound care 2 times per week. Record review for Resident #4 revealed: -A Physician's Order sheet signed 11/23/16 to change Levemir 100units/ml to 60 units SQ twice daily and for Humalog 100units/ml (used to treat high blood sugar levels) inject 3 units SQ along with sliding scale insulin (SSI) dose three times daily before meals: 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units and call MD. -An order dated 12/26/16 to discontinue Humalog	D 358		

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100units/ml.
-A hemoglobin A1c level of 6.6% (normal range 3.0 to 5.6) from a blood sample taken on 9/26/16.

Review of Resident #4's MAR for December 2016 revealed:
-An entry for Humalog 100 units/ml inject 3 units (fixed dose) SQ 3 times daily before meals along with dose per sliding scale insulin 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units and call PCP.
-An entry to check FSBS levels at 7:30am, 11:30am, and 4:30pm.
-An entry for Levemir inject 60 units SQ twice daily.
-A Medication Note on the back of the MAR dated 12/21/16 at 4pm which documented the resident had refused the FSBS and the Humalog because "it made him feel faint/sick."
-No documentation of notification of the PCP for the refusal of FSBS readings and injections.

Review of Resident #4's Blood Sugar Documentation Sheet and MAR for December 2016 revealed:
-18 documented errors in administration of sliding scale insulin (SSI) with either the wrong amount of SSI given, no SSI given but required, or no blood sugar or SSI documented.
-The resident's blood sugars ranged from 108-235.

Review of examples of SSI insulin errors from Resident #4's MAR and Blood Sugar Documentation Sheet for December 2016 revealed:
-No blood sugars or SSI or fixed dose for 7:30am documented for 12/5/16.
-A 7:30am blood sugar reading of 220 on

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12/22/16 with 0 units of SSI and scheduled insulin documented as administered and 7 units required.
-An 11:30am blood sugar reading of 221 on 12/16/16 with 0 units of SSI and fixed dose insulin documented as administered and 7 units required.
-An 11:30am blood sugar reading of 213 on 12/22/16 with 0 units of SSI and fixed dose insulin documented as administered and 7 units required.
-A 4:30pm blood sugar reading of 356 on 12/16/16 with 10 units of SSI and fixed dose insulin documented as administered and 13 units required.

Interview with Resident #4 on 3/10/17 at 4:00pm revealed he currently received Levemir injections twice daily and had blood sugars checked 1-2 times a day.

Confidential interview with a MA revealed:
-The current order for FSBS was once daily before breakfast.
-The FSBS order was changed to once daily after the Humalog was discontinued in December.
-The MA was unable to explain why Resident #4 had missed and refused FSBS and injections in December 2016, and why the SSI or fixed insulin dose was incorrect or not documented.

Telephone interview with the Primary Care Provider (PCP) on 3/16/17 at 12:27pm revealed she was not aware that incorrect doses of insulin were given to Resident #4.

Interview with the Administrator on 3/13/17 at 3:40pm revealed:
-The RCC was responsible for ensuring all current orders were on the MAR.

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-The RCC was responsible for order clarification.
-The most recent chart audits were completed by the facility in November 2016.

Telephone interview with the RCC on 3/15/17 at 10:34am revealed:
-She and another MA would compare the current MAR to the upcoming month's MAR, and not MAR to orders when a new month began.
-She could not recall any issues Resident #4 was having in December 2016.
-She started working as the RCC at the end of December 2016.

Telephone interview with the Administrator on 3/17/17 at 4:40pm revealed she did not know why staff were not documenting blood sugar readings properly on the MAR.

Refer to review of the facility's policy and procedures for administration of medications.

Refer to telephone interview with the Administrator on 3/17/17 at 4:40pm.

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Telephone interview with the Administrator on 3/17/17 at 4:40pm revealed:
-The RCC was responsible for reviewing the MARs daily.
-She had observed the RCC reviewing the MAR's but did not know why the MARs were not correct.

Review of the facility's policy and procedures for administration of medications revealed Medication Aides are to follow physician's orders in accordance with NC Rules and Regulations.

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The facility's failure to administer medications as

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ordered by the physician resulted in a medication pass error rate of 7% (3 errors out of 41 opportunities). The failure of the facility to administer medications as ordered also resulted in Novolog Sliding Scale insulin, Tradjenta, and Tresiba not administered as ordered for 3 residents diagnosed with diabetes, Oxycodone not administered as ordered for 3 residents diagnosed with pain, Klonopin not administered as ordered for 1 resident diagnosed with mental health disorders, and Lorazepam not administered as ordered for 1 resident diagnosed with depressive disorder, delusional disorder, and mild neurological disorder. The failure of not receiving sliding scale insulin or other diabetes medications as ordered can result in failure to treat diseases properly or exacerbations of clinical symptoms, the failure of not receiving Klonopin and Lorazepam for mental health disorders can result in psychological duress, increased anxiety and agitation, and the failure to administer Oxycodone as ordered can result in uncontrolled pain. The facility's failure to administer Zocor and Forteo as ordered exposed residents to decreased effectiveness of the medications with the resultant increase in the risk of heart disease and bone fractures respectively. These failures of medication administration were detrimental to the health and safety of the residents and constitutes a Type B Violation.

The Plan of Protection provided by the facility on 3/8/17 revealed:
-All medication aides will be re-inserviced on insulin and sliding scale insulin administration.
-All medication aides will be retrained on reading MARs and on proper documentation.
-The resident care coordinator will follow medication aides on each shift once weekly on first and second shift, and once monthly on third

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D 358	Continued From page 72 shift to watch for appropriate medication administration of the med pass and documentation on the MARs. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2017.	D 358		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with	D 363		

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the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.

This Rule is not met as evidenced by:
Based on observations, record review, and interviews, the facility failed to assure medications prepared in advance were protected from contamination and identified up to the point of administration for 4 unknown residents.

The findings are:

Observation of the morning medication pass on 3/8/17 at 8:20am revealed four uncovered and unlabeled souffle cups containing multiple medications on the top self of the New Hall (400 Hall) medication cart.

Interview with the Medication Aide (MA) passing medications on that cart at 8:25am on 3/8/17 revealed:
-She was not sure which residents the souffle cups belonged to.
-She was not sure who prepared the medications in the souffle cups in the top shelf of her medication cart.
-She believed they may have been medications pulled for residents who were currently out of the facility.
-The medications should have been disposed of and not saved or stored on the top shelf of the medication cart.

Review of facility provided census records revealed no residents on the 400 Hall (New Hall) were out of the facility at this time.

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Interview with the Administrator on 3/8/17 at 4:20pm revealed:
-MAs are not supposed to be pre-pouring medications.
-She was not aware of any MAs pre-pouring medications.
-Pre-pouring medications was against facility policy.

Interview with a second MA on 3/8/17 at 4:40pm revealed:
-She normally worked 3rd shift.
-She had never pre-poured medications for administration at a later time for any residents.
-It was against facility policy to pre-pour medications.

Confidential interview with a third MA revealed first shift MAs routinely pre-poured medications for administration at a later time.

Confidential interview with an resident revealed:
-He had seen souffle cups filled with medications, "usually 3 or 4 at a time," sitting on top of the medication carts.
-He observed this almost every day and on all shifts.
-He had not mentioned this observation to any facility management.

Review of new facility policies and procedures created during the survey revealed:
-The company does not allow MAs to pre-pull or pre-pour any medications.
-In the event of an emergency, only oral solid medications ordered routinely will be prepared within 24 hours of the prescribed time for administration.
-Liquids and prn medications will not be pre-poured.

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10A NCAC 13F .1004 Medication Administration
(j) The resident's medication administration record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure accurate documentation on the Medication Administration Record and failed to document justification and effect of as needed (PRN) medications for 6 of 6 residents (#1, #2, #4, #6, #12, and #14) sampled with PRN medication orders.

The findings are:

A. Review of Resident #2's current FL2 dated 3/2/17 revealed diagnoses included diabetes, respiratory failure, muscle wasting, and chronic

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obstructive pulmonary disease.

Review of Resident #2's Resident Register revealed a date of admission of 2/7/17.

1. Review of FL2 clarification orders dated 3/3/17 and 2/7/17 revealed a medication order for Forteo, 20mcg injected subcutaneously daily. (Forteo is a medication used to treat severe osteoporosis in patients with a high risk of bone fracture.)

Observation of the morning medication pass on 3/8/17 at 8:35am revealed:
-Resident #2 received 17 oral medications, 2 inhalers, 3 injections, and 1 nasal spray.
-One of the injections given was Forteo.
-The Forteo was given subcutaneously in the posterior region of the upper right arm by the medication aide.

Review of Resident #2's Medication Administration Record (MAR) for March 2017 revealed:
-An entry for Forteo, inject 20mcg subcutaneously in the abdominal wall or thigh once daily with no scheduled administration time.
-An entry in the slot for the administration time stated "home health."
-The Forteo had not been initialed as administered for the entire month of March 2017.

Review of Resident #2's MAR for February 2017 revealed:
-An entry for Forteo, 20mcg daily with a scheduled administration time of 8am.
-The Forteo had been initialed as administered daily from 2/9/17 through 2/28/17.

Interview on 3/8/17 at 11:44am with the

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Medication Aide (MA) who administered the Forteo to Resident #2 revealed:
-She had forgotten to document the administration of the Forteo on the MAR.
-She had not noticed the entry of "Home Health" into the are of the MAR that contained the administration time.
-She administered the Forteo to Resident #2 daily when she worked.

Interview with Resident #2 on 3/10/17 at 10:57am revealed:
-He received his Forteo injection every day.
-He takes the Forteo injection because his spine was deteriorating and causing him back pain.

2. Review of Resident #2's record revealed medication orders dated 2/8/17 and 2/27/17 for Oxycodone 5/325mg, 1 tablet every 6 hours as needed for pain. (Oxycodone 5/325 is a narcotic analgesic use to treat moderate to severe pain.)

Review on 3/8/17 of Resident #2's MAR for March 2017 revealed:
-An entry for Oxycodone 5/325mg, 1 tablet every six hours as needed.
-Seven tablets were documented as administered on the front of the MAR.
-There were 2 entries on the back of the MAR documenting the reason and effectiveness for the administration of the Oxycodone 5/325mg.

Review of the narcotic count sheet for Resident #2's Oxycodone 5/325 revealed 18 doses of Oxycodone 5/325mg administered for the month of March 2017.

Review of the Resident #2's medications on hand on 3/8/17 at 11:40am revealed the Oxycodone 5/325 available to administer matched the

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number of tablets on the narcotic count sheet.

Interview with a medication aide on 3/8/17 at 11:44am revealed:
-She always documented administration of Resident #2's Oxycodone 5/325 on the narcotic count sheet.
-She sometimes forgot to document the Oxycodone 5/325 on the MAR.
-She forgot to document on the back of the MAR the effectiveness of the Oxycodone 5/325.

Refer to facility policies and procedures.

Refer to review of new facility policies and procedures.

Refer to telephone interview with the RCC on 3/17/17 at 11:30.

B. Review of Resident #6's current FL2 dated 6/13/16 revealed:
-Diagnoses included depressive disorder, delusional disorder, and mild neurological disorder "due to another medical condition."
-Physician orders for Lorazepam 1mg every 8 hours as needed (an antianxiety medication).

Review of subsequent physician orders, dated 11/23/16 revealed Lorazepam was changed to routine, 1mg at 9:00am and 5:00pm.
Interview with Resident #6 on 3/7/17 at 10:50am revealed;
-The medication aides did not give her Lorazepam for several days recently, times not specific.
-She said when she missed the Lorazepam, she did not feel any differently.

Review of the February and March 2017

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D 367	Continued From page 79 Medication Administration Records (MARs) revealed Lorazepam was documented as administered twice daily at 9:00am and 5:00pm from 2/1/17 through 3/8/17. Review of two Lorazepam Controlled Drug Sheets on 3/8/17 at 11:00am with dates of administration beginning with 2/12/17 and 2/24/17 revealed 11 doses Lorazepam out of 48 opportunities were not documented as administered at the following times: -2/23/17 at 5:00pm -2/24/17 at 8:00am -2/28/17 at 5:00pm -3/1/17 at 8:00am -3/1/17 at 5:00pm -3/2/17 at 5:00pm -3/3/17 at 8:00am -3/4/17 at 8:00am -3/4/17 at 5:00pm -3/5/17 at 5:00pm -3/6/17 at 5:00pm Review of the controlled drug count sheets revealed Lorazepam available for administration for the dates of 2/23/17 through 3/6/17. Confidential interview with one of the medication aides who initialed the administration of the lorazepam on the MAR but did not document the administration on the controlled drug sheet, revealed she must have been distracted, forgot to administer the lorazepam, and just initialed all the "holes in the MAR." Telephone interview with the prescribing physician on 3/10/17 at 2:20pm revealed that Resident #6 "probably felt a little more anxious" when she did not have the routine Lorazepam.	D 367		

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Interview with the Administrator on 3/9/17 at 3:31pm revealed:
-The Resident Care Coordinator (RCC) was responsible monitoring weekly to assure the medication aides were documenting the MARs accurately
-"I also spot check" to assure medication aides were documenting.

Telephone interview with the RCC on 3/17/17 at 11:30am revealed:
-She reviewed the MARs once a week.
-She checked for holes in the MARs and flow sheets.
-She was not aware of and did not why the medication aides were not administering the Lorazepam.

Review of pharmacy delivery sheets for Resident #6's Lorazepam revealed 60 Lorazepam were dispensed on 2/6/17.

Observations of medications on hand on 3/13/17 at 11:45am revealed 5 Lorazepam available for administration with a Lorazepam controlled drug sheet which corresponded to the count.

Refer to facility policies and procedures.

Refer to review of new facility policies and procedures.

Refer to telephone interview with the RCC on 3/17/17 at 11:30.

C. Review of Resident #12's current FL2 dated 11/9/16 revealed:
-Diagnoses included two part non displaced fracture of surgical right humus and anterior displaced fracture left clavicle and muscle

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weakness.
-Physician order for Oxycodone 10mg every 6 hours as needed.

Interview with Resident #12 on 3/10/17 at 11:20am revealed:
-He had constant pain in his right shoulder and left arm.
-He did not receive his Oxycodone as ordered about "2 months ago because they ran out."
-He did not know specific dates and times that he did not get his Oxycodone.

1. Review of the documentation on the back of January 2017 MAR revealed Oxycodone was administered 27 times with reason and effect documented.

Review of the Oxycodone controlled drug count sheets revealed 113 Oxycodone were administered from 1/2/17 through 1/31/17.

Comparison of the documentation on the back of the January 2017 MAR with the documentation on the controlled drug count sheets revealed Oxycodone was administered 86 times without documention of the reason and effect documented.

Review of the documentation on the back of February 2017 MAR revealed Oxycodone was administered 27 times with reason and effect documented.

Review of the documentation of administration of Oxycodone on the controlled drug count sheets revealed 101 Oxycodone were administered from 2/1/2017 through 2/28/17.

Comparison of the documentation on the back of

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the February 2017 MAR with the documentation on the controlled drug count sheets revealed Oxycodone was documented 78 times without reason and effect documented.

Interview with the Administrator on 3/9/17 at 3:31pm revealed:
-The RCC was responsible monitoring weekly to assure the medication aides were documenting reason and effectiveness on the MARs.
-"I also spot check" to assure MAs are documenting reason and effectiveness on the MARs.

2. Review of Resident #12's FL2 dated 11/9/16 revealed a physician order for Lorazepam 0.5mg every six hours as needed.

Review of the back of January 2017 Medication Administration Records (MAR) revealed Lorazepam was documented as administered 28 times with reason and effect documenting.

Review of the Lorazepam controlled drug count sheets revealed 115 Lorazepam were administered from 1/1/17 through 1/31/17.

Comparison of the documentation on the back of the January 2017 MAR with the documentation on the controlled drug count sheets revealed Lorazepam was administered 87 times without documentation of the reason and effect.

Review of the documentation on the back of February 2017 MAR revealed Lorazepam was administered 29 times with reason and effect.

Review of the Lorazepam controlled drug count sheets revealed Lorazepam was administered 104 times from 2/1/17 through 2/28/17.

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D 367	Continued From page 83 Comparison of the documentation on the back of the February 2017 MAR with the documentation on the controlled drug count sheets revealed Lorazepam was documented 75 times without reason and effect documented. Interview with the Administrator on 3/9/17 at 3:31pm revealed: -The RCC was responsible for monitoring the MARs to assure the reason and effectiveness of as needed medications was documented. -The MAs knew they were responsible for documenting the reason and effectiveness. Refer to facility policies and procedures. Refer to review of new facility policies and procedures. Refer to telephone interview with the RCC on 3/17/17 at 11:30. D. Review of Resident #15's current FL2 dated 10/21/16 revealed: -Diagnoses included chronic back pain, ileostomy, seizure disorder and insomnia. -The medication Oxycodone 10mg tablet 1 every 6 hours as needed for breakthrough pain DNE (Do not exceed) 3 tablets per day. Review of the Oxycodone 10mg controlled substance count down sheet for Resident #15 revealed: -On 1/1/17, she was administered 4 tablets. -On 1/3/17, she was administered 4 tablets. -On 1/13/17, she was administered 4 tablets. -On 1/14/17, she was administered 4 tablets. -On 1/15/17, she was administered 4 tablets.	D 367		

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-On 2/2/17, she was administered 4 tablets.
-On 2/3/17, she was administered 4 tablets.
-On 2/4/17, she was administered 4 tablets.
-On 2/5/17, she was administered 4 tablets.
-On 2/6/17, she was administered 4 tablets.
-On 3/12/17, she was administered 4 tablets.

Review of the January 2017 Medication Administration Record (MAR) for Resident #15 documented between 1/17/17 and 1/30/17 Oxycodone 10mg as needed had been administered 13 times with no documentation regarding reason for admission or effectiveness.

Review of the February 2017 Medication Administration Record (MAR) for Resident #15 documented between 2/1/17 and 2/28/17, Oxycodone 10mg as needed, had been administered 29 times with no documentation regarding reason for admission or effectiveness.

Review of the March 2017 Medication Administration Record (MAR) for Resident #15 documented between 3/2/17 and 3/7/17, Oxycodone 10mg as needed, had been administered 5 times with no documentation regarding reason for admission or effectiveness.

Confidential interviews with 3 Medication Aides (MAs) revealed:
-They had been told in the past the controlled substance count down sheet could be counted the same as the medication administration record.
-Sometimes they would sign both the medication administration record and the controlled substance sheet, but normally it was one or the other.
-They did know that they should documented the reason given and effectiveness of the (PRN) as

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needed medications on the MAR but they did not always do the documentation.
-The medication was never really effective with Resident #15.
-Resident #15 wanted the medication "all the time".
-Two of the medication aides did not know the medication was not to be given more than three times per day.
-The RCC checked the MARs and controlled sheets for accuracy.

Interview with the Administrator on 3/13/17 at 2:45pm revealed:
-The RCC was responsible for assuring the MARs and controlled substance sheets are correct.
-The MAs should have been signing in both places and documenting the reason given and effectiveness.

Interview with Resident #15 on 3/13/17 at 3:15pm revealed:
-She received the medication every time she asked for it.
-She could tell "a little" improvement but not much.
-She had never been told by a medication aide that she could not have the medication.
-Sometimes the medication aides would come back after giving her the medications and ask her "how she was feeling".
-She did not know that she was only supposed to get the medication only three times per day.

Refer to facility policies and procedures.

Refer to review of new facility policies and procedures.

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Refer to telephone interview with the RCC on 3/17/17 at 11:30.

____

Facility policies and procedures regarding documentation of administration of medications were requested but not received prior to exit.

Review of new facility policies and procedures created during the survey revealed:
-MAs are required to document all medications given, medications refused, and medications that have been properly disposed of.
-MAs are required to document the effects of all prn medications.
-The Resident Care Coordinator is to check the MARs weekly.
-MAs who do not follow policy will be given (1) a re-inservice by the facility's registered nurse, (2) written consult- re-inservice by facility's registered nurse, suspended off the cart for 3 days, (3) terminated or demoted.

Telephone interview with the RCC on 3/17/17 at 11:30am revealed:
-She reviewed MARs once a week.
-She checked for holes in the MARs and flow sheets.
-She did not why the medication aides were not documenting reason and effectiveness on the MARs.

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10A NCAC 13F .1008(a) Controlled Substances

10A NCAC 13F .1008 Controlled Substances
(a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These

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records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure Residents' Rights were maintained by providing readily retrievable records to account for the disposition of controlled substances (Oxycodone and hydrocodone-acetaminophen) and to ensure an accurate reconciliation of those controlled substances for 4 of 4 residents (#1, #4, #12, and #15) sampled including a resident with the diagnoses of displaced humerus fracture and left clavicle fracture (#12), a resident with the diagnoses of stage II pressure ulcer, diabetes mellitus and deep vein thrombosis (#4), a resident with the diagnosis of arm pain (#1), and a resident with the diagnosis of chronic back pain (#15).

The findings are:

A. Review of Resident #12's current FL2 dated 11/9/16 revealed:
-Diagnoses included two part non displaced fracture of right humerus, an anterior displaced fracture left clavicle, and muscle weakness.
-A physician order for Oxycodone 10mg every 6 hours as needed.

Interview with Resident #12 on 3/10/17 at 11:20am revealed:
-He had constant pain in his right shoulder and left arm.
-He did not receive his Oxycodone as ordered about "2 months ago because they ran out."

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D 392	Continued From page 88 -When he took Oxycodone, his pain was a number "7" for about 2 hours after administration of pain medication, but when he ran out of pain medication for 4 hours or more, the pain level was "10" on a scale of 1 to 10. -He did not know specific dates and times that he did not get his Oxycodone. Observations of medications on hand on 3/13/17 at 11:35am revealed: -An open bubble pack of Oxycodone with 17 remaining in the pack out of 30 of the 120 originally dispensed on 2/27/17 which correlated to a controlled substance count down sheet with a matching prescription number. -An unopened bubble pack of Oxycodone with a quantity of 30 of the 120 dispensed on 2/27/17 which correlated to a controlled substance count down sheet with a matching prescription number. Review of the three controlled drug count sheets with the same prescription number as the Oxycodone delivered on 2/27/17 revealed: -Three controlled drug sheets accounted for 90 out of the 120 Oxycodone dispensed. -One controlled drug sheet had the number 30 handwritten in on the top line with no Oxycodone documented as administered with label of 120 tablets dispensed on 2/27/17. -One controlled drug sheet had 17 Oxycodone remaining out of 30 which were administered from 3/7/17 at 2:00pm through 3/10/17 at 2:00pm and with label that 120 tablets were dispensed. -One controlled drug sheet had 30 Oxycodone documented as administered from 2/27/17 at 8:00pm through 3/7/17 at 8:00am with none remaining and with label that 120 tablets were dispensed. -The 3 controlled drug count sheets for 120 Oxycodone dispensed on 2/27/17 were identical	D 392		

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in labels but were not identified as page 1, 2, and 3 of 4 pages and did not have dispensing dates.

Review of the pharmacy delivery sheets for Resident #12's 120 Oxycodone delivered on 2/27/17 revealed:
-The delivery sheet for 2/27/17 had 60 Oxycodone dispensed typed in but someone had crossed it out and hand written in 120 tablets.
-The prescription number on the delivery sheet did not match the prescription number on the 3 Oxycodone controlled substance count down sheets and the prescription number on the Oxycodone available for administration.

Telephone interview with the facility's pharmacy provider on 3/9/17 at 11:15am revealed the prescription number for the 120 Oxycodone dispensed and delivered on 2/27/17 did not match because they at first had 60 Oxycodone ready to send but changed it to 120 Oxycodone, and then failed to change the prescription number on the delivery sheet.

Review of additional delivery sheets when compared to Oxycodone documented as administered on the controlled drug sheets were correlated from 2/27/17 back to 1/2/17, but a delivery of Oxycodone on 12/30/16 did not have a correlating controlled drug sheet.

Interview with the Administrator on 3/9/17 at 3:31pm revealed:
-She was not aware of the missing Oxycodone in March 2017 discovered by surveyors and staff had not reported it.
-A medication aide reported on 12/31/16 that a bubble pack of 30 Oxycodone was missing and her investigation revealed 30 Oxycodone delivered on 12/30/16 was not in the facility on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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12/31/16, but she did not know the prescription number and did not have a delivery sheet available.
-The 30 Oxycodone were never found and the pharmacy dispensed 30 more as replacement and charged them to the facility.
-When Resident #12's Oxycodone was identified as missing in December 2016, she reported it to the pharmacy, but she did not request a controlled substance accountability assessment by by the pharmacist who provided medication reviews.
-After 12/31/16 when Resident #12's Oxycodone was reported missing, the facility changed the system by having the medication aides immediately lock up the controlled medications when delivered rather than leaving them unlocked in the tote box in the medication room for 3rd shift to put away.

Review of the controlled substance count down sheets for Resident #12 for December 2016 and January 2017 revealed:
-The Oxycodone controlled substance count down sheets had labels with prescription numbers but no dispense date.
-The controlled substance count down sheet which began with staff administering on 12/25/16 had the last dose of Oxycodone documented as administered on 1/1/17 at 6:00am.
-The next dose of Oxycodone documented as administered on a controlled substance count down sheet began on 1/2/17 at 11:00am.
-There was no documentation of administration of Oxycodone from 1/1/17 at 6:00am until 1/2/17 at 11:00am, a total of 29 hours.

Review of the back of the January 2017 Medication Administration Record (MAR) had no documentation indicating Resident #12 requested

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Oxycodone with no availability.

Review of December 2016 Oxycodone controlled substance count down sheet which was first initialed on 12/25/16 revealed:
- Resident #12 had a pattern of requesting Oxycodone 3-4 times in a 24 hour time frame.
-For a 24 hour period, Oxycodone was documented as administered 4 times on 12/25/16, 3 times on 12/26/17, 4 times on 12/27/16, 4 times on 12/28/16, 4 times on 12/29/16, 4 times on 12/30/16 and 3 times on 12/31/16.

Telephone interview with a nurse at Resident #12's physician's office on 3/16/17 at 11:00am revealed the physician was not available.

Refer to interview with the Administrator on 3/9/17 at 3:31pm.

Refer to telephone interview with the facility's pharmacy provider on 3/13/17 at 2:09pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 3/15/17 at 10:15am.

Refer to review of the facility's drug diversion policy.

B. Review of Resident #4's current FL2 dated 6/4/16 revealed:
-Diagnoses included diabetes mellitus, insomnia, major depression, bipolar disorder, schizophrenia, poly-substance abuse, rectal prolapse, anxiety, deep vein thrombosis, and anemia.
-Physician order for Oxycodone 15mg tablet 4 times daily (used to treat moderate to severe pain).

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D 392	Continued From page 92 Record review for Resident #4 revealed an order dated 8/1/16 for Oxycodone 15mg tablet, take 1 every 4 hours. Interview with a Home Health nurse on 3/8/17 at 11:40am revealed: -Resident #4 was being treated for a Stage II pressure ulcer on the upper posterior thigh. -The Home Health nurse was performing wound care 2 times per week. Review of the pharmacy delivery sheets for Resident #4's Oxycodone revealed a quantity of 180 tablets with Rx A were delivered to the facility on 3/3/17 at 6:00pm, and signed for by a MA on the same date and time. Observation of medications on hand on 3/9/17 at 10:48am revealed: -An open bubble pack (pack #2) of Oxycodone 15mg with 27 tablets remaining out of the 30 of the 180 dispensed on 3/3/17, which correlated to a controlled substance count down sheet with Rx A. -There were 3 unopened bubble packs of Oxycodone 15mg with a quantity 30 tablets each (total quantity of 90) of the 180 dispensed on 3/3/17, which correlated to a controlled substance count down sheet with the Rx A. -The 6th bubble pack of Oxycodone 15mg #30 was not on the cart. Review of the filed controlled substance count down sheets for Resident #4's Oxycodone 15mg administered revealed: -A controlled substance count down sheet for 30 tablets, a 5 day supply Oxycodone 15mg was documented as administered from 3/4/17 at 12am to 3/8/17 at 8pm, labeled with Rx A (this	D 392		

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was the 1st sheet used for this prescription).
-There were no other filed controlled substance count down sheets for the Rx A.

Review of the controlled drug notebook on the 100 hall cart revealed:
There were 4 current controlled substance count down sheets for Resident #4's Oxycodone 15mg Rx A.
-The sheets in the controlled drug notebook were for bubble packs 2-5, as sheet #1 had been completed and filed.
-The controlled substance count down sheet for card #6 was missing for Rx A.

The facility was unable to locate the 6th controlled substance count down sheet or the 6th bubble pack of Oxycodone 15mg tablets, quantity 30 for Resident #4 with Rx A.

Interview with Resident #4 on 3/7/17 at 11:10am revealed:
-There were times when he requested pain medication, and he was told it was not time yet.
-He had asked for pain medications a couple times on the weekend, and he was told by the Medication Aide (MA) there was no Oxycodone available on the medication cart.

Interview with the RCC on 3/10/17 at 2:13pm revealed:
-She had talked to 2 different pharmacy staff and they both confirmed from the delivery sheet that 180 tablets were dispensed on 3/3/17.
-There were no bubble packs in the overstock box in the Administrator's office.

Interview with the RCC on 3/10/17 at 3:24pm she would check the delivery sheet for Resident #4's Oxycodone 15mg to confirm the quantity received

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in the facility and which MA had signed for the medications.

Confidential interview with a MA revealed the MA was unable to explain what happened to the missing bubble pack of Oxycodone 15mg for Resident #4.

Interview with the Administrator on 3/10/17 at 4:45pm revealed:
-She would order a bubble pack of quantity 30 Oxycodone 15mg for Resident #4 at no charge to the resident.
-She could not explain why the 30 Oxycodone 15mg tablets or the controlled count down sheet for Rx A was missing.

Interview with a MA on 3/10/17 at 4:01pm revealed:
-When they perform a controlled substance shift count, they would count how many bubble packs were on each medication cart.
-The shift count was performed on each 8 hour shift.

Interview on 3/10/17 at 4:05pm with the MA that had signed the delivery sheet for Rx A revealed:
-He signed that there were 180 pills/6 bubble packs of Oxycodone 15mg for Resident #4.
-The medication was signed as received on 3/3/17 at 6:00pm.

Observation on 3/10/17 at 4:13pm of the 2 second shift MAs checking through all medications on all 4 medication carts revealed they could not find the missing bubble pack for Resident #4's Oxycodone 15mg.

Observation on 3/10/17 at 6:18pm revealed local law enforcement had arrived after notification of

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D 392	Continued From page 95 the missing narcotics. Telephone interview with the facility's pharmacy provider on 3/13/17 at 2:09pm revealed: -Oxycodone 15mg was last dispensed (prior to 3/3/17) on 2/2/17 Rx B for quantity 180 which was packaged as 6 bubble packs with 30 tablets each. -The pharmacy had not received any returned Oxycodone 15mg tablets for Resident #4 from 2/2/17 to present. Telephone interview with the RCC on 3/15/17 at 10:34am and 12:38pm revealed: -No one was aware of the missing bubble pack of Oxycodone for Resident #4 until it was discovered by the State Surveyors on 3/10/17. -Resident #4 had never had Oxycodone 15mg tablets missing in the past. Telephone interview with the Primary Care Provider (PCP) on 3/16/17 at 12:27pm revealed she was not aware of the missing bubble pack of Oxycodone 15mg quantity 30 tablets with Rx A. Refer to interview with the Administrator on 3/9/17 at 3:31pm. Refer to telephone interview with the facility's pharmacy provider on 3/13/17 at 2:09pm. Refer to telephone interview with the RCC on 3/15/17 at 10:15am. Refer to review of the facility's drug diversion policy. C. Review of Resident #1's current FL2 dated 11/8/16 revealed: -Diagnoses included pain. -A physician order for	D 392		

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D 392	Continued From page 96 hydrocodone-acetaminophen 10/325mg every 8 hours as needed (a pain medication). Review of a physician order dated 11/10/16 revealed the hydrocodone-acetaminophen 10/325 was changed to a scheduled dose three times per day. Telephone interview with the physician assistant on 3/10/17 at 2:20pm revealed she saw Resident #1 on 3/8/17 and referred her to an orthopedic specialist for arm pain. Interview with Resident #1 on 3/9/17 at 2:45pm revealed she always received all her medications. Review of Resident #1's February 2017 MAR revealed the times entered for administration of hydrocodone-acetaminophen were 9:00am, 2:00pm, and 9:00pm. Observation of medications on hand for Resident #1 on 3/10/17 at 4:30pm revealed: -One unopened bubble pack of 30 hydrocodone-acetaminophen with label identifying 90 tablets were delivered on 2/24/17 of 90 tablets. -One opened bubble pack of 30 hydrocodone-acetaminophen with label identifying 90 tablets were delivered on 2/24/17 with 7 remaining. Review of the pharmacy delivery sheets for Resident #1's hydrocodone-acetaminophen revealed: -A 30 day supply, 90 count, was delivered on 2/1/17 which would have been a sufficient supply through 8:00pm on 3/2/17. -A 30 day supply, 90 count, was delivered on 2/24/17 with the prescription number which	D 392		

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D 392	Continued From page 97 matched the 2 controlled substance count down sheets on the medication cart and matched the label on the hydrocodone-acetaminophen in the cart. Review of 2 hydrocodone-acetaminophen controlled substance count down sheets on the medication cart revealed: -Both sheets had the same prescription number as the one on the labels of the 2 bubble packs Oxycodone on hand. -The first controlled substance count down sheet documented as administered after the 2/24/17 delivery of 90 tablets began with 30 on 3/3/17 at 8:00am and ended with 7 remaining on 3/10/17 at 4:30pm. -The second controlled substance count down sheet with the same prescription number had the number 30 handwritten on the top line with none documented as administered. -The 2 controlled substance count down sheets accounted for 60 of the 90 hydrocodone-acetaminophen delivered on 2/24/17. Review of the filed controlled substance count down sheets for Resident #1's hydrocodone-acetaminophen administered revealed: -There were no other sheets for hydrocodone-acetaminophen with the same prescription number as those delivered on 2/24/17. -Previous to 3/3/17 were 3 sheets for hydrocodone acetaminophen documented as administered from 2/1/17 at 8:00am through 3/2/17 at 8:00pm which would have been 90 tablets, a 30 day supply. Interview with the Administrator on 3/10/17 at	D 392		

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4:45pm revealed:
-She would order a pack of 30 count hydrocodone-acetaminophen and not charge the resident.
-She did not know why the controlled substance count down sheets and the hydrocodone-acetaminophen were missing and why staff had not discovered both were missing.

Refer to interview with the Administrator on 3/9/17 at 3:31pm.

Refer to telephone interview with the facility's pharmacy provider on 3/13/17 at 2:09pm.

Refer to telephone interview with the RCC on 3/15/17 at 10:15am.

Refer to review of the facility's drug diversion policy.

D. Review of Resident #15's current FL2 dated 10/21/16 revealed:
-Diagnoses included chronic back pain, ileostomy, seizure disorder and insomnia.
-There was an order for Oxycodone 10mg tablet 1 every 6 hours as needed for breakthrough pain DNE (Do not exceed) 3 tablets per day.

Review of an Oxycodone 10mg controlled substance count down sheet with the Rx A for Resident #15 documented:
-The administration dates on this sheet were 12/29/16 through 1/7/17 with the first two lines having no dates recorded.
-The starting count was 30 tablets.
-The first line with a quantity of 30 on hand had documentation that one tablet had been destroyed by crushing and was witnessed by another medication aide.

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D 392	Continued From page 99 -The second line with a quantity of 29 on hand had documentation that one tablet had been destroyed by crushing and was witnessed by another medication aide. -Line thirteen with a quantity of 18 on hand had documentation that one tablet had been destroyed by crushing and was witnessed by another medication aide. Review of an Oxycodone 10mg controlled substance count down sheet with the Rx B for Resident #15 documented: -The administration dates on this sheet were 1/7/17 through 1/15/17. -The starting count was 30 tablets. -Line 9 had a documented quantity of 22 tablets on hand and the words "Missing Pill" written in the destroyed by with no date, time, or signature. -Line thirty with quantity of 1 on hand had documentation that one tablet had been destroyed by crushing and had "crushed in pk water cat liter" with no signature documented. The facility could not produce the controlled substance count down sheet for Resident #15's Oxycodone 10mg between 1/15/17 through 1/30/17. Review of an Oxycodone 10mg controlled substance count down sheet with the Rx C for Resident #15 documented: -The administration dates on this sheet were 1/31/17 through 2/7/17. -The starting count was 30 tablets. -The fifth line had the number 26 changed to 25. -The sixth line had the number 25 changed to 24. -The sheet had 29 doses of medication administered. Refer to interview with the Administrator on 3/9/17	D 392		

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at 3:31pm.

Refer to telephone interview with the facility's pharmacy provider on 3/13/17 at 2:09pm.

Refer to telephone interview with the RCC on 3/15/17 at 10:15am.

Refer to review of the facility's drug diversion policy.

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Interview with the Administrator on 3/9/17 at 3:31pm revealed:
-After 12/31/16 when one residents' Oxycodone was reported missing, the facility changed the system by having the medication aides immediately lock up the controlled medications when delivered rather than leaving them unlocked in the tote box in the medication room.
-The facility did not change their system for labeling the controlled substance count down sheets to correlate with the bubble packs when there more than 1 pack was delivered.
-The facility did not put an inventory system in place to compare controlled medications on the delivery sheets with the medications on hand and the controlled substance count down sheets on hand.
-When medication aides did a controlled substance count at shift change, they correlated medications on hand with the controlled substance count down sheets, but if a controlled substance count down sheet was missing, they would not know the medications were supposed to be on hand.
-The facility did not write a delivery date on the controlled substance count down sheets to correlate with the bubble packs, which did have delivery dates.

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Telephone interview with the facility's pharmacy provider on 3/13/17 at 2:09pm revealed:
-The pharmacy will begin to send the medication totes with numbered tags to ensure they are opened by appropriate staff and to facilitate record keeping for all medications.
-Until now, they were just secured with standard zip ties.
-Starting in February 2017 the facility was to put the first bubble back on the medication cart and lock up the remaining 5 cards in the Administrator's office.
-The bubble packs were labeled 1 of 6, 2 of 6 and so on.

Telephone interview with the RCC on 3/15/17 at 10:15am revealed:
-When the MAs performed a controlled drugs count at shift change, they compared the controlled substance count down sheets in the book with the controlled medications in the drawer.
-There was never a medication cart audit completed where the pharmacy delivery sheet, controlled substance count down sheets and controlled medications in the bubble packs were matched and compared.
-The MAs were supposed to have her lock up the back up controlled medications in the Administrator's office if there was one open card in the drawer.
-If a controlled substance count down sheet was not in the controlled drug notebook on the medication cart, the MAs would not know if a bubble pack of medications were missing or know to look for the medication, because if more than one bubble pack was dispensed, there were no identifiers on the controlled substance count down sheets, which matched identifiers on each

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bubble pack.
-She had never been instructed to correlate pharmacy delivery sheets with controlled substance count down sheets when medications were dispensed, for controlled substance count, or when medications were discovered missing.
-She checked controlled drugs when it appeared on the corporate task calendar.
-She did not document when she monitored the controlled drugs, just put a check mark on the tasks calendar.

Review of the facility's drug diversion policy for Medication Aides contained in the employee handbook revealed:
-I understand that if I am a Medication Aide I am to count "Narcs" and look at the Narc Count sheet at the end of my shift.
-I understand that if I am a Medication Aide, I am NOT TO ACCEPT the keys to the cart if the Narc Count is NOT correct.
-I understand that if I am a Medication Aide, I am responsible for each and every medication on the cart that I have been assigned to.
-I understand that I am NOT to take nor give Resident/Facility medication to anyone other than the resident it is prescribed for.
-I understand I am NOT to sign another Medication Aide's name to a Narc sheet.
-I understand I am to call the Administrator, Assistant Administrator, Corp ED, Owner, and RCD, when medication is missing and when the Narc count is NOT correct.
-The facility will not tolerate any staff taking medication from the facility.

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The facility's failure to have a system of checks and balances and retrievable records for accurate

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D 392	Continued From page 103 narcotic reconciliation in place after an identified narcotic diversion was identified in December, 2016 resulted in further diversion and opportunity for diversion of residents' narcotics. This vulnerability of having no method for reducing and/or eliminating drug diversion by identifying person, time, or opportunity of diversion was exposed during the survey. Attempted reconciliation of delivery sheets, controlled drug sheets, and medications by the survey team revealed 60 Oxycodone and 30 hydrocodone-acetaminophen were missing which had not been identified by the facility. Additionally, a controlled drug sheet was missing and some had inaccurate flow counts. The failure to maintain accurate and retrievable records of receipt, administration, and disposition of controlled substances constitutes a B Violation. ______________________________ The Plan of Protection provided by the facility on 3/15/17 revealed: -Narcotics will be counted from the cart and back up pharmacy will be notified of missing medications. -Law enforcement will be notified. -All medication aides will be notified that they are not to leave community if count is not correct and the Administrator and RCC are to be called immediately. -The pharmacy will label each bubble pack and controlled substance count down sheet with the number of the bubble pack: example 1 of 4, 2 of 4. -The pharmacy will date each controlled substance count down sheet to match bubble pack delivery date. -The pharmacy will fax a copy of what is being delivered and it will be matched to what is in the medication cart daily.	D 392		

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D 392	Continued From page 104 -If a discrepancy occurs, the pharmacy will be called, interview of staff will occur, and further disciplinary action will occur. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2017.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care, medication administration, controlled substances, implementation, and adult care home infection prevention requirements. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of residents, related to notification of the Primary Care Provider regarding refusals of fingerstick blood sugars (FSBS) and insulin injections, refusals and missed blood pressure readings, and labs not obtained, for 1 of 5 sampled residents (Resident #4). [Refer to Tag	D912		

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273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]

B. Based on observations, interviews, and record reviews, the facility failed to assure medications (Forteo, simvastatin, and Novolog), were administered as ordered by a licensed prescribing practitioner for 3 of 6 residents (#2, #10, and #11) observed on a medication pass and failed to assure medications (Humalog, Klonopin, Oxycodone, Tradjenta, Tresiba, and lorazepam) were administered as ordered for 6 of 10 residents (#1, #4, #6, #12, #14, and #15) sampled. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]

C. Based on observations, interviews, and record reviews, the facility failed to assure Residents' Rights were maintained by providing readily retrievable records to account for the disposition of controlled substances (Oxycodone and hydrocodone-acetaminophen) and to ensure an accurate reconciliation of those controlled substances for 4 of 4 residents (#1, #4, #12, and #15) sampled including a resident with the diagnoses of displaced humerus fracture and left clavicle fracture (#12), a resident with the diagnoses of stage II pressure ulcer, diabetes mellitus and deep vein thrombosis (#4), a resident with the diagnosis of arm pain (#1), and a resident with the diagnosis of chronic back pain (#15). [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation).]

D. Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters without proper

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D912	Continued From page 106 disinfection for 2 of 3 sampled residents, (#4 and #10). [Refer to Tag 932 G.S. 131D-4.4(A)(b) Infection Control, (Type B Violation).] E. Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained rules related to housekeeping and furnishings, other requirements, health care, nutrition and food service, resident rights, medication administration, controlled substances, and adult care home infection prevention requirements. [Refer to Tag 980 G.S. 131D-25 Implementation (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure resident rights were maintained for 1 of 6 residents sampled (Resident #3) related to exploitation of funds when he was required to pay a co-pay at a second pharmacy when the veterans administration would have provided or did provide his medications and for 3 of 4 residents sampled (#1, #4, and #12) related to missing controlled substances, including a resident with the diagnoses of displaced humerus fracture and left clavicle fracture (#12), a resident with the diagnoses of stage II pressure ulcer, diabetes mellitus and deep vein thrombosis (#4), and a resident with the diagnosis of arm pain (#1).	D914		

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D914	Continued From page 107	D914		

The findings are:

A. Review of Resident #3's FL2 dated 12/28/16 revealed diagnoses included heart failure, seizures, hypertension, hyperlipidemia, edema, thyroid disorder, depression, diabetes type I, chronic pain, and allergies.

Review of Resident #3's FL2 dated 12/28/16 revealed physician orders included:
-Coreg 6.25 twice daily (used to treat hypertension and heart failure).
-Lisinopril 2.5 once daily (used to treat hypertension and heart failure).
-Pravastatin 40 mg daily (used to treat high cholesterol).
-Sertraline 25 mg daily (used to treat anxiety and depression).
-Levothyroxine 88 mcg daily (used to treat hypothyroidism).
-Levetiracetam 500 mg twice daily (used to treat seizure disorders).
-Vitamin B12 100 mcg/ml 1st of every month (a nutritional supplement).
-Loratadine 10 mg daily (an antihistamine).
-Neurontin 300 mg every 8 hours (used to treat nerve pain).
-Nystatin 100,000 unit/gram left groin twice daily (used to treat yeast infections of the skin).
-Vitamin D3 2000 units, 2 daily (a nutritional supplement).
-Zofran 4 mg every 6 hours as needed (used to prevent nausea and vomiting).

Telephone interview with Resident #3's power of attorney on 3/14/17 at 10:02am revealed:
-Resident #3 had been going to the veterans administration (VA) hospital for his medical care for at least one year.
-The VA would provide all his medications, a 90

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D914	Continued From page 108 day supply at a time, for most of his medications. -The facility had been ordering medications from the local facility pharmacy and then charging Resident #3 a monthly fee for co-payment of the medications received from the facility pharmacy. -He discussed the medication charges and the pharmacy provider with the Administrator in December 2016 (date not known) and requested they get all Resident #3's medication from the VA. -In December 2016, he also requested receipts of medications received from the facility pharmacy provider. Observations of the medications on hand for Resident #3 on 3/10/17 at 3:00pm revealed: -One unused 90 day supply of Lisinopril 2.5mg from the VA dispensed on 1/11/17. -One 30 day supply, 30 doses, of Lisinopril 2.5 mg, on 2/13/17 with 7 remaining and a 10 day supply, 30 doses, dispensed on 2/13/17 with 10 remaining from the facility pharmacy. -One unused 90 day supply of Pravastatin 40mg from the VA dispensed on 1/10/17. -One 30 day supply Pravastatin 40 mg dispensed from the facility pharmacy on 1/2/17 with 1 remaining and a 10 day supply dispensed on 2/13/17 with 10 remaining. Review of medication delivery sheets revealed Levetiracetam 500 mg and Sertraline HCL 25 were also received from the local facility pharmacy in January and February 2016. Telephone interview with the Resident care Coordinator (RCC) on 3/15/17 at 10:15am revealed: -She did not know who ordered Lisinopril and Pravastatin from the facility pharmacy in February when there was already a 90 day supply in the facility.	D914		

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D914	Continued From page 109 -When she became the RCC in December, she understood all Resident #3's medication came from the VA. -They were supposed to order medications from the VA 10 days ahead of time and if the medication did not come in, to order from the facility pharmacy, but no more than a 7 day supply. -If she called the automated VA telephone line to reorder medications, she did not document that she had ordered the medication. Review of the Nurse's Notes in Resident #3's record revealed no documention related to any medications ordered from the VA. Interview with the Business Office Manager on 3/10/17 at 10:00am revealed: -He understood a year ago that Resident #3's medications were provided by the VA. -The medications were ordered by the RCC and the medication aides. -He provided the family/power of attorney with a pharmacy receipt in February 2017. Interview with the Administrator on 3/10/17 at 2:10pm revealed: -She did not know why Lisinopril and Pravastatin were ordered from the local pharmacy when the medications were on hand from the VA. -The medication aides were supposed to check the medication supply before ordering medications. -The medication aides were supposed to document in the Nurse's Notes if they ordered medications from the VA. -They had no policy related to ordering medications from the VA. -When she came to work there in April 2016, she understood residents were to only receive	D914		

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D914	Continued From page 110 medications from the facility pharmacy. -They did not have a system in place to assure medication orders from a non VA source were sent to the VA physician for approval and for dispensing by the VA. -She had never been instructed to send non VA physician orders to the VA physician for approval and dispensing. Telephone interview with the nurse at Resident #3's primary care physician at the VA on 3/16/17 at 11:00am revealed: -If Resident #3 received medication orders from a non-VA physician, the facility should fax those orders to their office for the VA physician to approve and forward to the VA pharmacy for dispensing which would then be mailed to the facility. -If Resident #3 received medication orders which needed to be obtained within 1 or 2 days, the facility should also fax those orders for the VA physician to approve and forward to a local pharmacy for dispensing. -If the VA contacted the local pharmacy to dispense medications to the resident, the resident would not charged for the medication by the local pharmacy but by the VA if there were a charge. -When the VA mails a medication and it is received by the facility, the facility can immediately reorder do not have to wait until a few days before they run out of the medication. -Resident #3 had been seeing the VA physician for at least 1 1/2 years and could have received all his medications from the VA assuming the physician would have approved them. Telephone interview with the licensee on 3/16/17 at 11:15am revealed: -When she took over as licensee in January 2016, she did not have a policy stating residents	D914		

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could not receive medications from the VA.
-When she became aware in February 2017 that Resident #3 had been charged for medications at the facility pharmacy for medications he should have received from the VA, she talked to Resident #3's family/power of attorney and offered to pay the pharmacy for any balance owed, but the family refused to accept her offer.
-She was not aware the family/power of attorney requested pharmacy receipts until February 2017.
-Facility staff should have communicated with her when the receipts were first requested in December 2016.

Confidential interview with a medication aide revealed:
-They ordered medications from the VA only when the supply was "low, like a 10 day supply."
-If the medication did not arrive in time they ordered the medication from the facility's pharmacy provider.
-They did not have a system to document medications when the medication aide ordered medications from the VA, so staff would not know if medications were already ordered.

Review of the documentation of the money collected from Resident #3 for medications from May 2016 through February 2017 revealed it was applied to his pharmacy bill.

B. Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances.

D917	G.S. 131D-21(7) Declaration of Resident's Rights	D917		

G.S. 131D-21 Declaration of Resident's Rights
Every resident shall have the following rights:
7. To receive a reasonable response to his or her

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requests from the facility administrator and staff.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure 2 of 5 residents sampled (Residents #2 and #3) received a reasonable response regarding residents smoking in an unapproved area and provision of pharmacy bill receipts for medications provided by the local pharmacy and paid for by the resident.

The findings are:

A. Telephone interview with Resident #3's family/power of attorney on 3/14/17 at 10:02am revealed;
-The facility had been charging Resident #3 every month for the medications which were provided by the local pharmacy.
-He did not understand why the facility was ordering medications from the local pharmacy because Resident #3 was a veteran and should have been receiving all his medications from the VA.
-In December 2016, he talked to the facility Administrator and requested the pharmacy bills and that they order medications from the VA, but pharmacy receipts were not received until February 2017.

Interview with the Business Office Manager on 3/10/17 at 10:00am revealed:
-The facility had been receiving money monthly from Resident #3 to apply to the pharmacy bill.
-He had a list of all medications provided by the pharmacy and record of all money collected from Resident #3 for the medications.
-They provided Resident #3's family a pharmacy bill in February, 2017.
-He did not know the family requested the

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D917		D917		

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pharmacy bill in December, 2017.

Review of the documentation of the money collected from Resident #3 for medications from May 2016 through February 2017 revealed it was applied to his pharmacy bill.

Telephone interview with the Administrator on 3/14/16 at 2:40pm revealed;
-In December, when Resident #3's family discussed obtaining receipts, she misunderstood and thought they were requesting statements for his personal money.
-Resident #3 handled his own personal money.
-When she came to work there as the Administrator in April 2016 she understood that all residents were supposed to receive their medications from the local pharmacy.
-The medication aides or RCC ordered all medications for the residents.
-A new system was put into place during the survey which required the RCC to order all VA medications.

Telephone interview with the licensee on 3/16/17 at 11:15am revealed:
-When she took over the facility as licensee in January 2017 she never required the Residents to obtain all their medications from the local facility pharmacy.
-She was not aware Resident #3's family requested pharmacy receipts in December 2016 or she would have assured they received them.

B. Review of Resident #2's current FL2 dated 3/2/17 revealed
-Diagnoses included diabetes, respiratory failure, muscle wasting, and chronic obstructive pulmonary disease.
-Medication orders included prednisone 20mg, 1

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tablet daily, Advair 250/50, 1 puff inhaled twice daily, Duoneb, 1 ampoule every 6 hours as needed for shortness of breath, albuterol inhaler, 2 puffs every 6 hours as needed for shortness of breath. (All these medications are used to treat severe chronic obstructive pulmonary disease.)
-Oxygen 3.5 liters per minute via nasal cannula continuously.

Record review revealed a subsequent medication order dated 3/2/17 for Symbicort 160/4.5, 2 puffs twice daily. (Symbicort is combination inhaler used to treat chronic obstructive pulmonary disease.)

Review of Resident #2's Resident Register revealed a date of admission of 2/7/17.

Interview with Resident #2 on 3/7/17 at 4:34pm revealed:
-He liked to sit on the front porch of the facility but could not due to residents and staff smoking on the front porch.
-He believed the resident in room across from his room had smoked in the building.
-Residents and staff were not supposed to smoke on the front porch of the facility or in the building.
-Residents were only supposed to smoke in a covered designated smoking area approximately 75 feet north of the front porch.
-He could not stand to be around the smoke and it made breathing more difficult.
-Once a staff sat down beside Resident #2 on the front porch and began to smoke while Resident #2 was wearing his oxygen.
-He could not remember the staff person's name.
-He had complained to "everyone" including the Administrator about the smoking situation, but nothing had been done.
-He believed smoking on the front porch was

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against facility policy.
-Signs are posted on the front porch informing residents and staff no smoking was allowed on the front porch.

Observations during the survey revealed Resident #2 wore oxygen continuously and ambulated throughout the facility in a wheelchair.

Observation on 3/8/17 at 7:55am revealed:
-One resident smoking on the south end of the front porch, away from the entrance door.
-No staff on the porch.

Observation on 3/8/17 at 10:39am revealed:
-One resident smoking on the front porch.
-No staff on the porch.

Observation on 3/8/17 at 12:22pm revealed:
-One resident smoking on the front porch.
-No staff on the porch.

Observation on 3/8/17 at 5:44pm revealed there were 4 new no smoking signs printed on 8 x 11 printer paper, and 2 permanently mounted plastic no smoking signs on each end of the front porch.

Observation on 3/13/17 at 5:50pm revealed:
-Two residents smoking on the front porch.
-No staff on the porch.

Observation of the facility during a tour on 3/7/17 between 10am and 11:30am revealed no evidence of smoking inside the facility.

Observation of the facility during survey on 3/8/17, 3/9/17, 3/10/17, and 3/13/17 revealed no evidence of residents smoking inside the facility.

Interview with the facility Administrator on 3/8/17

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D917	Continued From page 116 at 4:20pm revealed: -Resident #2 had complained about residents smoking on the front porch. -Residents were not supposed to be smoking on the front porch, only in the designated smoking area down from the front porch. -Smoking on the front porch was not a policy of the facility. -"On January 1, 2017 we began to encourage resident not to smoke on the front porch." -"Smoking on the front porch did not look good for the facility, and residents tracked in cigarette butts making a mess of the floors." -Sometimes residents with dementia forgot and smoked on the front porch. -Staff tried to encourage them to smoke only in the designated smoking areas. Observation of an "After hours Smoking Supervision" notice posted in the medication room on 3/9/17 at 11:06am revealed: -Staff must supervise residents in the smoking area during after hours scheduled smoking times. -"Smoking is not allowed on the front porch by staff or residents at any time!" -This was signed by the former Administrator, but the notice was not dated. Interview with the current Administrator on 3/13/17 at 3:40pm revealed she had been administrator of the facility since 1/16/16. Random interview with a facility resident on 3/9/17 at 8:50am revealed: -She saw residents smoking on the front porch, but was not sure of their names. -She never saw staff smoking on the front porch. -She never saw staff stop residents from smoking on the front porch. -We are encouraged not to smoke on the front	D917		

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D917	Continued From page 117	D917		

porch in our monthly resident council meetings.

Random interview with a second facility resident on 3/9/17 at 11:15am revealed:
-He observed residents smoking on the front porch of the facility.
-Staff try to encourage them to move to the designated smoking area.
-He never saw Resident #2 on the front porch of the facility.

Random interview with a third facility resident on 3/10/17 at 11:30am revealed:
-Residents continued to smoke on the front porch of the facility.
-Staff encourage them to move to the smoking area on the north end of the building.
-He had never observed staff smoking on the front porch of the facility.
-He had observed Resident #2 on the porch once or twice since he (Resident #2) was admitted.

Interview with the facility's nurse practitioner on 3/10/17 at 2:10pm revealed:
-Exposure to second hand smoke was probably not good for Resident #2, but was not serious.
-It was probably not possible to completely eliminate exposure to second hand smoke in the facility.

Review of the facility's policy on use of tobacco products/cigarettes contained in the resident admission contract revealed:
-The facility does not allow any resident to smoke inside the facility, this is grounds for immediate discharge.
-Residents who smoke must smoke in designated smoke area only.
-Residents are asked not to throw cigarette butts in front of the entrance way.

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D917	Continued From page 118 -Staff will supervise residents if needed for their safety and facility safety. -Facility staff reserve the right to confiscate all smoking materials if resident fails to abide by smoking policy. Review of the facility's policy on employee use of tobacco products revealed: -Staff are asked to smoke only in designated smoking area. -Staff are asked not to throw cigarette butts on the ground.	D917		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body	D932		

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D932	Continued From page 119 fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters without proper disinfection for 2 of 3 sampled residents, (#4 and #10). The findings are: Observation of a finger stick blood sugar (FSBS) on 3/7/17 at 11:10am obtained from Resident #1 revealed: -The case containing the glucose meter was labeled with the name of Resident #1. -The meter was not labeled with the resident's name.	D932		

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D932	Continued From page 120 -A disposable lancing device was used to obtain a blood sample from Resident #1. -The FSBS was 161 and SSI was administered per physician's orders. -The glucose meter was not disinfected prior to returning it to the case for storage. Interview with the Medication Aide (MA) on 3/7/17 at 11:20am revealed: -Each resident has their own glucose meter. -No glucose meters are shared between residents. Review of Resident #10's current FL2, hospital discharge summary, and FL2 clarification orders all dated 2/21/17 revealed: -Diagnoses included generalized edema, elevated troponin level, and hepatitis C. -Medication orders for fixed dose Novolog insulin with meals and sliding scale insulin to be given with the fixed dose with time a day with meals. (Novolog is a quick acting insulin used to lower blood sugars around meal times.) Record review revealed a prior history and physical dated 8/15/15 with additional diagnoses of chronic obstructive pulmonary disease, diabetes, and congestive heart failure. Observation of morning medication pass on 3/8/17 at 8:10am revealed: -Resident #10 stood at the medication cart waiting to receive his morning dose of Novolog insulin. -An unlabeled glucose meter was laying on top of the medication cart with a FSBS reading reading of 221mg/dl. -A empty glucose meter case was also laying on top of the medication cart with Resident #10's name written on the side of the case.	D932		

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D932	Continued From page 121	D932		

-The MA indicated the meter and case belonged to Resident #10, and he was to receive SSI this morning.

Review of the facility's blood sugar documentation sheet for March 2017 for Resident #10 revealed the documented FSBS for 3/8/17 at 7am was 128 not 221 as observed on the glucose meter from the morning medication pass on 3/8/17 at 8:10am

Interview on 3/9/17 at 10:40am with the MA who administered Resident #10's morning medications on 3/8/17 revealed:
-Resident #10's FSBS was 128 on the morning of 3/8/17 and not 221.
-She could not explain the discrepancy with the reading on the glucose meter on the top of the medication cart on 3/8/17 at 8:10am, but they do not share glucose meters between residents.

Observation of Resident #10's glucose meter on 3/9/17 at 10:54am revealed:
-The time stamp on the meter was 11:14pm on 6/11.
-There were 47 readings in the memory of the meter.
-The last reading was 5:01am on 5/23 and first reading was 10:23pm on 6/11.

Review or Resident #10's blood sugar documentation sheet and MARs for February and March 2017 revealed:
-15 of the 47 readings in the glucose meter's memory are not documented anywhere on the MARs or blood sugar documentation sheets.
-12 documented FSBS for Resident #10 are not in the resident's glucose meter.

Interview with Resident #10 on 3/9/17 at 11:15am

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revealed:
-He received his FSBS "about 4 times a day."
-As far as he knew, they always used the same glucose meter.

Observation of the medication cart on the 400 Hall (New Hall) on 3/8/17 at 8:30am revealed all of the glucose meters were of the same brand and color.

A current facility policy and procedure for infection control and the obtaining of FSBS was requested but not provided prior to exiting the facility.

Refer to interview with the Administrator on 3/9/17 at 10:40am.

Refer to review of new facility policies and procedures created during the survey.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 3/15/17 at 10:34am.

B. Review of Resident #4's current FL2 dated 6/4/16 revealed:
-Diagnoses included diabetes mellitus, insomnia, major depression, bipolar disorder, schizophrenia, polysubstance abuse, rectal prolapse, anxiety, deep vein thrombosis, and anemia.
-Medications included Levemir (used to treat high blood sugar levels) 100 units/ml, inject 50 units subcutaneously (SQ) every morning and 60 units at bedtime; Novolog (used to treat high blood sugar levels) 100 units/ml inject 3 units SQ along with sliding scale insulin (SSI) dose three times daily before meals 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 14 units.

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D932	Continued From page 123 -An order to check FSBS levels at 7:30am, 11:30am, and 4:30pm. Record review for Resident #4 revealed: -There were changes on 11/23/16 and 12/26/16 to insulin doses. -There was no order to discontinue the FSBS checks before meals. -A hemoglobin A1c level of 6.6% (normal range 3.0 to 5.6) from a blood sample taken on 9/26/16. Review of Resident #4's MAR for February 2017 revealed there was no entry for FSBS to be obtained. Review of Resident #4's Blood Sugar Documentation Sheet for February 2017 revealed: -A note at the top of the form written by the MA to check FSBS before meals. -There were 6 FSBS readings documented that did not match the readings on the resident's glucometer: 2/9 at 7:30am = 222, 2/9 at 11:30am = 140, 2/10 at 7:30am = 146, 2/11 at 7:30am = 147, 2/12 at 7:30am = 192, and 2/13 at 7:30am = 159. Review of the readings on Resident #4's glucometer on 3/9/17 at 10:30am revealed: -There were 49 readings in the memory of the meter. -The last reading was 8:47am on 3/9 and first reading was 9:39pm on 2/7. -There were 19 readings that were not documented on the MAR or Blood Sugar Documentation Sheet for February 2017. -On 2/9 there were 2 readings of 123 at 12:44pm and 353 at 10:20pm. -On 2/10 there were 4 readings of 155 at 10:56am, 190 at 1:21pm, 350 at 5:23pm, and 268	D932		

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D932	Continued From page 124 at 10:30pm. -On 2/11 there were 4 readings of 201 at 10:15am, 259 at 1:30pm, 250 at 6:04pm, and 259 at 10:39pm - On 2/12 there were 4 readings of 138 at 8:42am, 237 at 12:37pm, 234 at 5:27pm, and 113 at 9:51pm. -On 2/13 there were 5 readings of 476 at 3:02am, 230 at 8:46am, 240 at 12:11pm, 216 at 5:31pm and 282 at 10:13pm. -The time stamp on the glucose meter read 10:30am on 3/9/17. Interview with Resident #4 on 3/10/17 at 4:00pm revealed: -Staff checked his blood sugar 1-2 times daily. -He was unsure if the MAs had ever used another resident's glucometer to check his FSBS. Interview with the Administrator on 3/13/17 at 3:40pm revealed the most recent chart audits were completed by the facility in November 2016. Telephone interview with the Primary Care Provider (PCP) on 3/16/17 at 12:27pm revealed she was unaware that Resident #4's glucometer had been used for other residents. Refer to interview with the Administrator on 3/9/17 at 10:40am. Refer to review of new facility policies and procedures created during the survey. Refer to telephone interview with the RCC on 3/15/17 at 10:34am. ____________________ Interview with the Administrator on 3/9/17 at 10:40am revealed:	D932		

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-The facility's policy was not to share glucose meters.
-Each resident had their own glucose meter and there would be no reason to share.

Review of new facility policies and procedures created during the survey revealed:
-At no time should a Medication Aide share blood glucose meters with other residents.
-If a resident's meter is broken or lost the Medication Aide needs to inform the RCC for a replacement.
-The RCC will match the memory in the meter with results recorded twice weekly.
-In the event results that do not match with meter, the MA will (1) be re-inserviced by the company registered nurse, (2) a written consult will be given, re-inserviced by the company registered nurse and suspended off the cart for 3 days, (3) terminated or demoted.

Telephone interview with the RCC on 3/15/17 at 10:34am revealed:
-The MAs were not supposed to share glucometers among residents.
-She was unaware if any glucometers were shared.

The facility failed to implement proper infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control for 2 of 3 sampled residents (Residents #4 and #10), with orders for FSBS monitoring by allowing the sharing of glucose meters between residents without proper disinfection. The failure to prevent sharing of glucose meters exposed residents to the risk of contracting serious blood borne illnesses including hepatitis and human immunodeficiency

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D932	Continued From page 126 virus and constitutes a Type B violation. ______________________________ The Plan of Protection provided by the facility on 3/9/17 revealed: -Pharmacy called to obtain new blood glucose meters. -Purchase of pencil boxes for each resident to keep blood sugar supplies separate. -MAs will be inserviced about sharing meters. -MA will check meters twice for accuracy to ensure correct result is written accurately on the MAR and blood sugar flow sheet and match the meters. -All blood sugar supplies will be labeled with resident's names. -The RCC will check meters twice weekly to match record with meter and ensure proper documentation is completed. -If the meters don't match, further disciplinary actions will be taken with staff to ensure resident's safety and health, and new meters will be obtained. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2017.	D932		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by:	D980		

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D980	Continued From page 127 TYPE B VIOLATION Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained rules related to housekeeping and furnishings, other requirements, health care, nutrition and food service, resident rights, medication administration, controlled substances, and adult care home infection prevention requirements. Non-compliance identified during the survey included: Interview with the Administrator on 3/13/17 at 3:40pm revealed: -She was responsible for the total operations of the facility. -She started in this position on January 16, 2016 and stated she had been on her own since March 2016. -She had experienced employee turnover in the Resident Care Coordinator (RCC) position. -The RCCs were responsible for ensuring orders for medications, labs and treatments were implemented for each resident. -The last time she had performed chart audits for the facility was in November 2016. -The Clinical Administrator made frequent rounds to the facility. -The Clinical Administrator had implemented a corporate task calendar in January 2017, but she had delegated those tasks to the RCC. -She tried to get the tasks done each day, but had not been able to do them all. Telephone interview with the RCC on 3/15/17 at 3:15pm revealed after she completed the tasks on the monthly calendar, she checked them off with a pencil, but the calendar was not forwarded	D980		

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D980	Continued From page 128 back to the Clinical Administrator after completion of the tasks. Interview with the Clinical Administrator on 3/10/17 at 1:45pm revealed the Administrator did not return the calendar to her upon completion of tasks. Telephone interview with the Administrator on 3/17/17 at 3:01pm revealed her normal work hours were Monday through Friday from 8am to 5pm. Review of the January, February, and March 2017 task calendars revealed the following scheduled tasks: -Check the Medication Administration Records (MARs) to make sure orders were correct. -Administrator (ADM) or Administrative Assistant (AA) to review the pharmacy logs weekly. -RCC to proof read the MARs for mistakes. -Administrator and RCC to perform a weekly controlled substance count with the MAs on both shifts (the AA/ADM was responsible for 1st shift and the RCC for 2nd shift). -RCC to perform a medication cart audit 1-2 times per month. -The AA/RCC/ADM to check the overstock controlled substance box daily. -The RCC was to make sure vital signs were recorded on the logs. -The ADM/RCC to check all lab orders and make sure results were in the charts. -ADM to check the oxygen storage area weekly. -The ADM/AA to review of the current health inspection reports for the building and kitchen, and review findings with housekeeping, maintenance and kitchen staff. -RCC/AA/ADM to monitor 2 charts every day. -ADM/AA to walk around facility daily to ensure	D980		

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D980	Continued From page 129	D980		

areas are clean.
-RCC to email maintenance log to the owner weekly.
-RCC to follow up on all orders and ensure a copy is in the file.
-RCC to check finger stick blood sugar sheets monthly.
-RCC to check glucometers monthly.
-ADM/AA to observe a medication pass monthly.
-RCC to observe a medication pass 1-2 times a month.
-ADM/AA to review transportation documentation monthly to ensure all heath care follow-up orders are done.
-ADM/AA to contact the pharmacy to communicate any issues.
-AA/RCC to contact the PCPs to ensure all orders are signed are clarified in 15 days.

Non-compliance identified during the survey included:

A. Based on observations, interviews, and record reviews, the facility failed to have walls, ceilings, and floors or floor coverings kept clean and in good repair for 1 common half bathroom, 1 common shower/bathroom, a small dining room on the 400 hall, a shared 1/2 bathroom, and all other common areas of the facility. [Refer to Tag 74, 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings.]

B. Based on observations, interviews, and record reviews, the facility failed to assure 8 oxygen tanks were stored securely in storage holders. [Refer to Tag 79, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings.]

C. Based on observations and interviews, the facility failed to assure there was a supply of

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	HAL036035	A. BUILDING: ______ B. WING ______	R 03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OAKS ASSISTED LIVING	**916 S. MARIETTA STREET GASTONIA, NC 28054**

(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
D980	Continued From page 130 clean towels and washcloths for resident use on hand at all times. [Refer to Tag 80, 10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings.] D. Based on observations and interviews, the facility failed to assure all washers and dryers were maintained in a safe and operating condition resulting in residents not having a clean towel and washcloth available at all times. [Refer to Tag 105 10A NCAC 13F .0311(a) Other Requirements.] E. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of residents, related to notification of the Primary Care Provider regarding refusals of fingerstick blood sugars (FSBS) and insulin injections, refusals and missed blood pressure readings, and labs not obtained, for 1 of 5 sampled residents (Resident #4). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation).] F. Based on observations, interviews, and record reviews the facility failed to assure documentation of the following in the resident's record: written procedures, treatments or orders from a licensed health professional; and implementation of procedures, treatments or orders for 3 of 5 sampled residents (Residents #1, #2, and #4) with orders for sliding scale insulin, blood sugar readings, daily blood pressures, and labs. [Refer to Tag 276 10A NCAC 13F .0902(c)(3-4) Health Care.] G. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 sampled resident (Resident #16) with a physician order for a puree diet was served as ordered. [Refer to Tag 310, 10A NCAC 13F .0904(e)(4)	D980		

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D980	Continued From page 131 Nutrition and Food Service.] H. Based on observations, interviews, and record reviews, the facility failed to assure medications (Forteo, simvastatin, and Novolog), were administered as ordered by a licensed prescribing practitioner for 3 of 6 residents (#2, #10, and #11) observed on a medication pass and failed to assure medications (Humalog, Klonopin, Oxycodone, Tradjenta, Tresiba, and lorazepam) were administered as ordered for 6 of 10 residents (#1, #4, #6, #12, #14, and #15) sampled. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] I. Based on observations, record review, and interviews, the facility failed to assure medications prepared in advance were protected from contamination and identified up to the point of administration for 4 unknown residents. [Refer to Tag 363 10A NCAC 13F .1004(f) Medication Administration.] J. Based on observations, record reviews, and interviews, the facility failed to assure accurate documentation on the Medication Administration Record and failed to document justification and effect of as needed (PRN) medications for 6 of 6 residents (#1, #2, #4, #6, #12, and #14) sampled with PRN medication orders. [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration.] K. Based on observations, interviews, and record reviews, the facility failed to assure Residents' Rights were maintained by providing readily retrievable records to account for the disposition of controlled substances (Oxycodone and hydrocodone-acetaminophen) and to ensure an	D980		

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D980	Continued From page 132	D980		

accurate reconciliation of those controlled substances for 4 of 4 residents (#1, #4, #12, and #15) sampled including a resident with the diagnoses of displaced humerus fracture and left clavicle fracture (#12), a resident with the diagnoses of stage II pressure ulcer, diabetes mellitus and deep vein thrombosis (#4), a resident with the diagnosis of arm pain (#1), and a resident with the diagnosis of chronic back pain (#15). [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation).]

L. Based on observations, interviews, and record reviews, the facility failed to assure resident rights were maintained for 1 of 6 residents sampled (Resident #3) related to exploitation of funds when he was required to pay a co-pay at a second pharmacy when the veterans administration would have provided or did provide his medications and for 3 of 4 residents sampled (#1, #4, and #12) related to missing controlled substances, including a resident with the diagnoses of displaced humerus fracture and left clavicle fracture (#12), a resident with the diagnoses of stage II pressure ulcer, diabetes mellitus and deep vein thrombosis (#4), and a resident with the diagnosis of arm pain (#1). [Refer to Tag 914 G.S. 131D-21(4) Declaration of Resident's Rights.]

M. Based on interviews and record reviews, the facility failed to assure 2 of 5 residents sampled (Residents #2 and #3) received a reasonable response regarding residents smoking in an unapproved area and provision of pharmacy bill receipts for medications provided by the local pharmacy and paid for by the resident. [Refer to Tag 917 G.S. 131D-21(7) Declaration of Resident's Rights.]

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D980	Continued From page 133	D980		

Continued From page 133

N. Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters without proper disinfection for 2 of 3 sampled residents, (#4 and #10). [Refer to Tag 932 G.S. 131D-4.4A (b) Adult Care Home Infection Prevention Requirements (Type B Violation).]

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Failure of management to provide oversight and monitor the facility for all licensure rule areas resulted in 10 residents not receiving 8 medications as ordered; no system to accurately account for controlled substances; exposing residents to the risk of of contracting serious blood borne illnesses when glucometers were shared; residents not receiving FSBS, blood pressures, and labs as ordered; placing a resident's nutritional status at risk when all menu items were not served; storing oxygen tanks without benefit of secure holders, floors not maintained clean and good repair, and a resident rights being denied when a response to a reasonable request was delayed and charging a resident for medications because of failure to order them from the VA. The failure of management in providing oversight in these areas constitutes a Type B Violation.

The Plan of Protection provided by the facility on 3/10/17 revealed:
-Supervisors will be met with immediately to discuss supervision of residents and staff to ensure no reoccurrences in cited areas.
-Administrator will make more frequent rounds in the building looking for issues, talking to residents, and meeting with staff.
-Administrator will check behind all staff

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D980	Continued From page 134 frequently and address any issues in a timely manner to ensure facility and staff are in compliance with rules. -Supervisors and Resident Care Director will be met with weekly to ensure facility is in compliance with rules. -Further disciplinary actions will be taken against supervisors if rules are violated. -All staff are to report any issues directed to the Resident Care Director and Administrator. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2017.	D980		