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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section completed an Annual survey on 11/18/14 and 11/19/14. | D 000 | | |
| D 269 | 10A NCAC 13F .0901(a) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.<br><br>This Rule is not met as evidenced by:<br>Based on observation interview and record review, the facility failed to provide personal care for 1 of 2 residents (#5), who required assistance with catheter care and hygiene. The findings are:<br><br>Review of Resident #5's most current FL-2 dated 11/12/14 revealed:<br>- Diagnoses included senile dementia, old age and general frailty.<br>- Resident ambulatory and constantly confused.<br><br>Resident record revealed an order from Resident's physician dated 12/13/14 for home health to come to facility and provide monthly catheter changes.<br><br>Review of resident care plan dated 9/12/14 revealed:<br>- Resident has dementia and is independent with activities of daily living (ADLs).<br>- Resident requires assistance with showering.<br>- Family want to make sure that resident is | D 269 | | |

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getting adequate amount of showers.
- Resident cannot remember taking a shower.
- Resident has a urinary catheter.

Interview with the Resident Assistant (RA) on 11/18/14 at 10:15am revealed:
- Resident #5 had a urinary catheter that he cared for himself.
- Resident does have dementia, but is able to take care of his personal care and catheter care without assistance from staff.
- Staff help resident with bathing 2 times a week.

Review of The Licensed Health and Professional Support (LHPS) review revealed:
- The home health nurse changes his catheter monthly.
- Staff at the facility had been validated to provide the LHPS task of helping to Position, empty and clean around Resident #5 ' s urinary catheter.

Observation of Resident #5 on 11/19/14 at 2:20pm revealed:
- Resident sitting in a recliner in his room with his wife neatly dressed, with a strong odor of urine on his person and in the room.
- Resident had a urinary catheter with a leg bag attached.
- Resident was not interviewable.

Interview with Resident Care Coordinator (RCC) on 11/19/14 at 2:30pm revealed:
- Resident #5 has dementia and is confused however, he provides his own personal care and cares for his urinary catheter.
- Staff provide Resident #5 with showering assistance 2 times a week.
- A home health nurse comes out to the facility

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once a month and changes his catheter.
- She was under the impression that Resident #5 was caring for himself independently, until his wife was hospitalized.
- When his wife was hospitalized, she realized resident had been prompted by his wife to care for himself and his catheter.
- The facility had to hire a sitter while resident ' s wife was out to stay with resident and cue him to care for himself and his catheter until his wife returned.
- She has smelled an odor of urine on Resident #5.
- Sometimes he doesn't tighten the cap on his urine leg bag and it drains onto his clothes.
- His laundry is done once a week and resident has at times put on clothes that he had previously worn and leaked urine on, causing him to have a urine odor.
- She thinks the urine odor coming from Resident #5's room is imbedded in his mattress.
- Recently 2-3 weeks ago, there was an incident where his catheter was leaking and drained all over his bed. His bed was soaked with urine.
- Resident #5 did not realize the home health nurse had not come to change his catheter that month.
- When staff realized his catheter was leaking all over, the facility contacted the home health nurse on 10/27/14, she came out on 10/28/14 and changed his catheter.
- She now realizes resident needs more assistance with the care of his catheter.
- She had spoken to the Administrator about having the staff at the facility start providing care for resident ' s personal care and assisting with care of the urinary catheter.
- The nurse and the administrator are responsible for making changes to the resident's

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| D 269 | Continued From page 3<br>care plan.<br>- She will order a new mattress for Resident's bed.<br><br>Review of home health nursing notes dated 10/28/14 for Resident #5 revealed:<br>- The nurse is contracted to go to facility for monthly catheter changes, per physician order.<br>- The nurse had been called by the facility due to Resident's urinary catheter leaking.<br>- The catheter was not leaking when she arrived.<br>- It was time for the catheter to be changed, so it was changed at that time.<br><br>Interview with the Administrator on 11/19/14 3:50pm revealed:<br>- Resident's mental status is the same now as it was when he was admitted.<br>- He is waiting for a bed in a memory care unit closer to one of his family members.<br>- His wife had been his stabilizer and would direct him on his care.<br>- She noticed an odor on Resident #5 some weeks ago. She updated his care plan at that time for staff to assist him with showering twice a week.<br>- She thought the odor was better after staff started assisting with his showering. | D 269 | | |
| D 298 | 10A NCAC 13F .0904(d)(2) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(d) Food Requirements in Adult Care Homes:<br>(2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for | D 298 | | |

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| D 298 | Continued From page 4<br>a total of three snacks per day and shown on the menu as snacks.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure foods and beverages appropriate to resident diets were offered or made available to all residents (census of 47) as snacks between the breakfast and lunch meals and the lunch and dinner meals for a total of three snacks per day.<br><br>The findings are:<br><br>Interview with the Executive Director on 11/18/14 at 9:55 a.m. revealed there were 47 residents residing in the facility.<br><br>Confidential interviews with 11 residents on 11/18/14 revealed:<br>- There was only an evening snack provided daily which was served from a snack cart.<br>-There were no snacks made available or offered to them between breakfast and lunch and between lunch and dinner.<br>-A refreshment was offered during the excersice group activity but not at the other activities.<br>-Some residents have snacks they purchased or their family purchased in their rooms.<br>-They did not know the facility was required to provide or offer snacks 3 times a day.<br>-They would like snacks to be provided to them.<br><br>Obeservation of a group activity on 11/18/14 at 11:05 a.m. in the central activity room revealed 12 residents were present and one staff and no refreshments or snacks were available.<br><br>Interview with the Dietary Services Coordinator on 11/18/14 at 11:50 a.m. revealed: | D 298 | | |

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| D 298 | Continued From page 5<br>-The kitchen staff prepare a snack cart for the evening snack and no other snacks were prepared for the residents during the day.<br>-If residents would like a snack they could ask for it.<br><br>Interview with the Executive Director on 11/18/14 at 12:45 p.m. revealed:<br>-The residents and families are told when they are admitted that refreshments are available upon request from the kitchen.<br>-A snack cart with a variety of foods and beverages was prepared by the kitchen staff and served by the resident assistant during the evening.<br>-Snack foods were not placed out or made available for self serve because some residents would take more than they needed and others would eat snacks that were not appropriate for their diet.<br>-Refreshments were offered in group activities during the day but there were no snacks offered or made available to all residents between breakfast and lunch and lunch and dinner.<br><br>Interview with 12 residents after a "menu chat meeting", a meeting with dietary manager, Executive Director and residents, on 11/19/14 at 2:00 p.m. revealed:<br>-No snacks were provided during the day between meals.<br>-One resident stated refreshments were given during the exercise group activity.<br>-They would like to be offered a snack between daytime meals.<br>-They were pleased with the evening snacks that the snacks evening snacks were excellent.<br><br>Observations and interviews with 5 residents on 11/19/14 at 3:50 p.m. revealed: | D 298 | | |

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| D 298 | Continued From page 6<br>-They had not been offered a snack this afternoon.<br>-They were not offered daytime snacks but would like to have one.<br>-They were not aware it was a requirement snacks had to be offered 3 times a day.<br><br>Interview with 2 Resident Assistants on 11/19/14 at 4:00 p.m. revealed:<br>-They were not aware of any snacks were offered during the day but if residents requested something to eat they would get it for them.<br>-They were told snacks were going to be offered during the day from now on.<br><br>Review of the facility's menu posted on the main hall and in the dining room on 11/19/14 at 4:20 p.m. revealed no snacks were listed on the menus.<br><br>Interview with the Executive Director on 11/19/14 at 4:25 p.m. revealed:<br>-She was not aware snacks were not listed on the menu.<br>-She would ensure these items were listed on the menu. | D 298 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures. | D 358 | | |

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| D 358 | Continued From page 7<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to assure medications, such as Ophthalmic, Proscar and Reglan were administered as prescribed for 3 of 5 residents observed during medication administration. The findings are:<br><br>The medication error rate of 24% was based on observation of 6 errors out of 25 opportunities, during the 11/18/14 12:00pm and the 11/19/14 8:00am medication administration.<br><br>1. Review of Resident #7's current FL-2 dated 12/7/13 revealed:<br><br>- Diagnoses included traumatic brain injury, hypertension, cognitive impairment, and aphasia.<br><br>a. Review of Physician orders dated 10/3/14 for Resident #7 revealed an order for Restasis 0.05% eye drops, instill 1 drop into the Right eye four times a day. (Restasis is used for increased tear production, in people who suffer from dry eyes).<br><br>Observation of medication administration on 11/18/14 at 12:05pm for Resident #7 revealed Medication Aide (MA) instilled 1 drop of Restasis 0.05 into both of the resident's eyes.<br><br>Interview with the MA on 11/18/14 at 12:10pm revealed:<br>- When she realized the she gave the Restasis eye drops in error, it was too late.<br>- She knew she was supposed to instill the drop in the right eye only, but she forgot that is not something that she usually did. | D 358 | | |

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| D 358 | Continued From page 8<br><br>Interview with Administrator on 11/19/14 at 2:10pm revealed the MA told her about the error immediately after she had done it, she was just nervous<br><br>b. Review of Physician orders dated 10/3/14 for Resident #7 revealed an order for Systane ultra 0.3-0.4% eye drop, instill 1 drop in both eyes four times a day. (Systane Ultra is used as an eye lubricant for dry irritated eyes).<br><br>Interview with MA on 11/18/14 at 12:07pm revealed:<br>- She had just instilled the other drops into Resident #7s eyes, she will wait a while before she instilled the other drops.<br>- She will let the Resident go to lunch and then give the eye drops after lunch.<br><br>Observation of medication administration on 11/18/14 at 1:25pm revealed Systane Ultra 0.3-0.4% eye drops were not found on the medication cart.<br><br>Interview with the MA on 11/18/14 at 1:25pm revealed:<br>- She just remembered she did not administer Resident #7 ' s Systane eye drops this morning for her 8:00am dose, because she was unable to find the medication on the cart this morning.<br>- She documented not given on the MAR this morning.<br>- She checked for the paperwork and saw the medication had been ordered by the night shift MA on 11/17/14.<br>- The night shift MA ordered the eye drops last night because she ran out of drops and was unable to give a couple of doses. | D 358 | | |

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| D 358 | Continued From page 9<br><br>Review of medication order sheet revealed Systane drops written on a pharmacy order sheet dated 11/17/14.<br><br>Review of the medication administration record (MAR) for November 2014 revealed:<br>- On 11/17/14 at 4:00pm Systain Ultra 0.3-0.4% eye drops initialed with a circle.<br>- On 11/17/14 at 8:00pm Systain Ultra 0.3-0.4% eye drops initialed with a circle.<br>- The explanation on the back of the MAR indicated the medication was unavailable.<br><br>Interview with 2nd medication aide revealed:<br>- She was the MA that ordered the Systain 0.03% eye drops.<br>- She realized the bottle was empty when she went to administer her 4:00pm dose.<br>- She documented not given on the MAR last night by initialing next to the date under the medication ordered and circling her initials and writing unavailable under the explanation on the back of the MAR.<br>- She filled out a pharmacy order sheet and ordered the medication at that time.<br>- The medication should come in tonight 11/18/14 between 8:30 and 10:00pm.<br>- The Resident usually has another bottle in the facility in back up, this time she didn ' t.<br>- It is rare that the Resident will run out of medications, unless there is a problem with billing, she has not run out of drops in over six months.<br><br>Interview with the RCC on 11/19/14 at 10:20am revealed:<br><br>- The medications taken as needed (PRN) and liquid medications are ordered by the MAs when | D 358 | | |

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| D 358 | Continued From page 10<br>they see they are getting low.<br>- Any medications that have to be reordered has to be done by 2:00pm in order to be included in the delivery that day.<br><br>Refer to interview with the Administrator on 11/19/14 below.<br><br>2. Review of Resident #8's current FL-2 dated 3/17/14 revealed:<br><br>- Diagnoses included malignant neoplasm of ovary, anemia, gastro esophageal reflux disease (GERD).<br>- Orders for Lactaid 3000 units 1 pill by mouth before meals. (A digestive enzyme used to treat lactose intolerance).<br>- Simethicone 80 milligram (mg) 2 tablets by mouth before meals and at bed time. (Used to relieve abdominal discomfort caused by extra gas and bloating.)<br><br>Review of physician visit summary dated 10/15/14 revealed, the following medication orders for Resident #8:<br>- Simethicone 80mg chew 2 tablets to be taken by mouth four times a day, before meals and at bedtime.<br>- Lactaid 3000 unit 1 tablet to be taken by mouth three times a day before meals.<br>- Reglan 5mg tablets 1 tablet to be taken three times a day before meals.<br><br>Observation of the MA administering medications on 11/18/14 at 1:08pm to Resident #8 revealed:<br>- She administered (2) 80 mg Simethicone chew tablets.<br>- She administered (1) 3000 unit Lactaid tablet.<br>- She administered (1) 5mg Reglan tablet. | D 358 | | |

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| D 358 | Continued From page 11<br>- Resident #8 informed the MA she had already eaten lunch.<br><br>Interview with the MA on 11/18/14 at 1:10pm revealed:<br>- She knows she was supposed to administer the medications before lunch.<br>- She usually administers Resident #8 her 12:00pm dose of medications around 11:45am.<br>- Resident #8 was already in the dining room by 11:45am.<br>- The MAs are not allowed to give medications in the dining room. It is against the facility's policy.<br>- She could have pulled her out of the dining room, but she did not think of that, her timing was just off.<br><br>3. Review of Resident #6's current FL-2 dated 9/15/14 revealed:<br><br>- Diagnoses included hypertension, atrial fibrillation, anemia, and muscle weakness.<br>- Proscar 5mg 1 tablet to be taken by mouth daily ordered under medications. (Used to prevent symptoms of enlarged prostate in men).<br><br>Observation of medication administration on 11/19/14 at 9:25am revealed:<br>- Proscar 5mg was not given, the medication was not found on the medication cart.<br>- The MA checked to see if the medication had been ordered.<br><br>Review of the November 2014 MAR for Proscar 5mg tablets revealed:<br>- On 11/17/14 the medication had been initialed and circled.<br>- On 11/18/14 the medication had been | D 358 | | |

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| D 358 | Continued From page 12<br>initialed and circled.<br>- The explanation on the back of the MAR indicated medication unavailable.<br><br>Interview with the MA on 11/19/14 at 9:45am revealed:<br>- There was no Proscar found on the medication cart.<br>- The initial with the circle around it on the MAR means the medication was withheld, the explanation is written in on the back of the MAR.<br>- The night shift MA is responsible for checking to ensure all medications are checked and available for administration.<br>- Resident #6 had been using medication from a bottle that he brought with him when he was admitted.<br>- If he had a medication card, the MA would be alerted to reorder the medication she started administering the tablets on the far right column indicated with blue packaging as a reminder to reorder the medicine.<br>- There was no faxed reorder sheet to indicate the medication had been ordered.<br>- She contacted the pharmacist and was informed the medication was not reordered because the insurance company refused to refill the medication.<br>- She then called the back-up pharmacy and ordered a 30 day supply to hold her until the insurance company and the pharmacy could reconcile the medication order and send in the refill.<br>- The medication would be available later that day and the facility would send staff to pick up the doses.<br>- Since the medication is a daily medication, she will administer the dose upon pick up.<br><br>Interview with the Resident Care Coordinator | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL074012 | A. BUILDING: _____ B. WING _____ | 11/19/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF GREENVILLLE | 2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834 |

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| D 358 | Continued From page 13<br>(RCC) on 11/19/14 at 10:20am revealed:<br>-<br><br>- Scheduled medications come in a cycle of 30 days from pharmacy.<br>- There is a list posted in the medication room.<br>- The medications should come in at night.<br>- The pharmacy send medications 3-4 days in advance.<br>- The 3rd shift MA or RCC will check medications in.<br>- The medication had been discontinued and restarted by his physician.<br>- Once the medication card is dispensed medication is used from the package it would not be credited, even though it was sent back to pharmacy.<br>- The insurance would not pay for the refill of a medication they have previously been charged for.<br>- Resident had some medication leftover in a bottle from when he was first admitted to the facility that had not been sent back to the pharmacy.<br>- Resident #6 ha started using that until it just ran out.<br>- The MA might not have known to look for the bottle versus the medication card.<br><br>Refer to interview with the Administrator below.<br><br>_____<br>_____<br><br>Interview with the administrator on 11/19/14 at 2:10pm revealed:<br>- She is aware medication administration is something that needs to be looked at closely.<br>- The facility has had a few turnovers with nursing staff within the last year. | D 358 | | |

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| D 358 | Continued From page 14<br>- The facility has hired a new nurse that will be responsible for handling the clinical side.<br>- The nurse will be responsible for conducting medication audits and will help the MAs with the medication cart. | D 358 | | |
| D934 | G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements<br><br>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements<br><br>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5<br><br>This Rule is not met as evidenced by:<br>Based on interview, and record review, the facility failed to provide mandatory annual infection prevention training for 2 of 2 medication aides (A and B) sampled and employed for more than one year. The findings are:<br><br>1. Review of Staff A's personnel record revealed:<br>- Staff A was hired on 10/19/13as a resident | D934 | | |

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|---|---|---|---|---|
| D934 | Continued From page 15 | D934 | | |

assistant/medication aide.
- No documentation the annual state approved infection control training had been completed.
- The was no documentation that Staff A had completed the annual state approved infection control training since being hired 13 months ago.

Staff A was unavailable for interview on 11/19/14.

Interview with the Resident Care Coordinator on 11/18/14 at 4:30 p.m. revealed Staff A usually worked day shift as a medication aide/resident assistant.

Refer to interview with the Resident Care Coordinator on 11/18/14 at 4:30 p.m..

2. Review of Staff B's personnel record revealed:
- Staff B was hired on 08/09/2011 resident assistant/medication aide.
- Staff B passed the written medication exam on 06/13/12.
- No documentation the annual state approved infection control training had been completed.
-The most recent annual state approved infection control training had been completed on 06/12/12.
-Staff B continued to pass medications including doing finger stick blood sugars.

Staff B was unavailable for interview on 11/19/14.

Interview with the Resident Care Coordinator on 11/18/14 at 4:30 p.m. revealed Staff B was a medication aide/resident assistant and usually worked the evening shift.

Refer to interview with the Resident Care Coordinator on 11/18/14 at 4:30 p.m.

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| D934 | Continued From page 16<br><br>Interview with the Resident Care Coordinator on 11/18/14 at 4:30 p.m. revealed:<br>-Infection contrtol training was done within their staff training.<br>-The State Approved Infection Control annual training was scheduled but had to be rescheduled due the nurse who would be doing the training was not available.<br>-She was not aware the 2 medication aides had not had the annual State Approved Infection Control annual training.<br><br>Interview with Executive Director on 11/20/14 at 3:50 PM revealed that the State Approved Infection Control annual training had not been done because the facility has not had a permanent RN on staff for several months. Since an RN has been hired and is training now, the State Approved Infection Control annual training is scheduled for 12/22/14. | D934 | | |