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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual survey on January 21-23, 2015. | D 000 | | |
| D 113 | 10A NCAC 13F .0311(d) Other Requirements<br><br>10A NCAC 13F .0311 Other Requirements<br>(d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observation, interview, and record review the facility failed to assure that water temperatures were maintained at a minimum of 100 degrees Farenheit (F) and did not exceed 116 degrees F for 2 of 2 fixtures (1 sink, 1 tub) located in the community shower room and 1 of 2 fixtures (sink) in resident private bathrooms.<br><br>The findings are:<br><br>Observations during the initial facility tour on 1/21/15 from 7:30am to 10:00am revealed:<br>-At 8:46am, the sink temperature was 85 degrees F in Bathroom #3 (the private room half bath in the second room on the right of the right hall).<br>-At. 9:05am, the tub temperature in was 118 degrees F in Bathroom #4 (the full bath at the end | D 113 | | |

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| D 113 | Continued From page 1 | D 113 | | |

of the right hall).
-Three other sink faucets were checked in three other bathrooms and those temperatures ranged from 104 degrees F to 112 degrees F.

Interview with the Administrator on 1/21/15 at 9:26am revealed:
-She was aware water temperatures were to be maintained between 100 and 116 degrees F.
-She was unaware the water temperature had been too low in the sink in Bathroom #3.
-She was unaware the water temperature had been too high in the tub in Bathroom #4.
-All the residents were oriented and most received some assistance with bathing.
-The Supervisor was supposed to check the water temperatures weekly and write them down in a log.
-She would have the Supervisor turn the water temperature down at the boiler, and put up a sign in Bathroom #4 to warn residents the water was too hot.
-"Last Friday, the repairman had to work on the boiler. Maybe [the water temperatures] got messed up then."

Observations on 1/22/15 at 1:15pm and recheck of the water temperatures in Bathroom #4 revealed:
-The sink measured 130 degrees F with steam.
-The tub measured 140 degrees F with steam.

Interview with the Administrator on 1/22/15 at 1:30pm revealed:
-When the Administrator was told about the high water temperatures she stated "no one has taken a shower today."
-She stated she would immediately make a sign and place on the door to Bathroom #4 warning the residents of high water temperatures.

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| D 113 | Continued From page 2<br>-She stated she would also go to each resident individually and verbally warn them the water was excessively hot.<br><br>Observation on 1/22/15 at 1:37pm , the Administrator and Staff A worked together to turn the temperature down on the water heater.<br><br>Interview with the Administrator on 1/22/15 at 1:40pm revealed:<br>-Staff A had not turned the water temperature down on 1/21/15 as she had asked him.<br>-She stated a repairman had come to fix the facility boiler on 1/17/15 which was heated by natural gas and the facility had no hot water that day.<br>-She thought maybe the repairman "may have" turned the temperature up at that time.<br><br>Review of the facility water temperature logs for Bathroom #4 revealed:<br>-On 11/5/14, sink temperature documented as 101.2, tub 106.5.<br>-On 11/11/11/14, sink temperature documented as 101, tub 110.1<br>-On 11/20/14, sink temperature documented as 102, tub 105.4<br>-On 12/23/14, sink temperature documented as 100.1, tub 102.5<br>-There was no documentation from 7/3/14 to 11/5/14.<br><br>Observation water temperatures in Bathroom #4 on 1/22/15 at 4:06pm revealed the sink and tub temperatures were 116 degrees F.<br><br>Confidential interviews with four residents revealed the following comments:<br>-"The water is mostly not hot enough, because I like a hot shower." | D 113 | | |

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| D 113 | Continued From page 3<br>-"I know how to add cold water in and it feels good. I like it hot."<br>-"It is usually just warm. I take a warm shower. It is never too hot."<br>-"I take a tepid shower..."<br>_____<br><br>A plan of protection was received from the facility on 1/22/15 which included:<br>-Posted signs warning the residents the water temperature was too high and not to use until staff informed them the temperatures were 100-116 degrees F.<br>-Turned the temperature down on the hot water tank.<br>-Checked hot water temperatures every 2 hours for correct temperature.<br>-Residents were informed to use the bathrooms with caution until the facility had the problem under control.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 9, 2015. | D 113 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to assure Resident #5 was treated with respect, consideration, dignity, and full recognition of the resident's individuality | D 338 | | |

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| D 338 | Continued From page 4 | D 338 | | |

related to being provided a raised toilet seat and use of a handicap accessible shower which did not require Resident #5 to enter the room of another resident in order to take a shower.

The findings are:

Review of Resident #5's current FL2 dated 12/2/14 revealed diagnoses including:
-Total hip replacement 2 months ago
-Disc degeneration
-Coronary artery disease
-Episode mood disorder

Review of Resident #5's current Care Plan dated 12/2/14 revealed:
-The resident required extensive staff assistance with bathing and dressing 3 or more times per week.
-The resident was independent with toileting.

A. Interview with Resident #5 on 1/21/15 at 8:29am revealed:
-He had lived at the facility "about 2 months."
-The resident had showered only once at the facility since he had lived there, because the only handicapped accessible shower (Bathroom #5 located in the first resident room on the left down the right hallway) was located in another resident's room.
-"I shower at my [family member's] house. Not here.."
-"Find it easier to shower at my [family member's name]. She has a handicapped accessible shower."
-He stated he could not use the shower located a the end of the right hallway, because he could not step over the side of the tub.
-He stated his family member picked him up everyday and took him home to shower.

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| D 338 | Continued From page 5<br>-He stated he did not like using handicapped accessible bathroom, because it was not always "clean" at the facility.<br><br>Observation of Bathroom #5 (located in the first resident room on the left on the right hall) on 1/21/15 at 9:03am revealed:<br>-The bathroom was only accessible by entering through another resident's room. There was no entrance from the hallway.<br>-The full bathroom was equipped with a sink, regular toilet with grab bar mounted on wall, ceramic tiled shower with shower chair and grab bar.<br>-There was a door on the bathroom for privacy while inside the bathroom.<br>-There were orange, dried splatters of a substance on the bottom of the toilet seat.<br><br>Interview with Staff A, Supervisor, on 1/22/15 at 3:06pm revealed:<br>-Staff assisted Resident #5 daily with putting on his socks and shoes, making his bed, and doing his laundry.<br>-Staff A stated he had given Resident #5 two showers, since the resident was admitted on 11/20/14.<br>-Staff A admitted he was the only one who had given Resident #5 showers since he was admitted.<br>-Staff A stated Resident #5 always told them he had taken a shower at his family member's house.<br><br>Interview with the Administrator on 1/23/15 at 10:45am revealed:<br>-"I guarantee that bathroom is checked every 30 minutes all day long and it's not that nasty."<br>-"I can move [the resident who currently lived in the room's name] and put [Resident #5] in that | D 338 | | |

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room."
-"He doesn't have to [go to his family member's to shower] that's his preference."
-"I think [Resident #5] needs extensive assistance because he's so unsteady on his feet."
-"I knew [Resident #5] needed help dressing...putting on socks and pants."

Based on record review and observation on 1/21/15 and 1/22/15, the resident residing in the room adjoining the handicapped accessible bathroom was independent with ambulation and transfer and required only staff supervision for bathing.

Attempted telephone interview with Resident #5's family member on 1/23/15 at 10:40am was unsuccessful by exit.

B. Interview with Resident #5 on 1/21/15 at 8:29am revealed:
-He had lived at the facility "about 2 months."
-"The toilets are very low here...hard to sit down on them."
-He stated he needed a raised toilet seat because he had difficulty getting up from low toilet seats.
-He stated he normally used Bathroom #1 (half bath located at the end of left hallway) for toileting.
-He stated he did not like using handicapped accessible bathroom, because it was not always "clean" at the facility.

Observation of Bathroom #5 (located in the first resident room on the left on the right hall) on 1/21/15 at 9:03am revealed:
-The bathroom was only accessible by entering through another resident's room. There was no entrance from the hallway.
-The full bathroom was equipped with a sink and

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| D 338 | Continued From page 7<br>regular toilet with grab bar mounted on the wall.<br>-There was no raised seat for the toilet.<br>-There were orange, dried splatters of a substance on the bottom of the toilet seat.<br><br>Observation of Bathroom #1 on 1/21/15 at 9:45am revealed:<br>-The half bathroom was equipped with a sink and regular toilet with a grab bar mounted on the wall.<br>-There was no raised seat for the toilet.<br><br>Interview with the Administrator on 1/23/15 at 10:45am revealed:<br>-She was unaware Resident #5 had difficulty using the toilet in Bathroom #1 and #5.<br>-The resident had not communicated a need for a raised toilet seat to her.<br><br>Attempted telephone interview with Resident #5's family member on 1/23/15 at 10:40am was unsuccessful by exit. | D 338 | | |
| 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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to assure Lamictal, Symbicort, Combivent, and Chantix were | D 358 | | |

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administered as ordered by the licensed prescribing practioner for 2 of 2 residents (Resident #1 and #4) observed on the morning medication pass.

The findings are:

A. Review of Resident #4's current FL2 dated 10/8/14 revealed:
-Diagnoses included seizure disorder and chronic obstructive pulmonary disease (COPD).
-A physician's order for Lamictal (used to prevent or control seizures) 200mg 1 tab two times a day.
-A physician's order for Lamictal 25mg 1 tab two times a day in addition to 200mg.
-A physician's order for Symbicort (used to prevent and control wheezing and shortness of breath)160-4.5 mcg inhale two puffs twice a day.
-A physician's order for Combivent Respimat (used to prevent bronchospasms in people with COPD) 20mcg/100mcg inhale 1 puff four times a day for wheezing.

Observation of morning medication pass on 1/21/15 at 7:45am to 8:10am revealed:
-Resident #4 received 19 oral medications, but no Lamictal 200mg tab.
-The resident did not receive Symbicort or Combivent inhalers.
-Staff A, Supervisor, referred to the Medication Administration Record (MAR) as he prepared the medications for administration.
-Staff A did not document any of the medications administered to the resident on the MAR, because documentation on the MAR reflected the scheduled morning medications for 8am 1/21/15 had already been administered by Staff A.

1. Review of Resident #4's MAR for January 2015 during the morning medication pass on 1/21/15 at

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| D 358 | Continued From page 9<br><br>8:10am revealed:<br>-An entry for Lamictal 200mg 1 tab twice a day with a scheduled administration time of 8am and 8pm.<br>-The 8am dose for 1/21/15 had been initialed as administered by Staff A.<br>-All other doses of Lamictal 200mg had been initialed by Staff A as administered from 1/1/15 through 1/20/15.<br><br>Interview with Staff A on 1/21/15 at 10:37am revealed:<br>-He knew he would be running late on the morning of 1/21/15, so he had taken the January MARs home with him the night before and signed off all the residents' morning medications as administered.<br>-He had missed giving Resident #4 the Lamictal 200mg tab because he was "nervous."<br><br>Observation of Resident #4's medications on the medication cart on 1/21/15 at 3:09pm revealed:<br>-There were 37 tablets of Lamictal 200mg on hand.<br>-There were 42 tablets of Lamictal 25mg on hand.<br><br>Telephone interview with the facility pharmacy on 1/21/15 at 3:15pm concerning Resident #4's Lamictal revealed:<br>-The pharmacy had dispensed Lamictal 200mg 60 tablets on 1/5/15.<br>-The pharmacy had dispensed Lamictal 25mg 60 tablets on 1/6/15.<br>-There current orders were Lamictal 200mg 1 tab twice a day and Lamictal 25mg 1 tab twice a day.<br><br>Telephone interview with Resident #4's physician on 1/22/15 at 3:40pm revealed:<br>-She managed the Lamictal for Resident #4. | D 358 | | |

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| D 358 | Continued From page 10<br>-The Lamictal 25mg 1 tab twice a day was an "artifact" dose from the "initial titration" of the Lamictal dosing.<br>-She should have written a discontinuation order for the Lamictal 25mg when Resident #4 had gotten to the 200mg dose, but she had not yet done so.<br>-The physician stated as she became aware Resident #4 had missed Lamictal 200mg 8am dose on 1/21/15 "As long as she gets the other dosing as scheduled no harm done."<br><br>Interview with Resident #4 on 1/21/15 at 8:46am revealed:<br>-She received her medications timely from facility staff.<br>-To her knowledge she received the medications her physician had ordered for her the way she was supposed to get them.<br>-She never ran out of medications.<br><br>Refer to interview with the Administrator on 1/22/15 at 3:20pm.<br><br>2. Observation of Staff A on 1/21/15 at 8:07am revealed Staff A placed a Symbicort 160-4.5mcg inhaler labeled with Resident #4's name on top of the medication cart.<br><br>Observation of Staff A on 1/21/15 at 8:11am revealed Staff A returned Resident #4's Symbicort inhaler back to the medication cart drawer without having had administered it to the resident.<br><br>Review of Resident #4's MAR for January 2015 during the morning medication pass on 1/21/15 at 8:10am revealed:<br>-An entry for Symbicort 160-45 mcg inhale two puffs twice a day with a scheduled administration time of 8am and 8pm. | D 358 | | |

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| D 358 | Continued From page 11<br>-The 8am dose for 1/21/15 had been initialed as administered by Staff A.<br>-All other doses of Symbicort 160-4.5 mcg had been initialed by Staff A as administered from 1/1/15 through 1/20/15.<br><br>Interview with Resident #4 on 1/21/15 at 8:46am revealed:<br>-She received her medications timely from facility staff.<br>-To her knowledge she received the medications her physician had ordered for her the way she was supposed to get them.<br>-She never ran out of medications.<br><br>Interview with Staff A on 1/21/15 at 10:37am revealed:<br>-He knew he would be running late on the morning of 1/21/15, so he had taken the January MARs home with him the night before and signed off all the residents morning medications as administered.<br>-He had missed giving Resident #4 the Symbicort 160-4.5mcg inhaler because he was "nervous."<br><br>Telephone interview with Resident #4's physician's nurse on 1/22/15 at 4:30pm revealed "missing one dose of Symbicort and Combivent if she's not having trouble breathing was of little concern."<br><br>Interview with Resident #4 on 1/21/15 at 2:34pm revealed:<br>-She had not gotten her Symbicort inhaler scheduled for 8am that morning.<br>-She had not noticed any problems with her breathing "today."<br><br>Refer to interview with the Administrator on 1/22/15 at 3:20pm. | D 358 | | |

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| D 358 | Continued From page 12<br><br>3. Observation of Staff A on 1/21/15 at 8:08am revealed Staff A placed a Combivent 20mcg/100mcg inhaler labeled with Resident #4's name on top of the medication cart.<br><br>Observation of Staff A on 1/21/15 at 8:11am revealed Staff A returned Resident #4's Combivent inhaler back to the medication cart drawer without having had administered it to the resident.<br><br>Review of Resident #4's MAR for January 2015 during the morning medication pass on 1/21/15 at 8:10am revealed:<br>-An entry for Combivent inhale one puff four times a day with a scheduled administration time of 8am, 12 noon, 4pm, and 8pm.<br>-The 8am dose for 1/21/15 had been initialed as administered by Staff A.<br>-All other doses of Combivent had been initialed by Staff A as administered from 1/1/15 through 1/20/15.<br><br>Interview with Resident #4 on 1/21/15 at 8:46am revealed:<br>-She received her medications timely from facility staff.<br>-To her knowledge she received the medications her physician had ordered for her the way she was supposed to get them.<br>-She never ran out of medications.<br><br>Interview with Staff A on 1/21/15 at 10:37am revealed:<br>-He knew he would be running late on the morning of 1/21/15, so he had taken the January MARs home with him the night before and signed off all the residents morning medications as administered. | D 358 | | |

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| D 358 | Continued From page 13<br>-He had missed giving Resident #4 the Combivent inhaler because he was "nervous."<br><br>Telephone interview with Resident #4's physician's nurse on 1/22/15 at 4:30pm revealed "missing one dose of Symbicort and Combivent if she's not having trouble breathing was of little concern."<br><br>Interview with Resident #4 on 1/21/15 at 2:34pm revealed:<br>-She had not gotten her Combivent inhaler scheduled for 8am that morning.<br>-She had not noticed any problems with her breathing "today."<br><br>Refer to interview with the Administrator on 1/22/15 at 3:20pm.<br><br>B. Review of Resident #1's current FL2 dated 6/27/14 revealed diagnoses included:<br>-Chronic Obstructive Pulmonary Disease<br>-Diabetes Type II<br>-Right sided heart failure<br><br>Review of a physician's order for Resident #1 dated 1/6/15 revealed "Start Chantix dose pack."<br><br>Observation of morning medication pass on 1/21/15 at 7:45am to 8:10am revealed:<br>-Resident #1 received 7 oral medications including Chantix (used to treat nicotine addiction) 0.5mg 1 tablet from a multidose sample pack.<br>-Staff A referred to the Medication Administration Record (MAR) as he prepared the medications for administration.<br>-Staff A did not document any of the medications administered to the resident in the MAR for the 1/21/15 8am medication pass because, | D 358 | | |

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documentation on the MAR reflected the scheduled morning medications for 8am 1/21/15 had already been administered by Staff A.

Observation of Resident #1's Chantix sample pack on 1/21/15 at 7:50am revealed:
-The sample pack was not dispensed from a pharmacy, but was a sample pack provided to the physician from the drug manufacturer representative.
-There were 10 doses left of the 0.5mg tablets for the "starting week."
-There were 14 doses of the 1mg tablets for the "continuing week."
-Only one 0.5mg tablet had been used from the sample pack.

Review of Resident #1's MAR for January 2015 during the morning medication pass on 1/21/15 at 7:55am revealed:
-An entry for Chantix 1mg 1 tab twice a day with a scheduled administration time of 8am and 8pm.
-The 8am dose for 1/21/15 had been initialed as administered by Staff A.
-All other doses of Chantix had been initialed by Staff A as administered from 1/1/15 through 1/20/15.

Interview with Staff A on 1/21/15 at 10:37am revealed:
-He knew he would be running late on the morning of 1/21/15, so he had taken the January MARs home with him the night before and signed off all the residents morning medications as administered.
-He was unaware he had given Resident #1 the Chantix 0.5mg tab out of the multidose sample pack.

Interview with Resident #1 on 1/22/15 at 4:10pm

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| D 358 | Continued From page 15<br>revealed:<br>-There were no issues with her medications of which she was aware.<br>-She received her medications on time.<br>-She had no complaints about how staff administered her medications.<br><br>Telephone interview with Resident #1's physician on 1/22/15 at 4:40pm revealed that the resident receiving a 0.5mg tablet of Chantix instead of a 1mg dose for one occasion was "not a problem."<br><br>Refer to interview with the Administrator on 1/22/15 at 3:20pm.<br>_____<br><br>Interview with the Administrator on 1/21/15 at 9:26am revealed:<br>-She was unaware Staff A had been taking the MAR book home with him at night.<br>-He knew better than to take it out of the facility.<br>-Staff A just lived in the trailer out behind the facility, so the MARs were easily accessible if needed.<br><br>Interview with the Administrator on 1/22/15 at 3:20pm revealed:<br>-Staff A had worked for her for 10 years.<br>-She thought Staff A "was just nervous" when being observed for the medication pass.<br>-"He knows how to administer medications properly."<br>-"He's been trained how to [administer medications] properly."<br>-Staff A had been trained to read order on the MAR, compare to the medication label, "make a dot" to help maintain his place, "put pill in cup", observe the resident swallow the medication, and to then initial the MAR after he was sure the resident had taken the medication. | D 358 | | |

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| D 366 | 10A NCAC 13F .1004 (i) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br><br>(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to assure medications were documented immediately following the 8am administration of medication for 2 of 2 residents observed during the medication pass (Resident #1 and #4) and for 3 random residents (Resident #2, #5, and #6) not observed during medication pass.<br><br>The findings are:<br><br>Observation of Staff A, Supervisor, during the 1/21/15 8am medication pass from 7:45am to 8:21am revealed:<br>-At 7:55am, Staff A administered Resident #1 medications including 7 oral medications and 3 inhalation medications.<br>-Staff A did not document the administrations of the medications on Resident #1's Medication Administration Record (MAR).<br>-At 8:10am, Staff A administered Resident #4's medications including 19 oral medications.<br>-Staff A did not documented the administrations of the medications on Resident #4's MAR after he | D 366 | | |

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| D 366 | Continued From page 17<br>observed the resident taking the oral medications.<br><br>Observation of the January MAR's on 1/21/15 at 8:19am for Resident #2, #5, and #6) revealed all of their 8am medications had been documented as administered although Staff A had not yet administered their medications.<br><br>Interview with Staff C, Medication Aide, on 1/21/15 at 8:19am revealed:<br>-"Sometimes" if Staff A had an appointment or was running late, Staff A would "pull the meds and I will run them for him."<br>-She stated when she took the residents the medications she would watch the residents take them.<br><br>Interview with Staff A on 1/21/15 at 8:20am revealed he had signed off the medications as administered "to show I have their medications ready."<br><br>Interview with Staff A on 1/21/15 at 10:37am revealed:<br>-He was responsible for administering all the medications in the facility.<br>-He had signed off all the residents medications for 1/21/15 8am administration time on the way to work that morning "to get a head start", because he knew he was going to be running late.<br>-He stated he had taken the January MARs home for all the residents the night before.<br>-He stated he always took the MAR book home when residents had new orders and he would go over the MARs at home to make sure the orders were right.<br>-He stated he sometimes would "punch meds into a cup and [Staff C] runs them to the residents..."<br>-He stated this was acceptable because Staff C had her medication aide "license." | D 366 | | |

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-Otherwise "I walk around and do it..it will take longer."
-He never allowed the other relief staff (Staff D and Staff E) to "carry" medications to the residents because they were not trained medication aides.

Interview with Staff C on 1/22/15 at 2:10pm revealed:
-She would "carry" medications to residents for Staff A only if Staff A had to take a resident to a physician's appointment.
-"Most of the time he does it."

Interview with the Administrator on 1/22/15 at 3:20pm revealed:
-Staff A had worked for her for 10 years.
-She thought Staff A "was just nervous" when being observed for the medication pass.
-"He knows how to administer medications properly."
-"He's been trained how to [administer medications] properly."
-Staff A had been trained to follow the MAR, compare MAR to the medication label, "make a dot" to help maintain his place, "put pill in cup", observe the resident swallow the medication, and to then initial the MAR after he was sure the resident had taken the medication.

Interview with Staff A on 1/22/15 at 5pm revealed:
-His regular work hours were Monday through Friday 7:30am to 7:30pm.
-Staff C or Staff B or the Administrator gave the residents their bedtime medications.
-"Most of the time I do."
-Staff C, Medication Aide, or Staff D, PCA, or Staff E, PCA would give the residents their medications on the weekends.
-He stated he lived in the trailer behind the facility

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and in the evenings or on the weekend he would be back in the medication room where the residents could not see him.
-He stated he would put the medications in a cup with the resident's name on it and then Staff C, D, or E would give it to the resident.
-"Oh I'm here. I stay at the trailer" directly behind the facility.

Interview with Staff C on 1/23/15 at 8:20am revealed:
-She had all of her qualifications to work as a Medication Aide.
-She worked all three shifts anytime they needed her.
-Her usual schedule was Monday and Tuesday 11pm to 9am; Wednesday and Thursday 5pm to 11pm; Friday-off; Saturday 3pm to 9pm, Sunday 9am to 9pm.
-When she worked on evening shift 3pm to 9pm "[Staff A's name] will come over here and he will pull them and I'll run them to the residents."
-The office/medication room was kept locked when Staff A, Staff B, and the Administrator were not there.
-She stated if she needed a MAR, Care Plan, or to get to the medication cart, she would call the Administrator or Staff A.
-When asked was there a lockable space where medications could be kept if not in the medication room she stated "There's lockable cabinets in the utility room off [Resident #3's name] room."
-Staff A was the only one allowed to give medications to residents because of "safety" and "that's just how they are" referring to Staff A and the Administrator.

Observation on 1/23/15 at 8:25am of the utility room beside Resident #3's room revealed:
-A line of cabinets at eye level.

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| D 366 | Continued From page 20<br>-The second cabinet had a door on it.<br>-The door had a hasp attached to it but did not have a padlock on it.<br>-Inside the cabinet there were cleaning supplies.<br><br>Interview with the Administrator on 1/23/15 at 9:07am revealed:<br>-Staff A, Staff B, and herself were salaried employees.<br>-Staff B and herself acted as backup for Staff A for medication administration coverage.<br>-Staff A worked 12 hour days Monday through Friday.<br>-Staff A ended up working more than 60 hours per week to cover medication administration on the weekends.<br><br>Interview with the Administrator on 1/23/15 at 10:15am revealed:<br>-"We don't have a time clock. The staff just turn in their hours on a piece of paper."<br>-"This is the schedule that staff work every week."<br><br>Review of the facility staffing schedule received from the Administrator on 1/23/15 at 10:15am revealed:<br>-The schedule was handwritten on a piece of notebook paper.<br>-The schedule submitted covered 1/2/15 to 1/7/15.<br>-On 1/2/15, Staff D worked from 5pm until 3pm on 1/3/15.<br>-On 1/3/15, Staff C worked from 3pm until 9pm.<br>-On 1/3/15, Staff E worked 9pm until 7:30am on 1/4/15.<br>-On 1/4/15, Staff C worked 7:30am until 9pm<br>-On 1/4/15, Staff E worked 9pm until 7:30am 1/5/15.<br>-On 1/5/15, Staff A worked 7:30am to 5pm.<br>-On 1/5/15, Staff D worked 5pm to 11pm. | D 366 | | |

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| D 366 | Continued From page 21<br>-On 1/5/15, Staff C worked 11pm to 7:30am on 1/6/15.<br>-On 1/6/15, Staff A worked 7:30am to 5pm.<br>-On 1/6/15, Staff D worked 5pm to 11pm.<br>-On 1/6/15, Staff C worked 11pm to 7:30am on 1/7/15.<br>-On 1/7/15, Staff A worked 7:30am to 5pm.<br>-On 1/7/15, Administrator worked 9am to 5pm.<br>-On 1/7/15, Staff D worked 5pm to 11pm.<br>-On 1/7/15, Staff E worked 11pm to 7am on 1/8/15.<br>-On 1/8/15, Staff A worked 7:30am to 5pm.<br>-On 1/8/15, Staff C worked 6:30am to 5pm.<br>-On 1/8/15, Staff D worked 5pm to 11pm.<br>-On 1/8/15, Staff E worked 11pm to 7:30am on 1/9/15.<br><br>Telephone interview with Staff D, PCA, on 1/23/15 at 10:20am revealed:<br>-Staff A "usually"administered medications to the residents on second and third shift.<br>-"He pushes the meds into the cups and I sometimes help by carrying the souffle cups to the kitchen door and the resident stands there and takes the medications."<br>-Staff A "comes in the back and does the meds."<br>-Staff A was at the facility "alot" and the residents didn't always know he's in the medication room because Staff A "doesn't come out on the floor."<br>-"Not many ever get prn's [at night], but [Staff A's name] takes care of that."<br>-"He lives in the trailer out back."<br>-She stated she worked in the kitchen and provided personal care for the residents.<br><br>Interview with the Administrator on 1/23/15 at 10:45am revealed:<br>-The Administrator stated Staff A signs off for all the medications administered or "the MAR just doesn't get signed until [Staff A's name] shows up | D 366 | | |

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| D 366 | Continued From page 22<br>when I give the meds."<br><br>Confidential interview with one resident revealed "In the evenings, [Staff C's name] brings me my cup of medicines. [Is Staff A here?] No. Just [Staff C's name]."<br><br>Confidential interview with a second resident revealed:<br>-"[Staff C's name] sometimes [Staff A's name] if he's still here" administered the evening medications.<br>-Staff A left "Sometimes 9 or 9:30pm. There's times he will leave early after he gets the nighttime meds ready. It depends on how busy he is."<br>-"[Staff A] puts the med cups on a tray after putting the meds in cups. That way [Staff C's name] or [Staff D's name] can give it out."<br>-"Now on Fridays he's here real late cause he has to get the whole weekend ready for us."<br><br>Confidential interview with a third resident revealed:<br>-"[Staff A's name] or whoever is here" administered the resident's evening medications.<br>-[Staff C's name] will be doing it tonight. Sometimes [Staff E's name] or [Staff D's name]."<br>-"They prepare [all the medications] by going through the charts."<br>-The medications are put "in cups that have our names on the bottom."<br><br>Confidential interview with a fourth resident revealed:<br>-"I think the meds are already setup with the initials on the little cup."<br>-"Whoever's working [Staff C's name], [Staff D's name], whoever's working" gave the souffle cup to the resident. | D 366 | | |

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| D 366 | Continued From page 23<br><br>Confidential interview with a fifth resident revealed the medications were given by Staff C or Staff D and the medications were "always in a cup."<br><br>Confidential interview with a sixth resident revealed "[Staff C's name], [Staff A's name], or [Staff D's name] give me my meds in a cup..." | D 366 | | |
| D 371 | 10A NCAC 13F .1004(n) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observation, record review and interview, the facility failed to assure medications were administered in accordance with infection control measures to prevent cross-contamination by 1 of 1 Supervisor (Staff A) observed during the 8am medication pass on 1/21/15 related to not washing hands or using hand sanitizer prior to and during medication administration, touching of oral medications, storing glucometers and lancing devices over medication containers, and not wearing gloves to perform fingerstick blood sugar testing.<br><br>The findings are: | D 371 | | |

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| D 371 | Continued From page 24<br><br>A. Observation of Staff A, Supervisor, during the 1/21/15 8am medication pass from 7:45am to 8:10am revealed:<br>-Staff A did not wash his hands or use hand sanitizer before beginning the medication pass.<br>-Staff A popped all 7 oral tablets for Resident #1 from the bubble packs into his ungloved hands and placed them into a souffle cup.<br>-Staff A administered the medications to Resident #1 and took the used souffle cup from the resident and threw it into the trash.<br>-Staff A did not wash his hands or use hand sanitizer before continuing to prepare medications for Resident #4.<br>-Staff A popped all 19 oral tablets for Resident #4 from the bubble packs and medicine bottles into his ungloved hands and placed them into a souffle cup.<br>-Staff A administered the medications to Resident #4 and took the used souffle cup from the resident and threw it into the trash.<br>-Staff A did not wash his hands or use hand sanitizer after throwing away Resident #4's used souffle cup.<br><br>Interview with Staff A on 1/21/15 at 8:24am revealed:<br>-He had been working in the facility for 10 years.<br>-He administered the majority of the medications to all the residents in the facility.<br>-He had been trained to wash his hands or use hand sanitizer before administering medications to residents.<br>-He was not aware he had touched each of the oral medications before placing them into the souffle cup.<br>-He was "nervous" during the medication pass and had forgotten to do things the way he had been trained. | D 371 | | |

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| D 371 | Continued From page 25<br><br>Review of Staff A's personnel record on 1/22/15 revealed he had received the state approved infection control course on 7/7/14.<br><br>Interview with the Administrator on 1/22/15 at 3:29pm revealed:<br>-She thought Staff A had just been "nervous" during the medication pass observed 1/21/15.<br>-Staff A had worked for her for 10 years and "He knows how to administer medications properly."<br>-He was the only person who administered medications except herself and one other relief Medication Aide (Staff B).<br>-Staff A had received training for infection control.<br>-Staff A had been trained to wash his hands or use hand sanitizer to prevent cross contamination during medication administration.<br><br>Telephone interview with the pharmaceutical consultant for the facility on 1/22/15 at 4:15pm revealed:<br>-She had taken over the facility in May 2014.<br>-She stated she had discussed with Staff A "a few weeks ago" during a medication pass observation that he should not touch medications when putting them into the souffle cups.<br><br>Interview with Staff C, Medication Aide, on 1/22/15 at 2:10pm revealed she had never seen Staff A touch the oral medications when he was preparing medications for residents.<br><br>Confidential interviews with three residents on 1/21/15, 1/22/15, and 1/23/15 revealed:<br>-All three residents agreed most of the time the medications were prepared in the medication room.<br>-One resident stated "I have never seen staff touch the oral meds...I don't see them | D 371 | | |

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popped...just see them in a cup."
-A second resident stated "I don't pay attention [to how they prepare my medications]. I don't know. I just make sure my meds are right."

B. Review of Resident #2's current FL2 dated 2/25/14 revealed:
-Diagnoses included: Diabetes Mellitus, Chronic Obstructive Pulmonary Disease,peripheral neuropathy, bipolar disorder, and dementia.
-A physician's order for fingerstick blood sugar (FSBS) testing every week.

Observation of Staff A performing FSBS testing for Resident #2 on 1/21/15 at 8:21am revealed:
-Staff A removed a glucometer (labeled with Resident #2's name Brand A) which was not stored in a pouch and two multiuse lancing devices (these devices were not labeled with a resident's name) from the back of the drawer where Resident #2's medications were stored. The equipment was stored on top of Resident #2's medication bottles in the back of the drawer. The equipment was not enclosed in a pouch or bag of any kind.
-Staff A then removed a 70% isopropyl alcohol swab from the top drawer of the cart and asked Resident #2 which finger he would like for him to use for the blood sample.
-As Staff A grasped Resident #2's finger and wiped it with the alcohol swab, the surveyor intervened and asked Staff A should he not wash his hands and apply gloves before collecting a FSBS from the resident.
-Staff A was then observed to wash his hands and apply gloves.
-Staff A performed the fingerstick blood sugar testing for Resident #2.
-Staff A placed glucometer and lancing devices back into the medication drawer for Resident #2

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without disinfecting the equipment or cleaning it with a alcohol swab.
-Staff A then removed his gloves and did not wash his hands or use hand sanitizer.

Interview with Staff A on 1/21/15 at 8:24am revealed:
-He had been working in the facility for 10 years.
-He administered the majority of the medications to all the residents in the facility.
-Resident #2 was the only resident who "gets fingerstick blood sugars here."
-The multiuse lancing devices belonged to Resident #2 even though they were not labeled and he knew this because they were stored in Resident #2's medication storage area.
-He had been trained to wash his hands or use hand sanitizer before performing FSBS testing.
-He had been trained to wear gloves during fingerstick blood sugar testing.
-He was "nervous" during the FSBS testing observation and had forgotten to do things the way he had been trained.

Review of the owner's manual for Brand A glucometer revealed:
-On page 6, the glucometer is designed for single patient use only.
-On page 52, if the glucometer is being operated by a second person who is providing testing assistance to the user, the glucometer and lancing device should be decontaminated.

Review of Resident #2's glucometer history on 1/21/15 at 11:26am revealed the data matched the documented blood sugars on the residents Medication Administration Record (MAR) for December 2014 and January 2015.

Interview with Staff A on 1/21/15 at 10:30am

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revealed:
-Staff A stated he never shared glucometers or lancing devices between residents.
-He stated he would wipe the residents' lancing devices "about every 2 days or when needed" with an alcohol swab.
-Then he stated "I normally wipe the lancing device tip with alcohol anytime I use it."
-When asked if there were CDC approved disinfecting wipes available in the facility he said "No. I just have alcohol pads."

Interview with the Administrator on 1/22/15 at 3:29pm revealed:
-She thought Staff A had just been "nervous" during the FSBS observed 1/21/15.
-Staff A had worked for her for 10 years.
-Staff A had received training for infection control.
-She expected her medication aides to use gloves when performing fingerstick blood sugar testing.
-Staff A had been trained to wash his hands or use hand sanitizer to prevent cross contamination during FSBS testing.
-She was unaware all the fingerstick blood sugar testing equipment for residents should be labeled and placed in labeled pouches for storage.

Interview with Resident #2 on 1/23/15 at 9:50am revealed:
-Staff administered his medications and performed his FSBS testing timely and as ordered by his physician.
-He stated he really did not pay attention to what staff did when preparing his equipment for FSBS testing.

C. Review of Resident #3's current FL2 dated 7/30/14 revealed:
-Diagnoses included: bipolar disorder,

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schizophrenia, alcohol dependency, post traumatic stress disorder.
-A physician's order for fingerstick blood sugar (FSBS) testing every morning before breakfast.

Interview with Resident #3 on 1/21/15 at 10:03am revealed:
-"I do my fingerstick blood sugar every morning."
-"My equipment is in the medication room."
-He stated everything was stored together in a black pouch.
-He had his own glucometer, a blue and white multiuse lancing device, lancet refills, and testing strips all stored together in the pouch.
-The resident stated his blood sugars were stable.
-He stated he never used anyone else's equipment to check his fingerstick blood sugars.

Observation of the medication cart on 1/21/15 at 10:06am revealed:
-In the bottom drawer of the cart there was a unlabeled black pouch.
-The black pouch contained a glucometer (Brand A) that was not labeled and one blue and white multiuse lancing device which was not labeled.

Review of the owner's manual for Brand A glucometer revealed:
-On page 6, the glucometer is designed for single patient use only.
-On page 52, if the glucometer is being operated by a second person who is providing testing assistance to the user, the glucometer and lancing device should be decontaminated.

Interview with Staff A on 1/21/15 at 10:30am revealed:
-The unlabeled black pouch of glucometer equipment stored in the bottom drawer on the

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medication cart belonged to Resident #3.
-He would immediately label the pouch with Resident #3's name.
-Resident #3 did his own fingerstick blood sugar testing.
-Staff A stated he never shared glucometers or lancing devices between residents.
-He stated he would wipe the residents' lancing devices "about every 2 days or when needed" with an alcohol swab.
-Then he stated "I normally wipe the lancing device tip with alcohol anytime I use it."
-When asked if there were CDC approved disinfecting wipes available in the facility he said "No. I just have alcohol pads."

Interview with Resident #3 on 1/21/15 at 11:11am revealed:
-The black pouch that was stored in the bottom drawer of the medication cart contained his fingerstick blood sugar testing equipment.
-That was his multiuse lancing device because it was navy and white and short.
-"They don't share [glucometers/lancing devices]. I would never let anyone use my blood meter. I would not want to get any bacteria in my blood or anything like that."

Interview with the Administrator on 1/22/15 at 3:29pm revealed:
-She thought Staff A had just been "nervous" during the medication pass observed 1/21/15.
-Staff A had worked for her for 10 years.
-He was the only person who administered medications except herself and one other relief Medication Aide (Staff B).
-Staff A had received training for infection control.
-She expected her medication aides to use gloves when performing fingerstick blood sugar testing.

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| D 371 | Continued From page 31<br>-Staff A had been trained to wash his hands or use hand sanitizer to prevent cross contamination during medication administration.<br>-She was unaware all the fingerstick blood sugar testing equipment for residents should be labeled and placed in labeled pouches for storage.<br><br>Review of Staff A's personnel record on 1/22/15 revealed he had received the state approved infection control course on 7/7/14.<br>_____<br><br>A plan of protection was received from the facility on 1/21/15 and included:<br>-Medication Aides will wash their hands before starting a medication pass.<br>-Medications will go into cup, medication aide will not touch pills.<br>-Medication Aide will disinfect all glucometers and lancing devices, label all the equipment, and make sure it is stored in pouches or plastic bag.<br>-Medication Aides will receive a medication management class on 2/16/15.<br>-All staff will receive infection control training on 3/9/15.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 9, 2015. | D 371 | | |
| D 401 | 10A NCAC 13F .1009(a)(2) Pharmaceutical Care<br><br>10A NCAC 13F .1009 Pharmaceutical Care<br>(a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there | D 401 | | |

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are medication problems in which the safety of residents may be at risk.
Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following:
(2) review of all aspects of medication administration including the observation or review of procedures for the administration of medications and inspection of medication storage areas;

This Rule is not met as evidenced by:
Based on observation and interview, the faciltiy failed to assure the pharmaceutical quarterly reviews included the inspection of the medication storage areas.

The findings are:

Observation of Staff A, Supervisor during the morning medication pass on 1/21/15 at 8:14am to 8:24am revealed:
-Staff A removed a glucometer (labeled with Resident #2's name) which was not stored in a pouch and two multiuse lancing devices (these devices were not labeled with a residents name) from the back of the drawer where Resident #2's medications were stored. The equipment was stored on top of Resident #2's medication bottles in the back of the drawer. The equipment was not enclosed in a pouch or bag of any kind.
-After performing fingerstick blood sugar (FSBS) testing for Resident #2, Staff A placed the glucometer and lancing devices back into the medication drawer for Resident #2 without disinfecting the equipment or cleaning the equipment with an alcohol swab.

Interview with Staff A on 1/21/15 at 10:37am

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| D 401 | Continued From page 33<br>revealed:<br>-When asked did the pharmacy consultant go through the medication cart storage areas during the pharmaceutical reviews? Staff A stated "Not like they are supposed too."<br>-The current consultant "doesn't really go in the cart to check things."<br><br>Telephone interview with the facility's pharmacy consultant on 1/22/15 at 4:15pm revealed:<br>-When in the facility for a review "I check all the meds against the orders to make sure they have labs, current orders for all meds, and not on any medications that should not be mixed."<br>-She stated she had not looked at how the facility stored glucometer equipement yet since she had just taken over the facility as the pharmaceutical consultant in May 2014.<br>-She stated she had made sure all of the residents that had orders for fingerstick blood sugar testing and had their own equipment. | D 401 | | |
| D911 | G.S. 131D-21(1) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to assure Resident #5 was treated with respect, consideration, dignity, and full recognition of the resident's individuality | D911 | | |

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| D911 | Continued From page 34<br>related to access to a handicapped accessible shower and raised toilet seat.<br><br>The findings are:<br><br>Based on observation, interview, and record review the facility failed to assure Resident #5 was treated with respect, consideration, dignity, and full recognition of the resident's individuality related to being provided a raised toilet seat and use of a handicap accessible shower which did not require Resident #5 to enter the room of another resident in order to take a shower.[Refer to Tag D338 10A NCAC 13F .0909 Resident Rights.] | D911 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to hot water temperatures and medication administration.<br><br>The findings are:<br><br>1. Based on observation, interview, and record review the facility failed to assure that water | D912 | | |

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| D912 | Continued From page 35<br><br>temperatures were maintained at a minimum of 100 degrees Farenheit (F) and did not exceed 116 degrees F for 2 of 2 fixtures (1 sink, 1 tub) located in the community shower room and 1 of 2 fixtures (sink) in resident private bathrooms. [Refer to Tag D113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation).]<br><br>2. Based on observation, record review and interview, the facility failed to assure medications were administered in accordance with infection control measures to prevent cross-contamination by 1 of 1 Supervisor (Staff A) observed during the 8am medication pass on 1/21/15 related to not washing hands or using hand sanitizer prior to and during medication administration, touching of oral medications, storing glucometers and lancing devices over medication containers, and not wearing gloves to perform fingerstick blood sugar testing.[Refer to Tag D371 10A NCAC 13F .1004(n) Medication Administration (Type B Violation).] | D912 | | |