Rec'd via email 01-12-15

PRINTED: 12/18/2014
FORM APPROVED

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
	HAL088015	A. BUILDING: _____ B. WING _____	R 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

County: Transylvania

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D 000	Initial Comments The Adult Care Licensure Section and the Transylvania County Department of Social Services conducted an annual and follow up survey and complaint investigation on December 2-4, 2014. The complaint investigation was initiated by the Transylvania County Department of Social Services on October 21, 2014.	D 000		
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 which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure administration of medications to 2 of 5 sampled residents (#1 and #2) with diagnosis of Dementia, was in accordance to the facility's policy and procedures as evidenced by residents not being observed to actually take medications administered including Aspirin, Atenolol, Lisinopril/Hydrochlorothiazide, Lorazepam, Furosemide and Acetaminophen/Diphenhydramine and creating an unsafe environment with medications being accessible to other residents in the Special Care Unit and the failure to follow the facility's policies and procedures by crushing an extended release potassium medication for 1 resident (Resident	D 358		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Velma Mathenia TITLE: Administrator (X6) DATE: 1/12/2015

Approved by: Charity Nimlos BSN, RN 1/13/15

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D 358	Continued From page 1 #1). The findings are: A. Review of the facility's license and interview with the Administrator revealed the facility is licensed as a 60 bed adult care home with all of the beds designated as Special Care. Review of the current FL2 for Resident #1 dated 9/4/14 revealed diagnoses included: -Dementia -Chronic Anxiety -Hypertension -Osteoporosis Continued review of the current FL2 for Resident #1 revealed medication included: -Aspirin EC 81mg daily (Enteric Coated - a special coating that prevents release and absorption of active ingredients until the medication reaches the small intestine). -Atenolol 50mg daily (used to treat high blood pressure, chronic chest pain, the prevention and treatment of heart attack and abnormal rhythms of the heart). -Bone-Up, one three times a day (a calcium supplement used to treat osteoporosis). -Furosemide 20mg daily (a diuretic used to treat edema and high blood pressure). -Lisinopril/Hydrochlorothiazide 20mg-12.5mg daily (used in the treatment of high blood pressure and acute heart attack). -Lorazepam 0.5mg twice a day (an anti-anxiety agent) . -KCl (potassium chloride) ER (extended release) 10meq once daily (an electrolyte replenisher used in conjunction with diuretics). -Thera Beta Carotine one daily (a multivitamin). -Vitamin D 1000 IU daily (a dietary supplement).	D 358		

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D 358	Continued From page 2 -Gabapentin 100mg three times a day (used to treat neuropathic pain). Additional information provided by the current FL2 dated 9/4/14 included: -An admission date of 9/23/04. -An order for Med Pass 2.0, 5 ounces three times a day (a dietary supplement). -The resident was intermittently confused. Observation of Resident #1 on 12/4/14 at 9:40am revealed: -She was sitting in her room beside a small table. -On the table were two stacked medication cups, one paper and one plastic, containing medications. -A plastic cup containing a thick off white liquid later identified as Med Pass 2.0 was with the medication cups. -The paper medication cup contained a crushed white tablet, later identfied as potassium chloride ER 10meq by the Medication Aide. -The plastic medication cup contained 9 medications later identified as Aspirin 81mg, Atenolol 50mg, Bone-Up 1 tablet, Furosemide 20mg, Lisinopril/Hydrochlorothiazide 20-12.5mg, Lorazepam 0.5mg, Thera Beta Carotene, Vitamin D 1000 IU and Gabapentin100mg. Observations on 12/2/14 at 12:02pm during the noon medication pass and on 12/3/14 at 8:10am during the morning medication pass revealed the two Medication Aides observed to stay with each resident until they had taken their medication before moving on to the next resident. 1. Interview of Resident #1 on 12/4/14 at 9:40am revealed: -The medications and supplement had been brought to her room earlier that morning, before	D 358		

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D 358	Continued From page 3 breakfast, by the Medication Aide (MA). -She was still in bed when the MA brought the medication and supplement and left them on the table by her chair. -She went to breakfast and returned to her room. -She had forgotten about the medication until it was found on the table. -She stated the MAs always brought the medications to her room "really early" and left them for her to take "when she was ready". -The resident stated her next door neighbor would wander into her room several times a day thinking it was his room -She stated she would tell him to get out, it wasn't his room, and he would leave. -She did not know if he, or any of the other residents, came into her room when she wasn't there. -She could not recall if she had ever forgotten to take her medications. -She felt her brain was slower than it had ever been, "I am more foggy headed and forgetful these days." Review of Resident #1"s December 2014 electronic Medication Administration Record (e-MAR) revealed the medications found in her room on 12/4/14 at 9:40am were documented as having been administered at 7:00am. Interview on 12/5/14 at 6:55am with the third shift Medication Aide (MA) who had worked the morning of 12/5/14 revealed: -Medications and supplement were taken to Resident #1's room at 5:55am. -She asked Resident #1 if she was okay and was there anything the MA could do for her. -She asked Resident #1 if she wanted to get up but the resident wanted to lay in bed a little longer.	D 358		

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D 358	Continued From page 4 -She had been instructed by another Medication Aide during orientation (13 months ago) to leave Resident #1's pills in her room. -She stated she knew not to leave medications, but did it because that was what she was instructed to do. -She stated, "Usually we don't do it (leave medications) but for her (Resident #1) we do". -She had observed a change in Resident #1 since she had been taking Gabapentin (ordered 11/13/14). -Resident #1 appeared to be more sleepy, unsteady, confused and forgetful. Resident #1's physician had been notified. Confidential interviews with three Medication Aides (MA) revealed: -The third shift MAs (more than one) left medications in the room for Resident #1. -Resident #1's medications had been left in her room for a year or more. -Other Medication Aides were aware of what was going on. -They did not think the Administrator knew medications were being left in Resident #1's room. Confidential interview with one staff revealed: -"I have seen other [Medication Aides] set pills down on the table and walk out." -"I confronted one [Medication Aide] and she said 'Don't tell on me'." -"I said 'You need to make sure they take it, so I went back and made sure the resident took the medications [that had been left on the bedside table]." -One person who had worked in dietary told this staff person they also had "found pills in residents' rooms." -When asked why the staff thought Medication	D 358		

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D 358	Continued From page 5 Aides might leave medications unattended on the table for residents to take on their own the staff stated "in a hurry to get it done" and more "convenient for staff." -When asked had staff reported these concerns to management the staff stated "Tried but couldn't" because the staff felt they were "not really listening." -The staff stated there were four residents who "are pretty with it" and there were some Medication Aides "putting the pills in the bedside drawers" for those residents. -"Have to do it that way to get it done in the amount of time." -"There are ways of getting around to make it easier on yourself." Confidential interview with a second staff revealed the staff knew of one occurrence where "one of the [other staff had] found a pill out in the hallway." Confidential interview with a third staff revealed: -They had found pills on the floor. -They took them to the Medication Aides. Confidential interview with a fourth staff revealed: -They had seen half dissolved pills on the floor like they had been in someone's mouth and spit out. -They did not feel like the Medication Aides checked the resident's mouths after giving them medications. Confidential interview with a fifth staff revealed: -They had found pills on the floor and beds of residents. -They had told the Medication Aides that they found the pills. -They had been asked by Medication Aides to	D 358		

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D 358	Continued From page 6 stay with certain residents to assure they did take all of the medications and not spit them out. Confidential interview with a sixth staff revealed "I haven't found any medications on room trays." Interview on 12/4/14 at 2:02pm with the Memory Care Manager revealed: -She was new to the position, but not to the facility. -She was unaware medications had been left in Resident #1's room by the third shift Medication Aide until she was notified medication had been found that morning. Interview on 12/4/14 at 2:30pm with the Administrator revealed: -She was not aware medications had been left in Resident #1's room until her staff informed her medications had been found that morning. Interview on 12/6/14 at 8:30am with Resident #1's family member revealed: -She regularly visited every Sunday afternoon and sometimes during the week. -No observations of medications left in the room. -The staff had left the afternoon supplement for the resident to drink during the Sunday afternoon visits. Confidential interviews with three residents revealed the following comments when asked if medication aides watch them take their medications : -"They hand [the medications] to us and make sure we take it." -"They watch me take my meds. They are very good about that." -"I can't say. I don't know. I can't remember things."	D 358		

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D 358	Continued From page 7 Interview with the Administrator on 12/4/14 at 8:45am revealed: -The staff had been trained to watch the residents take the medications. -"I think that third shift Medication Aide just thought [Resident #1's name] was with it enough to take her meds when she woke up." -"I think it was only done with [Resident #1's name]." -"I don't think our Medication Aides were just leaving medications out everywhere." Refer to the facility policy for the Administration of Oral Medications. Refer to interview with the Memory Care Manager on 12/3/14 at 3:00pm. 2. Interview on 12/5/14 at 6:55am with the third shift Medication Aide (MA) revealed: -She had been instructed by another Medication Aide during orientation (13 months ago) to leave Resident #1's pills in her room and to crush her potassium, because the resident was having difficulty swallowing it. -She stated she knew not to crush potassium, but did it because that was what she had been instructed to do. Review of Resident #1"s December 2014 electronic Medication Administration Record (e-MAR) revealed the crushed potassium found in her room on 12/4/14 at 9:40am was documented as having been administered at 7:00am. Confidential interviews with three Medication Aides (MA) revealed: -Resident #1's potassium was being crushed	D 358		

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D 358	Continued From page 8 because she was having difficulty swallowing it. -They had not notified Resident #1's physician about crushing the potassium. -They had not contacted the pharmacy about Resident #1's difficulty swallowing the potassium. -They were aware potassium was not to be chewed or crushed. Interview on 12/4/14 at 2:02pm with the Memory Care Manager revealed she was not aware the Medication Aides had been crushing Resident #1's potassium. Interview on 12/4/14 at 2:30pm with the Administrator revealed she stated she was not aware the Medication Aides had been crushing Resident #1's potassium. Telephone call placed to Resident #1's physician's office on 12/6/14 at 11:45am regarding the crushing of the potassium chloride prior to administration was not returned by exit. Refer to the facility policy for the Administration of Oral Medications. B. Review of Resident #2's current FL2 dated 10/29/14 revealed: -Diagnoses included multi-infarct dementia, umbilical hernia, atrial fibrillation, macular degeneration, type II diabetes, and hypertension. -Acetaminophen/Diphenhydramine (used to reduce pain and aids in sleep) 500mg/25mg 1 tablet every night at bedtime. Interview with Resident #2's family member on 12/3/14 at 9:25am revealed: -During a family visit in October 2014 sometime around 6pm, the family member found a loose pill in Resident #2's bed.	D 358		

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D 358	Continued From page 9 -The Medication Aide on duty identified the pill as Tylenol PM, which was prescribed for Resident #2 and was scheduled to be administered daily at 8pm. -When the family questioned the Medication Aide on duty, she told the family member she had always watched the resident swallow the dose of Tylenol PM whenever she administered it. -The Medication Aide was unsure where that particular pill had come from. Review of Resident #2's October 2014 e-MAR revealed: -An entry for Acetaminophen/Diphenhydramine 500mg/25mg documented administered daily at 8pm for 31 occurrences out of 31 opportunities. -No documented exceptions of the medication having been refused or held for any reason during the month of October. Review of Resident #2's November 2014 e-MAR revealed: -An entry for Acetaminophen/Diphenhydramine 500mg/25mg documented administered daily at 8pm for 30 occurrences out of 30 opportunities. -No documented exceptions of the medication having been refused or held for any reason during the month of November. Confidential interview with one staff revealed: -Resident #2's family member had "brought a blue pill" to Resident #2 and said it had been found in Resident #2's bed. -The pill was identified by staff as Tylenol PM which was prescribed for Resident #2. -When asked had the medication staff already given Resident #2 her 8pm medications when this had occurred the staff said "No mam, cause it was before eight o'clock and its not due until then."	D 358		

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D 358	Continued From page 10 -"I have seen other [Medication Aides] set pills down on the table and walk out." -"I confronted one [Medication Aide] and she said 'Don't tell on me'." -"I said 'You need to make sure they take it, so I went back and made sure the resident took the medications [that had been left on the bedside table]." -One person who had worked in dietary had told this staff person they also had "found pills in resident rooms." -When asked why the staff thought Medication Aides might leave medications unattended on the table for residents to take on their own the staff stated "in a hurry to get it done" and more "convenient for staff." -When asked had the staff reported these concerns to management the staff stated "Tried but couldn't" because the staff felt they were "not really listening." -The staff stated there were four residents who "are pretty with it" and there were some Medication Aides "putting the pills in the bedside drawers" for those residents. -"Have to do it that way to get it done in the amount of time." -"There are ways of getting around to make it easier on yourself." Confidential interview with a second staff revealed: -The staff knew of one occurrence where "one of the [other staff had] found a pill out in the hallway." -Second shift was a more challenging shift to work, due to "sundowners and increased agitation" of the residents which could lead to "mistakes" being made with medications. -The staff stated it would be helpful to have more staff on second shift.	D 358		

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D 358	Continued From page 11 -When asked if the staff on second shift were able to meet the needs of the residents the staff stated "We can, but it makes it a lot harder on us." Confidential interview with a third staff revealed: -They had found pills on the floor. -They took them to the Medication Aides. Confidential interview with a fourth staff revealed: -They had seen half dissolved pills on the floor like they had been in someone's mouth and spit out. -They did not feel like the Medication Aides checked the resident's mouths after giving them medications. Confidential interview with a fifth staff revealed: -They had found pills on the floor and beds of residents. -They had told the Medication Aides that they found the pills. -They had been asked by Medication Aides to stay with certain residents to assure they did take all of the medications and not spit them out. Confidential interview with a sixth staff revealed "I haven't found any medications on room trays." Confidential interviews with three residents revealed the following comments when asked if medication aides watch them take their medications : -"They hand [the medications] to us and make sure we take it." -"They watch me take my meds. They are very good about that." -"I can't say. I don't know. I can't remember things."	D 358		

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D 358	Continued From page 12 Interview with the Administrator on 12/4/14 at 8:45am revealed: -Resident #2's family member had not ever told her a pill had been found in the resident's bed. -The family member "had not told any staff at all." -"I did not find out until 10/30/14 when everything was presented to the Department of Social Services." -The staff had been trained to watch the residents take the medications. -"I don't think our Medication Aides were just leaving medications out everywhere." Refer to interview with the Memory Care Manager on 12/3/14 at 3:00pm. Refer to the facility policy for the Administration of Oral Medications. _____ Review of the facility policy for the Administration of Oral Medications revealed: -"The Medication Aide (MA) is to remain with the resident until the medication has been swallowed". -"It should not be recorded that the drug was administered unless the MA is positive that the resident has indeed swallowed the entire dose of medication." -"If it becomes apparent that a resident will require medications crushed, check their medications against the Do Not Crush List. In the event the resident has medication on the list, DO NOT CRUSH THEM. Check with the pharmacist regarding their availability in liquid or other suitable form and call the physician to obtain a change order, if necessary". Interview with the Memory Care Manager on 12/3/14 at 3:00pm revealed:	D 358		

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D 358	Continued From page 13 -"It is our policy for the Medication Aides to stay with the resident until the medication has been swallowed." -"I've not had any other [Medication Aides] come to me and say they found medications in a room or anything." _____ The facility provided a plan of protection on 12/3/14 which included the following: -Remove medication aide in question from the medication cart. -Retraining provided to all medication aides. -Will perform random spot checks (in resident accessible areas for unattended medications) on all three shifts 4 times weekly for 1 month. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 3, 2015.	D 358		
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, record reviews, and interviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with the relevant federal and state laws and rules and regulations related to medication administration.	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R-C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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
D912	Continued From page 14 The findings are: Based on observations, interviews, and record reviews, the facility failed to assure administration of medications to 2 of 5 sampled residents (#1 and #2) with diagnosis of Dementia, was in accordance to the facility's policy and procedures as evidenced by residents not being observed to actually take medications administered including Aspirin, Lorazepam, and Furosemide and creating an unsafe environment with medications being accessible to other residents in the Special Care Unit and the failure to follow the facility's policies and procedures by crushing an extended release potassium medication for 1 resident (Resident #1). [Refer to Tag D 0358,10A NCAC 13F.1004(a) Medication Administration (Type A2 Violation).]	D912		

Kingsbridge House

Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set-forth in the statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance.

10A NCAC 13 F .1004 (a) Medication Administration.

It is the policy of Kingsbridge House shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with the facility's Policies and Procedures.

(1) Orders by a licensed prescribing practitioner which are maintained in the resident's records; and
(2) Rules in this section and the facility's policy and procedures.

1. Medication Aides will administer medications to all residents as ordered.

2. All medications will be secure until administered to the resident for which it was prescribed.

3. All medication aides will receive re- training on the correct methods for medication administration from [redacted] Pharmacy scheduled on January 21, 2015 .

4. The Memory Care Manager will conduct random medication pass observation for 3x a week for 2 weeks and then weekly thereafter. The Administrator will conduct random medication pass observations monthly to ensure the same.

Date of Correction: January 3, 2015

Shook, Linda

From: Norville, Charity P
Sent: Tuesday, January 13, 2015 2:50 PM
To: louise.koontz@transylvaniacounty.org
Cc: Shook, Linda; Penland, Beverly D; Burns, Pam S
Subject: Kingsbridge House-Transylvania County
Attachments: Kingsbridge House 2015-01-12 POC 6OTC11.pdf

Please find attached copy of the approved Plan of Correction (POC) for the above referenced facility.

Thank you,

Charity Norville BSN, RN
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Division of Health Service Regulation
Nurse Consultant-Adult Care Licensure Section
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