STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CLARA'S COTTAGE # 2	5824 HOLLAND STREET MORGANTON, NC 28655

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C 000	Initial Comments The Adult Care Licensure Section and the Burke County Department of Social Services Department conducted a follow-up survey and complaint investigation on March 10-13, 2015 with an exit conference via telephone on March 13, 2015.	C 000		
C 076	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the living room sectional sofa and one of the chairs in a resident room were clean and in good repair. The findings are: Observation in the facility living room on 3/10/15 at 9:00am revealed: -There was a sectional couch in the left corner of the room. -The sectional couch and one recliner in the room were all that were available for residents to use in the living room. -The fabric of the sectional couch was heavily stained with black and gray colored stains. -There was a 3 inch tear in the fabric in the center section of the couch. -There was a 4 inch wide by 4 inch long tear in the fabric of the section adjacent to the center section of the couch.	C 076		

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C 076	Continued From page 1 Observation in the first resident room on the left down the hall on 3/10/15 at 9:20am revealed: -There were two chairs in a room shared by two residents. -One chair bottom had fabric which was shredded and the foam of the cushion was visible through the shredded fabric. Interview with the Co-Administrator on 3/10/15 at 9:50am revealed: -He was unaware the resident's chair was in such bad condition. -He was unsure what had happened to the chair to cause the heavy damage to the fabric. Interview with an Owner on 3/11/15 at 11:00am revealed: -"Most of the time we steam clean [the furniture in the living room] every 2 months." -The living room furniture had been steam cleaned before Christmas. -She stated the living room sectional couch was on her list to be replaced. -She had replaced the furniture in the resident's rooms not long ago and was planning to replace the sectional couch when she had paid down her bill from the other recent furniture purchases she had made for the facility. Confidential interviews with four residents revealed none of the residents had any complaints about the condition of the furniture in the living room or in their rooms.	C 076		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other	C 185		

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C 185	Continued From page 2 Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record reviews, the Administrator failed to be responsible for the total operation of the facility in meeting and maintaining compliance of the rules of this Subchapter as related to Housekeeping and Furnishings, Health Care, Medication Administration, Pharmaceutical Care, Healthcare Personnel Registry, and Reporting of Incidents and Accidents. The findings are: Interview with the facility Administrator on 3/10/15 at 9:10am revealed: -The Administrator had not spent as much time at the facility in the past year as she normally would due to serious illness. -The Owner of the facility (who was also an Administrator of several other facilities) came to the facility weekly during the time of the	C 185		

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Administrator's illness, to assist the Administrator in the operation of the facility.

Interview on 3/10/15 at 10:15am with the Owner, who filled in while the Administrator was ill, revealed:
- She had been in the facility every 1 to 2 weeks over the past year due to the Administrator's illness.
-"I checked the MARs and med cart for problems, but did not see anything unusual."

A.) Based on observations and interviews, the facility failed to assure the living room sectional sofa and one of the chairs in a resident room were clean and in good repair.[Refer to Tag 0076 10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings]

B.) Based on observation, interview, and record review, the facility failed to assure a physician was notified for 2 of 4 sampled residents one with a significant change in condition related to falls and a wound (Resident #4), and another resident with labwork not completed as ordered (Resident #2). [Refer to Tag 0246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]

C.) Based on observation, record review, and interview, the facility failed to assure documentation and implementation of physicians order for 1 of 4 sampled residents (Resident #1) including obtaining finger stick blood sugars (FSBS) four times per day and blood pressure checks three times per week. [Refer to Tag 0249 10A NCAC 13G .0902(c3-4) Health Care (Type B Violation)]

D.) Based on observation, interview, and record review the facility failed to assure medication

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C 185	Continued From page 4 administration records were accurate and complete for 2 of 4 sampled residents (Residents #1 and #2). [Refer to Tag 0342 10A NCAC 13G .1004(j) Medication Administration] E.) Based on interview and record review the facility failed to assure that action was taken in response to quarterly pharmaceutical reviews in 2 of 4 residents sampled (Resident #1 and #2). [Refer to Tag 0381 10A NCAC 13G .1009(b) Pharmaceutical Care] F.) Based on interviews and record reviews, the facility failed to protect residents by not reporting allegations of abuse, neglect, and drug diversion to the Health Care Personnel Registry (HCPR) for the former supervisor-in-charge (Staff B) within 24 hours of becoming aware of an allegations and completing an investigation report within 5 days of the initial notification to HCPR. [Refer to Tag 0428 10A NCAC 13G .1206 Healthcare Personnel Registry (Type A2 Violation)] G.) Based on observations, interviews, and record reviews, the facility failed to notify the county department of social services of an incident resulting in emergency evaluation for 1 of 1 resident (Resident #4). [Refer to Tag 0444 10A NCAC 13G .1213 Reporting of Accidents and Incidents] _____ The following plan of protection was provided by the Administrator on 3/26/15: -An Administrator is in the facility no less than 4-5 times per day now. -Resident records are monitored weekly to ensure compliance. -An Administrator will spend no less than 30	C 185		

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C 185	Continued From page 5 hours per week within the facility. -The Administrator will monitor all resident records to ensure compliance with physician visits and care of residents. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2015.	C 185		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure a physician was notified for 2 of 4 sampled residents one with a significant change in condition related to falls and a wound (Resident #4), and another resident with labwork not completed as ordered (Resident #2). The findings are: A. Review of Resident #4's FL2 dated 1/22/15 revealed: -Diagnoses included: history of traumatic brain injury, seizure disorder, schizoaffective bipolar type with depressed episodes, borderline intellectual functioning, osteoarthritis, and hypertension. -Documented as intermittently disoriented. -Semi-ambulatory with walker.	C 246		

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C 246	Continued From page 6 -Occasional incontinence of bowel and bladder. Review of Resident #4's Care Plan dated 1/22/15 revealed: -Resident required extensive assistance from staff for eating, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring. -Resident required limited assistance from staff with toileting. Review of Resident #4's facility notes revealed: -On 2/16/15, "[Resident #4's name] fell in her bedroom by the closet and hit her head and eye and skinned her knee up. I gave her some Tylenol and an ice pack for her eye. The result of her fall ended up being an black eye." -On 2/23/15, "[Resident #4's name] decided she was going to 'run away' because she claims nobody likes her. She took off out the road and made it to the neighbors driveway and fell. I went running up there and she said she was fine so I got her up and we came back home." -On 2/27/15, "[Resident #4's name] woke up and wasn't acting right. She wouldn't walk or eat at all. She would go thru spells and one minute could walk other times she would fall because she claimed she was dizzy. She fell a total of three times before I got her to bed. No scapes, bumps, or bruises." -On 2/28/15, "[Resident #4's name] woke up perfectly fine this morning. As time progressed she started doing the same thing as yesterday. We checked her blood pressure and it was 80/48. The O2 was 64% then we realized she was holding her breath. Then we retook it and it was 96. She was sent out by medics." Review of Resident #4's hospital history and physical dated 2/28/15 revealed:	C 246		

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-"Skin examination included: Sub-acute ecchymosis noted under/around the left eye and two small wounds noted over the infero-lateral aspect of the right buttock, one of which appears older and ulcerated, the other newer and akin to a skin tear. Mild erythema noted surrounding the buttock wounds, but with no increased warmth, tenderness, no purulent drainage or foul odor noted in association with either of the right buttock wounds."
-"We strongly suspect the abnormal renal function test results today represent an acute kidney injury most likely secondary to dehydration."

Review of Resident #4's discharge summary dated 3/10/15 revealed:
-Admitted to the hospital on 2/28/15.
-Admitting diagnoses included: hypotension, acute kidney injury, hypokalemia, abnormal urinalysis, serum leukocytosis, and stage 2 pressure ulcers of right buttock.
-The resident presented to the [local hospital emergency department] the afternoon of 2/28/15 due to generalized weakness and falls.
-The resident reported "feeling generally weak for the preceding 5 to 7 day period."
-The resident stated that she had suffered "a couple of accidental falls within the preceding week."
-One of the fall reportedly involved her falling into her closet or against the closet door which resulted in a bruise around her left eye.
-The resident was unable to say whether or not she had felt dizzy or lightheaded upon standing prior to her recent falls.
-The resident's initial blood pressure upon arrival to local emergency room was 63/29.
-The resident's white blood cell count (the body's increased production of white cells usually

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indicates infection) was 27.2 (normal range 4.5-11.0)
-The resident had multiple electrolyte abnormalities, abnormal renal function tests, and an abnormal urinalysis in the initial lab work completed on arrival to the local emergency department.

Review of Resident #4's wound care consultation dated 3/2/15 revealed:
-"62-year old lady with history of mental retardation admitted for falls and weakness at home was found to have a right buttock infection."
-"She had a scar to the right hip that spontaneously started draining purulent fluid."
-"There is significant cellulitis (bacterial skin infection) to the right buttock to right hip region."

Observation on 3/11/15 at 9:25am revealed:
-Resident #4 got up from the couch in the living room.
-She started off down the hallway to her room.
-The resident fell in the floor hitting her head on the floor and wall outside her room.
-Staff assessed the resident and assisted her to her room.
-The resident's blood pressure was 142/90.

Interview with Resident #4 on 3/11/15 at 9:50am revealed:
-"I was feeling bad for 2 to 4 days before I had to go to the hospital."
-"My legs were jerky if I laid down."
-"I wasn't feeling myself."
-"[Co-Administrator's name] had to carry me in from the bathroom to my room cause I kept falling."
-The resident was unable to remember how many times she had fallen before going to the hospital.

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-"I'd sit on the edge of my bed and I'd fall over."
-"In the dining room, I couldn't eat, kept on swaying back and forth."
-The resident stated the place on her right buttock "was a boil before I went to the hospital. It had been there a week. [Supervisor In Charge's (SIC) name] had doctored it. They had put tape and antibiotic cream on it. The hospital said the tape was causing the skin to breakdown. [SIC's name] knew I was peeing all the time."

Interview with Resident #3 on 3/11/15 at 10:05am revealed:
-She was Resident #4's roommate.
-Resident #4 had "started getting sick about a week and a half ago."
-Resident #4 had been sick "4 days to a week" before she had been sent out to the hospital.
-"She fell 2 times before she went to the hospital that I know of."
-The first fall had occurred in the hall and the second fall was in the bedroom that she remembered.

Interview with the SIC on 3/11/15 at 10:07am revealed:
-Resident #4 had been "very dizzy and her legs would give out. We would have to put a gait belt on her to keep her from falling. The day before and the day of when she went to the hospital her legs would just give out and go like spaghetti noodles."
-Resident #4 had four falls in the week prior to her hospitalization on 2/28/15.
-She stated she had "constantly kept an eye out for [Resident #4] and never let her out of sight. I stayed right behind her and held her to stabilize her when she was walking."
-When asked had she ever notified a physician concerning the fall occurrences and weakness

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the resident was experiencing she stated she had not.
-She had contacted Resident #4's guardian and he "told us perviously in other facilities she had fallen for attention."
-"I took precautions and I asked her how she felt and up until that Saturday (2/28/15) she had felt fine-nothing wrong."
-At the recommendation of the Co-Administrator, she had taken blood pressures all week and it was 140/80's. "That Saturday was when it dropped to 80/48 and 60/40."
-Friday night 2/27/15 was the first time the resident had shown her the boil.
-"It was about the size of a quarter, a bump with head in the center."
-"I was going to get her a doctor's appointment that next Monday morning to have it looked at."
-"I put triple antibiotic cream and a gauze with surgical tape over the area for padding."

Interview with the Co-Administrator on 3/11/15 at 2:25pm revealed:
-When Resident #4 started falling during the week prior to her hospitalization, they had contacted her guardian and the guardian had "said she's attention seeking."
-He had the SIC check the resident's blood pressure for two days prior to her being sent to the hospital, due to the increase in falls.
-"That's how we found her blood pressure was so low on 2/28/15 and we sent her out."
-"I got a call on 2/27/15 that she had a bump on her butt. [SIC's name] told me it looked like a little knot."
-The resident "couldn't hold her head up and was swaying and had we had to literally hold her in the chair."
-The two falls "were right after her [guardian] was supposed to be here and cancelled."

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-The Co-Administrator stated they had not found another primary care provider (PCP) for Resident #4, since the facility had dismissed the previous PCP on 1/15/15.
-"We were trying to get her in with [another PCP's name]."

Telephone interview with Resident #4's outpatient wound center on 3/12/15 at 2:20pm revealed:
-Resident #4 had been seen for a dressing change that morning in their office.
-The right buttock wound measured 6cm long x 4.3cm wide x 5.6cm deep.

Review of the facility's policy for "Health Care Instructions" signed by each staff member and located in their personnel file revealed:
-There was no information regarding when to contact the physician.
-When a resident had fallen, staff were instructed to assess the resident for "apparent injuries", help the resident up, and notify the Administrator.
-Staff were instructed to call the emergency medical service (911) if they were unsure about the possibility of injuries.
-An incident/accident report was to be filled out within 24 hours of the incident/accident and sent to the Department of Social Services.

Telephone interview with the Administrator on 3/13/15 at 9:15am revealed:
-"I did tell the [SIC's name] she should have done an incident report when [Resident #4's name] hurt her eye."
-"I didn't follow up to make sure [the SIC] had done it."
-"We were monitoring [Resident #4's] blood pressure, blood sugar, pulse oximetry, and pulse rate and all were normal readings."
-"The falls coincided with the [guardian's]

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cancelled visits."
-The guardian said the falls were "attention seeking."
-The guardian had called Resident #4 "that morning when she was so lethargic. [The guardian] said not to send her" to the hospital for evaluation.
-The guardian "talked to her on the phone and for the next 30-45 minutes she was normal."
-"The next 30 minutes she went limp again and that's when her blood pressure was real low. Her blood pressure that morning was fine."

Attempted telephone interview with Resident #4's PCP on 3/11/15 at 1:55pm was unsuccessful by exit.

B. Review of Resident #2's FL2 dated 12/11/14 revealed:
-Diagnoses included: diabetes mellitus type II, degenerative joint disease, hypothyroidism, and hypertension.
-Amaryl (used to control blood sugar levels) 4mg daily.
-Januvia (used to control blood sugar levels) 100mg daily.
-Lasix (used to reduce swelling) 20mg daily.
-Synthroid (used to treat hypothyroidism) 25mcg daily.
-Zestril (used to treat hypertension) 20mg daily.

Review of a primary care provider's (PCP) orders for Resident #2 dated 1/15/15 revealed the following laboratory tests ordered by the PCP:
-"Labs-Home Health to do..."
-CBC (used to evaluate overall health and detect a wide range of disorders)
-CMP (provides an overall evaluation of the body's chemical balance and metabolism)
-A1C (reflects the average blood sugar level over

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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the past 3 months)
-Lipids (measures cholesterol and other fats in the blood)
-Vitamin D (used to check levels of vitamin D in the blood)
-TSH (used to evaluate thyroid function)

Review of Resident #2's record revealed no documentation the laboratory tests ordered on 1/15/15 were obtained.

Interview with the Supervisor-In-Charge (SIC) on 3/10/15 at 3:24pm revealed:
-She was unaware an order had been written for lab work for Resident #2.
-The day the labs were ordered 1/15/15 had been the day when the previous SIC had quit.
-Her first day on the job had been 1/15/15, and she had missed seeing the order.
-She was unable to find any lab results for labs ordered for Resident #2 on 1/15/15.
-"As far as I know there was never any doctor's appointment made to have [Resident #2's name] labs done."

Interview with Resident #2 on 3/11/15 at 10:50am revealed she did not remember having lab work drawn any time recently either at a physician's office or by a home health agency.

Interview with the Co-Administrator 3/11/15 at 2:25pm revealed:
-He was unaware an order had been written for labs for Resident #2 on 1/15/15.
-As far as he knew the labs ordered on 1/15/15 were never drawn for Resident #2.
-The day the order was written had been a very chaotic day, because the previous SIC had quit and a new SIC began working in the facility.
-The PCP service was chosen for Resident #2,

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C 246	Continued From page 14 because the service promised all healthcare would be provided in the facility instead of having to take the resident to another site. -"We dropped the ball on that." Telephone interview with the Home Health Agency that normally provided services for residents at the facility on 3/13/15 at 8:56am revealed they had no record of Resident #2 ever having received services of any kind from their agency. Telephone interview with the Administrator on 3/13/15 at 9:02am revealed: -The order for lab work for Resident #2 was missed, because the SIC who had quit had put the order in a drawer. -The order had not been found by the current SIC until sometime later. -The previous SIC quitting unexpectedly and other issues going on in her other facility had proven overwhelming to her in the past couple months. Attempted telephone interview with Resident #2's PCP on 3/11/15 at 1:55pm was unsuccessful by exit. _____ The facility provided a plan of protection on 3/11/15 and included: -Facility staff would review all resident records in the facility for healthcare follow-up issues. -A PCP would be notified to address any healthcare issues found. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2015.	C 246		

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C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Type B Violation Based on observation, record review, and interview, the facility failed to assure documentation and implementation of physicians order for 1 of 4 sampled residents (Resident #1) including obtaining finger stick blood sugars (FSBS) four times per day and blood pressure checks three times per week. The findings are: A. Review of Resident #1's current FL2 dated 9/23/14 revealed: - Diagnoses included: Diabetes - Medications included: Insulin Detemir 90 units subcutaneous injection at bedtime (long acting insulin used to lower elevated blood sugar levels), Insulin lispro 14 units subcutaneous injection three times daily before meals (short acting insulin used to lower elevated blood sugar levels), and Actos 45 mg daily (oral medication used to treat diabetes). -A physician order for a 1600 to 1800 calorie diet. Review of physician orders dated 10/6/14 for	C 249		

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Resident #1 revealed:
-Finger stick blood sugars (FSBS) to be monitored 4 times daily: once fasting, once before bed, and at 10:00 am and 4:00 pm.
-Order to change Insulin Detemir to 45 units subcutaneous injection each morning and 45 units at bedtime.

Review of Resident #1's record revealed:
-A lab result for HbA1c (glycated hemoglobin test) of 7.0 on 10/12/14.
-The resident had a documented weight gain of 39 pounds since 11/3/14.

Review of physician order dated 1/15/15 for Resident #1 revealed that Insulin Lispro was discontinued on 1/15/15.

Review of January 2015 through March 2015 Medication Administration Record (MAR) revealed:
-No documented FSBS for January 2015 and February 2015.
-Documented FSBS for 3/2/15 of 121.
-Documented FSBS for 3/9/15 of 142.

Interview with the Supervisor-in-Charge (SIC) on 3/10/15 at 9:15am revealed the residents that required FSBS only get checked one time per week, usually on Sunday or Monday.

Review of Resident #1's blood sugar monitoring form revealed:
-The resident's blood sugar had been checked weekly on the following dates: 1/2/15, 1/9/15, 1/17/15, 1/25/15, 2/1/15, 2/10/15, 2/18/15, and 2/25/15 with a range of 121 to 181.

Interview with Resident #1 on 3/10/15 at 10:25am revealed:

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-"I got [blood sugar] checked once in January or February, that is the only time since I came here in November."
-That she feels that she needs to be on a special diet related to her diabetes.
-When asked about being on a special diet she replied, "I should be, but no."
-"I have gained 40 pounds since I got here."

Interview with Resident #1 on 3/11/15 at 2:37pm revealed the staff had never checked her FSBS 4 times per day.

Interview with Co-Administrator and SIC on 3/11/15 at 2:55pm revealed: The SIC and Co-administrator were unaware of the order dated 10/6/14 for FSBS 4 times daily.

Telephone interview with the physician on 3/12/15 at 12:41pm revealed:
-"This is imperative to her health" (referring to the need for FSBS four times daily).
-The physician wanted this monitoring to be done because she had added Metformin 500mg twice daily on 10/6/14, changed the dose and frequency of Insulin Detemir on 10/6/14, and discontinued Insulin Lispro on 1/15/15.
-The physician was expecting the facility to provide documentation of the FSBS four times daily when the resident comes to the physician's office for her monthly visit.

B. Review of Resident #1's current FL2 dated 9/23/14 revealed:
- Diagnoses included: Hypertension
- Medications included: Clonidine 0.1 mg three times daily (used to treat elevated blood pressure), Norvasc 10 mg daily (used to treat elevated blood pressure), and propranolol 20 mg daily (used to treat elevated blood pressure).

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C 249	Continued From page 18 Review of physician orders dated 10/6/14 for Resident #1 revealed monitor blood pressure (BP) three times per week. Review of physician orders dated 11/25/14 for Resident #1 revealed an order for Cozaar 50 mg 1 tablet two times daily. Review of physician orders dated 1/15/15 for Resident #1 revealed an order to discontinue Cozaar 50 mg 1 tablet two times daily. Review of Resident #1's record revealed blood pressure checks were performed: -On 9/24/14, BP documented as 118/70. -On 12/22/14 BP documented as 122/74. -On 1/17/15 BP documented as 130/80. -On 2/17/15 BP documented as 141/84. -On 3/1/15 BP documented as 120/72. Interview with the Supervisor-in-Charge (SIC) on 3/10/15 at 9:15am revealed the residents get their blood pressures checked one time per month. Interview with Resident #1 on 3/11/15 at 2:37pm revealed that Resident #1 has never had her blood pressures taken three times per week. Interview with Co-Administrator and SIC on 3/11/15 at 2:55pm revealed: The SIC and Co-Administrator were unaware of the order dated 10/6/14 for blood pressure checks three times weekly. Telephone interview with the physician on 3/12/15 at 12:41pm revealed: -"This is imperative to her health" (referring to the need for blood pressure checks three times per week).	C 249		

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C 249	Continued From page 19 -The physician wanted this monitoring to be done because she had added Cozaar 50 mg 1 tablet two times daily on 11/25/14 and then discontinued Cozaar on 1/15/15. -The physician was expecting the facility to provide documentation of the blood pressure checks three times weekly when the resident comes to the physician's office for her monthly visit. _____ The facility provided a plan of protection on 3/11/15 and included: -The facility staff was going to immediately check all resident records for physician orders. -Make sure those orders matched the resident's Medication Administration Records (MAR). -Immediately implement health care orders as prescribed and document on the residents MARs. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2015.	C 249		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	{C 342}		

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medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observation, interview, and record review the facility failed to assure medication administration records were accurate and complete for 2 of 4 sampled residents (Residents #1 and #2).

The findings are:

A. Review of Resident #2's current FL2 dated 12/11/14 revealed diagnoses included:
-Hypertension
-Diabetes Mellitus Type II.

1. Review of Resident #2's current FL2 dated 12/11/14 revealed a physician's order for lisinopril (used to treat high blood pressure) 20mg daily.

Review of a signed physician's order for Resident #2 dated 1/15/15 revealed:
-Lisinopril 20mg every morning.
-Lisinopril 10mg every evening.

Review of Resident #2's January 2015 Medication Administration Record (MAR) revealed:
-A computer generated entry for Lisinopril 20mg once daily.

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{C 342}	Continued From page 21 -The medication was scheduled to be administered at 8am. -The medication was documented as administered 31 occurrences out of 31 opportunities from 1/1/15 to 1/31/15. -There was no entry for the additional dose added 1/15/15 of Lisinopril 10mg every evening on the MAR. Review of Resident #2's February 2015 MAR revealed: -A computer generated entry for Lisinopril 20mg daily at 8am and documented as administered 2/1/15 to 2/28/15 for 28 occurrences out of 28 opportunities. -A computer generated entry for Lisinopril 10mg daily at 8pm and documented as administered 2/1/15 to 2/28/15 for 28 occurrences out of 28 opportunities. Review of Resident #2's March 2015 MAR revealed: -A computer generated entry for Lisinopril 20mg daily at 8am and documented as administered 3/1/15 to 3/10/15 for 10 occurrences out of 10 opportunities. -A computer generated entry for Lisinopril 10mg daily at 8pm and documented as administered 3/1/15 to 3/10/15 for 10 occurrences out of 10 opportunities. Interview with the Supervisor-In-Charge (SIC) on 3/10/15 at 2:08pm revealed: -She had first begun working in the facility on 1/15/15. -That was the same day the new order for Resident #2 had been written and the previous SIC had quit. -She had not seen the order written on 1/15/15 adding lisinopril 10mg evening dose, so she had	{C 342}		

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only given Resident #2 lisinopril 20mg in the morning the entire month of January as was documented on the MAR.

Telephone interview with the facility pharmacy on 3/11/15 at 1:35pm revealed:
-They had received an order from the facility on 1/15/15 to add lisinopril 10mg every evening for Resident #2.
-They clarified the order with the physician on 1/16/15 and dispensed 29 tablets of lisinopril 10mg to the facility in the evening delivery on 1/16/15.

Review of Resident #2's dispensing records from the facility pharmacy revealed:
-On 1/16/15, Lisinopril 10mg 29 tablets were dispensed to the facility.
-On 2/11/15, Lisinopril 10mg 28 tablets were dispensed to the facility.

Observation on 3/10/15 at 2:43pm of the medications on hand for Resident #2 in the facility medication cart revealed:
-There were 3 tablets of Lisinopril 10mg on hand in the cart.
-There were 8 tablets of Lisinopril 20mg on hand in the cart.

Telephone interview on 3/11/15 at 1:55pm with Resident #2's primary care provider's (PCP) assistant revealed:
-The PCP was unavailable for interview.
-She believed the order to increase Resident #2's lisinopril to an additional dose of 10mg in the evening had been ordered because the resident's blood pressure had been 144/90 on 1/15/15 when seen by the PCP.

Interview with the Co-Administrator on 3/11/15 at

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{C 342}	Continued From page 23 2:25pm revealed: -He had an SIC quit on 1/15/15 the day the order to increase the lisinopril for Resident #2 had been written by the PCP. -"We dropped the ball on that." Telephone interview with the Administrator on 3/13/15 at 9:15am revealed: -The order to increase Resident #2's lisinopril to 10mg every evening had been found "stuck in a drawer in the [previous SIC's name] room." -This was why there was a delay beginning to administer the correct dose to Resident #2. Attempted telephone interview with Resident #2's PCP on 3/11/15 at 1:55pm was unsuccessful by exit. Refer to interview with the Co-Administrator on 3/11/15 at 2:25pm. 2. Review of Resident #2's current FL2 dated 12/11/14 revealed a physician's order for lorazepam (used to treat anxiety) 2mg daily at bedtime as needed for anxiety. Review of Resident #2's January 2015 MAR revealed: -A computer generated entry for lorazepam 2mg once daily at bedtime as needed for anxiety. -"As needed for anxiety" had been marked through in pen and "order change" had been written out to the side of the entry and 8pm had been handwritten in on the MAR. -Lorazepam 2mg was documented as administered 1/1/15 to 1/31/15 scheduled at 8pm for 26 occurrences out of 31 opportunities. Review of Resident #2's February 2015 MAR revealed:	{C 342}		

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{C 342}	Continued From page 24 -A computer generated entry for lorazepam 2mg once daily at bedtime as needed for anxiety. -As needed for anxiety had been marked through in pen and order change had been written out to the side of the entry and 8pm had been handwritten in on the MAR. -Lorazepam 2mg was documented as administered 2/1/15 to 2/28/15 scheduled at 8pm for 28 occurrences out of 28 opportunities. Review of Resident #2's March 2015 MAR revealed: -A computer generated entry for lorazepam 2mg once daily at bedtime as needed for anxiety. -As needed had been marked through in pen and 8pm was handwritten in as if the medication was to be administered scheduled. -Lorazepam 2mg was documented as administered 3/1/15 to 3/9/15 at 8pm for 9 occurrences out of 9 opportunities. Review of Resident #2's medication review recommendation dated 2/19/15 revealed "The orders for [lorazepam] to be given scheduled not readily available in the chart." Observation of Resident #2's medications on hand in the facility medication cart on 3/10 at 2:43pm revealed there were 9 tablets of lorazepam 2mg. Interview with Resident #2 on 3/11/15 at 10:50am revealed: -Lorazepam "helps me sleep at night." -The staff gave her a dose every night. -"I would know if I didn't get [the lorazepam] because I would be up all night." Telephone interview with the facility pharmacy on 3/11/15 at 1:35pm revealed:	{C 342}		

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{C 342}	Continued From page 25 -The last order they had for Resident #2's lorazepam 2mg at bedtime as needed for anxiety written on 11/17/14. -They had never received an order from a physician to change lorazepam from as needed to scheduled for Resident #2. Interview with the SIC on 3/11/15 at 10:52am revealed: -She administered Resident #2's lorazepam daily at bedtime scheduled. -She stated the resident wanted the lorazepam every time she could have it. -She had not reached out to the PCP to get an order for the medication to be given scheduled. Telephone interview with the Administrator on 3/13/15 at 9:15am revealed Resident #2's PCP refused to make the lorazepam a scheduled order, however the resident "asks for it everyday." Attempted telephone interview with Resident #2's PCP on 3/11/15 at 1:55pm was unsuccessful by exit. Refer to interview with the Co-Administrator on 3/11/15 at 2:25pm. 3. Review of Resident #2's current FL2 dated 12/11/14 revealed a physician's order for hydrocodone-acetaminophen 10-325mg every 4 hours as needed for pain. Review of Resident #2's January 2015 MAR revealed: -A computer generated entry for hydrocodone-acetaminophen 10-325mg every 4 hours as needed for pain. -Documented as administered 40 occurrences from 1/1/15 to 1/15/15.	{C 342}		

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{C 342}	Continued From page 26 -Documented as administered scheduled on the back of the MAR at 8am, 12pm, and 8pm for back and knee pain with documented effectiveness for the resident. Review of Resident #2's February 2015 MAR revealed: -A computer generated entry for hydrocodone-acetaminophen 10-325mg every 4 hours as needed for pain. -No documented administrations for 2/1/15 to 2/28/15. Review of Resident #2's March 2015 MAR revealed: -A computer generated entry for hydrocodone-acetaminophen 10-325mg every 4 hours as needed for pain. -A handwritten entry out beside the entry "D/C 1-19-15." Review of Resident #2's record revealed there was no physician order present in the record to discontinue the hydrocodone-acetaminophen 10-325mg. Review of Resident #2's medication review recommendation dated 3/11/15 revealed "She has orders for both [hydrocodone-acetaminophen] and [oxycodone-acetaminophen] [as needed]. Not using the [hydrocodone-acetaminophen]. Observation of Resident #2's medications on hand on 3/10/15 at 2:43pm revealed there were no hydrocodone-acetaminophen 10-325mg tablets on the medication cart. Telephone interview with the facility pharmacy on 3/11/15 at 1:35pm revealed:	{C 342}		

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{C 342}	Continued From page 27 -Original order for hydrocodone-acetaminophen 10-325mg every 4 hours as needed was ordered on 12/11/14. -They did not have a physician's order to discontinue the medication. Review of Resident #2's dispensing records from the facility pharmacy revealed: -100 tablets of hydrocodone-acetaminophen 10-325mg were dispensed to the facility on 10/13/14. -100 tablets of hydrocodone-acetaminophen 10-325mg were dispensed to the facility on 11/14/14 -93 tablets of hydrocodone-acetaminophen 10-325mg were dispensed to the facility on 12/15/14. Interview with the SIC on 3/11/15 at 10:52am revealed: -Resident #2 had no hydrocodone-acetaminophen 10-325mg tabs on hand when she began as SIC on 1/15/15. -The SIC stated "I ended up calling the pharmacy and they said there was no problem" it was time for the resident's pain medication to be refilled. All of Resident #2's other medications were here. Review of a physician's order for Resident #2 dated 1/19/15 revealed Percocet 10-325 1 tablet every 4 hours as needed for pain. Review of Resident #2's dispensing records from the facility pharmacy revealed on 1/19/15 100 tablets of oxycodone-acetaminophen (used to treat pain) 10-325mg were dispensed to the facility for the resident's use. Interview with Resident #2 on 3/11/15 at 10:50am revealed:	{C 342}		

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{C 342}	Continued From page 28 -"I have been on pain meds for a long time. At least 5 years for my back pain." -The resident stated staff had given her the pain medications as ordered by her PCP. -She stated she had never had to go without pain medication. -She stated she took pain medication usually every 4 hours. Attempted telephone interview with Resident #2's PCP on 3/11/15 at 1:55pm was unsuccessful by exit. Refer to interview with the Co-Administrator on 3/11/15 at 2:25pm. 4. Review of a physician's order for Resident #2 dated 1/19/15 revealed Percocet 10-325 1 tablet every 4 hours as needed for pain. Review of Resident #2's January 2015 MAR revealed: -A handwritten entry for Percocet 10mg tablet take 1 tablet every 4 hours as needed. -The Percocet was documented as administered to the resident from 1/19/15 to 1/31/15 for 48 occurrences. Review of Resident #2's February 2015 MAR revealed: -A computer generated entry for Percocet 10-325mg 1 tablet every 4 hours as needed for pain do not exceed 6 in 24 hours. -The Percocet was documented as administered to the resident from 2/1/15 to 2/28/15 for 136 occurrences. -Documented as administered scheduled on the back of the MAR at 8am, 12pm, 4pm, and 8pm for back and knee pain with documented effectiveness for the resident.	{C 342}		

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{C 342}	Continued From page 29 Review of Resident #2's March 2015 MAR revealed: A computer generated entry for Percocet 10-325mg 1 tablet every 4 hours as needed for pain do not exceed 6 in 24 hours. -The Percocet was documented as administered to the resident from 3/1/15 to 3/10/15 for 47 occurrences. -Documented as administered scheduled on the back of the MAR at 8am, 12pm, 4pm, and 8pm for back and knee pain with documented effectiveness for the resident. Observation of Resident #2's medications on hand in the facility on 3/10/15 at 2:43pm revealed: -There were 8 tablets of Percocet 10-325mg in one bubble pack. -There were 2 bubble packs of 60 tablets of Percocet 10-325mg also available for the resident. Review of Resident #2's dispensing records from the facility pharmacy revealed: -On 1/19/15, there were 180 tablets of Percocet 10-325mg sent to the facility. -On 2/24/15, there were 180 tablets of Percocet 10-325mg sent to the facility. Interview with the SIC on 3/11/15 at 10:52am revealed: -Resident #2 wanted her as needed pain medication everytime she could have it. -She had not contacted the PCP to get an order for the medication to be given scheduled. Interview with Resident #2 on 3/11/15 at 10:50am revealed: -"I have been on pain meds for a long time. At least 5 years for my back pain."	{C 342}		

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-The resident stated staff had given her the pain medications as ordered by her PCP.
-She stated she had never had to go without pain medication.
-She stated she took pain medication usually every 4 hours.

Telephone interview with the facility pharmacy on 3/11/15 at 1:35pm revealed:
-Original order for Percocet 10-325mg every 4 hours as needed was ordered on 1/19/15.
-The as needed order was renewed again on 2/23/15.

Attempted telephone interview with Resident #2's PCP on 3/11/15 at 1:55pm was unsuccessful by exit.

Refer to interview with the Co-Administrator on 3/11/15 at 2:25pm.

B. Review of Resident #1's current FL2 dated 9/23/14 revealed:
- Diagnoses included: major depression recurrent with psychotic features, generalized anxiety disorder, hypertension, diabetes, and hypothyroidism.
-A physician's order for Tegretol 100 mg 1 by mouth two times daily (used to treat major depression).

Review of a physician's order dated 1/5/15 for Resident #1 revealed Tegretol 200 mg 1 tablet twice daily.

Review of Resident #1's January 2015 Medication Administration Record (MAR) revealed:
-Computer generated entry for Tegretol 100 mg

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tab take 1 tablet twice daily at 8:00 am and 8:00 pm.
-The medication was documented as administered 61 occurrences out of 62 opportunities from 1/1/15 to 1/31/15.
-No documentation found on MAR to reflect the new order for Tegretol written and received on 1/5/15.

Observation of Resident #1's medications on 3/10/15 at 2:10pm revealed:
-A bubble pack with a dispense date of 2/11/15 for Resident #1 labeled Tegretol 200 mg take 1 tablet twice daily.
-There were 10 tablets remaining on the card.

Interview on 3/12/15 at 1:31pm with the SIC revealed:
- "I gave her the [Tegretol] 200 mg twice daily [in January 2015], I gave her what was in the packs."
-SIC said the 100 mg tablets had been sent back to the pharmacy.
-SIC was unable to find any documentation of the returned medications.

Review of pharmacy records dated from 9/1/12 to 3/10/15 revealed:
-On 1/8/15 Tegretol 200 mg with 13 tablets sent to facility.
-On 1/12/15 Tegretol 200 mg with 62 tablets sent to facility.
-On 2/11/15 Tegretol 200 mg with 56 tablets sent to facility.

Attempted telephone interview with facility pharmacy on 3/13/15 at 8:22am and was unsuccessful by exit.

Refer to Interview with the Co-Administrator on 3/11/15 at 2:25pm.

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{C 342}	Continued From page 32 Interview with the Co-Administrator on 3/11/15 at 2:25pm revealed: -"We normally get changes made to the MAR's as soon as they come back [from the physician]." -The SIC was primarily responsible to ensure the MAR's were accurate for all the resident records. -The SIC was responsible for checking all the residents MARs once a month. -Quality assurance was performed once a month by management. -During quality assurance tours management would "check different areas of the home." -"One of us was here at least once a week to walk through the house and talk to the residents." -During the quality assurance checks full resident record reviews were not performed. -He stated with "these issues coming to light we are going to have to re-address some issues."	{C 342}		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interview and record review the facility failed to assure that action was taken in response to quarterly pharmaceutical reviews in 2 of 4 residents sampled (Resident #1 and #2). The findings are: A. Review of Resident #1's current FL2 dated	C 381		

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9/23/14 revealed:
- Diagnoses included: major depression recurrent with psychotic features, generalized anxiety disorder, hypertension, diabetes, and hypothyroidism.
- Medications included: Ativan 1 mg every 8 hours (used to treat anxiety).

Review of Resident #1"s pharmacy review dated 11/10/14 revealed:
- 9/25/14 change Ativan to Xanax secondary to insurance.
- Alprazolam 1 mg twice daily.

Review of a physician's order for Resident #1 dated 11/3/14 revealed alprazolam 0.5 mg 1 tablet by mouth twice daily for 30 days, then 1 tablet by mouth daily.

Review of Resident #1's January 2015 Medication Admin0istration Record (MAR) revealed:
-A computer generated entry for alprazolam 0.5 mg tablet take 1 tablet by mouth once daily.
-Handwritten entry of "D/C" was written over the date area on the MAR with no effective date.
-No doses were documented as administered for January 2015.

Review of Resident #1's pharmacy review dated 2/19/15 revealed the following recommendations by the consultant: "Need to go through this FL2/orders and verify that the MAR is correct. Example: Ativan DC, change to Xanax, Xanax DC'd."

Review of Resident #1's record revealed:
-No physician's order for Ativan to be discontinued in the record.
-No physician's order in the record for 9/25/14

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alprazolam 1 mg twice daily.
-No physician's order for alprazolam to be discontinued after 11/3/14 order was completed.
-No documentation of action or communication with the physician or facility pharmacy requesting the missing physician orders.

Telephone interview with pharmacy staff on 3/11/15 at 1:35pm revealed:
-The order for alprazolam written on 11/3/14 was meant to wean the resident off of the medication.
-The first step of the 11/3/14 order for alprazolam (0.5 mg 1 tablet twice daily) was filled on 11/3/14 with 60 tablets.
-The second step of this order (0.5 mg 1 tablet daily) was filled on 11/26/14 with 30 tablets. This was the last time alprazolam was filled by the pharmacy.
-The physician's order for alprazolam 0.5 mg 1 daily was discontinued on 1/5/15 per pharmacy staff.

Refer to the interview with the Co-Administrator on 3/11/15 at 2:25pm.

Telephone interview with the Administrator on 3/13/15 at 9:02am revealed:
-"We fax those [pharmacy review sheets] to the doctor and they respond to us."
-"Sometimes the doctor's don't respond."

B. Review of Resident #2's current FL2 dated 12/11/14 revealed diagnoses included:
-degenerative joint disease
-insomnia
-chronic pain

1. Review of Resident #2's current FL2 dated 12/11/14 revealed a physician's order for lorazepam (used to treat anxiety) 2mg 1 tab at

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C 381	Continued From page 35 bedtime as needed. Review of Resident #2's pharmacy review dated 2/19/15 revealed "The orders for [lorazepam] to be given scheduled not readily filed in the chart." Review of Resident #2's January 2015 MAR revealed: -A computer generated entry for lorazepam 2mg once daily at bedtime as needed for anxiety. -As needed for anxiety had been marked through in pen and order change had been written out to the side of the entry and 8pm had been handwritten in on the MAR. -Lorazepam 2mg was documented as administered 1/1/15 to 1/31/15 scheduled at 8pm for 26 occurrences out of 31 opportunities. Review of Resident #2's February 2015 MAR revealed: -A computer generated entry for lorazepam 2mg once daily at bedtime as needed for anxiety. -As needed for anxiety had been marked through in pen and order change had been written out to the side of the entry and 8pm had been handwritten in on the MAR. -Lorazepam 2mg was documented as administered 2/1/15 to 2/28/15 scheduled at 8pm for 28 occurrences out of 28 opportunities. Review of Resident #2's March 2015 MAR revealed: -A computer generated entry for lorazepam 2mg once daily at bedtime as needed for anxiety. -As needed had been marked through in pen and 8pm was handwritten in as if the medication was to be administered scheduled. -Lorazepam 2mg was documented as administered 3/1/15 to 3/9/15 at 8pm for 9 occurrences out of 9 opportunities.	C 381		

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C 381	Continued From page 36 Review of Resident #2's record revealed no clarification with a physician to continue to administer lorazepam scheduled. Refer to the interview with the Co-Administrator on 3/11/15 at 2:25pm. Refer to the telephone interview with the Administrator on 3/13 at 9:02am. 2. Review of Resident #2's current FL2 dated 12/11/14 revealed a physician's order for hydrocodone-acetaminophen (used to treat pain) 10-325mg 1 tab every 4 hours as needed. Review of a physician's order for Resident #2 dated 1/19/15 revealed oxycodone-acetaminophen 10-325mg 1 tab every 4 hours as needed for pain. Review of Resident #2's pharmacy review dated 2/19/15 revealed the following recommendations by the consultant: -"She has orders for both [hydrocodone-acetaminophen as needed] and [oxycodone-acetaminophen as needed] . Not using the [hydrocodone-acetaminophen]." -Oxycodone-acetaminophen 10-325mg every 4 hours as needed for pain is being given 4 times everyday. May we schedule this dose? -"May we DC [hydrocodone-acetaminophen]?" Review of Resident #2's record revealed: -No clarification with a physician to continue or discontinue hydrocodone-acetaminophen 10-325mg 1 tab every 4 hours as needed. -No clarification with a physician to continue administering oxycodone-acetaminophen 10-325mg scheduled rather than as needed as	C 381		

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C 381	Continued From page 37 the order was written. Refer to the interview with the Co-Administrator on 3/11/15 at 2:25pm. Refer to the telephone interview with the Administrator on 3/13 at 9:02am. _____ Interview with the Co-Administrator on 3/11/15 at 2:25pm revealed: -"We normally get changes made to the MAR's as soon as they come back [from the physician]." -The Supervisor In Charge (SIC) was primarily responsible to ensure the MAR's were accurate for all the resident records. -The SIC was responsible for checking all the residents MARs once a month. -Quality assurance was performed once a month by management. -During quality assurance tours management would "check different areas of the home." -"One of us was here at least once a week to walk through the house and talk to the residents." -During the quality assurance checks full resident record reviews were not performed. -He stated with "these issues coming to light we are going to have to readdress some issues." Telephone interview with the Administrator on 3/13 at 9:02am revealed: -"We fax those [pharmacy review sheets] to the doctor and they respond to us." -"Sometimes the doctor's don't respond." -"We are trying to get new physician's for these residents" who were under the care of the primary care provider we are no longer using as of January 2015. -"We actually have scheduled appointments" for several of the residents with a new physician, but	C 381		

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C 381	Continued From page 38 the residents haven't gotten to see the new physician yet to address the pharmacy recommendations."	C 381		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry 10A NCAC 13G .1206 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: THIS IS A TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to protect residents by not reporting allegations of abuse, neglect, and drug diversion to the Health Care Personnel Registry (HCPR) for the former supervisor-in-charge (Staff B) within 24 hours of becoming aware of an allegations and completing an investigation report within 5 days of the initial notification to HCPR. The findings are: On March 9, 2015, the Adult Care Licensure Section received complaints against Facility #1 and Facility #2 (Clara's Cottage #1 and #2) alleging the following: - Staff A and B (former supervisors-in-charge) for Facility #1 and Facility #2 respectively left the facilities sometime in January, and took 2 residents with them. - Staff A and B diverted resident's medications, including narcotics, and residents did not receive	C 428		

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their medications as ordered by their physicians.
- Staff B duct taped a resident's hands together to keep her from scratching.
- Facility management failed to report these allegations to the Health Care Personnel Registry (HCPR), both the 24 hour and 5 day report.

Interview with the facility Administrator on 3/10/15 at 9:10am revealed:
- Staff A and B had left the facility on 1/15/15 with 2 residents.
- Staff A and B took the 2 residents' records, all their medications, narcotic medications for a resident still residing in Facility #1, and all the medication administration records (MARs) prior to January 2015.

Interview with a law enforcement officer investigating the case on 3/11/15 at 9:13am revealed:
- The investigation was not complete.

- There will be multiple charges on both staff.
- The charges will be related to obtaining controlled substances by fraud.
- Staff A and B would fax a copy of a narcotic order into one pharmacy, and take the other copy to another pharmacy.
- The agent hasn't had a chance to talk to the 2 residents who left the facility with Staff A and B.
- She had no evidence the Administrator was aware of drug diversion in the facility.
- The Administrator seemed to be proactive after the fact in trying to figure out what happened.
- The agent was not certain of the number of doses of narcotic involved at this time, but "it would be safe to say the number of doses of Oxycodone was in the thousands."

Review of a corrective action report (CAR) written

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	FCL012037	A. BUILDING: _____ B. WING _____	R-C 03/13/2015

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CLARA'S COTTAGE # 2	5824 HOLLAND STREET MORGANTON, NC 28655

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C 428	Continued From page 40	C 428		

by the county on 12/9/14 and delivered to the facility on 12/22/14 revealed:
- A Type B Violation was written in the area of health care referral and follow-up.
- A resident stated Staff B duct taped her hands across the tips of her fingers to keep her from scratching.
- Staff B denied she actually duct taped the resident hands, but did threaten to do so if she didn't stop scratching.
- The Administrator was questioned on 12/4/14 about the duct tape incident and stated, "Why would someone duct tape a resident?"

Review of a summary report from Adult Protective Services (APS) dated 1/9/15 concerning the above incident as it related to Staff B revealed:
- Evidence of abuse was found.
- Evidence of neglect was found.

Interview with the Administrator on 3/11/15 at 3:00pm revealed:
- She did not report Staff B to the HCPR for the duct tape incident in December 2014.
- She did not report Staff B to the HCPR for the diversion of controlled medications when Staff B and Staff A left Facilities #1 and #2 on January 15, 2015.
- The Administrator asked the county Adult Home Specialist (AHS) to help her with the HCPR on January 15, 2015 reporting because she was "slammed."
- Staff A had been reported to the HCPR in January 2015 with the help of the AHS.
- She didn't report the incident in December 2014 with Staff B to the HCPR because APS was involved.
- She thought APS would report the incident with Staff B to the HCPR.
- She was unaware of the facility's requirements

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C 428	Continued From page 41 of reporting allegations against health care personnel to the HCPR. Interview with the HCPR registered nurse (RN) on 3/12/15 at 9:10am revealed: - The Administrator was instructed by the HCPR RN in January 2015 to report Staff B within 24 hours. - The HCPR RN provided 24 hour and 5 day forms for reporting health care personnel staff to the Administrator in January 2015. - The HCPR RN was at the facility on 3/3/15 to investigate Staff A, and the Administrator reported Staff B at that time. - On 3/3/15, the HCPR RN assisted the Administrator in completing the 24 hour report for Staff B. _____ On 3/11/15 the facility provided the following plan of correction: - Any persons, whether it be the resident or someone else, regarding an allegation of abuse by a staff member will be reported within 24 hours. - An investigation will be completed within 5 days, with a 5 day report to follow. - All staff will receive inservice training regarding abuse or neglect. - This training will include all resident rights and will be completed within 24 hours of the date of this plan of correction. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 12, 2015.	C 428		

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C 444	Continued From page 42	C 444		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the county department of social services of an incident resulting in emergency evaluation for 1 of 1 resident (Resident #4). The findings are: Review of Resident #4's current FL2 dated 3/10/15 revealed diagnoses included: -acute kidney injury -hypotension -hypokalemia -abnormal urinalysis -serum leukocytosis -stage 2 pressure ulcer of right buttock Interview with the Supervisor In Charge (SIC) on 3/10/15 at 9:10am revealed: -The current facility census was 4 residents. -One resident was currently hospitalized. Review of Resident #4's facility notes revealed: -On 2/28/15, "[Resident #4's name] woke up	C 444		

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perfectly fine this morning. As time progressed she started doing the same thing as yesterday. We checked her blood pressure and it was 80/48. The O2 was 64% then we realized she was holding her breath. Then we retook it and it was 96. She was sent out by medics."

Review of Resident #4's discharge summary dated 3/10/15 revealed:
-Admitted to the hospital on 2/28/15.
-Admitting diagnoses included: hypotension, acute kidney injury, hypokalemia, abnormal urinalysis, serum leukocytosis, and stage 2 pressure ulcers of right buttock.
-The resident presented to the [local hospital emergency department] the afternoon of 2/28/15 due to generalized weakness and falls.
-The resident stated that she had suffered "a couple of accidental falls within the preceding week."
-One of the falls reportedly involved her falling into her closet or against the closet door which resulted in a bruise around her left eye.

Interview with Resident #4 on 3/11/15 at 9:50am revealed:
-"I was feeling bad for 2 to 4 days before I had to go to the hospital."
-"My legs were jerky if I laid down."
-"I wasn't feeling myself."

Review of Resident #4's documentation of fall history revealed:
-Five falls documented from 2/16/15 to 2/27/15.
-1 of 5 falls required emergency medical treatment at the local hospital.

Review of the facility's policy for "Health Care Instructions" signed by each staff member and located in their personnel file revealed:

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C 444	Continued From page 44 -Within 24 hours of the accident, an accident report must be filled out and sent to the Department of Social Services. -The information on the report should include what type of accident, when, where, how the accident occurred and the plan of treatment used. Interview with the SIC on 3/11/15 at 9:20am revealed: -She was unable to find a the Incident and Accident report for Resident #4 for the resident being sent out to local hospital for emergency evaluation due to low blood pressure on 2/28/15. -"I can't recall if I filled one out or not." Telephone interview with the Administrator on 3/13/15 at 9:15am revealed: -"I did tell [SIC's name] she should have done an incident report when [Resident #4 fell and] hurt her eye." -"I did not follow up and make sure [the SIC] had done it."	C 444		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 relevant federal and state laws, rules and regulations	C 912		

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C 912	Continued From page 45 related to health care referral and follow up and health care implementation of orders. The findings are: A. Based on observation, interview, and record review, the facility failed to assure a physician was notified for 2 of 4 sampled residents one with a significant change in condition related to falls and a wound (Resident #4), and another resident with labwork not completed as ordered (Resident #2). [Refer to Tag C 0246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. B. Based on observation, record review, and interview, the facility failed to assure documentation and implementation of physicians order for 1 of 4 sampled residents (Resident #1) including obtaining finger stick blood sugars (FSBS) four times per day and blood pressure checks three times per week. [Refer to Tag C 0249 10A NCAC 13G .0902(c3-4) Health Care (Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure residents were free from physical abuse, neglect, and exploitation by diversion of their controlled medications by failing to report health care personnel (Staff B) to the Health Care Personnel Registry in a timely manner.	C 914		

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C 914	Continued From page 46 The findings are: Based on interviews and record reviews, the facility failed to protect residents by not reporting allegations of abuse, neglect, and drug diversion to the Health Care Personnel Registry (HCPR) for the former supervisor-in-charge (Staff B) within 24 hours of becoming aware of an allegations and completing an investigation report within 5 days of the initial notification to HCPR. [Refer to Tag 428 10A NCAC 13G .1206 Health Care Personnel Registry, (Type A2 Violation.)]	C 914		