STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/CRANE VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/11/15, 03/13/15, and 03/16/15.	D 000		
D 160	10A NCAC 13F .0503 (e) Medication Administration Competency 10A NCAC 13F .0503 Medication Administration Competency (e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. Copies of this form and instructions for its use may be obtained at no cost by contacting the Adult Care Licensure Section, Division of Facility Services, 2708 Mail Service Center, Raleigh, NC 27699-2708. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the Medication Administration Skills Validation was completed for 4 of 4 sampled staff (Staff A, B, C, and D) and was not transferred from one facility to another. The findings are: Observation of the physical plant and review of licensing records revealed: -There were 5 individually licensed facilities on the property.	D 160		

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D 160	Continued From page 1 -All 5 facilities were under the same ownership and management. A. Review of Staff C's personnel records revealed: -Hire date of 11/18/10 as a medication aide. -Medication Administration Skills Validation dated 11/18/10. -The skills validation form had the company name listed but the licensed facility name was not indicated on the form. -Staff C was the full-time supervisor for the facility. Review of the facility staffing schedule revealed Staff C was the medication aide on duty 5 days each week and every night from 7:00 pm until 7:00 am. Staff C was not available for interview regarding the skills validation. Refer to interview on 03/16/15 at 11:59 am with the Administrator. Refer to interviews on 03/11/15, 03/13/15, and 03/16/15 with residents. B. Review of Staff A's personnel records revealed: -Hire date of 08/06/13 as a medication aide. -Medication Administration Skills Validation dated 09/10/13. -The skills validation form had the company name listed but the licensed facility name was not indicated on the form. Review of the facility staffing schedule revealed: -Staff A was the medication aide on duty for 11	D 160		

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days from January 2015 through March 11, 2015.
-Staff A was the medication aide on duty at various times in 2 of the 5 facilities on the property.

Interview on 03/16/15 at 2:00 pm with Staff A revealed:
-She was "fill-in" staff and worked in multiple buildings as needed.
-She was validated by the nurse once in 2013.
-She usually worked in this facility one day each week.

Refer to interview on 03/16/15 at 11:59 am with the Administrator.

Refer to interviews on 03/11/15, 03/13/15, and 03/16/15 with residents.

C. Review of Staff D's personnel records revealed:
-Hire date of 09/01/14 as a medication aide.
-Medication Administration Skills Validation dated 09/18/14.
-The skills validation form had the company name listed but the licensed facility name was not indicated on the form.

Review of the facility staffing schedule revealed:
-Staff D was the medication aide on duty for 7 days from January 2015 through March 11, 2015.
-Staff D was the medication aide on duty at various times in 4 of the 5 facilities on the property.

Interviews on 03/11/15 at 4:20 pm and 03/16/15 at 1:50 pm with Staff D revealed:
-She was "fill-in" staff and worked in multiple buildings as needed.
-She was validated by the nurse once in

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September 2014.
-In September 2014, she was working in another facility on the property and began working in this facility in November 2014.
-She usually worked one day each week in this facility.

Refer to interview on 03/16/15 at 11:59 am with the Administrator.

Refer to interviews on 03/11/15, 03/13/15, and 03/16/15 with residents.

D. Review of Staff B's personnel records revealed:
-Hire date of 07/26/06 as a medication aide.
-Medication Administration Skills Validation dated 07/26/06.
-The skills validation form had the company name listed but the licensed facility name was not indicated on the form.

Review of the facility staffing schedule revealed:
-Staff B was the medication aide on duty for 2 days from January 2015 through March 11, 2015.
-Staff B was the medication aide on duty at various times in 5 of 5 of the facilities on the property.

Interview on 03/16/15 at 4:34 pm with Staff B revealed:
-She was "fill-in" staff and worked in multiple buildings as needed.
-She was validated by the nurse once in 2006.
-She did not recall in which building she was originally validated by the nurse.

Refer to interview on 03/16/15 at 11:59 am with the Administrator.

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D 160	Continued From page 4 Refer to interviews on 03/11/15, 03/13/15, and 03/16/15 with residents. _____ Interview on 03/16/15 at 11:59 am with the Administrator revealed: -All medication aides were competency validated once and one form completed to be used for all 5 facilities on the property. -She was not aware the Medication Aide Skills Validation was nontransferable. -She thought since all the facilities were owned by the same company and located on the same property, only one skills validation was required. Interviews on 03/11/15, 03/13/15, and 03/16/15 with 10 of 12 residents revealed: -They relied on staff to administer their medications. -They had no complaints regarding the administration of their medications. -The medications were administered timely and according to physician orders.	D 160		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff	D 167		

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person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

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

Based on interviews and record reviews, the facility failed to have at least one staff person on the premises at all times who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management.

The findings are:

Observation of the physical plant and review of licensing records revealed:
-There were 5 individually licensed facilities on the property, each facility from 50 to 150 feet from the other four facilities.
-All 5 facilities were under the same ownership and management.

Review of facility staffing schedules revealed there is one staff person scheduled for duty in the facility at any given time.

A. Review of Staff A's personnel records revealed:
-Hire date of 08/06/13 as a medication aide.
-No documentation of current CPR certification.

Review of the facility staffing schedule from 01/01/15 through 03/11/15 revealed Staff A was the only staff on duty in the facility for nine 12-hour shifts and two 6-hour shifts.

Interview on 03/16/15 at 2:00 pm with Staff A

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revealed:
-She was "fill-in" staff and worked in multiple buildings as needed.
-She had been CPR certified in the past but her certification expired in 2012.
-She was the staff person on duty during one occasion when a resident began choking during a meal.
-She instructed another resident to call the supervisor of a sister facility on the property while she performed the Heimlich maneuver.
-By the time the supervisor arrived, Staff A had already cleared the resident's airway and she was breathing normally.
-Staff A stated if a resident required CPR, she would perform CPR until a certified staff person arrived.

Refer to interview on 03/16/15 at 10:52 am and 2:25 pm with the Administrator.

B. Review of Staff D's personnel records revealed:
-Hire date of 09/01/14 as a medication aide.
-No documentation of current CPR certification.
-CPR certification issued 01/09/13 and expired in 01/2015.

Review of the facility staffing schedule from 01/01/15 through 03/11/15 revealed Staff D was the only staff on duty in the facility for seven 12-hour shifts.

Interviews on 03/11/15 at 4:20 pm and 03/16/15 at 1:50 pm with Staff D revealed:
-She was "fill-in" staff and worked in multiple buildings as needed.
-She began working in this facility in November 2014.
-She usually worked one day each week in this

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facility.
-Her CPR certification expired in January of this year.
-She did not know she needed to keep her certification current as long as someone on the property was certified.
-If a resident required CPR or Heimlich maneuver, she would do it anyway because the Good Samaritan Law would protect her.
-No residents had ever required CPR or Heimlich while she was on duty.

Refer to interview on 03/16/15 at 10:52 am and 2:25 pm with the Administrator.

C. Review of Staff B's personnel records revealed:
-Hire date of 07/26/06 as a medication aide.
-No documentation of current CPR certification.

Review of the facility staffing schedule from 01/01/15 through 03/11/15 revealed Staff B was the only staff on duty in the facility for two 6-hour shifts.

Interview on 03/16/15 at 4:34 pm with Staff B revealed:
-She was "fill-in" staff and worked in multiple buildings as needed.
-Her CPR certification expired in October 2014.
-If a resident required CPR or Heimlich, she would tell someone to call 911 while she initiated CPR or Heimlich because a supervisor "probably wouldn't be right there" with her.
-After 911 was called, she would instruct a resident to call the extension for the office to get help.

Refer to interview on 03/16/15 at 10:52 am and 2:25 pm with the Administrator.

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D 167	Continued From page 8 Interviews on 03/16/15 at 10:52 am and 2:25 pm with the Administrator revealed: -She knew she was required to have a CPR-certified staff person on the premises at all times, but thought "premises" meant on the property location for all 5 facilities, and not within each licensed facility. -There was one staff person scheduled in each facility at any given time and she always ensured at least one was CPR-certified in one of the five facilities on the property. -This facility's supervisor was CPR certified and was on duty in the facility from 7:00 am until 7:00 pm five days a week and daily from 7:00 pm until 7:00 am. -If there was an emergency, she would expect the staff person on duty to utilize the telephone intercom system and announce that there was an emergency in that building. -The telephone intercom feature enabled simultaneous announcements in all five facilities as well as the office. -"Everyone" would respond if an emergency was announced over the intercom system. On 03/13/15, the Administrator submitted a Plan of Protection as follows: -Beginning immediately, the Administrator will ensure a CPR-certified staff person will be onsite in the facility at all times. -A CPR class was scheduled this day for 03/19/15 and all staff not currently certified would take the class. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2015.	D 167		

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D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure food and beverages were offered or made available to all residents as snacks between each meal for a total of three snacks per day for 12 of 12 residents residing in the facility. The findings are: Review of the facility's daily posted menu revealed: -There were 3 daily snacks listed on the menu to be served to the residents. -On 03/11/15, the residents should have been served fresh fruit and fruit punch for the morning snack and iced tea and cheese and crackers for the afternoon snack. Observation on 03/11/15 from 7:30 am until 5:30 pm revealed: -There were no snacks served to the residents. -No resident was observed to request a snack. Interviews on 03/11/15, 03/13/15, and 03/16/15 with 12 residents revealed:	D 298		

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-Snacks were not served three times daily.
-The supervisor served snacks "once in a while", "not even once a week", "periodically at night", "maybe once every other week", or "every now and then".
-Three residents reported they were "always hungry".
-One resident stated "we don't get enough to eat".
-Two residents reported weight loss.
-One resident stated she bought her own snacks, which were required to be kept in the kitchen pantry. She could get her snack if she asked before the kitchen was cleaned and the door locked after each meal, because "once she (supervisor) locks that kitchen door, you ain't getting nothing".
-Four residents reported being afraid to ask the supervisor for snacks because she would yell or curse at them.
-One resident stated she had never asked for a snack. "No one asks".
-Another resident, when asked if she ever requested a snack, responded by saying "NO!" and put her finger to her lips indicating to talk quietly. She then stated, "I don't need it (snack)" and stated she takes one only if it is offered to her.
-Two residents reported if they asked for a snack, the supervisor stated, "you don't need nothing right now" or "I don't have time".
-One resident stated, "There ain't no need in asking, I can tell you that".
-Another resident reported her family once sent her a cake in the mail and she was told she had to put it in the dining room. The resident said she was "never invited to have any" and she never asked. She said she did not know what ever happened to the cake.
-On Thursdays and Fridays when the supervisor was off duty, the fill-in staff served snacks twice

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during their shift.
-One resident stated, "When the fill-ins work, we can get whatever we ask for".
-Three of the 12 residents did not know how many snacks were served but reported they got enough to eat.

Review of residents' weight records revealed:
-Seven of 12 residents had documented weight loss ranging from 1 pound to 7.2 pounds from 02/01/15 through 03/01/15, for a total weight loss of 23 pounds; five residents gained weight ranging from 0.6 pounds to 5 pounds.
-Eleven of 12 residents had documented weight loss ranging from 0.2 pounds to 22.2 pounds from 01/01/15 through 02/01/15, for a total weight loss of 45.6 pounds; one resident gained 2 pounds.
-Seven of 12 residents had documented weight loss ranging from 1.4 pounds to 7.4 pounds from 12/01/14 through 01/01/15, for a total weight loss of 22.4 pounds; five residents gained weight ranging from 0.6 pounds to 3.6 pounds.

Additional interviews on 03/16/15 with 5 residents with weight loss revealed:
-One resident stated she did not mind losing weight because she was "too heavy" but would eat 2 or 3 snacks per day if they were offered.
-One resident stated she did not mind losing weight because she has arthritis, but she was not dieting or trying to lose weight. She would probably only eat one snack daily if it was offered.
-One resident stated she did not care if she had lost weight; she was glad because she "was getting too much fluid on" her. She had not been dieting and would routinely eat 1 or 2 snacks daily if they were offered, particularly in the afternoon and at bedtime.
-One resident stated she was on medication that

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made her gain weight so she was glad she had lost weight because she was gaining too much. She had recently been exercising and could now tie her shoes without difficulty. She would eat "maybe 1" snack daily if it was offered because she gets more hungry between supper and bedtime. Fill-in staff worked over the past weekend and served 3 snacks daily; she ate all three snacks both days. There was no more fruit at the present time because "they (residents) ain't used to having it so they done ate it all!".
-One resident stated snacks were served three times daily over the past weekend and she ate all three snacks both days. She stated, "We weren't hungry this weekend". She reported she had lost a lot of weight because she did not like the food being served and could not get an alternate meal or snacks, but recently she started gaining weight again because she "just learned to eat whatever they had whenever they had it".

Interviews on 03/11/15 at 12:13 pm and 4:44 pm with the supervisor parent revealed:
-She had worked at the facility for 4 years.
-She routinely served snacks three times daily "about every other day".
-Some resident had their own snacks, which were kept in the kitchen pantry.
-The residents were not allowed to eat in their rooms; they could eat in the dining room or go outside.
-The residents didn't always eat the snacks when she provided them; "I give peanut butter and crackers and they throw them away".
-No resident had ever asked for food and did not get it.
-It did not surprise her that the residents complained about her because she was "just stern" with them.

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D 298	Continued From page 13 Interviews with one medication aide revealed: -She sometimes worked as a "fill in". -She always served snacks when she worked. -The residents had complained to her that they did not receive snacks when the supervisor was on duty, received small portions of food, and was not allowed to have seconds. Interviews with a second medication aide revealed: -She sometimes worked as a "fill in". -She always served snacks when she worked and kept fruit or cookies out during the shift to be available for residents. -Sometimes residents asked her for snacks and she provided them to the residents. -No residents had ever complained to her about the supervisor but she "heard them talk bad about her between themselves". -She did not know what the residents said about the supervisor when they talked about her between themselves because she "wasn't really listening". Interviews with a third medication aide revealed: -She sometimes worked as a "fill in". -She always served snacks when she worked. -Sometimes she followed the snack menu but sometimes she just asked the residents what they would like to have. -She routinely put out fruit, peanut butter and crackers, coffee, and water to be available for the residents at all times when she was on duty. -No residents had ever complained to her about not receiving snacks when the supervisor was working. Interviews on 03/11/15 at 1:42 pm and 3:44 pm and 03/16/15 at 10:25 am with the Administrator revealed:	D 298		

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D 298	Continued From page 14 -She was not aware snacks were not being served to the residents three times daily. -She thought there was fruit and snacks put out and available for the residents at all times. -Residents could also have their own snacks and were supposed to keep them in a cabinet in the dining room to have whenever they wanted them. -No residents had voiced concerns or complained about being hungry or not having snacks available. -Some residents had lost weight because they were specifically trying to lose. -There was currently no system in place for monitoring to ensure snacks were being served three times daily. -It was the supervisor's responsibility to monitor weights; the Administrator did not review resident weights. -There were no specific parameters for monitoring weight loss because it was individualized for each resident; weight loss in a small resident would be more concerning than the same amount in a larger resident. On 03/16/15, the Administrator submitted a Plan of Protection as follows: -All staff would be instructed prior to their next scheduled shift that snacks were to be available and served three times daily. -The Administrator or designee would conduct random checks to ensure snacks were available and served three times daily. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2015.	D 298		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		

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D 338	Continued From page 15 10A NCAC 13F .0909 Resident Rights 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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure residents were free from mental abuse and neglect for the 12 residents residing in the facility. The findings are: Confidential interviews on 03/11/15 and 03/13/15 with residents revealed: -Eight of 12 residents reported being yelled at and/or cursed at by the supervisor on a regular basis. -Seven of 12 residents reported being afraid of the supervisor and/or afraid to ask the supervisor for anything, such as medications, snacks, and medical follow up. -One resident reported if she asked for some medication for a headache, the supervisor often turned down her request saying, "Wait until the next med pass". -Another resident reported she once asked the supervisor for a pain pill and the supervisor stated, "I'm making up my medicine right now and it's about my break time". The supervisor gave her the medication at the next medication pass and the resident noticed the medication had already been pulled up in a cup, but the resident did not know the supervisor had prepared the medication prior to the medication pass because she was afraid to ask for the medication a second	D 338		

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time.
-Two residents stated the supervisor treated the residents like they were her children.
-Two residents reported hearing the supervisor complaining about cleaning the bathrooms and stated, "I'm not your slave".
-One resident stated when she was incontinent at night, the supervisor said she was "too grown to be peeing in the bed" and embarrassed her "out in public". She stated, "I feel bad when I do it but I don't always remember. I know I'm ___ years old".
-One resident stated the supervisor "calls us smartasses, smart mouth, and lazy".
-Five residents reported being "made" to clean their rooms weekly. Weekly duties included changing the sheets, washing their clothes, mopping the floor and dusting.
-One resident reported another resident was recently sick and vomited. The supervisor "made her clean up her own puke and change her sheets".
-The resident who had been sick stated she cleaned it up because "it was my fault. Staff had me clean it up. I didn't mind doing it".
-One resident stated the supervisor "makes me change my sheets and mop" and if the resident did not do it, she would "get fussed at" or "get cussed out".
-The supervisor "yells" about making up the beds. "She don't do it (make the beds) she makes me do it".
-One resident stated her roommate does her cleaning for her if she does not feel good.
-Another resident reported routinely changing her roommate's sheets weekly and making her bed daily for her because she was unable to do it herself.
-Another resident stated staff won't clean the rooms; "It's our room, we're supposed to do it".

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-"I feel like I should be retired."
-"Fussing and screaming makes you feel bad. That mouth can hurt people."
-"We don't DARE ask her for nothing."
-"The sign says we are supposed to be treated with dignity and respect. Sometimes I feel like calling an activist."
-"She runs all over the old people. She fusses at everybody except (one named resident)."
-One resident reported that on one occasion, she felt like she "blacked out" but did not report it because she tries to just stay to herself. The supervisor had never physically assaulted anyone and "that's the main thing".
-One resident stated the supervisor was "just raising hell all the time".
-"She's a good person but she hates her job and takes it out on us. It could be worse."
-Four of 12 residents reported they had not heard the supervisor yelling or cursing, she was nice to them, and they were not afraid of her.

Additional interviews with residents revealed:
-One resident stated she reported the supervisor's behavior to the Administrator but she "didn't believe it".
-One resident, when asked if she ever reported the supervisor's behavior to management, stated, "NO!" When asked why she had not reported it, the resident stated, "I won't say why".
-Another resident asked, "Who could I report it to? Everybody is on her side."
-Another resident stated, "I've never told on her to (management) because she tells them what she wants and if she wants to get rid of us, she can."
-Another resident stated, "Some people told some stuff. I think it was worth investigating, but..." The resident would not finish the sentence.

Confidential interviews with medication aides

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(MA) revealed:
-Two MAs reported witnessing at least one episode of the supervisor "screaming" at residents.
-On one occasion, a resident was coming out of her room "in just a diaper". The supervisor was at the end of the hallway and yelled, "Get back in your room! Now!! You know you're not supposed to come out like that! Get back in there!" The MA stated she held her hand up toward the supervisor (in a "stop" motion) and said, "I got it". The MA felt the behavior was inappropriate but did not report it to management because that was the only time she had witnessed the behavior herself.
-One MA stated two residents had reported to her "stuff like yelling and cursing" by the supervisor and that she "acts that way all the time". She stated she received reports of the supervisor yelling and cursing "maybe about 5 times a month" for more than 6 months, but she could not report what she heard because she did not know if it was embellished.
-One MA stated she had witnessed the supervisor "rushing them when they're cleaning, yelling at them. A lot." The MA had heard the supervisor yell things at the residents such as, "Get that s___ off the floor", "You know d___ well you're not supposed to do that", "I'm not your slave", and "You're too grown to be peeing in the bed". The MA stated she reported to management that the supervisor had an "attitude" with the residents and was yelling at them.
-One MA stated she frequently encouraged the residents to report the supervisor's behavior to management and they would say they were going to, but then they would "back out" and later told her they were afraid of what would be said to them.
-One MA stated she had personally heard the

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supervisor yell at 10 of the 12 residents in the facility.
-One MA stated the supervisor was inappropriate, demeaning, and embarrassing to the residents.
-One MA stated she had not heard any complaints from residents of staff yelling or cursing, but she had heard the residents "talk bad about her between themselves. She did not know what the residents said about the supervisor when they talked about her between themselves because she "wasn't really listening".

Interview on 03/13/15 at 11:02 am with a family member revealed:
-The resident had reported to her on several occasions that the supervisor was rude to her, yelled at her for no reason, would not give her a snack because she was late, and complained when she was incontinent.
-The family member stated the resident "was not getting help".
-The supervisor once told the family member, "These are grown women; they should be able to clean themselves up".
-On one occasion, the resident called the family member to report she had been sick with vomiting and diarrhea all night. When the family member visited around 2:00 pm, she found the resident "sitting in it (feces) on the side of the bed". There was feces in the bed, on the side of the bed, and on the floor and there were "flies in the diarrhea". The supervisor gave the family member a pair of gloves and stated, "I'm sick as well". The family member cleaned up the resident. The family member stated, "I didn't complain; I just dealt with it".
-The family member stated the resident had been in other places that were worse so, "in comparison, (this facility) is better".

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D 338	Continued From page 20 Interviews on 03/11/15 at 1:42 pm and 3:44 pm and on 03/13/15 at 1:12 pm with the Administrator revealed: -Around February 2015, a MA told the Administrator that two residents had reported the supervisor was yelling at them. -When the Administrator questioned the residents individually, one resident (A) "wouldn't say anything at all" and when asked if the supervisor was mean, replied, "No, she's good to us". The other resident (B) stated, "We just had an argument. I was yelling too". -The Administrator spoke with the supervisor who stated that Resident B was mad because the facility was having to bag everything because of bedbugs. -The Administrator went to the facility and talked to residents to see if there were other complaints but none were voiced; the only complaint she ever heard about was from Resident B, who was "disgruntled quite a bit", but had not reported yelling or cursing to the Administrator. -The Administrator contacted the MA who had reported the complaints to her and told the MA she was "at a loss" and "can't do anything if they won't tell me anything". -The Administrator further stated she offered Resident B the opportunity to move to another facility and she declined the offer. -The facility tried to do staff evaluations at least yearly, so these were done in February after Resident A's conversation with the Administrator. The staff evaluations are an anonymous method for residents to rate, on a 1-5 scale, the staff routinely working in their facility. -In addition to the staff evaluations, there was a suggestion box in the hallway outside the Administrator's office in which residents could put concerns during business hours. Additionally, there were multiple opportunities for residents to	D 338		

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report issues to the Administrator or other staff when they were alone during transport to appointments.
-The Administrator stated since the staff evaluations were good, she felt if there was an issue, it must have been resolved.

Review of the facility staff evaluations dated 02/11/15 revealed:
-There were 6 of 12 evaluations returned to Administration by the residents.
-One of the six evaluations was blank.
-The evaluation scale was as follows: 1=poor, 2=fair, 3=average, 4=good, 5=excellent. Each staff person was rated in the following areas: Respectful, Cleanliness, Meal Preparation, Professional, Medication Accuracy.
-Two of the five evaluations scored every employee as "5" under every category, with one of the evaluations having "5s" in columns and rows where there was no staff person's name or rating category.
-Of the remaining 3 evaluations, the supervisor was scored as follows: Respectful=4, 4, and 5; Cleanliness=4, 5, and 5; Meal Preparation=4, 5, and 5; Professional=4, 4, and 5; Medication Accuracy=4, 5, and 5.

Interview on 03/11/15 at 4:44 pm with the supervisor revealed:
-She had worked at the facility for 4 years.
-It did not surprise her that the residents complained about her because she was "just stern" with them.
-When told there were reports from residents that she complained about cleaning up or when they were incontinent, the supervisor replied, "Well I'll tell them in a minute, 'I'm not your mama'".
-The supervisor stated she felt the way she talked to the residents was appropriate "but it may not

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D 338	Continued From page 22 be". On 03/11/15, the Administrator submitted a Plan of Protection as follows: -The supervisor would be immediately relieved of her duties and would have no further contact with residents. -All staff would be inserviced regarding abuse and reporting procedures prior to their next scheduled shift. -A new form for reporting would be created for reporting abuse allegations. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 15, 2015.	D 338		
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: Based on observations, record reviews, and interviews, the facility failed to assure for 1 of 5 residents (Resident #6) received medications (Actos Plus Metformin 15/850) as ordered by a licensed prescribing practitioner during the noon medication pass on 3/13/15.	D 358		

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D 358	Continued From page 23 The findings are: Review of Resident #6's Resident Register revealed an admission date of 8/4/2003. Review of Resident #6's current FL2 and discharge summary dated 2/27/15 revealed: - Diagnoses including: hypertension, Diabetes Mellitus, mental retardation, and anemia. - Medication order for ferrous sulfate 325 mg (used to treat anemia) 2 times a day. - Medication order for sulfacetamide 10% ophthalmic solution 2 drops 4 times a day. Review of Resident #6's record revealed a physician's order dated 3/11/15 prescribing Actos Plus Metformin 15/850 3 times a day. (Actos Plus Metformin 15/850 is a combination of two medications used to treat diabetes by lowering the amount of sugar in the blood.) Observation on 3/13/5 at 12:00 pm of 12:00 pm (Noon) medication administration by the Supervisor/Medication Aide (S/MA) revealed: - The S/MA referred to Resident #6's Medication Administration Record (MAR) during medication administration. - The S/MA administered one ferrous sulfate 325 mg tablet and 2 drops of sulfacetamide 10% ophthalmic (to the left eye) as scheduled. - She documented administration of ferrous sulfate and sulfacetamide 10% ophthalmic on the MAR. - No Actos Plus Metformin 15/850 was administered. (S/MA) did not document administration of the medication on the MAR. Observation on 3/13/15 at 12:10 pm of Resident #6 ' s medication on hand for administration revealed a prescription bottle of Actos Plus	D 358		

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D 358	Continued From page 24 Metformin 15/850 labeled as dispensed on 3/12/15 for 90 tablets. Review of Resident #6's March 2015 MAR revealed: - Ferrous sulfate 325 mg was listed, scheduled for administration at 12:00 noon and 8:00 pm and documented as administered at 12:00 noon on 3/13/15. - Sulfacetamide 10% ophthalmic was listed, scheduled for administration at 8:00 am, 12:00 noon, 4:00 pm, and 8:00 pm and documented as administered at 12:00 noon on 3/13/15. - Actos Plus Metformin 15/850 was transcribed on the MAR, scheduled to begin at 12:00 pm on 3/13/15, with additional scheduling for 8:00 AM, 12:00 pm, and 8:00 pm. Interview on 3/13/15 at 5:10 pm with the S/MA revealed: - She did not administer Resident #6's Actos Plus Metformin 15/850 because she was not aware the medication had arrived from the resident's pharmacy. - She stated she had been informed by the staff member working the day before her that the medication would be in the facility later on 3/13/15. - She overlooked the medication being available at 12:00 pm on 3/13/15. Interview on 3/13/15 at 5:00 pm with the Administrator revealed: - Medication aide staff were responsible to administer medications as ordered on the MAR. - Staff should monitor medications closely when new orders were entered on the MAR and awaiting delivery from the pharmacy. - The Administrator relied on the staff to administer medications as ordered.	D 358		

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D 358	Continued From page 25 Based on record review and observation on 3/13/15, it was determined Resident #6 was unable to provide reliable information.	D 358		
D 360	10A NCAC 13F .1004 (c) Medication Administration 10A NCAC 13F .1004 MedicationAdministration (c) Only oral solid medications that are ordered for routine administration may be prepared in advance and must be prepared within 24 hours of the prescribed time for administration. Medications prescribed for prn (as needed) administration shall not be prepared in advance. This Rule is not met as evidenced by: Based on observations, interviews, and resident record reviews, the facility failed to assure solid medications that were ordered for routine administration were prepared no more than 24 hours in advance for 4 of 4 sampled residents (Residents # 1, #2, #3 and #6). The findings are: Based on observation and interview with the Supervisor/Medication Aide (S/MA) on 3/13/15 at 8:30 am, the facility had 12 residents residing in the home. Interview on 3/13/15 at 12:10 pm with S/MA revealed: - She was filling in at this building due to recent staff turnover.	D 360		

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D 360	Continued From page 26 - The medication aides routinely administered medications that had been prepared in advance (pre-poured). - She did not prepare the medications that were in the jars, including the medications she was administering today. - The medications were prepared by the supervisor (staff member that lived at the facility and was on duty 24 hours a day for all but 2 or 3 days each week). - She had been employed by the facilty owner and worked as a fill in staff at this and sister facility located in the cluster of homes, for almost 2 years. - She was not aware medications that were prepared in advance could not be prepared more than 24 hours ahead of time. - She stated no control medications, as needed medications (prns), or liquids were pre-poured. - She stated the supervisor routinely worked 5 days, and off 2 days. - The supervisor routinely prepared the medication in advance for the 2 days she was off and left the medications in the trays labeled by time of day and resident. - The S/MA stated she used the resident's Medication Administration Record (MAR) document administration of medications and to verify the medications for the number of medications each resident should be receiving, administer any control drugs, prn, liquids, drops, or topicals. - She stated the medications prepared in advance sometimes presented a problem when medications were discontinued or changed because identifying the medications was sometimes hard. - She stated she was trained on the facility's system for pre-pouring when she first started working by one of the supervisors and checked	D 360		

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D 360	Continued From page 27 off as medication aide by a facility contract nurse. - She stated she routinely logged the medication on another MAR sheet used by the person preparing the medications: she had prepared at 2 to 5 days worth of medications for residents in another sister facility but not at this facility. - She was not aware of a written policy for pre-pouring medications, only what she was taught when she started working at the facility. Observation on 3/13/15 at 12:10 pm into the locked medication room during medication administration by the Supervisor/Medication Aide (S/MA) revealed: - Four shelves on the right side of a counter top with one shelf labeled for breakfast, noon, supper, and bedtime. - Sitting on each shelf was a metal tray (muffin pan) with 12 holders molded in the tray. - Many of the holders contained a white plastic 4 ounce screw cap jar (ointment jar). - The cap of the jars were labeled with a resident's name and time of administration. - The outside of most (but not all) of the plastic container contained a label with the name of a resident, birth date, and facility name typed on the label. (In the bedtime tray, one plastic jar had the name of a current resident on the top of the jar but the jar was labeled for a former resident along with a list of medications for the former resident, and one jar had a current resident's name on top but no name or list of medications on the jar.) - In addition, a list of medications with the quantity of each was printed on the outside of the container. - Inside several of the 4 ounce plastic screw cap jars were paper souffle cups containing one or several oral dosage forms of medications. - Some jars had from 2 to 4 souffle cups stacked one on top of the other.	D 360		

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D 360	Continued From page 28 A. Review of Resident #6's Resident Register revealed an admission date of 8/4/2003. Review of Resident #6's current FL2 and discharge summary dated 2/27/15 revealed: - Diagnoses including: hypertension, Diabetes Mellitus, mental retardation, and anemia. Review of Resident #6's current FL2 dated 2/27/15 revealed medication orders as follows: - Aspirin 81 mg EC daily (used to help circulation). - Atorvastatin 80 mg daily (used to treat high cholesterol). - Calcium Carbonate-Vitamin D 2 tablets daily (used to treat calcium deficiency). - Cetirizine 10 mg daily (used to treat allergies). - Divalproex 250 mg 24 hour tablet daily (used to treat seizure disorders). - Ferrous sulfate 325 mg 2 times a day (used to treat anemia). - Multiple vitamins with Iron daily at bedtime (used to treat vitamin deficiencies). - Omeprazole 40 mg daily (used to treat acid reflux). - Risperidone 1 mg one tablet at bedtime daily (used to treat mental disorders).. - Solifenacin 5 mg mg tablet take 10 mg daily (used to treat high blood pressure). Review of Resident #6's record revealed a physician's order dated 3/11/15 prescribing Actos Plus Metformin 15/850 3 times a day. (Actos Plus Metformin 15/850 is a combination of two medications used to treat diabetes by lowering the amount of sugar in the blood.) Review of Resident #6's record revealed no documentation for a log recording when	D 360		

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pre-poured medications were packaged.

Observation on 3/13/5 at 12:00 pm of 12:00 pm (Noon) medication administration by the Supervisor/Medication Aide (S/MA) revealed:
- The S/MA referred to Resident #6's Medication Administration Record (MAR) during medication administration.
- The S/MA removed a 4 ounces screw cap white plastic jar from the tray labeled 12:00 Noon in the medication room.
- The jar was labeled with Resident #6's name on top and ferrous sulfate 325mg on the outside.
- When the lid was unscrewed, the jar contained 2 paper souffle cups, stacked one inside the other, with no cover on each individual cup.
- She removed one souffle cup containing one ferrous sulfate 325 mg tablet, screwed the lid back on the jar, and returned the jar to the tray.

Observation on 3/13/15 at 3:30 pm of the 3 remaining trays revealed Resident #6 had medications in a jar labeled with the resident's name on top and time of day as follows:
- Breakfast tray (8:00 am)- one souffle cup in jar label for the resident containing one capsule.
- Supper tray (5:00 pm)- No medications scheduled.
- Bedtime tray (8:00 pm)- one souffle cup containing 6 tablets (not including Actos Plus Metformin for diabetes ordered 3/11/15).

Based on record review and observation on 3/13/15, it was determined Resident #6 was unable to provide reliable information.

Refer to interview on 3/13/15 at 5:00 pm with the Administrator.

B. Review of Resident #2's Resident Register

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revealed an admission date of 2/16/2012.

Review of Resident #2's current FL2 and dated 2/18/15 revealed diagnoses including Schizoaffective Disorder Bipolar Type, hypertension, personality disorder, obesity anemia, history of insomnia, and hyperlipidemia.

Review of the 2/18/15 FL2 revealed medications ordered including:
- Ferrous Sulfate 325 mg daily (for anemia).
- Furosemide 20 mg daily (for fluid and high blood pressure).
- Loratadine 10 mg daily (for allergies).
- Cozaar 1000 mg daily (for high blood pressure).
- Mobic 7.5 mg one daily (for pain).
- Potassium Chloride 20 milli-equivalents daily (for potassium supplement).
- Inderal LA 120 mg daily (for high blood pressure).
- Detrol LA 4 mg daily (for overactive bladder).
- Vitamin E 400 international units twice a day (for vitamin supplement).
- Cogentin 1 mg 3 times a day (for twitching movements).
- Thorazine 100 mg 3 times a day (for mental disorders).
- Norvasc 5 mg daily (for high blood pressure).
- Lipitor 20 mg daily (for high cholesterol).
- Depakote ER 500 mg 2 tablets at bedtime (for mental disorders).
- Mysoline 50 mg 2 tablets at bedtime (for seizures or some mental disorders).
- Artane 2 mg at bedtime (for mental disorders).

Record review revealed a physician's order dated 3/11/15 prescribing Sinemet 10/100 take one-half tablet 3 times a day.

Review of Resident #2's record revealed no

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documentation for a log recording when pre-poured medications were packaged.

Observation on 3/13/5 at 12:00 pm of 12:00 pm (Noon) medication administration by the Supervisor/Medication Aide (S/MA) revealed:
- The S/MA referred to Resident #2's Medication Administration Record (MAR) during medication administration..
- S/MA pulled a souffle cup from the Noon tray with no resident name or name of the medication containing one-half tablet that she identified as Resident #2's new medication.
- She also located a 4 ounces plastic screw lid jar from a basket in the medication room, removed a label with another resident's name and the label on the outside of the jar, and stated she needed to make a new jar for the Noon medication since the resident had not had a medication previously scheduled for this time a day.
- S/MA administered the one-half tablet of Sinemet 10/100 to Resident #2 and documented on the resident's March 2015 MAR.

Observation on 3/13/15 at 3:30 pm of the 3 remaining trays revealed Resident #2 had medications in a jar labeled with the resident's name on top and time of day as follows:
- Breakfast tray (8:00 am)- no medications in jar.
- Supper tray (5:00 pm)- 4 souffle cups, each containing the same 3 tablets, stacked on top of each other with no cover for the individual cups.
- Bedtime tray (8:00 pm)- one souffle cup containing 9 tablets.

Interview on 3/16/15 at 5:05 pm with Resident #2 revealed she "did not know" when staff prepared her medication stating "she coulda [could have] done that anytime".

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Refer to interview on 3/13/15 at 5:00 pm with the Administrator.

C. Review of Resident #1's Resident Register revealed an admission date of 7/03/2012.

Review of Resident #1's current FL2 dated 5/09/14 revealed diagnoses including irritable bowel syndrome, headaches, anxiety, Bipolar Disorder, asthma, and back pain.

Review of Resident #1 current signed physician's order dated 2/09/15 revealed medications ordered included:
- Meloxican 15 mg daily with food and water (for pain).
- Seroquel XR 200 mg every evening (for mental disorders).
- Lorazepam 0.5 mg twice a day (for anxiety).
- Ranitidine 150 mg twice a day (for acid reflux).
- Dicyclomine 10 mg one before meals and at bedtime (for irritable bowel).
- Pro Air 90 mcg per actuation inhaler 2 puffs 4 times a day (for asthma).
- Topiramate 50 mg 2 tablets at bedtime (for headaches).

Observation on 3/13/5 at 12:03 pm of 12:00 pm (Noon) medication administration by the Supervisor/Medication Aide (S/MA) revealed:
- The S/MA referred to Resident #1's Medication Administration Record (MAR) during medication administration.
- The S/MA removed a 4 ounces screw cap white plastic jar from the tray labeled 12:00 Noon in the medication room.
- The jar was labeled with Resident #1's name on top and dicyclomine 10 mg.
- She removed one souffle cup containing one dicyclomine 10 mg capsule, screwed the lid back

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on the jar, and returned the jar to the tray.

Observation on 3/13/15 at 3:30 pm of the 3 remaining trays revealed Resident #1 had medications in a jar labeled with the resident's name on top and time of day as follows:
- Breakfast tray (8:00 am)- no medications in jar.
- Supper tray (5:00 pm)- 2 souffle cups each containing 2 tablets (same in each cup), stacked one inside the other with no cover for the individual souffle cups..
- Bedtime tray (8:00 pm)- one souffle cup containing 4 tablets.

Review of Resident #1's record revealed no documentation for a log recording when pre-poured medications were prepared.

Interview on 3/16/15 at 5:05 pm with Resident #1 revealed she did not know when or how the medication aide prepared her medications for administration.

Refer to interview on 3/13/15 at 5:00 pm with the Administrator.

D. Review of Resident #3's Resident Register revealed an admission date of 2/15/2013.

Review of Resident #3's current FL2 dated 02/12/15 revealed diagnoses including hyperglycemia, hypertension, acute renal failure, anemia, systolic heart failure, insulin dependant diabetes, hepatitis C, and chronic pancreatitis.

Review of Resident #3's current FL2 dated 2/12/15 revealed medications ordered included:
- Aspirin EC 81 mg daily (for blood circulation).
- Bumetanide 2 mg daily (for excess fluid in the body).

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- Cymbalta 20 mg 3 capsules daily (for mental disorders).
- Levothyroxine 50 mcg daily (for thyroid replacement).
- Omeprazole DR 20 mg every morning (for acid reflux).
- Vitamin D 2000 international units daily (for vitamin supplement).
- Coreg 25 mg two times a day (for high blood pressure); changed to 12.5 mg on prescription order 2/12/15.
- Docusate Sodium 100 mg two times a day (for constipation).
- Mag-Oxide 400 mg two times a day (for magnesium supplement).
- Creon DR 12,000 units 2 capsules 3 times a day, with meals (for digestive disorders).
- Lyrica 150 mg 3 times a day (for pain).
- Imdur 120 mg at bedtime (for heart disease).
- Lisinopril 5 mg at bedtime (for high blood pressure).
-Melatonin SR 3 mg at bedtime (for sleep).
- Trazadone 150 mg at bedtime (for depression).

Review of Resident #3's record revealed a physician's order dated 3/9/15 for prednisone 10 mg taper one tablet 3 times a day for 3 days, then one tablet 2 times a day for 2 days, then one tablet daily for 2 days. (Prednisone is a steroid use to treat various abnormalities).

Review of Resident #3's record revealed a physician's order dated 3/9/15 prescribing levofloxacin 500 mg daily for 10 days.

Observation on 3/13/15 at 3:30 pm of the 4 trays in the medication room revealed Resident #3 had medications in a jar labeled with the resident's name on top and time of day as follows:
- Breakfast tray (8:00 am)- one souffle cup

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containing 13 medications in jar.
- Lunch tray (12:00 pm-Noon)- no medication in the jar.
- Supper tray (5:00 pm)- 2 souffle cups, the one on top containing 4 tablets, and the second one containing 3 tablets (not including a prednisone 10 mg tablet) stacked one inside the other with no cover for the individual souffle cups.
- Bedtime tray (8:00 pm)- two souffle cups, each containing 8 tablets, stacked one inside the other with no cover for the individual souffle cups.

Review of Resident #3's record revealed no documentation for a log recording when pre-poured medications were prepared.

Interview on 3/16/15 at 5:08 pm with Resident #3 revealed she was uncertain when her medications were prepared but she stated "I think she fixed them up every night".

Refer to interview on 3/13/15 at 5:00 pm with the Administrator.

_____

Interview on 3/13/15 at 5:00 pm with the Administrator revealed:
- The facility had a policy for pre-pouring medications that conformed to rules for pre-pouring.
- Medication Aide (MA) staff were supposed to be trained on the policy when they came to the facility by medication aides already working at the facility.
- Staff were trained to pre-pour medications no more than 24 hours in advance.
- The facility had a copy of the MAR for documenting the medications pre-poured and by the staff person preparing the medication.
- She was not aware staff were pre-pouring medications more than 24 hours and not

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D 360	Continued From page 36 documenting the preparation on the appropriately. - She did not currently have a system in place to monitor the pre-pouring of medications.	D 360		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	D 363		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept enclosed in a sealed container that identified the name and strength of each medication prepared and the resident's name for 3 of 5 residents (Residents #1, #2 and #6) observed during the noon (12:00 pm) medication pass and 1 sampled resident (Resident #3).

The findings are:

Refer to Tag D 0360 10A NCAC 13F .1004(c).
Based on observations, interviews, and resident record reviews, the facility failed to assure solid medications that were ordered for routine administration were prepared no more than 24 hours in advance for 4 of 4 sampled residents (Residents # 1, #2, #3 and #6).

A. Review of Resident #6's Resident Register revealed an admission date of 8/4/2003.

Review of Resident #6's current FL2 and discharge summary dated 2/27/15 revealed:
- Diagnoses including: hypertension, Diabetes Mellitus, mental retardation, and anemia.

Review of Resident #6's March 2015 Medication Administration Record (MAR) revealed:
- Aspirin 81 mg EC daily scheduled for 8:00 am.
- Atorvastatin 80 mg daily scheduled for 8:00 pm.
- Calcium Carbonate-Vitamin D 2 tablets daily scheduled for 8:00 am.
- Cetirizine 10 mg daily scheduled for 8:00 pm.
- Divalproex 250 mg 24 hour tablet daily scheduled for 8:00 pm.

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D 363	Continued From page 38 - Ferrous sulfate 325 mg 2 times a day scheduled for 12:00 pm and 8:00 pm.. - Multiple vitamins with Iron daily at bedtime scheduled for 8:00 pm. - Omeprazole 40 mg daily scheduled for 7:00 am. - Risperidone 1 mg one tablet at bedtime daily scheduled for 8:00 pm. - Solifenacin 5 mg mg tablet take 10 mg daily scheduled for 8:00 am. Review of Resident #6's record revealed a physician's order dated 3/11/15 prescribing Actos Plus Metformin 15/850 one 3 times a day scheduled for 8:00 am, 12:00 pm and 8:00 pm. Observation on 3/13/15 at 3:30 pm of the 3 remaining trays revealed Resident #6 had medications in a jar labeled with the resident's name on top and time of day as follows: - Breakfast tray (8:00 am)- one souffle cup in jar label for the resident containing one omeprazole 40 mg capsule. - Supper tray (5:00 pm)- No medications scheduled. - Bedtime tray (8:00 pm)- one souffle cup containing 6 tablets (One each of atorvastatin 80 mg, daily vitamin with iron, divalproex 250 mg 24 hour tablet, risperidol 1 mg, cetirizine 10 mg, and ferrous sulfate 325 mg). Continued observation of the 4 ounces screw cap plastic jars labeled with Resident #6's name and the bedtime (8:00 pm) administration on the lid revealed the jar was labeled to contain Actos Plus Metformin 15/850 but it was not included in the container. Refer to interview on 3/16/15 at 12:00 pm with a Medication Aide.	D 363		

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D 363	Continued From page 39 B. Review of Resident #2's current FL2 and dated 2/18/15 revealed diagnoses including Schizoaffective Disorder Bipolar Type, hypertension, personality disorder, obesity anemia, history of insomnia, and hyperlipidemia. Review of Resident #2's March 2015 MAR revealed: - Ferrous Sulfate 325 mg daily scheduled for 8:00 am. - Furosemide 20 mg daily scheduled for 8:00 am. - Loratadine 10 mg daily scheduled for 8:00 am. - Cozaar 1000 mg daily scheduled for 8:00 am. - Mobic 7.5 mg one daily scheduled for 8:00 am. - Potassium Chloride 20 milli-equivalents daily scheduled for 8:00 am. - Inderal LA 120 mg daily scheduled for 8:00 am. - Detrol LA 4 mg daily scheduled for 8:00 am. - Vitamin E 400 international units twice a day scheduled for 8:00 am. - Cogentin 1 mg 3 times a day scheduled for 8:00 am, 5:00 pm, and 8:00 pm. - Thorazine 100 mg 3 times a day 8:00 am, 5:00 pm, and 8:00 pm. - Norvasc 5 mg daily scheduled for 5 pm. - Lipitor 20 mg daily scheduled for 8:00 pm. - Depakote ER 500 mg 2 tablets at bedtime scheduled for 8:00 pm. - Mysoline 50 mg 2 tablets at bedtime scheduled for 8:00 pm. - Artane 2 mg at bedtime scheduled for 8:00 pm. - Sinemet 10/100 take one-half tablet 3 times a day scheduled for 8:00 am, 12:00 pm and 8:00 pm. Observation on 3/13/15 at 3:30 pm of 3 medication trays revealed Resident #2 had medications in a jar labeled with the resident's name on top and time of day as follows: - Breakfast tray (8:00 am)- no medications in jar.	D 363		

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D 363	Continued From page 40 - Supper tray (5:00 pm)- 4 souffle cups, each containing the same 3 tablets,(Thorazine 100 mg, Norvasc 5 mg, and Cogentin 1 mg), stacked on top of each other with no cover for the individual cups. - Bedtime tray (8:00 pm)- one souffle cup containing 8 and one-half tablets. (Thorazine 100 mg, Depakote ER 500- 2 tablets, Sinemet 10/100 one-half tablet, Vitamin E 400, Mysoline 50 mg 2 tablets, Cogentin 1 mg, and Artane 2 mg.) Observation of Resident #2's medication container in the tray labeled for Supper (5:00 pm) revealed the label on the container listed Norvasc 5 mg and Cogentin 1 mg. Observation of Resident #2's medication container in the tray labeled for bedtime revealed the label one the container listed the following: - Lisinopril 40 mg - Cogentin 1 mg - Thorazine 100 mg - Depakote 1 gm. Based one the observation and medication review, the bedtime container was not labeled for Sinemet 10/100 one-half tablet, Vitamin E 400, and Mysoline 50 mg 2 tablets pre-poured in the container. Refer to interview on 3/16/15 at 12:00 pm with a Medication Aide. C. Review of Resident #1's current FL2 dated 5/09/14 revealed diagnoses including irritable bowel syndrome, headaches, anxiety, Bipolar Disorder, asthma, and back pain. Review of Resident #1's March 2015 MAR revealed:	D 363		

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D 363	Continued From page 41 - Meloxican 15 mg daily with food and water was scheduled for 8:00 am. - Seroquel XR 200 mg every evening was scheduled at 5:00 pm. - Lorazepam 0.5 mg twice a day was scheduled for 8:00 am and 8:00 pm. - Ranitidine 150 mg twice a day was scheduled for 8:00 am and 8:00 pm. - Dicyclomine 10 mg one before meals and at bedtime was scheduled for 7:00 am, 11:30 am, 4:30 pm and 8:00 pm. - Topiramate 50 mg 2 tablets at bedtime was scheduled for 8:00 pm. Observation on 3/13/15 at 3:30 pm of the 3 remaining trays revealed Resident #1 had medications in a jar labeled with the resident's name on top and time of day as follows: - Breakfast tray (8:00 am)- no medications in jar. - Supper tray (5:00 pm)- 2 souffle cups each containing 2 tablets (Seroquel XR 200mg and Dicyclomine 10 mg), stacked one inside the other with no cover for the individual souffle cups. - Bedtime tray (8:00 pm)- one souffle cup containing 4 tablets. (Dicyclomine 10 mg, ranitidine 150 mg, and topiramate 50 mg 2 tablets.) Observation of Resident #1's medication container in the tray labeled for Supper (5:00 pm) revealed the label on the container listed Seroquel 50 mg and Dicyclomine 10 mg. Observation of Resident #1's medication container in the tray labeled for bedtime revealed the label on the container listed the following: - Ativan 0.5 mg (lorazepam) - Zantac 150 mg (ranitidine) - Dicyclomine 10 mg - Topamax 100 mg (topiramate).	D 363		

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D 363	Continued From page 42 Based one the observation and medication review, the container was not labeled for the medications contained in the cup. Refer to interview on 3/16/15 at 12:00 pm with a Medication Aide. D. Review of Resident #3's current FL2 dated 02/12/15 revealed diagnoses including hyperglycemia, hypertension, acute renal failure, anemia, systolic heart failure, insulin dependant diabetes, hepatitis C, and chronic pancreatitis. Review of Resident #3's March 2015 MAR revealed: - Aspirin EC 81 mg daily was scheduled for 8:00 am. - Bumetanide 2 mg daily was scheduled for 8:00 am. - Cymbalta 20 mg 3 capsules daily was scheduled for 8:00 am. - Levothyroxine 50 mcg daily was scheduled for 7:00 am. - Omeprazole DR 20 mg every morning was scheduled for 7:00 am. - Vitamin D 2000 international units daily was scheduled for 8:00 am. - Coreg 12.5 mg two times a day was scheduled for 8:00 am and 8:00 pm. - Docusate Sodium 100 mg two times a day was scheduled for 8:00 am and 8:00 pm. - Mag-Oxide 400 mg two times a day was scheduled for 8:00 am and 8:00 pm. - Creon DR 12,000 units 2 capsules 3 times a day, with meals was scheduled for 7:30 am, 12:00 pm, and 5:00 pm. - Lyrica 150 mg 3 times was scheduled for 8:00 am, 2:00 pm, and 8:00 pm. - Imdur 120 mg at bedtime was scheduled for	D 363		

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8:00 pm.
- Lisinopril 5 mg at bedtime was scheduled for 8:00 pm.
-Melatonin SR 3 mg at bedtime was scheduled for 8:00 pm.
- Trazadone 150 mg at bedtime was scheduled for 8:00 pm.
- Prednisone 10 mg taper one tablet 3 times a day for 3 days, then one tablet 2 times a day for 2 days, then one tablet daily for 2 days scheduled for 8:00 am and 8:00 pm on 3/13/15.
- Levofloxacin 500 mg daily scheduled for 8:00 pm from 3/09/15 to 3/18/15.

Observation on 3/13/15 at 3:30 pm of the 4 trays in the medication room revealed Resident #3 had medications in a jar labeled with the resident's name on top and time of day as follows:
- Breakfast tray (8:00 am)- one souffle cup containing 13 medications in jar.(Levothyroxine 50 mcg, Creon 12,000 units 2 capsules, Cymbalta 30 mg 3 capsules, Vitamin D 2000 IU, Omeprazole 20 mg, Aspirin 81 mg EC, Docusate 100 mg, Mag-Oxide 400 mg, Coreg 25 mg, Bumetanide 2 mg, and prednisone 10 mg.
- Lunch tray (12:00 pm-Noon)- no medication in the jar.
- Supper tray (5:00 pm)- 2 souffle cups, the one on top containing 4 tablets (Creon 12,000 units 2 capsules, Coreg 12.5 mg, and prednisone 10 mg) and the second one containing 3 tablets (Creon 12,000 units 2 capsules, and Coreg 12.5 mg,) stacked one inside the other with no cover for the individual souffle cups.
- Bedtime tray (8:00 pm)- two souffle cups, each containing 8 tablets (Lisinopril 5 mg, Imdur 120 mg, docusate 100 mg, Mag-Oxide 400 mg, Melatonin SR 3 mg, Trazadone 150 mg, levofloxacin 500mg, and prednisone 10 mg.) stacked one inside the other with no cover for the

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D 363	Continued From page 44 individual souffle cups. Observation of Resident #3's medication container in the tray labeled for Breakfast (8:00 am) revealed the label on the container listed the following: - Aspirin 81 mg, - Bumex 2 mg, - Omeprazole 20 mg, - Elavil 50 mg, - Coreg 25 mg, - Docusate Sodium 100 mg, - Mag-Oxide 400 mg, - Creon 24,000 units, - Lyrica 150 mg (controlled and cannot be prepoured). Observation of Resident #3's medication container in the tray labeled for Supper (5:00 pm) revealed the label on the container listed the following: - Coreg 25 mg, - Creon 24,000 units, - Lyrica 150 mg. Observation of Resident #3's medication container in the tray labeled for bedtime revealed no label on the container listed the medications. Based one the observation and medication review, the containers were not labeled for the medications contained in the cup. Refer to interview on 3/16/15 at 12:00 pm with a Medication Aide. _____ Interview on 3/16/15 at 12:00 pm with a Medication Aide revealed: - She had recently been assigned to assist the Administrator for comparing the resident's orders	D 363		

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D 363	Continued From page 45 and MARs to the containers to verify the accuracy of the medication labels for the resident's jars. - She stated the facility had started the pre-pouring about a year ago. - She stated staff were supposed to prepare only 24 hours ahead of time and log on the pre-pour log when they prepared the medications. - She stated she had not had a chance to audit the pre-pour containers for the facility as of yet.	D 363		
D 365	10A NCAC 13F .1004 (h) Medication Administration 10A NCAC 13F .1004 Medication Administration (h) If medications are not prepared and administered by the same staff person, there shall be documentation for each dose of medication prepared for administration by the staff person who prepared the medications when or at the time the resident's medication is prepared. Procedures shall be established and implemented to identify the staff person who prepared the medication and the staff person who administered the medication. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure procedures were in place to identify the staff person preparing medications and the staff person administering medications when the tasks were performed by a different person. The findings are: Refer to Tag D 0360 10A NCAC 13F .1004(c).	D 365		

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D 365	Continued From page 46 Based on observations, interviews, and resident record reviews, the facility failed to assure solid medications that were ordered for routine administration were prepared no more than 24 hours in advance for 4 of 4 sampled residents (Residents # 1, #2, #3 and #6). Interview on 3/13/15 at 12:10 pm with Supervisor/Medication Aide (S/MA) revealed: - She was filling in at this building due to recent staff turnover. - The medication aides routinely administered medications that had been prepared in advance (pre-poured). - She did not prepare the medications that were in the jars, including the medications she was administering today. - The medications were prepared by the former S/MA (staff member that lived at the facility and was on duty 24 hours a day for all but 2 or 3 days each week). - She had been employed by the facilty owner and worked as a fill in staff at this and sister facility located in the cluster of homes, for almost 2 years. - She was not aware medications that were prepared in advance could not be prepared more than 24 hours ahead of time. - She stated no control medications, as needed medications (prns), or liquids were pre-poured. - She stated the previous S/MA routinely worked 5 days, and off 2 days. - The previous Supervisor/Medication Aide routinely prepared the medication in advance for the 2 days she was off and left the medications in the trays labeled by time of day and resident. - The S/MA stated she used the residents' Medication Administration Record (MAR) document administration of medications and to verify the medications for the number of	D 365		

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medications each resident should be receiving, administer any control drugs, prn, liquids, drops, or topicals.
- She stated the medications prepared in advance sometimes presented a problem when medications were discontinued or changed because identifying the medications was sometimes hard.
- She stated she was trained on the facility's system for pre-pouring when she first started working by one of the other S/MA and checked off as medication aide by a facility contract nurse.
- She stated she routinely logged the medication on another MAR sheet used by the person preparing the medications: she had prepared at 2 to 5 days worth of medications for residents in another sister facility but not at this facility.
- She was not aware of a written policy for pre-pouring medications, only what she was taught when she started working at the facility.

Interview on 3/16/15 at 12:00 pm with a Medication Aide revealed:
- She had recently been assigned to assist the Administrator for comparing the resident's orders and MARs to the containers to verify the accuracy of the medication labels for the resident's jars.
- She stated the facility had started the pre-pouring about a year ago.
- She stated staff were supposed to prepare only 24 hours ahead of time and log on the pre-pour log when they prepared the medications.
- She stated she had not had a chance to audit the pre-pour containers for the facility as of yet.

Interview on 3/13/15 at 5:00 pm with the Administrator revealed:
- The facility had been using the system for pre-pouring resident's medications for approximately one year.

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D 365	Continued From page 48 - The facility had a policy for pre-pouring medications that conformed to rules for pre-pouring. - Medication Aide (MA) staff were supposed to be trained on the policy when they came to the facility by medication aides already working at the facility. - Staff were trained to pre-pour medications no more than 24 hours in advance. - The facility had a copy of the MAR for documenting the medications pre-poured and by the staff person preparing the medication. - She was not aware staff were pre-pouring medications more than 24 hours and not documenting the preparation on the appropriately. - She did not currently have a system in place to monitor the pre-pouring of medications.	D 365		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding snacks and cardiopulmonary resuscitation requirements. The findings are:	D912		

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D912	Continued From page 49 A. Based on interviews and record reviews, the facility failed to have at least one staff person on the premises at all times who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management. [Refer to Tag 167, 10A NCAC 13F .0507 (Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to ensure food and beverages were offered or made available to all residents as snacks between each meal for a total of three snacks per day for 12 of 12 residents residing in the facility. [Refer to Tag 298, 10A NCAC 13F .0904(d)(2) (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents were free of mental abuse. The findings are: Based on interviews and record reviews, the facility failed to ensure residents were free from mental abuse and neglect for the 12 residents residing in the facility. [Refer to Tag 338, 10A NCAC 13F .0909 (Type A2 Violation).]	D914		