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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, follow-up survey, and complaint investigation survey on April 15 - 17, 2015.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews and review of records, the facility failed to provide supervision in accordance with each resident's assessed needs for 1 of 4 sampled residents(Resident #4) who had a history of being found on the floor or had falls with injuries. The findings are: Review of Resident #4's current FL-2 dated 02/11/15 revealed: -Diagnoses included Alzheimer's dementia, hypertension, depression and schizophrenia. -Constantly disoriented, ambulatory, considered a "wanderer" and incontinent of both bowel and bladder. Review of Resident #4's care plan dated 04/07/15 revealed: -Resident #4 has "mental illness, wanders, and has limited ambulatory ability". -Resident #4's had "significant loss of memory	D 270		

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and must be directed" and is "always disoriented".
-Resident #4 required "limited assistance with transfers and ambulation".

Observation and attempted interview on 04/15/15 at 11:04 AM of Resident #4 revealed:
-Resident was in a semi-private room without a roommate on the memory care unit.
-Resident was resting in the bed closest to the bathroom and hallway door.
-Resident was sleeping soundly; it took several attempts speaking with increasing volume before Resident responded.
-When asked specific questions, Resident would only mumble in response.
-The Resident was observed wearing a hospital band dated 04/13/15 on his wrist.

Observation of Resident #4 on 04/16/2015 at 12 noon during the lunch meal revealed:
-Resident #4 got up from the dining room table.
-A staff member asked Resident #4 if he had finished eating the meal.
-Resident #4 let the staff member know he had finished the lunch meal.
-The staff member walked out of the dining room in front of Resident #4.
-Resident #4 approached the dining room door, Resident #4 stumbled to the left and grabbed onto the divider frame located in the center of the dining room doors.
-Another staff member sitting at a table feeding a different resident noticed Resident #4 stumble and stated "I thought he was gonna fall."
-The staff member did not attempt to assist Resident #4 with ambulation back to his room.

Review of Care Notes for Resident #4 from 09/26/14(date of admission) to 04/14/15 revealed:
-There were 17 occasions that Resident #4 had

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D 270	Continued From page 2 either fallen or "was found on floor": 10/18/14, 10/25/14, 10/30/14, 11/22/14(8:30 PM), 11/22/14(9:30 PM), 12/01/15, 12/07/15, 12/15/15, 12/28/15, 12/30/15, 01/05/15, 03/03/15, 03/09/15, 03/20/15 (8:30 PM), 04/02/15, 04/02/15, and 04/13/15. Review of the Accident/Injury Report for Resident #4 dated 10/25/14 at 7:30PM, revealed: -Resident was coming out of bathroom (BR) with CNA and he "snatched away", fell and hit his head. -Resident was sent to local Emergency Department (ED) via Emergency Medical Service (EMS). -Resident returned from hospital with diagnosis (Dx) of " head contusion". -A "fall sheet was started" by the facility for staff to document more frequent checks on the Resident. Review of Resident #4's care plan revealed no changes were documented for the resident's supervision needs, after the "fall sheet" expired. Review of the Accident/Injury Report for Resident #4 dated 12/01/14, 9:30PM, revealed: -Resident was found on the floor leaning against the BR door, "yelling for help". -Wound on elbow (which elbow not specified) cleansed with normal saline and a dressing applied. -Resident was transported to local ED via EMS. -Resident returned from hospital with Dx of elbow laceration closed with sutures. -Facility started a "fall sheet". Review of Resident #4's care plan revealed no changes were documented for the resident's supervision needs after the "fall sheet" expired.	D 270		

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Review of the Accident/Injury Report for Resident #4 dated 12/05/15, 8:30 AM, revealed:
-Resident was "laying on the floor, face up, in the 200 hall doorway".
-Resident complained of back pain.
-Resident was transported to local ED via EMS.
-Resident returned from hospital with Dx of "back pain, fell down".
-Facility started a "48 hour fall sheet".

Review of Resident #4's care plan revealed no changes were documented for the resident's supervision needs after the "fall sheet" expired.

Review of the Accident/Injury Report for Resident #4 dated 01/05/15 at 10:00 PM revealed:
-Resident was "walking down the hall ... slipped ... fell to the floor hitting his head on the floor".
-No visual sign of injury was noted by staff.
-No mention of object or substance Resident "slipped" on.
-Resident was transported to local ED via EMS.
-Resident returned from hospital with Dx of "fell down".
-Documentation of a "fall sheet" being initiated was not found.

Review of Resident #4's care plan revealed no changes were documented for the resident's supervision needs.

Review of the Accident/Injury Report for Resident #4 dated 03/19/15 at 5:15 PM, revealed:
-Resident was sitting at dining room table "and leaned to right and fell on floor bumping head on floor".
-No visual sign of injury was noted by staff.
-Resident was transported to local ED via EMS.
-Resident returned from hospital with Dx of "fall, depression".

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D 270	Continued From page 4 -The facility started a "24 hour fall sheet". Review of Resident #4's care plan revealed no changes were documented for the resident's supervision needs after the "fall sheet" expired. Review of the Accident/Injury Report for Resident #4 dated 03/20/15 at 8:30 PM, revealed: -Staff walked into Resident's room "and found Resident on the floor in front of bed". -No visual sign of injury was noted by staff. -Resident was transported to local ED via EMS. -Resident returned from hospital with Dx of "fall". -The facility started a "30 minute, 24 hour watch". Review of Resident #4's care plan revealed no changes were documented for the resident's supervision needs after the "fall sheet" expired. Review of the Accident/Injury Report for Resident #4 dated 04/02/15 at 6:30 AM, revealed: -Resident laying in in bed with blood on the pillow and dry blood on his head laceration". -Resident stated that he "had fallen sometime last night". -Staff cleansed head laceration with normal saline and covered with band aide. -Resident was transported to local ED via car. -Resident returned from hospital with Dx of "bleeding, dementia, scalp abrasion". -The facility "implemented a fall sheet". Review of Resident #4's care plan revealed no changes were documented for the resident's supervision needs after the "fall sheet" expired. Review of the Accident/Injury Report for Resident #4 dated 04/02/15 at 9:00 PM, revealed: -Staff "said she went to check on Resident and he was in floor lying down".	D 270		

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-No visual sign of injury was noted by staff.
-Resident was sent to local ED via EMS.
-Resident returned from hospital with Dx of " fall, dementia".
-The facility "implemented a fall sheet".

Review of Resident #4's care plan revealed no changes were documented for the resident's supervision needs after the "fall sheet" expired.

Based on staff interview a "fall sheet" consisted of a 24-48 hour time period with visual checks every 15-30 minutes then returned to hourly checks unless other wise indicated.

Review of Resident's Care Notes revealed:
-Resident fell or "was found on floor" 17 times.
-Resident was sent to ED for evaluation on 12 occasions.
-Resident was not sent to ED on 12/28/14 when found with "skin tear on L [left] elbow and L [left] eyebrow/temple area".

Interview with Memory Care Unit (MCU) Care Manager on 04/16/15 at 09:55 AM revealed:
-"In the MCU we encourage the Residents to do what they can for themselves".
-"Resident #4 loves his snacks and I keep some here (at desk) for the residents so when I see him coming down the hall at night, I know what he wants. I ask him what is he going to do for the snack and he would do a little gig (dance)".
- Care Manager also stated Resident #4 "seems to get tired when he stands for so long, he starts shuffling and you can see his knees start to buckle".

Interview with Staff A (Medication Aide) on 04/16/15 at 4:15 PM revealed:
-Staff A stated that Resident #4 falls more often in

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the evenings particularly around "7 PM or 8 PM" while looking for "another snack", she thinks.
-Staff A stated that Resident #4 falls "sometimes before sometimes after his bedtime medications".

Interview with Staff B (Personal Care Aide) on 04/16/15 at 4:30 PM revealed:
-"Sometimes Resident #4 walked just fine and then other times his legs got weak and they just buckle:.
-"Once [Resident #4] fell to the floor in the dinning room; everyone was there " .
-Staff B also stated that Resident #4 "shuffles his feet sometimes when he walks".

Review of Physical Therapy (PT) notes revealed:
-Resident #4 was seen a total of 6 visits on 03/27/15, 03/31/15, 04/07/15, 04/09/15, 04/13/15 and 04/16/15.
-PT documented varying degrees of cooperation from the Resident.
-On 04/13/15 visit, PT planned to discharge Resident #4 on next visit "due to reaching maximum rehab potential".
-On 04/16/15 visit PT documented that Resident #4 had fallen on 04/13/15. "However, patient has decreased safety awareness and is again encouraged to call health care staff for assistance. Health care staff encouraged to check on patient due to mobility level in combination with lack of safety awareness."

Telephone interview with Physical Therapist on 04/17/15 at 04:15 PM revealed:
-Resident #4's low safety awareness had been discussed with different staff members from nursing assistants to administrator.
-The need for frequent checks was stressed to staff members.
-The use of a cane or walker would only present

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D 270	Continued From page 7 additional fall risk for Resident #4. Telephone interview with Resident #4's Mental Health Provider on 04/17/15 at 04:07 PM revealed: -The Mental Health Provider did not remember being told about the Resident's frequent falls. -The Mental Health Provider stated if he had been told about falls, he would have addressed it in the documentation in the Resident's record at facility. Review of record shows the Mental Health Provider saw Resident #4 on 10/28/14 and 12/02/14. Physician order sheets documented "patient appears stable on current treatment; no change indicated "and" patient appears stable on present treatment, no changes indicated at this time " . Review of the Licensed Health Professional Support (LHPS) evaluation for Resident #4 on 04/14/15 recommended "MD to evaluate due to multiple falls". Interview with Resident Care Manager (RCM) on 04/16/15 at 3:50PM about facility's fall policy revealed: -Resident's that are at high risk for falls have a leaf cut-out taped to the doorframe of their room. This lets staff know which Residents are to be checked frequently. -High risk Residents are asked if they would like to go to the "TV room" were activities are available throughout the day. -Residents are escorted to their rooms as needed for changes and to and from the dining area. -Resident #4 "vary rarely chose to go the TV room, he would rather stay in his room and sleep".	D 270		

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D 270	Continued From page 8 -Once a Resident has fallen, they are placed on a 24 or 48 hour fall watch which involves a staff member checking on the Resident every 15 or 30 minutes for the allotted time frame then return to hourly checks. -Resident's remain on hourly, visual checks until 3 months without a fall. -On 04/16/15 "Resident became aggressive after the fall, so the facility staff called Primary Care Provider rather than EMS". -The facility has an assessment tool to identify fall risks that is used to screen all Residents. -She was aware that the local hospital had notified Adult Protective Services due to Resident #4's "multitude of falls" and that facility's Primary Care Provider had also been notified. Interview with the former Executive Director (ED) on 4/17/15 at 5:00 PM revealed: -Resident #4 shuffles and wobbles when he walks -Staff are supposed to monitor the resident closely when the resident is placed on 24-48 hourly checks. -The ED had been notified by staff that the local hospital was concerned about the multitude of falls for Resident #4. _____ The Facility provided the following Plan of Protection dated 04/17/15. Resident identified will be place on 1:1 supervision until assessed by PCP to determine if higher level of care is required. Facility will follow recommended level of care as indicated by physician. Fall Risk assessment will be completed on identified Resident today. Implement a new fall management program to include 24 hour follow up on resident falls, Fall Management Team meeting approach, Fall Risk	D 270		

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D 270	Continued From page 9 Worksheet and a Fall Management Team meeting to include recommendations. Nursing staff will begin to train staff on Fall Management Protocol today (04/17/15) and be completed by 04/20/15. A copy of Facility's new Falls Management Protocol was provided with the Plan of Protection today (04/17/15). CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 1, 2015.	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 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: Based on interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to the manner and tone in which staff speak to residents. The findings are: Confidential interview with a resident revealed: - Resident reported staff are "hateful". - Staff talk hateful to the resident. Confidential interview with a second resident revealed: - Staff are "mean, hateful, and rude" to the resident. - Resident reported staff are rude to other residents too.	D 338		

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D 338	Continued From page 10 Confidential interview with a third resident revealed: - Staff are rude to the resident. - Medication aides are hateful and talk mean to the resident and other residents. Confidential interview with a staff person revealed: - The staff person had overheard medication aides "holler" at residents if too many residents gathered around the medication cart. - The staff person reported they had observed this more often during second shift. Confidential interview with a second staff person revealed: - A family member and a resident have complained about a medication aide being "very mean verbally" to the resident. - Staff person reported a second medication aide was "very loud" verbally toward the residents. - At least 3 residents had reported to the staff person that a medication aide was "hateful talking" to residents. - Staff person stated they did not report this to management. - Staff person was supposed to report the complaints to management but they did not because the staff person did not feel like anything would be done about it. Confidential interview with a fourth resident revealed: - A medication aide was having a bad day and took it out on the resident about a month ago. - The medication aide was rude and told the resident that the resident was not going to heaven because of the way the resident treated the staff	D 338		

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person.
- The resident stated it hurt the resident's feelings when the staff person talked to the resident that way.
- The resident reported the resident cried for 5 hours afterwards.
- The medication aide came back to apologize but the resident did not feel the medication aide was sorry because she did not sound sincere.

Confidential interview with a family member revealed:
- A staff person was rude to a resident a few weeks ago.
- The resident reported to the family member that a staff person was "hateful" to the resident.
- The family member reported the resident cried for 3 days because the staff person was rude to the resident.
- The family member reported it to management but the staff person denied it.

Interview with the Resident Care Manager (RCM) on 04/17/15 at 4:35 p.m. revealed:
- A family member had reported that a medication aide had talked "roughly" to a resident related to the resident requesting a "prn" pain medication.
- RCM spoke with the medication aide who denied speaking roughly to the resident.
- RCM stated the medication aide reported she had forgotten to take a "prn" medication to a resident and the resident got upset.
- RCM reported the resident had to wait about an hour for the pain medication.
- RCM stated no other concerns about the way staff treat residents had been reported to her.

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D 358	Continued From page 12	D 358		
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 observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 9 residents (#10 #11) observed during the medication passes, including errors with an inhaler for breathing problems and a "prn" (as needed) medication for diarrhea and 1 of 7 residents (#3) sampled for review related to errors with administration of prn pain medication. The findings are: 1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 29 opportunities during the 3:00 p.m. / 4:00 p.m. medication pass on 04/15/15 and the 8:00 a. m. / 9:00 a.m. and 11:00 a.m. / 11:30 a.m. medication passes on 04/16/15. A. Review of Resident #10's record revealed: - FL-2 dated 12/17/14 included diagnoses of chronic obstructive pulmonary disease, dementia, congestive heart failure, chronic kidney disease, insulin dependent diabetes mellitus, and deep vein thrombosis.	D 358		

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D 358	Continued From page 13 Review of Resident #10's record revealed: - Physician's order dated 03/10/15 for Albuterol inhaler, inhale 2 puffs 4 times daily as needed for wheezing. (Albuterol is an inhaled medication used to treat acute lung/breathing problems.) Observation of the medication pass on 04/16/15 revealed: - Resident #10 was walking to his room from the dining room. - The resident appeared short of breath. - The medication aide got the Albuterol inhaler from the top drawer of the medication cart. - The medication aide shook the Albuterol inhaler and handed it to the resident at 8:49 a.m. - The resident pressed the inhaler 2 quick times in a row without inhaling the medication. - The medication aide did not instruct the resident to wait one minute between puffs. (Waiting one minute between puffs may permit additional puffs to penetrate the lungs better.) - The medication aide did not instruct the resident to inhale the medication when the inhaler was pressed down nor to hold breath in for approximately 10 seconds to allow the medication to reach the lungs. - The resident did not inhale and the medication vapors came back out of the resident's mouth. Interview with Resident #10 on 04/16/15 at 12:18 p.m. revealed: - He had more than one inhaler and one was to be used as needed. - He got short of breath when walking down the hallway. - No one at the facility had instructed him on how to use the inhaler. - He preferred to hold the inhaler himself.	D 358		

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D 358	Continued From page 14 Interview with the medication aide on 04/16/15 at 12:26 p.m. revealed: - She usually handed the inhaler to the resident because he preferred to hold it himself. - She had training on how to administer inhalers. - She was aware the resident needed to take a deep breath in and they should wait between puffs. - She did not instruct the resident because he would not usually listen. - She did not know if the physician was aware the resident was not using the proper technique. - She usually saw vapors come back out of the resident's mouth when he used the inhaler. - She should have instructed the resident on how to use the inhaler. Interview with the Resident Care Manager (RCM) on 04/16/15 at 1:45 p.m. revealed: - Some residents could hold the inhaler and administer it as long as the medication aide was cueing and instructing the resident. - The medication aide should instruct the resident to seal mouth around the inhaler and take a deep breath in when the device is pressed. - The resident should be instructed to wait 2 minutes between puffs. - RCM had administered the inhaler to Resident #10 in the past and she would hold and administer it to the resident. - She was unaware staff was handing the inhaler to Resident #10 to administer. - She reported if the medication aides allowed the resident to hold the inhaler to administer, they should be instructing him. - If he was non-compliant, they should notify the physician. B. Review of Resident #11's record revealed: - FL-2 dated 01/18/15 included diagnoses of	D 358		

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insulin dependent diabetes mellitus, anxiety, constipation, hypertension, hyperlipidemia, arthritis, and neuropathy due to diabetes mellitus.

Review of Resident #11's record revealed:
- Physician's standing order dated 01/07/15 for Imodium 2mg take 1 tablet by mouth as needed for diarrhea after each loose stool, not to exceed 8 tablets in 24 hours. (Imodium is used to treat diarrhea.)

Observation of the medication pass on 04/16/15 revealed:
- Resident #11's blood sugar was checked at 11:41 a.m.
- Resident #11 reported to the medication aide at 11:41 a.m. that she had diarrhea and needed an Imodium.
- The medication aide administered sliding scale insulin to Resident #11 at 11:44 a.m.
- The medication aide did not administer any Imodium to the resident.
- The medication aide stated she needed to do one more blood sugar for another resident before lunch.
- The medication aide checked another resident's blood sugar and administered insulin at 11:53 a.m. and four oral medications at 11:54 a.m.
- The medication aide then left the medication cart parked near nurses' station and went to dining room to assist with lunch.
- No Imodium was observed to be administered to Resident #11.

Interview with Resident #11 on 04/16/15 at 12:16 p.m. revealed:
- She was still waiting for the medication aide to bring her an Imodium.
- She had been having problems with diarrhea

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D 358	Continued From page 16 since that morning. Interview with the medication aide on 04/16/15 at 12:30 p.m. revealed: - She had forgotten to administer the Imodium to Resident #11. - She had planned to give it after she checked the other resident's blood sugar. - She usually gave "prn" (as needed) medications to the residents as soon as they asked for it. Observation on 04/16/15 at 12:35 p.m. revealed: - The medication aide went to Resident #11's room to administer the Imodium. - The medication aide had to wait for the resident come out of the bathroom to administer the medication. - The resident indicated she still needed the Imodium. - The resident was administered Imodium at 12:38 p.m., 57 minutes after she requested the medication. Interview with the Resident Care Manager (RCM) on 04/16/15 at 1:45 p.m. revealed: - The facility's policy was for "prn" (as needed) medications to be administered when they are requested. - The RCM stated the residents do not need to be made to wait for prn medications. - The RCM stated she was standing at the medication cart at 12:00 noon when Resident #11's family member came to the cart and asked about the Imodium. - The RCM stated she told the medication aide to administer the Imodium at that time at 12:00 noon to Resident #11. - The RCM thought the medication aide had administered the Imodium after the RCM told her	D 358		

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to but she did not stay to observe if it was done.
- The RCM stated she would talk to the medication aide about proper procedure for "prn" medications again.
- They had this same issue come up within the last few months when another resident had to wait for a prn medication for about an hour because another medication aide said they were busy and did not stop to get the medication.
- Staff know they are supposed to administered "prn" medications when they are requested.

2. Review of Resident #3's current FL-2 dated 12/03/14 revealed:
- Diagnoses included status post left hip fracture, hypokalemia, hypertension, diabetes mellitus type II, depression, and paroxysmal atrial fibrillation.
- Order for Norco 5/325mg 1 tablet every 4 hours as needed for pain not relieved by scheduled doses. (Norco is a narcotic pain medication.)

Review of Resident #3's record revealed a subsequent physician's order dated 02/11/15 for Norco 5/325mg 1 tablet every 8 hours as needed for pain not relieved by the scheduled dose.

Review of the February and March 2015 medication administration records (MARs) revealed:
- Order for Norco 5/325 1 tablet every 4 hours as needed for pain was discontinued on the MAR on 02/12/15.
- The new order for Norco 5/325mg 1 tablet every 8 hours as needed was started on 02/12/15.
- On 15 occasions staff documented the administration of Norco 5/325 prn less than every 8 hours apart:

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D 358	Continued From page 18 - 02/12/15 - 11:48 a.m. and 3:12 p.m. (not due until 7:48 p.m.) - 02/13/15 - 11:50 a.m. and 3:35 p.m. (not due until 7:50 p.m.) - 02/14/15 - 11:38 a.m. and 4:04 p.m. (not due until 7:38 p.m.) - 02/15/15 - 1:22 p.m. and 5:23 p.m. (not due until 9:22 p.m.) - 02/17/15 - 12:36 p.m. and 5:03 p.m. (not due until 8:36 p.m.) - 02/18/15 - 12:07 p.m. and 5:14 p.m. (not due until 8:07 p.m.) - 02/19/15 - 11:58 a.m. and 4:26 p.m. (not due until 7:58 p.m.) - 02/20/15 - 1:23 p.m. and 5:02 p.m. (not due until 9:23 p.m.) - 02/23/15 - 11:36 a.m. and 5:22 p.m. (not due until 7:36 p.m.) - 02/24/15 - 11:28 a.m. and 3:19 p.m. (not due until 7:28 p.m.) - 02/25/15 - 2:02 p.m. and 6:08 p.m. (not due until 10:02 p.m.) - 02/26/15 - 11:54 a.m. and 3:25 p.m. (not due until 7:54 p.m.) - 02/27/15 - 12:31 p.m. and 4:12 p.m. (not due until 8:31 p.m.) - 03/02/15 - 2:03 p.m. and 5:01 p.m. (not due until 10:03 p.m.) - 03/04/15 - 11:46 a.m. and 4:06 p.m. (not due until 7:46 p.m.) Review of Resident #3's record revealed a subsequent physician's order dated 03/05/15 changing the prn order to Norco 5/325mg 1 tablet every 4 hours as needed for pain with a maximum of 3 doses in 24 hours. Review of the March 2015 MARs revealed: - Order for Norco 5/325 1 tablet every 8 hours as needed for pain was discontinued on the MAR	D 358		

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on 03/06/15.
- The new order for Norco 5/325mg 1 tablet every 4 hours as needed was started on 03/06/15.
- On 8 occasions staff documented the administration of Norco 5/325 prn less than every 4 hours apart:
- 03/14/15 - 2:06 p.m. and 4:44 p.m. (not due until 6:06 p.m.)
- 03/15/15 - 11:47 a.m. and 3:28 p.m. (not due until 3:47 p.m.)
- 03/16/15 - 11:33 a.m. and 3:18 p.m. (not due until 3:33 p.m.)
- 03/20/15 - 11:55 a.m. and 3:20 p.m. (not due until 3:55 p.m.)
- 03/23/15 - 11:47 a.m. and 3:18 p.m. (not due until 3:47 p.m.)
- 03/26/15 - 11:53 a.m. and 3:45 p.m. (not due until 3:53 p.m.)
- 03/27/15 - 11:32 a.m. and 3:18 p.m. (not due until 3:32 p.m.)
- 03/29/15 - 11:56 a.m. and 3:16 p.m. (not due until 3:56 p.m.)

Interview with Resident #3 on 04/17/15 at 4:18 p.m. revealed:
- She was unsure how often she received her pain medication.
- She thought the label indicated she could have it 4 times a day but she had to ask for it.

Interview with the Resident Care Manager (RCM) on 04/17/15 at 4:35 p.m. revealed:
- Staff should not administer "prn" medications more frequently than they are ordered.
- The date and time a "prn" medication was last administered always pops up on the electronic MAR computer screen.
- Staff should only give the "prn" medication after the appropriate time has passed based on

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D 358	Continued From page 20 the physician's order. - The one hour before time frame does not apply to "prn" medications.	D 358		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure a resident's (#12) Ambien, a controlled substance, was only borrowed and administered to another resident (#3) in an emergency situation and they failed to assure the borrowed medication was replaced 2 of 2 occasions the Ambien was borrowed. The findings are: Review of Resident #3's current FL-2 dated 12/03/14 revealed: - Diagnoses included status post left hip fracture, hypokalemia, hypertension, diabetes mellitus type II, depression, and paroxysmal atrial fibrillation. - Order for Ambien 10mg 1 tablet at bedtime. (Ambien is a controlled substance used to treat insomnia.) Review of Resident #3's March 2015 medication	D 372		

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administration record (MAR) revealed:
- Ambien 10mg was scheduled to be administered daily at 8:00 p.m.
- Staff initialed and documented "pending hardscript" on the electronic MAR for 03/16/15 and 03/17/15.

Review of Resident #3's controlled substance logs revealed:
- 30 Ambien 10mg tablets were received on 01/08/15.
- The first dose documented as administered from this supply was 02/14/15 at 8:00 p.m. and the last tablet was administered on 03/15/15 at 8:00 p.m.
- Staff documented they borrowed two Ambien 5mg tablets each on 03/16/15 (Monday) and 03/17/15 (Tuesday) at 8:00 p.m. from Resident #12.
- These borrowed tablets were administered to Resident #3 on 03/16/15 and 03/17/15.
- No documentation the borrowed tablets were replaced.

Review of Resident #12's controlled substance log revealed:
- 30 Ambien 5mg tablets were received by the facility on 12/15/14.
- Staff documented they borrowed two Ambien 5mg tablets (to equal 10mg) each on 03/16/15 and 03/17/15.
- No documentation the borrowed tablets were replaced.

Interview with a medication aide on 04/16/15 at 4:20 p.m. revealed:
- They are supposed to reorder medications when there is a 7 day supply remaining.
- Medications usually come in the next day after they are ordered.

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- If not, staff are supposed to call the pharmacy.
- The electronic MAR would usually flag when a narcotic needed a hard script to be refilled.
- The medication aides would leave a note for the Resident Care Manager (RCM) who would contact the physician.
- She reported Resident #3 ran out of Ambien last month.
- She called the RCM who told her to borrow Ambien from Resident #12.
- She borrowed two Ambien 5mg tablets from Resident #12 and gave to Resident #3 because Resident #3 took 10mg tablets.
- She did not replace the Ambien borrowed from Resident #12.
- If Resident #12 needed some Ambien, she would take it from Resident #3's supply to pay him back.
- It was unusual to borrow medications.

Interview with a medication aide on 04/17/15 at 3:45 p.m. revealed:
- The medication aide on duty was responsible for ordering medications when there was a 7 day supply remaining.
- The medications usually come in the next day.
- If not, staff are supposed to leave a note for the RCM.
- They never borrow controlled substances.
- She had not borrowed any medications in over 8 months.

Interview with Resident #3 on 04/17/15 at 4:18 p.m. revealed:
- The facility ran out of her Ambien twice about a month ago.
- She was told staff forgot to order the medication.
- She thought staff borrowed Ambien from another resident and gave it to her.

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D 372	Continued From page 23 Interview with Resident #3's family member on 04/16/15 at 3:22 p.m. revealed: - The facility staff has let the resident's medications run out at least 5 times since the resident was admitted a little over a year ago. - It was usually either her pain medication or her sleeping pill. - The last time she ran out of her Ambien, staff borrowed Ambien from another resident. - They borrowed 2 Ambien 5mg tablets from another resident because Resident #3 took Ambien 10mg. - The facility was supposed to order 7 days before the medication ran out. - The facility knows they need a hard script for the controlled substances. Interview with the Resident Care Manager (RCM) on 04/17/15 at 4:35 p.m. revealed: - The facility's policy was to borrow medications if it was an emergency. - If staff have to borrow, they are supposed to document it in the common log book. - They rarely borrow controlled substances. - The last time a controlled substance was borrowed was in March 2015. - This was the first time in a year the RCM had allowed staff to borrow a controlled substance. - They failed to get a hard script in time for Resident #3's Ambien. - Staff called the RCM and told her Resident #3 was out of Ambien so the RCM told the staff to borrow from Resident #12. - They borrowed two Ambien 5mg tablets for 2 nights from Resident #12 to give to Resident #3. - Medication staff documented the borrowing on both residents' controlled substance logs. - The Ambien tablets borrowed from Resident #12 have not been replaced yet.	D 372		

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D 372	Continued From page 24 - RCM was unaware the Ambien tablets had to be replaced promptly.	D 372		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on interview, the facility failed to assure residents were treated with respect, consideration, and dignity by facility staff. The findings are: Based on interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to the manner and tone in which staff speak to residents. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Standard Deficiency)].	D911		
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:	D912		

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D912	Continued From page 25 Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observation, interviews and review of records, the facility failed to provide supervision in accordance with each resident's assessed needs for 1 of 4 sampled residents(Resident #4) who had a history of being found on the floor or had falls with injuries. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912		