STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 000	Initial Comments The Adult Care Licensure Section and the Mitchell County Department of Social Services conducted a complaint investigation on May 4, 2015 and May 5, 2015.	D 000		
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: TYPE A2 VIOLATION Based on interview and record review, the facility failed to assure that residents were free of abuse as related to one staff (B) to resident (#5) verbal and physical abuse. The findings are: Review of Resident #5's current FL2 dated 11/6/2014 revealed: -Diagnoses included Alzheimer's Dementia - Senile. -The resident was ambulatory and disoriented constantly. -Resident was admitted to the facility on 11/15/2013. Review of Resident #5's current care plan dated 12/12/2014 revealed the resident wandered. Review of Resident #5's current Special Care Unit quarterly review dated 3/5/2015 revealed resident is forgetful and needs reminders.	D 338		

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D 338	Continued From page 1 Interview with Staff C, Supervisor-In-Charge (SIC) on 5/4/2015 at 2:50pm revealed: -She had worked at the facility for "a little over one year". -She had received resident right's training in the past "3 or 4 months". -She stated physical or mental abuse was to be reported "right then" to the Special Care Coordinator (SCC) or Resident Care Coordinator (RCC). -She stated on Saturday, 4/18/2015, a sign had been posted indicating the on-call administrator was the Resident Care Coordinator (RCC). -She worked on the Special Care Unit (SCU) on Saturday, 4/18/2015. -Between "10:00 and 11:00 am" she had been in the "spa" bathing a resident when Staff D, Personal Care Aide (PCA), came to the door and reported Staff B, PCA, was "hollering and fussing" at [Resident #5]. -She reported the spa door was closed and she heard Staff B say "get your [expletive] off my bed, I'm tired of you messing up my [expletive] beds". -She told Staff B "I'll be there in a minute" after making sure the resident in the spa was safe (Staff C reported the resident in the spa was ambulatory and could be left alone). -She had approached Staff B in the hallway and had told Staff B to calm down and go outside and "get some fresh air". -When Staff B left the area, she returned to finish bathing the resident in the spa. -Staff B came back "from somewhere and headed towards the dining hall". -She had attempted to "stop Staff B and ask questions" but Staff B ignored her. -"I couldn't send [Staff B] home, there would not have been enough coverage if [Staff B] went home, I had no one to call."	D 338		

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D 338	Continued From page 2 -She had brought Staff B to the nurses' station to "explain they needed to work as a team". -She had asked the PCA's and housekeeper to provide written statements before the end of their shift. -Upon reading the written statements, she learned Staff B had grabbed and pushed Resident #5. -"No one reported" that Staff B had grabbed and pushed Resident #5. -She did not hear Staff B "threaten" Resident #5, only heard the "yelling and cursing". -She made a copy of the written statements and slid them under the Executive Director's (ED) door. -She did not call the on-call administrator because they "didn't know what to do and always had to call someone else". -She stated Staff B "finished the shift". -"I did what I thought I was supposed to do, took statements and slid under the [ED's] door." A second interview with Staff C on 5/4/2015 at 5:40pm revealed, "How was I to send her (Staff B) home when I did not witness the hands-on". A third interview with Staff C on 5/5/2015 at 3:20pm revealed: -"I did not complete an incident report, it was all hearsay." -It was all "he said/she said". Phone interview with Staff B, PCA, on 5/5/2015 at 3:14pm revealed: -She had been working at the facility for "two years" as a PCA and always worked first shift. -"I know about resident rights, I've passed all the on-line courses. I don't go through the screens like other staff do, I take my time and read what is there."	D 338		

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D 338	Continued From page 3 -"[Staff D] told [Staff C] I was rough with [Resident #5]. I don't do that, never have, never will. I have never mistreated a resident. I love them as if they were my own, you can ask any family member." -"I was upset at the med tech and CNA because they work second shift and wanted to get all of the second shift work done on first shift." -"I never manhandled [Resident #5]." -"It was 11:30 and I had already did 28 beds and [Staff C] wanted to start doing showers. I said I'm not doing showers, need to get the residents to lunch." -"[Staff C] wants everything for second shift to get done." -"I went to get [Resident #5] out of a bed and the girl (Staff D) in the room with me got upset." -"I got [Resident #5] by the arm and escorted him out the door to take him to the dining room. " -"You don't want to take [Resident #5] to his room, he will just get out of bed again and go into another room." -"I had to get him (Resident #5) by the arm, I didn't grab him and pull him up, you have to lead him to go to the dining room for lunch." -The "med tech came in and wanted to know what the argument was about. [Staff D] said I was rough with [Resident #5] but I did not do that. I don't mistreat the residents." Based on observation and record review, Resident #5 was not interviewable. Phone interview attempted during the survey with Resident #5's Power of Attorney was not successful by time of exit. Interview with Staff D, PCA, on 5/4/2015 at 3:40pm revealed: -She had started working at the facility "just about	D 338		

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D 338	Continued From page 4 a year ago". -She reported receiving resident rights training, "many, many people talk to us about resident rights". -She would "immediately report abuse to the med tech". -She worked on the SCU on Saturday morning, 4/18/2015. -She had been working in a resident room sorting clothes and heard Staff B say "[Resident #5] stay out of the beds". -Staff D heard Staff B start yelling at Resident #5 and went to tell the SIC. -The SIC was bathing a resident and indicated she would come address the situation "in a moment". -She returned to the room to sort clothes and Resident #5 came into the room and laid down on the bed. -"Before I could say something to [Resident #5], [Staff B] came into the room and yelled get your [expletive] out of the bed." -She stated Resident #5 was starting to rise out of the bed when "[Staff B] grabbed [Resident #5] and pulled him up" (Staff D demonstrated on a surveyor how Staff B had grabbed Resident #5 on the left arm above the elbow and pulled him from the bed). -Staff B started "pushing [Resident #5] out the door". -She had attempted to get Staff B to stop when Staff B said she "wasn't having these [expletive] residents messing up the beds". -She observed Staff B walking down the hall, holding Resident #5 by the arm (she could not recall if Staff B kept pushing Resident #5 down the hall). -The SIC intervened, telling "[Staff B] to go take a 5-minute breather". -She stated Staff B was "screaming in [Resident	D 338		

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D 338	Continued From page 5 #5's] ear not to be in the beds". Interview with Staff G, housekeeper, on 5/4/2015 at 11:30am revealed: -She had been working the Saturday morning of 4/18/2015 and heard Staff B say "If I catch [Resident #5] in another bed, he's had it." -She stated Staff B went into a room (where Resident #5 had gone) and was overheard saying to Resident #5, "Get up, this isn't your [expletive] room." -Resident #5 asked, "Where is my room?" Staff B said "You know where your [expletive] room is." -Staff B "screamed" at the resident and could be heard yelling down the hallway. -Staff C came down the hall and told Staff B to "go take a break". Interview with Resident Care Coordinator (RCC) on 5/5/2015 at 11:30am revealed: -She was hired as the RCC and started on 3/30/2015. -She was temporarily filling in as the SCC, the previous SCC left on 5/1/2015. -The weekend of 4/18/2015 was the first weekend she was "on-call by herself and the (Regional RCC) was back-up". -"I did not know of the incident until Monday morning, 4/20/2015." -"There was a note under my door from [Staff C] recapping what happened and a statement from [Staff D]." -There was a meeting with the Executive Director (ED) and Special Care Coordinator (SCC), and "it was left in the ED and SCC hands because I was so new". -"I never did talk with [Staff B]." -"[Staff D's] note said [Staff B] had pulled him (Resident #5) out of bed and was cussing." -"On 4/20/2015 I asked [Staff C] if she tried to call	D 338		

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D 338	Continued From page 6 and [Staff C] said, I didn't call because she did not see [Staff B] put hands-on or jerk him out of the bed." -"I would have expected a call" from the SIC. Phone interview attempted during the survey with former Special Care Coordinator was not successful by time of exit. Interview with the Executive Director (ED) on 5/4/2015 at 4:35pm revealed: -She was hired as ED in October of 2014. -If abuse was suspected and she was not at the facility, "call the on-call or myself". -She would "expect" the SIC to call her or the "care manager". -They should "call as soon as it comes to their attention". -On Monday, 4/20/2015 she became aware of an incident that occurred on 4/18/2015. -Written statements from staff had been put under the doors of the ED, SCC and RCC and "all had the same copies". -"One was [Staff B] was cursing and being disrespectful to [Resident #5], something like that." -One allegation had to do with Staff B stating she was "tired about making these [expletive] beds, the resident going from room to room." -"Another said they heard her (Staff B) cursing him (Resident #5), nudging and pushing him towards the TV room." -On 4/20/2015 ED discussed incident with the Administrator. -Administrator instructed ED to talk to Staff B about "resident rights and to write her up". -She interviewed Staff B who denied abusing Resident #5 but "admitted getting loud with staff in hallway at the nurses station" due to her workload.	D 338		

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D 338	Continued From page 7 -On Monday (4/20/2015) it was "he said/she said" and "I wrote her (Staff B) up for interaction with staff". -She "did not interview those who wrote the notes under the door." -She reported hearing "staff talking about" the incident and spoke with Staff D on Monday, 4/27/2015. -She stated Staff D reported that "[Staff B] pulled [Resident #5] up by the arms". -She stated she "had nothing like that in my statements. I did not have the second page to a statement. None of the managers had the second page". -"The second page was given to me on Monday 4/27." -"That was when I started my investigation." -"I don't know if [Staff C] knew on 4/18 if hands have been put on, she had the statements that Saturday. I would have expected her to call me and get coverage". -"Letting [Staff B] work, I would say no, call and get coverage." -She stated "I don't know what they had" regarding abuse training. -She stated the SIC's can write people up but "they are not even comfortable with that". -"I don't know if we have a policy regarding reporting that is even that specific." -"[Staff C] neglected to immediately report an allegation of abuse." -She submitted the HCPR 24-Hour Initial Report on 4/27/2015 and the 5-Working Day Report on 5/1/2015. -"I think [Staff B] should have been suspended on Saturday, 4/18 and we did not suspend her on the 20th either." -"I did not know about the pulling out of bed until 4/27." -"I would have expected [Staff C] to call me."	D 338		

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D 338	Continued From page 8 -"I would have expected a phone call from [Staff C] knowing what I know now." -"To my knowledge no phone call was made to the care manager at the time." -"[Staff C] should have known about the on-call list at the nursing station." Review of the Health Care Personnel Registry (HCPR) reports on 5/4/2015 revealed: -The 24-Hour Initial Report was signed and dated by the ED on 4/27/2015. -The 5-Working Day Report was signed and dated by the ED on 5/1/2015. Review of Staff B working time record on 5/5/2015 revealed Staff B had worked on the following days after the incident: -4/19/2015. -4/20/2015. -4/21/2015. -4/23/2015. -4/24/2015. -4/27/2015. Interview with the Business Office Manager (BOM) on 5/5/2015 at 9:19am revealed Staff B had been suspended on 4/28/2015. Interview with the Administrator on 5/4/2015 at 5:20pm revealed: -The "expectation was if staff suspected abuse, they were to report it to their supervisor or go up the chain of command immediately". -"I would expect the SIC to call the on-call person to let them know." -The on-call person "should come in immediately". -"I would expect the alleged staff member be suspended until completion of an investigation." -"[Staff B] should have been suspended	D 338		

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D 338	Continued From page 9	D 338		

immediately."
-"The person on-call has the authority to suspend and send someone home."
-"We would want the SIC to call (the on-call person) before sending staff home."
-The SIC "probably did not know" to send someone home.
- She did not know why the on-call person was not called.
-"I'm sure she knows she (Staff C) should call somebody, but she did not know she could send [Staff B] home."
-She "found out" about the incident "on Monday" (4/20/2015), "I think she (ED) started the 24-hour report".
-"I think when she (ED) got the second page with the damning information, she took action."
-"This was not a pattern for [Staff B], she was very appropriate."
-It was "neglect on our part for not addressing it immediately".
-"That day they should have called and should have sent her (Staff B) home."

Review of a written statement by Staff C, SIC, signed and dated 4/19/2015 revealed:
-Note addressed to ED, SCC and RCC.
-"Here are some statements of an event that took place this weekend, and if you need to speak with about this please let me know. [Resident] family members, and [Resident] family members were upset about this situation as well because they were sitting in the TV room visiting."

Review of written statement by Staff D, PCA signed and dated 4/18/2015 revealed:
-She had been in a resident's room "marking clothes".
-"I heard [Staff B] from the hallway screaming at [Resident #5]" to "stay out of the beds she made."

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D 338	Continued From page 10 -There were "5 or 6 residents' family members sitting in the TV room". -"I immediately went to [Staff C] and informed her of the issue." -She returned to the room to continue to mark clothes when "[Resident #5] came walking in the door and laid down on the bed closest to the window." -She went to redirect Resident #5 when "[Staff B] came storming in yelling and proceeded to tell him to get out of that [expletive] bed now ". -"She got him by his arm and brought him up out of that bed and continued to yell." -She told Staff B, "its fine, let him lay there for a minute and I will take care of it". -Staff B screamed "I am not going to have these [expletive] residents messing up all the [expletive] beds I have made". Review of the written statement by Staff G, Housekeeper, signed and dated 4/18/2015 revealed: -She had seen Staff B coming down the hall "looking for [Resident #5]". -She heard Staff B say "[Resident #5] better not be in a bed again." -Staff B went into another resident's room and [Resident #5] was laying on a bed next to the window, on top of the covers." Staff D, PCA, was also working in that room at this time. -Staff B went in the room and told [Resident #5] to get up, "that was not his [expletive] bed". -[Resident #5] asked "where is my bed?" -Staff B told the resident "you know where your [expletive] bed is." -Staff D told Staff B "[the resident] is not hurting anything on top of the covers." -She had gone into another resident's room to clean and heard Staff B yelling in the hallway, "I am tired of making up these [expletive] beds after	D 338		

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D 338	Continued From page 11 these [expletive] residents." -She walked out in the hall and saw Staff B "nudging/pushing" Resident #5 into the living room. -Staff C came out of the spa room and told Staff B "we can't be yelling like that at the residents and we have visitors in the building, go walk outside for a minute and get you some fresh air and calm down." Review of the written statement by Staff L, PCA, signed and dated 4/18/2015 revealed "Today is first shift I heard [Staff B] yelling and cussing one of the residents [Resident #5] all because he was laying in a residents' bed. Our residents should not be cussed or screamed at anytime. Please address this matter so that our residents can be treated the way they should and always should be and that's with RESPECT." Interview with the Administrator on 5/5/2015 at 8:55am revealed: -She had provided abuse training and recent "1068" training information to all second shift staff on duty on 5/4/2015 and third shift staff on duty on 5/5/2015. -She would be training all first shift staff at 9:00am. Review of the facility's resident abuse reporting procedures on 5/5/2015 revealed "Employees of this Community are reminded of their responsibility to report any incident of resident abuse, or suspected resident abuse, to the supervisor on duty, or the Executive Director following the guidelines for mandatory reporting". Review of facility's Supervisor job description on 5/5/2015 revealed: -Staff are to "be familiar with the Adult Care	D 338		

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D 338	Continued From page 12 Home Residents' Bill of Rights and be willing to assist residents in exercising their rights". -Under the supervisory section, "Able to suspend pending investigation when conditions warrant it after consultation with RCM and/or Executive Director". Interview with BOM on 5/5/2015 at 9:20am revealed there was no signed SIC job description for Staff C. A plan of protection was received from the facility on 5/4/15 and included the following: -Immediate training with medication aides/SICs regarding appropriate notification procedures which include immediately notifying management of suspected abuse, neglect or exploitation. -Training will be provided to all staff regarding immediately reporting suspected abuse, neglect and exploitation to management. -The accused staff member was suspended pending investigation. -Immediate, face-to-face training with staff regarding definition of abuse, neglect and exploitation with second shift staff. -Conference call with third shift. -Mandatory training regarding abuse, neglect planned for 5/7/2015. -Training on resident's rights, elder abuse and neglect to be provided by the Ombudsman on 6/8/2015. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 4, 2015.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 05/05/2015

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D 344	Continued From page 13 (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record review and interview, the facility failed to clarify medication orders upon admission for 1 of 2 sampled residents prescribed warfarin (an anticoagulant) which resulted in warfarin toxicity and hospitalization for Resident #2. The findings are: Review of Resident #2's record revealed an admission date of 2/10/2015. Review of an FL2 (signed by the Resident #2's primary physician) dated 2/4/2015 consisted of 4 pages with a faxed stamp date of 2/4/2015 which revealed: -Page 1 had diagnoses of AF (atrial fibrillation) and a note to "see list" attached for medications. -Page 3 had a list of medications that included the dose and instructions on how to administer all medications except warfarin which only had 5mg	D 344		

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D 344	Continued From page 14 (no other instructions). -Page 4 was lab results from a local community medical clinic dated 1/21/2015 with results of an INR of 3.0 (International Normalized Ratio, used to measure blood clotting times with a reference range of 2.0-3.5) and current dose of warfarin at 5mg on Friday and 2.5mg all other days. -No orders to check INR. Review of an FL2 for Resident #2 (transcribed by facility staff and signed by the facility's Primary Care Provider) dated 2/10/2015 revealed orders for warfarin 5mg one tablet by mouth every day and no orders to check INR. Review of Resident #2's February 2015 MAR (Medication Administration Record) revealed warfarin 5mg documented as administered every day at 5pm. Review of Resident #2's record revealed an order (signed by the facility's Primary Care Provider) dated 2/13/15 to check INR on 3/5/2015. Review of an Accident/Injury Report dated 3/1/2015 at 12:00pm revealed: -Staff discovered Resident #2 bleeding from vagina. -Resident was sent to local hospital per advice of PCP. -Status of resident after hospital: "warfarin toxicity, rectal bleeding." Review of ED (Emergency Department) records for Resident #2 dated 3/1/2015 revealed: -Rectal bleeding. -INR results of 15.1. -Diagnosis of "over anticoagulation with rectal bleeding". -Vitamin K, 5mg ordered intravenously (used to	D 344		

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D 344	Continued From page 15 reverse anticoagulation). -Warfarin held; admitted for anticoagulation reversal. -Discussed with [Resident's Primary Physician]. Review Resident #2's Hospital History & Physical, dated 3/1/2015 revealed: -The resident's condition was "guarded". -10mg of Vitamin K given orally due to no venous access. -Will recheck INR in morning. -Resident's warfarin dose "reported" as doubled since being at the [name of facility], reason unknown. -Last INR was checked 1/21/2015 with results of 3.0 and "at that time" resident was on 2.5 mg all days except Friday was 5mg. -Physician spoke with Medication Aide at Adult Care Home, who stated not sure why medication error occurred but "paperwork from [local medical clinic] indicated [the resident] takes 2.5 mg daily] and she is going to speak with her superiors regarding the matter." Review of a Discharge Summary for Resident #2, dated 3/2/2015 revealed: -Resident "feeling better this morning". - Discussed that resident had had her warfarin dose doubled at [Adult Care facility]. -"INR down to 4.7, although thinner than desired, it is no longer critical". - Warfarin to be held for two days, INR to be checked on Wednesday (March 3), called to [Primary Physician] and warfarin restarted per [Primary Physician's] order. -Discharge instructions included [Adult Care Home name] needs to ask resident's primary physician for correct dosing for warfarin, no warfarin until then.	D 344		

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D 344	Continued From page 16 Review of a Care Note dated 3/2/2015 documented Resident #2 returned to the facility at 1:30pm but was sent back to the hospital at 2:15pm due to blood in stool. Review of Hospital History & Physical for Resident #2, dated 3/2/2015 revealed: -"Warfarin toxicity due to unintentional overdose from med error at facility." -Resident #2 was readmitted to hospital. -Will wait a few more days before assuming warfarin to make sure bleeding has stopped. - INR 3.1. Review of a local hospital Progress Notes dated 3/3/2015 revealed: -Resident #2 had diagnosis of over anticoagulation with warfarin and resultant GI bleed with mild anemia not requiring transfusion. -Resident #2 had an INR of 2.5, "will keep resident until tomorrow to verify this is stable" before discharging again. Review of facility Care Notes dated 3/4/2015 revealed Resident #2 returned to the facilty with new orders for warfarin, to follow-up with Primary Care Provider on 3/5/15 who would clarify when to recheck INR. Review of a Medication Error Report dated 3/4/2015 revealed: -Upon admission to the facility warfarin order was not clarified. -Failure to clarify caused the resident to start bleeding and was hospitalized due to a high INR. -Error was discovered on 3/1/2015 during treatment at hospital by resident's primary physician. -Precaution to prevent similar error was to get clarification on orders with FL2s.	D 344		

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D 344	Continued From page 17 Interview with Staff M (Memory Care Manager who worked for the same corporation at another facility) on 5/5/2015 at 9:00am revealed: -Upon admission, if an FL2 was more than 3 days old, a new FL2 would be generated for verification of medications. -Staff M did not like to accept "see medication list" on the FL2s. Telephone interview with Staff F (former Memory Care Manager) on 5/5/2015 at 2:15pm revealed: -Staff F had worked for the corporation at several different buildings since 2009. -He had worked at the facility since September 2014 but left employment (by his own choice) the day after Resident #2 was admitted (2/11/2015). -He routinely worked on the Memory Care Unit. -Staff F stated when a new resident was admitted, if the FL2 was older than 3 days, they would get medication clarification verbally from the resident's physician or write a new FL2 and get the facility's PCP to sign it if the resident was switching their primary care physician to the facility's provider. -Staff F stated Resident #2's primary care physician should have been the one to sign the new FL2. -He did not remember anything about Resident #2 because he left employment the day after the resident was admitted. -He stated he had not transcribed the new FL2 for Resident #2 (even though that would have been his responsibility at that time) because a new person was training and that new manager may have transcribed the new FL2. A joint interview was conducted on 5/5/2015 at 10:10am with the Adminstrator and the Executive Director and revealed:	D 344		

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D 344	Continued From page 18 -Upon admission, Care Managers were supposed to verify medications listed on the FL2 with the physician who signed the FL2. -It was not the facility's policy to make a new FL2, but Managers transcribed new FL2s as means of clarification. -Expectations would have been for staff to clarify the warfarin dose and frequency with Resident #2's prescribing physician upon admission (since there were no instructions). -The Adminstrator stated they were not sure which Care Manager had transcribed the new FL2 with the incorrect dose of warfarin, since a new manager was in training at the time of Resident #2's admission. -The Adminstrator stated they were not aware Resident #2 had been receiving the incorrect dose of warfarin until the resident was sent to the hospital on 3/1/15 where Resident #2's physician discovered the error. -The Administrator stated since the error (regarding Resident #2's warfarin) the proper protocol had been put in place to call and verify orders, not create a new FL2. _____ A Plan of Protection was submitted by the facility on 5/5/2015 that included: -The former employee (who would have been responsible for the new FL2 and clarifying orders) no longer worked at the facility. -Immediate face-to-face training would be done with Care Managers regarding medication clarification upon admission with resident's Primary Care Physicians. -All Care Managers would be trained regarding the expectation (as above) with completing clarification of any medication order that was unclear or incomplete.	D 344		

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D 344	Continued From page 19 THE DATE OF CORRECTION FOR THIS A1 VIOLATION SHALL NOT EXCEED JUNE 4, 2015.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interviews, the facility failed to administer medications in accordance with physician orders and facility policies and procedures which resulted in 1 of 1 resident (Resident #4) receiving 12 wrong medications ordered for another resident. The findings are: Record review of Resident #4's most recent FL2 dated 12/1/2015 revealed diagnoses that included atrial fibrillation, chronic kidney disease, hypothyroidism, hypertension and dementia. Review of Resident #4's most recent assessment completed on 1/12/2015 revealed the resident was sometimes disoriented, forgetful and needed reminders.	D 358		

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D 358	Continued From page 20 Record review of Resident #4's medication administration record (MAR) for March, 2015 revealed the resident received the following ordered medications scheduled for 8:00am on 3/4/2015: -Digoxin (used to regulate heart rate) 0.125mg dose. -Furosemide (used to treat fluid retention) ½ of a 40mg tablet for a 20 mg dose. -Lisinopril (used for high blood pressure) 20mg dose. -Metoprolol (used for high blood pressure) 100mg dose. -Petroleum Gel (used as an emollient) apply to heels twice a day. -The resident's room number was noted at the top of the MAR. Review of a Medication Error Report, signed by Staff E (Medication Aide, MA) and the former Resident Care Coordinator on 3/4/2015 revealed Resident #4 received the following medications at 8:45am: -Buspirone (used to treat anxiety) 10mg dose. -Diltiazem (used to treat high blood pressure) 90mg dose. -Diphenhydramine (an antihistamine) 25mg dose. -Docusate Sodium (a stool softener) 100mg dose. -Duloxetine (used to treat depression) 30mg dose. -Fluticasone (used to ease breathing) 50 mcg dose. -Gabapentin (used to treat seizures or nerve pain) 100mg dose. -Isosorbide Mononitrate (used to treat heart disease) 30mg dose. -Digoxin (used to regulate heart rate) ½ of a 0.125mcg tablet (dose of 0.0625 mcg). -Omeprazole (used to treat gastric reflux) 20mg	D 358		

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D 358	Continued From page 21 dose. -Oxycodone (used for pain) 5mg dose. -Pramipexole (used for Parkinson's disease) 0.125mg dose Further review of the Medication Error Report signed on 3/4/2015 revealed: -Description of the medication error: "wrong name." -Reason for making the error: "wrong resident." -Effect of the wrong medication on the resident: "N/A, resident is on 30 minute checks, pulse has remained stable thus far." -Error discovered by: "trainee [not referenced with a proper name] noticed wrong resident." -Name of provider contact: documented with date and time of notification, with no new orders. -Precautions to be taken in the future to prevent a similar error: "always use last name. Always go with the trainee to administer meds." -The name of the resident (for whom the listed medications were intended) was not noted. Closed record review of Resident #4's care notes dated 3/4/2015 at 10:00 am revealed: -"A med error was done to this resident this am. She received her regular scheduled meds and she also received more addition[al] to the med error. MT [medication tech or medication aide] put on 30 min[ute] checks. Contacted Dr [physician] and reported to management." -This care note was signed by Staff E. -The resident's room number was noted on the top margin of the care note, which matched the room number at the top of the MAR. Review of Staff E's MA training dated 3/16/2015 revealed: -Six rights of medication administration including right resident.	D 358		

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D 358	Continued From page 22 -"Always check medication 3 times before administering meds to resident." -"Med Techs in training is not allowed to administer any kind of medication until signed off by the RN." Telephone interview on 5/4/2015 at 3:19pm with Resident #4's primary care provider revealed: -She remembered a staff member contacting her regarding the resident being given another resident's medications. -The medication error was just one time with no adverse outcome, with her instructions to the staff to monitor Resident #4 and note any changes to her general condition. Attempted telephone interview with Resident #4's POA on 5/5/2015 was unsuccessful. Attempted telephone interview with Staff E on 5/4/2015 and 5/5/2015 was unsuccessful. Review of Discharge/Transfer information revealed Resident #4 was transferred to a skilled nursing facility 3/24/15. Review of facility census for 5/4/2015 revealed: -Resident #4's name was not on the census. -Resident #3, another resident with the same first name but different last name than that of Resident #4, was on the census -Resident #3 was assigned a room across from that room (noted on Resident #4's care note of 3/4/2015 and March, 2015 MAR) occupied by Resident #4 during her admission to the facility. Interview on 5/4/2015 at 9:30am with Resident #3 revealed: -She received all her medications at the correct dosages, with no mistakes.	D 358		

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D 358	Continued From page 23 -She remembered another resident who shared her first name but who no longer resided in the facility, had been gone for at least a month. -She did not think she had ever received the other resident's medications and as it concerned her, staff did not mix her and the other resident up. Review of the MAR for March 2015 revealed Resident #3's received the following medications scheduled for 8:00am on 3/4/2015: -Buspirone (used for anxiety) 10mg dose. -Diltiazem (used to treat high blood pressure) 90mg dose. -Diphenhydramine (an antihistamine) 25mg dose. -Docusate Sodium (a stool softener) 100mg dose. -Duloxetine (used for depression) 30mg dose. -Fluticasone (used to ease breathing) 50 mcg dose. -Gabapentin (used for seizures or nerve pain) 100mg dose. -Isosorbide Mononitrate (used to treat heart disease) 30mg dose. -Digoxin (used to slow heart rate) ½ of a 0.125mcg tablet (dose of 0.0625 mcg). -Omeprazole (used to treat gastric reflux) 20mg dose. -Oxycodone (used for pain) 5mg dose. -Olopatadine hydrochloride ophthalmic solution 02% (for itchy eyes) one drop in each eye -Pramipexole (used to treat Parkinson's disease) 0.125mg dose Interview on 5/5/2015 at 7:45am with Staff I (Medication Aide) revealed: -Residents did not have identification bracelets. -Calling residents by name and looking at their last name would confirm a resident's	D 358		

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D 358	Continued From page 24 identification. -The computerized MAR had photos of residents but she had worked at the facility so long she knew the residents pretty well. -She was aware of two current residents with the same first name and another two current residents with another same first name. -She was aware of a situation with Resident #4 and Resident #3, both with the same first name and with one of them got the other's medications. -She stated the medication error with Resident #4 and Resident #3 involved a trainee. Interview on 5/5/2015 at 8:00am with Staff J (Medication Aide) revealed: -Residents did not have identification bracelets. -New staff would need to use photos of residents, ask residents for their full names and if they could not respond due to confusion then get another staff member to confirm resident identification. Interview on 5/5/2015 at 9:00am with the Resident Care Coordinator (RCC) revealed: -She started as RCC after Resident #4 was discharged to a skilled nursing facility. -After the 5 hour and 10 hour medication training was completed, prospective MAs would "shadow" an experienced MA for 3 days then be checked off by the licensed health professional support (LHPS) staff. -At the time of the interview, no staff were currently in training as an MA. -Resident identification for medication administration included photos on the MAR, name, date of birth and a room number. -Other staff were available to help confirm resident identity. -For a new staff member, she expected them to ask the resident to state their name. -At the time of the interview there were two	D 358		

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D 358	Continued From page 25 residents with similar first names and in this situation the new staff member would be expected to ask them for their full name. -She became aware of a medication error involving Staff H (Personal Care Aide,PCA) who was training as a MA . -Staff E pulled medications and told Staff H to give them to a resident, mentioned only the resident's first name and left off the last name. -A MA trainee could pull medications out of the cart and check them against the MAR but were expected to give them back to the trained MA to administer. -Staff E should have taken the medications back from Staff H. -After the medication error occurred, leadership discussed it, had a meeting with staff and provided training. Interview with the Administrator on 5/5/2015 at 9:00am revealed she expected resident identification to be made by staff asking residents to state their first and last names and to compare names against the MAR. Interview on 5/5/2015 at 10:05am with Staff H revealed: -She trained on the medication cart about a month ago. -She was handed medications by Staff E who said "here are [proper first name] meds" and Staff H administered the medications to Resident #4. -When Resident #4 was given the fluticasone spray, Staff H remembered the resident asked how to do it and after the Resident took one spray, Staff H stated she had reservations and did not let Resident #4 take the second spray of fluticasone. -She went into the hallway and was told the medications she gave to Resident #4 were	D 358		

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MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(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 358	Continued From page 26 intended for Resident #3. -The Administrator was notified by Staff E and Resident #4 was monitored all day long. -After the medications were given, Resident #4 slept through lunch but the next day was alert when Staff H returned to work. -Staff H finished her training, requested and received additional shadow days, was checked off by the LHPS, but had requested to be returned to PCA duties. Review of Staff H's MA training dated 3/16/2015 revealed: -Six rights of medication administration including right resident. -"Always check medication 3 times before administering meds to resident." -"Med Techs in training is not allowed to administer any kind of medication until signed off by the RN." Telephone interview with the LHPS nurse on 5/5/2015 at 11:45am revealed: -Staff training to be a MA were required to complete computer modules, then a four day shadow experience with a trained MA, then the LHPS was called to go through the checklist with them and sign them off if they successfully passed medications. -Shadowing meant the trainee followed the experienced MA but they did not actually pass medications. A second interview with Staff H on 5/5/2015 at 2:30am revealed: -When she administered the medications to Resident #4 on 3/4/2015 the resident seemed coherent. -Although she normally did not work the hallway where Resident #4 resided, she was familiar	D 358		

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D 358	Continued From page 27 enough with the resident to determine the resident was not confused. -Resident #4 responded to her first name, did not question the medications given to her and it was only after giving Resident #4 the fluticasone spray that Staff H thought that "something was not right." _____ A Plan of Protection was obtained from the Executive Director on 5/5/2015 at 4:30 PM which included the following: -Trainer and Trainee at time of the incident received training as previously noted. -Trainee had stepped down from a MA position at her request with no further care concerns. -MAs in training were not permitted to pass medications until they had been signed off by the RN (LHPS). -On-going training was planned and staff would receive refresher training on using the resident's last name and calling them by name for positive resident identification. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2015.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by:	D 438		

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D 438	Continued From page 28 TYPE B VIOLATION Based on record review and interview, the facility failed to protect residents by not reporting allegations of staff to resident verbal and physical abuse to the Health Care Personnel Registry (HCPR) within 24 hours (Staff B, Personal Care Aide to Resident #5). The findings are: Review of Resident #5's current FL2 dated 11/6/2014 revealed: -Diagnoses included Alzheimer's Dementia - Senile. -The resident was ambulatory and disoriented constantly. -Resident #5 was admitted to the facility on 11/15/2013. Review of Resident #5's current care plan dated 12/12/2014 revealed the resident wandered. Review of Resident #5's current Special Care Unit quarterly review dated 3/5/2015 revealed the resident was forgetful and needed reminders. Review of Staff B, Personal Care Aide (PCA), personnel record revealed: -Date of hire 2/19/2014. -HCPR check completed 2/17/2014 with no substantiated findings. -A criminal back ground check completed on 2/18/2014. Interview with Business Office Manager (BOM) on 5/5/2015 at 3:00pm revealed: -Facility's failure to complete HCPR checks per State regulations was cited on the 8/5/2014 annual survey.	D 438		

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D 438	Continued From page 29 -Facility's plan of correction included rechecking HCPR on all staff. Interview with Staff D on 5/4/2015 at 3:30pm revealed: -She witnessed the incident between Staff B and Resident #5 that occurred on 4/18/2015. -She immediately reported the incident to the SIC, her immediate supervisor. -She had provided the SIC with a written statement of the incident. -She considered Staff B's behavior towards Resident #5 to be abusive. Interview with Staff C on 5/4/2015 at 2:50pm revealed: -On Saturday, 4/18/2015 between "10:00 and 11:00 am" Staff D reported Staff B was "hollering and fussing" at [Resident #5]. -She was bathing a resident, the door was closed and could hear Staff B say "get your [expletive] off my bed, I'm tired of you messing up my [expletive] beds". -She stated physical or mental abuse was to be reported "right then" to the Special Care Coordinator (SCC) or Resident Care Coordinator (RCC). -She did not call the on-call administrator because the on-call administrator "didn't know what to do and always had to call someone else". -"No one reported" that Staff B had grabbed and pushed Resident #5. -She did not hear Staff B "threaten" Resident #5, only heard her yelling and cursing. -She made a copy of the written statements and slid them under the Executive Director's (ED) door. -She stated "I did what I thought I was supposed to do, took statements and slid under the [ED's] door."	D 438		

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D 438	Continued From page 30 A second interview with Staff C on 5/4/2015 at 5:40pm revealed, "How was I to send her (Staff B) home when I did not witness the hands-on". A third interview with Staff C on 5/5/2015 at 3:20pm revealed: -"I did not complete an incident report, it was all hearsay." -It was all "he said/she said". Interview with the Executive Director (ED) on 5/4/2015 at 4:35pm revealed: -If abuse was suspected and she was not at the facility, "call the on-call or myself". -She would "expect" the SIC to call her or the "care manager". -They should "call as soon as it comes to their attention". -On Monday, 4/20/2015 she became aware of an incident that occurred on 4/18/2015. -Written statements from staff had been put under the doors of the ED, SCC and RCC and "all had the same copies". -"One was [Staff B] was cursing and being disrespectful to [Resident #5], something like that." -One allegation had to do with Staff B stating she was "tired about making these [expletive] beds, the resident going from room to room." -"Another said they heard her (Staff B) cursing him (Resident #5), nudging and pushing him towards the TV room." -On 4/20/2015 ED discussed incident with the Administrator. -Administrator instructed ED to talk to Staff B about "resident rights and to write her up". -She interviewed Staff B who denied abusing Resident #5 but "admitted getting loud with staff in hallway at the nurses station" due to her	D 438		

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D 438	Continued From page 31 workload. -On Monday (4/20/2015) it was "he said/she said" and "I wrote her (Staff B) up for interaction with staff". -She "did not interview those who wrote the notes under the door." -She reported hearing "staff talking about" the incident and spoke with Staff D on Monday, 4/27/2015. -She stated Staff D reported that "[Staff B] pulled [Resident #5] up by the arms". -She stated she "had nothing like that in my statements. I did not have the second page to a statement. None of the managers had the second page". -"The second page was given to me on Monday 4/27." -"That was when I started my investigation." -"[Staff C] neglected to immediately report an allegation of abuse." -She submitted the HCPR 24-Hour Initial Report on 4/27/2015 and the 5-Working Day Report on 5/1/2015. Interview with the Administrator on 5/4/2015 at 5:22pm revealed: -The "expectation was if staff suspected abuse, they were to report it to their supervisor or go up the chain of command immediately." -"I found out on Monday 4/20 and think she (ED) started the 24-hour report." -"I think when [ED] got the second page with the damning information, she took action." -"We are failing with not empowering our staff." -It was "neglect on our part for not addressing it immediately." -"That day they should have called and should have sent her home." -The ED was responsible for submitting reports to the HCPR.	D 438		

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D 438	Continued From page 32 On 5/4/2015, the facility Executive Director submitted a Plan of Protection which included: -Investigations regarding allegations of abuse were completed. The 24-hour and 5-day reports were sent to Health Care Personnel Registry. -Management will report allegations of abuse, neglect and exploitation immediately per State regulations. -Will suspend accused staff member pending investigation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, JUNE 19, 2015.	D 438		
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 observation, interview and record review, the facility failed to assure that every resident received care and services which are adequate, appropriate and in compliance with relevant federal and State laws and rules and regulations as related to management of the facility, medication orders and medication administration. The findings are: A. Based on record review and interview the	D912		

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D912	Continued From page 33 facility failed to clarify medication orders upon admission for 1 of 2 residents prescribed warfarin (an anticoagulant) which resulted in warfarin toxicity and hospitalization for Resident #2. [Refer to Tag 344, 10A NCAC 13F .1002(a) Medication Orders (Type A1 Violation).] B. Based on record review and interviews, the facility failed to administer medications in accordance with physician orders and facility policies and procedures which resulted in 1 of 1 resident (Resident #4) receiving 12 wrong medications ordered for another resident. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (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 interview and record review, the facility failed to assure that every resident was free from mental and physical abuse, neglect and exploitation as related to staff to resident verbal and physical abuse (Staff B to Resident #5) and failure to report allegation of staff to resident abuse to the Health Care Personnel Registry. The findings are: A. Based on interview and record review, the facility failed to assure that residents were free of abuse as related to one staff (B) to resident (#5) verbal and physical abuse. [Refer to Tag 338, 10A NCAC 13F .0909	D914		

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D914	Continued From page 34 Resident Rights (Type A2 Violation).] B. Based on record review and interview, the facility failed to protect residents by not reporting allegations of staff to resident verbal and physical abuse to the Health Care Personnel Registry (HCPR) within 24 hours (Staff B, Personal Care Aide to Resident #5). [Refer to Tag 438, 10A NCAC .1205 Health Care Personnel Registry (Type B Violation).]	D914		