STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUSTIN ADULT CARE	511 BUMGARNER INDUSTRIAL DRIVE CONOVER, NC 28613

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D 000	Initial Comments On January 6-8, 2016 and January 11-12, 2016, the Adult Care Licensure Section conducted an annual and follow-up survey and a complaint investigation.	D 000		
D 050	10A NCAC 13F .0305(e) Physical Environment 10A NCAC 13F .0305 Physical Environment (e) The requirements for bathrooms and toilet rooms are: (1) Minimum bathroom and toilet facilities shall include a toilet and a hand lavatory for each 5 residents and a tub or shower for each 10 residents or portion thereof; (2) Entrance to the bathroom shall not be through a kitchen, another person's bedroom, or another bathroom; (3) Toilets and baths for staff and visitors shall be in accordance with the North Carolina State Building Code, Plumbing Code; (4) Bathrooms and toilets accessible to the physically handicapped shall be provided as required by Volume I-C, North Carolina State Building Code, Accessibility Code; (5) The bathrooms and toilet rooms shall be designed to provide privacy. Bathrooms and toilet rooms with two or more water closets (commodes) shall have privacy partitions or curtains for each water closet. Each tub or shower shall have privacy partitions or curtains; (6) Hand grips shall be installed at all commodes, tubs and showers used by or accessible to residents; (7) Each home shall have at least one bathroom opening off the corridor with: (A) a door of three feet minimum width; (B) a three feet by three feet roll-in shower designed to allow the staff to assist a resident in taking a shower without the staff getting wet;	D 050		

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D 050	Continued From page 1 (C) a bathtub accessible on at least two sides; (D) a lavatory; and (E) a toilet. (8) If the tub and shower are in separate rooms, each room shall have a lavatory and a toilet; (9) Bathrooms and toilet rooms shall be located as conveniently as possible to the residents' bedrooms; (10) Resident toilet rooms and bathrooms shall not be utilized for storage or purposes other than those indicated in Item (4) of this Rule; (11) Toilets and baths shall be well lighted and mechanically ventilated at two cubic feet per minute. The mechanical ventilation requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation; (12) Non-skid surfacing or strips shall be installed in showers and bath areas; and (13) The floors of the bathrooms and toilet rooms shall have water-resistant covering. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide privacy in 2 of 2 toilet rooms with 4 of 5 commodes not having a privacy partition or curtain. The findings are: Observations on 1/6/16 at 9:05am revealed only male residents lived in the facility, with a census of 24. Observations on 1/6/16 at 9:45am revealed: -The "Women's" shower room had 2 toilet rooms between stalls/partitions but no privacy door or curtain in front of the commodes. -The "Men's" shower room had 3 toilets, but only one of them had a curtain around it for privacy, the other 2 toilets were between stalls/partitions	D 050		

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D 050	Continued From page 2 but no privacy door or curtain in front of the commodes. Confidential interviews with residents revealed: -The only commode that had a privacy curtain around it was not always available (if occupied by another resident). -There had not been any privacy curtains in "more than a year". -A curtain or door would give some privacy when doing "your business". -"I hate it...the curtains get torn down...have almost had fights over other residents looking at or seeing me". -"I need privacy...it bothers me...we need doors." Interview with the Manager on 1/7/16 at 2:20pm revealed: -The facility did have curtains months ago, June or July (2015). -The residents would tear the curtains down. -No one had ever complained to her about not having a curtain. -Some residents had complained about a curtain getting in their way. -The Manager stated she would have privacy curtains placed by the next morning. Observations on 1/8/16 at 9:00am revealed privacy curtains had been installed in each toilet room.	D 050		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor	D 074		

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D 074	Continued From page 3 coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have floors, ceiling fans and doors, clean and in good repair in the living area, dining room, hallway and one resident room. The findings are: Observations on 1/6/16 from 9:30am to 11:00am revealed: -A floor drain grate trap in the middle of the tiled floor in the hallway was covered with black tape that had a sticky residue around the area approximately 12x12 inches. The edges of the tape had come loose from the floor and curled up. -The side of the door to a resident room, on the left just past the laundry room, was split down the center and held together with black tape. The strike plate on this door frame was split and held together with black tape. -2 ceiling fans' blades in the resident living area were covered with a thick dark coat of dust. -1 ceiling fan was missing a blade. -The blades on all four ceiling fans in the dining room were covered with a thick coat of dark dust. -None of the fans were observed to be in use. Review of the facility's most recent inspection by North Carolina Department of Environmental and Natural Resources, Division of Environmental Health, dated 9/1/15 revealed: -Status code "A" with a score of 96. -A demerit for "floors easy to clean, no obstacles, drains where needed." -A demerit for "walls, ceilings clean and in good	D 074		

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D 074	Continued From page 4 repair." Random resident interviews revealed no concerns with the dirty ceiling fans, no one knew how long the floor had been taped up or how long the door had been broken. Interview with the Housekeeper on 1/6/16 at 9:45am revealed: -The ceiling fans were cleaned every month. -She was not sure but thought the last time they were cleaned was around Thanksgiving. Interview with the Manager on 1/6/16 at 4:00pm revealed: -The floor drain/fixture had been loose and missing a screen for about "1 week." -Maintenance had been working on this. -The tape was an effort to prevent residents' canes or walkers from getting caught in the drain. -A resident had broken the door "a few months" ago and maintenance was working on repairing it. -She did not know how long the ceiling fan blade had been missing. -The fans were supposed to be cleaned weekly. -She was not aware the ceiling fans were dirty.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 076		

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D 076	Continued From page 5 failed to keep 2 end tables and 1 chair in the resident's living area clean and in good repair. The findings are: Observations of the resident's living area on 01/06/16 at 10:30am revealed: -2 wood finished ply board end tables with the entire finish worn down to the fiber board surface. -1 cloth straight back chair with dark stains all over the arms and seat. The arm of the chair was torn loose from the seat. Interview with the Manager on 01/06/16 at 4:00pm revealed: -The tables need to be replaced but this has to be done "as we can." -The chair won't come clean so it needs to be replaced. Random interviews with several residents revealed no concerns regarding the chair or tables.	D 076		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by:	D 079		

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D 079	Continued From page 6 Based on observations and interviews, the facility failed to maintain an environment free of hazards in 2 of 2 shower rooms. The findings are: Observations of the "Women's" shower room on 01/06/16 at 10:30am revealed: - 2 toilets whose tissue dispensers were covered with a heavy build up of rust. -The front of the soap dispenser between two sinks was broken exposing sharp edges around the dispenser. -No towel dispenser noted in the room. Observations during the entire 4 days survey revealed male residents used the "Women's" shower room. Observations of the "Men's" shower room on 01/06/16 at 10:25am revealed: -3 toilets whose tissue dispensers were covered with a heavy build up of rust. -The front of the soap dispenser between two sinks was broken exposing sharp edges around the dispenser. -The front cover of the towel dispenser was broken off, completely missing, and exposed sharp edges all around the edge of the dispenser. Interview with the Manager on 01/06/16 at 4:00pm revealed: -She was not aware the soap dispensers or the towel dispensers were broken. -She was aware of the rusty tissue holders and maintenance was supposed to replace them.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements	D 105		

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D 105	Continued From page 7 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to maintain the water fountain, (3) ceiling fans and (23) light fixtures in a safe and operating condition. The findings are: A. Observations of the water fountain attached to the wall in the hallway on 01/06/16 at 10:00am revealed: -No protective covering on the front of the water fountain. -Numerous wires, lines and tubing were exposed. -The water spigot was turned out away from the water bowl towards the hallway. -The fountain was not operable. -Random residents' interviews revealed the fountain had been broken for a while and they would like to have cold water to drink. Refer to review of the facility's most recent County's Food Establishment Inspection Report dated 11/18/15. Refer to interview with the Manager on 01/06/16 at 4:00pm. B. Observation of the facility dining room, living room, and residents' rooms on 01/08/16 at	D 105		

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D 105	Continued From page 8 2:45pm revealed: -9 of 13 resident occupied rooms contained wall lamps with missing light bulbs. -The living room had 2 ceiling fans, and 5 of 6 light sockets on the fans had missing light bulbs. -1 of the 2 ceiling fans in the living room had missing blades making the fan inoperable. -2 of 2 lamps in the living room had missing light bulbs with empty sockets. -The dining room had 4 ceiling fans with 4 missing bulbs out of 12 sockets. -1 of the 4 ceiling fans/light fixtures in the dining room was inoperable. -1 unnumbered resident room across from the clean linen closet had a ceiling fan with only 1 of 4 blades attached, making it inoperable. Interview with a resident in the living room at 3:00pm on 01/08/16 revealed: -Staff put light bulbs in the lamps and fans, but residents steal them. -Staff will give residents light bulbs for their rooms if we ask for them. Refer to review of the facility's most recent County's Food Establishment Inspection Report dated 11/18/15. Refer to interview with the Manager on 01/06/16 at 4:00pm. --- Review of the facility's most recent County's Food Establishment Inspection Report dated 11/18/15 revealed: -Status code "A" with a score of 96. -A demerit for requirements meeting lighting in designated areas; light bulbs, protective shielding. Interview with the Manager on 01/06/16 at	D 105		

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D 105	Continued From page 9 4:00pm revealed: -She was unsure how long the water fountain had been broken. -Maintenance had been working on it. -Residents took bulbs out of the light fixtures. -The ceiling fan/light in the dining room did not work, unsure how long. -She was not sure how long the fan blades had been broken. _____ On 01/08/16 the facility provided the following Plan of Protection: -The facility will monitor all lighting fixtures that are broken and do not work to ensure the safety of the residents. -All fixtures will be repaired within the week. -We will ensure light bulbs are back in each light fixture. -The facility will place a plastic bag over the broken water cooler to protect residents until the new water cooler arrives. -A new water cooler had been ordered and will be in the facility the week of 01/11/16. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2016.	D 105		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting	D 176		

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D 176	Continued From page 10	D 176		

and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.

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

Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility met and maintained rules related to physical environment, housekeeping and furnishings, other requirements, nutrition and food service, resident rights, pharmaceutical care, and ACH infection prevention requirements.

The findings are:

Interview with the Resident Care Coordinator on 1/11/16 at 10:45am revealed the Administrator was "not in the facility real often, maybe once or twice a month."

Interview with the facility Manager on 1/11/16 at 11:00am revealed:
-The Administrator was in the facility once or twice a month, "unless we need him."
-When we call him, "he will come to the facility."
-When the Administrator was in the facility he took care of maintenance issues and talked with residents.

Areas of non-compliance identified during the survey were:

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D 176	Continued From page 11 A. Based on observations and interviews, the facility failed to provide privacy in 2 of 2 toilet rooms with 4 of 5 commodes not having a privacy partition or curtain. [Refer to Tag D 050 10A NCAC 13F .0305(e) Physical Environment.] B. Based on observations and interviews, the facility failed to have floors, ceiling fans and doors, clean and in good repair in the living area, hallway and one resident room. [Refer to D 074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings.] C. Based on observations and interviews, the facility failed to keep 2 tables and 1 chair in the resident's living area clean and in good repair. [Refer to D 076 10A NCAC 13F .0306(a)(3) Housekeeping and Furnishings.] D. Based on observations and interviews, the facility failed to maintain an environment free of hazards in 2 of 2 shower rooms. [Refer to D 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings.] E. Based on observations, record review and interviews, the facility failed to maintain the water fountain, (3) ceiling fans and (23) light fixtures in a safe and operating condition. [Refer to D 105 10A NCAC 13F .0311(a) Other Requirements (Type B Violation).] F. Based on observations and interviews, the facility failed to provide table service that included a knife and spoon for all residents. [Refer to D 287 10A NCAC 13F .0904(b)(2) Nutrition and Food Service.] G. Based on observations and interviews, the	D 176		

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D 176	Continued From page 12 facility failed to serve water to each resident at meal times. [Refer to D 306 10A NCAC 13F .0904(a)(1) Nutrition and Food Service.] H. Based on observation, record reviews and interviews, the facility failed to maintain the rights for 1 of 1 resident by neglecting to provide care and services to meet residents' needs. (Resident #4) [Refer to D 338 10A NCAC 13F .0909 Resident Rights (Type B Violation).] I. Based on record reviews and interviews, the facility failed to provide adequate pharmaceutical care to identify medication related problems related to refusal of medications, and medications omitted during extended absences from the facility for 1 of 4 (#4) sampled residents. [Refer to D 400 10A NCAC 13F .1009(a)(1) Pharmaceutical Care (Type B Violation).] J. Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring for at least 4 of 7 residents with orders for finger stick blood sugars (FSBS) by borrowing a lancet device or glucose meter from a discharged resident for 2 of 7 residents (#5 and #6) and borrowing lancet devices from other current residents for 2 of 7 residents (#2 and #7). [Refer to D 932 G.S. 131D-4.4A (b) ACH Infection Prevention Requirements. (Type A2 Violation.)] _____ On 01/13/16 the facility provided the following Plan or Protection: -The Administrator will replace/repair all areas in need of such (furnishings, water cooler, towel racks, light fixtures, etc.) to ensure they are clean and in proper working order.	D 176		

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D 176	Continued From page 13 -The Administrator has hired additional staff to assist with these repairs. -Lancets/meters have been provided for each individual resident to ensure safety in blood sugar testing. -The Administrator will be in the facility no less than 2 times a week to monitor needed repairs and to assist with all issues of the facility. -Additional training in bloodborne pathogens and infection control has been scheduled for the second week of February to be conducted by staff from the local medical group to ensure that staff are thoroughly trained. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2016.	D 176		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide table service that included a knife and spoon for all residents. The findings are:	D 287		

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D 287	Continued From page 14 Observations of the lunch meal on 01/06/16 at beginning at 11:30am through 12:15pm revealed: -All residents received a paper napkin and a regular fork. -The ham served from the kitchen had been cut into bite size pieces. Interview with the Dietary Manager (DM) on 01/06/16 at 12:30pm revealed: -The residents can't have a knife "because it can be used as a weapon". -There are no knives available for resident use. -There are spoons available for resident use. -The residents can only have a spoon if they ask. Confidential interviews with alert and oriented residents revealed: -No one can have a knife because "they" are afraid the residents will fight. -"I could use a knife." -The residents never remembered ever having a knife. Interview with the Manager on 01/06/16 at 4:00pm revealed: -The facility had never had knives because knives could be used a potential weapons. -She did not know of any time when a knife was used as a weapon. -She was unaware of any assessments completed to determine if residents were safe to use a table knife. Observations of the lunch meal on 01/07/16 at 12 noon revealed each resident received a knife, fork and spoon. Interview with the DM on 01/07/16 at 12 noon revealed she had gone to the store last night and	D 287		

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D 287	Continued From page 15 bought knives for resident use.	D 287		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve water to each resident at meal times. The findings are: Observations of the lunch meal on 01/06/16 at beginning at 11:30am through 12:15pm revealed: -All residents received a six ounce glass of purple/gray colored beverage, (staff stated it was kool-aide.) -No other beverages were served or offered. Interview with the assistant cook on 01/06/16 at 12:30pm revealed water was not served because the residents did not drink it. Confidential interviews with residents revealed: -Water was never served with meals. -They would like to have water with their meals especially since the water fountain was not working. Interview with the Manager on 01/06/16 at 4:00pm revealed:	D 306		

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D 306	Continued From page 16 -Water was supposed to be served with meals. -She thought water was being served and did not know why kitchen staff had not served water with lunch today. -She was not aware water was never being served with meals. -The Manager showed the surveyor a large stack of bottled water cartons in the corner of her office and stated residents knew this water was available if they wanted water. Observations on 01/07/16 of the lunch meal at 12 noon revealed each resident was served water with their meal.	D 306		
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 B VIOLATION Based on observations, record reviews and interviews, the facility failed to maintain the rights for 1 of 1 resident by neglecting to provide care and services to meet residents' needs. (Resident #4). The findings are: Review of Resident #4's current FL2 dated 12/28/15 revealed: -Diagnoses included alcohol use disorder-severe and paranoid schizophrenia.	D 338		

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-The resident was independent with all Activities of Daily Living (ADL), alert and oriented to person, place and time, no wandering, not verbally or physically abusive, and not dangerous to self or others.

Review of Resident #4's current Care Plan, dated and signed by the Primary Care Provider (PCP) on 10/11/15 revealed:
-The resident was verbally abusive, received medications for mental illness, had a history of substance abuse, and received mental health services.
-The resident was alert and oriented with adequate memory and independent with all ADL.
-"[Resident's name] is still refusing all of his medications except his injection. He is signing out days at a time."

Observations of Resident #4 on 1/7/16 at 2:05pm revealed the resident was lying on the ground, dressed in a coat, pants, socks, shoes, gloves, reading and smoking.

Review of National Weather Service records for the location of the facility revealed the high temperature for 1/7/16 was 57 degrees Fahrenheit (F), with a low of 27 degrees F and a mean temperature of 42 degrees F.

Interview with Resident #4 on 1/7/16 at 2:05pm revealed:
-The resident was alert and oriented and had been at the facility "12 years".
-The resident denied being cold and stated he used to live in the woods in a tent.
-The resident refused to see the facility's PCP.
-The resident agreed to see the psychiatric nurse who gave his injections.
-The resident refused to answer questions about

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signing out of the facility saying it was his right and he did not like "everyone messing in my business."

Observations of Resident #4 on 1/8/16 at 9:45am revealed:
-The resident was lying outside on the damp ground (it was raining), next to the facility, under the edge of the roof overhang, by the dryer vent, reading and smoking.
-The resident had on a coat, pants, shoes, socks, gloves and hat.

Review of National Weather Service records for the location of the facility revealed the high temperature for 1/8/16 was 44 degrees Fahrenheit (F), with a low of 37 degrees F and a mean temperature of 40 degrees F.

Interview with Resident #4 on 1/8/16 at 9:45am revealed:
-He had lived at the facility "about 13 years."
-When he left the facility, he always signed out and came back.
-He wanted a new roommate because his roommate watched porn, "I don't like that."
-He told the facility Manager he wanted a new roommate.
-He went to his "place in the woods" near a convenience store and close to the interstate.
-He got food by panhandling (begging), and had a sign that said, "will work for food."
-Sometimes his friends gave him food.
-He had a 4 pack a day cigarette habit.
-He did not want to go to detox for his alcohol abuse, because "they wanted me to quit smoking too."
-He got cold sometimes when he's out of the facility.
-Before he came to the facility, he lived outside in

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a tent.
-He did not have a tent now, but stayed dry under the trees.
-He did not want a guardian, and wanted his "freedom to come and go as I please" without any restrictions.
-He wanted to quit drinking, and had not had any alcohol for the past 4 days.

Observations of Resident #4 on 1/11/16 at 9:40am revealed:
-The resident was lying outside on the ground in the sun, reading and smoking one cigarette after another.
-The resident had on a coat, pants, shoes, socks and gloves.

Review of National Weather Service records for the location of the facility revealed the high temperature for 1/11/16 was 42 degrees Fahrenheit (F), with a low of 21 degrees F and a mean temperature of 32 degrees F.

Interview with Resident #4 on 1/11/16 at 9:40am revealed:
-He was alert and oriented.
-He was not cold but "loved it" (being outside).
-He was "miserable" inside because he could not smoke.
-He would sign out to go "beg" money for cigarettes and alcohol.
-Sometimes he held a sign "please help, need work" and people would give him money.
-He refused his medications because they made him "sick...all I need is Cogentin and Prolixin". He stated he could not afford cigarettes and medicine.
-He stated he was sick because he drinks and his liver was bad... had been told to quit drinking and smoking but "they can't make me."

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-He did not want to go to detox because he was against the "AA meetings" and he could not smoke there.
-"I like it here...I love them...it is a good place to live...they make sure I am fed, I have a bed, a radio, cigars and I get my money every month out of my check... and new clothes... they offer my meds but sometimes I refuse them."
-The resident refused to see the facility's PCP but would see "[Local Mental Health Provider]...they take good care of me... I am not always here when they come".
-The [Local Mental Health Provider] had worked with the resident regarding help with housing but [name of housing assistance] did not follow up with the resident.

Review of the facility's Behavioral Notes for September 2015 revealed Resident #4 was documented by staff as out of facility (OOF) with no exact times documented, on 9/1, 9/2, 9/3 (and back the same day), 9/4, 9/5, 9/6, 9/7, 9/8, 9/9, 9/10, 9/14, 9/15, 9/16, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, 9/24, 9/26, 9/27, 9/28, 9/29, and 9/30.

Review of the facility's Sign Out Sheet for September 2015 revealed Resident #4 signed himself out, designation "out" (no specific location or destination) as follows:
- 9/2 at 2:35 (am or pm not indicated) for 3 days.
- 9/4 at 1:05 (am or pm not indicated) for 3 days, and signed himself back in on 9/4 at 9:30 (am or pm not indicated.)
-9/7 at 9:30 (am or pm not indicated) and signed back in at 9:30 (am or pm not indicated).
-9/9 at 12:15 (am or pm not indicated) for 3 days and signed back in on 9/9 at 11:30 (am or pm not indicated).
-9/13 at 11:30 (am or pm not indicated) for 3

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days.
-9/17 at 9:30 (am or pm not indicated) for 3 days.
-9/19 at 9:25 (am or pm not indicated).
-9/26 at 3:15 (am or pm not indicated) for 3 days.
-9/30 at 8:25 am for 3 days and signed back in 10/4 at 8:30 am.

Review of the facility's Behavioral Notes for October 2015 revealed Resident #4 was documented by staff as OOF,(with no exact times documented) on 10/1, 10/2, 10/3, 10/6, 10/7, 10/8, 10/9, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/23 and 10/24.

Review of the facility's Sign Out Sheet for October 2015 revealed Resident #4 signed himself out, designation "out" (no specific location or destination) as follows:
-10/5 at 4:00 (am or pm not indicated) for 3 days.
-10/9 at 8:45 (am or pm not indicated) for 3 days.
-10/11 at 11:45 (am or pm not indicated) for 3 days.
-10/20 at 1:30 (am or pm not indicated) for 3 days.

Review of the facility's Behavioral Notes for November 2015 revealed Resident #4 was documented by staff as OOF, (no exact times documented) on 11/5, 11/6, 11/7, 11/25, 11/26 and 11/27.

Review of the facility's Behavioral Notes for December 2015 revealed Resident #4 was documented by staff as OOF, (no exact times documented) on 12/6, 12/7, 12/8, 12/10, 12/11, 12/13, 12/14, 12/15, (12/16 and 12/17 at the hospital), 12/24, 12/25, 12/26 and 12/27.

The facility's Sign Out Sheets for November and

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D 338	Continued From page 22 December 2015 were not available for review. Review of the facility's Behavioral Notes for January 2016 revealed Resident #4 was documented by staff as OOF, (no exact times documented) on 1/1 and 1/5 (survey began on 1/6.) Review of the facility's Sign Out Sheet for January 2016 revealed Resident #4 signed himself out, designation "out" (no specific location or destination) as follows: -1/1 at 11:15 (am or pm not indicated) for 3 days, and signed back in on 1/1 at 3:05 (am or pm not indicated). -1/3 at 12:10 (am or pm not indicated) for 3 days and signed back in on 1/3 at 4:05 (am or pm not indicated). -1/5 at 9:45 (am or pm not indicated) for 3 days and signed back in on 1/5 at 9:00pm. Record review revealed Resident #4 missed medications on a regular basis from refusals and or being out of the facility. (Refer to D 400 10A NCAC 13F .1009(a)(1) Pharmaceutical Care.) Review of records from a local hospital (Hospital A) dated 10/12/15 revealed admission History and Physical that included: -Resident #4 admitted 10/12/15 with chief complaint: "I am here for detoxing." -Well known schizophrenic, presents intoxicated, depressed, suicidal with psychotic symptoms. -Longstanding psychiatric disease, substance dependence and abuse with multiple detoxes at this facility in the past. -Having lots of financial worries. -Is disheveled and unkempt, disorganized in thinking, suspicious and guarded, vague and avoidant in answering questions.	D 338		

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-Judges to be at risk to himself and to others and will be admitted for evaluation and stabilization.
-Prior treatment at [name of state hospital] and [name of psychiatric unit at another hospital].
-Smokes 3 packs a day.
-No acute distress, appropriately attired, flat mood, depressed.
-Average intellectual functioning, memory for recent and remote events poor.
-Weight of 170 pounds, well developed, well nourished.
-Blood alcohol level 259, TSH 56.10 with recheck of 25.44 (suggesting non-compliance.)
-Admitting impression included: Schizoaffective schizophrenia, bipolar type, substance-induced mood disorder, continuous alcohol dependence, continuance nicotine dependence, chronic obstructive pulmonary disease and constipation.
-Treatment plan: Start medications, monitor and adjust as necessary given daily psychotherapy encounters.

Review of driving directions revealed a distance from the facility to Hospital A of 7.1 miles.

Review of the Hospital Discharge Summary from Hospital A, dated 10/20/15 included:
-Diagnoses of acute exacerbation of paranoid type schizophrenia, alcohol intoxication, alcohol dependence, alcohol withdrawal, nicotine dependence, provisional personality disorder, and hypothyroidism, under replaced.
-During hospitalization he was detoxed without complication, remained chronically psychotic, cooperative, and not aggressive to others or himself.
-At discharge he was free of any suicidal ideation.

Review of records from Hospital A dated 12/16/15 revealed admission History and Physical that

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included:
-Resident #4 presented to emergency room (ER) with complaints of chest pain (was in ER approximately 2 weeks ago with same complaint.)
-Past history significant included: paranoid schizophrenia, gastroesophageal reflux disease, and hypothyroidism.
-Vital signs stable, afebrile, chest pain most likely secondary to alcohol abuse and alcohol gastritis.
-Will be admitted and placed on detox protocol.

Review of records from Hospital A dated 12/17/15 revealed a Discharge Summary that included:
-Diagnoses included chest pain, alcohol abuse, paranoid schizophrenia, alcoholic gastritis, tobacco abuse and hyponatremia.
-Negative nuclear stress test, and normal ejection fraction, myocardial infarction ruled out.
-Discharged home to follow up with his PCP in one week.

Review of records from another local hospital's (Hospital B) ER dated 12/23/15 at 3:50pm revealed admission History and Physical that included:
-Resident #4 presented with complaints of difficulty sleeping, denied suicidal or homicidal plans, stated he drank a 12 pack of beer daily and last drank 4 beers at 12 o'clock today .
-The resident requested alcohol detox.
-Diagnoses of alcohol addiction, alcohol intoxication and history of schizophrenia (stable).
-The resident was "medically clear for detox."

Review of driving directions revealed a distance from the facility to Hospital B of 2.5 miles.

Review of Hospital B's psychiatric admission evaluation dated 12/24/15 revealed:
-Resident #4 presented with history of mental

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D 338	Continued From page 25 disorder causing inability to care for self, chronic and continuing self destructive behavior associated with alcohol consumption. -Resident #4 was well known for repeated hospitalizations, "several this year... drinks daily...has very little insight or concern about his ongoing substance abuse problem....is often observed not far from this hospital crossing the street obtaining alcohol at a nearby convenience store...his assisted living is not far away.... says voices are bothering him significantly. This is a little bit different from his last hospitalization here in September, when he presented to the ER several times over a couple of days appearing to just be seeking admission with limited psychiatric complaint. This time he comes in saying he is having bad suicidal ideas and voices." -The resident has had "multiple psychiatric admissions to [name of mental hospital] and [local hospital] for chronic schizophrenia as well as alcohol abuse, and is outpatient at [name of Behavioral Health (BH).]" -The resident lived in [name of facility] for about 12 years, is non-compliant with medications but takes all psychotropic given to him (received Prolixin yesterday). -Resident #4 was "alert and oriented to person time and place, disheveled, smelled strongly of body odor and feces, seemingly obvious." -Severe pervasive mental illness but supportive ALF (Assisted Living Facility). -Discussed benefits of taking medication and risks of not taking medication. Review of the Psychiatric Discharge summary dated 12/28/15 revealed: 12/27/15: The resident took medications "fairly well"...agreed to stay until tomorrow where the resident wanted to be discharged back to the facility who would be able to pick him.	D 338		

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D 338	Continued From page 26 -12/28/15: The resident "has done fairly well...sleep and appetite are good...compliant and cooperative....[Facility name] was told about his discharge and will pick him up later today." The resident was advised to follow up with outpatient provider for medications and therapy and to avoid future relapse, hospitalizations and use of drugs and alcohol. Interview with the facility's Manager on 1/7/16 at 2:20pm revealed: -Resident #4 had been at the facility for 12 years and signed out several times every week. Sometimes he would be gone a few hours, sometimes for days. -"We have talked to [Behavioral Health] about it" (Resident #4's noncompliance) however, could not provide any written documentation to verify. -"We can't make him stay here...he always signs out...he always comes back within 3 days"...if the resident did not come back in 3 days, law enforcement was notified to "be on the lookout"...he always returned "eventually". -The resident never left the facility unless he signed out but had been doing it more and more over the past several months. -While they did not know the exact location the resident may be while he was out, they could usually find him near the facility at local service stations, restaurants or at homeless folks' hangout. -They had discussed Resident #4 situation/behaviors with the County's Department of Social Services, the Ombudsman and the Behavioral Mental Health team many times had been advised it was against Resident's Rights to restrain or restrict Resident #4 from going out since he was his own responsible party and did not have a guardian. -The manager did not know when guardianship	D 338		

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had last been attempted but believed it was a long time ago.

Further interview with the facility's Manager on 1/7/16 at 4:00pm revealed:
-Even when Resident #4 was at the facility he often refused his medications and refused to be seen by the facility's Primary Care Provider (PCP).
-The facility had many PCPs over the years and Resident #4 had refused to see them as well.
-The Primary Care and Local Mental Health Providers were aware of Resident #4's outings and medication refusals.
-When Resident #4 was at the facility, the facility provided meals, laundry, medications, and assistance with activities of daily living (if needed when he returned to the facility inebriated which happened about once a week).
-The resident had been encouraged regularly by the facility staff to comply with taking medications and seeing the PCP but this had not been successful.
-Resident #4 had several different roommates over the years through efforts of the facility to find a roommate Resident #4 would like, but the resident had never been content no matter who his roommate had been.

Follow-up interview with the facility's Manager on 1/11/16 at 10:00am revealed:
-Resident #4 had signed the House Rules policy (updated on 9/16/11), but there had been no consequences for failing to comply with the rules.
-The resident drank several times a week, but not at the facility since May 2015, when he had been drinking outside and told he could not have alcohol on the grounds, got mad and left but came back before dark.
-The facility policy was to hold medications any

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time a resident was inebriated or smelled of alcohol but there had not been any efforts/plans to see if/when Resident #4 could have medications if he refused or came back after routine dose times.
-Many times while he was out, the resident went to the local Mental Health Provider or to the local hospital asking for help.
-Each referenced hospitalization was as result of the resident taking himself to the hospitals.
-The resident went to Hospital A on 10/12/15, was admitted. The Manager was not aware the resident was in the hospital until she received a call on 10/19/15 alerting her the resident was being discharged and needed to be picked up.
-The resident went to Hospital A on 12/16/15 and kept for observation. The Manager was not aware the resident went to the hospital until she received a call 12/17/15 alerting her the resident was being "discharged" and needed to be picked up.
-The resident went to Hospital B on 12/23/15 and was admitted.
-The Manager received a call on 12/24/15 inquiring whether the resident could come back to the facility when discharged. The resident was discharged back to the facility 12/28/15.
-The Manager did not know what else to do, she had "thought about it so much".
-The Manager had not thought about discharging Resident #4 because there was no safe place to discharge him.

Review of the House Rules for Residents signed and dated by Resident #4 on 9/16/11 revealed in part:
-Take medication as prescribed.
-Keep scheduled doctor's appointments and comply with doctor's recommendations.
-When leaving the facility for any reason, please

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make sure you have signed out. Failure to sign out results in you being considered a missing person and law enforcement will be notified.

Telephone interview on 1/8/16 at 10:00am with the Team Leader at the local Behavioral Health (BH) Provider for Resident #4 revealed:
-Resident #4 was seen 2 or 3 times a week by someone on the team and one time a month by the psychiatrist.
-The nurse would be coming out "today" to administer the resident's injection of psychiatric medication that was scheduled every 2 weeks.
-The resident was often not at the facility but the team tried to find him at alternate places where the resident hung out.
-"We have a good relationship with the facility, they call us if he has been gone and does not come back" [after signing out].
-"Facility staff were good to know where the resident is."
-Sometimes the resident could not be found.
-The resident "has done this for years."
-The resident "knows where he is and where he wants to go".
-The resident "is very resourceful...he is not stupid...does not make good decisions when he is drinking."
-Resident #4 often came to the Mental Health facility and would be given a shower, clean clothes (if needed) and then brought back to the facility by the BH team.
-"We have given him a sleeping bag....we try".
-In cold months, the resident stayed at the facility more.
-The resident "gets very depressed and had been in the hospital recently".
-She was unsure about guardianship efforts.
-"We have looked for placement (for Resident #4) but no one wants him....[Local Mental Hospital]

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won't keep him...he goes into the hospital...he's been arrested for panhandling out by the interstate."
-Other placement options have been tried/considered for [the resident] but they always failed either because the resident would not be able to leave (would be locked up) or could not smoke.
-[If not for the facility], "Our concern is: where would he go...where would he have a roof over his head...?"

Record review revealed no BH documentation other than the Prolixin injection administration.

Interview with a representative from the county Department of Social Services on 1/8/16 at 12:26pm revealed:
-The facility Manager had talked with her about guardianship, but she could not remember when.
-The county records went back 2 years and there had not been a formal assessment of Resident #4 for guardianship in that time.

Telephone interview with the former facility's Ombudsman on 1/8/16 at 1:45pm revealed:
-She was not the current Ombudsman for the facility.
-She did not remember Resident #4 (specifically) but did recall past discussions with the facility in reference to Residents' Rights if a resident was their own responsible party, the facility could not restrain or stop him/her from going and coming as they pleased.

Interview with the local BH's Registered Nurse (RN) on 1/8/16 at 4:45pm revealed:
-The RN had known Resident #4 for more than 13 years, however, the RN had only seen the resident (as a client) over the past 5 years.

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-Resident #4 was "down to be seen 3 times a week" by the BH team and the team "tried to see him at a minimum of 1 time a week".
-Resident #4 was scheduled to get an injection of Prolixin every 2 weeks but sometimes it would be more than two weeks (due to not being able to locate the resident).... the resident "maybe missed 4 injections in the last year".
-Resident #4 "knows the area very well....is safe in the community....is a survivor....likes to and used to live in a tent.... chooses what he does...is capable of making good decisions...is not safe when intoxicated."
-The RN believed it was "more than 11 years ago" when guardianship for Resident #4 was petitioned. At that time it was determined the resident made bad decisions, however, that did not qualify him for a guardian, "nothing would change if he had a guardian."
-The RN stated during the Mental Health Reform about, 13 years ago, Resident #4 was placed in this facility and was told he could choose to stay at the facility or continue to live in the woods, however, the facility was where his money would come.
-The RN stated the fact that the facility "keeps it's door open [for Resident #4], is a huge support."
-BH had often tried to get the resident into detox but the resident refused.
-BH had made efforts to get the resident into individual housing but the resident would not agree to stop drinking.
-The RN stated "the facility is the best place for him...he knows he can come here.... staff will treat him nice....and try to keep his dignity intact....where else could he go?....no other facility will have him".

Telephone interview with the facility's Primary Care Provider (PCP) on 1/8/16 at 5:30pm and

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1/12/16 at 10:00am respectively, revealed:
-She had been the PCP for "close to a year".
-She visited the facility once or twice each month.
-Resident #4 always refused to see her, however, she would stop and talk to the resident "almost every time I visit" because he would be outside lying on the ground; sometimes he would talk, other times he would just curse her.
-The PCP stated she had "long conversations" with Resident #4 about his medications and care, but all the resident would talk to her about would be money or cigarettes.
-The resident was his own guardian.
-The resident continually asked the PCP to discontinue his medications so he would have more money at the end of the month.
-The PCP tried to encourage the resident to take his medications and she would not discontinue them.
-The resident refused to take his medications, refused to see her, left the facility and went "off drinking a lot".
-She was not sure when she had last seen (assessed) Resident #4.
-She had not assessed the resident in the past three months.
The resident was scheduled to see her on 1/5/16 (after his last hospitalization) but he refused.
-Facility staff were good with Resident #4.
-With his noncompliance, she did not know what the difference would be for Resident #4 being homeless or living in a shelter.
-She had never thought about discontinuing Resident #4 from her practice and had never had a meeting with the facility or BH to discuss how to better meet the needs of Resident #4.

Telephone interview with the RCC on 1/12/16 at 10:20am revealed no documentation on a

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D 338	Continued From page 33 Physician Note Sheet where Resident #4 had been seen by a PCP since December 2014. _____ The facility provided a Plan of Protection on 1/11/16 that included: -The facility will contact Resident #4's primary physician, mental health provider and the pharmacy consultant to try to figure a way to better provide services for the resident. -A meeting will be scheduled as soon as possible with these providers and if it is determined the needs of Resident #4 can't be met, the facility will seek other safe placement. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2016.	D 338		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and	D 400		

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D 400	Continued From page 34 medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to provide adequate pharmaceutical care to identify medication related problems related to refusal of medications, and medications omitted during extended absences from the facility for 1 of 4 (#4) sampled residents. The findings are: Review of Resident #4's previous FL2 dated 10/20/15 revealed: -Diagnoses included schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, mood disorder, and alcohol dependence. -Medications orders as follows; Aspirin 81mg, 1 tablet once daily. (Low dose aspirin is a medication used to prevent blood clots in conditions such as coronary artery	D 400		

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disease.)
Benztropine 0.5mg, 1 tablet twice daily. (Benztropine is a medication used to treat tremors associated with antipsychotic use.)
Brintellix 10mg, 1 tablet once daily. (Brintellix is a medication used to treat depression.)
Docusate 100mg, 1 capsule twice daily. (Docusate is used as a stool softener with constipation.)
Fluphenazine 5mg, 2 tablets by mouth at bedtime. (Fluphenazine is a medication used to treat the psychotic manifestations of schizophrenia.)
Fluphenazine Decanoate 25mg/ml, 37.5mg intramuscularly every 2 weeks. (Fluphenazine Decanoate. 25mg/ml is a long acting injectable form of Fluphenazine used to treat the psychotic manifestations of schizophrenia.)
Levothyroxine 100mcg, 1 tablet twice daily. (Levothyroxine is a synthetic form of thyroid hormone use to treat hypothyroidism.)
Polyethylene Glycol 3350 powder, 1 capful (17grams) by mouth once daily. (Polyethylene Glycol 3350 is a laxative used to treat constipation.)
Simvastatin 20mg, 1 tablet at bedtime. (Simvastatin is a medication used to treat elevated cholesterol levels.)
Trazodone 50mg, 1 tablet at bedtime. (Trazodone is a medication used to treat depression and insomnia.)

Review of the Resident #4's signed physician's order sheets dated 09/8/15, 10/20/15, and 11/05/15 revealed additional diagnoses of hypothyroidism and coronary artery disease.

Review of Resident #4's Medication Administration Records (MARs) for November 2015 revealed:

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D 400	Continued From page 36 -21 days out of 30, Resident #4 refused some of his medications. -7 days out of 30, Resident #4 missed medications due to being out of the facility. -18 doses of Aspirin were documented as administered out of 30 opportunities. -35 doses of Benztropine were documented as administered out of 60 opportunities. -14 doses of Brintellix were documented as administered out of 30 opportunities. -34 doses of Docusate were documented as administered out of 60 opportunities. -16 doses of Fluphenazine were documented as administered out of 30 opportunities. -1 dose of Fluphenazine Decanoate were documented as administered out of 2 opportunities. -34 doses of Levothyroxine were documented as administered out of 60 opportunities. -13 doses of Polyethylene Glycol 3350 were documented as administered out of 30 opportunities. -16 doses of Simvastatin were documented as administered out of 30 opportunities. -19 doses of Trazodone were documented as administered out of 30 opportunities. Review of a signed physician's order sheet dated 9/8/15 revealed the following medication orders: -Docusate 100mg, 2 capsules twice daily. -Fluoxetine 20mg, 1 capsule daily in the morning. (Fluoxetine is an antidepressant in the same family of medications as the Brintellix.) -Levothyroxine 100mcg, 1 tablet daily. -Linzess 290mcg, 1 capsule daily. (Linzess is a medication used to treat irritable bowel syndrome.) -Therem M, 1 tablet daily. (Therem is a multivitamin/multimineral supplement.)	D 400		

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D 400	Continued From page 37 Review of Resident #4's October 2015 MARs revealed: -Resident #4 was out of the facility and in the hospital for 4 days. -10 days out of 27, Resident #4 refused some of his medications. -22 days out of 27, Resident #4 missed medications due to being out of the facility. -5 doses of Aspirin were documented as administered out of 27 opportunities. -12 doses of Benztropine were documented as administered out of 54 opportunities. -3 doses of Brintellix were documented as administered out of 10 opportunities. -10 doses of Docusate were documented as administered out of 54 opportunities. -6 doses of Fluphenazine were documented as administered out of 27 opportunities. -1 dose of Fluphenazine Decanoate were documented as administered out of 2 opportunities. -9 doses of Levothyroxine were documented as administered out of 38 opportunities. The dose of Levothyroxine was changed to 100mcg twice daily on 10/20/15. -3 doses of Polyethylene Glycol 3350 were documented as administered out of 11 opportunities. Polyethylene Glycol 3350 was started on 10/20/15. -16 doses of Simvastatin were documented as administered out of 27 opportunities. -19 doses of Trazodone were documented as administered out of 27 opportunities. -1 dose of Fluoxetine was documented as administered out of 16 opportunities. -1 dose of Linzess was documented as administered out of 16 opportunities. -2 doses of Therem-M were documented as administered out of 16 opportunities.	D 400		

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Review of Resident #4's September 2015 MARs revealed:
-Resident #4 was out of the facility and in the hospital for 7 days.
-16 days out of 23, Resident #4 refused some of his medications.
-16 days out of 23, Resident #4 missed medications due to being out of the facility.
-4 doses of Aspirin were documented as administered out of 24 opportunities.
-7 doses of Benztropine were documented as administered out of 47 opportunities.
-5 doses of Docusate were documented as administered out of 47 opportunities.
-3 doses of Fluphenazine were documented as administered out of 23 opportunities.
-No doses of Fluphenazine Decanoate were documented as administered out of 2 opportunities.
-2 doses of Levothyroxine were documented as administered out of 24 opportunities.
-4 doses of Simvastatin were documented as administered out of 24 opportunities.
-3 doses of Trazodone were documented as administered out of 23 opportunities.
-4 doses of Fluoxetine were documented as administered out of 24 opportunities.
-1 dose of Linzess was documented as administered out of 24 opportunities.
-4 doses of Therem-M were documented as administered out of 24 opportunities.

Review of Resident #4's records revealed an injection medication administration sheet from the local mental health provider that revealed:
-Fluphenazine Decanoate documented as administered on 09/2/15 and 09/22/15.
-The mental health provider noted on 10/6/15, 10/7/15, and 10/9/15, "unable to locate resident."
-On 10/13/15, Fluphenazine Decanoate 37.5 was

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documented as administered at a local hospital.
-Another dose of Fluphenazine Decanoate was documented as administered on 10/30/15.
-The only dose of Fluphenazine Decanoate documented as administered in November 2015 was on 11/24/15, 25 days after the last dose in October 2015.

Review of Resident #4's record revealed:
-Drug Regimen Reviews (DRRs) were completed on 03/02/15, 06/02/15, 09/02/15, and 12/02/15.
-No recommendations were made on any of the above DRRs related to Resident #4's refusal of medications, missed doses of medications while on extended absences from facility, and medications held due to resident's intoxication.
-No recommendations were made in the DRRs suggesting discontinuation of non-essential medications, increased monitoring of Resident #4's behaviors due to missed antipsychotic medications, or increased lab monitoring due to missed thyroid replacement hormone and elevated cholesterol medication.
-No recommendations were made in the DRRs to suggest which medications would be safe to give when Resident #4 returned to the facility intoxicated.
-No recommendations were made in the DRRs to suggest which medications would be safe to give when Resident #4 returned to the facility after the scheduled administration times.
-Under the assessment section of the DRRs, all noted "med refusals, or med/lab refusals noted; NP (Nurse Practitioner) aware, available VS (vital signs) reviewed."
-Under the lab section of the DRRs, all noted a normal TSH (thyroid stimulating hormone is a measure of the effectiveness of thyroid hormone replacement therapy) of 4.2 (no normal range given) from a lab performed on 10/16/13.

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AUSTIN ADULT CARE	511 BUMGARNER INDUSTRIAL DRIVE CONOVER, NC 28613

(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 400	Continued From page 40 -Depending on the lab, a normal range for TSH would be 0.5 to 5.0. Review of Resident #4's record revealed elevated TSH levels of 23.6 on 12/24/15, 56.10 on 10/12/15 (with a recheck of 25.44), 42.8 on 07/26/15, and 78.18 on 10/27/14. Interview with the facility Manager on 01/11/16 at 3:45pm revealed: -She had talked to the Consultant Pharmacist about Resident #4's medication refusals and "what we (facility staff) could do to encourage him to take his medications." -The Manager was told by the Consultant Pharmacist, "it's his right to refuse," with no other recommendations. -The Manager could not remember any recommendations from the Consultant Pharmacist DRR concerning Resident #4's refusal of medications. -The facility Manager did not feel it was safe to give Resident #4 his medications to take while he was on leave of absence because he might take them all at once, or try to sell them. -The facility's policy regarding refusal of medications was to call the doctor after three missed doses. Interview with the Consultant Pharmacist from the provider pharmacy on 01/12/16 at 8:15am revealed: -During DRR, she looked at medication changes, labs, MARs, and vital signs. -She did not have any specific recommendations she would make for residents who come back to the facility late, or come back to the facility intoxicated, except to call their physician. -If a resident refused medications, she would recommend encouraging residents to take their	D 400		

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D 400	Continued From page 41	D 400		

medications and to call the physician.
-She did not recall ever seeing Resident #4 at the facility, either in his room or outside laying on the ground smoking.
-The pharmacy would work with the facility to provide leave of absence medications for any resident, if requested.
-She stated residents do have the right to refuse medications.

A second interview with the same Consultant Pharmacist from the provider pharmacy on 01/12/16 at 10:55am revealed:
-She did not see the elevated TSH levels from July 2015, or October 2014.
-She made a recommendation on 9/13/13 to the facility to make Resident #4's physician aware of an elevated TSH (no level specified) at that time.
-On the next DRR in December 2013, she noted a normal TSH of 4.2 from a recheck of Resident #4's TSH in October 2013.

Telephone interview with the facility's Primary Care Provider (PCP) on 01/8/16 at 5:30pm and 01/12/16 at 10:00am respectively, revealed:
-She had been the PCP for Resident #4 for "close to a year".
-She visited the facility once or twice each month.
-Resident #4 always refused to see her, however, she would stop and talk to the resident "almost every time I visit" because he would be outside lying on the ground; sometimes he would talk, other times he would just curse her.
-The PCP stated she had "long conversations" with Resident #4 about his medications and care, but all the resident would talk to her about would be money or cigarettes.
-The resident was his own guardian.
-The resident continually asked the PCP to

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D 400	Continued From page 42	D 400		

discontinue his medications so he would have more money at the end of the month.
-The PCP tried to encourage the resident to take his medications and she would not discontinue them.
-The resident refused to take his medications, refused to see her, left the facility and went "off drinking a lot".

Review of Resident #4's care plan signed by the PCP on 10/11/15 revealed "Resident #4 is still refusing all of his medications except his injection. He is signing out days at a time. "

Interview with Resident #4 on 01/11/16 at 9:40am revealed:
-He was alert and oriented.
-He would sign out to go "beg" money for cigarettes and alcohol.
-Sometimes he held a sign "please help, need work" and people would give him money.
-He refused his medications because they made him "sick (no specifics)..all I need is Cogentin and Prolixin". He stated he could not afford cigarettes and medicine.
-He stated he was sick because he drinks and his liver was bad... had been told to quit drinking and smoking but "they can't make me."
-He did not want to go to detox because he was against the "AA meetings" and he could not smoke there.
-"I like it here...I love them...it is a good place to live...they make sure I am fed, I have a bed, a radio, cigars and I get my money every month out of my check... and new clothes... they offer my meds but sometimes I refuse them."

On 01/11/16, the facility provided the following Plan of Protection:

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D 400	Continued From page 43 -The facility will set up a meeting as soon as possible with the Consultant Pharmacist to learn how to assist Resident #4 with taking his medications. -The meeting will address how to give Resident #4 his medications while he is out of the facility. -The meeting will address how to give Resident #4 his medications when he returns to the facility late, after the medication pass has been completed. -The meeting will address how to give Resident #4 his medications when he returns to the facility intoxicated. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2016.	D 400		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the areas of other requirements, management of facility, pharmaceutical care, and infection prevention requirements.	D912		

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D912	Continued From page 44 The findings are: A. Based on observations, record review and interviews, the facility failed to maintain the water fountain, (3) ceiling fans and (23) light fixtures in a safe and operating condition. [Refer to D 105 10A NCAC 13F .0311(a) Other Requirements (Type B Violation).] B. Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility met and maintained rules related to physical environment, housekeeping and furnishings, other requirements, nutrition and food service, resident rights, pharmaceutical care, and ACH infection prevention requirements. [Refer to D 176 10A NCAC 13F .0601(a) Management of Facilities (Type B Violation).] C. Based on record reviews and interviews, the facility failed to provide adequate pharmaceutical care to identify medication related problems related to refusal of medications, and medications omitted during extended absences from the facility for 1 of 4 (#4) sampled residents. [Refer to D 400 10A NCAC 13F .1009(a)(1) Pharmaceutical Care (Type B Violation).] D. Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring for at least 4 of 7 residents with orders for finger stick blood sugars (FSBS) by borrowing a lancet device or glucose meter from a discharged resident for 2 of 7 residents (#5 and #6) and borrowing lancet devices from other current residents for 2 of 7 residents (#2 and #7). [Refer to D 932 G.S. 131D-4.4A (b) ACH Infection	D912		

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D912	Continued From page 45 Prevention Requirements. (Type A2 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 observations, record reviews, and interviews, the facility neglected to provide care and services meet a resident's needs. Based on observations, record reviews and interviews, the facility failed to maintain the rights for 1 of 1 resident by neglecting to provide care and services to meet residents' needs. (Resident #4). [Refer to D 338 10A NCAC 13F .0909 Resident Rights (Type B Violation.)]	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple	D932		

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D932	Continued From page 46 residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring for at least 4 of 7 residents with orders for finger stick blood sugars (FSBS) by borrowing a lancet device or glucose meter from a discharged resident for 2 of 7 residents (#5 and #6) and borrowing lancet devices from other current residents for 2 of 7 residents (#2 and #7).	D932		

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D932	Continued From page 47 The findings are: Interview with Staff A, Medication Aide (MA), on 01/06/16 at 11:05am revealed: -She had been a MA since September 2015. -All residents had their own glucose meters and lancet devices. -They do not share glucose meters and lancet devices between residents. -She did not believe the glucose meters or lancet devices were labeled with residents' names, but the plastic totes the FSBS supplies are kept in had residents' names on them. Observation of a FSBS for Resident #6 on 01/06/16 at 11:07am revealed: -The facility kept FSBS supplies for each resident in a small plastic tote in the medication room. -Each tote was labeled with the resident's name. -Staff A removed a lancet device and glucose meter from Resident #6's tote and prepared to perform a FSBS. -Neither the glucose meter or lancet device appeared to have any resident names on them. -Staff A gloved, placed a new lancet needle in the lancet device, swabbed Resident #6's finger, and obtained a FSBS of 115mg/dl. -Staff A did not clean the glucose meter or lancet device after obtaining the FSBS. Observation of the glucose meter and lancet device used on Resident #6 at 11:09am on 01/06/16 revealed: -A small dirty sticker on the back of the glucose meter used on Resident #6 with a partial name of another resident. -A small dirty sticker on the back of the lancet device used on Resident #6 with the partial name of Resident #2.	D932		

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D932	Continued From page 48 Observation of the other resident's FSBS totes at 11:10am on 1/6/16 revealed: -Resident #5's lancet device was found in Resident #7's FSBS tote. -Resident #5's initials were on a small sticker on the back of the lancet device. -Resident #5's tote contained a lancet device with the same initials found on the glucose meter used on Resident #6. Interview with Staff A on 1/6/16 at 11:20am revealed: -She was not sure how the lancet devices got switched around. -Staff were using a discharged resident's glucose meter for Resident #6 because his insurance had not started and he did not have his own FSBS supplies. -The lancet device found in Resident #5's FSBS tote, and the glucose meter found in Resident #6's tote were from a resident who had been discharged over a year ago. -She cleaned the glucose meters and lancet devices weekly with an EPA approved disinfectant wipe. -She had infection control training at the facility, but "not related to medications." -Staff A was unaware lancet devices could not be disinfected. Review of Staff A's personnel record on 01/11/16 revealed she had the state approved infection control training on 11/2/15. Review of the manufacturer's recommendations for the glucose meter used on Resident #6 revealed: -The glucose meter could be disinfected weekly with an EPA approved disinfectant.	D932		

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D932	Continued From page 49 -The glucose meter was designed for single patient use only and was not to be shared. Interview with the facility's Manager on 01/06/16 at 1:55pm revealed: -The policy of the facility was for each resident to have their own glucose meter and lancet device. -The glucose meter and lancet device were not to be shared between residents. -She was not aware MAs were sharing the glucose meters and lancet devices between residents and from discharged residents. -Resident #6 had a new glucose meter of his own. -Resident #6's new glucose meter was found in the medication room and placed in his FSBS tote on the afternoon of 01/06/16. Interview with facility's Resident Care Coordinator on 01/06/16 at 2:03pm revealed no residents in the facility had diagnoses of human immunodeficiency virus or hepatitis. Interview with Resident #6 on 01/08/16 at 11:25am revealed: -The MA had always used the same glucose meter and lancet device to obtain his FSBS. -He believed the meter and lancet device were his. -He's only been at the facility a few months. Attempted interviews with Residents #2 and #5 on 01/08/16 at 2:40pm and 2:45pm respectively were unsuccessful. _____ On 01/06/16, the facility provided the following plan of protection: -The facility obtained disposable lancets for all residents with orders for FSBS.	D932		

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D932	Continued From page 50 -All the old lancet devices were discarded. -All glucose meters were labeled with resident names. -New lancet devices will be obtained for all residents as soon as possible and labeled with resident's names. -A new lancet device and glucose meter will be kept on hand in the event of a new admission of a resident with orders for FSBS so they will have the supplies they need. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 11, 2016.	D932		