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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, follow-up survey, and complaint investigation on January 26, 2016 to January 30, 2016 with an exit conference via telephone on February 2, 2016.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record reviews the facility failed to ensure cleaning supplies were monitored by staff while in use resulting in 1 resident (Resident #18) ingesting an unspecified amount of cleaning agent. The findings are: Review of Resident #18's current FL2 dated 08/05/15 revealed diagnoses included moderate mental retardation, mood disorder, and impulse control disorder. Review of a hospital discharge summary for Resident #18 dated 12/04/15 revealed:	D 056		

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-Resident #18 presented in the Emergency Room (ER) on 12/04/15 at 11:13 pm with a diagnosis of Toxic effect of substance, Accidental Overdose.
-Resident #18 had been transported via Emergency Medical Services (EMS) on 12/04/15 to the ER.
-Resident #18 ingested approximately 100 ml of a cleaning agent and vomited after ingesting the cleaning liquid.
-Resident #18 denied pain or sore throat.
-The ER contacted Poison Control and was advised to keep Resident #18 from eating or drinking for 2 hours then slowly added ice chips, fluids and then creams.
-Resident #18 tolerated the fluids and ice cream and was discharged back to the facility at 3:00 am on 12/05/15.

Review of Resident #18's nurse care notes revealed:
-On 12/04/15 a Nurse Aide (NA) was performing cleaning duties when he realized Resident #18 had ingested a cleaning agent.
-When the Medication Aide (MA) arrived she found Resident #18 had thrown up a large amount.
-The MA contacted management and then called 911.
-The MA used the Material Safety Data Sheet (MSDS) for the cleaning agent and followed the instruction for accidental ingestion.
-Resident #18 was given 2 or 3 cups of clear liquid (water).
-Resident #18 was transported via EMS to the ER.
-On 12/05/15 at 3:30 am Resident #18 arrived back to the facility from the ER.

Interview on 01/27/16 at 10:40 pm with a night shift Nurse Aide (NA) revealed:

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-He had worked on 12/04/15.
-His duties included mopping the hallways during the night shift
-He had added a cleaning agent brought from home into the mop water bucket to mop the floors in the hallway.
-He placed the cleaning agent bottle on the hallway banister rail after he had poured some of the cleaning agent in the mop water bucket.
-Resident #18 had been standing in the hallway near the banister and picked up the bottle of cleaning agent.
-The NA had informed Resident #18 to put the cleaning agent bottle down,"Not to touch it", and took it from Resident #18's hands.
-The NA placed the cleaning agent bottle back on the hallway banister rail and turned his back to Resident #18, to complete the mopping duties.
-The NA tuned back around and saw Resident #18 had walked away with the cleaning agent bottle, turned the cleaning agent bottle up to his mouth, and ingested the remains of the bottle of cleaning agent.
-The NA immediately tried to stop Resident #18, he grabbed the bottle of cleaning agent from Resident #18's hands.
-The NA immediately got the Medication Aide (MA) and told her Resident #18 had "Drank the cleaning agent."
-The NA stated "The bottle was empty".
-The NA stated "It was a small bottle of cleaning agent" approximately, a 12 ounce bottle.
-The NA said the cleaning agent bottle was approximately half full when Resident #18 ingested the cleaning agent.
-The NA was aware cleaning agents were to be monitored while in use and secured in a locked area for storage.
-The NA said Resident #18 thought the cleaning agent was kool-aid because of the color and

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smell.
-Management was aware he used the cleaning agent brought into the facility from home.

Telephone interview on 01/28/16 at 1:15 pm with a night shift MA revealed:
-She worked night shift on 12/04/15 when Resident #18 ingested the cleaning agent.
-The NA brought the bottle of cleaning agent to her, and informed her Resident #18 had ingested the cleaning agent.
-There was a small amount of cleaning agent in the bottom of the bottle.
-Resident #18 had thrown up a large amount of purplish red substance that had smelled like the cleaning agent.
-She said Resident #18 said the cleaning agent looked like Kool-Aid.
-She called 911 on 12/04/15.
-She contacted the on-call management staff on 12/04/15 and they contacted the Executive Director.
-She was instructed by the Resident Care Coordinator (RCC) to follow the instructions on the MSDS for ingestion of the cleaning agent.
-She had given Resident #18 2-3 cups of water.
-She said Resident #18 did not thrown up again after he had drank the water.
-The local police and the EMS arrived at the facility.
-Resident #18 was taken to the ER via EMS transport.
-The MA sent the cleaning agent bottle with Resident #18 to the ER.
-She had not contacted Poison Control.
-She was aware cleaning agents were to be monitored while in use and cleaning agents were to be stored in a locked secured area.
-She said this was the first time a resident had ingested a cleaning agent since she had been

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D 056	Continued From page 4 employed. -Observation on 01/28/16 at 10:00 am of the facility storage rooms revealed: -There were three locked storage rooms. -The storage rooms had chemicals which included window cleaner, disinfectant spray, odor eliminator, furniture polish, neutralizer cleaner and disinfectant cleaner. -The storage area contained no cleaning agent that matched the cleaning agent ingested by Resident #18 on 12/04/15. Interview on 01/28/16 at 11:00 am with a facility Housekeeper (Hk) revealed: -Her duties included cleaning resident rooms, bathroom and the common areas in the facility. -She prepared and stocked the house keeping cart daily. -The house keeping cart was kept in the locked storage rooms. -All staff and management had a key to the house keeping storage rooms. -The house keeping cart with the chemicals were to be kept within view at all times while on the floor performing the cleaning duties. -The house keeping carts was to be pushed into resident rooms while cleaning the rooms or left in the door way of the room. -The MSDS book was kept in the house keeping secured storage room and the kitchen. Review on 01/28/16 at 10:15 am of the facility MSDS book revealed: -The book was located in the house keeping storage locked room. -The MSDS book had information on the cleaning agent Resident #18 had ingested. -The MSDS hazards identification potential side affects were harmful if swallowed in large	D 056		

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quantities.
-The MSDS rated the cleaning agent severity of harm as "slight acute health hazard" which was the lowest safety rating.
-The MSDS first aide measures for ingestion, included to drink 2 or 3 glasses of a clear liquid, and get medical attention.
-The MSDS had an emergency telephone number to contact if the cleaning agent had been ingested.
-The MSDS listed the following ingredients in the cleaning agent:
-Sodium Dodecylbenzene Sulfonate which is a colorless salt added to detergents, which may cause vomiting if ingested.
-Butoxydiglycol which is an organic cleaning agent that smells pleasant and used to dissolve residue like oils and soaps; it is a low toxicity solvent.
-Glycol Ethers is a colorless liquid solvent with a slight odor, used in cleaning soap and cosmetics; acute short term exposures to high levels of glycol ethers may result in pulmonary edema, liver and kidney damage and narcosis (a state of drowsiness or unconsciousness produced by drugs).

Observation on 01/28/16 and 01/29/16 between 8:00 am and 4:30 pm revealed house keeping carts had been in view of house keeping staff while in use to clean the facility and residents' rooms.

Observation on 01/26/16, 01/27/16 and 01/28/16 revealed Resident #18 was ambulating in the halls with multiple small stuffed animals in a book bag he wore on his shoulder and a stuffed monkey hung around his neck.

Based on observation, interview, and record

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review Resident #18 was not interviewable.

Telephone interview on 02/02/16 at 12:00 pm with a Medical Representative from Poison Control revealed:
-The cleaning agent listed what to do in case of ingestion on the back of the bottle.
-Poison Control should have been called.
-The MSDS and the information on back of the cleaning agent bottle are recommendations.
-The Medical Representative was aware the MSDS had instructions to give 2-3 glasses of clear liquid.
-The recommendation on the MSDS was to seek medical advice.

Interview on 1/27/16 at 10:40 pm with the Resident Care Coordinator (RCC) revealed:
-She was aware Resident #18 had ingested the cleaning agent on 12/04/15.
-She was aware the cleaning agent was brought from home by the staff to use in the facility.
-She was aware cleaning agents were to be stored in a secured locked area and monitored while in use.
-This was the first time a resident had ingested a cleaning agent.
-The Executive Director had a mandatory meeting with all staff after Resident #18 ingested the cleaning agent.

Interview on 01/28/16 at 12:30 pm with the Executive Director revealed:
-She was aware Resident #18 had ingested a cleaning agent that had been brought into the facility by staff.
-She said staff used the cleaning agent because, "It smelled good."
-The cleaning agent was used in the facility until a year ago, a different cleaning agent was now

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used in the facility.
-The NAs responsibilities on third shift were to mop the floors in the hallways.
-She was aware the NA had placed the cleaning agent bottle on the side rail banister in the hallway.
-She was unaware the NA had taken the cleaning agent from Resident #18 hands and placed the cleaning agent back on the side rail banister, prior to Resident #18 ingesting the cleaning agent.
-The cleaning agents were secured in a locked storage house keeping room when not in use, and monitored when used in the facility while cleaning.
-She was aware the MSDS book was located in the kitchen and house keeping locked storage rooms.
-She was aware all staff and management had keys to the locked storage house keeping rooms.
-She conducted two mandatory meetings at different times for staff on 01/8/16 regarding chemical safety.
-The facility did not have a policy or procedure for the storage of chemicals or the accidental ingestion of a chemicals.

Review of the mandatory staff meeting minutes held on 01/08/16 at 1:30 pm revealed 13 staff attended the first meeting, and 14 staff attended the second meeting.
The facility provided the following Plan of Protection on 01/28/16:
-Immediate training with staff on proper storage of cleaning agents.
-Any staff found not following policies will be reprimanded to include additional training and/or disciplinary action.
-Management will do an immediate walk through to assure chemicals are stored properly.
-The Regional Director, Executive

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D 056	Continued From page 8 Director/designee will complete random walk through of the facility on all shifts to assure chemicals are stored properly in addition to interviews with staff. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 18, 2016.	D 056		
D 105	10A NCAC 13F .0311(a) Other Requirements 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: Based on observation and interview, the facility failed to assure the building was maintained in a safe and operating condition in regards to 13 of 13 ceiling attic access panels left open in the hallways throughout the building, placing all residents at an increased risk for spread of a fire in the event of a facility fire. The findings are: Observation of the weather outside on 01/26/16 revealed the temperature was in the mid 50's with melting snow and ice from a winter storm on 01/21/16 to 01/23/16 and brought sleet, snow, and ice with high temperatures around 32 degrees Fahrenheit. Observation during the initial tour of the facility on 01/26/16 between 9:30 am and 11:30 am revealed:	D 105		

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-The facility had a census of 77 residents.
-The facility was designed in a combination T and H shape; the front section was H shaped and had a long hall extending across the far end of the left side of the H.
-The facility had 3 assigned halls (A, B, and C), and a front corridor connecting Hall A and Hall B.
-There were 13 attic access points with closure panels (approximately 2 feet by 3 feet) located in the hallway ceilings throughout the building.
-The access closure panels were constructed of either locking metal closures panels or drop-in ceiling tile panels.
-Hall C had 2 metal access closure panels; Hall B had 1 metal access closure panel and 4 ceiling tile access closure panels; the connecting corridor (hall) had 2 ceiling tile access closure panels; and Hall A had 4 ceiling tile access closure panels.
-Thirteen of thirteen attic access panels were opened completely creating a cold air draft underneath each attic access.

Observation on 01/26/16 at 1:38 pm revealed:
-A resident sitting in her wheelchair near the entrance to her room on B hall with no socks on.
-An opening in the hallway ceiling directly to the right of the entrance to the resident's room.
-A cold air was felt coming from the ceiling when standing under the opening.
-Residents room were heated by individual wall heating units.

Observation on 01/26/15 at 3:28 pm revealed a resident standing under an open ceiling on B-Hall with shampoo, soap, and a towel in her hand.

Interview on 1/26/15 at 3:30 pm with a resident on B Hall revealed:
-She was waiting to take her shower in the

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common bathroom on B Hall.
-She washed her hair in the shower.
-She was aware that ceiling tiles were removed in several ceiling areas on B Hall, but did not know why.
-"You can feel the cool air when you walk under them."
-She had to walk under one when she returned to her room from the common bath after taking a shower.
-She had not noticed her room being cooler, but had noticed the hallway being cooler.

Observation on 01/26/16 at 4:00 pm revealed all 13 of the ceiling attic access points had been closed securely.

Interview on 01/26/16 at 12:52 pm with a resident on Hall C revealed:
-Maintenance staff opened the attic access when the weather got really cold. (Not sure of the exact day.)
-The panels had been open around the clock since being opened.

Interview on 01/26/16 at 1:05 pm with a second resident on Hall C revealed:
-Maintenance staff had opened the attic access panels about 3 or 4 days ago when the colder weather hit.
-The panels had been left open around the clock since being opened.
-The facility had an incident a few weeks ago when an overhead pipe had broken and wet the ceiling.
-Maintenance staff said the attic access panels were opened to allow heat in the attic to protect the pipes from freezing.
-The resident was able to keep his room warm because the residents' rooms had wall heaters for

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heat.
-"It would be good if (facility) closed the ceiling opening (in the halls) so hall could warm up."

Interview on 01/26/16 at 3:32 pm with a Nurse Aide (NA) revealed:
-She was told by another NA that the ceiling attic access tiles were removed at various spots in the hallways to keep the pipes from freezing during the snow storm last week.
-The tiles were removed just last week.
-She had not received any complaints from residents about the hallways or their rooms being colder.
-The removal of the tiles had not affected the room temperatures in the common bathrooms when giving residents showers.
-She had noticed no changes in the building temperatures.

Interview on 01/26/16 at 3:30 pm with a second shift Medication Aide (MA) revealed:
-Today (01/26/16) was her first day back working after being off duty for 2 weeks.
-She had observed the attic access panels being open today when she came back to work.
-The access panels were not opened before she left 2 weeks ago.

Interview on 01/26/16 at 3:35 pm with another second shift MA revealed:
-She had worked at the facility for 3 weeks.
-The attic access panels were opened last Thursday or Friday (01/21/16 or 01/22/16) by Corporate Maintenance staff.
-As best she could remember, she was told the panels were opened to keep the pipes warm.

Interview on 01/26/16 at 5:45 pm with the Executive Director (ED) revealed:

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D 105	Continued From page 12 -The facility had a part-time Maintenance staff member and Corporate Maintenance staff providing maintenance to the building. -Corporate Maintenance staff traveled to different facilities providing various maintenance services, but did not come to the facility every day. -Corporate Maintenance staff put the ceiling attic access panels down on Friday (01/22/16) last week to help keep the overhead pipes warm. -Corporate Maintenance staff had come to the facility today (01/26/16) and closed all the ceiling attic access panels after being called by the ED. Telephone interview on 01/27/16 at 3:30 pm with the Corporate Maintenance staff member revealed: -He had opened the ceiling attic access panels on Thursday, 01/21/16. -He opened the panels to allow heat to get to the overhead pipes to help prevent them from freezing during the predicted winter storm. -He had not routinely opened attic access panels in the past, but had gotten the idea from a facility in the eastern part of the state that had been recently acquired. -He came back to the facility on 01/26/16 and closed the panels when he was called by the facility. Based on observation and interview, the facility placed all residents at increased risk for the spread of fire as evidenced by 13 of 13 ceiling attic access panels left open in the hallways throughout the building that could increase air drafts and fuel a fire.	D 105		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	Continued From page 13 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 6 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G. S. 131E-256. The findings are: Review of Staff C's personnel records revealed: -Staff C's hire date was 03/02/12. -Staff C's position was Office Manager and also worked as a Medication Aide (MA) as needed. -Staff C had Medication Clinical Skills validated on 10/12/12. -Staff C passed the MA test on 05/21/13. -Staff C completed the state approved Infection Control training on 11/20/15. -An undated HCPR check form utilized by the facility with Staff C's name and social security number, but no tracking number to confirm the facility checked the HCPR to ensure Staff C had no substantiated findings prior to hire. -Documentation of a Health Care Personnel Registry check on 01/29/16 with no substantiated findings. Interview on 01/27/16 at 11:15 pm with Staff C revealed: -She worked today as Office Manager. -She was working on third shift (10:00 pm to 6:00	D 137		

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pm) because the facility needed a MA for third shift due to not having enough staff.
-She was a Medication Aide.
-Her Medication Clinical Skills were validated prior to her passing medications.

Interview on 01/27/16 at 11:15 pm with the Resident Care Coordinator (RCC) revealed:
-Staff C was working as the Medication Aide/Supervisor for third shift.
-Management, including Staff C, filled in when they did not have enough staff to work a shift.
-Staff C would be responsible for Medication Administration tonight.

A second interview with Staff C on 02/01/16 at 12:00 pm revealed she did not know if the facility had completed a HCPR check on her prior to hire.

Interview with the Executive Director on 01/29/16 at 7:30 pm revealed:
-Staff C's position was Office Manager, but she also filled in as a MA as needed when they had staff to call out.
-She thought a HCPR check had been completed prior to Staff C's hire.
-The Office Manager or the Executive Director were responsible for completing HCPR checks prior to hire.
-The facility was "in the middle of some transitions about the time" Staff C was hired.
-She was unaware the HCPR check form in Staff C's file did not have a tracking authorization number to confirm the facility had checked the HCPR to ensure there were no findings for Staff C prior to hire.
-She would run a HCPR immediately for Staff C.

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D 163	10A NCAC 13F .0504(c) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to obtain physician certification and ensure non-licensed staff met the requirements for training and competency validation prior to obtaining a urine specimen from an indwelling suprapubic catheter for a urine culture and sensitivity test (Resident #3). The findings are: Review of Resident #3's current FL2 dated 11/06/15 revealed: -Diagnoses included chronic pain, insomnia, schizophrenia, anxiety, seizures, hypothyroidism, gastroesophageal reflux disease, and irritable bowel syndrome. -Resident #3 had a suprapubic catheter which was a thin, sterile tube inserted into the bladder through a small hole in the abdomen and is used	D 163		

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to drain urine from the bladder when a person cannot urinate.

Review of Resident #3's Resident Register revealed an admission date of 12/18/15.

Review of Resident #3's assessment and orders completed by the Nurse Practitioner (NP)dated 01/20/16 revealed:
-Resident #3 was seen by the NP at the facility on 01/20/16.
-Resident #3 was diagnosed with a neurogenic bladder (Neurogenic bladder is the dysfunction of the bladder caused by neurological damage with a high risk of recurrent infections).
-The NP noted the resident complained of dysuria (pain, burning, or discomfort upon urination) and back pain.
-The suprapubic catheter had sediment in it.
-The NP diagnosed a urinary tract infection (UTI) and ordered a urinalysis with culture and sensitivity on 01/20/16.
-The order for the urinalysis did not specify home health to obtain the urine specimen.
-No documentation of a physician order certifying a non-licensed personnel to be competency validated to perform other tasks to meet Resident #3's needs for obtaining a urine specimen from an indwelling suprapubic catheter for a urine culture and sensitivity test.

Interview on 01/27/16 at 10:40 am with the Nurse Practitioner revealed:
-She saw Resident #3 on 01/20/16 during her routine weekly rounds.
-Resident #3 had an infection and she ordered a urinalysis with culture and sensitivity.
-She thought the Home Health Nurse (HHN) would have obtained the urine sample.

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D 163	Continued From page 17 Interview on 01/29/16 at 9:20 am with Resident #3 revealed: -She had the suprapubic catheter for 10 years. -She was able to empty the urine out of the bag herself. -She could not obtain a urine sample herself. -On 01/26/16, the RCC attempted to get the urine sample from the catheter with a syringe that had a small needle, but could not obtain it. -On 01/27/16, before supper, "the Home Health nurse came in and "let" the Executive Director get the urine sample. -The HHN told the ED to use a syringe and take the urine specimen out of the "the wrong place and it deflated the balloon and the catheter came out on Wednesday (01/27/16) after supper." -There was not a needle in the syringe the ED used. -The ED "got the saline instead of the urine." -"I knew that wasn't right because that is not how my urologist does it." -"The doctor would sometimes take the port out where the catheter is hooked to get a clean sample. They would let a little urine run out and then they would get the sample." -"I could feel it pull when the urine came out of the port" when the ED used the syringe. -The suprapubic catheter had only come out twice in 10 years - "once at the place I was before here, and now here." -She was transported to the emergency room by ambulance on 01/27/16 to have the suprapubic catheter reinserted. -The staff at the hospital changed her catheter, but did not collect a urine sample. -The sample the Executive Director obtained on 01/27/16 froze in the refrigerator overnight, so on 01/28/16, the RCC tried to get the urine sample again. -On 01/28/16 the RCC "used a syringe with a	D 163		

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small needle" and tried to get a sample out of the catheter, but was unable to get the urine, so "she had me open the bag and pour the urine from the bag into the cup."
-On 1/28/16 the RCC held the cup for her to pour urine into from the catheter bag.
-The NP started her on an antibiotic (Cipro) on 01/27/16.

A second interview on 01/29/16 at 3:30 pm with Resident #3 revealed:
-On 1/28/16 when the Home Health nurse was in the room with the ED, "the nurse didn't do anything."
-The nurse made the ED "do it all."
-The ED poured the urine into the specimen cup.
-The ED changed the catheter bag for her.

Review of hospital emergency department records for Resident #3 revealed Resident #3 was seen in the emergency department on 01/27/16 at 6:19 pm for replacement of a dislodged 20 French suprapubic catheter and was discharged back to the facility on 01/27/16 at 7:14 pm.

Interview on 01/27/16 at 11:13 pm with the RCC revealed:
-The Nurse Practitioner (NP) ordered on 01/20/16 Resident #3 to have a urine culture and sensitivity.
-The RCC contacted the Home Health Nurse on 01/21/16 to request the home health nurse obtain the urine specimen and was told that the Home Health Nurse could not obtain the urine sample "because they can't start services until February."
-She was not sure why home health could not start until February 1st.
-The Home Health Nurse "told me to either get the urine from the catheter or use an insulin

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syringe to get the urine sample."
-She had not had training on how to obtain urine from a catheter.
-"I don't know how to do that."
-On 01/22/16, a snow and ice storm occurred and prevented them from transporting the resident to have a urine culture obtained by a medical provider.
-On 01/26/16, she attempted to get the urine sample, "but I could not get it."
-The Executive Director "got the urine sample this morning" (01/27/16).
-"We have it in the refrigerator today and I will take it to the hospital's lab in the morning."

Interview on 01/29/16 at 11:35 am with a HHN revealed:
-Resident #3 was not currently a patient of their home health agency.
-She was in the facility on 01/27/16 seeing other patients and the ED asked her to come in Resident #3's room "for moral support in case she needed me".
-The ED had a specimen cup in her hand.
-She thought the ED told her the resident needed a bag change and to obtain a urine sample for a urine culture and sensitivity.
-She observed the ED obtain the specimen "from the port where you would normally get the specimen from, not the catheter itself.
-The ED used gloves.
-She did not know if the ED washed her hands.
-Resident #3 was "very knowledgeable about the catheter".
-She was not aware that the catheter was a suprapubic catheter.
-"I didn't touch the resident".

A second interview on 01/29/16 at 4:10 pm with the RCC revealed:

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-On 01/26/16, she gave the resident a specimen cup and the resident went into the bathroom to get the urine sample.
-The resident was unable to obtain the specimen "because she didn't have urine in her bag".
-The resident had a cover on her urine bag, so the urine could not be observed unless the cover was removed.
-The resident had no complaint of pain on 01/26/16.
-The resident saw the NP on 01/27/16 and she was started on Ciprofloacin that evening.
-On the evening of 01/27/16, the resident's suprapubic catheter came out and the resident was sent to the emergency department to have it reinserted.
-She called the urologist office twice on 1/28/16 and left messages with the nurse that the resident's suprapubic catheter had come out on 1/27/16 and the resident was sent to the emergency room to have it reinserted.
-The urologist's office did not return her calls.
-On 01/28/16, the RCC gave Resident #3 a specimen cup and the resident went into the bathroom and got the urine specimen.
-The RCC did not observe the resident obtain the urine sample.

A third interview on 02/01/16 at 12:05 pm with the RCC revealed:
-She found the urine sample collected on 01/27/16 frozen in the refrigerator on the morning of 01/28/16.
-She did not, at any time, attempt to obtain a urine sample from Resident #3's catheter.
-She did not use a needle or syringe to obtain a urine sample.
-"I do not have training to get urine samples."

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D 163	Continued From page 21 Interview on 01/28/16 at 10:45 am with the ED revealed: -She was the ED, but also a MA. -Resident #3 did her own "self cath care". -The facility was "getting her set up with home health" for catheter changes. -Resident #3 had seen her urologist at least twice since she was admitted. -The HHN was in the building on 01/27/16 and "assisted the resident with collecting the urine sample". -The ED stated she did not take urine from the catheter. -"I can't get the urine sample." -She could help empty the catheter bag, but it had been a long time since she had training on catheter care. -"I did steady the catheter while the resident took the syringe and put it into the port to get the urine sample." -"The urine was blue." A second interview on 01/29/16 at 5:38 pm with the ED revealed: -On 01/27/16, the Home Health Nurse was in the building and "had a syringe". -The Executive Director asked her to come with her to Resident #3's room in case she needed her help in knowing how to obtain the urine sample. -The resident was shown how to put the syringe in the port with verbal instructions by the nurse. -The resident inserted the syringe into the port and pulled the plunger up to obtain the urine specimen. -It was approximately 4:00 pm on 1/27/16 when the urine sample was obtained. -She was notified by staff Resident #3's suprapubic catheter had come out of her abdomen.	D 163		

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-She thought the resident's suprapubic catheter came out about 5:30 or 6:00 pm.
-When the suprapubic catheter came out, the MA arranged for the resident to go to the hospital emergency department.
-The resident returned to the facility on 01/27/16 with orders to follow-up as soon as possible with her urologist.
-On 01/28/16, she asked the RCC to contact the urologist to see if the previously scheduled appointment for 02/03/16 for Resident #3 was acceptable or if they needed to bring her sooner than 02/03/16.
-She did not know how the RCC would have known how to obtain a urine sample from the suprapubic catheter.
-In MA training, they were taught how to clean around the catheter, empty the bag, but not how to get urine out of a catheter for a specimen.

An interview on 02/02/16 at 8:15 am with a nurse at Resident #3's urologist office revealed:
-The facility did notify the urologist on 1/28/16 that Resident #3's suprapubic catheter had come out and the resident was sent to the emergency room for replacement of the suprapubic catheter.
-The resident was last seen by the urologist on 01/06/16 for a tubing change and 20 cc's of sterile clear water was inserted in the 20 French catheter to help prevent leakage.
-A urine specimen should never be collected from the urine bag.
-A needle should never be used to collect a urine sample because it would cause a leakage.
-The resident does take Uribel which could turn the urine blue. (Uribel is a prescription medication used to relieve the discomfort, pain, frequent urge to urinate, and cramps/spasms of the urinary tract caused by a urinary tract infection)

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D 163	Continued From page 23 Interview on 01/29/16 at 7:40 pm with the facility's Corporate Vice-President revealed: -It was the facility's policy for unlicensed staff to not perform tasks that required validation of competencies prior to a staff person performing a task. -The facility should have obtained a specific order for home health to obtain the urine specimen for the urine culture and sensitivity. -If home health could not obtain the urine specimen, the facility should have taken Resident #3 to a medical provider to obtain the urine specimen from the suprapubic catheter. -She was aware the facility could have obtained a physician certification to ensure non-licensed staff met the requirements for training and competency validation prior to obtaining a urine specimen from an indwelling suprapubic catheter for a urine culture and sensitivity test _____ A Plan of Protection was requested from the facility on 02/09/16. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 18, 2016.	D 163		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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Based on observations, interviews, and record reviews the facility failed to assure referral and follow-up for 4 of 7 sampled residents by not obtaining a urine culture and sensitivity for one resident (Resident #3), not notifying the medical provider of changes in a resident's medical condition (Resident #2), not following up with a resident's medical provider after the resident ingested chemical cleaner and was sent to the hospital (Resident #18), and not notifying the medical provider for a resident receiving medications late on dialysis days (Resident #6) .

The findings are:

A. Review of Resident #3's current FL2 dated 11/06/15 revealed:
-Diagnoses included chronic pain, insomnia, schizophrenia, anxiety, seizures, hypothyroidism, gastroesophageal reflux disease, and irritable bowel syndrome.
-Resident #3 had a suprapubic catheter which was a thin, sterile tube inserted into the bladder through a small hole in the abdomen and was used to drain urine from the bladder when a person could not urinate.

Review of Resident #3's Resident Register revealed an admission date of 12/18/15.

Review of a Pre-Admission Screening dated 10/29/15 and completed by the Executive Director revealed Resident #3 had "an indwelling catheter she cared for."

Interview on 01/26/16 at 11:35 am with Resident #3 during the initial tour revealed:
-She had a suprapubic catheter and "I have an

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infection."
-She saw the NP on 01/20/16 at the facility and she was supposed to have a urinalysis completed to determine what type of antibiotic would treat the infection.
-The urine sample for the urinalysis had not been obtained.
-She went "to the front office this morning and told the RCC I had an infection and was supposed to have a urinalysis done."

Review of Resident #3's assessment and orders by the Nurse Practitioner (NP) revealed:
-Resident #3 was seen by the NP at the facility on 01/20/16.
-Resident #3 had a diagnosis of neurogenic bladder (Neurogenic bladder is the dysfunction of the bladder caused by neurological damage with a high risk of recurrent infections).
-The NP noted the resident complained of dysuria (pain, burning, or discomfort upon urination) and back pain.
-The suprapubic catheter had sediment in it.
-The NP diagnosed a urinary tract infection (UTI) and ordered a urinalysis, with culture and sensitivity, on 01/20/16.

Review of Resident #3's assessment and orders by the NP dated 01/27/16 revealed:
-Resident #3 complained of dysuria and stated "I think I have a UTI."
-The urinalysis, with culture and sensitivity, had not been obtained.
-An order re-written on 01/27/16 for a urinalysis, with culture and sensitivity.
-An order written on 01/27/16 by the NP for Ciprofloxacin (Cipro is an antibiotic used to treat bacterial infections) 250 mg twice a day for five days.

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Review of Resident #3's record revealed:
-There was no order for a home health nurse to obtain a urine sample, with culture and sensitivity, for Resident #3.
-There were no results of a urinalysis with culture and sensitivity ordered on 01/20/16.

A second interview on 01/29/16 at 9:20 am with Resident #3 revealed:
-She could not obtain a urine sample herself from the suprapubic catheter.
-On 01/26/16, the RCC attempted to get the urine sample, but could not obtain it.
-On 01/27/16, before supper, "the Home Health Nurse came in and "let" the Executive Director get the urine sample.
-The HHN told the Executive Director to use a syringe and take the urine specimen out of the "the wrong place and it deflated the balloon and the catheter came out on Wednesday (01/27/16) after supper".
-Resident #3 was transported to the emergency room by ambulance on 01/27/16 to have the suprapubic catheter reinserted.
-The staff at the hospital did not collect a urine sample.
-The urine sample the Executive Director obtained on 01/27/16 froze in the refrigerator overnight, so on 01/28/16, the RCC tried to get the urine sample again.
-The urine sample was obtained on 01/28/16 by the RCC having the resident pour urine from her catheter bag into the specimen cup.

Review of the Resident #3's Nurse Care Notes revealed documentation by the RCC on 01/26/16 "staff having trouble receiving urinalysis from resident. RCC will try again tomorrow."

Interview on 01/27/16 at 11:10 pm with the RCC

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revealed:
-She faxed the order for the urinalysis with culture and sensitivity to the home health agency on 01/20/16.
-She did not document in the record the referral had been made to the home health agency.
-She realized on 01/21/16 the urinalysis had not been obtained by the home health nurse.
-She contacted the HHN on 01/21/16 and was told that the HHN could not see the resident "until February", but was not sure why.
-The Executive Director "got the urine sample this morning" (01/27/16).
-"We have it in the refrigerator today and I will take it to the hospital's lab in the morning."

Interview on 01/27/16 at 10:40 am with the NP revealed:
-She saw Resident #3 on 01/20/16 during her routine weekly rounds.
-Resident #3 had an infection and she ordered a urinalysis with culture and sensitivity.
-She was unaware the urine culture had not been completed as ordered on 01/20/16.
-The urine sample should have been drawn within a day of the order for the urinalysis.
-"If it was not done by 1/26/15 as the resident reported, that is too long to wait for a urinalysis."
-The Home Health Nurse (HHN) would have been the person who would have obtained the urine sample.
-She did not order antibiotics on 01/20/16 because she wanted to review the results of the urinalysis culture and sensitivity report to identify which antibiotics would treat the infection.

A second interview on 1/27/16 at 1:35 pm with the NP revealed:
-She talked with staff and they were not sure why the HHN had not obtained the urinalysis.

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-"They are going to get the urinalysis today."
-Today she ordered Ciprofloxacin 250 mg to be given twice a day for five days.
-When the urine culture and sensitivity report was available, she would determine if the Ciprofloxacin was treating the type of infection or order a different antibiotic.

Interview on 01/28/16 at 10:45 am with the ED revealed:
-She was unaware until 01/27/16 the urine sample for the urinalysis that was ordered by the NP on 01/20/16 had not been obtained.
-The facility was "getting her set up with home health" for catheter changes once a month that were ordered by her urologist.
-The doctor should have been contacted if the urine sample was not obtained when the order was written.
-The MAs, the RCC, or she were responsible for contacting physicians if an order could not be completed.

A second interview on 01/29/16 at 5:30 pm with the ED revealed:
-Staff usually obtained urine samples from the resident by having them "pee in a cup", but they were unable to do this due to Resident #3's suprapubic catheter.
-The facility asked home health to get the urine sample for Resident #3, but they could not because their services did not start until 02/03/16.

Telephone interview on 02/01/16 at 11:50 am with the Executive Director revealed:
-She obtained the the final urine culture report on 01/30/16 and the RCC had contacted the NP to give her the results.
-There were no new orders from the NP.

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B. Review of Resident #2's current FL2 dated 02/16/15 revealed:
-Diagnoses included mental retardation, chronic renal failure, hypertension, osteoarthritis, hyperlipidemia, and goiter.

Review of Resident #2's Resident Register revealed an admission date of 11/07/96.

Review of Resident #2's Nurse Care Notes revealed:
-Resident #2 was seen by the medical provider at the facility on 12/02/15 during routine weekly visit.
-Documentation on 12/03/15 on third shift, the Medication Aide (MA) and Nurse Aide (NA) attempted to get Resident #2 up, but she could not stand. The resident's feet were "black looking" and she was hard to roll from side to side.
-Documentation on 12/06/15 by the Resident Care Coordinator (RCC) Resident #2's feet were swollen, discolored, and the resident had trouble standing on them.
-Documentation on 12/14/15 by the MA on third shift Resident #2 had not urinated at all during the night.
-Documentation on 12/17/15 by the RCC Resident #2 was sent to the emergency room "for irregular heart beat and staff was unable to obtain blood pressure."
-Documentation on 12/17/15 Resident #2 returned to the facility on first shift "with a new script".
-Documentation on 12/17/15 by a MA on third shift the resident had blood "in her pull-up and was bleeding when she urinated."
-Documentation on 12/20/15 by a MA on 2nd shift "post dated for 12/19" that Resident #2 did not urinate at all on second and third shifts. The resident complained that her stomach hurt.

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-There was no documentation in the Nurse Care Notes Resident #2's medical provider had been notified of any of the documented symptoms from 12/03/15 to 12/17/15.
-Documentation on 12/23/15 by the RCC Resident #2 was seen by her medical provider on 12/23/15 during routine weekly visits at the facility.
-A physician's order for Hospice services on 1/6/16.

Review of the hospital emergency room visit dated 12/17/15 revealed:
-A diagnosis of atrial fibrillation and hypertension.
-A new prescription was given for Eliquis 5 mg twice a day. (Eliquis is a medication used to thin the blood to prevent blood clots).

Review of the Nurse Practitioner's (NP) assessment on 12/23/15 revealed:
-Resident #2 was being seen for follow-up to the emergency room visit.
-The resident had loss of consciousness and an irregular heart rate with a diagnosis of atrial fibrillation.
-The resident was being treated with Eliquis and denied having symptoms of chest pain, shortness of breath on 12/23/15.
-The resident had a diagnosis of Alzheimer's dementia.
-The resident's blood pressure during the exam was 88/40 and her heart rate was 88.
-The resident's heart rate was stable.
-The facility was to notify the medical provider of any signs of bleeding.
-The resident's blood pressure was low and the medical provider decreased the Lisinopril (Lisinopril is a medication used to treat high blood pressure and heart failure) from 10 mg daily to 5 mg daily.

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D 273	Continued From page 31 Based on observation, interview, and record review on 01/26/16, 01/27/16 and 01/28/16, it was determined Resident #2 was not interviewable. Interview on 01/27/16 at 1:00 pm with a MA revealed: -She was the MA for Resident #2 today. -She usually worked as a NA, but filled in as a MA when needed. -Resident #2 was able to tell staff when she was sick or hurting. -"If she is sick, we check her blood pressure and heart rate." -"We call the doctor if there are any concerns." -She knew that recently Resident #2 had to go to the hospital because her feet were discolored and "turning blue". -"It was her heart. Her feet were blue because she was not getting enough circulation to her feet. Her doctor started her on a heart medicine and she is doing better." Interview on 01/27/16 at 10:23 am with the RCC revealed: -She had been the RCC for two months and was a MA at the facility prior to becoming the RCC. -The NP visited the facility every Wednesday to see residents. -The MAs and RCC "put notes on the doctor's list" for any residents that need to be seen by the NP during the next visit to the facility. -When a resident returned from a hospital stay or emergency room visit, the RCC placed the resident's name on the list to be seen by the NP during the next scheduled visit. -She had the NP's personal cell phone number and she texted any concerns to the provider. -She had texted the NP when the staff reported to her that Resident #2's legs and feet were blue,	D 273		

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but she was not sure of the exact date and could not locate the text.
-She documented in the progress notes when a resident was seen by the medical provider.
-The facility's policy was for the MAs or the RCC to notify the medical provider of any concerns related to a resident's condition.
-The facility's policy was for the MAs or the RCC to document in the progress notes any changes in the resident's condition, when a medical provider was notified, and what the instructions were from the medical provider for the care of the resident.
-She did not know why she did not document in the record when she notified the physician of the resident's discoloration of the feet and legs.

Interview on 12/27/15 at 10:30 am with the NP revealed:
-She did not know if the facility contacted her regarding Resident #2's changes in symptoms from 12/03/15 to 12/17/15.
-The RCC normally contacted her from the facility, either by phone or text.
-The facility recently had a change in the RCC position.
-The Home Health nurse saw Resident #2 in November 2015 because of lower extremity edema and to check her lung fields.
-Staff were supposed to "write acute issues on a board in the medication room", but the provider's agency also had 24-hour call service.
-Staff could contact the on-call medical provider any time there was a concern about a resident's changes in condition.
-She would have wanted to be contacted regarding the symptoms Resident #2 was having from 12/03/15 to 12/17/15, including the discoloration of her feet and legs, problems standing, and changes in her heart rate.

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-The symptoms the resident was having from 12/03/15 to 12/17/15 could have been coming from the atrial fibrillation.
-The discoloration of the feet could have been caused by the heart having difficulty getting blood circulated to the feet.
-She recently ordered Hospice for Resident #2 and she was receiving these services, including nursing visits.

Interview on 01/27/16 at 12:40 pm with the Executive Director revealed:
-It was the facility's policy that the MA or the RCC notify the medical provider for residents' acute symptoms.
-She was unaware there was no documentation in the record the medical provider had been contacted regarding Resident #2's symptoms from 12/03/15 to 12/17/15.
-Resident #2's medical provider should have been notified regarding the changes in Resident #3's condition from 12/03/15 to 12/17/15.
-The RCC had only been in the position for two months and "is still learning" the new role.
-She would re-educate the MAs and the RCC regarding the need to notify the medical provider as well as document what information they gave the medical provider and their response when there was a concern regarding a resident's care needs.

C. Review of Resident #18's current FL2 dated 08/05/15 revealed:
-Diagnoses included moderate mental retardation, mood disorder, and impulse control disorder.

Review on 01/27/16 of a hospital discharge summary for Resident #18 dated 12/04/15

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revealed:
-Resident was sent to Emergency Room (ER) on 12/04/15 at 11:13 pm for ingestion of a cleaning agent.
-Resident returned to the facility on 12/05/15 with an order to follow up with his primary physician.

Review on 01/27/16 of the facility incident report for Resident #18 revealed:
-The incident occurred on 12/04/15 at 10:30 pm.
-The resident had ingested a cleaning agent.
-The incident happened in a hallway in the facility.
-The Guardian was notified on 12/04/15 at 10:30 pm, documented "message left."
-The Department of Social Services was notified via fax on 12/07/15.
-Documented description of follow-up orders from ER, "Follow up with primary doctor."
-Documented on incident report the primary physician was not notified on 12/04/15.

Further review on 01/27/16 of Resident #18's record revealed a nurse care note the physician had seen Resident #18 on 12/09/16.

Telephone interview on 01/28/16 at 4:30 pm with the facility Nurse Practitioner revealed:
-She had seen Resident #18 on 12/09/16 for a routine visit.
-She was unaware Resident #18 had ingested a cleaning agent until 12/09/16.
-If the facility had faxed or emailed the office they would inform her of the incident, but the office had not informed her.
-When Resident #18 was sent to the ER on 12/04/15 a physician had seen Resident #18, so it might not be necessary for the physician to see him immediately after returning from the ER.
-She would expect the facility to contact her or the office when Resident #18 had ingested the

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D 273	Continued From page 35 cleaning agent. Interview on 02/02/16 at 11:00 am with Resident #18's Guardian revealed: -She was not made aware Resident #18 had ingested the cleaning agent on 12/04/15 until her routing monitoring visit January 2016. -She reviewed Resident #18's record and found documentation of the incident in the care notes. -She visited Resident #18 on 12/22/15, and the facility had not mentioned Resident #18 had ingested the cleaning agent on 12/04/15. -The facility had provided no documentation by phone, fax or email, to her or the office in regard to Resident #18 ingesting a cleaning agent on 12/04/15. Observation on 01/26/16, 01/27/16 and 01/28/16 revealed Resident #18 was ambulating in the halls with multiple small stuffed animals in a book bag he wore on his shoulder and a stuffed monkey hung around his neck. Based on observation, interview, and record review on Resident #18 was not interviewable. Interview on 01/27/16 at 10:40 pm with the night shift Nurse Aide revealed: -He worked on 12/04/15 when Resident #18 had ingested the cleaning agent. -He informed the Medication Aide (MA) Resident #18 ingested the cleaning agent and had taken the empty bottle of cleaning agent to her. -He was unaware if Resident #18's physician was notified or if the Guardian was notified. -The County police and the Emergency Medical Service came to the facility on 12/04/15. Telephone interview on 01/28/16 at 1:15 pm with a night shift MA revealed:	D 273		

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D 273	Continued From page 36 -She worked night shift on 12/04/15 when Resident #18 ingested the cleaning agent. -She had called 911 on 12/04/15. -She contacted the on-call management staff on 12/04/15 and they contacted the Executive Director. -She had not contacted Resident #18's physician. -She could not recall contacting Resident #18's Guardian. -She had not contacted Poison Control. Interview on 1/27/16 at 10:40 pm with the Resident Care Coordinator (RCC) revealed: -She worked as the on-call management staff on 12/04/15. -She was contacted by the MA that Resident #18 had ingested a cleaning agent on 12/04/15. -She contacted the Executive Director on 12/04/15. -She transported Resident #18 back to the facility from the ER on 12/05/15. -She had not contacted Resident #18's physician on 12/04/15 or 12/05/15. -She had not contacted Resident #18's guardian on 12/04/15. Interview on 01/28/16 at 12:30 pm with the Executive Director revealed: -The RCC had contacted her on 12/04/15 in regard to Resident #18 ingestion of a cleaning agent. -She had completed an incident report on 12/07/15. -She had contacted Resident #18's guardian on 12/05/15 and had left a message. -She did not contact Resident #18's physician, but placed Resident #18 on the Nurse Practitioner's list to see next time she was in the facility.	D 273		

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D. Review of Resident #6's current FL2 dated 11/17/15 revealed:
-Diagnoses included end stage renal disease, hypertension, and paranoid schizophrenia.
-A Physician's order for Buspar (buspirone) 10 mg 3 times a day. (Buspirone is used to treat mental health disorders.)
-A Physician's order for labetalol 300 mg every 8 hours. (Labetalol is used to treat high blood pressure.)
-A Physician's order for Deep Sea nose spray one spray in each nostril 3 times a day.

Review of Resident #6's Resident Register revealed an admission date of 11/26/14.

Review of Resident #6's previous FL2 dated 11/25/14 revealed dialysis was ordered 3 times a week.

Review of Resident #6's Medication Administration Records (MARs) for November 2015, December 2015, and January 2016 revealed:
-Buspirone 10 mg 3 times a day was listed and scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily.
-Deep Sea Mist 3 times a day was listed and scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily.
-Labetalol 300 mg every 8 hours was listed on the MAR and scheduled for 6:00 am, 2:00 pm and 10:00 pm daily.
-Buspirone 10 mg, Deep Sea Mist, and labetalol 300 mg were documented administered as ordered except when the resident was documented out of the facility as follows: at 2:00 pm on 11/23/15; 2:00 pm and 8:00 pm on 11/26/15; at 8:00 am, 2:00 pm, and 8:00 pm on 11/27/15 and 11/28/15; at 8:00 am and 2:00 pm

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on 11/29/15, at 2:00 pm on 12/04/15; at 2:00 pm and 8:00 pm on 12/25/15; at 8:00 am, 2:00 pm, and 8:00 pm on 12/26/15; at 8:00 am and 2:00 pm on 12/27/15; at 2:00 pm on 12/30/15; and at 2:00 pm on 01/22/16.

Continued review of Resident #6's MARS for for November 2015, December 2015, and January 2016 for Buspirone 10 mg, Deep Sea Mist, and labetalol 300 mg administration revealed:
-Eleven of 12 opportunities on Monday, Wednesday and Friday in November 2015 had documentation for administration at 2:00 pm when the resident was at dialysis and did not receive medications until returning at 4:30 to 5:00 pm.
-Ten of 13 opportunities on Monday, Wednesday and Friday in December 2015 had documentation for administration at 2:00 pm when the resident was at dialysis and did not receive medications until returning at 4:30 to 5:00 pm.
-Eleven of 11 opportunities on Monday, Wednesday and Friday in January 2016 had documentation for administration at 2:00 pm when the resident was at dialysis and did not receive medications until returning at 4:30 to 5:00 pm.

Review of Resident #6's record revealed no documentation for notifying Resident #6's physician for the resident not receiving buspirone 10 mg, labetalol 300 mg, and Deep Sea Mist scheduled at 2:00 pm on dialysis days of Monday, Wednesday, and Friday until 4:30 pm to 5:00 pm.

Interviews on 01/27/16 at 12:45 pm and 3:50 pm with the Resident Care Coordinator (RCC) revealed:
-She had been in current position less than 8 weeks.

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-Resident #6 had dialysis on Monday, Wednesday, and Friday.
-Resident #6 routinely was transported to dialysis at 11:15 am to 11:30 am and returned to the facility around 5:00 pm on dialysis days.
-She was not sure how Resident #6 received medications scheduled for 2:00 pm on dialysis days.
-Staff should document in the residents' record any physician notification.
-She had notified Resident #6's physician for 2:00 pm medications being administered when the resident returned around 5:00 pm on dialysis days until 01/27/16.

Interview on 01/27/16 at 1:00 pm with a dayshift Medication Aide (MA) revealed:
-Resident #6 was administered his medications scheduled for 11:30 am on dialysis days (Monday, Wednesday, and Friday) before he left for dialysis.
-No medications were sent with Resident #6 to dialysis.
-She was not working when Resident #6 returned from dialysis but as far as she knew, Resident #6 received medications scheduled for 2:00 pm when he returned from dialysis around 4:30 pm to 5:00 pm on Monday, Wednesday, and Friday.
-She had not had occasion to notify Resident #6's physician for failure to receive 2:00 pm medications as ordered on dialysis days.

Interview on 01/27/16 at 1:15 pm with the facility Nurse Practitioner revealed:
-She provided primary care for Resident #6.
-Many of Resident #6's medications were ordered by the physician at the dialysis center.
-She was not aware Resident #6 was not receiving labetalol 300 mg, buspirone 10 mg, and Deep Sea Mist at the times ordered on the MAR.

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D 273	Continued From page 40 -She expected the facility to notify her when residents were not receiving medications as ordered. -She was not aware of any notification of Resident #6's repeated late medications on dialysis days. Interview on 01/27/16 at 3:55 pm with an evening MA revealed: -She routinely administered Resident #6's labetalol, buspirone, and Deep Sea nasal spray (scheduled for 2:00 pm) when the resident returned, around 5:00 pm, from dialysis on Monday, Wednesday or Friday. -She was trained by a former MA to administer Resident #6's medications when he returned from dialysis. Interview on 01/27/16 at 4:00 pm with a second evening shift MA revealed: -She worked part-time as a MA. -She documented labetalol, buspirone, and Sea Mist nasal spray as not administered at 2:00 pm when she worked, and noted the resident was out of the facility on back of the MAR. Interview on 01/27/16 at 4:30 pm with the transportation staff member revealed: -Resident #6 was transported to dialysis on Monday, Wednesday, and Friday around 11:15 am to 11:30 am. -Resident #6 typically returned back to the facility from dialysis between 4:30 pm and 5:00 pm. Review of faxed information for Resident #6's facility NP provided by the Executive Director on 01/29/16 revealed: -The NP had changed buspirone 10 mg to 2 times a day, at 8:00 am and 8:00 pm, on dialysis days on 01/29/16.	D 273		

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D 273	Continued From page 41 -The NP had changed Deep Sea nasal spray to 2 times daily, at 8:00 am and 8:00 pm, on dialysis days on 01/29/16. -The NP had ordered labetalol 300 mg 2 times daily, at 6:00 am and 10:00 pm, on dialysis days on 01/29/16. _____ A Plan of Protection was provided by the facility on 01/29/16 as follows: -Staff shall be retrained on referral and follow-up based on the residents' needs or orders. -Training will be held by 02/01/16. -The Regional Director, Executive Director, and Resident Care Coordinator shall randomly audit residents' charts to assure orders are followed in a timely manner, changes in residents' medical status is reported to assure procedures are followed for referral and follow-up. THE CORRECTION DATE FOR THIS A2 VIOLATION SHALL NOT EXCEED MARCH 3, 2016.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the	D 280		

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resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to assure a registered nurse who was responsible for the Licensed Health Professional Support (LHPS) evaluations and reports participated in the onsite review and evaluation of 1 of 3 sampled resident's (Resident #3) health status, care plan, and care initially within the first 30 days of admission, in regards to care of a suprapubic catheter and stoma care (A stoma is a small opening created surgically on the abdomen where the catheter is inserted into the bladder).

The findings are:

Review of Resident #3's current FL2 dated 11/06/15 revealed:
-Diagnoses included chronic pain, insomnia, schizophrenia, anxiety, seizures, hypothyroidism, gastroesophageal reflux disease, and irritable bowel syndrome.
-Resident #3 had a suprapubic catheter which was a thin, sterile tube inserted into the bladder through a small hole in the abdomen and is used to drain urine from the bladder when a person cannot urinate.

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D 280	Continued From page 43 Review of Resident #3's Resident Register revealed an admission date of 12/18/15. Review of a Pre-Admission Screening dated 10/29/15 and completed by the Executive Director (ED) revealed: -Resident #3 had a suprapubic catheter "she cares for." -Resident #3 was independent with toileting. Review of Resident #3's Care Plan dated 01/11/16 revealed: -The Care Plan was completed by the Assistant Director, who was a Registered Nurse (RN), and signed by the resident on 01/11/16. -LHPS Personal Care Tasks included use of a walker daily and suprapubic catheter daily. Review of Resident #3's record on 01/27/16 revealed: -There was no documented LHPS evaluation completed for Resident #3 for the tasks for care of the suprapubic catheter or using a walker for ambulation. -There was no assessment of the resident's ability to care for the suprapubic catheter and the stoma site. -Staff Competency had not been validated for LHPS Personal Care Tasks for Resident #3. Observation on 01/29/16 at 9:30 am revealed the urine in Resident #3's catheter bag and tubing was clear yellow with no visible blood or sediment. Observation on 01/29/16 at 9:25 am revealed the stoma had bright red boundaries approximately 1.5 by 0.5 inches in diameter with greenish brown discharge with a liquidly appearance.	D 280		

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D 280	Continued From page 44 Observation on 01/29/16 at 10:35 am after Resident #3 had taken her shower revealed the stoma site was clean and with yellow brown discharge on the left side of the stoma and a small amount of clear fluid leaking at the site. Observation on 01/29/16 at 4:30 pm of the stoma revealed: -The stoma appeared beefy red around the catheter with minimal clear liquid drainage. -The tissue on the left upper side of the stoma had a thick yellowish white substance with cottage cheese consistency that ws approximately 1/2 inch in length. Interview on 01/29/16 at 9:20 am with Resident #3 revealed: -She had the suprapubic catheter for 10 years. -She was able to empty the urine out of the bag herself. -The NP started her on an antibiotic (Cipro) on 01/27/16 for a urinary tract infection. -Her stoma had been itching "since I got the infection last week." -She bathed on Mondays, Wednesdays, and Fridays and that was when she cleaned the stoma. -The NP did not observe the stoma when she saw her on 01/20/16. -The facility staff did not observe or provide care to the stoma area. Interview with Resident #3 on 01/29/16 at 10:40 am revealed: -She had an infection at the stoma site previously, but did not recall how often or the last time she had one. -She still had itching and odor even after her shower that morning. -"Sometimes when my urologist mashed on my	D 280		

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stomach, "pus" would come out."
-She had just completed taking her bath.
-She washed the area around the stoma with a washcloth "and it hurt."
-She used to wear gauze at the stoma site and put medicine on the site when it got irritated or drained.

Interview with the MA on 01/29/16 at 9:30 am revealed:
-She was assigned to Resident #3 today.
-The resident was complaining last week of abdominal pain.
-The MA did not observe the suprapubic catheter or the stoma site.
-"The resident does her own care."
-Staff helped the resident with washing her back and hair when she took her showers.

Interview on 01/29/16 at 9:35 with a NA revealed:
-She would be assisting Resident #3 with her bath today and had assisted her on 01/27/16.
-Resident #3 had not mentioned any concerns about itching or having discharge from the catheter site.
-Resident #3 showered in the common bathroom sitting in a shower chair.
-Resident #3 liked privacy while bathing herself.
-Staff only assisted the resident with washing her hair and back.
-She had not observed the area on Resident #3's abdomen where the catheter was inserted.
-She thought Resident #3 cleaned around the catheter when she bathed herself.
-Resident #3 "told us from day one when she came that she does all of that herself."

Interviews on 01/29/16 with NAs revealed:
-One NA usually worked on another hall and had not seen Resident #3's stoma, "but I know the

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staff says she takes care of it herself.
-One NA had not worked with Resident #3, but had received training on suprapubic catheter care at a former employer, but not at this facility.
-One NA said Resident #3 was a new resident and had a catheter, but the resident took care of it.
-One MA said she was not aware of any issues with Resident #3's catheter.

Interview on 01/29/16 with a MA revealed:
-She had been trained to care for a suprapubic catheter at the facility.
-You apply gloves, and at the end of the catheter near the resident you swab it with alcohol and "go away from the resident to clean it."
-Resident #3 was the only resident with a suprapubic catheter they had at the facility.
-She had not seen the stoma, was not working when the catheter came out, and was not present when the specimen was collected.

Interview on 01/28/16 at 4:35 pm with the NP revealed:
-She had not observed the stoma site when she saw the resident on 01/27/16.
-She was unaware there was currently greenish/yellow drainage around the stoma.
-She was currently on Ciprofloxacin.

Interview on 02/02/16 at 8:20 am with a Nurse at Resident #3's urologist office revealed she could not say if the resident could perform care of the catheter and stoma site independently.

Interview on 01/28/16 at 5:21 pm with a Registered Nurse revealed:
-She was responsible for completing the LHPS assessments for new residents and when a resident had a new LHPS task.

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-The RCC was the person at the facility that notified her of residents to be seen for LHPS task evaluations.
-She was informed by the RCC during her visit to the facility last month (she did not recall the date) of the admission of Resident #3.
-She was aware residents with an LHPS task were to be assessed within 30 days of admission.
-She knew Resident #3 had a suprapubic catheter, but the RCC "said she takes care of it herself", including emptying the bag.
-She thought the resident was being seen by the Home Health Nurse and they supplied catheter supplies to the resident.
-She "looked at it differently" since the resident was caring for the catheter herself and home health was seeing her.
-She would be returning to the facility in the next day or two "because my visit is due now."
-She would evaluate Resident #3 for LHPS tasks.

Interview on 01/28/16 at 10:50 am with the ED revealed:
-Resident #3 did her own "self cath care."
-The facility had a Registered Nurse who did the LHPS quarterly assessments for residents who had LHPS tasks.
-The facility's policy was for the LHPS nurse to see residents with LHPS tasks within 30 days of admission.

Interview on 01/29/16 at 7:30 pm with the facility's Corporate Vice-President revealed:
-She was aware residents were to be seen within 30 days of admission if the resident had an LHPS task.
-The LHPS Nurse stated to her today she was unable to find Resident #3 when she came to do LHPS reviews on her last visit.
-The LHPS Nurse thought Resident #3 was out of

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D 280	Continued From page 48 the facility at the time of her last visit in January 2016. -The LHPS Nurse reviewed Resident #3's record during her last visit to the facility and was aware the resident had a suprapubic catheter. -The LHPS Nurse thought the resident was receiving nursing services from home health. -The LHPS stated she would come back to see the resident at the next scheduled appointment. -The LHPS Nurse had come to the facility at unscheduled times to see residents. -The LHPS Nurse would assess the Resident #3 on either 01/29/16 or 01/30/16.	D 280		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the kitchen floor under the freezers and one magnetic trashcan lid were clean and free of contamination. The findings are: A. Observation on 01/26/16 at 11:30 am during the initial tour of the kitchen revealed: -The kitchen floor under the freezers had trash which included an unopened food can, foil paper which was crinkled, multiple small pieces of paper, and unidentified crumbs of food. -An Establishment Inspection report posted in the	D 282		

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D 282	Continued From page 49 kitchen with a Score of 96 dated 12/4/15. Observation on 01/27/16 at 8:00 am of the kitchen revealed the floor under the freezers had trash which included an unopened food can, foil paper which was crinkled, multiple small pieces of paper, and unidentified crumbs of food. Interview on 1/26/16 at 11:50 am and on 01/27/16 at 8:00 am with the day shift Dietary Manager revealed: -She was responsible for overseeing the kitchen. -Her duties included cooking meals, ordering supplies, and cleaning the kitchen area daily. -The kitchen had a Cleaning Log book for assigned cleaning duties that were to be completed daily for first and second shift. -She was aware the kitchen Cleaning Log had not been completed for the past week. - " I would rather the Kitchen Aide get the cleaning done, and not worry about charting on the cleaning log that it had been completed. " -One Dietary Aide assisted her on day shift. -There had been a recent turning-over in the kitchen Dietary Aide staff. -The night shift dietary staff was responsible for sweeping and mopping the floors in the kitchen prior to leaving at night. -She was unaware of the trash under the freezer on the floor. -She was unsure when the floor under the freezer had been swept or mopped last. Interview on 01/26/16 at 5:30 pm with the second shift Dietary Aide revealed her responsibilities included assisting the cook with meals, serving and preparing the beverages, and sweeping and mopping the kitchen floor daily. Observation on 01/27/16 at 8:10 am of the	D 282		

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kitchen Cleaning Log book revealed no documentation the kitchen cleaning duties had been completed on 1/26/16.

Interview on 01/27/16 at 8:15 am with the day shift Dietary Aide revealed:
-Her duties included serving and preparing beverages for the meals, washing dishes, and sweeping and mopping the kitchen floor.
-She swept and mopped the kitchen area on 01/26/16, but had not swept or mopped the floor underneath the freezers.
-She thought it was night shift Dietary Aide's responsibility to deep clean the floors in the kitchen as well as to get under the freezers.
-She was unaware of the unopened food can, foil paper which was crinkled, multiple small pieces of paper, and unidentified crumbs of food that were on the floor in the kitchen under the freezer.

Interview on 01/27/16 at 9:15 am with the Executive Director revealed:
-It was the Dietary Manger's responsibility to keep the floors clean in the kitchen area.
-She was unaware the kitchen Cleaning Log book was incomplete.
-She was unaware that trash, papers, food can, and food crumbs were under the freezer on the floor.

B. Observation on 01/26/16 at 11:30 am during the initial tour of the kitchen area revealed:
-There was a large magnetic trash can used to collect silverware that had accidentally been thrown in the trash approximately 7 foot from the kitchen entrance.
-The magnetic trash can was positioned approximately 2 inches from the dishwashing station.
-The top lid of the trash can was hard plastic with

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D 282	Continued From page 51 dark black dirt/grout around the base of the lid. Interview on 01/26/16 at 11:50 am with the day shift Dietary Manager revealed: -The trash can was used daily at meals to prevent the silverware from being discarded in the trash when the resident's food trays were emptied. -The top lid was cleaned after every meal by the Kitchen Aide. -She was unsure what the black areas were on the lids, "I think it is dirt". -The black dirt had been on the trash can lid for several months. -The Dietary Aide sprayed it after every meal with a bleach cleaner. -The magnetic trash can lid had broken last month and the Maintenance Director had repaired the lid. Interview on 01/27/16 at 8:15 am with the day shift Dietary Aide revealed: -The magnetic trash can was used after each meal. -The residents' food trays were emptied into the magnetic trash can, if the silverware was accidentally put in the trash can the lid would collect it. -She cleaned the lid after breakfast and lunch meal on 01/26/16. -She had taken the magnetic trash can lid outside and sprayed it with bleach, let it sit for several hours and then sprayed it with the water hose which was located outside. -She said this procedure was done three times daily after each meal. -She was unsure what the black substance was around the outside lid of the trash can. - "I would not want it used in my home." Interview on 01/27/16 at 8:30 am with the facility	D 282		

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D 282	Continued From page 52 Maintenance Director revealed: -He had worked on the magnetic trash can lid last month, "It usually breaks one time a month". -He repaired it by reinforcing the metal part on the sides of the trash can lid. -He was unaware what the black substance around the outside base of the trash can lid was, but said it was "probably dirt " Observation on 01/27/16 at 8:35 am revealed the facility Maintenance Director took his fingernail and scrubbed the black substance off a small area on the magnetic trash can lid. Interview on 01/27/16 at 9:15 am with the Executive Director revealed: -She was not aware of the black substance around the outside lid of the magnetic trash can. -She was aware the magnetic trash can was used daily to prevent the silverware from accidentally being discarded. -She was aware the magnetic trash can lid was sprayed outside with a bleach cleaner after each meal. -She told the kitchen staff on 01/27/16 not to bring the magnetic trash can lid with the black substance back into the kitchen. -She would order a new magnetic trash can lid as soon as possible.	D 282		
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	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 6 sampled residents with orders for clobetasol 0.05% ointment (Resident #3), and metformin and tizanidine (Resident #19).

A. Review of Resident #3's current FL2 dated 11/06/15 revealed:
-Diagnoses included chronic pain, insomnia, schizophrenia, anxiety, seizures, hypothyroidism, gastroesophageal reflux disease, and irritable bowel syndrome.

Review of Resident #3's Resident Register revealed an admission date of 12/18/15.

Review of Resident #3's Physician's Order Sheet dated 12/18/15 revealed an order signed by the Nurse Practitioner (NP) for clobetasol 0.05% ointment (clobetasol is a corticosteroid used to treat various skin disorders) apply twice a day to affected area, not on face, groin, and under arms.

Review of the NP's progress note dated 12/23/15 revealed the resident had dry cracking skin from hand sanitizer.

Review of Resident #3's December 2015 Medication Administration Record revealed:
-Clobetasol 0.05% ointment was scheduled to be applied twice a day at 8:00 am and 8:00 pm.
-The start date for the clobetasol was 12/18/15.
-Documentation by staff that the clobetasol 0.05%

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ointment was applied twice a day at 8:00 am and 8:00 pm.

Review of Resident #3's January 2016 MAR revealed:
-A computer generated MAR with an entry for "clobetasol 0.05% ointment apply 2 times a day to affected area not on face, groin, and under arms."
-The entry for the clobetasol 0.05% ointment was marked through and "PRN = REWRITTEN" was written to the right with no documentation of the ointment being administered.
-On the second page of the January 2016 MAR the entry was re-written as "Clobetasol 0.05% apply twice daily to affected areas as needed not to face, groin, or underarms".
-PRN (as needed) was written under the time for administration.
-There was no documentation of the clobetasol 0.05% ointment being administered from 01/01/16 to 01/28/16.

Observation on 01/26/16 at 11:38 am during the initial tour revealed:
-Resident #3 sitting in a chair in her room watching television.
-Resident #3 showed the surveyor the palms of both hands.
-The palms of both hands appeared dry with cracks that were white in color and extended from the center of the palms to the base of her fingers.

Interview on 01/26/16 at 11:40 am with Resident #3 revealed:
-She had arrived at the home "about six weeks ago."
-She was admitted to the facility from another facility.
-She had sensitive skin and her hands would crack sometimes.

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D 358	Continued From page 55 A second interview on 01/29/16 at 9:15 am with Resident #3 revealed: -She had very sensitive skin and was allergic to a lot of soaps. -Some bodywash made her hands dry and sometimes they would break out. -A family member recently brought her a bar of soap that would not break her out. -She used to have some cream the doctor "at the other home" ordered for her hands because they would become very dry. -"I had the cream here, but then they stopped giving it to me so I started using a lotion another doctor told me to use." -When staff did apply the lotion to her hands at this facility and the previous facility, they did it twice a day "every morning and every night." -She did not know why the staff did not give her the lotion anymore. -She had not asked the staff why they were not applying the lotion to her hands anymore. -Her right ring finger at the base was red, but she had not told the Medication Aide (MA). Observation on 01/29/16 at 9:18 am revealed Resident #3 had a red area at the base of her right ring finger approximately 1/2 inch in diameter with no breakage of the skin. Interview on 01/27/16 at 4:28 pm with the Nurse Practitioner (NP) revealed: -Resident #3's previous physician had ordered the clobetasol 0.05% cream to be applied twice a day. -When Resident #3 was admitted, the NP wrote an order for clobetasol 0.05% cream to be applied twice a day to affected area not on face, groin, and under arms. -She had not changed the frequency of the	D 358		

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application of the clobetasol 0.05% cream to prn (as needed) "because when a new resident comes in, I don't change any orders the previous doctor ordered until I get to know the resident."
-The clobetasol 0.05% cream was supposed to be applied to Resident #3's hands twice a day for dryness and cracking of the skin.
-She was surprised the resident had not questioned why she was not getting the cream applied twice a day.
-There were no negative outcomes to her not receiving the cream.
-She would clarify the order with the Resident Care Coordinator (RCC).

Interview on 01/28/16 at 4:30 pm with the RCC revealed:
-Resident #3 was admitted to the facility with signed orders from her previous physician, which included an order for the clobetasol 0.05% to be administered twice a day.
-When a new resident was admitted, she or the Executive Director would rewrite the orders on the facility's Physician Order Sheet, have the NP sign it, and then fax it to the pharmacy.
-The Executive Director had rewritten the orders for Resident #3 for the NP to sign.
-The RCC faxed the orders for Resident #3 to the pharmacy on 12/18/16 so they could print the MARs.
-The pharmacy requested clarification of the order for the clobetasol 0.05% cream, but she did not recall the date.
-The RCC was responsible for clarifying physician orders.
-She contacted the NP for clarification and thought the NP said the clobetasol 0.05% cream was to be administered as needed, so she marked through the clobetasol 0.05% cream order that was scheduled twice a day to affected

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areas, not face, groin, or under arms on the January MAR, wrote PRN = rewritten, and then rewrote the order to be administered as needed.
-She did not realize there was not a written order for the clobetasol 0.05% cream to be administered as needed.
-The tube of clobetasol 0.05% cream the resident brought at admission "said as needed."
-She knew the resident had sensitive skin and a lot of soaps, lotions, and body washes could make her break out.
-She would contact the NP and clarify if the clobetasol 0.05% cream was to be administered as needed or scheduled twice a day.

B. Review of Resident #19's current FL2 dated 05/01/15 revealed diagnoses included diabetes, alcohol dementia, chronic back pain, and pancreatitis.

Review of Resident #19's Resident Register revealed an admission date of 05/01/15.

1. Review of Resident #19's current FL2 dated 05/01/15 revealed an order for metformin extended release (ER) 500 mg two tablets daily with evening meal (Metformin is used to lower sugar in diabetics.)

Review of Resident #19's Physician's Order Sheet dated 10/07/15 revealed a signed order for metformin extended release (ER) 500 mg two tablets daily with evening meal.

Observation of the medication pass on 01/26/16 at 4:15 pm revealed:
-The evening shift Medication Aide (MA) prepared 3 oral medications, including 2 tablets of metformin ER 500 mg for administration to

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Resident #19.
-The MA administered the medications to Resident #19 outside the resident's room and documented administration on the resident's Medication Administration Record (MAR).

Continued observation on 01/26/16 revealed Resident #19 received his evening meal at 5:45 pm.

Review of Resident #19's January 2016 MAR at 5:30 pm on 01/26/16 revealed metformin ER 500 mg take 2 tablets with evening meal was listed, scheduled at 5:00 pm on the MAR, and documented as administered at 5:00 pm daily.

Interview on 01/26/16 at 4:55 pm with the Resident Care Coordinator (RCC) revealed:
-The RCC was responsible for routinely transcribing new orders on the MAR.
-Copies of residents' orders were faxed to the contract pharmacy and the pharmacy added the orders to residents' MARs.
-The Medication Aides (MAs) were responsible for administering medications according to the times scheduled on the MAR, taking into consideration the one hour before or after scheduled time of administration grace period.
-The MAs were responsible for following any specific administration instructions listed on the MAR.
-She was not aware of the physician's order for Resident #19 to receive metformin ER 500 mg with evening meal.
-She was aware medications ordered with meals should be administered while the resident was eating or shortly after the resident had eaten.

Interview on 01/26/16 at 5:07 pm with the evening shift MA revealed:

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-She started administering medications at the facility 3 weeks ago.
-She routinely administered Resident #19's medications close to 4:00 pm daily.
-She started administering medications scheduled for 5:00 pm on the MARs at 4:00 pm daily because she was trained that medications could be administered up to one hour before or one hour after the scheduled time.
-She was aware that medications ordered to be administered with a meal should be given when the resident started eating or shortly after eating.
-She overlooked the instructions printed on Resident #19's MAR for administering metformin ER 500mg with the evening meal.

Interview on 01/26/16 at 5:45 pm with Resident #19 revealed:
-He routinely received metformin ER 500 mg daily around 4:00 pm.
-He was not aware metformin ER 500 mg was ordered to be taken with the evening meal.
-He was not aware of experiencing any medication related stomach distress or other side effects.

2. Review of Resident #19's current FL2 dated 05/01/15 revealed an order for tizanidine 2 mg three times a day. (Tizanidine is used as a muscle relaxant.)

Review of Resident #19's Physician's Order Sheet dated 10/07/15 revealed signed order for tizanidine 2 mg three times a day.

Observation of the medication pass on 01/26/16 at 4:15 pm revealed:
-The evening shift Medication Aide (MA) prepared 3 oral medications, including tizanidine 2 mg for administration to Resident #19.

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D 358	Continued From page 60 -The MA administered the medications to Resident #19 outside the resident's room and documented administration on the resident's Medication Administration Record (MAR). Review of Resident #19's January 2016 MAR at 5:30 pm on 01/26/16 revealed tizanidine 2 mg three times a day was listed, scheduled at 8:00 am, 2:00 pm, and 8:00 pm daily on the MAR, and documented as administered from 01/01/16 to 01/26/16. Review of Resident #19's record revealed no documentation of notification for Resident #19 receiving tizanidine 2 mg scheduled for 2:00 pm after 4:00 pm. Interview on 01/26/16 at 4:55 pm with the Resident Care Coordinator (RCC) revealed: -The RCC was responsible for routinely transcribing new orders on the MAR. -Copies of residents' orders were faxed to the contract pharmacy and the pharmacy added the orders to residents' MARs. -Medication Aides (MAs) were responsible for administering medications according to the times scheduled on the MAR, taking into consideration the one hour before or after scheduled time of administration grace period. -MAs were responsible for following any specific administration instructions listed on the MAR. -She was not aware the evening shift MA administered tizanidine 2 mg to Resident #19 with 5:00 pm medications instead of at 2:00 pm when ordered. Interview on 01/26/16 at 5:07 pm with the evening shift MA revealed: -She started administering medications at the facility 3 weeks ago.	D 358		

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D 358	Continued From page 61 -She routinely administered Resident #19's medications close to 4:00 pm daily. -She started administering medications scheduled for 5:00 pm on the MARs at 4:00 pm daily because she was trained that medications could be administered up to one hour before or one hour after the scheduled time. -Resident #19 preferred to have his tizanidine 2 mg, scheduled for 2:00 pm to be administered with the medications scheduled for 5:00 pm. Interview on 01/26/16 at 5:45 pm with Resident #19 revealed: -He routinely received tizanidine 2 mg around 4:00 pm when he received other medications. -He was not aware of experiencing any medication related stomach distress or other side effects.	D 358		
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 record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to referrals and follow-up for residents' care needs, ensuring cleaning supplies were monitored to prevent resident	D912		

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ingestion of chemicals, staff competencies were validated with return demonstration prior to performing an Licensed Health Professional Support task, specifically obtaining a urine specimen from a suprapubic catheter, and a Licensed Health Professional Support assessment was completed on a resident within 30 days of admission for care of a suprapubic catheter.

A. Based on observations, interviews, and record reviews the facility failed to assure referral and follow-up for 4 of 7 sampled residents by not obtaining a urine culture and sensitivity for one resident (Resident #3), not notifying the medical provider of changes in a resident's medical condition (Resident #2), not following up with a resident's medical provider after the resident ingested chemical cleaner and was sent to the hospital (Resident #18), and not notifying the medical provider for a resident receiving medications late on dialysis days (Resident #6). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care. (Type A2 Violation)]

B. Based on observation, interviews, and record reviews the facility failed to ensure cleaning supplies were monitored by staff while in use resulting in 1 resident (Resident #18) ingesting an unspecified amount of a cleaning agent. [Refer to Tag D 056, 10A NCAC 13F .0305(f)(4) Physical Environment. (Type B Violation)]

C. Based on interview and record review, the facility failed to obtain physician certification and ensure non-licensed staff met the requirements for training and competency validation prior to obtaining a urine specimen from an indwelling suprapubic catheter for a urine culture and sensitivity test (Resident #3).[Refer to Tag D 163,

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D912	Continued From page 63 10A NCAC 13F .0504(c) Competency Validation for Licensed Health Professional Support Tasks. (Type B Violation)]	D912		