STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079092	A. BUILDING: _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S REST HOME	5767 HWY 135 STONEVILLE, NC 27048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 02/09/16, 02/10/16, 02/11/16, 02/16/16, and 02/17/17 with an exit conference via telephone on 02/18/16.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 2 of 6 sampled staff (Staff A and E) were tested upon employment for Tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: A. Review of Staff A's personnel file revealed: -A hire date of 1/16/16 as a cook. -Staff A had a TB skin test documented as placed on 2/09/16 but it had not been read. -Staff A had no other documentation of having a TB skin test prior to or upon hire. -There was no documentation of two TB skin tests within 12 months of each other.	D 131		

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D 131	Continued From page 1 -The TB had not been read 72 hours after placement. Interview with Staff A on 2/16/16 at 12:30 pm revealed: -She had a TB skin test this month (February 2016) but no other TB skin test prior to February 2016. -She did not know it was required that she was to have a TB skin test either prior to or upon hire. Interview with the Facility Registered Nurse on 2/17/16 at 11:41 am revealed: -The Administrator and the Resident Care Coordinator were responsible for the personnel files. -She placed and read all the TB tests when the Administrator or RCC informed her the testing was needed. -She did place the TB skin test on Staff A. Attempted interview with the Administrator was unsuccessful. B. Review of Staff E's personnel file revealed: -She was hired on 9/01/07 as a Personal Care Aide and Medication Aide. -There was no documentation of a TB skin test prior to or upon hire. -There was no further documentation of two TB skin tests. Interview with Staff E on 2/16/17 at 11:45 am revealed -She had to get two TB skin tests for her other employment and both TB skin tests had been placed and read at the local health department. -The results were both negative for TB. -She did not know where this documentation was, but she had provided two TB skin tests with	D 131		

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D 131	Continued From page 2 negative results to the Administrator upon hire. Interview with the Facility Registered Nurse on 2/17/16 at 11:41 am revealed: -The Administrator and the Resident Care Coordinator were responsible for the personnel files. -She placed and read all the TB tests when the Administrator or RCC informed her the testing was needed. Attempted interview with the Administrator was unsuccessful.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 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 A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry(HCPR) according to G.S. 131E-256. The findings are: Review of Staff A's personnel records revealed: -A hire date of 1/16/16 as a cook. -No documentation of a HCPR check.	D 137		

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D 137	Continued From page 3 A HCPR check completed on 2/10/16 for Staff A revealed no substantiated findings listed on the registry. Interview with Staff A on 2/16/16 at 12:27 pm revealed:: -She did not know if the Administrator or Resident Care Coordinator had completed a HCPR on her. -She worked in the kitchen as a cook and worked Monday, Tuesdays and Wednesdays. Interview with the Administrator on 2/10/16 at 11:20am revealed: -She knew that all staff were required to have a HCPR check. -She ran HCPR checks on clinical and non-clinical staff. -She did not have an opportunity to do this for Staff A until 2/10/16. -All of the other staff had the HCPR check complete prior to or upon hire.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure a Criminal Background check was completed prior to hire for 1 of 6 sampled staff (Staff A). The findings are: A. Review of Staff A's personnel records	D 139		

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D 139	Continued From page 4 revealed: -Staff A was hired on 1/16/16 as a cook. -Documentation of a completed Criminal Background check in Staff A's personnel record dated 2/10/16. -Staff A's daily responsibilities included providing 3 meals a day and snacks to all the residents. Interview with Staff A on 2/16/16 at 12:30 pm revealed: -She started working as a cook at the facility on 1/16/16. -Her current job duties included providing the residents with 3 meals a day and snacks. -She signed a Criminal Background check consent when she came to work on 01/16/16, but did not know if they had done a background check on her. Interview with the Facility Registered Nurse on 2/17/16 at 11:25 am revealed: -The facility did background checks on staff prior to or upon hire. -The Administrator may not have had a chance to run a background check on Staff A until 2/10/16. -Staff A's background check came back without findings. Attempted interview with the Administrator was unsuccessful.	D 139		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on	D 167		

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cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

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

Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 9 of 15 days on first shift, 11 of 15 days on second shift and 5 of 15 days on third shift from 2/1/16-2/15/16.

The findings are:

A. Review of Staff C's personnel file revealed:
-Staff C was hired as a Medication Aide on 3/27/13.
-Her title was Resident Care Coordinator (RCC).
-No documentation of CPR training within the last 24 months.

Review of the staff schedule from 2/01/16-2/15/16 revealed
-Staff C worked first shift (2/1, 2/2, 2/4, 2/9, 2/11, 2/15/16) with a Personal Care Aide (PCA).
-This PCA was not CPR certified based on her staff record.

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Telephone interview with Staff C, RCC on 2/17/16 at 9:24 am revealed:
-She took the CPR training offered by the facility around the time she was hired but did not know the expiration date.
-She had worked at the facility for about 3 years as a Medication Aide and RCC.
-She routinely worked first shift.
-She worked first shift with one Personal Care Aide.
-She did not know her CPR certification had expired.
-No resident had required CPR or had an incident of choking during any shifts she had worked at the facility.

Refer to Interview with the Administrator on 2/17/16 at 11:05 am.

B. Review of Staff D's personnel file revealed:
-Staff D was hired as a Medication Aide on 10/01/13.
-Her title was Supervisor.
-No current documentation of CPR training in the last 24 months.

Review of the staff working schedule (2/1/16-2/15/16) for Staff D revealed:
-Staff D worked second shift (2/2, 2/8, 2/11/16) with a Personal Care Aide (PCA), whom was not CPR certified.

Interview with Staff D, SIC on 2/17/16 at 11:34 am revealed:
-She took the CPR training in the past.
-She had worked at the facility for 2-3 years as a Medication Aide and SIC.
-She worked both first and second shift, but mostly second shift.
-She worked second shift with one PCA.

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D 167	Continued From page 7 -She did not know her CPR certification had expired. -She and the Administrator did the staffing schedule, and she was not aware that one person had to be CPR certified on each shift at all times. -No resident had required CPR or had an incident of choking during any shifts she had worked at the facility. Refer to Interview with the Administrator on 2/17/16 at 11:05 am Interview with the Administrator on 2/17/16 at 11:05 am revealed: -She was a certified CPR instructor and her certification was not expired. -She instructed CPR for her staff on an as needed basis. -It was the responsibility of the RCC to ensure that staff folders were up-to-date and complete. -The RCC had not notified her that CPR training was due for most of the staff. -She and the Administrator were aware that one person had to be CPR certified on each shift at all times. -She was not aware that many of the staff's CPR certifications had expired. -No resident had required CPR or had an incident of choking. On 02/17/16, the facility's Registered Nurse Consultant submitted a Plan of Protection as follows: -The Administrator or designee will immediately begin an audit of personnel files along with the posted employee schedule to ensure a staff person on the premises at all times who has passes a class in CPR training with the last 24 months. -Beginning immediately a CPR trained staff will	D 167		

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D 167	Continued From page 8 be onsite at all times. -Administrator or designee will develop a system for monitoring expiration dates of CPR certification on an ongoing basis as well as develop a system for ensuring CPR trained staff are onsite at all times. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 3, 2016.	D 167		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the Administrator was responsible for the total operation of the facility to maintain compliance in the rule areas of health care, medication	D 176		

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administration, medication orders, nutrition and food service, tuberculosis testing, medical examination and immunizations, training on cardiopulmonary resuscitation, examination and screening for the presence of controlled substances, and other staff qualifications.

The findings are:

Interviews on 02/16/16 at 10:20 am and 3:30 pm with the Administrator revealed:
-The Administrator worked another job during the day.
-The Resident Care Coordinator (RCC) was in charge when the Administrator was not in the facility.
-The RCC was in charge of following up behind the other Medication Aides (MAs), ensuring new orders were faxed to the pharmacy and transcribed to the Medication Administration Record (MAR), ensuring accuracy of the MARs, auditing MARs, communicating new dietary orders to the kitchen, and oversight of the kitchen and meal service.
-She was not aware the RCC was not completing assigned responsibilities or providing oversight of the day to day operations of the facility.
-She was not aware of facility noncompliance in various rule areas.
-There were currently no systems in place to ensure responsibilities and assigned duties were completed and compliance in all rule areas maintained.

Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:30 am with the RCC revealed:
-She had worked at the facility since it opened in in 2013.
-The MA on duty in the facility was considered the Supervisor.

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-She did not supervise the other MAs.
-She had the same responsibilities as the other MAs and there was "nothing different" except she completed the annual FL-2s and careplans.
-She did not supervise the kitchen or dining room. "They (kitchen staff) come get me" if they need anything.
-The Administrator was available by telephone "depending on how busy she is".

Based on findings from the annual survey and complaint investigation completed by staff with the Adult Care Licensure Section on 02/09/16, 02/10/16, 02/11/16, 02/16/16, and 02/17/17, the following areas of noncompliance were identified:

A. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 3 of 3 sampled residents (Residents #1, #2, and #3). [Refer to Tag 358, 10A NCAC 13F .1004(a) (Type A2 Violation).]

B. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the routine and acute health care needs for 2 of 3 sampled residents (Residents #1 and #2) regarding physician notification of noncompliance, discharges to the hospital and re-admissions to the facility, and clarification of order for enzymatic debriding agent. [Refer to Tag 273, 10A NCAC 13F .0902(b) (Type A2 Violation).]

C. Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 2 of 3 sampled residents (Residents #2 and #4) upon admission to the facility. [Refer to Tag 276, 10A NCAC 13F .0902(c)(3-4) (Type B

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D 176	Continued From page 11 Violation).] D. Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for 3 of 3 sampled residents (Residents #2, #3, and #5) with orders for therapeutic diets (Carb Controlled No Added Salt, Renal/Carb Modified, and Heart Healthy). [Refer to Tag 296, 10A NCAC 13F .0904(c)(7) (Type B Violation).] E. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 9 of 15 days on first shift, 11 of 15 days on second shift and 5 of 15 days on third shift from 2/1/16-2/15/16. [Refer to Tag 167, 10A NCAC 13F .0507 (Type B Violation).] F. Based on observations, interviews, and record reviews, the facility failed to ensure the FL-2 was in the facility before admission or accompanied the resident upon admission and reviewed by the facility before admission for 2 of 3 sampled residents (Residents #1 and #2) who were nonemergency admissions. [Refer to Tag 236, 10A NCAC 13F .0703(c)(2) (Type B Violation).] G. Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for verification of orders for medications which were not dated and signed within 24 hours of admission to the facility for 3 of 3 sampled residents (Residents #1 and #2, and #3). [Refer to Tag 344, 10A NCAC 13F .1002(a)(1) (Type B Violation).] H. Based on interviews and record reviews, the	D 176		

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facility failed to assure 2 of 6 sampled staff (Staff A and E) were tested upon employment for Tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 131, 10A NCAC 13F .0406(a).]

I. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry(HCPR) according to G.S. 131E-256. [Refer to Tag 137, 10A NCAC 13F .0407(a)(5).]

J. Based on record review and interview, the facility failed to assure a Criminal Background check was completed prior to hire for 1 of 6 sampled staff (Staff A). [Refer to Tag 139, 10A NCAC 13F .0407(a)(7).]

K. Based on observations, interviews, and record reviews, the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff for 2 of 3 sampled residents (Residents #2 and #3). [Refer to Tag 309, 10A NCAC 13F .0904(e)(3).]

L. Based on interview and record reviews, the facility failed to assure medication administration records (MARs) were accurate and complete for 2 of 3 sampled Residents (Residents #2 and #3) regarding medications for diabetes and gastroesophageal reflux disease. [Refer to Tag 367, 10A NCAC 13F. 1004(j).]

M. Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled

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D 176	Continued From page 13 substances was performed for 1 of 6 sampled staff (Staff A) hired after 10/1/13 before the employee began working at the facility. [Refer to Tag 992, G.S. 131D-45.] On 03/04/16, the Administrator submitted a Plan of Protection as follows: -The Administrator will be present at the facility for a minimum of 6 hours daily for 30 days. -When the Administrator is not present in the facility, there will be an Administrator-In-Charge present at all times who meets the qualifications required for Administrator-In Charge and who is responsible to the Administrator for carrying out the program in the Administrator's absence. -The Administrator will be responsible for the total operation of the facility to achieve and maintain compliance in all rules areas. -The Administrator will develop a system for monitoring all rule areas to ensure ongoing compliance. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 19, 2016.	D 176		
D 236	10A NCAC 13F .0703 (c-2) Tuberculosis Test Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:	D 236		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S REST HOME	5767 HWY 135 STONEVILLE, NC 27048

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D 236	Continued From page 14 (2) The FL-2 or MR-2 shall be in the facility before admisssion or accompany the resident upon admission and be reviewed by the facility before admission except for emergency admissions. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the FL-2 was in the facility before admission or accompanied the resident upon admission and reviewed by the facility before admission for 2 of 3 sampled residents (Residents #1 and #2) who were nonemergency admissions. The findings are: A. Review of Resident #2's current FL-2 dated 01/13/16 revealed diagnoses included pneumonia, type II diabetes mellitus, and chronic pain. Review of Resident #2's record revealed: -There were two Resident Registers for Resident #2. -The latest Resident Register revealed an admission date of 01/16/16 from a skilled nursing facility, and a prior Resident Register revealed an admission date of 11/06/15 from a sister facility. -There was no FL-2 or other physician orders to accompany the 11/06/15 admission to the facility. Review of Resident #2's November 2015 Medication Administration Records (MARs) revealed: -There was a paper MAR from the sister facility	D 236		

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with documentation of medication administered from 11/01/15 through 11/12/15.
-There was an electronic MAR (eMAR) with documentation of medications administered, with beginning dates ranging from 11/12/15 to 11/14/15.

Review of Resident #2's current FL-2 dated 01/13/16 revealed:
-Physician orders included four medications the resident was not taking when she was admitted to the facility on 11/06/15 [Perforomist nebulizer twice daily (bronchodilator), ipratropium-albuterol nebulizer every six hours (bronchodilator), Klor-Con 20 meq daily (potassium supplement), alprazolam 0.25mg three times daily (anti-anxiety agent), and hydromorphone 1 mg every six hours as needed for pain (narcotic pain reliever)].
-Several medications were routinely administered which were not ordered on the 01/13/16 FL-2, which included Norvasc 10 mg daily (calcium channel blocker), atorvastatin 40 mg daily (treats high cholesterol), hydralazine 25 mg three times daily (vasodilator), Novolog 10 units three times daily (rapid-acting insulin), and vitamin B6 100 mg twice daily (vitamin supplementation).
-The 01/13/16 FL-2 included orders for dosage changes for 2 medications the resident was receiving (omeprazole and aspirin).

Interview on 02/16/16 at 3:50 pm with a representative from the facility's contracted pharmacy revealed:
-The pharmacy did not receive a new FL-2 or any new orders when the resident was admitted to this facility from their sister facility in November 2015.
-The medications were transferred from the sister facility to this facility and entered into the computerized system by the pharmacy staff.

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D 236	Continued From page 16 Interviews on 02/10/16 at 9:15 am and 02/11/16 at 10:40 am with the Resident Care Coordinator (RCC) revealed: -Resident #2 transferred to this facility on 11/06/15. -She was not aware she needed to have a new FL-2 when a resident transferred from one of their sister facilities. -The facility just brought the MAR and the resident's medications from the sister facility and continued "the same orders". -It took "a couple of days--maybe 5" for the pharmacy to enter the resident's information into the electronic system. Interview on 02/16/16 at 3:30 pm with the Administrator revealed: -Resident #2 transferred to this facility on 11/06/15. -She was not aware she needed to have a new FL-2 when a resident transferred from one of their sister facilities. -The facility used the MAR from the sister facility until the pharmacy put the resident's information into the computerized system. Interview on 02/10/16 at 11:15 am and 02/11/16 at 9:30 am with Resident #2 revealed: -She transferred from the sister facility to this facility in November 2015 because there was more staff at this facility to assist her. -There were no interruptions in the administration of her medications or other care when she transferred to this facility in November 2015. B. Review of Resident #1's current FL-2 dated 02/08/16 revealed diagnoses included, hypercarbic respiratory failure, anasarca, sepsis, type I diabetes mellitus, chronic kidney disease	D 236		

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D 236	Continued From page 17 stage III, history of toe amputation (x2). Review of Resident #1's record revealed: -The Resident Register for Resident #1 had an admission date of 2/07/16. Review of a discharge summary dated 2/06/16 revealed Resident #1 was discharged from the local hospital on 2/06/16. Interview with the hospital discharge Social Worker on 2/17/16 at 10:14 am revealed: -Resident #1 was discharged from the hospital to this facility on 2/06/16. -She was late supplying the facility with the FL2. -She faxed the facility the FL2 on 2/08/16. Interview on 02/16/16 at 3:50 pm with a representative from the facility's contracted pharmacy revealed the pharmacy received the FL2 for Resident #1 on 2/08/16 at 2:46 pm. -The medications were transferred from the sister facility to this facility and entered into the computerized medication administration system by the pharmacy staff. Interviews on 02/09/16 at 4:00 pm with the Resident Care Coordinator (RCC) revealed: -Resident #1 transferred to this facility on 2/06/16 from the hospital. -Resident #1 lived at a sister facility and was at this facility visiting and had all of her medications during this visit. -The pharmacy was closed over the weekend and they could not enter Resident #1 into the electronic Medication Administration Record (eMAR) because the person that entered new residents into the eMAR was out of town. -Resident #1's information and medications were entered into the eMAR on 2/09/16. -She and the staff administered medications	D 236		

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D 236	Continued From page 18 based on the instructions on the medication cards she had prior to the hospitalization. -She was able to compare these to the FL2, but did not know what staff compared them to prior to receiving the FL2. Interview on 02/16/16 at 3:25 pm with the Administrator revealed: -Resident #1 was visiting (was not a resident) at this facility from a sister facility and she became ill and was sent to the hospital. -She thought that Resident #1 was admitted to this facility on 2/07/16. -She was not aware she did not have an FL2 upon admission to this facility from the hospital. Interview on 02/11/16 at 10:30 am with Resident #1 revealed: -She was visiting this facility from a sister facility when she was sent to the hospital. -She thought that she was admitted to this facility on Saturday (02/06/16) but was not exactly sure. -She thought the medications looked "about the same" as prior to her hospitalization. _____ On 02/11/16, the facility's Registered Nurse Consultant submitted a Plan of Protection as follows: -The Administrator or designee will audit all resident records beginning immediately to ensure correct and accurate FL2s. -The Administrator or designee will be informed of all new admissions and ensure FL2 accompanies the resident on admission to the facility. -All Medication Aides (MAs) will be inserviced prior to their next scheduled shift. -Administrator or designee will review and monitor all new admissions within 24 hours to ensure FL2 and physician orders accompany the resident on admission to the facility.	D 236		

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D 236	Continued From page 19 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 3, 2016.	D 236		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the routine and acute health care needs for 2 of 3 sampled residents (Residents #1 and #2) regarding physician notification of noncompliance, discharges to the hospital and re-admissions to the facility, and clarification of order for enzymatic debriding agent. The findings are: A. Review of Resident #2's current FL-2 dated 01/13/16 revealed diagnoses included pneumonia, type II diabetes mellitus, and chronic pain. Review of Resident #2's Resident Register revealed she was originally admitted to the facility on 11/06/15 from a sister facility. Review of Resident #2's record revealed:	D 273		

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-The facility did not obtain a new FL-2 for admission to this facility on 11/06/15.
-The facility staff transferred the resident's Medication Administrator Records (MARs) and medications, and continued care as at the previous facility.

Telephone interviews on 02/17/16 at 12:40 pm and 02/18/16 at 9:42 am with Resident #2's Nurse Practitioner (NP) revealed:
-She did not know the facility needed a new FL-2 when Resident #2 transferred from the sister facility to this facility in November 2015. If she had been asked, she would have provided a new FL-2.
-She intended for Resident #2 to continue the same medications and orders, including the 1500 cc fluid restriction, upon transfer to this facility in November.

Review of Resident #2's physician orders prior to the 11/06/15 admission revealed:
-A physician's order dated 02/24/15 to "Start 1500 ml (50 ounce) (6 cups) fluid restriction/24 hours".
-A physician note dated 09/23/15 with instructions to "continue 1500 ml fluid restriction".

Review of Resident #2's record revealed a communication from the facility to the physician's office as follows: "this is to make you aware that (Resident #2) has been in the hospital on two occasions since your visit on 11/23/15 both for CHF. She left on December 5th, came back on Friday the 11th and Saturday morning she had to be taken out by ambulance. She could not breathe. As of today she is still in the hospital."

Review of hospital discharge information dated 12/11/15 and 12/22/15 revealed:
-Admitting diagnoses included congestive heart

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failure (CHF).
-There was no mention of the resident's previously-ordered fluid restrictions.

Interview on 02/17/16 at 11:03 am with a Medication Aide (MA) revealed:
-Resident #2 was noncompliant with the fluid restrictions "pretty much every day".
-The MA reminded the resident about the fluid restrictions whenever she saw her with extra fluids or soda.
-The MA did not notify the physician of the resident's noncompliance with the fluid restrictions because she "just didn't think to".

Interview on 02/17/16 at 10:45 am with a Personal Care Aide (PCA) revealed:
-Resident #2 was noncompliant with the fluid restriction.
-The PCA had to be "constantly after" her about her fluid intake.
-When the PCA observed the resident to be noncompliance with her fluid restriction, she reported it to the MA on duty.
-It was the responsibility of the MA on duty to communicate with physicians.

Interview on 02/10/16 at 2:35 pm with the Administrator revealed:
-She was aware Resident #2 was not compliant with the order for fluid restrictions.
-She talked with Resident #2 last week and told her she should only drink what was served to her by the facility staff.
-She had not notified the physician of the resident's noncompliance with the fluid restriction.

Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed:

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D 273	Continued From page 22 -The RCC knew Resident #2 was on fluid restriction because the RCC's family member worked at the sister facility and had told the RCC about the resident's fluid restriction and "numerous" hospital admissions for congestive heart failure. -The resident was noncompliant with the fluid restriction. -The resident was sent out to the hospital on 12/05/15 because she was "moaning and not acting like herself". -A Personal Care Aide (PCA) reported to the RCC that the previous day, the resident had been "drinking, drinking, and drinking". This was the first time the RCC was aware of the resident's noncompliance with the fluid restriction. -The RCC did not notify the physician of the resident's noncompliance with the fluid restriction because she had never witnessed the noncompliance herself. -The RCC did not notify the physician's office on 12/05/15 or 12/12/15 of the resident's transfer to the hospital. -The RCC would only notify the physician if a resident was in the hospital for a "couple of days". -The RCC notified the physician's office on 12/09/15 of the resident's two admissions to the hospital for CHF. Interviews on 02/10/16 at 11:15 am and 02/11/16 at 9:30 am with Resident #2 revealed: -As long as she was (urinating), she could drink whatever she wanted. -Staff routinely served coffee, milk, and juice at breakfast, but she did not usually drink the milk or juice. -Staff routinely served tea and water at lunch and supper and she usually drank the tea, but "had her own water". -Resident #2 routinely prepared for herself 16	D 273		

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ounces of water with a flavor packet every morning and 18 ounces every evening.
-The resident stated she has had to go to the hospital for "a heart attack and fluid filling the lungs" with inability to breathe and was on a ventilator, but if she (urinated) it out, she did not have to go to the hospital.

Telephone interviews on 02/17/16 at 12:40 pm and 02/18/16 at 9:42 am with Resident #2's Nurse Practitioner (NP) revealed:
-She knew Resident #2 had been noncompliant at the previous facility, but thought she was being more compliant with fluid restrictions at this facility.
-The facility staff had not notified the NP of noncompliance regarding fluid restriction since the resident transferred in November 2015.
-She could not order daily weights to monitor for increase fluid for Resident #2 because the facility did not have a wheelchair scale on which to weigh the resident, but she would have asked the staff to monitor the resident closely for edema if she had been informed of the resident's noncompliance, even though edema would be a "late sign".
-The facility did not notify the physician's office when the resident was admitted to the hospital on 12/05/15, when she returned on 12/11/15, when she went out again on 12/12/15, or when she returned on 01/16/16.
-The office received a fax on 12/19/15 informing them of the two hospitalizations for congestive heart failure (CHF) and that the resident was still in the hospital.
-While making rounds at a skilled facility sometime in December 2015, the NP was surprised to see Resident #2 had been admitted to the skilled nursing facility.
-The NP was not aware Resident #2 was back in

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this facility until the surveyor called on 02/17/16.
-The NP would expect to be notified "at least by the next day" if a resident went out to the hospital so she could review the discharge summary and other information when the resident returned.
-Resident #2 would have been seen by the physician's office for a follow up visit if the office had been aware she had returned to the facility.
-While reviewing the resident's hospital discharge information on 02/17/16 from the resident's hospitalization on 12/12/16, the NP learned the resident had been in the Intensive Care Unit (ICU) and on the ventilator.
-The hospital physicians ordered Perforomist nebulizers (bronchodilator) which should help once the medication (included on the 01/16/16 re-admission FL-2) was started.

B. Review of Resident #1's current FL-2 dated 02/08/16 revealed an order for Santyl ointment - apply one application topically daily (an enzymatic debridement ointment used to remove unhealthy tissue from wounds).

Review of Resident #1's hospital discharge summary dated 2/06/16 revealed:
-A physician's order for Santyl ointment to be applied topically daily.
-Instructions to provide local wound care to left lower extremity with nonstick dressings and change daily.

Review of Resident #1's February 2016 eMAR revealed:
-An entry for Santyl ointment to be applied topically, once daily at 8:00 am.
-Santyl ointment was documented as applied until 2/11/16.
-Santyl ointment was documented as applied daily 2/11/16 through 2/16/16.

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D 273	Continued From page 25 -Two MAs documented the application of Santyl ointment. Observation of Resident #1's medication on hand on 2/09/16 at 3:21 pm revealed there was no Santyl ointment available for application. Interview with a representative from the contracted pharmacy on 2/10/16 at 12:30 pm revealed the Santyl ointment was sent with the rest of the medications being sent that day and was to be at the facility shortly. Observation of medication on hand on 2/10/16 at 1:30 pm revealed an unopened, 30 gram tube of Santyl ointment with a fill date of 2/10/16 for Resident #1. Interview with a RCC on 2/17/16 at 9:24 am revealed: -She knew that she was not to apply the Santyl ointment because she was not a nurse. -She signed out the Santyl ointment when she knew that the RN had applied the ointment. -She did not know why the ointment did not come from the pharmacy until 2/10/16. -She did not notify the RN of the physician order to apply the Santyl ointment. Interview with a MA on 2/17/16 at 9:24 am revealed: -She did not know she was not able to apply the Santyl ointment. -She did not apply the Santyl ointment and signed it out because she knew the RN had applied it. -She had faxed the FL2 on 2/08/16 to the pharmacy and the pharmacy had to order the ointment. -She did not notify the physician that it was not being applied from 2/06/16 to 2/11/16.	D 273		

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D 273	Continued From page 26 -She did not notify the RN there was an order for Santyl ointment. Interview with Resident #1 on 2/11/16 at 9:04 am revealed: -She did not know her medications but "for the most part they look they same as they always have". -She denied having been short of breath since admission to this facility. -Her legs were more swollen, tight and they were extremely painful. -She had just taken a pain pill. -She was afraid to lay in bed and elevate her legs because she had a history of deep vein thrombosis. -She did not have any wound care done to her legs or buttocks until late yesterday afternoon. -She did not know if Santyl ointment was applied to her wounds. Observation of Resident #1's lower extremities during administration of wound care on 2/11/16 at 10:01 am revealed: -Bilateral lower extremities were edematous, taut and red. -There was a foam dressing secured with an occlusive adhesive drape on the entire right dorsal surface of the foot that was not removed. -Right lateral heel had an open area 1.5 inch by 1 inch. -The right posterior to medial heel had non-blanchable redness as the Registered Nurse Consultant applied mild pressure to the area that was approximately 1 inch by 1 inch. -On the distal anterior shin right there was a bullous lesion (a circumscribed superficial fluid-filled blister greater than 0.5 cm in diameter) that was approximately 1/2 inch by 1/2 inch, extremely taut.	D 273		

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-There was an open stasis lesion on the mid-anterior shin right that was approximately 1.5 inch by one inch, weeping clear, pink fluid.
-Two smaller bullous blisters on proximal anterior shin right approximately .5cm by .5cm and 1cm by 1 cm.
-The left foot had three remaining toes.
-The left great toe had a bullous blister that measured 1 inch by 1 inch.
-The dorsal surface of the left foot proximal to the great toe also had a bullous blister approximately 1 inch by 1 inch.
-Proximal to this blister there was another small bullous blister approximately 1cm by 1 cm.
-The distal anterior shin had a bullous blister approximately 1cm by 1 cm and proximal to this an open area approximately 1.5 cm by 1.5 cm with no drainage or odor.
-Proximal to this open wound there was another approximately 1.5 inch by 1.5 inch, no drainage, no odor.
-Proximal to this open wound there was a bullous blister approximately 1.5 inch by 1.5 inch. Proximal to this blister there was a bullous blister 1/2 inch by 1.25 inches.
-The left heel had an open area approximately 1.5 inches by 2 inches.
-The facility nurse consultant (RN) cleansed both bilateral lower extremities with normal saline, applied abdominal pads, thick roll gauze and secured with tape.
-The wound care caused Resident #1 severe pain as evidenced by facial grimaces, covering her face with both hands and occasionally screaming out expletive curse words.

Interview with Resident #1 on 2/16/16 at 11:05 am revealed:
-Her lower legs were causing her pain.
-They were extremely swollen from her knees

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D 273	Continued From page 28 down. -She got new blisters, they popped and then she got more blisters that formed in 2 days. -Now she had blisters between her toes. Observation of wound care provided by the RN to Resident #1's sacral region on 2/11/16 at 10:25 am revealed: -A sacral wound approximately 1.5 cm by 1 cm with yellow slough and slight erythema. -Distal to this wound was an open area which was red, healthy tissue 2 inches by 2 inches and in the center of this was an area of yellow slough tissue approximately 1cm by 1 cm. -There was scant drainage, no odor and the periwound was red approximately 1-1.5 inches. -The RN cleansed the wound with normal saline, applied Santyl ointment and covered the area with a stack of 4 x 4 non-sterile gauze and secured the dressing with paper tape. Interview with the RN on 2/11/16 at 10:40 am revealed: -She knew to put the Santyl ointment on the sacral region because it required debridement. -She did not observe any areas on Resident #1's lower extremities that required debridement and did not apply the Santyl ointment. -Resident #1 was going to her primary care physician's office later this afternoon and they were going to have all wound care orders clarified and they were going to seek an order for home health skilled nursing for the wound care. -This was the first time she administered wound care to Resident #1. -Staff did not notify her until 2/11/16 that there was a Santyl ointment order. _____ On 02/11/16, the Registered Nurse (RN) Consultant submitted a Plan of Protection as	D 273		

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D 273	Continued From page 29 follows: -The Administrator or designee would begin an immediate audit of all resident records to ensure implementation and documentation of all orders, treatments, and/or procedures. -Any identified issues will be communicated to the physician immediately. -The Administrator or designee would audit all physician orders weekly x4, monthly x4, and quarterly thereafter. -The RN Consultant or the Administrator would be notified of all new orders. -All MAs would be inserviced prior to their next scheduled shift. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 19, 2016.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 2 of 3 sampled residents (Residents #2	D 276		

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and #3) upon admission to the facility.

The findings are:

A. Review of Resident #2's current FL-2 dated 01/13/16 revealed diagnoses included pneumonia, type II diabetes mellitus, and chronic pain.

Review of Resident #2's Resident Registers revealed she was originally admitted to the facility on 11/06/15 from a sister facility.

Review of Resident #2's record revealed:
-The facility did not obtain a new FL-2 for admission to this facility on 11/06/15.
-The facility staff transferred the resident's records and medications, and continued care as at the previous facility.
-A fax communication dated 12/19/15 from the facility to the physician's office as follows: "this is to make you aware that (Resident #2) has been in the hospital on two occasions since your visit on 11/23/15 both for CHF. She left on December 5th, came back on Friday the 11th and Saturday morning she had to be taken out by ambulance. She could not breathe. As of today she is still in the hospital."

Review of hospital discharge information dated 12/11/15 and 12/22/15 revealed admitting diagnoses included congestive heart failure (CHF).

Review of Resident #2's physician orders prior to the 11/06/15 admission revealed:
-A physician's order dated 02/24/15 to "Start 1500 ml (50 ounce) (6 cups) fluid restriction/24 hours".
-A physician note dated 09/23/15 with instructions to "continue 1500 ml fluid restriction".

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D 276	Continued From page 31 Review of dietary information posted in the kitchen revealed: -Resident #2 was on 1500 cc (6 cups) fluid restriction daily. -No further information was posted regarding amount of fluid to be served with each meal. Telephone interviews on 02/17/16 at 12:40 pm and 02/18/16 at 9:42 am with Resident #2's Nurse Practitioner (NP) revealed: -She did not know the facility needed a new FL-2 when Resident #2 transferred from the sister facility to this facility in November 2015. If she had been asked, she would have provided a new FL-2. -She intended for Resident #2 to continue the same medications and orders, including the 1500 cc fluid restriction, upon transfer to this facility in November. -She knew Resident #2 had been noncompliant at the previous facility, but thought she was being more compliant with fluid restrictions at this facility. -The facility did not notify the physician's office when the resident was admitted to the hospital on 12/05/15, when she returned on 12/11/15, or when she went out again on 12/12/15. -The office received a fax on 12/19/15 informing them of the two hospitalizations for CHF and that the resident was still in the hospital. -The facility did not notify the physician's office when the resident was readmitted to the facility on 01/16/16 and the NP was not aware she was in the facility until the surveyor called on 02/17/16. Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed: -Resident #2 transferred to this facility on Friday	D 276		

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afternoon 11/06/15, after the RCC had left for the day.
-When the RCC returned on Monday, 11/09/15, the Medication Aides (MAs) were using the Medication Administration Records (MARs) from the sister facility to administer medications and Resident #2's information had not yet been entered into this facility's eMAR system.
-The RCC contacted the facility's contracted pharmacy, who told her they would enter the resident's information into the computer system that day.
-The RCC did not work on 11/10/15 through 11/12/15. When she returned to work on 11/13/15, she noted that some of Resident #2's information had not been included in the computer system, including the order for fluid restriction.
-The RCC knew Resident #2 was on fluid restriction because the RCC's family member worked at the sister facility and had told the RCC about the resident's fluid restriction and "numerous" hospital admissions for congestive heart failure.
-The resident was noncompliant with the fluid restriction.
-The RCC contacted the pharmacy to have the order for fluid restriction included in the eMAR system.
-The pharmacy staff entered Resident #2's fluid restriction into the eMAR system as a prn (as needed) order and it had "been that way since".
-The facility staff did not implement a plan for dividing the resident's daily allowable fluid intake for meals, snacks, and medication administration.
-"The only thing" the RCC did was post the diet orders in the kitchen; she "assumed" the kitchen staff would serve 4 ounces with each meal.
-The RCC routinely gave the resident a small plastic cup (4 ounces) of water at each

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medication pass. The resident received medications 4 times daily.
-The RCC did not know "for sure" whether or not Resident #2 was still on fluid restriction.

Interview on 02/11/16 at 8:35 am with a cook revealed:
-The posted information for Resident #2 was "old" and the resident was "not on that anymore".
-Resident #2 was supposed to be served the same as all the other residents except that she could not have second helpings.
-The cook stated she did not think there were any residents on fluid restrictions.
-All residents were served milk, coffee, water, and juice at every breakfast meal and their choice of tea, water, or milk at the other two meals.

Interview on 02/09/16 at 11:20 am with a second cook revealed:
-Resident #2 was on fluid restrictions and could only have 6 cups of fluid in a day.
-She routinely gave Resident #2 "three things at breakfast, one at lunch, and two at supper".
-The beverage containers were various sizes; she gave a total of 6 containers (without respect to size) each day.
-She interpreted the instructions for "six cups" as six beverage containers, not a measured 8-ounces of fluid.
-She did not measure the fluid ounces of the beverages she served.

Interview on 02/10/16 at 2:55 am with a Personal Care Aide (PCA) revealed:
-She was aware Resident #2 was on fluid restrictions.
-The facility had various sizes of beverage containers, but residents on fluid restrictions were served one 8-ounce glass and "that's all". The

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PCA clarified "that's all" meant no refills.
-Residents on fluid restrictions were served 8 ounces of milk, 8 ounces of juice, and 8 ounces of coffee at breakfast; 8 ounces of tea and 8 ounces of water at lunch; 8 ounces of tea, 8 ounces of water, and 8 ounces of milk if they want it at supper.
-The PCA stated she really had not done the math to know whether or not this amount of fluid was too much.

Interview on 02/17/16 at 11:03 am with a Medication Aide (MA) revealed:
-She was aware Resident #2 was on fluid restrictions.
-Resident #2 was noncompliant with the fluid restrictions "pretty much every day".
-The MA reminded the resident about the fluid restrictions whenever she saw her with extra fluids or soda.

Interviews on 02/10/16 at 11:15 am and 02/11/16 at 9:30 am with Resident #2 revealed:
-No one told her "anything about decreased fluid".
-As long as she was (urinating), she could drink whatever she wanted.
-Staff routinely served coffee, milk, and juice at breakfast, but she did not usually drink the milk or juice.
-Staff routinely served tea and water at lunch and supper and she usually drank the tea, but "had her own water".
-Resident #2 routinely prepared for herself 16 ounces of water with a flavor packet every morning and 18 ounces every evening.
-The resident stated she has had to go to the hospital for "a heart attack and fluid filling the lungs" with inability to breathe and was on a ventilator, but if she (urinated) it out, she did not have to go to the hospital.

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D 276	Continued From page 35 B. Review of Resident #3's current FL-2 dated 12/04/15 revealed: -Diagnoses included acute on chronic systolic heart failure, hypoxia, and acute renal failure. -A physician's order for 1200 cc fluid restriction. Review of information posted in the kitchen revealed: -There was a bulletin board with information posted, including therapeutic menus and multiple small pieces of paper with various notes regarding residents' diets and preferences. -A piece of paper totally obscured by other postings as follows: "(Resident #3) can only have 4 ounces of any liquid at mealtimes per (named agency) home care nurse". Interview on 02/11/16 at 8:35 am with a cook revealed: -The posted information for Resident #3 was "old" and the resident was "not on that anymore". -Resident #3 was supposed to be served the same as all the other residents except that he could not have second helpings. -The cook stated she did not think there were any residents on fluid restrictions. -All residents were served milk, coffee, water, and juice at every breakfast meal and their choice of tea, water, or milk at the other two meals. Interview on 02/09/16 at 11:20 am with a second cook revealed: -She was not aware Resident #3 was on fluid restrictions. -She did not measure the fluid ounces of the beverages she served. Interview on 02/10/16 at 2:55 am with a Personal Care Aide (PCA) revealed:	D 276		

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-She was aware Resident #3 was on fluid restrictions.
-The facility had various sizes of beverage containers, but residents on fluid restrictions were served one 8-ounce glass and "that's all". The PCA clarified "that's all" meant no refills.
-Residents on fluid restrictions were served 8 ounces of milk, 8 ounces of juice, and 8 ounces of coffee at breakfast; 8 ounces of tea and 8 ounces of water at lunch; 8 ounces of tea, 8 ounces of water, and 8 ounces of milk if they want it at supper.
-The PCA stated she really had not done the math to know whether or not this amount of fluid was too much.

Interview on 02/17/16 at 11:03 am with a Medication Aide (MA) revealed:
-She was aware Resident #3 was on fluid restrictions.
-Resident #3 was noncompliant with the fluid restrictions "pretty much every day".
-The MA reminded the resident about the fluid restrictions whenever she saw him with extra fluids or at the water fountain.

Interview on 02/17/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed:
-She was aware Resident #3 was on fluid restrictions.
-Resident #3 was not compliant with the fluid restrictions; he had his own vehicle and bought and drank what he wanted.
-Staff could "only advise. It's up to him".

Interview on 02/10/16 at 11:15 am with Resident #3 revealed:
-He thought he was on small portions and could not ask for seconds.
-Staff routinely served him milk, coffee, water,

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and orange juice at breakfast.
-At breakfast, he "mostly" drank the coffee, but sometimes he drank the juice.
-Resident #3 stated, "I drink water all day. I try not to drink too much though to keep the fluid down."
-Resident #3 picked up an aluminum cup with a lid, approximately 20 ounces, and stated, "I fill this up a couple times a day and sip on it".
-At lunch and supper, staff routinely served him tea and water, but he "mostly" drank the tea.
-No staff ever told him he should be drinking a specific amount of fluid.
-The staff did not allow him to have second helpings beverages.
-In December (2015), he was in the hospital and the physician put him on a 1200 cc fluid restriction, but he thought the fluid restriction was stopped when he was released from the hospital.
-He was in the hospital because he had "too much fluid" and "trouble breathing".
-He had not experienced any problems with his breathing since the December 2015 hospital admission.

Telephone interview on 02/18/16 at 3:10 pm with Resident #3's physician revealed:
-The resident was put on fluid restrictions "about two months prior" to his hospitalization in December for CHF.
-He was not aware the facility staff did not measure the resident's fluids as ordered.
-The resident had his own car and often left the facility and purchased items himself.
-The facility informed him of the resident's noncompliance.
-He knew Resident #3 was told about the fluid restrictions again when he left the hospital (in December 2015).

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D 276	Continued From page 38 On 02/11/16, the facility's Registered Nurse (RN) Consultant submitted the following Plan of Protection: -Beginning immediately, the Administrator or designee will audit all resident records to ensure implementation and documentation of all orders, treatments, and/or procedures. -Any identified issues will be communicated to the physician and implemented immediately. -The Administrator or designee will audit all physician orders weekly x4, monthly x4, and quarterly thereafter to ensure ongoing compliance. -The RN consultant and/or Administrator will be notified of all new orders. -All MAs will be inserviced prior to their next scheduled shift. CORRECTION DATE FOR THE B VIOLATION SHALL NOT EXCEED APRIL 3, 2016.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for 3 of 3 sampled residents (Residents #2, #3, and #5) with orders for therapeutic diets (Carb Controlled No Added	D 296		

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D 296	Continued From page 39 Salt, Renal/Carb Modified, and Heart Healthy). The findings are: A. Review of Resident #2's current FL-2 dated 01/13/16 revealed: -Diagnoses included pneumonia, type II diabetes mellitus, and chronic pain. -A physician's order for a Carbohydrate Controlled No Added Salt diet. Review of information posted in the kitchen revealed: -There was a bulletin board with information posted, including therapeutic menus and multiple small pieces of paper with various notes regarding residents' diets and preferences. -The posted information for Resident #2 was 1800 Calorie No Added Salt. -The posted information for Resident #2 did not include a date. Review of Resident #2's records revealed: -There were two Resident Registers for Resident #2. -The latest Resident Register revealed an admission date of 01/16/16 from a skilled nursing facility, and a prior Resident Register revealed an admission date of 11/06/15 from the facility's sister assisted living facility. -There was no FL-2 completed when the resident was admitted to the facility on 11/06/15. -Prior hospital discharge summaries dated 12/11/15 and 07/13/15, both with orders for 1800 Calorie No Added Salt diet. Review of the therapeutic spreadsheet posted in the kitchen revealed: -There was not a therapeutic menu for a Carb Controlled No Added Salt diet, nor for an	D 296		

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D 296	Continued From page 40 1800-Calorie No Added Salt Diet. -Therapeutic menus offered and posted on the bulletin board were "Puree, Low Sodium/4 Gram Sodium, No Concentrated Sweets/Diabetic, Low Fat/Low Cholesterol, Renal Diet/Low Na+/Low K+/Low PO4, and Low Protein/Low Sodium (Pre-Renal)". Observation on 02/09/16 of the lunch meal revealed: -Resident #2 was served 1 cup of chicken and dumplings, 1/2 cup carrots, 3/4 cup green beans, 1/2 cup peaches in light syrup, 4 ounces milk, 4 ounces water, and 6 ounces unsweetened tea. -Without a matching therapeutic menu for the physician-ordered diet, it was unable to be determined whether or not the resident was served the correct meal. Observation on 02/10/16 of the breakfast meal revealed: -Resident #2 was served 2 slices of bacon, 1/2 cup scrambled eggs, 1/2 cup grits, 12 ounces coffee, 4 ounces milk, and 4 ounces orange juice. -Without a matching therapeutic menu for the physician-ordered diet, it was unable to be determined whether or not the resident was served the correct meal. Interview on 02/10/16 at 11:15 am with Resident #2 revealed: -She was on a regular diet. -She felt staff served her the right food. Interview on 02/11/16 at 8:35 am with a cook revealed: -The posted diet information for Resident #2 was "old" and the resident was "not on that anymore". -Resident #2 was supposed to be served the same as all the other residents except that she	D 296		

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D 296	Continued From page 41 could not have second helpings. Refer to interview on 02/09/16 at 11:20 am with a second cook. Refer to interview on 02/16/16 at 10:20 am with the Administrator. Refer to interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:20 am with the Resident Care Coordinator (RCC). B. Review of Resident #3's current hospital-generated FL-2 dated 12/04/15 revealed: -Diagnoses included acute on chronic systolic heart failure, type II diabetes mellitus, and acute renal failure. -A physician's order for a Renal/Carb Modified diet with 1200 cc fluid restriction. Review of information posted in the kitchen revealed: -There was a bulletin board with information posted, including therapeutic menus and multiple small pieces of paper with various notes regarding residents' diets and preferences. -Posted dietary information for Resident #3 was: "Cannot have any snacks or seconds during meal times per (named physician)." Directly under this statement was another: "Is also on a low sodium and low carb diet". -The dietary information posted for Resident #3 did not include a date. Review of the therapeutic spreadsheet posted in the kitchen revealed: -There was not a therapeutic menu for a Renal/Carb Modified diet, nor for a Low Carb diet. -Therapeutic menus offered and posted on the bulletin board were "Puree, Low Sodium/4 Gram	D 296		

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D 296	Continued From page 42 Sodium, No Concentrated Sweets/Diabetic, Low Fat/Low Cholesterol, Renal Diet/Low Na+/Low K+/Low PO4, and Low Protein/Low Sodium (Pre-Renal)". Observation on 02/09/16 of the lunch meal revealed: -Resident #3 was served 1 cup of chicken and dumplings, 1/2 cup carrots, 3/4 cup green beans, 1/2 cup peaches in light syrup, 4 ounces milk, 4 ounces water, and 6 ounces unsweetened tea. -Without a matching therapeutic menu for the physician-ordered diet, it was unable to be determined whether or not the resident was served the correct meal. Interviews on 02/09/16 at 9:30 am and 02/10/16 at 11:15 am with Resident #3 revealed: -"They" (the facility staff) had him on a diet because he retained fluid and his legs swelled. -He thought he was on small portions and could not ask for seconds. -The staff did not allow him to have second helpings of food or beverages. -In December (2015), he was in the hospital because he had "too much fluid" and "trouble breathing". -He had not experienced any problems with his breathing since the December 2015 hospital admission. Interview on 02/11/16 at 8:35 am with a cook revealed: -The posted diet information for Resident #3 was "old" and the resident was "not on that anymore". -Resident #3 was supposed to be served the same as all the other residents except that he could not have second helpings. Refer to interview on 02/09/16 at 11:20 am with a	D 296		

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D 296	Continued From page 43 second cook. Refer to interview on 02/16/16 at 10:20 am with the Administrator. Refer to interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:20 am with the RCC. C. Review of Resident #5's current FL-2 dated 09/02/15 revealed: -Diagnoses included hypertension, dementia, and syncope. -A physician's order for a Heart Healthy diet. Review of information posted in the kitchen revealed: -There was a bulletin board with information posted, including therapeutic menus and multiple small pieces of paper with various notes regarding residents' diets and preferences. -The posted information for Resident #5 was "healthy heart. No fried foods". Review of the therapeutic spreadsheet posted in the kitchen revealed: -There was not a therapeutic menu for a Heart Healthy diet. -Therapeutic menus offered and posted on the bulletin board were "Puree, Low Sodium/4 Gram Sodium, No Concentrated Sweets/Diabetic, Low Fat/Low Cholesterol, Renal Diet/Low Na+/Low K+/Low PO4, and Low Protein/Low Sodium (Pre-Renal)". Observation on 02/09/16 of the lunch meal revealed: -Resident #5 was served 1 cup of chicken and dumplings, 1/2 cup carrots, 3/4 cup green beans, 1/2 cup peaches in light syrup, 4 ounces milk, 4 ounces water, and 6 ounces unsweetened tea.	D 296		

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D 296	Continued From page 44 -Without a matching therapeutic menu for the physician-ordered diet, it was unable to be determined whether or not the resident was served the correct meal. Observation on 02/10/16 of the breakfast meal revealed: -Resident #5 was served 2 slices of bacon, 1/2 cup scrambled eggs, 1/2 cup grits, 12 ounces coffee, 4 ounces milk, and 4 ounces orange juice. -Without a matching therapeutic menu for the physician-ordered diet, it was unable to be determined whether or not the resident was served the correct meal. Interview on 02/11/16 at 8:30 am with Resident #5 revealed he was not on a special diet and was served the same food as everybody else. Refer to interview on 02/09/16 at 11:20 am with a second cook. Refer to interview on 02/16/16 at 10:20 am with the Administrator. Refer to interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:20 am with the RCC. Interview on 02/11/16 at 8:35 am with a cook revealed: -She used the "Regular" column of the therapeutic spreadsheet as a guide to serve all the residents. -She did not use any of the other columns on the therapeutic spreadsheet. Interview on 02/09/16 at 11:20 am with a second cook revealed: -She was instructed during her training to serve meals according to the column designated as	D 296		

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D 296	Continued From page 45 "Regular" and to follow any other posted instructions, so to be safe, she "just don't add anything to anything". -She did not use any of the other columns on the therapeutic spreadsheet. Interview on 02/16/16 at 10:20 am with the Administrator revealed: -She was not aware the facility did not offer therapeutic menus for current physician-ordered therapeutic diets. -It was the Resident Care Coordinator's (RCC's) responsibility to oversee the kitchen and meal service. Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:20 am with the RCC revealed: -"Technically, nobody is over the kitchen. They come to me for supplies." -She was not aware residents had physician-ordered therapeutic diets for which the facility did not have corresponding menus. -There was no current system in place to ensure physician-ordered therapeutic diets had a matching therapeutic menu. _____ On 02/11/16, the facility's Registered Nurse Consultant submitted the following Plan of Protection: -The Administrator or designee would clarify with the physician every resident's current diet orders and ensure a therapeutic menu was available and used for each physician-ordered therapeutic diet. -All meals would be served according to the residents' ordered diets. -All staff would be inserviced prior to their next scheduled shift. -The Administrator or designee would review all incoming diet orders to ensure communication with kitchen staff and residents and to ensure a	D 296		

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D 296	Continued From page 46 therapeutic menu was available for each physician-ordered diet. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 3, 2016.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff for 2 of 3 sampled residents (Residents #2 and #3). The findings are: A. Review of Resident #2's current FL-2 dated 01/13/16 revealed: -Diagnoses included pneumonia, type II diabetes mellitus, and chronic pain. -A physician's order for a Carbohydrate Controlled No Added Salt diet. Review of information posted in the kitchen revealed: -There was a bulletin board with information posted, including therapeutic menus and multiple small pieces of paper with various notes	D 309		

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regarding residents' diets and preferences.
-There was a small, approximately 3x4-inch piece of paper, with a different resident's name at the top followed by dietary instructions for that resident.
-A second resident's dietary instructions were written underneath the first, and information regarding Resident #2 was written diagonally along the side of the paper.
-The posted information for Resident #2 was "(Resident #2) is on fluid restriction 6 cups in 24 hours. Diet 1800 calorie no added salt".
-The posted information for Resident #2 did not include a date.
-The posted information for Resident #2 did not include how much fluid was to be served to Resident #2 at each meal.

Review of Resident #2's records revealed:
-There were two Resident Registers for Resident #2.
-The latest Resident Register revealed an admission date of 01/16/16 from a skilled nursing facility, and a prior Resident Register revealed an admission date of 11/06/15 from the facility's sister assisted living facility.
-There was no FL-2 completed when the resident was admitted to the facility on 11/06/15.
-A physician's order dated 02/24/15 to begin 1500 cc fluid restriction and a physician's visit note dated 09/23/15 from the sister facility included "continue 1500 ml fluid restriction".
-Prior hospital discharge summaries dated 12/11/15 and 07/13/15 orders for 1800 Calorie No Added Salt diet.

Interview on 02/16/16 at 10:20 am with the Administrator revealed:
-She was not aware the diet information posted in the kitchen for Resident #2 did not match the

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D 309	Continued From page 48	D 309		

current physician orders.
-It was the Resident Care Coordinator's (RCC's) responsibility to oversee the kitchen and meal service and to ensure correct diet orders were posted in the kitchen.

Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:20 am with the RCC revealed:
-She was not aware the diet information posted in the kitchen for Resident #2 did not match the current orders.
-It was the responsibility of the Medication Aide (MA) on duty when new orders were received to ensure the new orders were posted in the kitchen.
-The RCC sometimes reworded diet orders to "put in words they (kitchen staff) can understand, like 'no fried foods', but it was the cook's responsibility to ensure the list was accurate."
-The RCC knew Resident #2 was on fluid restrictions because the RCC's family member worked at the sister facility Resident #2 came from, and the family member told the RCC about the resident's fluid restrictions and "numerous" hospitalizations due to CHF (congestive heart failure).
-There was no system for monitoring to ensure accuracy of the posted therapeutic diet list.

Interview on 02/11/16 at 8:35 am with a cook revealed:
-It was the RCC's responsibility to inform the kitchen staff if there were orders for diet changes.
-The posted information for Resident #2 was "old" and the resident was "not on that anymore".
-Resident #2 was supposed to be served the same as all the other residents except that she could not have second helpings.
-The cook stated she did not think there were any residents on fluid restrictions.

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D 309	Continued From page 49 Interview on 02/09/16 at 11:20 am with a second cook revealed: -She was not aware the diet information posted for Resident #2 did not match the current physician orders. -The MAs were responsible for posting the residents' diet orders on the bulletin board in the kitchen. -She was instructed during her training to serve meals according to the column designated as "Regular" and to follow any other posted instructions, so to be safe, she "just don't add anything to anything". Interview on 02/10/16 at 11:15 am with Resident #2 revealed: -She was on a regular diet. -No one told her "anything about decreased fluid". -As long as she was (urinating), she could drink whatever she wanted. -Staff routinely served coffee, milk, and juice at breakfast, but she did not usually drink the milk or juice. -Staff routinely served tea and water at lunch and supper and she usually drank the tea, but "had her own water". -Resident #2 routinely prepared for herself 16 ounces of water every morning and 18 ounces of water every evening. -The resident stated she has had to go to the hospital for "a heart attack and fluid filling the lungs" with inability to breathe and was on a ventilator, but if she (urinated) it out, she did not have to go to the hospital. -She felt staff served her the right food. B. Review of Resident #3's current hospital-generated FL-2 dated 12/04/15 revealed: -Diagnoses included acute on chronic systolic	D 309		

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heart failure, hypoxia, and acute renal failure.
-A physician's order for a Renal/Carb Modified diet with 1200 cc fluid restriction.

Review of information posted in the kitchen revealed:
-There was a bulletin board with information posted, including therapeutic menus and multiple small pieces of paper with various notes regarding residents' diets and preferences.
-A 4x6-inch piece of paper with Resident #3's name partially obscured by another piece of paper with another resident's information.
-Dietary information on the sheet for Resident #3 was: "Cannot have any snacks or seconds during meal times per (named physician)." Directly under this statement was another: "Is also on a low sodium and low carb diet".
-The dietary information posted for Resident #3 did not include a date.
-Further review revealed a second piece of paper totally obscured by other postings as follows: "(Resident #3) can only have 4 ounces of any liquid at mealtimes per (named agency) home care nurse".

Interview on 02/16/16 at 10:20 am with the Administrator revealed:
-She was not aware the diet information posted in the kitchen for Resident #3 did not match the current physician orders.
-It was the Resident Care Coordinator's (RCC's) responsibility to oversee the kitchen and meal service and to ensure correct diet orders were posted in the kitchen.

Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:20 am with the RCC revealed:
-She was not aware the diet information posted in the kitchen for Resident #3 did not match the

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current orders.
-It was the responsibility of the Medication Aide (MA) on duty when new orders were received to ensure the new orders were posted in the kitchen.
-The RCC sometimes reworded diet orders to "put in words they (kitchen staff) can understand, like 'no fried foods', but it was the cook's responsibility to ensure the list was accurate."
-There was no system for monitoring to ensure accuracy of the posted therapeutic diet list.

Interview on 02/11/16 at 8:35 am with a cook revealed:
-It was the RCC's responsibility to inform the kitchen staff if there were orders for diet changes.
-The posted information for Resident #3 was "old" and the resident was "not on that anymore".
-Resident #3 was supposed to be served the same as all the other residents except that she could not have second helpings.
-The cook stated she did not think there were any residents on fluid restrictions.

Interview on 02/09/16 at 11:20 am with a second cook revealed:
-She was not aware the diet information posted for Resident #3 did not match the current physician orders.
-The MAs were responsible for posting the residents' diet orders on the bulletin board in the kitchen.
-She was instructed during her training to serve meals according to the column designated as "Regular" and to follow any other posted instructions, so to be safe, she "just don't add anything to anything".

Interview on 02/10/16 at 11:15 am with Resident #3 revealed:

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D 309	Continued From page 52 -He thought he was on small portions and could not ask for seconds. -Staff routinely served him milk, coffee, water, and orange juice at breakfast. -At breakfast, he "mostly" drank the coffee, but sometimes he drank the juice. -Resident #3 stated, "I drink water all day. I try not to drink too much though to keep the fluid down." -Resident #3 picked up an aluminum cup with a lid, approximately 20 ounces, and stated, "I fill this up a couple times a day and sip on it". -At lunch and supper, staff routinely served him tea and water, but he "mostly" drank the tea. -No staff ever told him he should be drinking a specific amount of fluid. -The staff did not allow him to have second helpings of food or beverages. -In December (2015), he was in the hospital and the physician put him on a 1200 cc fluid restriction, but he thought the fluid restriction was stopped when he was released from the hospital. -He was in the hospital because he had "too much fluid" and "trouble breathing". -He had not experienced any problems with his breathing since the December 2015 hospital admission.	D 309		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or	D 344		

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D 344	Continued From page 53 (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for verification of orders for medications which were not dated and signed within 24 hours of admission to the facility for 3 of 3 sampled residents (Residents #1 and #2, and #3). The findings are: A. Review of Resident #2's current FL-2 dated 01/13/16 revealed: -Diagnoses included pneumonia, type II diabetes mellitus, and chronic pain. -A total of 21 medication orders. Review of Resident #2's record revealed: -The resident was admitted to the facility on 01/16/16 from a skilled nursing facility. -There was no documentation the medication orders on the 01/13/16 FL-2 were verified by a physician within 24 hours of admission. Review of the January 2016 and February 2016 Medication Administration Records (MARs) revealed: -When the resident was re-admitted to the facility on 01/15/16, none of the orders included on the 01/13/16 FL-2 were implemented.	D 344		

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D 344	Continued From page 54 -Medications administered from 01/15/16 through 02/16/15 matched the medication orders the resident was on prior to the 12/05/15 and 12/12/15 hospitalizations. -Medications routinely administered from 01/15/16 through 02/16/16 that were not ordered on the 01/13/16 FL-2 included Norvasc 10 mg daily (calcium channel blocker), atorvastatin 40 mg daily (treats high cholesterol), hydralazine 25 mg three times daily (vasodilator), Novolog 10 units three times daily (rapid-acting insulin), and Vitamin B6 100 mg twice daily (vitamin supplementation). -Medications ordered on the 01/13/16 FL-2, but not implemented included Perforomist nebulizer twice daily (bronchodilator), ipratropium-albuterol nebulizer every six hours (bronchodilator), Klor-Con 20 meq daily (potassium supplement), alprazolam 0.25mg three times daily (anti-anxiety agent), and hydromorphone 1 mg every six hours as needed for pain (narcotic pain reliever). -The facility continued a previously ordered sliding scale for Novolog insulin and did not implement a new sliding scale ordered on 01/13/16 using Novolin R and a different scale. -The facility continued a previously ordered dose of 325 mg aspirin daily and did not implement the new order of 81 mg ordered on 01/13/16. (Aspirin is used to thin the blood in patients with cardiovascular disease.) -The facility continued a previously ordered dose of omeprazole 40 mg and did not implement the new order of 20 mg ordered on 01/13/16. (Omeprazole is a proton pump inhibitor.) -The facility continued a previously ordered dose of Lantus insulin 30 units daily and did not implement the new order of 32 units ordered on 01/13/16. (Lantus is a long-acting insulin.) Telephone interview on 01/18/16 at 3:09 pm with	D 344		

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D 344	Continued From page 55 a Medication Aide (MA) revealed she was the MA on duty on 01/13/16, but did not recall receiving Resident #2's faxed FL-2 from the skilled nursing facility. Telephone interview on 02/17/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed: -She was on duty on Friday, 01/15/16 when Resident #2 was transferred to the facility from the skilled nursing facility. -A Personal Care Aide (PCA) picked up the resident from the skilled facility and transported her to this facility. -The PCA did not get the resident's FL-2 or medications from the skilled facility. -The RCC did not work again until Monday, 01/18/16, at which time she saw the resident's 01/13/16 FL-2 on the desk. -She did not contact the physician for verification of the medication orders. Interview with a MA on 02/17/16 at 11:03 am revealed: -She was the MA on duty Saturday, 01/16/16. -The MA stated she was not sure if she saw admission paperwork for Resident #2 or not, and it was possible she just assumed the medications were the same as prior to discharge and administered what was available in the medication cart. -The resident's previous orders were still in the eMAR system because the resident's orders were "never discontinued from the system when she left" (was discharged on 12/12/15). -The MA did not contact the physician for verification of the 01/13/16 medication orders. Interviews on 02/11/16 at 9:30 am and 02/17/16 at 12:00 pm with Resident #2 revealed: -She was admitted to the hospital in December	D 344		

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2015 for congestive heart failure (CHF) and was on a ventilator.
-She routinely took medications to help with her breathing.
-She routinely had chronic pain in both legs (left leg and right below-the-knee amputation) and the right leg "moves by itself" and "is painful".
-She routinely had "chronic back pain".
-The resident told staff she needed the Dilaudid (narcotic pain reliever) she had been receiving at the previous skilled facility.
-The resident "told everybody who works here" that she needed the Dilaudid, but she never got any.

B. Review of Resident #1's current FL-2 dated 02/08/16 revealed diagnoses included, hypercarbic respiratory failure, anasarca, sepsis, type I diabetes mellitus, chronic kidney disease stage III, history of toe amputation (x2).

Review of discharge summary dated 02/06/16 revealed:
-Resident #1 was discharged from the local hospital on 02/06/16.
-Discharge diagnoses included: Sepsis secondary to left lower extremity cellulitis, left lower extremity cellulitis, anasarca with severe hypoalbuminemia, brittle type 1 diabetes, acute kidney injury secondary superimposed on chronic kidney disease stage III, anemia of critical illness, thrombocytopenia and acute metabolic encephalopathy.

Review of Resident #1's Resident Register revealed an admission date of 02/07/16.

Interview with the hospital discharge Social Worker on 02/17/16 at 10:14 am revealed Resident #1 was discharged from the hospital to

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D 344	Continued From page 57 this facility on 02/06/16. 1. Further review of physician's orders on FL2 dated 2/08/16 revealed: -An order for doxycycline 100mg 1 every 12 hours for six tablets (an antibiotic used to treat bacterial infections). -An order for torsemide 20mg - take 2 tablets (40mg) daily (a diuretic used to treat excess fluid accumulation). Further Review of the hospital discharge summary dated 02/06/16 revealed: -An order for doxycycline 100mg 1 every 12 hours for six tablets (three days). -An order for torsemide 20mg - take two (40mg) tablets daily. Observation of Resident #1's medications on hand on 02/09/16 at 3:21 pm revealed there was no doxycycline or torsemide available for administration. Review of the February 2016 electronic Medication Administration Record (eMAR) on 2/16/16 revealed: -An entry for Doxycycline 100mg 1 capsule twice daily at 8:00 am and 8:00 pm was not documented as administered until 02/09/16 at 8:00 pm.. -An entry for torsemide 20mg take 2 tablets once daily and not documented as administered until 02/11/16 at 8:00 am. Interview with a Medication Aide (MA) on 2/09/16 at 4:11 pm revealed: -She had worked at this facility for approximately two years as a MA. -She did not know when Resident #1 was admitted, but thought it was the evening of	D 344		

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D 344	Continued From page 58 02/07/16. -She knew what medications to give Resident #1 by reading the instructions on the medications cards on hand and comparing the medications listed on the hospital discharge summary. -She knew there were medications on the FL2 that were not in the facility ans she did not request the torsemide or doxycycline from the back up pharmacy. -She thought the Resident Care Coordinator (RCC) was responsible for requesting medications from the back up pharmacy. -The RCC was responsible for making sure the FL2 was faxed to the pharmacy and that the eMARs were correct. -She did not have the ability to enter new orders into the eMAR. -She did not notify the RCC when Resident #1 was been admitted. Interview with a second MA on 02/09/16 at 4:20 pm revealed: -She had worked at this facility for a little less than a year. -She knew what medications to give Resident #1 by reading the instructions on the medications cards on hand and comparing them with what was on the FL2. -She knew there were medications on the FL2 she should have administered but did not have in the facility. She did not administer these medications because "I can only give what I have to give". She never requested medications from the back up pharmacy. -When a resident was admitted it was the responsibility of the RCC to make sure the medications were in the facility and the eMARs were accurate. Interview with a third MA on 02/10/16 at 3:10 pm	D 344		

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revealed:
-Resident #1 was admitted from the hospital the evening of 02/06/16.
-Resident #1 came with a large envelope of papers, and she did not do anything with the paperwork.
-It was the responsibility of the RCC to process the resident's paperwork.
-The paper work was sitting on the desk so that the RCC could process it when she came to work on Monday, 02/08/16.
-Resident #1 did not have any new medications, and she did not know of any new medication orders.
-She did not call the RCC to notify her that Resident #1 was admitted to the facility.

Interview with the RCC on 02/11/16 at 10:39 am revealed:
-She was employed at this facility for almost three years.
-It was the responsibility of the MA on duty to fax the any new orders or FL2 to the pharmacy and make sure the medications were at the facility.
-The MAs on duty were responsible for any medication changes that came from a hospitalization or a physician's office visit.
-She was not working over the weekend or on Monday, 02/08/16.
-On Tuesday, 02/09/16 she came in to work to ensure the FL2 was faxed to the pharmacy.
-If things were not done correctly or completed she would make sure they were.
-She was not informed by staff that Resident #1 was being admitted over the weekend.
-The Administrator was responsible for all admissions.
-She knew there were medications that were started late because they were not entered into the eMAR system and they were not faxed to the

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D 344	Continued From page 60 pharmacy. A second interview with the RCC on 02/17/16 at 9:24 am revealed: -Resident #1 was admitted to the facility on 02/06/16, but she did not know what time. -She did not call Resident #1's physician to clarify the new orders from the hospital as compared to those medications Resident #1 was taking prior to hospitalization. -The MAs administered Resident #1's medications that were sent from her previous facility. -Resident #1 was a resident from one of the sister facilities. Interview with the Administrator on 02/10/16 at 11:20 am revealed: -The RCC was scheduled to work Mondays, Wednesdays and Fridays to do nothing but to ensure accuracy and timeliness of all paperwork. -The admission paperwork should have been processed by the RCC on 2/08/16. -She had worked Saturday up until about 6:00 pm and Resident #1 had not been admitted at that time. -She thought Resident #1 was admitted on 02/07/16. -She did not review the FL2 prior to admission. -Resident #1 was a resident at one of the sister facilities. -Resident #1 had come to visit this facility and had her medications with her. -She was visiting one of her friends and did want to be transferred to this facility when a vacancy became available. -Resident #1 complained of feeling bad and was sent to the hospital from this facility. -She did not know why Resident #1's information was not entered into the eMAR system.	D 344		

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D 344	Continued From page 61 -She expected the pharmacy would have sent any new medications at least by Monday night and knew that they did not. Interview with a representative from the contracted pharmacy on 02/10/16 at 12:27 pm revealed: -They received Resident #1's FL2 on 02/08/16 at 2:26 pm. -They filled the doxycycline 100mg (6 tablets) and torsemide 20mg (2 tablets per dose) on 02/09/16. -These medications were sent to the facility on 2/09/16. -They were not sent on 02/08/16 because the FL2 was received by the pharmacy after their cut off time. -The facility did not request these orders be sent any sooner than the regularly scheduled delivery which was around noon. Interview with a second pharmacy representative on 02/10/16 at 3:15 pm revealed: -Resident #1's medications were not entered in the eMAR because she was out of town and she was the only one at the pharmacy that could enter Resident #1's new information. -She was out of town and would not be able to enter Resident #1's information into the eMAR until after 6:00 pm on 02/09/16. -She would get the information in the eMAR before the evening medication pass [on 02/09/16]. 2. Further review of Resident #1's hospital discharge summary dated 02/06/16 revealed an order for oxycodone 5mg immediate release tablet every 4 hours as needed for severe pain (a narcotic medication used to treat pain). Further Review of the hospital discharge	D 344		

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D 344	Continued From page 62 summary dated 02/06/16 revealed an order for oxycodone 5mg immediate release tablet every 4 hours as needed for severe pain. Review of Resident #1's February 2016 eMAR revealed: -An entry for oxycodone 5mg 1 tablet 3 times daily at 8:00 am, 2:00 pm and 8:00 pm. -A second entry for oxycodone 5mg 1 tablet three times daily with administration time set for 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm. -A third entry for oxycodone 5mg 1 tablet four times daily at 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm. -A forth entry for oxycodone 5mg 1 tablet every 4 hours as needed for severe pain. -A fifth entry for oxycodone 5mg 1 tablet every four hours as needed for severe pain. Observation of Resident #1's medication on hand on 02/09/16 at 3:21 pm revealed: -34 tablets of oxycodone 5mg filled on 01/04/16 with instructions on label to give 1 tablet three times daily. Interview with a second MA on 02/09/16 at 4:20 pm revealed: -She had worked at this facility for a little less than a year. -She documented the narcotics that she administered in the narcotic count book. -She knew what medications to give Resident #1 by reading the instructions on the medications cards on hand and comparing them with what was on the FL2. -She noticed the label for oxycodone and the FL2 were different and administered according to the label because that was what Resident #1 was taking before she went to the hospital. -She did not inform the physician that the	D 344		

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medication had been given routinely three and then four times a day routinely.

Interview with the RCC on 02/09/16 at 4:00 pm revealed:
-"Often residents' FL2s were inaccurate and did not have correct orders."
-She gave oxycodone three times a day because that was what Resident #1 was taking prior to her hospitalization.
-She would get clarification, but she had not obtained clarification yet.

A second interview with the RCC on 02/17/16 at 9:26 am revealed:
-She did not know why there were so many entries for oxycodone.
-She did not make any of the entries.
-She did not inform the physician that the medication had been given routinely three and then four times a day routinely.

Interview with Resident #1 on 02/16/16 at 11:05 am revealed she did not have to ask for her pain medication and staff automatically brought her pain medication.

Interview with a pharmacy representative on 02/17/16 at 11:50 am revealed:
-There were several entries of the oxycodone because a mistake was identified in that the three times a day entry had four administration times and this order was discontinued and the entry was re-entered with three administration times.
-Then, on the 15th another error was identified with the order in that the current order was interpreted at four times a day and this order was discontinued and re-entered again with the corrections.
-There were two prn entries for the oxycodone

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because the facility entered these into the eMAR.
-There was staff at the facility that could enter data into the eMAR [named 3 staff members, The Administrator, The RCC and one MA].

C. Review of Resident #3's current FL2 dated 12/04/15 revealed diagnoses included type II diabetes with accelerated hyperglycemia and early DKA (diabetic ketoacidosis).

1. Review of the 12/04/15 FL-2 revealed an order for Novolog 25 units into the skin three times daily with meals in addition to the sliding scale as follows: 150-200=1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 - 5 units and greater than 400 = 6 units and call MD.

Review of Resident #3's record revealed that Resident #3 was released from the hospital to this facility 12/04/15.

Review of Resident #3's record revealed:
-A fax request from the facility for permission to resume previous dose Resident #3 was on prior to the hospitalization of Novolog Insulin 30 units three times daily with meals with the following sliding scale: 150-200=1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, and greater than 400 = 6 units, and call MD.

Review of Resident #3's December 2015 eMAR revealed:
-An entry for Novolog insulin 30 units to be given at meals (8:00 am, 12:00pm and 4:00 pm) in addition to the sliding scale.
-From 12/01/15 through 12/04/15 this was documented as "Out of Facility."
-An entry for a sliding scale as follows:
150-200=16 unit, 201-250 = 17 units, 251-300 =

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D 344	Continued From page 65 18 units, 301-350 = 19 units, 351-400 = 20 units and greater than 400 = 21 units and call MD. -From 12/05/15 through 12/09/15 Novolog insulin 30 units was documented as administered without requiring the sliding scale. -There were 2 opportunities where SSI was not documented administered as ordered. Further Review of Resident #3's Record revealed an order dated 12/09/15 to administer Novolog 25 units three times a day with no order for sliding scale insulin. Review of Resident #3's December 2015 eMAR revealed: -An entry with a start date of 12/09/15 for Novolog 25 units three times daily in addition to a sliding scale. -From 12/10/15 through 12/16/15 Novolog insulin 25 units was documented as administered. There was no sliding scale insulin required based on the resident's sliding scale. -From 12/10/15 through 12/16/15 there were two occasions a sliding scale was implemented without an order Interview with the RCC on 2/09/16 at 4:10 pm revealed: -Often residents' FL2s were inaccurate and did not have correct orders. -She faxed the physician a clarification on 12/05/15 when Resident #3 returned from the hospital on in regards to the Novolog insulin. -She kept the orders the same as they had been prior to the hospitalization until she heard from Resident #3's physician because she thought these were correct. -She did not get a response from Resident #3's physician until 12/09/15 and provided documentation that she faxed him twice.	D 344		

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D 344	Continued From page 66 -She did not know the new order did not include a sliding scale. -She did not know why the eMAR did not reflect the sliding scale as ordered from the hospital. -She knew that the order for the Novolog sliding scale had a different base number than was ordered from the hospital as compared to the 12/09/15 physician order but did not report the discrepancy to the physician. A second interview with the RCC on 02/11/16 at 10:32 am revealed: -No one was responsible for record review, MAR, order audits to assure new orders were entered correctly. -The Novolog insulin orders on the FL2 dated 12/04/15 were never entered or initiated. Interview with the Administrator on 02/16/16 at 10:13 am revealed she expected the RCC to verify orders were correct with the primary physician or prescribing practitioner. Interview with the Registered Nurse at Resident #3's physician office on 02/16/16 at 9:27 am revealed: -They were unaware that MAs applied a sliding scale to the Novolog order from 12/09/15. 2. Review of Resident #3's current FL2 dated 12/04/15 revealed an order for Lantus insulin 90 units at bedtime. Review of Resident #3's record revealed that Resident #3 was released from the hospital to this facility 12/04/15. Review of the December 2015 electronic Medication Administration Record (eMAR) revealed:	D 344		

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D 344	Continued From page 67 -An entry for Lantus 60 units at 8:00 am and 8:00 pm and documented as administered twice daily from 12/04/15 through 12/08/15 (as ordered prior to hospitalization). Interview with a Medication Aide (MA) on 02/09/16 at 4:20 pm revealed: -She did not fax FL2s to the pharmacy when residents returned from the hospital. -It was the responsibility of the Resident Care Coordinator (RCC) to do admissions and fax the FL2s to the pharmacy. -She was not aware that there were new insulin orders for Resident #3 when Resident #3 returned from the hospital. -She just gave the medications according to what the eMAR said and assumed it was correct. Interview with the RCC on 02/09/16 at 4:10 pm revealed: -Often FL2s were inaccurate and did not have correct orders. -She faxed the physician a clarification when Resident #3 returned from the hospital in regards to both the Lantus but did not get a response until 12/09/15. -She kept the orders the same as they had been prior to the hospitalization until she heard from Resident #3's physician, because she thought those orders were correct. -The documentation that was returned from the physician on 12/09/15 included orders that were different from what they were administering. A second interview with the RCC on 02/11/16 at 10:32 pm revealed: -Resident #3 returned from the hospital on a Friday and she was not at the facility. -The pharmacy was closed when Resident #3 was re-admitted to the facility.	D 344		

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D 344	Continued From page 68 -Whoever the MA was when he was admitted was responsible for faxing the FL2. -She faxed a clarification to the physician on Tuesday when she came in to the facility. -From the date of re-admission until the physician responded the MAs gave what Resident #3 was ordered prior to the hospitalization. -The Lantus insulin orders on the FL2 dated 12/04/15 were never implemented. Interview with the Administrator on 02/10/16 at 11:20 am revealed: -It was the responsibility of the RCC to assure all the orders were on the eMAR and that they were correct. -The RCC "dropped the ball" and should have ensured the orders on the FL2 were on the eMAR and implemented by staff. -She was unaware there were orders on the FL2 that were never implemented. -She did not know why the new orders were not on the eMAR. On 02/17/16, the Registered Nurse (RN) Consultant submitted a Plan of Protection as follows: -Administrator or designee will immediately begin an audit of all resident records to ensure all current orders are complete and clear. -Any unclear or incomplete orders will be verified immediately with the physician. -Administrator or designee will review all MD orders weekly x4, monthly x4, and quarterly thereafter. -The RN or Administrator will be notified of all new orders. -All MAs will be inserviced prior to their next scheduled shift. CORRECTION DATE FOR THE TYPE B	D 344		

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D 344	Continued From page 69 VIOLATION SHALL NOT EXCEED APRIL 3, 2016.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 3 of 3 sampled residents (Residents #1, #2, and #3). The findings are: A. Review of Resident #1's current FL-2 dated 02/08/16 revealed diagnoses included, hypercarbic respiratory failure, anasarca, sepsis, type I diabetes mellitus, chronic kidney disease stage III, history of toe amputation (x2). Review of discharge summary dated 02/06/16 revealed: -Resident #1 was discharged from the local hospital on 02/06/16. -Discharge diagnoses included: Sepsis secondary to left lower extremity cellulitis, left	D 358		

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lower extremity cellulitis, anasarca with severe hypoalbuminemia, brittle type 1 diabetes, acute kidney injury secondary superimposed on chronic kidney disease stage III, anemia of critical illness, thrombocytopenia and acute metabolic encephalopathy.

Review of Resident #1's Resident Register revealed an admission date of 02/07/16.

Interview with the hospital discharge Social Worker on 02/17/16 at 10:14 am revealed Resident #1 was discharged from the hospital to this facility on 02/06/16.

1. Further review of physician's orders on FL2 dated 02/08/16 revealed:
- An order for doxycycline 100mg 1 every 12 hours for six tablets (an antibiotic used to treat bacterial infections).
-An order for torsemide 20mg - take 2 tablets (40mg) daily (a diuretic used to treat excess fluid accumulation).

Further Review of the hospital discharge summary dated 02/06/16 revealed:
-An order for doxycyline 100mg 1 every 12 hours for six tablets (three days).
-An order for torsemide 20mg - take two (40mg) tablets daily.

Observation of Resident #1's medications on hand on 02/09/16 at 3:21 pm revealed there was no doxycycline or torsemide available for administration.

Observation of Resident #1's lower extremities during administration of wound care on 02/11/16 at 10:01 am revealed:
-Bilateral lower extremities were edematous, taut

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and red.
-Right lateral heel had an open area 1.5 inch by 1 inch.
-On the distal anterior shin right there was a bullous lesion (a circumscribed superficial fluid-filled blister greater than 0.5 cm in diameter) that was approximately 1/2 inch by 1/2 inch, extremely taut.
-There was an open stasis lesion on the mid-anterior shin right that was approximately 1.5 inch by one inch, weeping clear, pink fluid.
-Two smaller bullous blisters on proximal anterior shin right approximately .5cm by .5cm and 1cm by 1 cm.
-The left foot had three remaining toes.
-The left great toe had a bullous blister that measured 1 inch by 1 inch.
-The dorsal surface of the left foot proximal to the great toe also had a bullous blister approximately 1 inch by 1 inch.
-Proximal to this blister there was another small bullous blister approximately 1cm by 1 cm.
-The distal anterior shin had a bullous blister approximately 1cm by 1 cm and proximal to this an open area approximately 1.5 cm by 1.5 cm with no drainage or odor.
-Proximal to this open wound there was another approximately 1.5 inch by 1.5 inch, no drainage, no odor.
-Proximal to this open wound there was a bullous blister approximately 1.5 inch by 1.5 inch. Proximal to this blister there was a bullous blister 1/2 inch by 1.25 inches.

Review of the February 2016 electronic Medication Administration Record (eMAR) on 02/16/16 revealed:
-An entry for Doxycycline 100mg 1 capsule twice daily at 8:00 am and 8:00 pm with a stop date of 02/16/16 and documented as administered

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D 358	Continued From page 72 02/09/16 at 8:00 pm, 02/10/16 at 8:00 pm, 02/11/16 at 8:00 am and 8:00 pm, 02/12/16 at 8:00 am and 02/14/16 at 8:00 am and 8:00 pm and 02/16/16 at 8:00 am. -An entry for torsemide 20mg take 2 tablets once daily and documented as administered at 8:00 am on 02/11, 02/12, 02/13, 02/14, 02/15 and 02/16/16. Interview with Resident #1 on 02/11/16 at 9:04 am revealed: -She did not know her medications but "for the most part they look they same as they always have". -She denied having been short of breath since admission to this facility. -Her legs were more swollen, tight and they were extremely painful. -She had just taken a pain pill. A second interview with Resident #1 on 02/16/16 at 11:05 am revealed: -Her lower legs were causing her pain. -They were extremely swollen from her knees down. -She got new blisters, they popped and then she got more blisters that formed in 2 days. -Now she had blisters between her toes. Interview with a Medication Aide (MA) on 02/09/16 at 4:11 pm revealed: -She had worked at this facility for approximately two years as a MA. -She did not know when Resident #1 was admitted, but thought it was the evening of 02/07/16. -She knew what medications to give Resident #1 by reading the instructions on the medications cards on hand and comparing the medications listed on the hospital discharge summary.	D 358		

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D 358	Continued From page 73 -She knew there were medications on the FL2 that were not in the facility ans she did not request the torsemide or doxycycline from the back up pharmacy. -She thought the Resident Care Coordinator (RCC) was responsible for requesting medications from the back up pharmacy. -The RCC was responsible for making sure the FL2 was faxed to the pharmacy and that the eMARs were correct. -She did not have the ability to enter new orders into the eMAR. -She did not notify the RCC when Resident #1 was been admitted. -She did not document medications she administered on the eMAR or a paper MAR. -She did document the narcotics she administered in the narcotic count book. -She knew to document the administration of medication right after a resident took their medication, but did not for Resident #1 because was not an eMAR for Resident #1 yet. Interview with a second MA on 02/09/16 at 4:20 pm revealed: -She had worked at this facility for a little less than a year. -She did not write down medications that she gave the evening of 02/08/16 except for Resident #1's blood sugars and Novolog insulin she administered, according to the sliding scale. -She documented the narcotics that she administered in the narcotic count book. -She knew what medications to give Resident #1 by reading the instructions on the medications cards on hand and comparing them with what was on the FL2. -She knew there were medications on the FL2 she should have administered but did not have in the facility. She did not administer these	D 358		

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medications because "I can only give what I have to give". She never requested medications from the back up pharmacy.
-When a resident was admitted it was the responsibility of the RCC to make sure the medications were in the facility and the eMARs were accurate.
-She did know to document the administration of medication right after a resident took their medication, but did not do so for Resident #1 because Resident #1 was not in the eMAR system yet.

Interview with a third MA on 02/10/16 at 3:10 pm revealed:
-Resident #1 was admitted from the hospital the evening of 02/06/16.
-Resident #1 came with a large envelope of papers, and she did not do anything with the paperwork.
-It was the responsibility of the RCC to process the resident's paperwork.
-The paper work was sitting on the desk so that the RCC could process it when she came to work on Monday, 02/08/16.
-Resident #1 did not have any new medications, and she did not know of any new medication orders.
-She did not call the RCC to notify her that Resident #1 was admitted to the facility.

Interview with the RCC on 02/11/16 at 10:39 am revealed:
-She was employed at this facility for almost three years.
-It was the responsibility of the MA on duty to fax the any new orders or FL2 to the pharmacy and make sure the medications were at the facility.
-The MAs on duty were responsible for any medication changes that came from a

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hospitalization or a physician's office visit.
-She was not working over the weekend or on Monday, 02/08/16.
-On Tuesday, 02/09/16 she came in to work to ensure the FL2 was faxed to the pharmacy.
-If things were not done correctly or completed she would make sure they were.
-She was not informed by staff that Resident #1 was being admitted over the weekend.
-The Administrator was responsible for all admissions.
-She was administering Resident #1's medication based on the FL2 dated 2/08/16.
-She administered the medications that were at the facility from her visit prior to her going to the hospital.
-The only thing she did that other MAs did not do was the annual care plans and FL2 updates.
-She knew there were medications that were started late because they were not entered into the eMAR system and they were not faxed to the pharmacy.

A second interview with the RCC on 02/17/16 at 9:24 am revealed:
-Resident #1 was admitted to the facility on 02/06/16, but she did not know what time.
-She did not call Resident #1's physician to clarify the new orders from the hospital as compared to those medications Resident #1 was taking prior to hospitalization.
-The MAs administered Resident #1's medications that were sent from her previous facility.
-Resident #1 was a resident from one of the sister facilities.

Interview with the Administrator on 02/10/16 at 11:20 am revealed:
-The RCC was scheduled to work Mondays,

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D 358	Continued From page 76 Wednesdays and Fridays to do nothing but to ensure accuracy and timeliness of all paperwork. -The admission paperwork should have been processed by the RCC on 02/08/16. -She had worked Saturday up until about 6:00 pm and Resident #1 had not been admitted at that time. -She thought Resident #1 was admitted on 02/07/16. -She did not review the FL2 prior to admission. -Resident #1 was a resident at one of the sister facilities. -Resident #1 had come to visit this facility and had her medications with her. -She was visiting one of her friends and did want to be transferred to this facility when a vacancy became available. -Resident #1 complained of feeling bad and was sent to the hospital from this facility. -She did not know why Resident #1's information was not entered into the eMAR system. -She expected the pharmacy would have sent any new medications at least by Monday night and knew that they did not. Interview with a representative from the contracted pharmacy on 02/10/16 at 12:27 pm revealed: -They received Resident #1's FL2 on 02/08/16 at 2:26 pm. -They filled the doxycycline 100mg (6 tablets) and torsemide 20mg (2 tablets per dose) on 02/09/16. -These medications were sent to the facility on 02/09/16. -They were not sent on 02/08/16 because the FL2 was received by the pharmacy after their cut off time. -The facility did not request these orders be sent any sooner than the regularly scheduled delivery which was around noon.	D 358		

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D 358	Continued From page 77 Interview with a second pharmacy representative on 02/10/16 at 3:15 pm revealed: -Resident #1's medications were not entered in the eMAR because she was out of town and she was the only one at the pharmacy that could enter Resident #1's new information. -She was out of town and would not be able to enter Resident #1's information into the eMAR until after 6:00 pm on 02/09/16. -She would get the information in the eMAR before the evening medication pass [on 02/09/16]. Interview with Resident #1's primary care physician on 02/17/16 at 9:50 am revealed: -The orders from the hospital should have started sooner 02/09/16 given that she was discharged from the hospital on 02/06/16. -He did not think Resident #1 suffered any untoward effects of the medication not having been started sooner. 2. Further review of Resident #1's hospital discharge summary dated 02/06/16 revealed an order for oxycodone 5mg immediate release tablet every 4 hours as needed for severe pain (a narcotic medication used to treat pain). Further Review of the hospital discharge summary dated 02/06/16 revealed an order for oxycodone 5mg immediate release tablet every 4 hours as needed for severe pain. Review of Resident #1's February 2016 eMAR revealed: -An entry for oxycodone 5mg 1 tablet 3 times daily at 8:00 am, 2:00 pm and 8:00 pm and documented as administered 2/10/16 at 2:00 pm and 8:00 pm.	D 358		

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D 358	Continued From page 78 -A second entry for oxycodone 5mg 1 tablet three times daily with administration time set for 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm and documented as administered 02/09/16 at 8:00 pm. -A third entry for oxycodone 5mg 1 tablet four times daily at 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm and documented as administered 02/11/16 at 4:00 pm and 8:00 pm, 02/12/16 at 8:00 am, 4:00 pm and 8:00 pm, 02/13/16 at 8:00 am, 12:00 pm, 4:00 pm and 8:00pm, 02/14/16 at 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm and 02/15/16 at 8:00 am and 12:00 pm. -A forth entry for oxycodone 5mg 1 tablet every 4 hours as needed for severe pain and documented as administered at 10:11 am on 02/11/16 and effective. -A fifth entry for oxycodone 5mg 1 tablet every four hours as needed for severe pain and documented as administered at 4:25 pm on 02/15/16, 8:32 pm on 02/15/16, 7:48 pm on 02/16/16, 12:33 pm on 02/16/16 and 4:54 pm on 02/16/16. Observation of Resident #1's medication on hand on 02/09/16 at 3:21 pm revealed: -34 tablets of oxycodone 5mg filled on 01/04/16 with instructions on label to give 1 tablet three times daily. Resident #1's hospital discharge summary dated 02/06/16 revealed an order for oxycodone 5mg immediate release tablet every 4 hours as needed for severe pain and not on a routine basis. Review of the narcotic count book for Resident #1 revealed: -Oxycodone 5mg was documented as administered on 02/06/16.	D 358		

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D 358	Continued From page 79 -Oxycodone 5mg was documented as administered three times daily (8:00 am, 12:00 pm and 8:00 pm) from 02/07/16 through 02/13/16. -Oxycodone 5mg was documented as administered four times daily (8:00 am, 12:00 pm, 4:00 pm and 8:00 pm) on 02/14/16 and 02/15/16. -Oxycodone 5mg was documented as administered at 8:00 am and 12:00 pm on 02/16/16. Interview with a second MA on 02/09/16 at 4:20 pm revealed: -She had worked at this facility for a little less than a year. -She documented the narcotics that she administered in the narcotic count book. -She knew what medications to give Resident #1 by reading the instructions on the medications cards on hand and comparing them with what was on the FL2. -She noticed the label for oxycodone and the FL2 were different and administered according to the label because that was what Resident #1 was taking before she went to the hospital. -She did not inform the physician that the medication had been given routinely three and then four times a day routinely. Interview with the RCC on 02/09/16 at 4:00 pm revealed: -"Often residents' FL2s were inaccurate and did not have correct orders." -She gave oxycodone three times a day because that was what Resident #1 was taking prior to her hospitalization. -She would get clarification, but she had not obtained clarification yet. A second interview with the RCC on 02/17/16 at	D 358		

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D 358	Continued From page 80 9:26 am revealed: -She did not know why there were so many entries for oxycodone. -She did not make any of the entries. -She did not inform the physician that the medication had been given routinely three and then four times a day routinely. Interview with Resident #1 on 02/16/16 at 11:05 am revealed she did not have to ask for her pain medication and staff automatically brought her pain medication. Interview with a pharmacy representative on 02/17/16 at 11:50 am revealed: -There were several entries of the oxycodone because a mistake was identified in that the three times a day entry had four administration times and this order was discontinued and the entry was re-entered with three administration times. -Then, on the 15th another error was identified with the order in that the current order was interpreted at four times a day and this order was discontinued and re-entered again with the corrections. -There were two prn entries for the oxycodone because the facility entered these into the eMAR. -There was staff at the facility that could enter data into the eMAR [named 3 staff members, The Administrator, The RCC and one MA]. B. Review of Resident #3's current FL2 dated 12/04/15 revealed: -Diagnoses included type II diabetes with accelerated hyperglycemia and early DKA (diabetic ketoacidosis). -An order for Novolog 25 units into the skin three times daily with meals in addition to the sliding scale as follows: 150-200=1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units,	D 358		

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D 358	Continued From page 81 351-400 - 5 units and greater than 400 = 6 units and call MD. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 09/02/14. Review of Resident #3's record revealed that Resident #3 was released from the hospital to this facility 12/04/15. Review of Resident #3's record revealed: -A fax request from the facility for permission to resume previous dose Resident #3 was on prior to the hospitalization of Novolog Insulin 30 units three times daily with meals with the following sliding scale: 150-200=1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, and greater than 400 = 6 units, and call MD. Review of Resident #3's December 2015 eMAR revealed: -An entry for Novolog insulin 30 units to be given at meals (8:00 am, 12:00pm and 4:00 pm) in addition to the sliding scale. -From 12/01/15 through 12/04/15 this was documented as "Out of Facility." -An entry for a sliding scale as follows: 150-200=16 unit, 201-250 = 17 units, 251-300 = 18 units, 301-350 = 19 units, 351-400 = 20 units and greater than 400 = 21 units and call MD. -From 12/05/15 through 12/09/15 Novolog insulin 30 units was documented as administered without requiring the sliding scale. -There were 2 of 2 opportunities where SSI was not documented administered as ordered as follows: -On 12/06/15 the blood sugar was documented as 292 and 32 units of Novolog were documented	D 358		

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D 358	Continued From page 82 as administered. -On 12/08/15 the blood sugar was documented as 365 and 32 units were documented as administered. Further Review of Resident #3's Record revealed an order dated 12/09/15 to administer Novolog 25 units three times a day with no order for sliding scale insulin. Review of Resident #3's December 2015 eMAR revealed: -An entry with a start date of 12/09/15 for Novolog 25 units three times daily in addition to a sliding scale. -From 12/10/15 through 12/16/15 Novolog insulin 25 units was documented as administered. There was no sliding scale insulin required based on the resident's sliding scale. -On 12/10/15 at 8:00 pm the blood sugar was documented as 250 and 3 additional units were documented as administered (there was no sliding scale order at this time). -On 12/17/15 at 8:00 pm the blood sugar was documented as 222 and 4 additional units were documented as administered (there was no sliding scale order at this time). Further Review of Resident #3's Record revealed an order dated 12/17/15 to administer Novolog 15 units three times a day with an order for sliding scale insulin as follows: 150-200= 1 units (total=16 units), 201-250 = 2 units (total=17 units), 251-300 = 3 units (total=18 units), 301-350 = 4 units (total=19 units), 351-400 = 5 units (total=20 units) and greater than 400 = 21 units and call MD. Review of the December 2015 eMAR revealed: -An entry with a start date of 12/18/15 for Novolog	D 358		

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D 358	Continued From page 83 insulin 15 units to be given at breakfast, lunch and dinner and the sliding scale as follows: 150-200=16 unit, 201-250 = 17 units, 251-300 = 18 units, 301-350 = 19 units, 351-400 = 20 units and greater than 400 = 21 units and call MD. -On 12/30/15 at 8:00 am the blood sugar was documented as 189 and 31 units were documented as administered (a total of 16 units of Novolog should have been administered). Review of Resident #3's January 2016 eMAR revealed: -An entry for Novolog insulin 15 units to be given at breakfast, lunch and dinner and the sliding scale as follows: 150-200=16 unit, 201-250 = 17 units, 251-300 = 18 units, 301-350 = 19 units, 351-400 = 20 units and greater than 400 = 21 units and call MD. -There were 11 of 51 opportunities where SSI was not administered as ordered with examples as follows: -On 1/16/16 at 8:00 pm the blood sugar was documented as 237 and 19 units were documented as administered. -On 1/17/16 at 8:00 am the blood sugar was documented as 312 and 15 units were documented as administered. -On 1/19/16 at 8:00 am the blood sugar was documented as 175 and 15 units were documented as administered. -On 1/19/16 at 12:00 pm the blood sugar was documented as 166 and 15 units were documented as administered. -On 1/20/16 at 12:00 pm the blood sugar was documented as 170 and 17 units were documented as administered. -On 1/22/16 at 8:00 pm the blood sugar was documented as 160 and 15 units were documented as administered. -On 1/23/16 at 8:00 pm the blood sugar was	D 358		

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D 358	Continued From page 84 documented as 284 and 17 units were documented as administered. -On 1/25/16 at 8:00 am the blood sugar was documented as 189 and 30 units were documented as administered. -On 1/26/16 at 8:00 pm the blood sugar was documented as 315 and 16 units were documented as administered. -On 1/28/16 at 8:00 pm the blood sugar was documented as 310 and 17 units were documented as administered. -On 1/30/16 at 8:00 am the blood sugar was documented as 311 and 17 units were documented as administered. Review of the February 1 - February 10, 2016 eMAR revealed: -An entry for Novolog insulin 15 units to be given at breakfast, lunch and dinner and the sliding scale as follows: 150-200=16 unit, 201-250 = 17 units, 251-300 = 18 units, 301-350 = 19 units, 351-400 = 20 units and greater than 400 = 21 units and call MD. -There were 5 of 18 opportunities where SSI was not administered as ordered with examples as follows: -On 02/01/16 at 8:00 am the blood sugar was documented as 155 and 15 units were documented as administered. -On 02/04/16 at 12:00 pm the blood sugar was documented as 247 and 19 units were documented as administered. -On 02/05/16 at 8:00 am the blood sugar was documented as 310 and 16 units were documented as administered. -On 02/05/16 at 12:00 pm the blood sugar was documented as 189 and 17 units were documented as administered. -On 02/05/16 at 8:00 pm the blood sugar was documented as 291 and 19 units were	D 358		

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D 358	Continued From page 85 documented as administered. Interview with a MA on 02/17/16 at 10:30 am revealed: -She did not know she had made errors when she had administered Resident #3's sliding scale insulin. -She understood how to use the sliding scale and had been trained. -Her errors may have been made because she may have been in a rush. -She did not remember what amounts she administered and just administered what the eMAR indicated. Interview with the RCC on 02/09/16 at 4:10 pm revealed: -Often residents' FL2s were inaccurate and did not have correct orders. -She faxed the physician a clarification on 12/05/15 when Resident #3 returned from the hospital on in regards to the Novolog insulin. -She kept the orders the same as they had been prior to the hospitalization until she heard from Resident #3's physician because she thought these were correct. -She did not get a response from Resident #3's physician until 12/09/15 and provided documentation that she faxed him twice. -She did not know the new order did not include a sliding scale. -She did not know why the eMAR did not reflect the sliding scale as ordered from the hospital. -She knew that the order for the Novolog sliding scale had a different base number than was ordered from the hospital as compared to the 12/09/15 physician order but did not report the discrepancy to the physician. A second interview with the RCC on 02/11/16 at	D 358		

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D 358	Continued From page 86 10:32 am revealed: -No one checks back to see if the insulin was administered correctly according to the sliding scale. -The facility did not have a policy for medication errors. -It was not her responsibility to detect errors or to report them to the Administrator. -No one was responsible for record review, MAR, order audits. -The erroneous numbers she entered on the eMAR for Resident #3's sliding scale were typo errors. -Once she entered a wrong number she was unable to go back and correct it. -She knew how to implement a sliding scale and had been trained on the sliding scale. -The Novolog insulin orders on the FL2 dated 12/04/15 were never implemented. Interview with the Administrator on 02/16/16 at 10:13 am revealed: -It was the responsibility of the RCC to check for errors and report them. -She was not aware that the MAs were making errors when administering Resident #3's sliding scale insulin. -She did have the RN train and check off MAs prior to administering insulin. -She did provide training on insulin and diabetic residents prior to the administration of insulin. -She expected the RCC to identify medication errors and report them to her. Interview with the Registered Nurse at Resident #3's physician office on 02/16/16 at 9:27 am revealed: -They were unaware that MAs applied a sliding scale to the Novolog order from 12/09/15. -The physican ordered Novolog 25 units three	D 358		

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times a day with no sliding scale on 12/09/15.
-The physician ordered a sliding scale with the base starting at 15 units to be given at breakfast, lunch and dinner and the sliding scale as follows: 100-150 = 1 unit, 150-200=2 units, 201-250 = 3 units, 251-300 = 4 units, 301-350 = 5 units, 351-400 = 6 units and greater than 400 = 5 units and call MD.
-They were unaware that MAs had made errors when implementing the ordered sliding scale.

2. Review of Resident #3's current FL2 dated 12/04/15 revealed:
-Diagnoses included type II diabetes mellitus with accelerated hyperglycemia and early diabetic ketoacidosis.
-An order for Lantus insulin 90 units at bedtime.

Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 09/02/14.

Review of Resident #3's record revealed that Resident #3 was released from the hospital to this facility 12/04/15.

Review of the December 2015 electronic Medication Administration Record (eMAR) revealed:
-An entry for Lantus 60 units at 8:00 am and 8:00 pm and documented as administered twice daily from 12/04/15 through 12/08/15.

Interview with a Medication Aide (MA) on 02/09/16 at 4:20 pm revealed:
-She did not fax FL2s to the pharmacy when residents returned from the hospital.
-It was the responsibility of the Resident Care Coordinator (RCC) to do admissions and fax the FL2s to the pharmacy.

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D 358	Continued From page 88 -She was not aware that there were new insulin orders for Resident #3 when Resident #3 returned from the hospital. -She just gave the medications according to what the eMAR said and assumed it was correct. Interview with the RCC on 02/09/16 at 4:10 pm revealed: -Often FL2s were inaccurate and did not have correct orders. -She faxed the physician a clarification when Resident #3 returned from the hospital in regards to both the Lantus but did not get a response until 12/09/15. -She kept the orders the same as they had been prior to the hospitalization until she heard from Resident #3's physician, because she thought those orders were correct. -The documentation that was returned from the physician on 12/09/15 included orders that were different from what they were administering. A second interview with the RCC on 02/11/16 at 10:32 pm revealed: -Resident #3 returned from the hospital on a Friday and she was not at the facility. -The pharmacy was closed when Resident #3 was re-admitted to the facility. -Whoever the MA was when he was admitted was responsible for faxing the FL2. -She faxed a clarification to the physician on Monday when she came in to the facility. -From the date of re-admission until the physician responded the MAs gave what Resident #3 was ordered prior to the hospitalization. -The Lantus insulin orders on the FL2 dated 12/04/15 were never implemented. Interview with the Administrator on 02/10/16 at 11:20 am revealed:	D 358		

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-It was the responsibility of the RCC to assure all the orders were on the eMAR and that they were correct.
-The RCC "dropped the ball" and should have ensured the orders on the FL2 were on the eMAR and implemented by staff.
-She was unaware there were orders on the FL2 that were never implemented.
-She did not know why the new orders were not on the eMAR.
-She expected any MA to fax the FL2 to the pharmacy, and the RCC to follow up and make sure the orders were on the FL2 and were accurate.

Interview with the Registered Nurse at Resident #3's physician office on 02/16/16 at 9:27 am revealed:
-They were unaware that the Lantus orders from the hospital were not implemented from 12/04/15 to 12/09/15.
-The physician ordered Lantus 100 units at bed time on 12/09/15.
-On 12/17/15 Lantus insulin was to be decreased to 80 units at bedtime.
-These were the only changes to Lantus insulin for Resident #3.

C. Review of Resident #2's current FL-2 dated 01/13/16 revealed diagnoses included pneumonia, type II diabetes mellitus, and chronic pain.

Review of Resident #2's record revealed:
-There were two Resident Registers for Resident #2.
-The latest Resident Register revealed an admission date of 01/16/16 from a skilled nursing facility, and a prior Resident Register revealed an admission date of 11/06/15 from the facility's

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sister assisted living facility.

1. Review of Resident #2's record revealed there was no FL-2 or other physician orders to accompany the 11/06/15 admission to the facility.

Review of the November 2015 Medication Administration Records (MARs) revealed:
-There was a paper MAR from the sister facility with documentation of medication administered from 11/01/15 through 11/12/15.
-There was an electronic MAR (eMAR) with documentation of medications administered, with beginning dates ranging from 11/12/15 to 11/14/15.
-There was an entry for Novolog insulin 15 units three times daily with each meal on the paper MAR with documentation of administration from 6:00 am on 11/01/15 through the 4:00 pm dose on 11/12/15.
-The eMAR Novolog entry was for Novolog insulin 10 units three times daily with each meal and was documented as administered from 6:30 am on 11/11/15 through 4:30 pm on 11/30/15.

Interview on 02/16/16 at 3:50 pm with a representative from the facility's contracted pharmacy revealed:
-The medications were transferred from the sister facility to this facility and entered into the computerized system by the pharmacy staff.
-The pharmacy representative did not know why the Novolog dose changed from 15 units to 10 units and may have been an "entry error".

Interviews on 02/16/16 at 10:20 am and 3:30 pm with the Administrator revealed:
-Resident #2 originally transferred to this facility on 11/06/15.
-The facility used the MAR from the sister facility

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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until the pharmacy put the resident's information into the computerized system.
-She did not know the insulin entries did not match.
-She was not aware Resident #2's medications were not being administered according to the current physician's orders.
-It was the responsibility of the Resident Care Coordinator (RCC) to ensure new orders are faxed to the pharmacy, ensure accuracy of orders entered into the eMAR system, and to audit the MARs at the end of each month to ensure ongoing accuracy of medication administration.

Interviews on 02/10/16 at 9:15 am, 02/11/16 at 10:40 am, and 02/17/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed:
-Resident #2 originally transferred to this facility on 11/06/15 from a sister facility.
-The facility just brought the MAR and the resident's medications from the sister facility and continued "the same orders".
-It took "a couple of days--maybe 5" for the pharmacy to enter the resident's information into the electronic system.
-The RCC did not check the new eMAR to ensure the medication orders had been transferred correctly.
-The RCC was not aware the insulin entries did not match.
-The RCC continued to administer 15 units of Novolog three times daily instead of 10 units as scheduled on the eMAR because she did not notice the eMAR instructions were for 10 units.
-The RCC "never" gave a dose of 10 units of Novolog.
-The RCC stated she had no supervisory responsibilities or responsibilities to audit MARs or physician orders for accurate administration of medications.

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D 358	Continued From page 92 Interview on 02/17/16 at 11:03 am with a Medication Aide (MA) revealed: -When Resident #2 was admitted to the facility in November 2015, the staff continued the paper MARs that came with the resident from the previous facility. -The MA noticed the eMAR included instructions to administer 10 units Novolog three times daily instead of 15, but the MA "assumed the order changed". -The MA administered 10 units Novolog three times daily. Interview on 02/11/16 at 9:30 am with Resident #2 revealed: -She transferred from the sister facility to this facility in November 2015 because there was more staff at this facility to assist her with personal care needs. -She was not aware of any interruptions in the administration of her medications when she transferred to this facility in November. 2. Review of Resident #2's current FL-2 dated 01/13/16 revealed physician orders included Perforomist nebulizer twice daily (bronchodilator), ipratropium-albuterol nebulizer every six hours (bronchodilator), Klor-Con 20 meq daily (potassium supplement), alprazolam 0.25mg three times daily (anti-anxiety agent), and hydromorphone 1 mg every six hours as needed for pain (narcotic pain reliever). Review of the January 2016 and February 2016 electronic Medication Administration Records (eMARs) revealed: -There were no entries for Perforomist nebulizers, ipratropium-albuterol nebulizers, Klor-Con, alprazolam, and hydromorphone on the eMAR for	D 358		

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administration to Resident #2.

Observation on 02/17/16 at 12:30 pm of Resident #2's medications on hand revealed there was no Perforomist, ipratropium-albuterol, Klor-Con, alprazolam, or hydromorphone available for administration to Resident #2.

Interview on 02/16/16 at 4:10 pm with a representative from the facility's contracted pharmacy revealed:
-The last FL-2 received from the facility was dated 12/11/15.
-The facility did not fax the 01/13/16 FL-2.
-The pharmacy was not aware the resident had been discharged from the facility on 12/12/15 and readmitted on 01/15/16; therefore, none of the new medications ordered on 01/13/16 had been dispensed from the pharmacy, nor did they appear on the MARs for administration.

Interview on 02/16/16 at 10:20 am with the Administrator revealed:
-She was not aware Resident #2's medications were not being administered according to the current physician's orders.
-It was the responsibility of the Resident Care Coordinator (RCC) to ensure new orders are faxed to the pharmacy, ensure accuracy of orders entered into the eMAR system, and to audit the MARs at the end of each month to ensure ongoing accuracy of medication administration.

Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed:
-The RCC did not check the eMAR to ensure the 01/13/16 medication orders had been entered correctly.
-The RCC stated she had no supervisory

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responsibilities or responsibilities to audit MARs or physician orders for accurate administration of medications.

Interviews on 02/11/16 at 9:30 am and 02/17/16 at 12:00 pm with Resident #2 revealed:
-She was admitted to the hospital in December 2015 for congestive heart failure (CHF) and was on a ventilator at the hospital.
-She relied on the facility staff to administer medications according to physician orders.
-She routinely took medications to help with her breathing.
-The only physician orders of which she was aware not being carried out by the facility staff was for Dilaudid (brand name hydromorphone).
-She routinely had chronic pain in both legs (left leg and right below-the-knee amputation) and the right leg "moves by itself" and is painful.
-She routinely had "chronic back pain".
-The resident had told staff on numerous occasions since admission on 01/16/16 that she needed the Dilaudid for pain.
-The resident "told everybody who works here" but they (staff) won't give her the Dilaudid.
-She was not aware of any other medications that were not being administered according to the physician's orders.

3. Review of Resident #2's January 2016 and February 2016 electronic Medication Administration Records (eMARs) revealed:
-Several medications which were not ordered on the 01/13/16 FL-2 were routinely administered from 01/15/16 through 02/16/16.
-Medications administered but not ordered on the current FL-2 included Norvasc 10 mg daily (calcium channel blocker), atorvastatin 40 mg daily (treats high cholesterol), hydralazine 25 mg three times daily (vasodilator), Novolog 10 units

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three times daily (rapid-acting insulin), and vitamin B6 100 mg twice daily (vitamin supplementation).

Observation on 02/17/16 at 12:30 pm of Resident #2's medications on hand revealed:
-The atorvastatin, hydralazine, Novolog, and vitamin B6 were included in the medication cart with Resident #2's other medications, each medication label showing a dispense date prior to 01/15/16.
-Norvasc 10 mg was included in the medication cart with Resident #2's other medications with a medication label showing a refill date of 02/04/16.

Interview on 02/16/16 at 4:10 pm with a representative from the facility's contracted pharmacy revealed:
-The last FL-2 received from the facility was dated 12/11/15.
-The pharmacy did not have a copy of the 01/13/16 FL-2.
-The pharmacy was not aware the resident had been discharged from the facility on 12/12/15 and readmitted on 01/15/16; therefore, the current eMARs continued to include the medications discontinued during the resident's absence from the facility from 12/12/15 through 01/14/16.

Interview on 02/16/16 at 10:20 am with the Administrator revealed:
-She was not aware Resident #2's medications were not being administered according to the current physician's orders.
-It was the responsibility of the Resident Care Coordinator (RCC) to ensure new orders are faxed to the pharmacy, ensure accuracy of orders entered into the eMAR system, and to audit the MARs at the end of each month to ensure ongoing accuracy of medication administration.

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D 358	Continued From page 96 Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed: -The RCC did not check the eMAR to ensure the 01/13/16 medication orders had been entered correctly. -The RCC stated she had no supervisory responsibilities or responsibilities to audit MARs or physician orders for accurate administration of medications. Interviews on 02/11/16 at 9:30 am and 02/17/16 at 12:00 pm with Resident #2 revealed: -She was admitted to the hospital in December 2015 for congestive heart failure (CHF) and had been a ventilator. -She relied on the facility staff to administer medications according to physician orders. -She routinely took medications to help with her breathing. -The only physician orders of which she was aware not being carried out by the facility staff was for Dilaudid (brand name hydromorphone). -She routinely had chronic pain in both legs (left leg and right below-the-knee amputation) and the right leg "moves by itself" and is painful. -She routinely had "chronic back pain". -The resident told staff on numerous occasions that she needed the Dilaudid for pain. -The resident "told everybody who works here" but they (staff) won't give her the Dilaudid. -She was not aware of any other medications that were not being administered according to the physician's orders. 4. Review of Resident #2's current FL-2 dated 01/13/16 revealed: -Physician's orders included an order for omeprazole 20 mg daily.	D 358		

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D 358	Continued From page 97 -Physician's orders included an order for aspirin 81 mg daily. Observation on 02/17/16 at 12:30 pm of Resident #2's medications on hand revealed: -A bubble pack containing 18 of 30 capsules of omeprazole 40 mg dispensed by the pharmacy on 01/04/16, prior to the resident's admission to the facility on 01/15/16. -A bubble pack containing 20 of 30 tablets of aspirin 325 mg dispensed by the pharmacy on 01/04/16, prior to the resident's admission to the facility on 01/15/16. -There was no omeprazole 20 mg available for administration to the resident. -There was no aspirin 81 mg available for administration to the resident. Review of Resident #2's January 2016 electronic Medication Administration Records (eMARs) revealed: -Aspirin 325 mg was scheduled for administration daily at 8:00 am and was documented as administered daily from 01/16/16 through 01/31/16. -Omeprazole 40 mg was scheduled for administration daily at 8:00 am and was documented as administered daily from 01/16/16 through 01/31/16. Review of Resident #2's February 2016 eMARs revealed: -Aspirin 325 mg was scheduled for administration daily at 8:00 am and was documented as administered daily from 02/01/16 through 02/16/16. -Omeprazole 40 mg was scheduled for administration daily at 8:00 am and was documented as administered daily from 02/01/16 through 02/16/16.	D 358		

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D 358	Continued From page 98 Interview on 02/16/16 at 4:10 pm with a representative from the facility's contracted pharmacy revealed: -The last FL-2 received from the facility was dated 12/11/15. -The pharmacy did not have a copy of the 01/13/16 FL-2. -The pharmacy was not aware the resident had been discharged from the facility on 12/12/15 and readmitted on 01/15/16; therefore, dosage changes ordered on the 01/13/16 FL-2 were not changed in the eMAR system, and no omeprazole 20 mg capsules or aspirin 81 mg tablets had been dispensed. Interview on 02/16/16 at 10:20 am with the Administrator revealed: -She was not aware Resident #2's medications were not being administered according to the current physician's orders. -It was the responsibility of the Resident Care Coordinator (RCC) to ensure new orders are faxed to the pharmacy, ensure accuracy of orders entered into the eMAR system, and to audit the MARs at the end of each month to ensure ongoing accuracy of medication administration. Interviews on 02/11/16 at 10:40 am and 02/17/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed: -The RCC did not check the eMAR to ensure the 01/13/16 medication orders had been entered correctly. -The RCC stated she had no supervisory responsibilities or responsibilities to audit MARs or physician orders for accurate administration of medications. Interviews on 02/11/16 at 9:30 am and 02/17/16	D 358		

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D 358	Continued From page 99 at 12:00 pm with Resident #2 revealed: -She was admitted to the hospital in December 2015 for congestive heart failure (CHF) and had been on a ventilator. -She relied on the facility staff to administer medications according to physician orders. -She routinely took medications to help with her breathing and pain. _____ On 02/11/16, the facility's Registered Nurse (RN) Consultant submitted a Plan of Protection as follows: -The Administrator or designee will immediately begin an audit of all current physician orders and resident MARs to ensure medications are administered as ordered by the physician -An immediate audit of medication cart will be completed to ensure ordered medications are available for administration. -Administrator or designee will audit mediation orders and medication cart weekly x 4 weeks, then monthly x 4 months and then quarterly thereafter. -RN is to be notified of all admissions. -All MAs will be inserviced prior to their next scheduled shift. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 19, 2016.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	D 367		

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D 367	Continued From page 100 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to assure medication administration records (MARs) were accurate and complete for 2 of 3 sampled Residents (Residents #2 and #3) regarding medications for diabetes and gastroesophageal reflux disease. The findings are: A. Review of Resident #3's current FL2 dated 12/04/15 revealed diagnoses included Type II diabetes with accelerated hyperglycemia and early DKA (diabetic ketoacidosis) 1. Review of Resident #3's record revealed: -Current FL2 dated 12/04/15 revealed an order for Lantus insulin - 90 units into the skin at bedtime. -A physician's order dated 12/09/15 for Lantus 100units daily. -A physician's order dated 12/17/15 for Lantus 80	D 367		

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D 367	Continued From page 101 units at bedtime. Review of the December 2015 eMAR revealed: -An entry for Lantus insulin 60 units in the morning and 60 units at bedtime and documented as administered 8:00 pm 12/04/15, 8:00 am and 8:00 pm from 12/05/15 through 12/08/15. -An entry for Lantus insulin 100 units at bedtime and documented as administered on 12/09/15 8:00 pm with amount given 60 units documented under the initials, 12/10/15 through 12/16/15 at 8:00 pm with amount given as 100 units documented under the initials and 12/17/15 at 8:00 pm with amount given as 80 units documented under the initials. -An entry for Lantus insulin 80 units at bedtime and documented as administered at 8:00 pm from 12/18/15 through 12/31/15. Review of the January 2016 eMAR revealed: -An entry for Lantus insulin 100 units at bedtime and documented as administered on 1/01/16-1/03/16, 1/05/16-1/07/16, 1/11, 1/12, 1/14, 1/15, 1/16, 1/17, 1/21-1/26 and 1/29-1/31/16 at 8:00 pm with amount given as 80 units documented under the initials. -A second for Lantus 80 units at bedtime and documented as administered on 1/01/16-1/03/16, 1/05/16-1/07/16, 1/11, 1/12, 1/14, 1/15, 1/16, 1/17, 1/21-1/26 and 1/29-1/31/16 at 8:00 pm with amount given as 80 units documented under the initials. -On 1/04/16 the amount documented as administered was 25 units documented under the initials. -On 1/20/16 the amount documented as administered was 19 units documented under the initials. -On 1/27/16 the amount documented as administered was 19 units documented under the	D 367		

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D 367	Continued From page 102 initials. -On 1/28/16 the amount documented as administered was 17 units documented under the initials. -On 1/08 and 1/15/16 it was documented as "held per DR/RN instructions". -On 1/13 and 1/18/16 it was documented as "Resident Refused". -01/09 and 1/10/16 were blank. Interview with a representative from the contracted pharmacy on 2/10/16 at 12:27 pm revealed: -Resident #3 was sent 15 ml of Lantus on 9/28/15, 12/08/15 and 1/19/16 which is consistent with the physician's order. -If they did give 180 units per day they would have had to order more insulin. A second interview with a representative from the contracted pharmacy on 2/10/16 at 12:38 pm revealed: -The pharmacy entered one of the Lantus entries and the facility staff had entered the other. -The pharmacy expected that the facility staff either call and request the double entry be removed or that the facility staff remove the double entry themselves. -The facility staff should not be signing the Lantus entries out as having been administered at different dose than ordered. -There were facility staff that could change the entries on the eMAR [named 3 facility staff members.] -If the MA could not remove it they could have signed it out with an exception for it not having been administered. -No one from the facility called to have the Lantus entries corrected.	D 367		

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D 367	Continued From page 103 Interview with a Medication Aide (MA) on 2/10/16 on 3:10 pm revealed: -She only gave 80 units of Lantus insulin even though she signed that she administered 100 units of Lantus in one place and 80 units of Lantus in another. -She remembered Resident #3 had an order for Lantus 100 units a while back and administered it then but never gave 180 units of Lantus. -She did not notice that there were two Lantus entries on the eMAR. -She did not have the ability to change the eMAR entries. -She only gave one capsule of dexilant and did not notice that there were two entries for this medication. Interview with the Resident Care Coordinator (RCC) on 2/11/16 at 10:41 am revealed: -There was no one responsible for checking the eMARs from one month to the next. -She was not aware that the Lantus order was entered twice with different doses. -She was not aware that she signed them both out as having been administered. -She only gave Resident #3 Lantus 80 units and never administered the Lantus as entered 100 units and documented the 80 units in the eMAR. Interview with the Administrator on 2/16/16 at 10:15 am revealed: -She was not aware that there were double entries for Lantus insulin for Resident #3. -It was the responsibility of the RCC to check the eMARs from one month to the next to ensure accuracy of the entries. -She expected that the RCC do this at the end of every month. -She set aside Mondays, Wednesdays and Fridays for the RCC to do nothing but paper work	D 367		

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D 367	Continued From page 104 and this paper work included ensuring the accuracy of the eMARs from one month to the next as well as new orders. 2. Review of Resident #3's record revealed a physician's order dated 1/18/16 for dexilant 60mg 1 tablet daily (a medication used to treat gastroesophageal reflux disease.) Review of January 2016 eMAR revealed: -An entry for dexilant 60mg one tablet by mouth daily at 8:00 am with a start date of 1/19/16 and documented as administered daily at 8:00 am 1/20/16 through 1/31/16. -A second entry for dexilant 60mg one tablet by mouth daily at 8:00 am with a start date of 1/20/16 and documented as administered daily at 8:00 am 1/20/16 through 1/31/16. Review of February 1 - 10, 2016 eMAR revealed: -An entry for dexilant 60mg one tablet by mouth daily at 8:00 am and documented as administered daily at 8:00 am 2/01/16 through 2/10/16. -A second entry for dexilant 60mg one tablet by mouth daily at 8:00 am and documented as administered daily at 8:00 am 2/01/16 through 2/10/16. Interview with a representative from the contracted pharmacy on 2/10/16 at 12:46 pm revealed: -The pharmacy sent 30 capsules on January 19, 2016. -If they were administering 2 capsules daily the facility would have had to re-order the dexilant. Interview with a Medication Aide (MA) on 2/10/16 on 3:10 pm revealed: -She was not aware she signed out the dexilant	D 367		

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	HAL079092	A. BUILDING: _____ B. WING _____	02/18/2016

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D 367	Continued From page 105	D 367		

twice in the months of January and February.
-She did not know who was responsible for checking the accuracy of the eMARs from month to month.

Interview with the Resident Care Coordinator (RCC) on 2/11/16 at 10:41 am revealed:
-She knew the dexilant order showed up on the eMAR as a double entry.
-She only gave him one capsule daily and never gave him two capsules.
-She could not change the eMAR entries.
-She did not inform the pharmacy that there were double entries.

Interview with the Administrator on 2/16/16 at 10:15 am revealed:
-She was not aware that there were double entries for dexilant insulin for Resident #3.
-It was the responsibility of the RCC to check the eMARs from one month to the next to ensure accuracy of the entries.
-She expected that the RCC do this at the end of every month.
-She set aside Mondays, Wednesdays and Fridays for the RCC to do nothing but paper work and this paper work included ensuring the accuracy of the eMARs from one month to the next as well as new orders.
-The RCC should have caught these errors and does have the ability to change entries on the eMAR.

Interview with a representative from the contracted pharmacy on 2/10/16 at 12:38 pm revealed:
-The pharmacy entered one of the dexilant entries and the facility staff had entered the other.
-The pharmacy expected that the facility staff either call and request the double entry be

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D 367	Continued From page 106 removed or that the facility staff remove the double entry themselves. -The facility staff should not be signing both of the dexilant entries out as having been administered. -There were facility staff that could change the entries on the eMAR [named 3 facility staff members.] -If the MA could not remove it they could have signed it out with an exception for it not having been administered. -No one from the facility called to have the dexilant entries corrected.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding health care, nutrition and food services, TB testing and medical examinations, medication orders, and training in cardiopulmonary resuscitation. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to implement physician	D912		

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D912	Continued From page 107 orders for 2 of 3 sampled residents (Residents #2 and #4) upon admission to the facility. [Refer to Tag 276, 10A NCAC 13F .0902(c)(3-4) (Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for 3 of 3 sampled residents (Residents #2, #3, and #5) with orders for therapeutic diets (Carb Controlled No Added Salt, Renal/Carb Modified, and Heart Healthy). [Refer to Tag 296, 10A NCAC 13F .0904(c)(7) (Type B Violation).] C. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 9 of 15 days on first shift, 11 of 15 days on second shift and 5 of 15 days on third shift from 2/1/16-2/15/16. [Refer to Tag 167, 10A NCAC 13F .0507 (Type B Violation).] D. Based on observations, interviews, and record reviews, the facility failed to ensure the FL-2 was in the facility before admission or accompanied the resident upon admission and reviewed by the facility before admission for 2 of 3 sampled residents (Residents #1 and #2) who were nonemergency admissions. [Refer to Tag 236, 10A NCAC 13F .0703(c)(2) (Type B Violation).] E. Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for verification of orders for medications which were not dated and signed within 24 hours of admission to the facility for 3 of 3 sampled residents (Residents #1 and #2, and #3). [Refer to Tag 344, 10A NCAC 13F .1002(a)(1) (Type B Violation).]	D912		

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D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 sampled residents (Residents #1, #2, and #3) were free of neglect related to health care, medication administration and management of facilities. A. Based on observations, interviews, and record reviews, the facility failed to ensure the Administrator was responsible for the total operation of the facility to maintain compliance in the rule areas of health care, medication administration, medication orders, nutrition and food service, tuberculosis testing, medical examination and immunizations, training on cardiopulmonary resuscitation, examination and screening for the presence of controlled substances, and other staff qualifications. [Refer to Tag 176, 10A NCAC 13F .0601(a) (Type A2 Violation).] B. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 3 of 3 sampled residents (Residents #1, #2, and #3). [Refer to Tag 358, 10A NCAC 13F .1004(a) (Type A2 Violation).] C. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the routine and acute health	D914		

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D914	Continued From page 109 care needs for 2 of 3 sampled residents (Residents #1 and #2) regarding physician notification of noncompliance, discharges to the hospital and re-admissions to the facility, and clarification of order for enzymatic debriding agent. [Refer to Tag 273, 10A NCAC 13F .0902(b) (Type A2 Violation).]	D914		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or	D992		

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D992	Continued From page 110 employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 6 sampled staff (Staff A) hired after 10/1/13 before the employee began working at the facility. The findings are: Review of Staff A's personnel file revealed: -Staff A was hired on 1/16/16. -Staff A began employment at the facility on 1/16/16. -Staff A was hired as a cook. -No documentation a controlled substance exam/screening had been completed. Interview on 2/16/16 at 12:27 pm with Staff A revealed: -The Administrator asked her to sign the consent form for taking controlled substance screening. -She never supplied any type of specimen to the Administrator or Resident Care Coordinator. -She did not know she was supposed to have submitted the controlled substance exam/screening prior to being hired. Interview on 2/17/16 at 11:40 am with the Registered Nurse revealed:	D992		

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D992	Continued From page 111 -The Administrator, along with the Resident Care Coordinator, were responsible for controlled substance exam/screening on new hires. -They utilized an in-house dip-stick screening test and documented the results prior to hire. -She did not know if Staff A had submitted a specimen to be screened for controlled substances or not. Attempted interview with the Administrator was unsuccessful.	D992		