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LIBERTY COMMONS ASSISTED LIVING	3045 HENDERSON DRIVE EXTENSION JACKSONVILLE, NC 28546

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on April 20 - 22, 2016.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 5 sinks of 35 sinks and showers located in the resident bathrooms that were monitored. The findings are: 1. Observations during the initial tour of the 400 Hall of the facility from 11:30am to 12:30pm on 4/20/16 revealed precautionary hot water signs were posted on the walls by the sink in all resident bathrooms. Observation on 4/20/16 between 11:30am and 12:30pm revealed the following hot water temperatures:	D 113		

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D 113	Continued From page 1 -At 11:40am in Room 403, the hot water temperature at the bathroom sink was 122 degrees F. -At 11:45am in Room 404, the hot water temperature at the bathroom sink was 120 degrees F. -At 11:50am in Room 405, the hot water temperature at the bathroom sink was 120 degrees F. -At 12:05pm in Room 409, the hot water temperature at the bathroom sink was 120 degrees F. Thermometers of the surveyor and the Maintenance Staff Person were calibrated simultaneously. - When using ice water, the facility surveyor thermometer read 32 degrees and the Maintenance Staff Person's digital thermometer read 36.8 degrees. - The thermometer of the Maintenance Staff Person consistently read 4 degrees higher than that of the facility surveyor when rechecking 5 rooms on 400 Hall. Interview with the resident who resided in Room 403 on 4/20/16 at 3:45pm, revealed: - The water was too hot for her in the bathroom. -The resident knew to regulate hot water temperatures by adding cold water when using the bathroom sink and shower. -The resident had never been burned by the hot water. Interview with the resident who resided in Room 405 on 4/21/16 at 2:30pm revealed: -The water was hot but not too hot, as far as she knew. -She would rather have hot water than cool water in her shower.	D 113		

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D 113	Continued From page 2 -The resident knew to regulate hot water temperatures by adding cold water when using the bathroom sink and shower. Interview with the resident who resided in Room 409 on 4/21/16 at 4:30pm revealed: -The resident needed help when using the bathrooms. -A Personal Care Aide (PCA) regulated hot water temperatures by adding cold water when assisting her in using the bathroom sink and shower. -The resident had never been burned by the hot water. Recheck of hot water temperatures with the Maintenance Staff Person on 4/22/16 revealed: - At 4:15pm in Room 403, the hot water temperature at the bathroom sink was 108 degrees on the facility surveyor thermometer, and 110 degrees on the Maintenance Staff Person's thermometer. - At 4:20pm in Room 404, the hot water temperature at the bathroom sink was 110 degrees on the facility surveyor thermometer, and 112 degrees on the Maintenance Staff Person's thermometer. - At 4:25pm in Room 405, the hot water temperature at the bathroom sink was 108 degrees on the facility surveyor thermometer, and 112 degrees on the Maintenance Staff Person's thermometer. - At 4:30pm in Room 409, the hot water temperature at the bathroom sink was 108 degrees on the facility surveyor thermometer, and 112 degrees on the Maintenance Staff Person's thermometer. Interview and review with the Maintenance staff person on 04/21/16 at 8:05am revealed:	D 113		

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D 113	Continued From page 3 -There was a written log to record water temperature checks. -A hot water temperature check was done on all hallways. -The water typically was the hottest on the 400 hall in the morning hours which was usually around 8:00am. -He had attempted to adjust the temperature at the boiler. -A recheck was done with the digital thermometer in room 405 at the sink on 04/20/16 around 2:30pm and a hot water temperature was obtained at "116 or less". -The hot water could not be adjusted any lower by turning the valve or the hot water temperature would be shut off. -The plumbing contractor for the boiler would be contacted. A recheck done with the Maintenance staff person on 04/21/16 at 8:00am revealed: -The facility used a digital thermometer to check the water temperatures. - A water temperature was measured at the sink in a public restroom located at the entrance of the facility of 100 degrees F with a glass thermometer and measured 105.4 degrees F when Maintenance checked the water at the same time with a digital thermometer. -A water temperature check in room 405 at the sink measured 116 degrees F with a glass thermometer and measured 118.4 degrees F when Maintenance checked the water at the same time with a digital thermometer. 2. Observations during the initial tour of the 300 hall on 04/20/16 from 11:30am to 12:30pm revealed: -The water temperature at a resident's sink in room 304-B measured 118 degrees.	D 113		

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D 113	Continued From page 4 -A precautionary hot water sign was posted by the sink. Confidential interviews with 3 residents revealed: - The residents never noticed the water being too hot. - The hot water in some bathrooms warm up faster compared to other bathrooms in the facility. - The residents had never been burned by the hot water. A recheck of the water temperature for the sink in room 304-B revealed a measurement of 116 degrees F on 04/20/16 at 5:00pm Observation in the boiler room with the Maintenance staff person on 04/21/16 at 8:15am revealed: -The boiler's temperature was 108 degrees F. -The Maintenance staff person demonstrated how to adjust the hot water by use of a control valve; with a slight turn made, he could not turn the valve any further in that direction. Review of the Daily Temperature log for the month of March 2016 and April 2016 revealed: -There was a list of hot water temperature readings from each hallway when temperature checks were documented as done. -The hot water temperature checks were not documented as done daily. -There was one hot water temperature documented on 04/04/16 from room 405 that measured "123". There was documentation that the water temperature was adjusted. Interview on 4/20/16 at 12:35pm with the Administrator revealed: -She was disappointed that the hot water temperatures in the resident bathrooms were	D 113		

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high [over 116 degrees].
-The facility had been working on hot water issues for at least 10 years. Mixing valves had been replaced on a regular basis, and plumbing contractors had been hired to repair plumbing problems as they occurred.
-The "CAUTION HOT WATER" signs had been up for years, ever since the facility was cited for high hot water temperatures about 10 years ago, per her estimate.
-She kept the "CAUTION HOT WATER" signs posted all the time for resident safety.
-No residents had not been injured by hot water.
-Hot water temperatures should not be over 116 degrees F.
-The Maintenance Staff Person kept a log of hot water temperatures.
-Plumbers had been called to fix the high hot water temperatures whenever the Maintenance Staff Person noticed too-hot water temperatures in resident areas.
-She called a plumbing contractor again to check the water system and hot water temperatures this afternoon, on 4/20/16.

Interview with the Maintenance Staff Person at 2:30pm on 4/21/16 revealed:
-He had not noticed temperatures greater than 116 degrees when last checked this month.
-He kept a log of hot water temperatures.
-He conducted spot checks of hot water temperatures throughout the facility on a weekly basis.
-He knew how to adjust the temperature on the facility boiler system to keep hot water temperatures in the acceptable range.
-He last adjusted hot water temperature downward via a valve on the hot water boiler last week.

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Interview with the Administrator on 04/21/16 at 9:05am revealed:
-There was no policy for hot water temperature checks for the facility.
-There had been an issue long term at this facility with hot water temperatures.

Interview with the Maintenance Staff Person at 11:00am on 4/22/16 revealed:
The plumbing contractor adjusted boiler temperatures on 4/21/16.
-The plumbing contractor adjusted 2 valves on the boiler system to bring hot water temperatures to 108 - 110 degrees.
-The facility Maintenance Staff Person was shown by the plumbing contractor how to adjust both boiler valves to keep hot water temperatures within recommended range for resident areas of the facility.

Interview with a Housekeeper at 1:45pm on 4/22/16 revealed:
-There were no problems with hot water in the facility.
-Most residents knew how to adjust hot water by adding cold water to it.
-Residents with dementia and mobility problems were assisted in the bathrooms by the facility Personal Care Aides (PCAs).
-Residents with health problems, such as poor eyesight or inability to walk, were taken care of by the PCAs.
-The precautionary hot water signs had been posted for years; they were never taken down.

Interview with a PCA on 4/22/16 at 2:00pm revealed:
-No residents had complained to her about the water temperatures.
-The resident's care plan documented which

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D 113	Continued From page 7 residents needed assistance by staff with bathing, toileting, and personal hygiene where residents may come in contact with hot water. -The facility PCAs and Medication Aides (MAs) adjusted water temperatures in the bathrooms before the "heavy care" and disoriented residents used the showers and sinks. -She asked residents if they wanted their hot water hot, lukewarm, or cooler. -If the hot water was not too hot for her, she adjusted it. Interview with an MA on 4/22/16 at 2:15pm. revealed: -No residents had complained to her about the water temperatures. -To her knowledge no residents had been burned or injured by hot water temperatures. -She sometimes adjusted the hot water temperature by adding cold water, when the water was uncomfortable for her.	D 113		
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 observation, record review and interviews the facility failed to assure physcian notification for 2 of 5 sampled residents (#1 and #2) for one resident with pain and decreased mobility resulting in a fall (Resident #2), and for	D 273		

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one resident with low and high blood sugars (Resident #1).

The findings are:

1. Review of Resident #2's current FL-2 dated 04/08/16 revealed:
-Diagnoses included left hip fracture, (status post) left hip arthroplasty, senile dementia and hypertension.
-Resident #2 was readmitted to the facility from a local hospital on 04/09/16.

Review of Resident #2's Resident Register revealed:
-An initial admission date of 02/19/15.
-Resident#2 had a Power of Attorney (POA).
-Resident#2 had a second contact person.

Review of Nurse's Notes in Resident #2's record revealed:
-An entry by the Supervisor dated 02/27/16 at 7:00 am read that Resident #2 had issues with turning un-aided and complained (of pain) when being re-positioned. Resident #2 asked that her left leg not be touched.
-An entry dated 02/28/16 by the Supervisor, without time given, read that Resident #2 complained of pain and discomfort in the left leg and hip. Resident had issues turning over even with assistance and asked that her left leg and hip not be touched.
-An entry by the Supervisor dated 02/28/16 on 7 am to 7 pm shift read that Resident #2 was still having pain in her left leg. The Supervisor called Resident #2's family member to inform the family member abour Resident #2's discomfort. The family member stated that Resident #2 would be taken to the doctor tomorrow, 02/29/16, by a family member. Resident #2 was given a prn

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medication.
-An entry by the Supervisor dated 02/28/16 at 6:45 pm read that Resident #2 fell out of bed. Visual inspection did not reveal any injury and the resident denied any pain. (The) Supervisor attempted unsucessfully to contact Resident #2's family member by telephone. The Supervisor left the family member a voice mail message.
-An entry by the Supervisor dated 02/29/16 on the 7am to 7 pm shift stated that Resident #2 slept very "restless" and had complaints and discomforts when re-positioned. The resident asked that her left leg and hip not be touched.
- An entry by the Supervisor dated 02/29/16 during the 7am to 7pm shift read that Resident #2 was still having left leg and hip pain but had been able to bear weight to ambulate and reposition. The resident had been given a prn medication.
-An entry by the Supervisor dated 02/29/16 at 2:35 am read that Resident #2 had awoken screaming the house is on fire, the house is burning down! The resident continue yelling for over an hour. The resident was placed in a recliner in the common area where she remained wide awake.
-An entry by the Memory Care Coordinator (MCC) dated 03/01/16 at 9 am read that Resident #2 was still complaining of pain and was very confused. Staff had attempted unsuccessfully to contact the Resident's family member.
-An entry by the MCC 03/01/16 at 1:30 pm read that Resident #2 was being sent to a local hospital for evaluation of left leg and hip pain. The resident was yelling that she was suffering. Family was notified and Emergency Services were called, the MD was aware of the situation.
-An entry on 03/01/16 at 4pm read that Resident #2's family member had telephoned to confirm that the Resident had a fractured left hip.

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D 273	Continued From page 10 Review of hospital records revealed: -Resident #2 was admitted to a local hospital on 03/01/16 with a diagnosed left hip fracture. -Resident #2 underwent surgery for a left partial hip replacement on 03/05/16. -Resident #2 was discharged from the hospital to a local rehabilitation center. A telephone interview on 04/21/16 at 7:48 pm with the Personal Care Aide (PCA) who worked 7am-7pm shift the weekend of 02/26/16-02/28/16 revealed: -The PCA was Supervisor on the 7 am to 7 pm shift -The staff was getting the residents ready for bed on 02/28/16 at 6:45 pm. -Resident #2 was resting in bed with the room door open. -The staff heard Resident #2's bed alarm sound and they found her on the floor. -Resident #2 appeared unharmed and refused to go to the hospital. -Resident #2 did complain of back pain. -The Supervisor called Resident #2's family member to report the incident. -The Supervisor asked the family member if Resident #2 should be sent to the hospital for evaluation; the the family member replied "no", that the family member would make an appointment the next day (Monday, February 29th) for Resident #2. -The facilty's fall policy was to assess the resident's vital signs, check for injuries, and ask the Resident if they would like to go to the hospital. -Staff was to call the Resident's responsible party and complete an accident report. A telephone interview on 04/21/16 at 7:30 pm with	D 273		

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the Personal Care Aide (PCA) who worked 7pm-7am shift the weekend of 02/26/16-02/28/16 revealed:
-The PCA was Supervisor on the 7 am to 7 pm shift.
-Resident #2 seemed to be in a lot more pain as compared to last weekend.
-The Supervisor assessed Resident #2 for signs of injury but did not see any bruising or swelling.
-Resident #2's family had told the 7am to 7pm Supervisor that it was probably arthritis that was causing Resident #2's pain and this was shared with the 7pm to 7am Supervisor.

Interview with the facility's WC on 04/22/16 at 3pm revealed:
-The WC and the Memory Care Coordinator (MCC) alternated weekends on call.
-The WC was on call 02/27/16 through 02/29/16.
-The WC did not receive any calls from the facility's staff during the weekend of 02/27/16-02/29/16.

Interview with the facility Administrator on 04/22/16 at 3:20 pm revealed:
-Resident #2's physcian reviewed and signed the accident report dated 02/28/16 while in the facility on 02/29/16.
-Plans had been made for the Quality Assurance (QA) team to review the facility's current policies.
-The Administrator has contacted the facility's Registered Nurse (RN) to assist with updating the existing fall policy.

Attempeted telephone interviews with Resident #2's family members was unsuccessful.
2. Review of Resident #1's current FL-2 dated 11/16/2015 revealed:
-Diagnoses included diabetes with neuro manifest type II, and thyrotox with goiter.

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D 273	Continued From page 12 -There was a physician's order for finger stick blood sugar (FSBS) checks every morning and at bedtime. -There was a physician's order for Lantus Insulin inject 15 units at bedtime (Lantus is used to lower blood sugars). -The physician's order for FSBS checks included documentation of "no sliding scale, no parameters". Review of the facility pharmacy policy for diabetic residents revealed: -Diabetic residents should have physician orders that indicate blood sugar parameters that required interventions for low or high blood sugar readings. -In the event there were no physician orders indicating parameters and treatment for hypoglycemia for a diabetic resident, guidelines the Medication Aides (MAs) should follow included if the blood sugar was 60 or below and/or the resident was symptomatic, the MA should repeat the FSBS. If the second blood sugar reading remained 60 or below the MA would immediately give the resident 4 ounces of orange juice or call 911 if the resident was unresponsive and unable to take anything by mouth. - In the event there were no physician orders indicating parameters and treatment for hyperglycemia for a diabetic resident, guidelines the Medication Aides (MAs) should follow included give any insulin if ordered for blood sugar above 300 and immediately contact the resident's physician for any additional orders. Review of the February 2016 FSBS log for Resident #1 revealed: -FSBS readings were documented for 6:30am and 8:00pm daily.	D 273		

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-There were 3 times at 6:30am when Resident #1's FSBS was documented as 60 or below, ranging from 42 to 48, and no documentation Resident #1 was given food or drink.
-There were 10 times when Resident #1's FSBS was documented as less than 60 at 6:30am, ranging from 42 to 54, and no documentation for Resident #1's FSBS being rechecked.
-There were 21 times when Resident #1's 8:00pm FSBS readings were recorded as 300 or above.
-The FSBS readings recorded as 300 or above for February 2016 ranged from 306 to 510.
-There was no documentation the physician was contacted for any additional orders.

Review of the February 2016 Medication Administration Records (MARs) revealed documentation of administration of Lantus Insulin 15 units at 9:00pm 02/01/2016 through 02/29/2016.

Review of the March 2016 FSBS log for Resident #1 revealed:
-FSBS readings were documented for 6:30am and 8:00pm daily.
-There were 5 times when Resident #1's 6:30am FSBS was documented as 60 or below, ranging from 47 to 60, and no documentation for Resident #1's FSBS being rechecked.
-There were 17 times when Resident #1's 8:00pm FSBS readings were recorded as 300 or above.
-The FSBS readings recorded as 300 or above for March 2016 ranged from 306 to 551.
-There was no documentation the physician was contacted for any additional orders.

Review of the March 2016 MAR revealed there was documentation of administration of Lantus Insulin 15 units at 9:00pm from 03/01/2016 through 03/30/2016, with the exception of

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03/24/2016 and 03/31/2016 when no insulin was documented as administered.

Review of the April 2016 FSBS log for Resident #1 revealed:
-FSBS readings were documented for 6:30am and 8:00pm daily.
-There were 3 times when Resident #1's 6:30am FSBS was documented as 60 or below, ranging from 49 to 50, and no documentation for Resident #1's FSBS being rechecked.
-There was one time when Resident #1's 6:30am FSBS reading was recorded as 310 and no documentation the physician was contacted for any additional orders.
-There were 12 times when Resident #1's 8:00pm FSBS readings were recorded as 300 or above.
-The FSBS readings recorded as 300 or above for April 2016 ranged from 306 to 465.
-There was no documentation the physician was contacted for any additional orders.

Review of the April 2016 MAR revealed documentation of administration of Lantus Insulin 15 units at 9:00pm from 04/01/2016 through 04/20/2016.

Review of documented nurses notes for Resident #1 revealed:
-On 02/10/2015 at 1:20am Resident #1's blood sugar was 23. Resident would not take juice, EMS was called and Resident #1 was sent to the hospital. No documentation of physician notification.
-On 02/11/2015, Resident #1's blood sugar was "low" (no blood sugar reading documented), and staff would continue to monitor.
-On 02/14/2015 at 1:30am Resident #1's blood sugar was 34, resident was given peanut butter and jelly with orange juice. Resident #1's blood

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D 273	Continued From page 15 sugar was 115 at 2:30am. -On 02/27/2016 at 11am, Resident #1 "had an episode of weakness" and "checked sugar and it was 46, gave resident orange juice and breakfast and resident is better now." There was no documentation the blood sugar was rechecked. -There were no additional care notes regarding Resident #1's high or low blood sugar readings. -There was no documentation the physician had been notified of any high or low blood sugar readings. Interview with a Medication Aide (MA) on 04/21/2016 at 10:45am revealed: -Resident #1's FSBS checks were performed by the night shift MA. -She had not had to call the physician about any blood sugar results obtained for Resident #1. -The MA who performed the FSBS would be responsible to contact the physician unless the MA left a message for the day shift to contact the physician. -If there was a problem with a high or low blood sugar for Resident #1, the physician would be called. -If Resident #1 had signs/symptoms of high or low blood sugar -"weak, sweating, not acting right"- the physician would be called. Interview with a night shift MA on 04/22/2016 at 8:25am revealed: -The MA checked Resident #1's FSBS around 9pm at night and in the morning around 5:45am. -Resident #1's blood sugar was sometimes down to 50 or 60 and the resident would be given orange juice and graham crackers to bring the blood sugar back up. -If the resident's blood sugar was "too low - in the 40's", the resident would be given sugar and monitored throughout the night.	D 273		

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D 273	Continued From page 16 -The MA kept an eye on Resident #1 because the resident's blood sugar would go down. -The MA had not called the physician for a high or low blood sugar for Resident #1. -The MA considered a high blood sugar to be over 200 and the MA "believed" the resident had some blood sugars over 200. -The MA just monitored Resident #1 when the blood sugar was high because the resident "appears to be herself". -The MA was aware the pharmacy policy for diabetic residents indicated to notify the physician for high blood sugars. -The MA did not think to call the physician when Resident #1's blood sugar was over 300. -The MA did not call anyone but did document the blood sugar result on the MAR. -The MA was told by the Wellness Coordinator (WC) to keep an eye on the resident. -The MA believed the WC had talked to a family member. -The MA had not called the physician about any blood sugar results for February 2016, March 2016, or April 2016 because the MA went by what Resident #1's family member told her. -The MA was unsure if the physician knew about Resident #1's high and low blood sugars. Interview with the WC on 04/20/2016 at 8:30am and on 04/21/2016 at 10:50am revealed: -If the night shift MA got a high or low blood sugar, the MA usually called her and she would tell the MA to monitor the resident and the WC would call the physician the next morning. -The WC had not documented when the physician was called. -The WC did not remember when she had called the physician. -The MA's were not leaving her information of a need to contact the physician.	D 273		

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D 273	Continued From page 17 -If the resident was "serious - weak, clammy, sweating - will tell them to call 911 and send to emergency room". -The WC considered a low blood sugar to be under 60. -If the resident's blood sugar did not come up after giving orange juice, the resident should be sent to the hospital emergency room and the physician contacted. -If the resident had a low blood sugar, the blood sugar should be rechecked and documented on the blood sugar flow sheet next to the original blood sugar. -She was not aware of any other place the blood sugar recheck would be documented. -The WC considered a high blood sugar to be anything over 150 and if the blood sugar was over 300, the resident should be sent to the ER and the physician called. -The WC looked at the blood sugar norm for the resident. -Resident #1's blood sugar was low in the morning and high in the evening. -If the MA had not documented a recheck blood sugar, then the blood sugar probably was not rechecked. -When Resident #1 went to a physician appointment, a copy of the blood sugar flow sheet was sent with the Resident. Interview with the Administrator on 04/21/2016 at 9:00am revealed: -Resident #1 had a Power of Attorney (POA). -Resident #1's POA always accompanied the resident to physician appointments. -Resident #1's POA did not want additional FSBS checks performed on Resident #1. -Resident #1's POA did not want parameters for FSBS's and did not want the resident to have a sliding scale.	D 273		

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-The facility took direction from the POA regarding any emergency visits.
-Resident #1's physician had not provided parameters for when he wanted to be contacted regarding the resident's FSBS readings.
-If the facility noticed a low or high blood sugar, the physician was called for instructions.
-Staff were to document in the resident's notes or on the blood sugar log when the physician was called.
-A copy of the residents' MARs and blood sugar log was sent to the physician when the resident went for a physician appointment.

Interview with the Administrator on 04/21/2016 at 11:30am revealed:
-Resident #1 visited the physician about every 6 months.
-Resident #1 was last seen at the physician's office on 03/15/2016.
-The physician had not seen any blood sugar results for Resident #1 since the resident's last physician office visit.

Telephone interview with the nurse from Resident #1's Primary Care Provider (PCP) office on 04/22/2016 at 11:45am revealed:
-There had not been any notification from the facility for Resident #1's high and low blood sugars except for a faxed copy of the blood sugar results for 03/01/2016 through 03/17/2016 which was received at the physician office on 03/17/2016.
-The Physician had reviewed the faxed copy of blood sugar results on 03/17/2016.
-Resident #1 was seen at the physician office on 03/15/2016.
-There was no record of calls from the facility to the physician.

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D 273	Continued From page 19 -There was nothing seen in the physician office record where the facility had contacted the physician about Resident #1's blood sugar results. -The physician told the nurse on 04/21/2016 that he wanted to be notified of blood sugar results for Resident #1 that were less than 90 or greater than 300. -The nurse did not know if the facility had been notified of the physician parameters for notification. Interview with Resident #1 on 04/20/2016 at 11:30am revealed: -The resident ate three meals a day. -The resident got a snack "occasionally" and the resident did not think she had a snack on 04/20/2016. -The resident did not know about her medications. _____ Review of a Plan of Protection submitted by the facility on 04/22/2016 and an addendum submitted on 04/23/2016 included the following: -The facility pharmacy policy for diabetic residents would be implemented. -The pharmacy policy would be sent to the physician and specific parameters would be requested. -A copy of the pharmacy policy would be placed in the medication administration records (MARs) notebook. -The facility would begin an in-service for staff on 04/21/2016, prior to bedtime blood sugar checks, on the pharmacy policy. -The Medication Aides will be responsible to notify physicians of blood sugars per policy. -Daily checks of the MARs for proper documentation will occur.	D 273		

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D 273	Continued From page 20 -The Supervisor will contact the physician immediately for instructions for any resident incident. The on-call staff will be notified by the Supervisor if after hours or weekends. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 22, 2016.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and a record review the facility failed to assure a medication (Klonopin) was administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#3) from 02/08/16-02/16/16. The findings are: Review of Resident #3's current FL2 dated on 11/16/15 revealed: -Diagnoses included atrial fibrillation, anemia, Parkinson's disease, dementia, gastroesophageal reflux disease, depression, constipation, enlarged prostate. -There was a physician's order for Klonopin 0.5mg one tablet every hour of sleep. (Klonopin is	D 358		

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a controlled substance medication used to help involuntary muscle contractions in Parkinson's disease).

Review of Resident #3's Resident Register revealed an admission date of 11/04/10.

Review of Resident #3's February 2016 Medication Administration Record (MAR) revealed.
-There was an entry for Klonopin 0.5mg one tablet at bedtime, scheduled to be administered at 2100 (9pm).
-The Medication Aides (MA) documented administration of Klonopin from 02/01/16 to 02/07/16 at 9:00pm.
- The MA's documented a code "#9" on the row for administration of Klonopin from 02/08/16 to 02/16/16.
-There was a computerized entry that was labeled as code 9 meant Other/See Nurses note.
- The MA documented on 02/08/16, 2/10/16, 2/12/16, 2/14/16, and 2/16/16 that Klonopin was not given with reason being waiting on prescription.
- The MA documented on 02/09/16 at 8:45pm Klonopin, reason was waiting on prescription in the nurses note section. The section in the nurse's note for reason was blank.
-There was no documentation for the #9 code used on 02/11/16, 02/13/16, or 02/15/16 in the nurses note section.

Interview with the Administrator on 04/21/16 at 4:00pm revealed:
-The facility had run into issues a lot with getting medications into the facility and often the reason was related to requirements for medication pre-authorizations.
-There had been some issues with medications

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not being available in the facility related to residents having to decide which medications they were going to pay for.
-The administrator suggested to speak the Medication Aide/Supervisor in Charge (MA/SIC).

Interview with a MA/SIC on 04/21/16 at 4:05pm revealed:
-There were times that controlled medications for residents were unavailable at the facility because of the wait time from the ordering physician to actually write the new prescription for the controlled medication.
-There was a known, ongoing issue of an extended wait time for the facility to actually obtain a hard script from Resident #3's primary provider.
-At times there were required authorizations from insurance companies that would delay the availability of the resident's medications.
- All medication refill requests were done with the pharmacy provider for the resident's medications every Tuesday by her and the Wellness Director.
- When a resident had "about a week's worth" of tablets on a medication card, the MA's were responsible for communicating this to the Wellness Director to reorder.

Interview with the Wellness Director on 04/21/16 at 5:05pm revealed:
-The Wellness Director was responsible for ordering all medications from the pharmacy for the residents.
-There had been some issues obtaining controlled medications on time in the facility due to a wait time of 2-3 days before it was available to be picked up from the resident's provider.
-There was an expectation for the MA's to inform her when the pills were down to the blue area to the left of the medication card which would

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indicate there would be 7 pills that remained.
-She "Didn't think" the MA's let her know in time to reorder Resident #3's Klonopin in February 2016.

Interview with Resident #3 on 04/21/16 at 5:50pm revealed:
-The medications he was prescribed had been administered to him as his physician had ordered them.
-There had only been one to two times since he had lived at the facility that his medications were not available at the facility.

Interview with Resident #3's pharmacy provider on 04/22/16 at 8:44 am revealed:
-There had been a known issue with Resident #3 having delayed prescription refills due to wait times from the primary provider in the past.
-There were attempts made a month ahead of time for needed refills to avoid lapse times in needed refills.
-There had been no issues within this past year with Resident #3's primary provider submitting a prescription refill for Klonopin.
-There were potential side effects or withdraw/symptoms that could occur when Klonopin was stopped abruptly and it would be best to be titrated off this medication.

Telephone interview with Resident #3's Primary Care Provider on 04/22/16 at 12:00pm revealed:
-There was a refill written for Klonopin on 01/27/16.
-The resident should not have been out of Klonopin in February 2016.
-There was no notification from the facility that the Resident was out of Klonopin from 02/08/16 thru 02/16/16 that she is aware of.

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D 358	Continued From page 24 -There were side effects associated with stopping Klonopin suddenly such as problems with anxiety, getting to sleep and potential for seizures however with the low dose of Klonopin the Resident takes, the risk was minimal. Record review of Resident #3's Nurse's notes from 02/06/16 thru 02/20/16 revealed: -There was no documented issues of anxiety or restlessness from 02/06/16 - 02/20/16. -There was documentation throughout this time period that resident had no issues. Interview with the Administrator on 04/22/16 at 12:30pm revealed: -The facility was responsible for ordering all of Resident #3's medications. -It was unknown why Resident #3 was out of Klonopin for 9 days in February 2016.	D 358		
D 410	10A NCAC 13F .1010(c) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure provision of pharmaceutical services to meet the needs of a resident related to procedures that assure the	D 410		

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accurate ordering, receiving, and administering of all prescribed medications to 1 of 5 residents (#3) sampled whose medications were not administered as ordered due to the medications being unavailable at the facility.

The findings are:

Review of Resident #3's current FL2 dated on 11/16/15 revealed:
-Diagnosis included atrial fibrillation, anemia, Parkinson's disease, dementia, gastroesophageal reflux disease, depression, constipation, enlarged prostate.
-There was a list of ordered medications that included Klonopin 0.5mg one tablet every hour of sleep (Klonopin is a controlled substance medication used to help involuntary muscle contractions in Parkinson's disease).

Review of Resident #3's Resident Register revealed an admission date of 11/04/10.

Review of Resident #3's record revealed a medication order summary report with a date of 02/12/16 that listed current medications which included an order for Klonopin 0.5mg at bedtime and was signed and dated on 02/17/16 by the provider to continue the orders for 180 days unless otherwise specified.

Review of Resident #3's February 2016 Medication Administration Record (MAR) revealed.
-There was a computer generated entry for Klonopin 0.5mg one tablet at bedtime.
-Klonopin was scheduled to be administered at 2100 (9pm).
-The Medication Aides (MA) entered initials for the administration of Klonopin from 02/01/16 thru

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D 410	Continued From page 26 02/07/16. - The MA's documented a code "#9" on the row for administration of Klonopin from 02/08/16 thru 02/16/16. -There was a computerized entry that was labeled as Chart Codes/Follow Up Codes that listed 9 as Other/See Nurses note. - The MA documented on 02/08/16 at 9:00pm Klonopin, site was by mouth, reason was waiting on prescription, and result was "not given" in the nurses note section. - The MA documented on 02/09/16 at 8:45pm Klonopin, site was by mouth, reason was waiting on prescription in the nurses note section. The section in the nurse's note for reason was blank. - The MA documented on 02/10/16 at 9:00pm Klonopin, site was by mouth, reason was waiting on prescription, and result was "not given" in the nurses note section. - The MA documented on 02/12/16 at 9:00pm Klonopin, site was by mouth, reason was waiting on prescription, and result was "not given" in the nurses note section. - The MA documented on 02/14/16 at 8:00pm Klonopin, site was by mouth, reason was waiting on prescription, and result was "not given" in the nurses note section. - The MA documented on 02/16/16 at 8:00pm Klonopin, site was by mouth, reason was waiting on prescription, and result was "not given" in the nurses note section. -There was no documentation for the #9 code used on 02/11/16, 02/13/16, or 02/15/16 in the nurses note section. Interview with the Administrator on 04/21/16 at 4:00pm revealed: -The facility had run into issues a lot with getting medications into the facility and often the reason was related to requirements for medication	D 410		

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	HAL067008	A. BUILDING: _____ B. WING _____	R 04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 410	Continued From page 27	D 410		

pre-authorizations.
-There had been some issues with medications not being available in the facility related to residents having to decide which medications they were going to pay for.
-The administrator suggested to speak the Medication Aide/Supervisor in Charge (MA/SIC).

Interview with a MA/SIC on 04/21/16 at 4:05pm revealed:
-There were times that controlled medications for residents were unavailable at the facility because of the wait time from the ordering physician to actually write the new prescription for the controlled medication.
-There was a known, ongoing issue of an extended wait time for the facility to actually obtain a hard script from Resident #3's primary provider.
-At times there were required authorizations from insurance companies that would delay the availability of the resident's medications.
- All medication refill requests were done with the pharmacy provider for the resident's medications every Tuesday by her and the Wellness Director.
- When a resident had "about a week's worth" of tablets on a medication card, the MA's were responsible for communicating this to the Wellness Director to reorder.

Interview with the Wellness Director on 04/21/16 at 5:05pm revealed:
-The Wellness Director was responsible for ordering all medications from the pharmacy for the residents.
-There had been some issues obtaining controlled medications on time in the facility due to a wait time of 2-3 days before it was available to be picked up from the resident's provider.
-There was an expectation for the MA's to inform

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D 410	Continued From page 28	D 410		

her when the pills were down to the blue area to the left of the medication card which would indicate there would be 7 pills that remained.
-She "Didn't think" the MA's let her know in time to reorder Resident #3's Klonopin in February 2016.

Interview with Resident #3 on 04/21/16 at 5:50pm revealed:
-The medications he was prescribed had been administered to him as his physician had ordered them.
-There had only been one to two times since he had lived at the facility that his medications were not available at the facility.

Interview with Resident #3's pharmacy provider on 04/22/16 at 8:44 am revealed:
-There had been a known issue with Resident #3 having delayed prescription refills due to wait times from the primary provider in the past.
-There were attempts made a month ahead of time for needed refills to avoid lapse times in needed refills.
-There had been no issues within this past year with Resident #3's primary provider submitting a prescription refill for Klonopin.
-The facility provided a list of medications that needed refills and no medications were automatically sent to the facility.

Interview with another MA on 04/22/16 at 11:05am revealed:
-The SIC and the Wellness Director had a system in place to reorder the resident's medications.
-Residents' medications should be reordered when there was "about a week's worth" left.
-The needed refills were placed on a medication order sheet then faxed to the pharmacy, pharmacy filled the medication and delivered the

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D 410	Continued From page 29 medications to the facility. Telephone interview with Resident #3's Primary Provider on 04/22/16 at 12:00pm revealed: -There was a refill written for Klonopin on 01/27/16. -The resident should not have been out of Klonopin in February 2016. -There was no notification from the facility that the Resident was out of Klonopin from 02/08/16 thru 02/16/16 that she was aware of. Interview with the Administrator on 04/22/16 at 12:30pm revealed: -The facility was responsible for ordering all of Resident #3's medications. -It was unknown why Resident #3 was out of Klonopin for 9 days in February 2016. -A hard script was needed for controlled substances and staff should be ordering early because a hard script would be needed.	D 410		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations	D912		

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D912	Continued From page 30 related to referral and follow up. The findings are: Based on observation, record review and interviews the facility failed to assure physcian notification for 2 of 5 sampled residents (#1 and #2) for one resident with pain and decreased mobility resulting in a fall (Resident #2), and for one resident with low and high blood sugars (Resident #1). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D912		