Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 and the Chatham County Department of Social Services conducted an annual and follow-up survey and complaint investigation on April 12-14, 2016. The complaint investigation was initiated by the Chatham County Department of Social Services on April 8, 2016.	D 000	Responses to the cited deficiences do not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action report. The Plan of Correction is solely p prepared as a matter of compliance with State Law.	
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interview, the facility failed to have walls clean and in good repair in the Activity Room, the residents' rooms on the 400 hall of the Memory Care Unit and the residents' rooms and bathrooms on the 100 hall, 200 hall, and 300 hall of the Assisted Living side of the facility. The findings are: 1. Observations of the Memory Care Unit during the facility tour on 4/12/16 from 9:50am-11:00am revealed: -There were black scuff marks along the wall behind the door and by the bathroom door of Rooms 402, 405, 413, 416, and 421. -There was an approximate 5" by 2" hole in the closet door with pieces of wood splintered around the hole in Room 405. -There were areas, on the longest wall, where paint had peeled in Room 413. -The chair railing along the back wall, from the	D 074	The black scuff marks along wall behind door and bathroom door near rooms 402, 405, 413, 416 and 421. Holes in closet doors will be repaired, all peeling paint will be repaired near room 413. Missing chair rail will be replaced and wall joint sheetrock and exposed metal in Activity Room will be repaired.	5/27/2016

Division of Health Service Regulation
LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — DATE
Executive Director 5/17/16
STATE FORM — CMS11 — If continuation sheet 1 of 26

Revisions Accepted - BK 5/23/16

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D 074	Continued From page 1 window to the corner of the room, was missing in the Activity Room. -There was an area in the hallway going into the Activity Room that was approximately 2" by 2" at the wall joint where the sheetrock was missing and metal was exposed; there were also areas of black scuff marks and several small spots where paint was peeling. Refer to interview with Housekeeping/Maintenance Director on 04/14/16 at 3:50 p.m. Refer to interview with the Regional Director of Operations on 04/14/16 at 6:00 p.m. 2. Observations of the Back (100) Hallway during the facility tour on 4/12/16 from 9:50am-11:00am revealed: -There were areas of black scuff marks along the entrance walls near the bathrooms doors and closet doors of resident rooms 101, 103, 107, 109, and 111. -Rooms 101 and 103 had black scuff marks on the wall near the bed, along the wall near the bathroom and near the closet. -Room 107 had black scuff marks along the wall to the left by the resident's entrance door. -Room 109 had black scuff marks along the wall at the room entrance. -Room 111 had black scuff marks along the left entrance wall that went from the baseboard upward approximately 2 feet high, and extended the width of the wall. Refer to interview with Housekeeping/Maintenance Director on 04/14/16 at 3:50 p.m. Refer to interview with the Regional Director of	D 074	The black scuff marks on entrance walls, near bathroom doors, on room walls, and closet doors near rooms 101, 103, 107, 109, and 111on Back Hallway (100) will be cleaned.	5/27/2016

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D 074	Continued From page 2 Operations on 04/14/16 at 6:00 p.m. 3. Observation of the 200 hall of the assisted living side of the facility revealed walls were not clean or in good repair in the bathrooms and residents rooms 201, 202, 204, and 206. A. Observation of resident Room 202 and bathroom on the assisted living side of the facility on 04/12/16 at 9:58 a.m. revealed: -The wall on the right side of the sink in the bathroom had an area of chipped and peeling paint about 3 feet long at the bottom of the wall just above the baseboard. -The back wall of the bathroom, opposite of the sink and toilet, had chipped and peeling paint with black scuff marks along the width of the wall just above the baseboard. -The wall in the bedroom had an area of chipped and peeling paint with black scuff marks along the width of the wall approximately 3 feet long and continued around the corner of the wall to the closet door. -The wall near the closet had an area of chipped and peeling paint that spanned from the floor and extended up about 3 to 4 feet along the edge where the walls met. -The edge of the wall had areas where the walls met that were were cracked and separated from each other, leaving an open space about one-fourth of an inch. Interview with a resident in Room 202 on 04/12/16 at 10:00 a.m. revealed: -She had lived at the facility about a year. -The walls had been that way since she moved in. B. Observation of resident Room 201 and bathroom on the assisted living side of the facility on 04/12/16 at 10:10 a.m. revealed:	D 074	All chipped, peeling paint, black scuff marks, holes in walls and closet doors, exposed metal and cracked edges on 200 Hall near rooms 201, 202, 204, and 206 and bathroom walls will be cleaned/repaired.	5/27/2016

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D 074	Continued From page 3 -The wall above the paper towel dispenser in the bathroom had 3 holes that appeared to be nail holes from a previously installed dispenser. -There was chipped and peeling paint on the wall below the mirror and above the sink in the bathroom. -The back wall of the bathroom opposite the sink and toilet had black scuff marks along the width of the wall just above the baseboard. -The wall in the bedroom had an area of chipped and peeling paint with black scuff marks along the width of the wall approximately 3 feet long and continued around the corner of the wall to the closet door. Interview with a resident in Room 201 on 04/12/16 at 10:10 a.m. revealed: -She had lived at the facility about 3 years. -The walls had been that way for a while but she could not recall how long. C. Observation of resident Room 204 on the assisted living side of the facility on 04/12/16 at 10:20 a.m. revealed: -The wall in the bedroom had an area of chipped and peeling paint with black scuff marks along the width of the wall approximately 3 feet long and continued around the corner of the wall to the closet door. -The edge of the wall near the closet had an area of chipped and peeling paint that spanned from the floor and extended up about 5 feet high on the edge where the walls met. -The edge of the wall had areas where the walls met that were cracked and separated from each other leaving an open space about one-fourth of an inch. -There was a hole in the closet door that was about 1 inch by 3 inches.	D 074		

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D 074	Continued From page 4 Interview with a resident in Room 204 on 04/12/16 at 10:20 a.m. revealed: -She had lived at the facility about 2 years. -The walls had been that way since she came to the facility. -The hole in the closet door was already there when she came to the facility. D. Observation of resident Room 206 and bathroom on the assisted living side of the facility on 04/12/16 at 10:35 a.m. revealed: -The bottom third of the walls in the bathroom beside and behind the toilet had peeling paint. -The paint was peeling from the wall on the right side of the soap dispenser. -The wall in the bedroom had an area of chipped and peeling paint with black scuff marks along the width of the wall approximately 3 feet long and continued around the corner of the wall to the closet door. -The wall near the closet had an area of chipped and peeling paint that spanned from the floor and extended up about 4 to 5 feet on the edge where the walls met. -The edge of the wall had areas where the walls met that were cracked and separated from each other leaving an open space about one-fourth of an inch. Interview with a resident in Room 206 on 04/12/16 at 10:35 a.m. revealed: -He had lived at the facility for a few months. -The walls had been that way since he moved in. Refer to interview with Housekeeping/Maintenance Director on 04/14/16 at 3:50 p.m. Refer to interview with the Regional Director of Operations on 04/14/16 at 6:00 p.m.	D 074		

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D 074	Continued From page 5 4. Observation of resident Room 305 on the assisted living side of the facility on 04/12/16 revealed: -The wall in the bedroom on the right had two areas of chipped and peeling paint about 3 to 4 feet above the baseboard. -Metal in the walls was exposed at the chipped areas of paint. -The wall in the bedroom on the left side of the room had chipped and peeling paint with black scuff marks along the width of the wall approximately 3 feet long and continued around the corner of the wall to the closet door. -The edge of the wall near the closet had an area of chipped and peeling paint that left an open area exposing metal in the wall about 2 inches by 12 inches. -There was a darker color of paint on top of a lighter color paint on the wall but the darker color of paint did not cover the top and side edges of the wall leaving roll brush marks that stopped up to 4 to 5 inches from the covering the edges of the walls. Interview with the residents in Room 305 on 04/12/16 at 4:15 p.m. revealed the walls had always been that way. Refer to interview with Housekeeping/Maintenance Director on 04/14/16 at 3:50 p.m. Refer to interview with the Regional Director of Operations on 04/14/16 at 6:00 p.m. --- Interview with Housekeeping/Maintenance Director on 04/14/16 at 3:50 p.m. revealed: -He had worked at the facility since December	D 074		

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D 074	Continued From page 6 2015. -He had been busy working on things at the facility but he had not been able to get to everything that needed doing yet. -He had painted Room 305 recently but it was "a rush job" so a resident could move in. -He had painted a couple of other rooms in the SCU since he had started working at the facility. -He had to use two different paints on some of the rooms he painted because he would run out of paint and he could not find any that would match. Interview with the Regional Director of Operations on 4/14/16 at 6:00 p.m. revealed a contractor was scheduled to come to the facility on 4/19/16 to begin painting and repairing the walls.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure that residents' bedrooms, residents' bathrooms, the hallway, and inside the dining room of the Memory Care Unit as well as residents' bathrooms on the 200 hall of the Assisted Living side of the facility did not smell like urine and mildew. The findings are: * Observations of the Memory Care Unit during	D 075	Memory care unit, resident's bedrooms, resident bathrooms, the hallway and inside the dining room of Memory Care as well as 200 hall will be cleaned and urine and mildew smells will be cleaned/ removed.	5/27/2016

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D 075	Continued From page 7 the facility tour on 4/12/16 from 9:15am-11:00am revealed: -Upon entering the Memory Care Unit, there was a strong smell of urine from the entrance, past the dining room, and down the hallway toward resident bedrooms. -There was a strong urine odor in the bathroom and bedroom on Rooms 406 and 419. -There was a mildew, musky odor in Room 412. -From Room 406 down to the entrance, there was a mildew, musky odor. -The dining room smelled of old, stale food. Observation of the Memory Care Unit on 4/13/16 at 8:45am revealed: -There were two housekeeping staff sweeping and mopping the floors in resident bedrooms and in the hallway. -The hallway smelled of air freshener. Interview with a housekeeping staff on 4/13/16 at 8:55am revealed: -The housekeeping staff cleaned the floors and bathrooms daily. -They would also mop floors if there was an accident or spill. -She had not noticed an odor in the hallway or any resident rooms. Observation of the Memory Care Unit (MCU) on 04/13/16 at 11:45 a.m. revealed: -There was a strong urine odor and musky odor in the hallway when entering the MCU. -The odor started from the entrance and continued past the dining room down the hallway to room 404. -The odor was not quite as strong as the previous day on 04/12/16. Observation of the Memory Care Unit on 4/14/16	D 075		

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D 075	Continued From page 8 at 10:00 a.m. revealed: -The urine odor remained in Rooms 406 and 419, but the odor was not as strong as initially observed. -The hallway from the entrance to Room 406 continued to have a mildew odor. Observation of the Memory Care Unit (MCU) on 04/14/16 at 12:26 p.m. revealed: -There was a urine odor and musky odor in the hallway when entering the MCU. -The odor started from the entrance and continued past the dining room down the hallway to room 406. -The odor was not as strong as the previous day on 04/13/16. Refer to interview with the Housekeeping/Maintenance Director on 04/14/16 at 3:50 p.m. 2. Observation of the resident bathroom in Room 202 on the assisted living side of the facility on 04/12/16 at 9:58 a.m. revealed: - There was a strong urine odor in the bathroom. - There was a urine hat in the trashcan. - There did not appear to be any urine residue in the urine hat. - There was no urine in the toilet. Interview with a resident in Room 202 on 04/12/16 at 10:00 a.m. revealed: -There had always been a urine odor in the bathroom. -The resident had told housekeeping staff a few times and they always clean the bathroom but it does not help the urine odor. Re-check of resident bathroom in Room 202 on 04/14/16 at 5:15 p.m. revealed there was no	D 075	Housekeeping will continue to throughly clean bathrooms, and rooms 202, and 206, to remove urine odors.	5/27/2016

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D 075	Continued From page 9 current odor of urine. Observation of resident Room 206 on the assisted living side of the facility on 04/12/16 at 10:35 a.m. revealed: -There was a strong urine odor in the bathroom. -There was no urine in the toilet. Interview with a resident in Room 206 on 04/12/16 at 10:35 a.m. revealed: -He had lived at the facility for a few months. -There was always some odors in the bathroom. -The bathroom is cleaned daily but it did not usually help the odors. Recheck of resident bathroom in Room 206 on 04/12/16 at 2:55 p.m. revealed there was a strong urine odor in the bathroom. Recheck of resident bathroom in Room 202 on 04/14/16 at 5:15 p.m. revealed there was a strong urine odor in the bathroom. Refer to interview with the Housekeeping/Maintenance Director on 04/14/16 at 3:50 p.m. --- Interview with the Housekeeping/Maintenance Director on 04/14/16 at 3:50 p.m. revealed: -He had worked at the facility since December 2015. -He had been busy working on things at the facility but he had not been able to get to everything that needed doing yet. -Housekeeping staff cleaned the facility bathrooms everyday including mopping and cleaning the floors. -Sometimes they need to put "more elbow grease" in cleaning.	D 075		

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D 075	Continued From page 10 -The floors need stripping and the facility was working on a plan to get the floors stripped. -Housekeeping staff clean the bathrooms daily but the odors in the SCU and some of the bathrooms would come back even after cleaning.	D 075		
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: Based on observation, record review, and interview, the facility failed to contact the physician to clarify an unclear order for weights and notify the physician of weight gain for 1 of 5 residents (#5) sampled who had congestive heart failure and bilateral leg wraps for swelling in her lower extremities. The findings are: Review of Resident #5's current FL-2 dated 02/04/16 revealed the resident's diagnoses included congestive heart failure, edema in lower extremities, chronic kidney disease, atrial fibrillation, and difficulty walking. Review of the Resident Register revealed Resident #5 was admitted to the facility on 07/15/14. Review of Resident #5's assessment and care plan dated 11/20/15 revealed: -The resident was oriented and her memory was adequate -The resident was ambulatory with wheelchair	D 273	Medication Aides (MA) will obtain resident weights as ordered by the physician. MAs will notifiy Resident Care Manager (RCM) and/or Special Care Unit Manager (SCM) regarding any changes in weights as stated by physician orders. RCM/SCM will notifiy physician of changes in resident's weight. 5/27/2016 RCM/SCM will monitor weights weekly and communicate with Executive Director (ED) regarding acute changes. ED will monitor ongoing compliance. 5/27/2016 All MAs, RCM, SCM and ED were oriented to the "New Physician Order Tracking Process" (bucket list) as of 4-14-16. Nurse Consultants will continue to provide ongoing educational training and monitoring during site visits. 5/27/2016	

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D 273	Continued From page 11 -The resident required extensive assistance with dressing and bathing and limited assistance with grooming. Observation of Resident #5 on 04/12/16 at 10:20 a.m. revealed: -Resident #5 was sitting in a wheelchair. -The resident had bilateral leg wraps on both lower extremities. -Both legs and ankles were swollen. Interview with Resident #5 on 04/12/16 at 10:20 a.m. revealed: -She had congestive heart failure and sometimes had trouble breathing. -A home health nurse wrapped her legs about twice a week. -Both of her legs were swollen and had blisters on them. -The blisters have healed but her legs were still swollen. Review of a physician's order dated 12/22/15 revealed an order for weekly weights, check and record weight daily and contact the physician's office if weight gain more than 3 pounds in 24 hours or more than 5 pounds in 72 hours. Review of Resident #5's record revealed no documentation the order for weights was clarified. Review of the February 2016 medication administration record (MAR) revealed: -There was an entry for weekly weights with check and record weights daily and contact the physician's office if weight gain > 3 pounds in 24 hours or weight gain > 5 pounds in 72 hours. -Weights were marked to be checked and recorded 3 times a week on Mondays, Wednesdays, and Fridays.	D 273		

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D 273	Continued From page 12 -02/01/16: 207 pounds. -02/03/16: 198 pounds. -02/05/16: no weight recorded. -02/08/16: 207 pounds. -02/10/16: 189 pounds. -02/12/16: 189 pounds. -02/15/16: 190 pounds. -02/17/15: refused. -02/19/16: 198 pounds. -02/22/16: 198 pounds. -02/24/16 and 02/26/16: refused. -02/29/16: 198 pounds. -There was no documentation the physician was contacted for any weight gain. Review of the March 2016 MAR revealed: -There was an entry for weekly weights with check and record weights daily and contact the physician's office if weight gain > 3 pounds in 24 hours or weight gain > 5 pounds in 72 hours. -Weights were marked to be checked and recorded 3 times a week on Mondays, Wednesdays, and Fridays. -03/02/16: 198 pounds. -03/04/16: 197 pounds. -03/07/16: 199 pounds. -03/09/16: 198 pounds. -03/11/16: refused. -03/14/16: 198 pounds. -03/16/16: refused. -03/18/16: 218 pounds. -03/21/16: 219 pounds. -03/23/16: 220 pounds. -03/25/16: 03/28/24/16: refused. -03/30/16: no weight recorded due to weight machine not working. -There was no documentation the physician was contacted for any weight gain. Review of the April 2016 MAR revealed:	D 273		

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	HAL092203	A. BUILDING: _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 273	Continued From page 13 -There was an entry for weekly weights with check and record weights daily and contact the physician's office if weight gain > 3 pounds in 24 hours or weight gain > 5 pounds in 72 hours. -Weights were marked to be checked and recorded 3 times a week on Mondays, Wednesdays, and Fridays. -04/01/16: no weight recorded due to the weight machine not working. -04/04/16: 219.2 pounds. -04/06/16: 219.2 pounds. -04/08/16: 219 pounds. -04/11/16: 98 pounds. (This weight was not recorded accurately.) -There was no documentation the resident was reweighed on 04/11/16 for the recorded weight of 98 pounds. Interview with a medication aide on 04/13/16 at 1:05 p.m. revealed: -They checked the resident's weight when it popped up on the electronic MAR. -It usually popped up on the MAR about 3 times a week. -She did not know if the physician had been contacted about any weight gain. -The scale was broken for about a week or less but it was fixed now and has been working. -Resident #5 had swelling in her legs and her legs were being wrapped by the home health nurse. Interview with the Resident Care Manager (RCM) on 04/13/16 at 5:30 p.m. revealed: - She had not noticed the discrepancy with Resident #5's weight order. - If the physician was contacted, it should be documented in the resident's record or on the MARs. Review of a clarification order dated 04/14/16 for	D 273		

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D 273	Continued From page 14 Resident #5 revealed an order to check weight once a week and notify the physician if greater than 3 pounds weight gain. Attempt to contact the physician for interview during the survey was unsuccessful.	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 observation, interview, and record review, the facility failed to assure medications were administered as ordered for 3 of 12 residents (#8, #9, #10) observed during the medication passes, including errors with an oral antidiabetic (#8), insulin (#9) and an analgesic (#10); and 2 of 5 residents (#4, #5) sampled for record review including errors with medications for prevention of heart disease, for breathing problems for acid reflux, for gastroparesis, and for depression (#4) and errors with an antibiotic (#5). The findings are: 1. The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 8:00 a.m./9:00 a.m. medication pass on 04/13/16 and the 11:30 a.m. medication pass on 04/13/16	D 358	RCM and SCM are responsible for reviewing all medication orders on Quick Mar (electronic medication system) prior to approval. RCM and SCM are to notify resident's physician regarding any issues or concerns related to medication administration. RCM and SCM will retrain all MAs regarding medication orders as it relates to time frames of medication administration by 5-23-16. The facility LHPS Nurse will educate all MAs on medication administration by 5/27/2016. RCM and SCM to conduct medication pass observations weekly; intiated 5-12-16 and ongoing. ED to monitor compliance ongoing. All MAs, RCM, SCM and ED were oriented to the "New Order Tracking Process" on 4-14-16.	5/27/2016 5/27/2016

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D 358	Continued From page 15 A. Review of Resident #8's current FL-2 dated 04/11/16 revealed: - Resident #8's diagnoses included Alzheimer's dementia, esophageal reflux disease, hypothyroidism, psychosis, and acute kidney failure. - Medication orders included Metformin 500mg, take one tablet twice a day before meals. Review of the April 2016 medication administration record (MAR) revealed Metformin was scheduled to be administered 2 times a day at 7:30 a.m. and 3:30 p.m. Observation during the 8:00 a.m./9:00 am. medication pass on 04/13/16 revealed: - The medication aide (MA) administered the Metformin with sips of water at 9:06 a.m. - The resident was lying in her bed when the MA administered the medications. Interview with the MA on 04/13/16 at 9:15 a.m. revealed: - The resident would not take the Metformin by itself if the MA gave the medication before Resident #8 ate breakfast. - The MA did not know if the physician was aware that the resident would not take the medication before meals. - Resident #8 ate breakfast around 7:00 a.m. this morning, 04/13/16. Interview with the Memory Care Manager (MCM) on 04/13/16 at 10:40 a.m. revealed: - Resident #8 was noncompliant about her medications. - Resident #8's family was aware that she would not take her medication before meals, because Resident #8 would not just take one pill at a time	D 358		

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D 358	Continued From page 16 unless that was all she was scheduled to receive for a while. - The MCM would contact the physician to clarify the order because staff should have let the physician know that Resident #8 was being noncompliant. Interview with Resident #8 on 04/13/16 at 11:40 a.m. revealed that Resident #8 wanted to take all of her medications at one time instead of getting one pill here and there. Review of a physician's order dated 04/14/16 revealed to change the Metformin 500mg to twice daily, discontinue before meals. B. Review of Resident #9's current FL-2 dated 10/20/15 revealed: - Resident #9's diagnoses included dementia, congestive heart failure, hypertension, ischemic cardiomyopathy, parkinson's disease, osteoporosis, coronary artery disease, atrial fibrillation, constipation, hypothyroidism, and history of cerebrovascular accident. - Medication orders included Novolog mix flex pen, inject 13 units three times daily before meals. Review of a physician's order dated 12/29/15 revealed: - There was an order for Accuchecks before meals at 7:00 a.m., 11:30 a.m., and 4:30 p.m. - There was an order for Novolog mix flex pen, inject 13 units three times a day with each meal. Review of the April 2016 MAR revealed: - Accuchecks were scheduled to be obtained at 7:00 a.m., 11:30 a.m. and 4:30 p.m. - Novolog mix flex pen 13 units three times daily was scheduled to be administered at 7:30 a.m.,	D 358		

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D 358	Continued From page 17 11:30 a.m., and 4:30 p.m. Observation during the 11:30 a.m. medication pass on 04/13/16 revealed: - The MA obtained Resident #8's blood sugar at 11:43 a.m. - The blood sugar result was 166 mg/dl. - The MA administered 13 units of Novolog mix subcutaneously at 11:52 a.m. Observation during the lunch meal revealed Resident #8 was served his lunch meal and began eating at 12:33 p.m. Interview with the MA on 04/13/16 at 2:30 p.m. revealed: - Insulin should be given before meals if the order said before meals. - Insulin should be given with meals if that was the order which meant the resident should receive insulin when the meal was served. - The MA would get the order clarified from the physician who was coming to the facility on 04/14/16. Interview with the Assisted Living Care Manager on 04/14/16 at 11:50 a.m. revealed: - She was new and did not know a lot about orders. - The MAs should follow the orders for insulin; if the order said to give the insulin with meals, the MA should give the insulin when the resident was eating. - The MAs did have the one hour before and after to give medications but the MAs needed to watch their times with insulin. Interview with the facility's pharmacy staff on 04/14/16 at 3:45 p.m. revealed: - If insulin was ordered to be administered with	D 358		

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D 358	Continued From page 18 meals, the scheduled times should be 8:00 a.m., 12:00 p.m., and 5:00 p.m. - If the residents ate at different times, the MAs could adjust the times on the MAR to reflect the times meals are served so the residents received insulin as ordered. C. Review of Resident #10's current FL-2 dated 04/02/16 revealed: - The resident's diagnoses included congestive heart failure, osteoarthritis, chronic kidney disease, and pulmonary hypertension. - There was a medication order for Tylenol 500mg daily after lunch. Review of the April 2016 MAR revealed Tylenol 500mg was scheduled to be administered daily at 12:00 p.m. Observation during the 11:30 a.m. medication pass on 04/13/16 revealed: - The MA retrieved the medications for Resident #10 and took the medications to the resident in the dining room at 12:00 p.m. - Resident #8 was seated in a chair in the dining room and took the medications with sips of water. Observation during the lunch meal revealed Resident #10 was served her lunch meal and began eating at 12:30 p.m. Interview with the MA on 04/13/16 at 1:55 p.m. revealed - Resident #10 usually ate lunch at 12:30 p.m. everyday. - She usually gave Resident #10 her medications when Resident #10 came in the dining room. - The MA gave the medication at noon each day because the MAR scheduled other medications at	D 358		

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D 358	Continued From page 19 the same time, 12:00 p.m. 2. Review of Resident #4's current FL-2 dated 03/02/16 revealed: -The resident's diagnoses included Type I diabetes mellitus, depression, chronic pain syndrome, gastroparesis, chronic abdominal pain, and chronic kidney disease - stage 3. -There was an order for Aspirin 81mg once daily. (Aspirin is used to prevent heart disease.) -There was an order for Celexa 20mg once daily. (Celexa is an anti-depressant.) -There was an order for Advair HFA 45/21 inhaler, inhale 2 puffs twice a day. (Advair is for breathing problems / lung disease.) -There was an order for Protonix 40mg once daily. (Protonix is for acid reflux.) Review of a physician's orders for Resident #4 revealed: -There was an order dated 03/08/16 for Amitriptyline 10mg at bedtime. (Amitriptyline is an anti-depressant.) -There was an order dated 03/08/16 for Reglan 5mg twice daily. (Reglan is for gastroparesis.) -There was an order dated 03/29/16 for Protonix 40mg at bedtime in addition to the morning dose. Review of the Resident Register revealed Resident #4 was admitted to the facility on 03/04/16. Review of Resident #4's record revealed there was no documentation of any medications brought into the facility by the resident when he was admitted. Review of pharmacy dispensing records dated 01/01/16 - 04/14/16 revealed: -Eighteen Aspirin 81mg tablets were dispensed	D 358		

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D 358	Continued From page 20 on 03/14/16 and none were dispensed prior to that date. -Eighteen Celexa 20mg tablets were dispensed on 03/14/16 and none were dispensed prior to that date. -One Advair HFA inhaler was dispensed on 03/12/16 and none were dispensed prior to that date. -Thirty Protonix 40mg tablets were dispensed on 03/04/16 and 60 tablets were dispensed on 03/30/16. -Twenty-three Amitriptyline 10mg tablets were dispensed on 03/09/16. Review of the March 2016 medication administration record (MAR) revealed: -Aspirin 81mg was scheduled to be administered daily at 8:00 a.m. -Aspirin was not documented as administered on 03/13/16 and 03/14/16 due to "med not in facility". -Celexa 20mg was scheduled to be administered daily at 8:00 a.m. -Celexa was not documented as administered on 03/13/16 and 03/14/16 due to "med not in facility". -Advair HFA inhaler was scheduled to be administered daily at 8:00 a.m. and 8:00 p.m. -Advair HFA was not documented as administered from 03/09/16 - 03/12/16 due to "med not in facility". -Protonix 40mg was scheduled to be administered daily at 7:00 a.m. from 03/01/16 - 03/29/16. -Protonix was scheduled to be administered at 7:00 a.m. and 7:00 p.m. from 03/30/16 - 03/31/16 -Protonix was not documented as administered on 03/28/16 and from 03/30/16 - 03/31/16 due to "med not in facility". -The order to start Protonix at bedtime in addition to the morning dose was not included onto the	D 358		

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D 358	Continued From page 21 MAR. -Reglan 5mg was scheduled to be administered daily at 8:00 a.m. and 8:00 p.m. -Reglan was not documented as administered from 03/09/16 - 03/10/16 and 03/13/16 - 03/14/16 due to "med not in facility". -Amitriptyline 10mg was scheduled to be administered daily at 8:00 p.m. -Amitriptyline was not documented as administered from 03/09/16 - 03/10/16 and 03/13/16 - 03/14/16 due to "med not in facility" even though it was documented as administered on 03/11/16 and 03/12/16. Interview with a medication aide on 04/14/16 at 4:35 p.m. revealed: -She was not sure if Resident #4 had any medications with him when he was admitted to the facility. -She did not know why some of his medications ran out in March 2016. -The pharmacy usually sent cycle fills for scheduled medications. -If a medication was not available, the medication aide on duty was supposed to call the pharmacy. Interview with a Care Manager on 04/14/16 at 5:27 p.m. revealed: -She did not recall if Resident #4 had any medications upon admission. -If medications are brought in upon admission, it should be documented in the resident's record. -Medication aides should contact the pharmacy if medications were unavailable. Interview with Resident #4 on 04/14/16 at 4:05 p.m. revealed: -He was admitted to the facility in March 2016. -He had some medications with him when he was admitted.	D 358		

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D 358	Continued From page 22 -He did not recall missing any doses of medications. 3. Review of Resident #5's current FL-2 dated 02/04/16 revealed the resident's diagnoses included congestive heart failure, edema in lower extremities, chronic kidney disease, atrial fibrillation, and difficulty walking. Review of a physician's order dated 03/12/16 revealed: -There was an order dated 03/12/16 for Cipro 500mg twice daily for 5 days for urinary tract infection. (Cipro is an antibiotic.) -The fax stamp date at the top of the page was 03/12/16 at 12:30 p.m. -There was a handwritten note by facility staff that the order was faxed to the pharmacy on 03/14/16 at 2:40 p.m. Review of pharmacy dispensing records dated 01/01/16 - 04/14/16 revealed 10 Cipro 500mg tablets were dispensed on 03/14/16. Review of the March 2016 medication administration record (MAR) revealed: -There was an entry for Cipro 500mg 1 tablet twice daily for 5 days for urinary tract infection. -Cipro was scheduled to be administered at 8:00 a.m. and 8:00 p.m. -The administration of Cipro was not started until 03/15/16, 3 days after it was ordered on 03/12/16. -No reason for the delay in starting the Cipro was documented. Interview with a medication aide on 04/13/16 at 1:35 p.m. revealed: -She was unsure why there was a delay in starting the Cipro in March 2016. -They have a backup pharmacy that can be used	D 358		

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D 358	Continued From page 23 if it is after hours for the primary or for the weekends. Attempt to contact the physician for interview during the survey was unsuccessful. Interview with the Resident Care Manager on 04/13/16 at 5:30 p.m. revealed: -The physician group contracted by the facility occasionally made resident visits on Saturdays or would fax orders on Saturdays. -They have a backup pharmacy that was supposed to be used after hours or on weekends. -The medication aide on duty was supposed to fax new orders to the pharmacy as soon as the order was received. -They usually received the medication the same day the order was faxed. -She did not know why the Cipro was started late but she would check on it. Interview with the Senior Executive Director on 04/13/16 at 6:01 p.m. revealed: -Even though 03/12/16 was on a Saturday, the facility should use the backup pharmacy services and they can get the medication the same day they received the order. -If the facility was unable to get the medication from backup pharmacy, they should contact the physician and get an order to start the order once the medication was received.	D 358	RCM and SCM to educate all MAs on utilizing "Back Up Pharmacy" during after hours, weekends and holidays. Training initiated on 5-12-16. ED to monitor compliance.	5/27/2016
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been	D 406		

Division of Health Service Regulation

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D 406	Continued From page 24 informed of the findings when necessary. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to act upon 2 of 5 pharmacist recommendations related to recommendations to discontinue a benzodiazepine, an antihistamine, and a bladder relaxant (Resident #6) and changing a beta-blocker to an extended release strength (Resident #7). The findings are: 1. Review of Resident #6's current FL-2 dated 06/30/15 revealed: - Resident #6's diagnoses included chronic obstructive pulmonary disease, hypertension, hypothyroidism, type 2 diabetes mellitus, chronic pain, coronary atherosclerosis, constipation, and depression with anxiety. - Medication orders included Ativan 0.5mg, one tablet at bedtime, and Ditropan 10mg, one tablet daily. Review of a physician's order for Resident #6 dated 12/29/15 revealed: - There was an order for Allegra 180mg, take one tablet daily. Review of Resident #6's most recent medication regimen review dated 02/11/16 revealed: - The pharmacist noted the resident had a poly-pharmacy medication regimen of more than 31 medications and had recently fallen out of bed secondary to nightmare. - The pharmacist recommend the order for Ativan, Ditropan, and Allegra be discontinued due to contributing anticholinergic CNS Central Various System side-effects - The physician dated the recommendation on 02/11/16 and checked the box next to "agree."	D 406	ED will distribute Pharmacy Recommendation Reviews to RCM and SCM. RCM and SCM will fax recommendations to physician for review. Once response is received from physician, RCM and SCM will fax orders to pharmacy. RCM and SCM will review and approve orders in Quick Mar. Initiated on 4-14-16.	5/27/2016
			ED will monitor compliance ongoing.	
			Senior ED in-serviced both Care Care Managers on Pharmacy Recommendation Review follow up on 4-14-16.	5/27/2016

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	HAL092203	A. BUILDING: _____ B. WING _____	04/14/2016

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CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

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D 406	Continued From page 25 Review of Resident #6's record revealed no documentation the medication review recommendations had been followed up. Review of Resident #6's February 2016, March 2016, and April 2016 Medication Administration Records (MAR) revealed: - There was an entry for Ativan 0.5mg at bedtime. - Ativan was scheduled to be administered at 8:00 p.m. - Ativan was documented as administered at bedtime from 02/01/16-02/29/16, 03/01/16-03/31/16, and 04/01/16-04/13/16. - There was an entry for Ditropan XL 10mg daily. - Ditropan XL was scheduled to be administered at 8:00 a.m. - Ditropan XL was documented as administered at bedtime from 02/01/16-02/29/16, 03/01/16-03/31/16, and 04/01/16-04/13/16. - There was an entry for Allegra 180mg daily. - Allegra was scheduled to be administered at 8:00 a.m. - Allegra was documented as administered at bedtime from 02/01/16-02/29/16, 03/01/16-03/31/16, and 04/01/16-04/13/16. Interview with the medication aide/supervisor on 04/13/16 at 11:15 a.m. revealed: - Pharmacy reviews and notes to the physician were considered orders if the physician signed the review. - The physician was coming on 04/14/16 and she would get the orders clarified. Interview with Resident #6 on 04/13/16 at 11:50 a.m. revealed: - The resident thought she was still prescribed Allegra, but was not sure about Ditropan.	D 406		

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D 406	Continued From page 26 - Resident #6 knew she was still taking the Ativan every night before bedtime. Interview with the Assisted Living Care Manager on 04/14/16 at 11:50 a.m. revealed: - The physician did not know that pharmacy reviews were considered orders. - She did not know the reviews were considered orders either, so she was getting the orders clarified with the physician. - The medications that the pharmacy had recommended to be discontinued had not been removed from the MAR for Resident #6; therefore, Resident #6 continued to receive Allegra, Ditropan, and Ativan. - She was new and had only being in the position since January, and did not know a lot about orders. Interview with the Physician on 04/14/16 at 12:20 p.m. revealed: - The physician intended for the reviews by the pharmacist to be an order. - She only questioned the Care Manager because she did not know if she needed to write a separate order for the staff to send to the pharmacy. - She agreed with the pharmacist's recommendation that the Allegra, Ditropan, and Ativan be discontinued. - The facility should have discontinued the medications when she signed the recommendation on 02/11/16. Interview with the Clinical Specialist on 04/14/16 at 1:05 p.m. revealed: - The pharmacy reviews were orders if the physician signed and dated the recommendation. - She had asked the physician to evaluate the residents to ensure no outcome or effect had	D 406		

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D 406	Continued From page 27 resulted from not following the pharmacy recommendations and physician orders. - The Care Managers were responsible for ensuring the pharmacy reviews were followed up. 2. Review of Resident #7's current FL-2 dated 01/14/16 revealed: - Resident #7's diagnoses included posterior displaced dens fracture, displaced posterior arch fracture of the cervical vertebrae, rib fracture, and Alzheimer's disease. - Medication orders included Metoprolol Tartrate 25mg, daily. Review of Resident #7's most recent medication regimen review dated 02/11/16 revealed: - The pharmacist noted the resident was taking Metoprolol Tartrate 25mg daily. - The pharmacist recommend the order be changed to Metoprolol Succinate 25mg daily due to the Metoprolol Tartrate being of 12 hour duration formulation. - The physician dated the recommendation on 02/11/16 and checked the box next to "agree." Review of Resident #7's record revealed no documentation the medication review recommendations had been followed up. Review of Resident #7's February 2016, March 2016, and April 2016 Medication Administration Records (MAR) revealed: - There was an entry for Metoprolol Tartrate (Lopressor) 25mg daily. - The Metoprolol Tartrate was scheduled to be administered at 8:00 a.m. - Metoprolol Tartrate was documented as administered from 02/01/16-02/29/16, 03/01/16-03/31/16, and 04/01/16-04/13/16.	D 406		

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D 406	Continued From page 28 Attempted interview with Resident #7 on 04/13/16 at 12:10 p.m. revealed Resident #7 was not interviewable. Interview with the Assisted Living Care Manager on 04/14/16 at 11:50 a.m. revealed: - The physician did not know that pharmacy reviews were considered orders. - She did not know the reviews were considered orders either, so she was getting the orders clarified with the physician. - The medication that the pharmacy requested to be changed had not been changed for Resident #7. - She was new and had only being in the position since January, and did not know a lot about orders. Interview with the Physician on 04/14/16 at 12:20 p.m. revealed: - The physician intended for the reviews by the pharmacist to be an order. - She only questioned the Care Manager because she did not know if she needed to write a separate order for the staff to send to the pharmacy. - She agreed with the pharmacist's recommendation that the Metoprolol be changed to daily. - The facility should have changed the medication when she signed the recommendation on 02/11/16. Interview with the Clinical Specialist on 04/14/16 at 1:05 p.m. revealed - The pharmacy reviews were orders if the physician signed and dated the recommendation. - She had asked the physician to evaluate the residents to ensure no outcome or effect had	D 406		

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D 406	Continued From page 29 resulted from not following the pharmacy recommendations and physician orders. - The Care Managers were responsible for ensuring the pharmacy reviews were followed up.	D 406		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.	D 468	All new hires will complete 6 hours of SCU training during the first week of hire. Within the first 6 months of hire, the new hires will complete 20 hours of training specific to the Special Care Unit (SCU) resident. All staff will complete at least 12 hours of continuing education annually, of which 6 hours will be dementia specific. Completed SCU training certificates will be placed in staff files. The Business Office Manager (BOM) is responsible for scheduling required trainings and maintaining staff training files. ED and BOM will monitor compliance.	5/27/2016

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D 468	Continued From page 30 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 3 of 3 sampled staff (E, F, and G) who were responsible for personal care and supervision within the special care unit completed 6 hours of orientation within the first week of employment and 20 hours of training specific to the Dementia population being served within 6 months of employment. The findings are: 1. Review of Staff E's personnel file on 04/14/16 revealed: - Staff E was rehired as a Personal Care Aide (PCA) on 09/15/15. - There was no documentation of 6 hours of special care unit (SCU) orientation training within the first week of employment. - Three hours of training specific to the SCU population was completed from December 2015-January 2016. Observation during the survey revealed Staff E worked as a PCA on first shift in the special care unit on 04/12/16-04/4/16. Interview with Staff E on 04/14/16 at 3:00 p.m. revealed: - Staff E had completed some training on SCU and Dementia, but she did not know how many hours. - There should have been certificates in her file. - Staff E thought the Memory Care Manager (MCM) did the SCU trainings with the staff. Refer to interview with the Clinical Specialist on 04/14/16 at 1:05 p.m. Refer to interview with the Business Office	D 468		

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D 468	Continued From page 31 Manger (BOM) on 04/14/16 at 2:50 p.m. Refer to interview with the MCM on 04/14/16 at 3:20 p.m. 2. Review of Staff F's personnel file on 04/14/16 revealed: - Staff F was hired as a PCA on 06/01/15. - There was no documentation of 6 hours of SCU orientation training within the first week of employment. - One hour of SCU and Dementia training was completed in December 2015. - There was no documentation of any SCU or Dementia training since December 2015. Review of the facility's work schedule revealed Staff F worked in the special care unit on third shift on 04/12/16 and 04/13/16. Refer to interview with the Clinical Specialist on 04/14/16 at 1:05 p.m. Refer to interview with the Business Office Manger (BOM) on 04/14/16 at 2:50 p.m. Refer to interview with the Memory Care Manager (MCM) on 04/14/16 at 3:20 p.m. 3. Review of Staff G's personnel file on 04/14/16 revealed: - Staff G was hired as a Medication Aide (MA) on 09/15/15. - There was no documentation of 6 hours of SCU orientation training within the first week of employment. - Two hours of SCU and Dementia training was completed on 01/19/16. - There was no documentation of any SCU or Dementia training since 01/19/16.	D 468		

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D 468	Continued From page 32 Observation during the survey revealed Staff G worked as a MA on the first shift in the special care unit on 04/12/16, 04/13/16, and 04/14/16. Interview with Staff G on 04/14/16 at 2:30 p.m. revealed: - Staff G had completed training on SCU and Dementia, but she did not know how many hours. - There should have been certificates in her file. - Staff E could not recall who taught the SCU and Dementia trainings with the staff. Refer to interview with the Clinical Specialist on 04/14/16 at 1:05 p.m. Refer to interview with the Business Office Manger (BOM) on 04/14/16 at 2:50 p.m. Refer to interview with the Memory Care Manager (MCM) on 04/14/16 at 3:20 p.m. --- Interview with the Clinical Specialist on 04/14/16 at 1:05 p.m. revealed: - There were no additional training that had been completed that had not been put in the personnel files. - The BOM was responsible for the personnel files, and the BOM and the MCM were both responsible for seeing that SCU trainings were completed. - It ultimately goes back to the Administrator as to why the trainings were not completed or scheduled to be completed. Interview with the Business Office Manager (BOM) on 04/14/16 at 2:50 p.m. revealed: - BOM was responsible for completing the personnel files and making sure requirements	D 468		

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D 468	Continued From page 33 were on file. - She was unaware the SCU and Dementia training had not been completed. - The MCM was also responsible for assisting the BOM with ensuring the trainings were scheduled. Interview with the Memory Care Manager (MCM) on 04/14/16 at 3:20 p.m. revealed: - The BOM was keeping up with all staff trainings, not just the staff who worked in the SCU. - She was unaware the SCU and Dementia training had not been completed. - Since there were some staff who had not had SCU and/or Dementia trainings, she was going to help the BOM monitor that. - The MCM had set up some trainings in the facility's computer system to be done as soon as possible, and there was a county contact who did SCU and Dementia trainings for the facility that the MCM was going to contact to schedule additional trainings for the SCU staff.	D 468		