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

RECEIVED MAY 23 2016 ADULT CARE LICENSURE SECTION RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS ASSISTED LIVING	3045 HENDERSON DRIVE EXTENSION JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on April 20 - 22, 2016.	D 000	New Thermometer purchased with Calibration Instructions. Thermometer Calibration tested. See Attachment 1.	5/19/16
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	Mixing Valves identified and adjusted in the building to assist in regulating proper water temps. Maintenance and Housekeeping staff were trained on 1) Calibration and 2) How to properly check water temps (See Attachment 2) Maintenance or Housekeeping Designee Will check water temps daily Monday-Friday and document findings on Temp Log. (See Attachment 3) If there are deviations of temps <100 or >116, it will be documented on the back of the log what was done and new corrected temp. Hot Water "Caution" signs continue to be posted for residents, visitors, and employees and changed quarterly using different colored paper. (See Attachment 4)	5/19/16 5/20/16 5/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Traci Marks, Administrator — TITLE: Administrator — (X6) DATE: 5/20/16

5/20/16

Reviewed and Accepted w/ 6/10/2016 with revisions/addendum

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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	Monitoring will be done weekly by Administrative review of Temp Logs and sign. Monthly Safety/ QA meetings will review for any patterns or problems.	5/20/16

[redacted] A [redacted] Company

Att 1

Pocket Digital Thermometer

Part No: [redacted]

The [redacted] Pocket Digital Thermometer with 1.5mm Thin Tip Probe is an ideal pen-style digital cooking thermometer that is slim and fits flat in your pocket.

- Temperature Range: -50°C to +150°C (-58°F to +302°F)
- Thin Tip Probe: 1.5mm
- Accurate to ±1°C (±2°F)

[redacted] https://www.[redacted]

Operating Instructions

Powering On/Off

Press the «ON/OFF» button to start or stop operation. The unit will automatically power off after 35 minutes. Low Battery is indicated by «LOB» blinking alternately with a reading. Replace the [redacted] battery immediately.

Changing °F to °C

With the unit "off" hold the «ON/OFF» button and the display will alternate between °F and °C. Release the «ON/OFF» button when the desired mode is displayed.

Holding the Current Temperature

To hold a displayed reading, press the «D-H» (data hold) button. The reading will flash when the D-H is in operation. Press the «D-H» button again to return to normal operation.

water to run 5 minutes

Battery Replacement

Use a coin to open the case. Replace with an [redacted] battery and re-seat the case.

Field Calibration Procedures

1. The [redacted] is only calibratable in a slush ice solution (60% crushed ice and 40% tap water) or a water bath. Do not attempt to calibrate in any other manner
2. Immerse the stem of the thermometer to at least 1/2 length in the slush ice solution
3. Wait for the reading to become stable (usually ±2° of 32°F or ±1° of 0°C)
4. Press and hold the D-H button for 8 seconds to begin calibration
5. CAL will be displayed for two seconds and calibration at 32°F/0°C is completed
6. Remove the thermometer from the ice water and continue to take measurements

to be done daily

Note: CAL will be displayed any time the D-H key is pressed for 8 seconds, but the thermometer will not be re-

LIBERTY COMMONS ASSISTED LIVING

3045 HENDERSON DRIVE EXTENSION

JACKSONVILLE, NC 28540

POCKET DIGITAL THERMOMETER USE/PROCEDURES

On a routine basis water temperatures will be checked in various rooms throughout the building. Those temperatures should be between 100-116 degrees. If temperatures are not within those parameters the Administrator will be notified immediately to ensure the proper agency is contacted to begin solution.

*Review of the digital thermometer/how to turn on and off/changing between Celsius and Fahrenheit/battery replacement

*Checking water temperatures-random room will be selected and the water will run for FIVE minutes only

*Each day the thermometer will need to be calibrated to ensure accuracy. (See handout) Procedures reviewed

*Notes: the temperature log will be kept in the Maintenance office where I will review and sign weekly as well as quarterly we will change the "caution" hot water signs wherever there is a sink

Daily Water Temperature Checks for MAY 2016

Att 3

		Calibration						
M	5/2							
T	5/3							
W	5/4							
Th	5/5							
F	5/6							

Administrator's Weekly Signature:

		Calibration						
M	5/9							
T	5/10							
W	5/11							
Th	5/12							
F	5/13							

Administrator's Weekly Signature:

		Calibration						
M	5/16							
T	5/17							
W	5/18							
Th	5/19							
F	5/20							

NEW Quarterly
"Hot Water Notices" -placed throughout building. Date: Signature:

Administrator's Weekly Signature:

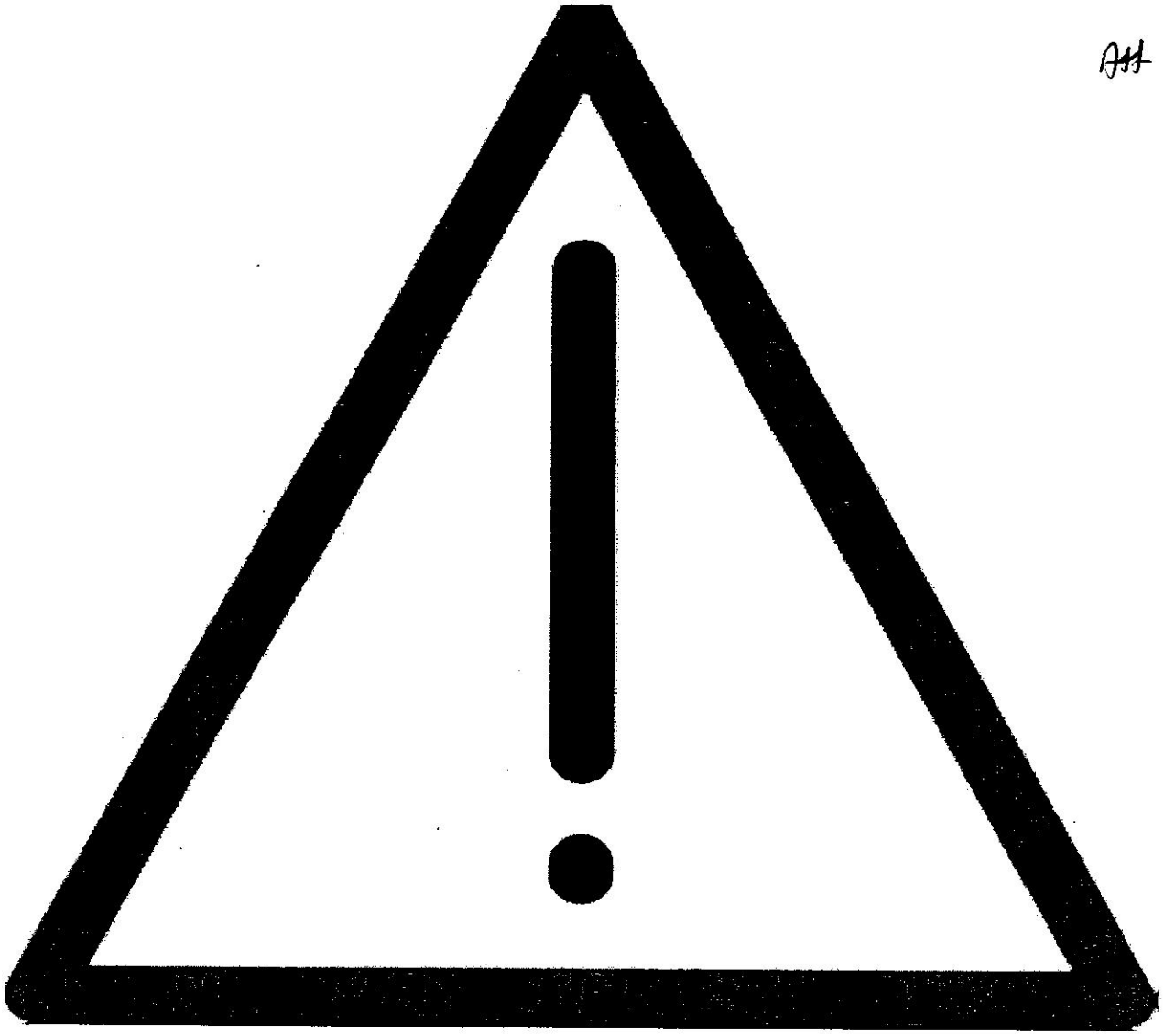
		Calibration						
M	5/23							
T	5/24							
W	5/25							
Th	5/26							
F	5/27							

Administrator's Weekly Signature:

		Calibration						
M	5/30							
T	5/31							

Date	Time	Notes on Variance

Att 4



Caution HOT Water!

Noticed placed on: May 2016

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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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D 113	Continued From page 5 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.	D 113		

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D 113	Continued From page 6 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	D 113		

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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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D 273	Continued From page 8 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 pm	D 273	Emergency Procedures Policy Updated (See Attachment 5) 5/20/16 Administrator/WC/SIC's/Med Techs all will be retrained on Emergency Procedures Policy to include a focus on "significant change" procedures and facility mgmt. and/or "On Call" person notification. 5/20/16 A List of "Types of Significant Changes" was posted in the WC's office, SCU Directors office, and placed in the MAR notebook for reference. (See Attachment 6) 5/20/16 Incident/Accident Reporting Policy (See Attachment 7) Administrator/WS/SIC's/Med Techs Will be retrained on this policy with a focus on proper notification of facility mgmt. and/or "On Call" person, physician, and responsible person as well as documentation of notification. 5/20/16	

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D 273	Continued From page 9 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.	D 273	All Incident/Accident Reports will be reviewed by the Administrator to ensure proper notification and documentation of notification was done. Incident/Accident Reports will be reviewed at the Safety/QA monthly meeting.	5/20/16 5/20/16

LIBERTY Senior Living MANAGEMENT SERVICES

Policy Title: Emergency Response - Resident
Issuing Date: October 1989
Revision Dates: July 21, 2005, December 29, 2010, October 6, 2014, May 18, 2016

POLICY

Residents are sent to the emergency room for evaluation and treatment for all emergent concerns related to any life threatening situation, acute change in status or any incident/accident with injury requiring immediate medical care.

The community recognizes the unique needs of residents who are at the end of life. We work collaboratively with the resident, family, primary care provider, and hospice home care agency to maintain the comfort and dignity of our residents. The resident may elect to stay at the community for comfort measures only provided the residents needs may be met at their current level of care.

PROCEDURES

For all emergency situations, remain CALM

1. Check the situation and call for Med Tech/SIC or other staff to help (use pull cord or PET, call supervisor's cell or community's main number, or attract another staff member's attention if nearby.)
2. Establish airway, check breathing and circulation. Staff will begin CPR if indicated.
3. Med Tech/SIC will dial **911** or direct other staff to call 911. Provide information requested such as signs and symptoms observed, level of consciousness, vital signs.
4. Do not leave the resident alone. Provide reassurance for the resident.
5. Med Tech/SIC directs a nursing assistant to stay with the resident.
6. The Med Tech/SIC may direct the nursing assistants to alternate every 15 minutes if needed until the emergency medical transport arrives.
7. Staff will provide first aid measures if needed and keep the resident as comfortable as possible.
8. If the resident is diabetic, check blood sugar and treat low blood sugar if indicated.
9. Staff do not move resident unless remaining endangers him/her.
10. Med Tech/SIC will complete the "Resident Transfer" Form and copy the resident's Medication Administration Record, Face Sheet, and Insurance Cards.
    a. It is important to complete the Briggs Transfer Form with the resident's name, date of birth, responsible person and their phone numbers, allergies, signs and symptoms observed with vital signs, etc.

b. Make a copy of the Face Sheet and Insurance Cards in the resident's medical record, and send with the Briggs Transfer Form.
c. Make a copy of the Medication Administration Record (cover the daily initial side) to send with the Briggs Transfer Form.
d. Send the original Golden Rod, "DO NOT RESCUSCITATE", or the original pink, "Medical Order for Scope of Treatment" form along with the other paperwork. This form(s) is found in the front of the resident's medical record.

11. Med Tech/SIC will notify the resident's primary care provider to report the situation and signs and symptoms observed, vital signs, level of consciousness, etc.
12. Med Tech/SIC will notify the resident's responsible person.
    a. The responsible person's name and phone number may be found in the medical record on the resident's Face Sheet. This information is also on the Resident Register in the resident's medical record.
    b. If the resident's responsible person cannot be reached, the Face Sheet or the Resident Register usually has another name listed as second or another contact person. If this person cannot be reached, call the "On Call" person to notify.
13. Med Tech will notify the supervisor and the "On Call" staff member of the events.
14. All other nursing assistants and other staff will continue with shift responsibilities and duties providing assistance to other residents

Significant Change, Fall or Sudden Illness

Should a resident develop signs and symptoms of illness, significant change or have a fall the following procedures are to be followed:

1. Notify the Supervisor-in-Charge/Med Tech and obtain vital signs.
2. Notify the Area Director, Wellness Director / Director of Services. On weekends or after regular business hours the "On Call" person should be notified.
3. Notify the resident's primary care provider with signs and symptoms, vital signs, etc.
4. Document and follow all orders from the primary care provider.
5. Notify the resident's responsible person (listed on the Face Sheet or on the Resident Register in the resident's medical record) of orders and actions taken.
6. For falls or incidents please initiate the Incident / Accident Reporting Policy

Note: For residents who have orders from their primary care provider for comfort measures only, do not transport, the Med Tech/SIC will notify the primary care provider and or hospice nurse for further instructions/orders related to any change in status.

For Sudden Death

In the event a resident is found without a pulse and not breathing, identify the resident's code status. The following procedures should be carried out:

Call **911**

The resident's "code" status should be determined immediately.

CODE – if the resident is a **"Code":**

1. *Immediately* begin CPR if resident found without a pulse and not breathing.
2. Send someone to **call 911**. (Inform 911 Center you have a code in progress.)
3. Continue CPR until the ambulance arrives and the paramedics take over the resuscitation efforts.
4. Notify your supervisor of events.
5. Notify the resident's primary care provider.
6. Notify the resident's responsible person.

CPR is to be started on any resident who is a "code" regardless of whether cardio-pulmonary arrest was witnessed or not witnessed.

No assumptions are to be made as to when the arrest occurred. Residents who have a "code" status will have this indicated on their Medication Administration Record and the resident's record will also be marked with a blue dot on the nameplate.

Only staff members with a current CPR participant card on file at the community are to actively carry out CPR. Other staff members may assist with other tasks as directed.

DNR – if the resident has a **Do Not Resuscitate** order: Notify your supervisor of finding the resident without a pulse and not breathing.

1. Notify the resident's primary care provider of the resident being found without pulse and not breathing.
2. Ask the primary care provider if they wish to call the resident's responsible person or if they would like for you to notify the responsible person.
3. The responsible person should be notified
4. Ask the responsible person if they would like to come to the community or if they would like you to call the mortuary.
5. Provide privacy for the resident and the resident's family if family present. Have the roommate wait in another area if necessary.

All residents with a Do Not Resuscitate status must have a current *Do Not Resuscitate* form (DNR) or a Medical Order for Scope of Treatment form (MOST) with a current DNR order in their medical record. Residents who have a DNR status will have this indicated on their Medication Administration Record and the resident's medical record will also be marked with a red dot on the nameplate.

IMPORTANT:

A resident's code status only indicates if CPR is to be performed in the event a resident's heart stops and the resident stops breathing. All residents will be treated as ordered by their primary care provider for health care needs and orders are followed for all resident care. Staff responds to emergencies and urgent health care needs immediately. Residents will be sent 911 if needed for injury or acute change in status.

Residents with specific orders for "end of life care" and "do not transport" from the resident's primary care provider will remain at the community; however, they may be sent to the hospital if determined it is needed for treatment of an acute change or injury that cannot be provided at the Community. Maintaining a resident at the Community for end of life care is done with the primary care provider's orders and with Hospice if the resident agrees. This must be discussed with the resident's responsible person and the Area Director, Wellness Director, or Director of Services to ensure that the resident's wishes are always carried out.

For Elopement

Elopement (Wandering): if a resident is missing and staff has been unable to locate resident in the building or near the building the following should take place immediately.

1. The Supervisor-in-Charge (SIC) will go to a designated area (generally a workstation) and coordinate the search efforts.
2. Staff will be notified using the intercom system, walkie talkies, and cell phones to notify department heads/supervisors to announce a "**Code Adam**".
    a. This communication may be delegated to the front desk when they are on duty; however, the SIC is responsible to direct this communication and staff.
3. The SIC will give the staff the name of the missing resident, when and where the resident was last seen, what clothing the resident was wearing, and a description of the missing resident. A picture of the resident is on the Medication Administration Record.
4. The SIC will call or direct a staff member to call 911 and give the police the following information:
    a. Resident name
    b. Description of resident and the clothes he/she was wearing when last seen
    c. The time the resident was last seen and where in the community
    d. Explain the level of confusion and cognitive impairment status of the resident.
5. The SIC will notify the Administrator, Area Director, Wellness Director / Director of Services in the event of a missing resident.
6. The Administrator will notify or direct the SIC to notify the resident's responsible person. In a drill this will be simulated.

a. All direct care staff on the halls will immediately begin on their halls, systematically and thoroughly looking in each room, starting with the last room on the hall and working their way to the workstation. Staff will check bathrooms, closets, under beds, in showers, etc. All storage closets and stairwells will be searched. Once a room is deemed "clear", the door will be closed.
b. Management/Supervisory staff will search in common areas (i.e. offices, kitchen, lobby, dining rooms, lounge areas, etc.).
c. When a hall or area is cleared, the SIC will direct the staff to other areas to search.
d. As the building is being searched, the SIC will designate a minimum of two people to search the grounds of the building. These two people should work in opposite directions so that they can meet after searching.
e. One additional person should be designated to search specifically any areas with a body of water such as a pond. From that point, they are to notify the SIC for further directions.
f. The SIC will also designate personnel to search in the surrounding neighborhood.
g. When the person is found the SIC will announce "CODE ALERT ALL CLEAR".
h. The resident's responsible person should be notified of locating the missing resident, and care should be provided for the resident as needed.

For Dangerous Behavior

Dangerous behavior: if a resident is exhibiting behavior that is causing direct harm to himself and/or others and is creating an immediate danger/threat, the following should take place immediately.

1. The Supervisor-in Charge calls or directs staff to call 911 and describes the dangerous situation and request someone come immediately.
2. The Supervisor-in-Charge notifies the Area Director, Wellness Director/Director of Services and the Administrator if they are not on site.
3. The Administrator calls the resident's responsible person or instructs the Supervisor-in-Charge to do so.
4. The Supervisor-in-Charge will engage the resident in diversion techniques to minimize the danger and ensure the safety of the residents and staff until assistance comes after calling and/or seeking assistance from other staff in the building as necessary.
   Staff should:
   - Attempt to identify the cause of the behavior and eliminate it, if possible.
   - If aggressive behavior occurs in a public area, move the resident if it is safe to do so. If not, move others out of the way.
   - If an altercation between two residents occurs staff should attempt to separate the residents using a calm, non-threatening approach.
   - It may be necessary to place the resident causing the altercation in a private room temporarily based on the possibility of further altercations with other residents.

- Allow the resident personal space and back off if the resident is safe and all staff is safe.
- Reassure the resident.
- Show the resident that you are interested in what the resident is saying.
- Empathize with the resident and acknowledge you understand how he or she feels.
- Praise the resident's efforts at self-control.
- Do not argue or try to reason with the resident.
- Watch your body language is not threatening.
- Take physical threats seriously and keep your distance.
- Watch the resident's eyes. They will usually focus on the part of the body to be attacked.
- Remain calm.
- Speak in a soft, low, calm voice.
- Do not make the resident feel trapped or cornered.
- Do not turn your back on the resident.
- Avoid touching the resident, as this may cause further agitation.
- Once the residents and the staff are safe, the SIC will instruct other staff to continue as normal.

LIBERTY COMMONS ASSISTED LIVING

Types of Significant Change

A. Fever
B. Overall weakness
C. Shortness of Breath
D. Increased pain
E. Increased confusion distinctly different than normal
F. Delirium
G. Vomiting, etc.
H. Unresolved constipation
I. Fatigue
J. Cough/Cold symptoms
K. Loss of Appetite
L. Dizziness
M. Weight Gain/Loss
N. Abdominal Pain
O. Dysphagia
P. Rash or skin change

Residents who are experiencing a significant change may temporarily be in jeopardy of fall: i.e., such as developing any of the above

AA 7

LIBERTY Senior Living MANAGEMENT SERVICES

Policy Title: Incident & Accident Investigation for Residents
Issuing Date: October 1, 2001
Revision Dates: October 2008, October 6, 2014

POLICY

It is the policy of this Community to investigate any accident or incident that occurs in the Community. Investigations will include reporting activities to the appropriate authority if abuse, neglect or criminal activities occur.

PURPOSE

1. To investigate the cause of all marks, discolorations, skin breaks and injuries that have not been witnessed.
2. To identify any injuries after a resident sustains an accident or incident.
3. To investigate any other unusual event.

General Guidelines for Checking the Resident may include, but are not limited to:

- Examine the entire skin surface.
- Interview the resident.
- Interview any witnesses.
- Take vital signs.
- Check pain.
- Identify all skin discolorations, redness, swelling, edema, tenderness, breaks, or change in temperature.
- Check peripheral pulses.
- Check range of motion of all joints.
- Check any change in mental and cognitive status.

Equipment that may be needed:

1. Thermometer.
2. B.P. apparatus.
3. Dressings of the type and amount appropriate.
4. Clean linen as necessary.
5. Flashlight.

Investigation Procedure

1. Handle resident gently.
2. Examine the entire skin surface.
3. Interview the resident to determine cause of any conditions identified.
4. Interview any witnesses to determine cause of any conditions identified.
5. Take vital signs.
6. Check pain.

7. Identify all skin discolorations, redness, swelling, edema, tenderness, breaks, or change in temperature.
8. Measure the size, depth, color and location of any skin conditions identified.
9. Palpate peripheral pulses.
10. Gently perform passive and active range of motion of all joints.
11. Check for any change in mental and cognitive status through observation and interview of the resident.
12. Observe and check all neurological signs as needed.
13. Notify the resident's primary care provider of a change of condition or any concerns that have been identified.
14. Notify the resident's representative of a change of condition or any concerns that have been identified.
15. Attempt to determine the cause of any conditions identified.
16. Implement preventive measures as appropriate. This may include every 15 minute checks or 1 on 1supervision if needed. Examples that might require 1:1 supervision might include those items listed below. However, this list is not exhausted and requires the judgment of the Supervisor on duty.
    a. Elopement events
    b. Dysphasia risk who is seeking food and mobile
    c. Residents who abuse or threaten to abuse other residents
    d. Others as deemed necessary by staff
17. If 1:1 supervision is required, this must be maintained until reviewed by the Administrator. Only the Administrator can stop 1:1 Supervision once initiated.

General Documentation Guidelines May Include:

•Complete Incident Report form
•Date, time (or shift) of accident or incident.
•Conditions and concerns identified.
•Cause or probable cause of any concern identified.
•Skin conditions including pain, swelling, change in temperature, site, size, depth, color and breaks.
•Pain, site, intensity and characteristics.
•Change in any physical condition.
•Change in mental status.
•Any treatment provided.
•Preventive measures implemented.
•Notification of the primary care provider.
•Notification of resident's responsible person.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067008	A. BUILDING: _____ B. WING _____	R 04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS ASSISTED LIVING	3045 HENDERSON DRIVE EXTENSION JACKSONVILLE, NC 28546

(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 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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D 273	Continued From page 11 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.	D 273		

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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	Facility Pharmacy Policy for Diabetics was implemented And a copy of the policy Placed in the Med. Adm Record (MAR) Notebook (See Attachment #8) Pharmacy Policy for Diabetics was sent to Resident #1's physician and specific parameters were requested. Received fax dated 4/22/16 At 12:04 pm that stated Parameters were if B/S are <90 or >300 to call physician. On 4/23/16 at 8 pm B/S was 383. Documentation indicates Physician's On Call person was Notified. On Call PA stated "no need to send to ER" that B/S would be noted in resident's record. On 4/24/16 at 8 pm B/S was 364. Documentation indicates Physician's On Call person was notified. No new orders were given.	4/21/16 4/21/16

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D 273	Continued From page 13 -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	D 273	On 4/25/16 resident had physician appointment. She was accompanied by [redacted] Facility received new parameters of if B/S <60 or >400 to call physician. Orders for Lantus to be changed from 8 pm to 8 am were received. Physician requested two weeks of B/S's to be sent to physician's office. Log of B/S's were sent on 5/9/16 at 2:15 pm. A follow-up Healthcare Fax was Sent on 5/11/16 at 12:03 pm notifying the physician that two-week's B/S's were sent. Faxed order was received 5/13/16 At 11:49 am. Physician ordered "continue current meds". "Will discuss with resident and family upon next visit which is June 8, 2016. Administrator/WC/SIC's/Med Techs will be trained on Pharmacy Diabetic Policy as well as proper Physician notification per policy. Administrator or her designee will check MAR's daily For all Diabetics to ensure policy Adherence, documentation of FSBS And physician notification per policy.	4/23/16

Traci Marks
5/23/16

Diabetic Residents Outline for Inservice

Diabetic residents require monitoring for signs and symptoms of complications. Diabetic residents should have physician orders that indicate blood sugar parameters that require interventions required for low or high blood sugar readings.

Med-Techs should follow physician's orders for all blood sugar monitoring and insulin administration.

In the event there are no physician orders indicating parameters and treatment for hypoglycemia/hyperglycemia for a diabetic resident, the Med-Tech should follow guidelines below:

- The Med-Tech should monitor resident's blood sugar via finger stick as needed for symptoms of hypoglycemia or hyperglycemia. (refer to charts next 2 pages for symptoms)
- If the blood sugar is 60 or below and/or the resident is symptomatic, the Med-Tech should repeat the finger stick blood sugar.
- If the second reading remains 60 or below the Med Tech will immediately give the resident 4 ounces of orange juice or
- Call 911 if the resident is unresponsive and unable to take anything by mouth and an emergency.
- The Med-Tech should recheck the blood sugar 20 minutes after giving orange juice and contact the physician if the blood sugar continues to be low or the resident remains symptomatic.
- The Med-Tech should document and follow any orders obtained from the physician.
- The Med-Tech should hold insulin if blood sugar is below 70 and immediately contact the resident's physician for orders regarding insulin administration.
- The Med-Tech should give any insulin if ordered for blood sugar above 300 and immediately contact the resident's physician for any additional orders.
- The Med- Tech should also notify the physician for blood sugar above 300 for residents who do not receive insulin.
- The Med-Tech should continue to observe the resident for signs and symptoms of hypoglycemia/hyperglycemia and intervene as appropriate.

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D 273	Continued From page 14 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	D 273		

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

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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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D 273	Continued From page 18 -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.	D 273		

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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	Medication Administration: Administrator/WC/SIC's/Med Techs will be retrained on Medication Errors Policy and Procedures with a special focus On "Omitted Medications". (See Attachment #9) Administrator will review all Med errors and investigations with Wellness Director to ensure Policy is followed, proper notification is done, as well as proper documentation. Patterns and/or problems will be addressed and corrective action taken. (See Attachment #10) Medication Errors will be reviewed at the Safety/QA monthly meeting.	4/20/16

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D 358	Continued From page 21 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	D 358	Medication Ordering Policy and Procedures were updated. (See Attachment #11) All Maintenance medication Refill orders will be processed on Monday, Wednesday, and Fridays to ensure timely ordering to prevent disruption of medication administration. The Administrator, Wellness Director, and/or Designated Med Tech will be responsible for Medication ordering. A Log Sheet will be used for Controlled Medications ordering to prevent disruption of med administration for residents. The Administrator and/or WC will be responsible for Controlled Medication reordering. (See Attachment #12) When reordering a Controlled Medication the resident's name, Medication, date, time, physician's Contact will be entered onto the Log Sheet. On subsequent Monday, Wednesday, and Friday's the Log sheet will be	5/20/16 5/20/16 5/20/16

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D 358	Continued From page 22 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	D 358	checked to see what meds are outstanding and follow up to the Physician's office or pharmacy will be done until the Medication prescription is received. Once the prescription is written, picked up, and pharmacy has delivered, the resident's name and medication will be highlighted in yellow on the Log Sheet. The Administrator will check The Log Sheet weekly to ensure proper ordering and follow up. The Log Sheets will be reviewed at the Safety/QA meeting for patterns and/or problems with controlled medications being received.	

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D 358	Continued From page 23 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.	D 358		

LIBERTY Senior Living MANAGEMENT SERVICES

AH 9

Policy Title: Medication Errors
Issuing Date: October 1, 2001
Revision Dates: October 6, 2014

POLICY

To safeguard the resident and provide emergency care as necessary each Med Tech has responsibility to report and follow up on any medication error or drug reaction.

PROCEDURES

- Report all medication errors immediately to the Supervisor-in-Charge.
- Provide emergency care to resident if needed.
- Take vital signs and record. (Temperature, Pulse, Respirations, and Blood Pressure).
- Check the resident for any change in mental status, rash, swelling, itching, or other concern.
- Notify the resident's primary care provider and follow any orders.
- Check resident every shift for at least seventy-two hours and more frequently as indicated.
- Complete a Medication Error form as soon as Med Error discovered.
- Supervisor should complete an Investigative Response and Action to Medication Error Form.

GENERAL DOCUMENTATION GUIDELINES

- Complete medication error report per policy

Include in Chart Notes:

- Date and time of error. Date and time error found.
- Type of Error.
- Explanation of the medication error in detail.
- Notification of the primary care provider and any orders given.
- Notification of Responsible Person.
- Time each individual was notified and time of response.
- Resident's response to medication and vital signs.
- Any actions taken and care provided to the resident and the resident's response to care.
- Frequent observation of the resident until condition is stable.
- Include date, time, signature and title with every entry.

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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	Medication Administration: Administrator/WC/SIC's/Med Techs will be retrained on Medication Errors Policy and Procedures with a special focus On "Omitted Medications". (See Attachment #9) Administrator will review all Med errors and investigations with Wellness Director to ensure Policy is followed, proper notification is done, as well as proper documentation. Patterns and/or problems will be addressed and corrective action taken. (See Attachment #10) Medication Errors will be reviewed at the Safety/QA monthly meeting.	4/20/16

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D 410	Continued From page 25 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	D 410	Medication Ordering Policy and Procedures were updated. (See Attachment #11) All Maintenance medication Refill orders will be processed on Monday, Wednesday, and Fridays to ensure timely ordering to prevent disruption of medication administration. The Administrator, Wellness Director, and/or Designated Med Tech will be responsible for Medication ordering. A Log Sheet will be used for Controlled Medications ordering to prevent disruption of med administration for residents. The Administrator and/or WC will be responsible for Controlled Medication reordering. (See Attachment #12) When reordering a Controlled Medication the resident's name, Medication, date, time, physician's Contact will be entered onto the Log Sheet. On subsequent Monday, Wednesday, and Friday's the Log sheet will be	5/20/16 5/20/16 5/20/16

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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	checked to see what meds are outstanding and follow up to the Physician's office or pharmacy will be done until the Medication prescription is received. Once the prescription is written, picked up, and pharmacy has delivered, the resident's name and medication will be highlighted in yellow on the Log Sheet. The Administrator will check The Log Sheet weekly to ensure proper ordering and follow up. The Log Sheets will be reviewed at the Safety/QA meeting for patterns and/or problems with controlled medications being received.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	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 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	D 410		

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D 410	Continued From page 28 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	D 410		

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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		