Division of Health Service Regulation

PRINTED: 05/26/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098028	A. BUILDING: _____ B. WING _____	R-C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD VILLAGE	1733 PARKWOOD BLVD WILSON, NC 27893

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up survey and complaint investigation on 05/10/16 - 05/12/16. The complaint investigation was initiated by Wilson County Department of Social Services on 02/23/16.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 5 staff (C, E) sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Staff C's personnel file revealed: -She was hired as a medication aide on 03/28/05. -She left employment with the facility on 06/15/13. -She was rehired as a medication aide on 11/08/13. -There was no documentation of any tuberculosis (TB) skin test for Staff C. Interview with the Administrator on 05/12/16 at	D 131	See attached D131 Addendum per telephone with Jaime Waters on 7/18/16: The facility will ensure a TB skin test is completed during the hiring process and a second step TB skin test is completed within 2-4 weeks of hire. ED or designee will conduct random audits at least quarterly. The correction date is 7/15/16. W. Williams 7/18/16	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jaime Waters TITLE: Executive Director (X6) DATE: 6-15-16

STATE FORM 6899 P0QQ11 If continuation sheet 1 of 46

* The plan of correction was reviewed and accepted with addendum on 7/18/16. Refer to addendum on pages 1, 3, 5, 15, 24, 37, and 42 of this Statement of Deficiencies.

W. Williams 7/18/16

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JUN 16 2016
ADULT CARE LICENSURE SECTION
RALEIGH

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D 131	Continued From page 1 6:10 p.m. revealed: -Staff C should have TB skin tests from original hire date and the rehire date. -Staff C's personnel file had been thinned and they were currently looking for the thinned file in storage. -Staff C usually worked third shift so she was not currently working in the facility. -She would contact Staff C to find out if she had any copies of her TB skin tests. Interview with the Administrator on 05/12/16 at 7:30 p.m. revealed: -She contacted Staff C who reported she had TB skin tests completed (no dates given). -Staff C told the Administrator she did not have copies of any of her TB skin tests. -She would keep looking for Staff C's thinned file. No further information was received by the end of the survey for Staff C's TB skin test. Refer to interview with the Administrator on 05/12/16 at 6:10 p.m. 2. Review of Staff E's personnel file revealed: -She was hired as a nurse aide / medication aide on 03/30/15. -She had one tuberculosis (TB) skin test placed on 03/31/15 and read as negative on 04/03/15. -There was no documentation of any other TB skin tests for Staff E. Interview with the Administrator on 05/12/16 at 6:10 p.m. revealed: -Staff E usually worked second shift but she was not working today. -Staff E should have a second step TB skin test. -She would check to make sure the TB skin test had not been thinned from the personnel file.	D 131	See attached	

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D 131	Continued From page 2 Staff E was unavailable for interview on 05/12/16. No further information was received by the end of the survey for Staff E's TB skin test. Refer to interview with the Administrator on 05/12/16 at 6:10 p.m. --- Interview with the Administrator on 05/12/16 at 6:10 p.m. revealed: -The Resident Services Director (RSD) was responsible for making sure TB skin tests were completed as required for all staff. -The RSD left the position in January 2016 and that position was currently vacant. -She did not realize TB skin tests were missing or incomplete for any staff.	D 131	see attached	
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on interview and review of personnel files, the facility failed to assure 1 of 6 sampled staff (C) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. The findings are: Review of Staff C's personnel file revealed: -She was hired as a medication aide on 03/28/05. -She left employment with the facility on 06/15/13. -She was rehired as a medication aide on	D 139	D139 Addendum per telephone with Jaime Waters on 7/18/16: ED or designee will conduct random audits at least quarterly to include the tracking tool and to ensure documentation of criminal background checks are maintained on file. The correction date is 6/17/16. W. Williams 7/18/16	

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D 139	Continued From page 3 11/08/13. -There was a consent for criminal background check signed by Staff C on 02/15/06. -There was a criminal background check completed on 02/15/06. -There was no documentation of a criminal background check or consent when Staff C was rehired on 11/08/13. Interview with the Administrator on 05/12/16 at 6:10 p.m. revealed: -The Resident Services Director (RSD) was responsible for making sure criminal background checks were completed as required for all staff. -The RSD left the position in January 2016 and that position was currently vacant. -Staff C should have a criminal background check when she was rehired. -Staff C usually worked third shift so she was not currently on duty at the facility. -Staff C had worked the previous night on third shift. -Staff C's personnel file had been thinned and they were currently looking for the thinned file in storage. Review of the staffing sheet provided by the facility on 05/10/16 revealed Staff C was scheduled to work on third shift from 05/10/16 - 05/12/16. No further information was received by the end of the survey for Staff C's criminal background check upon rehire.	D 139	see attached	
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 282		

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D 282	Continued From page 4 (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the reach-in cooler, walk-in freezer, walk-in cooler, kitchen appliances, ice machine, floors and walls in the kitchen were cleaned, in good repair and free of contamination. The findings are: Observation in the walk-in cooler on 05/11/16 at 12:00 p.m. revealed: -The outside of the walk-in cooler door had white hazy spots to the lower 1/3 of the door. -Four of four walls inside the walk-in cooler had scattered brown hazy spots. -Dark brown stains and brown food particles were on the floor inside of the walk-in cooler. -Four of four metal shelves in the walk-in cooler had scattered brown, white, and greenish food particles and stains. -Four of four sides of the ceiling in the walk-in cooler had blackish residue build-up. -The 3 seams along the surface of the ceiling were covered with a blackish residue. Observation in the walk-in freezer on 05/11/16 at 12:05 p.m. revealed: -The entrance of the door was covered with scattered brownish-white hazy spots along the lower half of the door. -The floors inside of the walk-in freezer was covered with dark blackish brown build-up mainly concentrated in the middle of the walk space. -Three of four floor corners had dark blackish brown residue build-up.	D 282	See attached D282 Addendum per telephone with Jaime Waters on 7/18/16: The F+B Director will observe the kitchen, dining, and food storage areas daily to assure cleanliness. The F+B Director will monitor the cleaning schedule daily. The ED or designee will monitor at least weekly to assure compliance. The correction date is 5/20/16. W. Williams 7/18/16	

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D 282	Continued From page 5 -Seventeen metal shelf racks were covered with scattered rusty-like spots. Observation of the reach-in cooler on 05/11/16 at 12:15 p.m. revealed: -The exterior doors of the reach-in cooler were covered with hazy white spots. -The 2 black receded door handles had brownish-white food particles in their corners. -The vent cover located below the exterior doors was covered with hazy white spots. -The lower 1/3 of the left and right exterior sides of the reach-in cooler had scattered brown and beige colored stains. -Two of two of the interior gaskets of the reach-in cooler were crusted with white dry particles. -White food particles were inside the 2 anterior corners inside of the reach-in cooler. Observation of the ice machine on 05/11/16 at 12:20 p.m. revealed: -The outer filter located to the upper area of the ice machine was covered with blackish gray dust particles. -The stainless steel exterior area of the ice machine had hazy white spots. -The black exterior areas of the ice machine were covered with a hazy brown residue. -There was a hazy brownish white residue to the top ledge interior of the lid of the ice machine. Observation of the kitchen on 05/11/16 at 12:30 p.m. revealed: -Four of four walls in the kitchen had dried brown stains scattered along the bottom halves of the walls. -The baseboards and corners of all 4 walls had dark brown residue build-up. -The floor to the left side of the ice machine had dark grey residue build-up with scattered black	D 282	see attached	

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D 282	Continued From page 6 particles. -The floor between the reach-in cooler and prep table had dark brownish black stains. -The stainless steel backsplash located behind the oven, steamer, fryer, grill, and stove was covered with numerous white greasy hazy stains. -The oven had old whitish crumbs mashed into the gasket around the opening of the oven. -The exterior of the oven was covered with hazy white spots and was greasy to touch. -The bottom panel of the steamer had brownish stains along its entire edge. -The exterior of the steamer was covered with hazy white spots and was greasy to the touch. -The stainless steel table supporting the steamer was covered with greasy brown and hazy white spots. -The floor between the steamer and the fryer was stained with dark brown stains. -The fryer was covered with hazy brown greasy residue. -The exterior lip of the fryer had brown stains that extended approximately 1 ½ inches down the sides of the fryer. -The blue gas supply lines for both the fryer and oven were covered with thick dark brown sludge that was greasy to the touch. -The floor between the fryer and grill/stove was stained dark brown stains. -The posterior upper edge of the grill located next to the stainless steel backsplash was covered with gray dust particles along its entire edge. -The outside of the grill/stove was covered with greasy hazy white spots. -The underside and legs of the mobile prep table had dark brown stains and was greasy to the touch. -The floor under the steamer table was covered black residue build-up. -The exterior of the food warmer was covered	D 282	See attached	

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D 282	Continued From page 7 with scattered brown and hazy white spots. -The bottom panel of the food warmer was crusted with brownish white residue. -Two of three walls in the dishwashing area had scattered brown and black dried stains. -The wall under the dishwasher had black stained drippings from the underside of the dishwasher down to the floor. -The floor under the dishwasher area had large dark brown stained area that measured approximate 1 foot along the wall border. -The floor next to the dishwasher had a large pad of white crystallized hard residue that measured approximately 8 inches wide by 6 inches long. Observation of the kitchen cleaning schedule form on 05/11/16 revealed: -The stove/catch pans, grill, ovens, all carts, all counters were scheduled to be cleaned after each use. -The reach-in cooler, freezer, dish room, and cook prep tables were scheduled to be cleaned daily. -The walk-in cooler was supposed to be swept and mopped daily. -The ice machine was supposed to be cleaned twice a month. -The kitchen walls in the cooking areas and kitchen floor were supposed to be cleaned daily. -The food steamer, food warmers, and fryer were not listed on the kitchen cleaning schedule Interview with a dietary aide on 05/11/16 at 2:45 p.m. revealed: -She was assigned to work in the dishwashing areas. -She was responsible to wash the dishes, keep the dishwashing area clean, and assist with keeping the cook and prep areas cleaned in the kitchen.	D 282	see attached	

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D 282	Continued From page 8 -She also helped with the food server if needed. -All walls in the kitchen were cleaned weekly. -The floors of the kitchen were swept and mopped after every meal and as needed. -The crystallized area on the floor next to the dishwasher had been there since 05/08/16. -She had told the food beverage director earlier in the week about the area. -She wasn't sure but she thought it was a leak in the detergent supply line from the dishwasher. Interview with a second dietary aide on 05/11/16 at 3:05 p.m. revealed: -She was assigned to be a server in the kitchen. -She helped the cooks, took the residents' food orders, served the plated food to the residents, cleaned the dining room, and helped wash dishes. -She was responsible to help clean the drink station, the food prep areas, and serving line. -She cleaned the walls in the kitchen as needed. -The floors of the kitchen were swept and mopped at end of shift. -She cleaned the ice machine when she saw it needed cleaning. -The reach-in cooler was the responsibility of everyone who worked in the kitchen. -The exterior of the reach-in cooler was wiped down with a sanitizing solution about once a shift. -The dietary staff was not allowed to use stainless steel cleaner in the kitchen. -The inside of the reach-in cooler was cleaned every other week. -The floor space between the ice machine and the front entrance wall was cleaned every shift. -She was not sure the last time this floor area was cleaned. -She was not responsible to clean the walk-in cooler, walk-in freezer, any of the main cooking areas, or the dishwashing areas.	D 282	See attached	

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D 282	Continued From page 9 Interview with the cook/kitchen shift manager on 05/11/16 at 3:15 p.m. revealed: -He was in charge of managing the dietary staff and maintaining the cleanliness of the food preparation and the kitchen. -The inside of the fryer was cleaned out every Tuesday. -The outside of the fryer was last cleaned about the middle of April 2016. -The dietary staff swept and mopped the floors in the kitchen at the end of each shift. -The problem with build-up and dirty areas on the kitchen floor was because he normally pressure washed the floors of the kitchen about twice a week but the pressure washer had been broken since mid-March 2016. -He did not tell the food beverage director the pressure washer was broken until 05/10/16. -A new pressure washer was coming in today and he would pressure wash the kitchen floors then. -The top and sides of the grill and stove were cleaned after each use. -The grill area next to the stainless steel back splash was cleaned whenever someone brought it to his attention the area needed to be cleaned. -The walls in the kitchen were cleaned as needed. -The walls in the kitchen were last cleaned about 2 weeks ago. -The reach-in cooler was supposed to be cleaned by whoever was assigned to the area. -He did not know the last time the reach-in cooler had been cleaned. -The facility had a kitchen cleaning schedule that was supposed to be checked off on daily. -He just cleaned the areas the cooks were responsible to cleaned. -The cooks were responsible to keep the cooking area, food prep areas, walk-in cooler, and walk-in	D 282	see attached	

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D 282	Continued From page 10 freezer clean. -The dishwasher was responsible to keep the dishwashing area clean. Interview with the food beverage director on 05/11/16 at 3:50 p.m. revealed: -The kitchen cleaning schedule and daily assignments sheets had been given to the dietary staff. -The kitchen cleaning schedule was supposed to be checked off daily as staff completed the cleaning tasks. -It was expected that all dietary staff cleaned the kitchen areas as assigned on the kitchen cleaning schedule. -She did not regularly check to see if the dietary staff had completed the check-off on the the cleaning list. -She trusted the all the dietary staff to do the cleaning as they were assigned to do. -The cooks were responsible to clean the cooking areas, food prep area, stove, grill, fryer, food steam, food warmer, steam table, and other cooking equipment. -The dishwasher was responsible to clean the dishes, the dishwashing area, and the stock room. -The food servers were responsible to clean the front kitchen area, beverage station, ice machine, and dining room. -The dietary staff was not allowed to use stainless steel cleaner in the kitchen because the county food sanitation inspector had said it was not supposed to be used in the kitchen. -The floors in the kitchen were swept and mopped daily. -All the wall in the kitchen were supposed to be cleaned every day. -The floors inside of the walk-in cooler and walk-in freezer were supposed to be swept and	D 282	see attached	

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D 282	Continued From page 11 mopped every day. -The racks inside of the walk-in cooler and walk-in freezer were supposed to be wiped down once a month. -The storage area was supposed to be cleaned every day. -The food prep area and the outside of the ice machine were supposed to be cleaned every day. -The problem with the greasy sludge on the gas lines in the kitchen was because the dietary staff was afraid to clean the areas due to the gas lines. -She would make sure the gas lines got cleaned. -She did not know about the leak under the dishwasher area. -She had called a repairman on 05/11/16 for the leak to be fixed. -She did not know the pressure washer was broken until last night. -It was expected for the dietary staff to notify her or the administrative staff of any repairs needed in the kitchen or the dining room so a work order could be put in. -She planned to monitor the dietary staff more closely to make sure cleaning was being done and repairs were reported. Interview with the Administrator on 05/11/16 at 4:20 p.m. revealed: -She was not aware of any problems with the cleanliness of the kitchen. -She had not check the kitchen for cleanliness. -She found out yesterday the pressure washer was broken. -A new pressure washer had been ordered for the facility. -She had trusted the food beverage director to monitor for the cleanliness of the kitchen. -She would be meeting with the food beverage director to talk about the cleaning of the kitchen. -The dietary staff would be doing some deep	D 282	See attached	

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D 282	Continued From page 12 cleaning in the kitchen this evening. Interview with a third dietary aide on 05/12/16 at 9:30 a.m. revealed: -The walls and floors in the kitchen were supposed to be cleaned every day but they were mainly cleaned every other day. -She wiped down the outside of the ice machine every other day. -She swept the floor area around and beside the ice machine every other day. -She was not sure about the last time this area had been swept. -The dietary staff cleaned the inside of the reach-in cooler every other day. -She wiped down the outside of the reach-in cooler every day but she did not wipe down the vent covers of the reach-in cooler. -The shelves, walls, and floors of the walk-in cooler and walk-in freezer were swept and mopped every other day. -The walls and floors in the dishwashing area were cleaned every other day. -The stock room was cleaned every day. -The floors in the stock room were swept and mopped every day. -The dietary staff was supposed to initial the kitchen cleaning schedule when a cleaning task was done. Interview with a second cook/kitchen shift manager on 05/12/16 at 9:45 a.m. revealed: -The cook was responsible to cook, make sure the kitchen was cleaned, and the kitchen equipment was working properly. -The stove, oven, and grill were cleaned after each use. -The dietary staff used degreaser and sanitizing solution to do the cleaning in the kitchen. -She wiped down the kitchen shelves and steam	D 282	See attached	

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D 282	Continued From page 13 table three times a week and as needed if there were spills. -She cleaned the floors and walls in the cooking areas about three times a week and if there was a spill. -The problem with dirt and grease build-up on the kitchen floors was because the pressure washer had been broken since mid-March. -The floors of the kitchen were normally pressure washed twice a week before the pressure washer broke down. -She did not tell the food beverage director or anyone else the pressure washer was broken. -She wiped down the outside of the food warmer and fryer every other day. -The inside of the fryer was last cleaned about two weeks ago. -The floor of the walk-in cooler was swept and mopped every day. -She was not sure the last time the floor inside of the walk-in freezer had been cleaned. -The shelves and walls inside of the walk-in cooler and walk-in freezer were cleaned about every other day. Interview with the Administrator on 05/12/16 at 11:20 a.m. revealed: -It was expected the cleanliness in the kitchen was maintained by the dietary staff. -The food beverage director was expected to supervise the dietary staff and make sure the kitchen was cleaned. -The food beverage director was in charge of the kitchen clean schedule and the kitchen assignments. -It was expected that if the food beverage director was having any problems with the cleanliness in the kitchen that she would report the problems to her. -No problems had recently been reported to her	D 282	see attached	

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D 282	Continued From page 14 from the food beverage director about the cleanliness in the kitchen. -During the kitchen inspection done by the county on April 27, 2016, the food beverage director had reported some cleaning needed to be done to the removable vents over the stove and oven. -This information was turned over to the facility maintenance to handle. -She had contacted her regional food dining director about problems with the cleanliness in the kitchen. -The regional food dining director had given her a weekly sanitation checklist that she planned to use to check the cleanliness in the kitchen weekly. -She planned to meet with the entire dietary staff to reinforce the expectations of maintaining cleanliness in the kitchen.	D 282	See attached	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by:	D 344	D344 Addendum per telephone with Jaime Waters on 7/18/16: FL-2 forms will be reviewed for accuracy when received and clarification will be obtained when needed. All residents records were audited and clarifications obtained if needed by the Regional Nurse, ED, and/or designee. The correction date is 5/16/16. W. Williams 7/18/16	

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D 344	Continued From page 15 Based on observation, interview, and record review, the facility failed to clarify and verify medication orders for 1 of 5 residents (#3) sampled who was being administered medications not included on the resident's current FL-2 including medications for diabetes, hypothyroidism, acid reflux, and depression. The findings are: Review of Resident #3's current FL-2 dated 10/28/15 revealed the resident's diagnoses included diabetes mellitus type II, hypothyroidism, hypertension, fibromyalgia, chronic pain, gastroesophageal reflux disease, and anxiety. Review of Resident Service Notes for Resident #3 revealed: -On 04/01/16, the resident requested to go to the hospital for vomiting and she felt she was dehydrated. -The resident was hospitalized and had not returned to the facility as of 05/12/16. Review of Resident #3's record revealed multiple discrepancies in medications ordered and administered including the following: A. Review of Resident #3's February 2016 and March 2016 medication administration records (MARs) revealed: -There was a computer printed entry for Levemir inject 20 units subcutaneously at bedtime. (Levemir is long-acting insulin used to lower blood sugar.) -Levemir was documented as administered daily at 8:00 p.m. from 02/01/16 - 03/31/16. -The resident's blood sugar was documented as 81 - 358 in February 2016. -The resident's blood sugar was documented as 58 - 246 in March 2016.	D 344	See attached	

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D 344	Continued From page 16 Review of Resident #3's current FL-2 dated 10/28/15 revealed there was no order for Levemir listed on the FL-2. Review of Resident #3's physician's orders revealed: -There was no subsequent order after to FL-2 for the resident to receive Levemir. -There was an order dated 02/05/15 (prior to the FL-2) for Levemir 20 units at bedtime. -There was no documentation of contact with the physician regarding the discrepancy with the Levemir. Observation of medications on hand on 05/12/16 revealed there was a Levemir insulin pen with an open date noted as 03/25/16. Refer to interview with Resident #3 on 05/11/16 at 8:30 p.m. Refer to interview with the Administrator on 05/11/16 at 4:14 p.m. Refer to interview with a medication aide on 05/12/16 at 3:55 p.m. Refer to interview with the Administrator on 05/12/16 at 1:30 p.m. Refer to interview with a nurse at Resident #3's primary physician's office on 05/12/16 at 4:14 p.m. B. Review of Resident #3's February 2016 and March 2016 medication administration records (MARs) revealed: -There was a computer printed entry for Levothyroxine 112mcg 1 tablet daily.	D 344	see attached	

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D 344	Continued From page 17 (Levothyroxine is used to treat hypothyroidism.) -Levothyroxine was documented as administered daily at 9:00 a.m. from 02/01/16 - 03/31/16. Review of Resident #3's current FL-2 dated 10/28/15 revealed there was no order for Levothyroxine listed on the FL-2. Review of Resident #3's physician's orders revealed: -There was no subsequent order after to FL-2 for the resident to receive Levothyroxine. -There was no documentation of contact with the physician regarding the discrepancy with the Levothyroxine. Observation of medications on hand on 05/12/16 revealed there was a supply of Levothyroxine 112mcg tablets dispensed on 02/09/16 with 2 of 30 tablets remaining. Refer to interview with Resident #3 on 05/11/16 at 8:30 p.m. Refer to interview with the Administrator on 05/11/16 at 4:14 p.m. Refer to interview with a medication aide on 05/12/16 at 3:55 p.m. Refer to interview with the Administrator on 05/12/16 at 1:30 p.m. Refer to interview with a nurse at Resident #3's primary physician's office on 05/12/16 at 4:14 p.m. C. Review of Resident #3's February 2016 and March 2016 medication administration records (MARs) revealed:	D 344	see attached	

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D 344	Continued From page 18 -There was a computer printed entry for Amaryl 2mg take ½ tablet with breakfast and with supper. (Amaryl is an oral antidiabetic medication used to lower blood sugar.) -Amaryl was documented as administered twice daily at 7:00 a.m. and 4:00 p.m. from 02/01/16 - 03/31/16. -The resident's blood sugar was documented as 81 - 358 in February 2016. -The resident's blood sugar was documented as 58 - 246 in March 2016. Review of Resident #3's current FL-2 dated 10/28/15 revealed there was no order for Amaryl listed on the FL-2. Review of Resident #3's physician's orders revealed: -There was no subsequent order after to FL-2 for the resident to receive Amaryl. -There was an order dated 01/27/15 (prior to the FL-2) for Amaryl 1mg with breakfast and supper. -There was no documentation of contact with the physician regarding the discrepancy with the Amaryl. Observation of medications on hand on 05/12/16 revealed there was a supply of Amaryl 2mg tablets dispensed on 03/14/16 with 2 half tablets remaining. Refer to interview with Resident #3 on 05/11/16 at 8:30 p.m. Refer to interview with the Administrator on 05/11/16 at 4:14 p.m. Refer to interview with a medication aide on 05/12/16 at 3:55 p.m.	D 344	See attached	

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D 344	Continued From page 19 Refer to interview with the Administrator on 05/12/16 at 1:30 p.m. Refer to interview with a nurse at Resident #3's primary physician's office on 05/12/16 at 4:14 p.m. D. Review of Resident #3's February 2016 and March 2016 medication administration records (MARs) revealed: -There was a computer printed entry for Remeron 30mg take 2 tablets at bedtime. (Remeron is an antidepressant.) -Remeron was documented as administered daily at 8:00 p.m. from 02/01/16 - 03/31/16. Review of Resident #3's current FL-2 dated 10/28/15 revealed there was no order for Remeron listed on the FL-2. Review of Resident #3's physician's orders revealed: -There was no subsequent order after to FL-2 for the resident to receive Remeron. -There was an order dated 09/29/15 (prior to the FL-2) for Remeron 30mg take 2 tablets at bedtime. -There was no documentation of contact with the physician regarding the discrepancy with the Remeron. Observation of medications on hand on 05/12/16 revealed there was a supply of Remeron 30mg tablets dispensed on 03/22/16. Refer to interview with Resident #3 on 05/11/16 at 8:30 p.m. Refer to interview with the Administrator on 05/11/16 at 4:14 p.m.	D 344	See attached	

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D 344	Continued From page 20 Refer to interview with a medication aide on 05/12/16 at 3:55 p.m. Refer to interview with the Administrator on 05/12/16 at 1:30 p.m. Refer to interview with a nurse at Resident #3's primary physician's office on 05/12/16 at 4:14 p.m. E. Review of Resident #3's current FL-2 dated 10/28/15 revealed an order for Protonix 40mg 1 daily before breakfast. (Protonix is for acid reflux.) Review of the February 2016 and March 2016 medication administration records (MARs) revealed: -Protonix was not included on the MARs. -There was computer printed entry for Omeprazole 40mg 1 capsule before breakfast and before supper. (Omeprazole is for acid reflux. Omeprazole is the generic for Prilosec. Prilosec and Protonix are not the same medication.) -Omeprazole was documented as administered twice daily at 7:00 a.m. and 3:30 p.m. from 02/01/16 - 03/31/16. Review of physician's orders for Resident #3 revealed: -There was no subsequent order after the FL-2 dated 10/28/15 indicating a change in order for the Protonix or an order for Omeprazole. -There was an order dated 12/16/14 (prior to the FL-2) to change Protonix to Omeprazole 20mg daily 30 - 60 minutes before eating. -There was an order dated 04/27/15 (prior to the FL-2) to increase Omeprazole to 40mg twice daily	D 344	See attached	

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D 344	Continued From page 21 before breakfast and supper. -There was no documentation of contact with the physician regarding the discrepancy with the Protonix and Omeprazole. Observation of medications on hand on 05/12/16 revealed there was a supply of Omeprazole 40mg capsules dispensed on 02/29/16. Refer to interview with Resident #3 on 05/11/16 at 8:30 p.m. Refer to interview with the Administrator on 05/11/16 at 4:14 p.m. Refer to interview with a medication aide on 05/12/16 at 3:55 p.m. Refer to interview with the Administrator on 05/12/16 at 1:30 p.m. Refer to interview with a nurse at Resident #3's primary physician's office on 05/12/16 at 4:14 p.m. _____ Telephone interview with Resident #3 on 05/11/16 at 8:30 p.m. revealed: -She was currently in a rehab facility to get her strength back and planned to return to the facility on Friday, 05/13/16. -She had gone to the hospital on 04/01/16 because she had been vomiting and she thought she was dehydrated. -She got some medication she was allergic to while at the hospital and got an infection at the hospital and had to go to rehab. -She did not have any problems with getting her medications when she was at the facility. -Her medications were administered like they	D 344	See attached	

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D 344	Continued From page 22 were supposed to be when she was at the facility. Interview with the Administrator on 05/11/16 at 4:14 p.m. revealed: -She was not aware of the discrepancies with Resident #3's medication orders. -There may have been two pages of the FL-2 and one was missing. -She would look for a second page to the FL-2. -The medication aides would be responsible for getting clarification if needed. -The Resident Services Director (RSD) was responsible for checking behind the medication aides. -The RSD left the position in January 2016 and that position was currently vacant. -She would check with the physician and the pharmacy. Interview with a medication aide on 05/12/16 at 3:55 p.m. revealed: -The medication aide on duty was responsible for clarifying any medications orders if needed. -If an FL-2 was received and medications orders did not match the medications a resident was receiving, the medication aide was supposed to get clarification. -She was unaware of the discrepancies with Resident #3's medication orders. Interview with the Administrator on 05/12/16 at 1:30 p.m. revealed: -She had contacted the pharmacy and they did not have any additional pages to the current FL-2 dated 10/28/15. -She asked the pharmacy to fax current orders for Resident #3's medications to the facility. -She also contacted Resident #3's primary physician's office about the medications and she was waiting to hear back from the physician for	D 344	See attached	

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D 344	Continued From page 23 clarification of the orders. Telephone interview with a nurse at Resident #3's primary physician's office on 05/12/16 at 4:14 p.m. revealed: -The primary physician was unavailable for interview. -The facility had requested clarification for some of Resident #3's medications today, 05/12/16. -The request was in the physician's folder and would be sent back to the facility once the physician had reviewed it. -The nurse did not want to answer questions about the resident's medications since the physician would be clarifying the orders. -The nurse did not know when the physician would review and clarify the orders. No further information was received from the pharmacy or primary physician's office regarding Resident #3's medication orders.	D 344	See attached	
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.	D 376	D376 Addendum per telephone with Jaime Waters on 7/18/16: The med aide on duty will communicate any clarifications or order changes to the resident when received. The med aides will review MARS, orders, and medications for S-A residents. If there are any discrepancies or non-compliance, the supervisor and physician will be notified. The RN case manager does S-A assessments at least quarterly and will notify the GD or RSD of any discrepancies or concerns. The correction date is 5/16/16. W. Williams 7/18/16	

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D 376	Continued From page 24 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure compliance with the facility's policies and procedures for self-administration of medications for 2 of 2 sampled residents (#6, #7) with orders to self-administer medications. The findings are: Review of the facility's policies and procedures for self-administration for medications revealed: -If a resident wishes to self-administer his/her medication, the Resident Service Director (RSD) (or designee) will assess the resident's ability to participate, by completing a Self-Administration of Medication Assessment. The assessment must be completed upon move-in or resident request. -The RSD will interview the resident to determine their ability to identify, prepare and administer medications/treatments. -Based on the assessment, a decision is made as to whether or not the resident is a candidate for self-administration. This will be recorded on the assessment tool. -A valid written physician's order must be obtained for each resident conducting self-administration of medications/treatments. -The RSD will assess accuracy and compliance of self-administration by periodic observation and counting of doses. -Storage of self-administered medications/treatments will comply with state/federal and community requirements for medication storage. -If the RSD determines that a resident is unwilling/unable to take medications as prescribed, he/she will meet with the resident concerning the need for possible assistance with medications. The RSD/Wellness Director will contact the resident's healthcare provider regarding questions, concerns and observations	D 376	see attached	

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D 376	Continued From page 25 related to the resident's medications. -The self-administration of medications will be documented on the resident's service plan. -An update list of the resident's medications will be maintained in the resident record/file. If the resident is not self-administering all of his/her medications, mark the medication administration record (MAR) to identify individual medications that are self-administered by the resident. -The RSD (or designee) will document all communication with the resident and his/her healthcare provider in the resident's record/file. 1. Review of Resident #6's current FL-2 dated 03/17/16 revealed the resident's diagnoses included hypertension, gastroesophageal reflux disease, hyperlipidemia, osteoarthritis, anemia, irritable bowel syndrome, low back syndrome, and depression. Review of Resident #6's current FL-2 dated 03/17/16 revealed medication orders included: -Aspirin 81mg 1 tablet once daily. (Aspirin may be used decrease risk of heart disease.) -Lasix 40mg 1 tablet every morning. (Lasix is a diuretic.) -Tab-A-Vite 1 tablet once daily. (Tab-A-Vite is a supplement.) -Macrodantin 50mg 1 tablet every morning. (Macrodantin is an antibiotic.) -Vitamin D-3 1000 units 2 tablets once daily. (Vitamin D-3 is a supplement.) -Lexapro 10mg 1 tablet once daily. (Lexapro is an anti-depressant.) -Losartan Potassium 100mg 1 tablet every morning. (Losartan Potassium lowers blood pressure.) -Vitamin B-12 1000mcg 2.5 tablets every day. (Vitamin B-12 is a supplement.) -Aciphex 20 mg 1 tablet twice daily. (Aciphex is	D 376	see attached	

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D 376	Continued From page 26 for acid reflux.) -FML Liquifilm 0.1% eye drops 1 drop to both eyes twice a day. (FML Liquifilm is used to treat certain eye conditions due inflammation or injury.) -Mobic 7.5mg 1 tablet twice a day. (Mobic is for pain and inflammation). -Metoprolol 25mg twice daily. (Metoprolol is for blood pressure/heart.) -Carafate 1gm/10ml take 10ml before meals and at bedtime. (Carafate is an anti-ulcer medication.) -TUMS 3 tablets once daily as needed for indigestion. (TUMS is an antacid.) -Hydrocodone-Chlorphen 10-8mg/5ml take 5ml every 12 hours as needed for cough. (Hydrocodone-Chlorphen is a narcotic used to treat cough.) -Tylenol 325mg 2 tablets twice daily as needed for pain. (Tylenol is a pain reliever.) -Nitrostat 0.4mg 1 tablet sublingually every 5 minutes times 3 doses as needed for chest pain. (Nitrostat is an antianginal medication used to treat chest pain). -Phenergan 25mg 1 tablet every 8 hours as needed for nausea. (Phenergan is used to treat nausea.) -Zyrtec 10mg 1 tablet daily at bedtime as needed. (Zyrtec is used to treat allergy symptoms.) -There was an order that the resident may self-administer all medications. Review of a subsequent physician's orders in Resident #6's record revealed: -There was an order dated 05/02/16 for FML Liquifilm 0.1 % eye drops to be given one drop both eyes four times a day for 2 weeks. -There was an order dated 03/26/16 for the medication aide to check/verify that all orders are current and that the resident was taking all medications as listed on the MAR. Any	D 376	see attached	

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D 376	Continued From page 27 discrepancies would be clarified with the medical doctor and reported to the RSD weekly. Review of the May 2016 MAR for Resident #6 revealed: -FML Liquifilm 0.1 % eye drops were scheduled to be administered at 9 a.m. and 8 p.m. on 05/01/12 and 05/17/16 through 05/31/16. -FML Liquifilm 0.1 % eye drops were scheduled to be administered at 8 a.m., 12 p.m., 4 p.m., and 8 p.m. from 05/02/16 through 05/16/16. -Mobic and Metoprolol were scheduled to be administered at 9 a.m. and 8 p.m. -Lexapro, Losartan, Tab-A-Vite and Vitamin B-12 were scheduled to be administered at 9 a.m. -Carafate 1gm/10ml was scheduled to be administered before meals and at bedtime but no administration times were listed. -Aspirin, Lasix, Macrodantin, and Vitamin D-3 were scheduled to be administered once daily but no administration times were listed. -Aciphex was scheduled to be administered twice daily but no administration times were listed. -Hydrocodone-Chlorphen 10-8mg/5ml was scheduled every 12 hours as needed for cough. -TUMS - 3 tablets was scheduled once daily as needed for indigestion. -Tylenol 325mg - 2 tablets was scheduled twice daily as needed for pain. -Nitrostat 0.4mg sublingually was scheduled every 5 minutes times 3 doses as needed for chest pain. -Phenergan 25mg was scheduled every 8 hours as needed for nausea. -Zyrtec 10mg was scheduled daily at bedtime as needed. -There was no documentation on the MAR that Resident #6's medications/orders were verified by the medication aide.	D 376	See attached	

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D 376	Continued From page 28 Review of the April 2016 MAR and March 2016 MAR for Resident #6 revealed there was no documentation on the MARs that the resident's medications/orders that were self-administered were verified by the medication aide. Interview with Resident #6 on 05/12/16 12:50 p.m. revealed: -She self-administered all of her medications except for her eye drops. -The medication aides at the facility administered her eye drops as ordered by her doctor. -She had 2 weekly pill organizers in her top right dresser drawer. -Her daughter came and prefilled the weekly pill organizer for her about every 2 weeks. -She took her medications as they were arranged in the weekly pill organizers. -She was currently self-administering Aspirin, Lasix, Macrodantin, Vitamin D-3, Lexapro, Losartan Potassium, Vitamin B-12, Aciphex and Mobic using her weekly pill organizers. -She self-administered her prescribed medication, Carafate before each meal and at bedtime. -TUMS, Nitrostat, Zyrtec were not placed in her weekly pill organizer and she took those medications as needed. -She was taking Tylenol 500mg as needed instead of Tylenol 325mg for pain. -She no longer took the Tab-A-Vite, Hydrocodone-Chlorphen, or Phenergan. -She was unsure of how long it had been since she last took Tab-A-Vite, Hydrocodone-Chlorphen, or Phenergan. -She had a prescription bottle that contained 6 Hydrocodone-APAP 5-325mg tablets. -She got this medication for pain from the hospital last month after she had a fall at the facility. -She no longer took the Hydrocodone-APAP	D 376	See attached	

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D 376	Continued From page 29 5-325mg. -Resident #6 was not sure when medication aide last came to check her medications in her room. -She did not recall if any staff at the facility had asked her what medications she was taking. -Resident #6 stated, "They (medication aides) trust me but I don't want to do anything that I am not supposed to do". -Her daughter called in and picked her medication refills from the pharmacy. Review of Resident #6's medications in her room on 05/12/16 at 12:50 p.m. and the resident's medication orders revealed: -The pill bottles for Aspirin, Lasix, Macrodantin, Vitamin D-3, Lexapro, Losartan Potassium, Vitamin B-12, Aciphex, Mobic, and Tylenol 500mg were kept in the top right dresser drawer of Resident #6. -There were 2 weekly pill organizers that contained pills in the top right dresser drawer of Resident #6. -The Carafate and TUMS for Resident #6 were kept in the right kitchenette cabinet in the room of Resident #6-TUMS. -Resident #6 kept her Nitrostat in her purse. -Aspirin, Lasix, Macrodantin, Vitamin D-3, Lexapro, Losartan Potassium, Vitamin B-12, Aciphex, Mobic, Carafate, TUMS, and Nitrostat were on hand and matched the most recent medication orders. -Tab-A-Vite and Phenergan were not on hand but were on the recent medication orders. -The prescription bottle that contained 6 Hydrocodone-APAP 5-325mg tablets was kept in the top right dresser drawer of Resident #6. -The label on the prescription bottle of Hydrocodone-APAP read the medication was dispensed on April 18, 2016 with an original quantity of 20 tablets dispensed.	D 376	See attached	

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D 376	Continued From page 30 -The instructions on the Hydrocodone-APAP 5-325mg label read take 1 tablet by mouth three times a day as needed for pain rated 2-5 on the pain scale. -Hydrocodone-APAP was on hand but there was not current medication order. Review of a written entry in the progress notes for Resident #6 dated 04/18/16 revealed: -Resident #6 fell in front of the reception's desk in the facility lobby on 04/18/16. -Resident #6's family took her to an urgent care center to be checked out after her fall. -Resident #6 came back to the facility with pain medication from the urgent care visit but no discharge instructions from the urgent care visit. Attempt to interview Resident #6's physician during the survey was unsuccessful. Review of the Medication Self-Administration Assessment Form for Resident #6 revealed: -The resident's initial assessment was done on 11/13/12. -The resident was reassessed for medication self-administration on 02/18/13, 05/17/13, 08/05/13, 12/09/13, 03/11/14, 06/20/14, 10/06/14, 01/04/15, 03/31/15, and 06/30/15. -No self-administration assessment were done for Resident #6 from July 2015 through March 2016. -The last self-administration assessment for Resident #6 was done on 04/09/16. -There was a score of satisfactory beside each of the questions on the all forms for all assessment dates. -No issues or concerns were documented on the assessment form. Attempt to interview facility nurse who did the self-administration assessments during the	D 376	see attached	

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D 376	Continued From page 31 survey was unsuccessful. Interview with a medication aide on 05/12/16 at 4:30 p.m. revealed: -She normally checked with Resident #6 for compliance with self-administration of her medications. -She usually checked the medications on hand for Resident #6 against the current MAR for Resident #6. -She did not ask if Resident #6 was actually taking the medications listed on the current MAR when she did the self-administration compliance checks. -She was not sure how often she was supposed to check Resident #6 for self-medication compliance. -She had not documented on the MAR when she checked Resident #6 for self-medication compliance. -She was not aware Resident #6 had Hydrocodone-APAP in her room with her other medications. -Resident #6 did not tell her when the resident got the Hydrocodone-APAP. Refer to interview with the Administrator on 05/12/16 at 5:10 p.m. 2. Review of Resident #7's current FL-2 dated 02/16/16 revealed the resident's diagnoses included hypertension, Vitamin D deficiency, polyarthritis, and shoulder pain. Review of Resident #7's current FL-2 dated 02/16/16 revealed medication orders included: -Estrace 0.01% cream apply vaginally twice weekly. (Estrace is hormonal treatment used for symptoms associated with menopause.) -Trimo-San with Milex Jector 0.25% gel apply	D 376	see attached	

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D 376	Continued From page 32 vaginally every Wednesday. (Trimo-San with Milex Jector is used with pessary for support of vaginal prolapse.) -Vitamin B-12 1000mcg once daily every Monday, Wednesday, and Friday. (Vitamin B-12 is a supplement.) -Vitamin D-3 1000mcg once daily every Monday, Wednesday, and Friday. (Vitamin D-3 is a supplement.) -Benicar HCT 20-12.5mg once daily. (Benicar HCT is used to treat hypertension). -Macrobid 100mg once daily. (Macrobid is an antibiotic used to treat urinary tract infection.) -Neurontin 100mg 3 times daily as needed. (Neurontin is used to treat nerve pain.) -Ativan 0.5mg once daily as needed for anxiety. (Ativan is used to treat anxiety.) -Tylenol ES 500mg every 4 hours as needed for pain/fever. (Tylenol is a pain reliever.) -There was an order that the resident may self-administer all medications. -There was an order to review medications/MAR with resident weekly to ensure compliance every Wednesday. Review of physician's orders for Resident #7 revealed: -There was an order dated 12/20/15 (prior to the current FL-2) for Norvasc 5mg once daily. (Norvasc is used to treat hypertension.) -There was an order dated 03/30/16 for Losartan HCT 50/12.5mg 1 tablet twice daily and Benicar HCT 20/12.5mg once daily was discontinued. (Losartan HCT is used to treat hypertension. Losartan HCT and Benicar HCT are not the same.) -There was a signed physician's order sheet dated 04/15/16 with an order to review medications/MAR with resident weekly to ensure compliance every Wednesday.	D 376	See attached	

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D 376	Continued From page 33 -Losartan HCT and Norvasc were not listed as current medications on the signed physician's order dated 04/15/16. Review of the April 2016 and May 2016 MARs for Resident #7 revealed: -Macrobid and Hydrochlorothiazide (lowers blood pressure) were scheduled to be administered at 9 a.m. -Estrace 0.01% cream was scheduled to be administered vaginally twice weekly on Mondays and Fridays. -Trimo-San with Milex Jector 0.25% gel was scheduled to be administered vaginally every Wednesday. -Vitamin B-12 and Vitamin D-3 were scheduled to be administered once daily every Monday, Wednesday, and Friday. -Neurontin was scheduled to be administered 3 times daily as needed. -Ativan was scheduled to be administered once daily as needed for anxiety. -Tylenol Extra Strength was scheduled to be administered every 4 hours as needed for pain/fever. -Norvasc was scheduled to be administered once daily on the May 2016 MAR but Norvasc was not listed on the April 2016 MAR. -Losartan/HCT was not listed on the April 2016 or May 2016 MARs. -It was documented on 05/05/16 the medication aide reviewed the medications and MAR with the resident to ensure compliance. -It was documented on 04/06/16, 04/13/16, 04/20/16, and 04/27/16 the medication aide reviewed the medications and MAR with the resident to ensure compliance. Interview with Resident #7 on 05/12/16 at 1:10 p.m. revealed:	D 376	see attached	

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D 376	Continued From page 34 -She self-administered all of her medications -She kept her medications in the second drawer of the chest in her bedroom. -She and her daughter ordered the refills of her medications mainly through the mail order pharmacy. -The medication aide last came and checked her medications sometime in April 2016. -No staff at the facility asked her if there were changes in her medications. -She had not taken Neurontin for about a year because the medication had been discontinued by her doctor. -She had not self-administered Trimo-San w/Milex-Jector for about 6-9 months because the medication had been discontinued by her doctor. -She reported she had been prescribed Losartan HCT about 2 months ago because Benicar HCT was too expensive. -She was unsure of how long she had been taking Norvasc but it had been prescribed by her physician. Review of Resident #7's medications in her room on 05/12/16 at 1:15 p.m. and the resident's medication orders revealed: -Estrace, Vitamin B-12, Vitamin D-3, Macrobid, Ativan, and Tylenol Extra Strength were on hand and matched the most current orders. -Losartan HCT 50/12.5 mg and Norvasc 5mg were on hand but no current orders for these medications. Attempt to contact Resident #6's physician during the survey was unsuccessful. Review of the Medication Self-Administration Assessment Form for Resident #7 revealed: -The resident was assessed for medication self-administration on 04/14/15, 06/30/15, and	D 376	See attached	

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D 376	Continued From page 35 02/06/16. -There was a score of satisfactory beside each of the questions on the all forms for all assessment dates. -No issues or concerns were documented on the assessment form. Attempt to interview facility nurse who did the self-administration assessments during the survey were unsuccessful. Interview with a second medication aide on 05/12/16 at 3:55 p.m. revealed: -She had reviewed the medications for Resident #7 for compliance for self-administration. -She checked the medications on hand for Resident #7 against what was listed on the MAR. -She did not ask Resident #7 if she actually took the medication as it was printed on the MAR. -She did not ask Resident #7 if she had stopped current medications or started any new medications when she looked at the medications on hand. -She initialed Resident #7's MAR after she checked the medications on hand for self-administration. -She last checked Resident #7 for self-medication compliance on 05/05/16. -Resident #7 did not tell her that she was not using the Trimo-San with Milex-Jector jelly. -She recalled Resident #7 had stopped talking the Neurontin. -The medication aide had called Resident #7's physician about the Neurontin but she was not able to talk to the physician to verify the discontinuation of the Neurontin. -The medication aide did not document the phone call to Resident #7's physician. -The medication aide did not do any further follow-up with Resident #7's physician about the	D 376	see attached	

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D 376	Continued From page 36 discontinuation of Neurontin. -She would have to check to see if Resident #7 was supposed to be taking Benicar HCT, Hydrochlorothiazide, or Norvasc. Refer to interview with the Administrator on 05/12/16 at 5:10 p.m. Interview with the Administrator on 05/12/16 at 5:10 p.m. revealed: -She was unaware of the discrepancies with the self-administration of medications for the residents. -It was expected for the medication aides to verify the residents' medications are current and any discrepancies should be reported to the resident's doctor for clarification. -She was not sure how often the medication aides did the compliance checks for self-administration of medications with the residents. -She would be meeting with the medication aides to make sure it was documented when compliance checks for self-administration of medications were done.	D 376	See attached	
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 informed of the findings when necessary. This Rule is not met as evidenced by: Based on record review and interview, the facility	D 406	Addendum per telephone with Jaime Waters on 7/18/16: All recommendations for all residents were followed up. The RCC is responsible for following up on recommendations. Recommendations will be faxed or hand-delivered to the physicians. If no response in 2 to 3 days, RCC will call the physicians' offices to follow up. RCC will implement and order changes. The ED and SCA Director will monitor at least quarterly. The correction date is 5/16/16. W. Williams 7/18/16	

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D 406	Continued From page 37 failed to follow up on medication review recommendations for 2 of 6 residents (#8, #9) sampled for review related to medications for high cholesterol and underactive thyroid (#9) and medications for anxiety (#8). The findings are: 1. Review of Resident #9's current FL-2 dated 02/15/16 revealed: -The resident's diagnoses included hyperlipidemia, muscle weakness, epilepsy, cerebrovascular disease, and rheumatoid arthritis. -There was an order for Questran (4gm) 1 packet into liquid and drink twice a day. (Questran lowers cholesterol. The manufacturer recommends Questran be taken at a different time than other medications because Questran can bind the other medications and prevent them from being absorbed.) -There was an order for Synthroid 150mcg take 1 tablet daily. (Synthroid is used to treat hypothyroidism.) Review of Resident #9's current medication review dated 03/25/16 revealed: -The pharmacist noted the resident took Questran and Synthroid. -The pharmacist noted the Questran should be administered one hour after or 4 hours prior to other medications. -The pharmacist noted the times of administration for Questran should be separated from other medications, including the Synthroid. Review of the April 2016 and May 2016 medication administration records (MARs) revealed: -Questran was documented as administered twice daily at 9:00 a.m. and 5:00 p.m. -Synthroid was documented as administered	D 406	See attached	

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	HAL098029	A. BUILDING: _____ B. WING _____	R-C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD VILLAGE	1730 PARKWOOD BLVD WILSON, NC 27895

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D 406	Continued From page 38 once daily at 9:00 a.m. -The resident also had six other oral medications documented as administered at the same time as Questran at 9:00 a.m. -The other 9:00 a.m. oral medications included K-Dur (a potassium supplement), Remeron (an antidepressant), Probiotic Formula (a supplement), Zoloft (an antidepressant), and Keppra (for seizures.) -There was no documentation the time of administration of Questran was changed based on the recommendation to avoid interactions. Interview with the lead medication aide on 05/12/16 at 9:48 a.m. revealed: -She was not aware of the medication recommendation to separate the administration time of Questran from the other medications. -She sometimes gave thyroid medications before breakfast to residents, including Resident #9's Synthroid. -She administered Resident #9's morning medications at the same time as the Questran today, including the Synthroid. Observation of the lead medication aide on 05/12/16 at 9:48 a.m. revealed: -She wrote "7:30 a.m." over the printed time of 9:00 a.m. for the administration time of Synthroid. -She wrote "12N" over the printed time of 9:00 a.m. for the morning administration of Questran. Review of labwork for Resident #9 dated 04/06/16 revealed the resident's thyroid stimulating hormone (TSH) level was 8.160 (0.350 - 4.500) on 04/06/16. Review of a physician's order dated 04/08/16 revealed the physician ordered an increase in the Synthroid dosage to 175mcg daily.	D 406	See attached	

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D 406	Continued From page 39 Refer to interview with the lead medication aide on 05/12/16 at 1:20 p.m. Refer to interview with the Administrator on 05/12/16 at 1:30 p.m. 2. Review of Resident #8's current FL-2 dated 02/15/16 revealed: -The resident's diagnoses included memory loss, atrial fibrillation, hypertension, hypercholesterolemia, and transient ischemic attack. -There was an order for Alprazolam 0.25mg take ½ tablet once daily as needed for anxiety. (Alprazolam is an anxiolytic.) Review of Resident #8's current medication review dated 03/25/16 revealed: -The pharmacist noted the resident had an order for prn (as needed) Alprazolam. -The pharmacist noted the resident had not used the Alprazolam in December 2015 or January 2016. -The pharmacist recommended the facility may wish to get an order to discontinue the Alprazolam due to non-use. Review of Resident #8's record revealed: -There was no documentation the recommendation to discontinue the Alprazolam had been forwarded to the physician. -There was no order to discontinue the Alprazolam. Review of the March 2016, April 2016, and May 2016 medication administration records (MARs) revealed: -There was an entry for Alprazolam 0.25mg take ½ tablet every day as needed.	D 406	see attached	

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D 406	Continued From page 40 -One dose of Alprazolam was documented as administered on 03/04/16 at 7:40 a.m. -No other doses of Alprazolam were documented from 03/05/16 - 05/12/16. Interview with a medication aide on 05/12/16 at 3:35 p.m. revealed: -Resident #8 did not usually have anxiety. -The resident did not usually need the Alprazolam. Refer to interview with the lead medication aide on 05/12/16 at 1:20 p.m. Refer to interview with the Administrator on 05/12/16 at 1:30 p.m. --- Interview with the lead medication aide on 05/12/16 at 1:20 p.m. revealed: -The Resident Services Director (RSD) was usually responsible for following up on the medication review recommendations. -The facility's previous RSD left in December 2015 or January 2016. -She had been working on catching up on the medication review follow-ups but she had not finished working on them. Interview with the Administrator on 05/12/16 at 1:30 p.m. revealed: -The RSD would usually follow-up on medication review recommendations. -The RSD left on 01/07/16 and the position was currently vacant. -She had given the medication recommendations to the lead medication aide to work on. -The facility also has a nurse case manager that works on weekends that could help with any nursing recommendations.	D 406	see attached	

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D 406	Continued From page 41 -She received the most recent recommendations from the Consultant Pharmacist around the first of April 2016. -She left copies of the recommendations for the nurse case manager to review. -She did not directly assign the nurse case manager the responsibility of following up on the recommendations. -She would make sure the recommendations got assigned and followed up.	D 406	See attached	
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	D 468	0468 Addendum per telephone with Jaime Waters on 7/18/16: New hires for the SCU will have 6 hours of orientation within the first week of employment and and additional 20 hours of SCU training within 6 months of employment. The ED and SCU Director will monitor tracking tool and certificates at least quarterly to assure compliance. The correction date is 6/16/16. W. Williams	

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D 468	Continued From page 42 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. This Rule is not met as evidenced by: Based on observation, interview, and review of personnel files, the facility failed to assure 2 of 3 staff (A, B) sampled who were responsible for personal care and supervision within the special care unit completed 20 hours of training specific to the population being served within 6 months of employment. The findings are: 1. Review of Staff A's personnel file on 05/12/16 revealed: -Staff A was hired as a medication aide on 09/10/12. -Staff A completed 6 hours of special care unit (SCU) orientation training on 09/11/12. -She had documentation of 5 additional hours of training specific to the SCU population on 09/11/12. -There was no documentation of any other training specific to the SCU population within 6 months of hire, from 09/10/12 - 03/10/13. -She had 9.75 hours of training specific to the SCU population from 06/03/13 - 06/16/15, more than 6 months after hire. Observation during the survey revealed Staff A worked as medication aide on first shift in the SCU from 05/10/16 - 05/12/16. Interview with the Administrator on 05/12/16 at 6:10 p.m. revealed: -Staff A had worked at the facility for a few years	D 468	see attacled	

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D 468	Continued From page 43 and should have the SCU training on file. -She would check the facility's training records to see if there was more documented training on file for Staff A. Refer to interview with the Administrator on 05/12/16 at 6:10 p.m. Refer to interview with the Memory Care Director (MCD) on 05/12/16 at 6:35 p.m. 2. Review of Staff B's personnel file on 05/12/16 revealed: -Staff B was hired as a nurse aide on 06/17/14. -Staff B completed 6 hours of special care unit (SCU) orientation training on 06/23/14 -She had documentation of 6 additional hours of training specific to the SCU population on 06/23/14, 2 hours on 11/14/14, and 2 hours on 11/25/14 (total 10 hours). -There was no documentation of any other training specific to the SCU population within 6 months of hire, from 06/17/14 - 12/17/14. -She had 1 hour of training specific to the SCU population on 06/15/15, more than 6 months after hire. Observation during the survey revealed Staff B worked as nurse aide on second shift in the SCU from 05/10/16 - 05/12/16. Interview with the Administrator on 05/12/16 at 6:10 p.m. revealed: -Staff B had worked at the facility for a couple of years and should have the SCU training on file. -She would check the facility's training records to see if there was more documented training on file for Staff B. Interview with Staff B on 05/12/16 at 6:30 p.m.	D 468	See attached	

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D 468	Continued From page 44 revealed: -She had worked in the SCU since she was hired in 2014. -She had two days of training on the SCU when she was first hired. -She did not know how many hours of training credit she received but the training lasted all day on both days. -She remembered watching a video during the training. -She did not recall any other training on the SCU population. Refer to interview with the Administrator on 05/12/16 at 6:10 p.m. Refer to interview with the Memory Care Director (MCD) on 05/12/16 at 6:35 p.m. --- Interview with the Administrator on 05/12/16 at 6:10 p.m. revealed: -The Resident Services Director (RSD) was responsible for making sure SCU training was completed as required within 6 months of hire. -The RSD left the position in January 2016 and that position was currently vacant. -She did not realize SCU training was missing or incomplete for some of the SCU staff. Interview with the Memory Care Director (MCD) on 05/12/16 at 6:35 p.m. revealed: -The RSD was responsible for staff training including SCU training. -She recently found during personnel file audits that some staff did not have all required hours for SCU training. -She was currently in the process of getting training set up. -The first class had been scheduled for 06/01/16	D 468	see attached	

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D 468	Continued From page 45 and 06/02/16 and would provide 14 hours of training credits. -The class would be held at least every 3 months to get staff caught up on their training.	D 468	See attached	

Preparation and/or execution of this plan of corrections does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Parkwood Village
Plan of Correction
Facility License # HAL-098-029

1) 10A NCAC 13F .0406(a) Test For Tuberculosis – (a) upon employment or living in an adult care home, the Executive Director and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.

Based on interview and record review, the facility failed to assure 2 of the 5 staff sampled were tested upon employment for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services.

A) The alleged deficient practice will be/has been corrected for the listed employees by taking the following action:

The two identified employees had a TB skin test administered by the facility on 6/11/16 and will have their 2nd step TB skin test administered by 7/11/16. A TB skin test audit was completed on all staff on 6/17/16 to ensure compliance.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents residing in the facility could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

On 6/1/16 the facility implemented a hiring manager checklist to ensure all steps of the hiring process are completed for new employees. (See checklist attached). The Executive Director and/or the Resident Services Director will ensure that a TB skin test is administered to all new hires and a copy will be kept in a binder labeled "Employee TB Skin Tests".

D) The facility will monitor the corrective actions as follows:

The Executive Director or designee will conduct random audits of the Employee TB Skin Tests to ensure compliance.

2) 10A NCAC 13F .0407 Other Staff Qualifications a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40.

* The plan of correction was reviewed and accepted with addendum on 7/18/16. Refer to addendum on pages 1, 3, 5, 15, 24, 37, and 42 of this Statement of Deficiencies. W. Williams 7/18/16

Based on interview and review of personnel files, the facility failed to assure 1 of 6 sampled staff (C) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40.

A) The alleged deficient practice will be/has been corrected for the listed employees by taking the following action:

The identified employee had a criminal background check completed on 6/8/16.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents residing in the facility could potentially be affected. A criminal background check audit was completed on all staff on 6/17/16 to ensure compliance.

C) The following systemic changes will be made to ensure compliance with this regulation:

On 6/1/16 the facility implemented a hiring manager checklist to ensure all steps of the hiring process are completed for new employees. (See checklist attached). The Executive Director and/or the Business Office Manager will be responsible for ensuring that a criminal background check is completed for all new hires. Once the background check is complete the employee name, date of hire and date of background check completion will be entered in the tracking tool that is kept by the Executive Director and/or Business Office Manager. (See tracking tool attached).

D) The facility will monitor the corrective actions as follows:

The Executive Director or designee will conduct random audits of the community's background tracing tool to ensure compliance.

3) 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.

Based on observation and interview, the facility failed to assure the reach-in cooler, walk-in freezer, walk-in cooler, kitchen appliances, ice machine, floors and walls in the kitchen were cleaned, in good repair and free of contamination.

A) The alleged deficient practice will be/has been corrected by taking the following action:

On 5/11/16 the facility corrected the identified concerns by immediately pressure washing the entire kitchen walls, floors, walk-in freezer and walk-in cooler. A kitchen staff in-service was held on 5/19/16 to introduce new procedures for cleaning duties by the Food & Beverage Director (F&B Director). (See attached sign in sheet). On 5/20/16 all kitchen appliances, ice machine and other free standing pieces in the kitchen were cleaned. (See attached cleaning schedule for 5/20/16).

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents residing in the facility could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

On 5/20/16 the F&B Director implemented daily cleaning schedule sheets for all kitchen staff. (See attached blank copies of the schedule sheets). The F&B Director will ensure the daily cleaning tasks & sheets are completed.

D) The facility will monitor the corrective actions as follows:

The Executive Director or designee will conduct random visual inspections of the kitchen & equipment to ensure compliance.

4) 10A NCAC 13F .1002(a) Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.

Based on observation, interview and record review, the facility failed to clarify and verify medication orders for 1 of 5 residents sampled who was being administered medications not included on the resident's current FL2 including medications for diabetes, hypothyroidism, acid reflux, and depression.

A) The alleged deficient practice will be/has been corrected by taking the following action:

Resident #3 was out of the facility at the time of survey for long term rehab. Resident returned to the community on 5/13/16 and clarification was obtained from primary physician. Copies of all new FL 2 forms will be kept in a binder after being faxed to pharmacy, which will be reviewed on a monthly basis by RSD or designee.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents residing in the facility could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

All new admissions/readmissions will have clarification orders sent to their primary care physician (PCP) within 24 hours of their admission/readmission to the facility by the Medication Aide. Once the clarification is faxed to the PCP, the confirmed fax will be kept in the

medication storage room in a file labeled, "Fax to MD". Each Medication Aide is responsible for checking the fax machine during their assigned shift to see if any new orders and/or clarifications arrive. When the clarification is faxed to the facility by the PCP the Medication Aide will compare the orders to the MAR and make any necessary changes. The Medication Aide will then fax the clarification orders to the pharmacy, put a copy in the binder labeled, "New Physician Orders" at the nurse's station and file the clarification orders in the resident's medical chart. On 5/16/16 the systematic changes were communicated to the Medication Aides.

D) The facility will monitor the corrective actions as follows:

The Resident Services Director (RSD) and/or designee will review the New Physician Orders binder weekly to ensure accuracy on the MAR. The RSD and/or designee will follow up on any faxed order requests sent to the physician that have not been answered within 24 hours.

5) 10A NCAC 13F .1005 (b) Self-Administration of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.

Based on observation, record review and interview, the facility failed to assure compliance with the facility's policies and procedures for self-administration of medications for 2 of the 2 sampled residents with orders to self-administer medications.

A) The alleged deficient practice will be/has been corrected by taking the following action:

On 5/11/16 the facility corrected the deficiency during the survey by hand delivering clarification orders to the two identified resident's PCPs. On 5/12/16 the PCPs of both identified residents signed and dated the clarification orders.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents residing in the facility could potentially be affected. A full audit of residents that self-administer medications was completed on 5/13/16 to ensure compliance.

C) The following systemic changes will be made to ensure compliance with this regulation:

All residents that self-administer medications will have communication/clarification orders sent to their primary care physician (PCP) within 24 hours of their admission/readmission to the facility by the Medication Aide. Once the clarification is faxed to the PCP, the confirmed fax will be kept in the medication storage room in a file labeled, "Fax to MD". Each Medication Aide is responsible for checking the fax machine during their assigned shift to see if any new orders and/or clarifications arrive. When the clarification is faxed to the facility by the PCP the Medication Aide will compare the orders to the MAR and make any necessary changes. The Medication Aide will then fax the clarification orders to the pharmacy, put a copy in the binder labeled, "New Physician Orders" at the nurse's station and file the clarification orders in the

resident's medical chart. On 5/16/16 the systematic changes were communicated to the Medication Aides. (See attached instructions with employee signatures). The RSD and/or designee will review the New Physician Orders binder every few days to ensure accuracy on the MAR. The RSD or designee will follow up on any faxed order requests sent to the physician that have not been answered within 24 hours. All self-medication residents' medications will be reviewed weekly by the medication aide on duty in comparison with the medications listed on their MAR. The RSD and/or designee will also review all self-medication residents' medications weekly to ensure accuracy.

D) The facility will monitor the corrective actions as follows:

The RSD or designee will review all MARs monthly to ensure accuracy and will conduct quarterly self-administration reviews for all residents that self-administer medications to ensure compliance.

6) 10A NCAC 13F .1009(b) Pharmaceutical Care; 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 informed of the findings when necessary.

Based on record review and interview, the facility failed to follow up on medication review recommendations for 2 of the 6 residents sampled for review related to medications for high cholesterol and underactive thyroid and medications for anxiety.

A) The alleged deficient practice will be/has been corrected by taking the following action:

The facility immediately corrected the deficiency for the 2 residents during the survey on 5/11/16. The facility reviewed the pharmaceutical recommendations for the 2 residents on 5/11/16 and made changes as recommended by the pharmacy on 5/11/16.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents residing in the facility could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

All medication recommendations received by the pharmacy will be reviewed by the RSD or designee and any recommendations will be communicated to the resident's PCP for clarification. Any/all communication and changes to orders will be documented in the resident medical chart.

D) The facility will monitor the corrective actions as follows:

The Executive Director and SCU Director or designee will review the effectiveness of this system during quarterly quality assurance meetings.

7) 10A NCAC 13F .1309 Special Care Unit Staff Orientation and Training; the facility shall assure that special care unit staff received at least the following orientation and training:

1) Prior to establishing a special care unit, the Executive Director 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 Executive Director 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 6 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 12 hours of continuing education annually, of which six hours shall be dementia specific.

Based on observation, interview and review of personnel files, the facility failed to assure 2 of the 3 staff sampled who were responsible for personal care and supervision within the special care unit completed the 20 hours of training specific to the population being served within 6 months of employment.

A) The alleged deficient practice will be/has been corrected by taking the following action:

The facility is holding a NC DHHS approved dementia specific training on 6/15/16 and 6/16/16 worth 14 Continuing Education Units (CEUs). (See attached approval for the training). The two staff identified as not having this training documented will attend this scheduled training and will have the required total of 20 hours of training by 6/16/16.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents residing in the Special Care Unit (SCU) could potentially be affected. A full audit of SCU staff training was completed on 6/8/16 to ensure compliance.

C) The following systemic changes will be made to ensure compliance with this regulation:

The SCU Director will hold monthly NC DHHS approved dementia related trainings worth 1 CEU starting 6/1/16. Additionally, the SCU Director will hold a NC DHHS approved dementia specific training worth 14 CEUs quarterly to ensure the staff receives 20 hours within six months of hire. (See attached calendar for 2016 and approval for dementia trainings held by the facility). All completed training will be documented and entered into a tracking matrix to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Executive Director and SCU Director or designee will review the effectiveness of this system during quarterly quality assurance meetings.

Respectfully,

Jaime Waters
Executive Director