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D 000	Initial Comments The Adult Care Licensure Section completed an on-site annual and follow-up survey and a complaint investigation on 6/21/16, 6/22/16, and 6/27/16 with a telephone exit on 6/28/16.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure an accurate functional assessment was completed for 1 of 3 residents sampled (Resident #1) related to blood pressure and blood sugar monitoring, ambulation and the use of assistive devices, shortness of	D 254		

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breath upon exertion, significant limited strength, peripheral neuropathy and pedal edema resulting from diabetes and stage 4 kidney disease diagnoses, the current diet order, and daily urinary incontinence.

The findings are:

Review of Resident #1's current FL2 dated 5/27/16 revealed diagnoses included:
-Chronic kidney disease (Stage 4)-advanced kidney damage resulting in decreased removal of waste products from the blood.
-Pedal edema-abnormal accumulation of fluid in the feet.
-Abnormal labs-(elevated creatinine and potassium levels in the blood) resulting from and indicating the severity of kidney disease/damage.
-Anemia-decreased red blood cells in the blood due to kidney disease.
-Essential hypertension-malignant-severe, persistent high blood pressure with a poor prognosis.
-Mental retardation with mild cognitive impairment.
-Type 2 Diabetes Mellitus.
-Knee pain, bilateral.
-Anxiety.
-Fatigue.
-Peripheral neuropathy- a disease of the nervous system mainly affecting the hands, legs and feet.
-Depression.
-PTSD (Post Traumatic Stress Disorder)-a mental health condition triggered by a terrifying event.
-Obesity.
-Physician orders for Sertraline 50mg daily (An anti-depressant used to treat anxiety, depression and PTSD) and Lorazepam 0.5mg 1/2 tab (0.25mg) at bedtime and as needed for

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anxiety/agitation. Not to exceed 2 [doses] within 24hours
-An order for a "Diabetic, Kidney Disease" diet.
-Ambulatory without assistive devices.
-Incontinent of urine at times.
-Her breathing was normal with some SOB (shortness of breath).
-Lower extremity edema.
-No indication of negative or disruptive behaviors.

Review of Resident #1's current Assessment and Care Plan, completed on 2/24/16 revealed:
-A seven page assessment form attached to a 2 page printed list of Physician's orders dated 3/2/16.
-It had originally been signed by the facility's Family Nurse Practioner on 3/8/16 but had been corrected with the signature of the Resident's current medical doctor.
-Pages 1-3 were the Resident Service Plan (documentation completed by the facility).
-Pages 4-6 were an assessment completed by the Medicaid assessment nurse.

Review of pages 1-3 of the Resident Service Plan revealed:
-No documentation in the Mental Health and Social History section of disruptive and/or socially inappropriate behavior, mental illness or developmental disabilities.
-Documentation the Resident ambulated with no problems and did not indicate she had a wheelchair and used a cane.
-Documentation of no upper extremity problems or limitations.
-Documentation of a regular diet.
-Respirations were normal.
-She was continent of bladder.

Review of pages 4-6 of the Resident Service Plan

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revealed:
-Risk Management provisions did not indicate the Resident's walker and cane.
-Bathing: Extensive assistance indicated with tub or shower, sponge bath, washing face, hands and feet, foot care, washing lower body, and shampooing hair.
-Dressing: Extensive assistance indicated with putting on and taking off shoes, socks and clothing. Fully dependent tying or fastening shoes.
-Mobility: No assistance level or assistive devices indicated.
Toileting: Extensive assistance indicated for removing, pulling up and fastening clothes and limited assistance indicated for hygiene after toileting.
-Eating: Limited assistance indicated with cutting food and opening packages.
-Special Assistance/Monitoring: No documentation of the Resident's need for blood sugar and blood pressure monitoring.

Observation of Resident #1 on 6//21/16 revealed:
-She had been ambulating using a cane.
-She appeared well groomed.
-She had become short of breath while walking a short distance.
-She had been alert and orientated.
-She demonstrated difficulty reading and comprehending a facility form she had been asked to read.

Interview on 6/21/16 with Resident #1 revealed:
-She used a cane when she went out of the facility and had to walk any distance.
-She became short of breath when she did her laundry, bathed herself, or walked to doctor's appointments.
-She was a little bit incontinent of urine.

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D 254	Continued From page 4 -She did her own toileting and personal hygiene. -She brushed her teeth, shampooed her hair, and showered independently. -She was able to put her socks and shoes on without assistance from the staff. -She stated she was "developmentally disabled" but took care of herself and didn't need help from the staff. -She took her own showers and dressed herself afterwards. -She did not want the staff around while she showered and often showered at night so she could be by herself. Interview on 6/21/16 with Resident #1's guardian revealed: -She had concerns regarding the accuracy of the Resident's "Assessment and Care Plan", dated 3/8/16, also called the "Resident Service Plan". -She had taken the Resident to see her previous medical doctor, after having care provided at the facility by their Family Nurse Practitioner. -The first appointment with the medical doctor had been on 2/23/16 and was a "meet and greet" type of visit. -That visit had allowed her physician to get re-acquainted with the Resident and to update her records. -The physician had ordered a psychiatric evaluation. -A return visit for a "regular re-check, fasting lab work etc. was to be scheduled in 2 months. -The physician had been sent a "Resident Service Plan" and had signed the document on 3/8/16. -On 5/2/16, she and the Resident had gone to an appointment with "a kidney doctor" who diagnosed the Resident with Stage 4 kidney disease, reduced Lisinopril to 10mg, and increased Lasix to 20mg twice a day.	D 254		

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-On 5/16/16, she and the Resident returned to the kidney doctor's office and met with a dietician regarding the Resident's new diet order: No Added Table Salt, No extra carbohydrates, No second helpings unless non-starchy vegetables or salads and (due to an elevated potassium level on 5/2/16 of 5.8) Limit french fries, mashed potatoes and legumes to once a week.
-The facility contacted the Resident's medical doctor and requested a list of current diagnoses.
-The medical doctor received an FL2 from the facility to be filled out for the Resident.
-The medical doctor had reviewed the Medicaid assessment document completed on Resident #1, dated 2/24/16, and requested the facility have a re-assessment completed because of the errors she had identified related to blood pressure and blood sugar monitoring, ambulation and the use of assistive devices, shortness of breath upon exertion, significant limited strength, peripheral neuropathy and pedal edema resulting from diabetes and stage 4 kidney disease diagnoses, the current diet order, and daily urinary incontinence.

Confidential interviews with three staff members revealed:
-They had seen Resident #1 walking with a cane but it was usually when she had been going out of the facility with a family member.
-She had been on a special diet and the Resident knew it was important to follow it.
-They were not able to describe her diet but there was a copy of it in the kitchen for them to look at.
-She could be loud, gruff, snappy and argumentative with the other resident's and staff but they thought it might have to do with her "mental retardation".
-She took her own showers, sometimes at night, and did her own laundry.

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-She became short of breath when she did her own laundry.
-The staff does very little, if anything, for her.
-They thought she would do well in a "group home."
-"She is probably the highest functioning resident here."

Telephone interview with the office nurse for Resident #1's medical doctor on 6/23/16 at 2:37pm revealed:
-The first appointment had been on 2/23/16 and was a "meet and greet" type of visit where the medical doctor had re-acquainted herself with the Resident and updated records.
-The facility notified the medical doctor of an issue with the Resident's behavior and a psychiatric evaluation had been ordered.
-The facility requested a list of current diagnoses and medications after the Resident was seen by the kidney/hypertension specialist.
-The facility requested the medical doctor fill out a new FL2.
-The Resident Care Coordinator (RCC) stated the facility could no longer provide the level of care since she had Stage 4 kidney disease and required a special diet and blood sugar checks.
-The medical doctor requested a re-assessment since the one in the Resident's record did not indicate she required blood pressure and blood sugar monitoring, used a cane when ambulating and also had a walker, her respirations were reported as normal but she had significant shortness of breath upon exertion, she had been receiving Physical Therapy due to significant limited strength, she was a diabetic with Stage 4 kidney disease, had weight gain, inaccurate diet order, her skin assessment did not reflect bilateral lower extremity edema, and the Resident had reported daily urinary incontinence.

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D 254	Continued From page 7 Interview with the RCC on 6/27/16 at 10:25am revealed: -She was responsible for filling out Resident #1's Service Plan. -She completed the Plan after reviewing the assessment received from the Medicaid Assessment nurse on 2/24/16. -Extensive or limited assistance depended on whether the staff did more than half of the activity (extensive assist) or if the resident did more than half (limited assistance). -She was aware there were inaccuracies with the assessments. -She had seen the Resident with a cane but she only used it when she left the facility. -She had been the one who informed the Resident's medical doctor of behaviors at the facility. -Her behaviors were disruptive and included resisting care, provoking other residents, verbally abusing the other residents by yelling at them. -She had been confused about whether the Resident had a developmental disability because her record stated "mild cognitive impairment". -She was not aware the medical doctor had specified "mental retardation, mild" as a diagnosis. -She was not sure how she should complete that area and did not know who she could call for clarification. -She stated the medical doctor had requested a re-assessment but one had not been scheduled. Telephone call to the Medicaid Assessment nurse on 6/27/16 at 2:00pm was not returned prior to exit. Interview with the Administrator on 6/27/16 at 11:10am revealed:	D 254		

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D 254	Continued From page 8 -He was not aware there were inaccuracies in Resident #1's assessments and care plan. -He was not aware the Resident's medical doctor had identified her concerns and requested a re-assessment. -He was not aware the RCC knew of the inaccuracies and was going to make an appointment for a re-assessment.	D 254		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure one of three residents sampled (Resident #1) and her guardian received a reasonable response to a request. The findings are: Based on interviews and record reviews, the facility failed to assure one of three residents sampled (Resident #1) and her guardian received a reasonable response to requests for medical information for Resident #1. [Refer to Tag 917 G.S. 131D-21 (7) Declaration of Resident's Rights]	D 338		
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:	D912		

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D912	Continued From page 9 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 interviews and record reviews, 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 related to Adult Care Home Medication Aides training and competency evaluation requirements. The findings are: Based on interviews and record reviews, the facility failed to assure 2 of 4 medication aides (Staff D and Staff E) successfully completed the medication competency examination within 60 days of hire as a medication aide. [Refer to G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation.)]	D912		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to assure one of three residents sampled (Resident #1) and her guardian received a reasonable response to requests for medical	D917		

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D917	Continued From page 10 information for Resident #1. The findings are: Review of Resident #1's current FL2 dated 5/27/16 revealed diagnoses included: -Chronic kidney disease, stage 4 (advanced kidney damage resulting in decreased removal of waste products from the blood). -Pedal edema (abnormal accumulation of fluid in the feet). -Abnormal labs (elevated creatinine and potassium levels in the blood) resulting from, and indicating the severity, of kidney disease/damage). -Anemia (decreased red blood cells in the blood due to kidney disease). -Essential hypertension, malignant (severe, persistent high blood pressure with a poor prognosis). -Mental retardation with mild cognitive impairment -Type 2 Diabetes Mellitus. -Knee pain, bilateral. -Anxiety. -Fatigue. -Peripheral neuropathy (a disease of the nervous system mainly affecting the hands, legs and feet). -Depression. -PTSD (Post Traumatic Stress Disorder) a mental health condition triggered by a terrifying event. -Obesity. Review of the Resident Register revealed Resident #1 had been admitted to the facility on 3/16/12. Review of records provided by the facility revealed guardianship for Resident #1 was granted to a family member on 6/8/16.	D917		

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D917	Continued From page 11 Interview with Resident #1 on 6/21/16 revealed: -She had been her own responsible party until 6/8/16. -She had been requesting copies of her medical records from the facility since December 2015. -She had not received any copies of her medical records. -She had been asking the current Administrator for copies of her medical records. -She had not received any copies of her medical records. -The Administrator eventually told her the company policy required she submit a written request and she had been given a form to fill out the end of April 2016. -She did not understand why she had to fill out the form to get copies of her own records. -She had not filled out the form but continued to ask for copies of her records. -When she didn't get the copies, she had given a family member permission to request them. -When the family member made the request, the Administrator did not give the family member copies of the records. -The family member became her guardian on 6/8/16, gave a copy of the guardianship document to the the Administrator and asked for copies of the Resident's medical records. -The Administrator told her guardian the company policy required she submit a written request for copies of the Resident's medical records. -As of 6/21/16, the resident had not received copies of her medical records from the facility. Interview with Resident #1's guardian on 6/21/16 revealed: -The Resident had repeatedly requested copies of her medical records from the facility	D917		

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Administrator for approximately 6 months.
-The Administrator had told the Resident company policy required she submit a written request to get copies of her medical records.
-The Resident had asked the Administrator to release copies of her medical records to a family member.
-The Administrator did not give the family member copies of the Resident's medical records.
-When the family member became the Resident's guardian on 6/8/16, she gave the Administrator a copy of the guardianship papers and requested copies of the Resident's medical records.
-The Administrator told her the company policy required medical records be requested in writing and it would take about 10 days to get the documents
-The guardian told the Administrator the Resident had the right to have copies of her records and, as her legal guardian, she did also.
-The Administrator sent a copy of the "Authorization for the Release of Records" form to her by certified mail on 6/9/16.
-She had not filled out the form because she felt it wasn't necessary.
-She felt the form she had been sent was to give insurance companies etc. permission to see a resident information.

Review of an "Authorization For The Release of Records" form revealed a statement stating "I, the Resident or person legally entitled to receive copies of requested records, authorize the designated records custodian (facility Executive Director or designee) to release, upon presentation of the authorization form, to the person or agency named on the form, any and all recorded information as indicated on the form, concerning the named resident".

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D917	Continued From page 13 Interview with the Administrator on 6/22/16 at 4:04pm revealed: -Resident #1 and a family member had been verbally requesting copies of the Resident's medical records for several months. -The company did not respond to verbal requests for the release of resident information or records. -The company policy required the request be made in writing using the "Authorization for Release of Records" form. -Once completed, he would immediately notify the company's legal department and submit the written request, and in this case, a copy of the guardianship papers. -Within 5 days, or sooner, the requested records would be sent to the company for review. - The company would then review the documents and send the copies of the requested documents to the Requestor and notify him they have been sent. -The process could take up to ten days. -Resident #1 had not filled out the request form and therefore had not been given copies of any of her records. -The family member/guardian had not filled out the request form and therefore had not been given copies of Resident #1's records. -This was the first time a resident, family member and/or guardian had requested copies of their medical records from the facility. Interview with the Business Office Manager on 6/27/16 at 10:05am revealed: -Resident #1 and her legal guardian had repeatedly requested copies of medical information from the Resident's Record. -The Administrator had told the staff all requests for documents made by the Resident and/or the Resident's guardian be referred to him.	D917		

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	HAL088014	A. BUILDING: _____ B. WING _____	R 06/28/2016

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D917	Continued From page 14 -The Administrator had given the Resident and her guardian each a copy of the "Authorization For The Release of Records" form but they had not been returned. Interview with the Resident Care Coordinator on 6/27/16 at 10:25am revealed: -Resident #1 and a family member had repeatedly requested copies of medical information from the Resident's Record. -The information requested included a list of the Resident's medications, a copy of the Resident's current Assessment and Care Plan dated 3/8/16, and a diagnoses list. -On 6/8/16, the family member had given the facility a copy of guardianship papers dated 6/8/16. -The Administrator had directed all requests for documents made by the Resident and/or Resident's guardian be referred to him. -The Administrator had given the Resident a copy of the "Authorization For The Release of Records" form in late April but it had not been returned. -The Administrator had given the Resident and her guardian each a copy of the "Authorization For The Release of Records" form but they had not been returned. -They would not be given the information they requested until the release forms had been filled out and returned to the Administrator because that was the company policy.	D917		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.	D935		

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D935	Continued From page 15 (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	D935		

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D935	Continued From page 16	D935		

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

Based on interviews and record reviews, the facility failed to assure 2 of 4 medication aides (Staff D and Staff E) successfully completed the medication competency examination within 60 days of hire as a medication aide.

The findings are:

A. Review of Staff D's personnel record revealed:
-Hire date of 7/16/15 as personal care aide.
-Hire date of 2/23/16 as Medication Aide (MA).
-A MA clinical skills evaluation completed 2/22/16.
-Completion of 15 hours medication training on 2/22/16.
-No documentaion of the MA test ever been taken or passed.

Review of the Medication Administration records for Resident #7 on 6/22/16 revealed Staff D intermittently documented the administration of medications including insulin after 60 days of becoming a medication aide from 4/27/16 through 6/19/16.

Sixty days after Staff D's hire date as a MA was 4/23/16.

Interview with the Resident Care Coordinator on 6/27/16 at 10:10am revealed:
-The MAs had been scheduling their own examinations but in the future she would be scheduling those.
-She was not aware it had been 60 days since Staff D became a MA because Staff C, another

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D935	Continued From page 17	D935		

MA, made the work schedules.
-She knew Staff A did not go to the previously scheduled test because she was sick.
-Staff A was scheduled to take the examination in July 2016 and would verify the date.

Interview with Staff C on 6/22/16 at 2:45pm revealed:
-She thought the MAs could be checked off again on medication clinical skills and have another 60 days to give medications before passing the examination.
-She was not aware if Staff D had been checked off for a second time on medication clinical skills.

Telephone interview with Staff D on 6/23/16 at 8:30am revealed:
-She was scheduled to take the MA test on 7/6/16.
-She was scheduled to take it on an earlier date, date not known, but she was sick that day, and had informed management.

B. Review of Staff E's personnel record revealed:
-Hire date of 11/23/15 as personal care aide.
-Hire date of 4/1/16 as Medication Aide (MA).
-A MA clinical skills evaluation completed 3/31/16.
-Completion of 15 hours medication training on 3/31/16.
-No documentation of the MA test ever been taken or passed.

Review of the Medication Administration records for Resident #7 on 6/22/16 revealed Staff E intermittently documented the administration of medications including insulin after 60 days of becoming a medication aide from 6/5/16 though 6/18/16.

Sixty days after Staff E's hire date as a

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D935	Continued From page 18 medication aide was 6/1/16. Interview with the Resident Care Coordinator on 6/27/16 at 10:10am revealed: -The MAs had been responsible for scheduling their own examinations but in the future she would be scheduling them. -She was responsible for tracking staff qualifications. -She was not aware it had been 60 days since Staff D became a medication aide because Staff C, a MA, made the work schedules. -Staff A could not go to the previously scheduled test because she was sick. -Staff A was scheduled to take the examination in July 2016, but was not sure of the date. -She would verify the date of the examination for Staff B. Interview with Staff C, MA, on 6/22/16 at 2:45pm revealed: -She made the work schedules for the MAs. -She thought the MAs could be checked off again on medication clinical skills and have another 60 days to give medications before passing the examination. -She was not aware if Staff B had been checked off for a second time on medication clinical skills and not aware it had been 60 days since Staff B became a MA. Telephone interview with Staff E on 6/23/16 at 12:43pm revealed she was scheduled to take the MA test on 8/4/16, and had never been scheduled to take it before that date. _____ The Plan of Protection provided by the facility on 6/22/16 revealed: -The Medication Aides involved in the rule area	D935		

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D935	Continued From page 19 cited were immediately removed from the medication cart and medication role until they have taken and successfully passed the state mandated medication aide exam on 7/6/16. -They will be replaced by qualified and approved medication aides. -In the future, a diligent effort will be made to ensure that all medication aides being trained in their new role are checked off and have taken and successfully completed the state mandated exam within 60 days of beginning their new assignment. -The Resident Care Coordinator (RCC) has been advised that she will be the principal supervisor ensuring this process is carried out according to state regulations and within all mandated time frames. -The Administrator will work with the RCC to further ensure this process is carried out in the expected manner. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 12, 2016.	D935		