Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL083013	A. BUILDING: _____ B. WING _____	R 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW PLACE ASSISTED LIVING & MEMORY	1703 STONEWALL ROAD LAURINBURG, NC 28352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Scotland County Department of Social Services conducted an annual and follow-up survey June 15-17, 2016.	D 000		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed, to provide documentation to support quarterly Licensed Health Professional Support	D 280		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lina Strickland RN. BSN — RN, Administrator — 7/14/16

Reviewed & accepted LE 7/19/2016

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D 280	Continued From page 1 (LHPS) evaluations and reviews for 1 of 5 residents sampled, (#5) who required personal care tasks for collecting and testing of finger stick blood samples and medication administrations through injection. The findings are: Review of Resident #5's current FL-2 dated 04/21/16 revealed: -Diagnoses included acute renal failure, syncope, diabetes, osteoarthritis, panic attack, anxiety, bipolar depression, and gastroesophageal reflux disease. -There was a medication order for Lantus (an injectable medication to control high blood sugar levels) 25 units subcutaneous every morning. -There was a medication order for Lantus 30 units subcutaneous every evening. -There was an order to perform diabetic blood testing twice daily. Review of a ringed binder designated for all of the residents LHPS evaluations and reviews revealed there were no LHPS documents for Resident #5. Interview with the Administrator on 06/17/16 at 8:50 a.m. revealed: -The Administrator had worked at the facility for 3 years. -The Administrator was a Registered Nurse and served as the facility's LHPS nurse. -The Administrator was responsible for completing the LHPS evaluations and LHPS reviews for all residents. -She had no explanation why the LHPS reviews were not in the designated ringed binder for Resident #5. -The Administrator felt sure that the LHPS reviews had been completed for Resident #5.	D 280	1. LHPS document completed on sample resident #5 on 6-17-16 2. A complete resident chart review completed 6/17/2016 and 6/18/2016, to assess need for LHPS assessments. 3. The facility shall ensure that participation by a registered nurse, occupational therapist, or physical therapisr in the on site review and evaulation of the residents health status, care plan and care provided, as required for LHPS is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quartely thereafter. 4. A completed LHPS assessment will be put in each residents clinical record and a copy kept in LHPS book in Administrators office. 5. Monitoring will be completed by HCC and Administrator by keeping auditing LHPS tracking tool book and reviewing monthly	

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D 280	Continued From page 2 -The LHPS reviews should not have been filed anywhere else except in the designated LHPS ringed binder. Interview with the Administrator on 06/17/16 at 1:00 p.m. revealed no LHPS reviews had been found for Resident #5 but she would continue to search for them. The LHPS documents for Resident #5 were not available by the end of the survey.	D 280		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by:	D 367		

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D 367	Continued From page 3 Based on record reviews, interviews, and observations the facility failed to assure accurate documentation of all staff initials who administered medications and a signature equivalent to those initials with the medication administration record (MAR) for 2 of 5 residents sampled (#4, #5). The findings are: 1. Review of Resident #5's current FL-2 dated 04/21/16 revealed diagnoses included acute renal failure, syncope, diabetes, osteoarthritis, panic attack, anxiety, bipolar depression, and gastroesophageal reflux disease. Review of Resident #5's MARs for April, May and June 2016 revealed: -There was a divided section on the reverse side of each MAR labeled nurse's medication notes. -There were instructions on the reverse side of the MAR to put initials in the appropriate box when a medication was given, circle initials when a medication was refused, and state reason for the refusal on the nurse's notes. -There was a section on the reverse side of the MAR to document initials and signatures. Review of Resident #5's April 2016 MAR revealed: -There were handwritten entries of dissimilar initials in the medication administration boxes. -There was one handwritten entry for initials and a signature that was equivalent to those initials for a staff member on all pages of the MAR, except page 1, there was no entries in the section for signatures and initials. -There were no entries documented in the nurse's note section on the reverse side of the MAR.	D 367	1. Each month a signature sheet will be made to go in the front of the MARS. All Med Aides and Nurses will sign and initial sheet. June signature sheet completed 6/20/2016. 2. Weekly MAR checks will be completed by Nurses and ED. MAR checks started 6/24/2016. 3. Specific employee re-education related to medication administration documentation. Completed 6-15-16 4. In Service related to medication administration documentation for all Med Aides and Nurses completed on 6-15-16. 5. On-going monitoring will be completed weekly by HCC and ED.	

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D 367	Continued From page 4 Review of Resident #5's May 2016 MAR revealed: -There were handwritten entries of dissimilar initials in the medication administration boxes. -There was one handwritten entry for initials and a signature that was equivalent to those initials for a staff member on all pages on the reverse side of the MAR, except page 1, there were no entries in the section for signatures and initials. -There were no entries documented in the nurse's note section on the reverse side of the MAR. Review of Resident #5's June 2016 MAR revealed: -There were handwritten entries of dissimilar initials in the medication administration boxes. -There was one handwritten entry for initials and a signature that was equivalent to those initials for one of the staff members on all pages of the MAR's on the reverse side. -There were entries documented in the nurse's note section on the reverse side of the MAR for as needed medications that were ordered and documentation of the Residents refusal of Carafate. - In the nurse's note section on the reverse side of the MAR there was 2 different Medication Aides (MA) that signed with a first initial and their last name; however no equivalent initial was documented. -There was one signed entry in the nurse's note section with different initials and no signature for those initials. Interview with Resident #5 on 06/15/16 at 12:00 p.m. revealed: -There had not been any issues with the administration of her medications. -The resident received her medications on time. -The resident never missed any doses and her	D 367		

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D 367	Continued From page 5 medications were always available at the facility. Interview with the Health Care Coordinator (HCC) on 06/16/16 at 4:35 p.m. revealed: -The HCC would provide a list of the staff's names and credentials of staff that worked on the days with the missing documentation, initials and signatures for the administration of medications, and for the blood sugar checked on the April, May and June MARs. -The HCC could not distinguish each staff members initials documented on the MARs, but would gather the information from the worked schedules. Telephone interview with a MA that had worked at the time of the missing documentation, initials and signature in April 2016 on 06/16/16 at 6:50 p.m. revealed: -The staff member had been employed at the facility for about 3 months. -The staff member was qualified/verified to administer medications. -The staff member had been trained to document initials on the MARs and not told to provide a signature. -The staff member was not aware of any other form that the facility used to verify initials and a signature equivalent to those initials when medications were given to residents or when blood sugar results were obtained. -The blank spaces on the MARs was an oversight, and all of the medications were administered as ordered unless the resident was out of the facility. -When a resident was out of the facility "OOF" should be used. Interview with a second MA on 06/17/16 at 9:55am revealed: -Staff members that administered medications to	D 367		

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D 367	Continued From page 6 the residents were required to initial each medication that was administered on the front of the MARs. -Staff were required to initial and sign the back of the MARs to distinguish who administered the medication. -The staff member was not aware of any other form that the facility used to verify who gave medications with dates, initials and a signature. -The resident would often sign out of the facility but would not tell the staff she was gone. Interview with a third MA, assigned to administer medications on some of the days with the missing medication administration documentation for the Month of April and May on 06/17/16 at 10:40 a.m. revealed: -The staff members were expected to initial each medication when it was administered. -There should not be any blank spaces at the scheduled medication administration times. -There were codes that should be entered in all the administration boxes if any medication was not administered as ordered. -There should be exceptions documented on the reverse side of the MAR when medications were not administered as ordered. -The blank spaces on the MARs was an oversight, because all medications were always given as ordered unless the resident was out of the facility. -The resident would leave the facility frequently. -The MA had already received re-education from management related to documenting her initials and a signature for those initials on 06/16/16. Attempted interview with a fourth MA that was scheduled to work in May 2016 on the days there was missing medication administration documentation, initials and signatures however	D 367		

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D 367	Continued From page 7 no return call received at the time of the facility exit. Review of the daily medication storage review logs revealed: -There was a section to document that the drug room was clean and orderly by entering initials on each day of the month on the 1st, 2nd and 3rd shift. -There was a section to document that the refrigerator was clean and the temperature checked by entering initials on each day of the month on the 1st, 2nd and 3rd shift. -There was a section to document the MARs were clean and checked for errors in charting by entering the initials on each day of the month on the 1st, 2nd, and 3rd shift. -There was a section to document the medication was ready for return to the pharmacy by entering initials on each day of the month on the 1st, 2nd and 3rd shift. -There was a section to document the controlled medications were checked and counted by entering initials on each day of the month on the 1st, 2nd and 3rd shift. -There was a section at the bottom of the form divided by 1st 2nd and 3rd shift to document initials and signatures -The daily medication storage review forms had blank spaces for some shifts. -There were no initials and signatures for two of the interviewed staff members. Review of Resident #5's MARs for April, May, and June 2016 compared with the daily storage review logs revealed each MA that initialed medications were administered or blood sugar checks performed did not have a signature equivilant to those initials.	D 367		

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D 367	Continued From page 8 Refer to the interview with the HCC on 06/17/16 at 10:15 a.m. Refer to the interview with the Administrator on 06/16/16 at 9:50 a.m. 2. Review of Resident # 4's current FL-2 dated 4/22/16 revealed: -Diagnoses included CVA with left sided hemiparesis, DVT, epilepsy, hypertension, depression, neurogenic bladder, left leg injury with deformity, and severe cystitis. -There was a medication order for Keppra 75 mg by mouth twice daily. -There was a medication order for Zanaflex 4 mg by mouth every 6 Hrs. -There was a medication order for Xarelto 20 mg by mouth at 7:30pm. -There was a medication order for Wellbutrin SR 100 mg by mouth twice daily. -There was a medication order for Oxycodone 15 mg by mouth twice daily -There was a medication order for Dilantin 100 mg by mouth three times daily. -There was a medication order for Neurontin 300 mg at Bedtime. -There was-a medication order for Senokot 8.6 mg by mouth at bedtime. -There was a medication order for Vanspar 7.5 mg by mouth twice daily. -There was a medication order for Urispas 100mg by mouth three times daily. -There was a medication order for Methadone 10 mg by mouth three times daily. Review of Resident # 4's Medication Administration Records (MAR) for May 2016 revealed: -There was no Medication Aide (MA) initialed documentation of administration for Keppra (for	D 367		

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D 367	Continued From page 9 seizures) on May 15th, 24th, 27th, 28th or 29th. for the 7:30 pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for methadone (for severe pain) on May 15th, 24th, 27th, 28th or 29th. for the 7:30pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for Zanaflex (for spasticity, reduction in muscle tone) on May 9th, 10th, 15th, 23rd 24th, 27th, 28th or 29th. for the 6pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for Xarelto (reduces risk for stroke) on May 15th, 24th, 27th, 28th or 29th. for the 7:30 pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for Wellbutrin (for depression) on May 15th, 24th, 27th, 28th or 29t.h for the 7:30 pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for Vanspar (for anxiety) on May 15th, 24th, 27th, 28th or 29th.for the 7:30 pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for Oxycodone (for moderate to severe pain relief) on May 4th, 8th, 11th, 15th,18th, 19th, 24th, 26th, 27th, 28th or 29th. for the 10 pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for Dilantin (for seizures) on May 15th, 24th, 27th, 28th or 29th for the 7:30 pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for Urispas (for cystitis) on on May 15th, 24th, 27th, 28th or 29th for the 7:30 pm dose showing that the dose had been given. -There was no MA initialed documentation of administration for Neurontin (for seizures with	D 367		

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D 367	Continued From page 10 epilepsy) on May 15th, 24th, 27th, 28th or 29th for the 10pm dose showing that the dose had been given. -There was no MA initialed documentation of admnistration for Senokot (laxative) on May 15th, 24th, 27th, 28th or 29th for the 10 pm dose showing that the dose had been given. Observation of Resident #4's MAR also revealed no MAs administering medications had placed their signatures on the back of the MAR which corresponded to the initials on the front of the MAR. Interview with a second shift MA on 6/16/16 at 3:30 pm revealed: -She had administered all medications to Resident # 4 for all dates but forgot to document using her intiials on the MAR that the medication was given. -She stated Resident #4 knew when her medications were due and came to the staff to take the medication at the time they were due. -The MA stated she got busy and forgot to document using her initials and signature on the MAR that the medication was given. -She stated she was not aware that she was required to place her signature equivalent to her initials on the back of the MAR. Interview with Resident # 4 on 6/16/16 at 10:30 am revealed the resident received all of her medications when she was supposed to and that she would go and find the staff giving out the medications when it was time for the medications to be administered. Telephone interview with Resident # 4's physican's nurse on 6/17/16 at 10:15am revealed: -according to the doctor's notes, Resident #4 was	D 367		

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D 367	Continued From page 11 seen in May and appeared to be in her normal health. -The nurse stated there was no evidence that Resident #4 had not been receiving her medications. Refer to interview with the HCC on 06/17/16 at 10:15 a.m. Refer to interview with the Administrator on 06/16/16 at 9:50 a.m. Interview with the Health Care Coordinator (HCC) on 06/17/16 at 10:15 a.m. revealed: -The facility had initiated a change on 06/16/16 to the facility's process and procedures related to the documentation of those initials and signatures for medication administration and blood sugar checks. -The MAs would be re-educated on the changed process. Interview with the Administrator on 06/16/16 at 9:50 a.m. revealed: -The Administrator was not aware of any documentation or administration issues with the resident's medications. -The Administrator understood that the MAs were required to initial and provide a signature for those initials when medications and treatments were administered. -The MAs were required to sign the facility's medication storage review form each shift which covered the requirment for a signature with initials.	D 367		

Edwards, Wanda A

From: Willow Place Admin <WILLOWPLACE@Tutera.com>
Sent: Monday, July 18, 2016 12:03 PM
To: Edwards, Wanda A
Subject: willow place poc
Attachments: plan of correction sent to state , july.pdf

Good Morning,

I have attached our plan of correction for your review. If you have any questions please feel free to contact me.

Thank you.

Tina Strickland
Executive Director

Willow Place
1703 Stonewall Road
Laurinburg, NC 28352

910.276.9211 (Office)
910.276.4535 (Fax)

Willow Place
Assisted Living
& Memory Care

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