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BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on August 23 - 25, 2016.	{D 000}		
{D 113}	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure hot water temperatures were maintained between a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 2 of 2 fixtures (1 sink and 1 shower) located in a common bath on the North Hall, 2 of 2 fixtures (1 sink and 1 shower) located in shared residents' bathroom on North Hall (rooms #6 & #7), and 2 of 2 fixtures (1 sink and 1 shower) located in resident's bathroom (Room #11 North). The findings are: Observations in the facility on 5/23/16 of hot water temperatures revealed: -At 2:05 pm, the hot water temperature at the sink in the common bath on North Hall was 92 degrees F. -At 2:08 pm, the hot water temperature at the	{D 113}		

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{D 113}	Continued From page 1	{D 113}		

tub/shower in the common bath on North Hall was 88 degrees F.
-At 2:12 pm, the hot water temperature at the sink in the shared bathroom for rooms 6-7 on North Hall was 94 degrees F.
-At 2:14 pm, the hot water temperature for the shower in the shared bathroom for rooms 6-7 was 92 degrees F.
-At 2:23 pm, the hot water temperature at the sink in the bathroom for room 11 on North Hall was 98 degrees F.
-At 2:25 pm, the hot water temperature for the shower in the bathroom for 11 North was 98 degrees F.

Review of the facility's water temperature log revealed:
-There were no entries for common bathrooms that had a sink and shower or tub/shower.
-A hot water temperature was logged for Room 7 on North Hall on 7/26/16 of 111.8 with no designation if the temperature was for the sink or the shower.
-A hot water temperature was logged for Room 6 North Hall on 5/20/16 of 112.3 with no designation if the temperature was for the sink or the shower.

Interview on 8/23/16 from 2:06 pm - 2:25 pm with 2 residents residing in rooms on the North Halls revealed:
-One resident stated there had been times "we didn't have any hot water", but not recently.
-One resident stated she thought the water temperatures were okay because "I like it barely warm."

Interview on 8/24/16 at 7:58 am with 2 residents residing in rooms on the North Halls revealed:
-One resident stated the water temperatures were

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{D 113}	Continued From page 2	{D 113}		

perfect.
-One resident stated the water temperatures in the common bath on North Hall were "a little cool, but he had no problem with it."
-One resident state "There were a lot of people to take showers."
-One resident used the common bath on the South hall because it was bigger.
-None of the residents had reported concerns related to water temperatures to management.

Interview with a Personal Care Aide (PCA) on 8/25/16 at 1:50 pm revealed:
-She worked on both North and South Halls.
-She assisted residents with showers, if needed.
-She had received no complaints from residents related to water temperatures.
-There were only 2 residents on the North Halls that required assistance with showers.

Interview with the Business Office Manager (BOM) on 8/23/16 at 2:25 revealed:
-The maintenance staff monitored random hot water temperatures throughout the building at least monthly.
-"I tell them to randomly check 2 bathrooms on each side (North and South) and the eye washing stations every month."
-The hot water temperature logs were kept in the BOM's office.
-The hot water temperature checks that had been completed by maintenance had been within the required water temperature range.

Interview with a Maintenance employee on 8/23/16 at 2:55 pm revealed:
-He had been employed by the facility for three months for maintenance job duties.
-He randomly checked, each month, 2 resident bathrooms on each side of the building [North

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{D 113}	Continued From page 3 and South]. -He documented the water temperatures on a water temperature log kept in the BOM's office. -The facility had purchased a digital thermometer for him to check water temperatures. -He had not checked water temperatures in the common baths for residents. -He had only checked shared bathrooms in residents' rooms, the eye-washing stations, and the staff rest room. -The water temperatures he had checked since he was hired had been within "the range they told me it had to be in." -He did not know the acceptable ranges from memory, but had them listed in the BOM's office. On 8/23/16 at 2:58 pm, calibration of thermometers, using ice-water slurry, revealed: -The surveyor's thermometer read 34 degrees F. -The facility's thermometer read 33.2 degrees F. Recheck on 8/23/16 of hot water temperatures on the North Hall of the facility revealed: -At 3:00 pm, the hot water temperature at the sink in the on the North Hall was 102 degrees F by the surveyor's thermometer and 103 degrees by facility's thermometer. -At 3:02 pm, the hot water temperature at the tub/shower in the common bath on the North Hall was 99 degrees F by the surveyor's thermometer and 103 degrees by the facility's thermometer. -At 3:04 pm, the hot water temperature at the sink in the shared bathroom for rooms #6-7 on the North Hall was 100 degrees F by the surveyor's thermometer and 101 degrees by the facility's thermometer. -At 3:05 pm, the hot water temperature for the shower in the shared bathroom for rooms #6-7 on the North Hall was 100 degrees F by the surveyor's thermometer and 100 degrees F by	{D 113}		

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{D 113}	Continued From page 4 the facility's thermometer. -At 5:05 pm, the hot water temperature for the sink in the bathroom for room #11 on the North Hall was 94 degrees F by the surveyor's thermometer. -At 5:07 pm, the hot water temperature for the shower in the bathroom for room #11 on the North Hall was 94 degrees F by the surveyor's thermometer. Recheck on 8/25/16 of hot water temperatures on the North Hall revealed: -At 3:05 pm, the hot water temperature at the sink in the common bath on the North Hall was 89 degrees F by the surveyor's thermometer and 90 degrees by facility's thermometer. -At 3:06 pm, the hot water temperature at the tub/shower in the common bath across from Room 2 North was 88 degrees F by the surveyor's thermometer and 88 degrees by the facility's thermometer. -At 3:10 pm, the hot water temperature at the sink in the shared bathroom for rooms #6-7 on the North Hall was 87 degrees F by the surveyor's thermometer and 88.5 degrees by the facility's thermometer. A second interview with a Maintenance employee on 08/25/16 at 2:30 pm revealed: -He had re-checked water temperatures this morning in the common bath on the North Hall and was getting temperatures of 92 degrees. -He had gradually increased the thermostat on the hot water heater, but this was as high as the temperature had gotten at this time. -He thought there could be a problem with a mixing valve since they had more than one hot water heater for the building. -The facility would contact a plumber for assistance.	{D 113}		

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{D 113}	Continued From page 5 Interview on 08/25/16 at 10:42 am with the Co-Administrator in Training revealed: -The Maintenance staff did hot water temperature checks randomly each month. -He was unaware there were hot water temperatures lower than 100 degrees F. -He would have maintenance to check water temperatures this morning to see if they increased. -He did not know if there could be a problem with the thermostat. -He would need to consult a plumber.	{D 113}		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE A2 VIOLATION Based on these findings, the previously unabated Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure supervision for 2 of 5 sampled residents, one resident identified as disoriented and at risk for elopement	{D 270}		

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{D 270}	Continued From page 6 (#1) and one resident with aggressive behavior (#4) resulting in injury to another resident. The findings are: A. Review of Resident #1's current FL2 dated 5/26/16 revealed: -The diagnoses included dementia. -The box for wanderer had been whited out. Review of Resident #1's current FL2 dated 5/31/16 revealed: -The diagnoses included dementia. -The box for wanderer was completely deleted. Review of an Agreement dated 07/07/16 revealed: -The agreement identified the facility as not being a locked facility and Resident #1 could leave at his will and the facility would not be responsible if he chose to leave without notifying staff. -The Agreement was signed by the Responsible Party (RP) and the Administrator. Review of a Physician Visit Summary dated 7/04/16 revealed: -Resident #1 was being seen for a mental health assessment. -The visit was requested by staff due to agitation, wandering and cognitive changes. -Resident #1's neurocognitive symptoms included: confusion, disorientation, inattention, long term and short term memory loss, and poor decision making. -Resident #1's Safety Evaluation included Resident #1 was at risk for falls and elopement and that "the patient has had attempts of elopement." -Resident #1 was oriented to person only.	{D 270}		

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Review of Resident #1's progress notes revealed there was no documented interventions that were implemented to prevent Resident #1 from eloping.

Reviewed of Resident #1's physician's orders revealed:
-A physician's order dated 7/01/16 for lorazepam 0.5mg ½ tablet (0.25mg)every eight hours as needed for agitation/anxiety (a narcotic medication used to treat anxiety and agitation).
-A physician's order dated 7/05/16 for clonazepam 0.5mg ½ tablet (0.25mg) every four hours as needed for agitation/anxiety (a narcotic medication used to treat anxiety/agitation).
-A physician's order dated 7/05/16 for donepezil 5mg 1 tablet at bedtime (a medication used to treat dementia).
-A physician's order dated 8/19/16 for sertraline 25mg, 1 tablet daily (a medication used to treat depression and anxiety disorders).

Review of Resident #1's July 2016 electronic Medication Administration Record (eMAR) revealed:
-Resident #1 was administered as needed lorazepam 0.5mg, ½ tablet (0.25mg) for agitation 4 times from 7/02/16 to 7/04/16 and this medication was discontinued on 7/06/16.
-Resident #1 was administered as needed clonazepam 0.5mg, ½ tablet (0.25mg) for agitation 38 times from 7/06/16 to 7/31/16.
-An entry for donepezil 5mg, 1 tablet at bedtime, dated 7/05/16 and documented as administered at 8:00 p.m. 7/05/16 through 7/31/16.

Review of Resident #1's August 2016 eMAR revealed:
-Resident #1 was administered clonazepam 0.5mg, ½ tablet (0.25mg) for agitation 39 times

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from 8/01/16 to 8/23/16.
-An entry for donepezil 5mg, 1 tablet at bedtime, documented as administered at 8:00 p.m. from 8/01/16 through 8/22/16.
-An entry for sertraline 25mg, 1 tablet daily, started 8/18/16 and documented as administered daily at 8:00 a.m. from 8/19/16 through 8/23/16.

Review of Resident #1's Progress Notes revealed:
-An entry dated 8/17/16 Resident #1 was outside in the road and another resident came and notified staff that Resident #1 was in the road.
-Staff redirected Resident #1 back inside and placed Resident #1 on 30 minute checks.
-They called and left the RP a message.
-The RP returned the call on 8/18/16 at 10:30 am and they informed the family member that Resident #1 was in the road the evening before on second shift and he was placed on 30 minute checks.

Review of Resident #1's Incident Reports revealed:
-Resident #1 was outside in the road and trying to cross the street.
-Staff went out to Resident #1 and redirected Resident #1 back into the facility.
-The incident occurred on 8/17/16 at 7:00 pm.

Observation on 8/23/16 at 4:59 pm revealed:
-Resident #1 was walking out the exit next to room 10 South Hall; no alarm sounded when the door was opened.
-A staff member saw him and called to another staff member to bring him back inside.
-Resident #1 was escorted back inside and taken to the dining room for dinner.

Observation of the road in front of the facility on

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{D 270}	Continued From page 9 8/24/16 at 1:19 pm to 1:24 p.m. revealed: -A four lane road with two lanes of traffic going in each direction. -There was no median between the north bound and south bound traffic. -The road was approximately 75 feet from the facility. -In 5 minutes, 2-18 wheeler trucks, 23 cars and 1 mo-ped passed the facility. Observation of the facility alarm system on 8/25/16 at 9:25 am revealed: -Two central stations that the building could be alarmed by flipping a switch. -The alarms were functional and could be heard throughout the facility. -The alarms would sound if any of the entry/exit doors were opened. Interview with a Medication Aide (MA) on 8/25/16 at 9:38 am revealed: -The alarm system was not used during the day because residents were free to go in and out to smoke and sit at will and the alarms would be going off constantly if they were on. -Resident #1 was placed on thirty minute checks and she was instructed by the RCC that she did not have to do the checks on 8/22/16. -Prior to Resident #1's incident on 8/17/16, the staff did keep a close eye on Resident #1 but they did not record this. Interview on 8/24/16 at 12:17 pm with a second MA revealed: -She was not aware of a written elopement policy but knew they monitored Resident #1 every 30 minutes. -They had monitored him every thirty minutes for a few days until the RCC told her to stop. -Resident #1 talked about going to his car, but he	{D 270}		

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had not tried to leave since 8/17/16.
-He may go to the door but he was easily redirected.
-When Resident #1 walked to the road, it was not on her shift and she did not know exactly what happened.
-The staff did document the thirty minutes checks.

Interview on 8/24/16 at 3:30 pm with a third MA revealed:
-If a resident eloped, it was their policy to go outside and redirect the resident back to the facility.
-Once back in the facility they were to notify the RP, the RCC and the Administrator.
-The staff were to place the resident on thirty minute checks and document these checks.
-The staff were to perform the checks every thirty minutes until further notice from either the physician, the RCC, or the Administrator.
-She was not working when Resident #1 eloped and went to the road in front of the facility on 8/17/16.

Interview with a fourth MA on 8/25/16 at 10:10 am revealed:
-They had always known to monitor Resident #1 closely because he was more confused than the other residents.
-They did not document this monitoring but they did document the monitoring checks after he eloped and walked to the road in front of the facility on 8/17/16.
-In the past, Resident #1 may have gone to the door to exit, but he had never left the building before to her knowledge.
-It was their policy to perform the thirty minute checks until further notice.
-She knew they had documented the thirty minute

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checks for at least 3 or 4, days but could not locate the documentation at that time.
-The alarm system had two central locations, one on the north side of the building and one on the south side of the building.
-The alarms were activated at the central stations and could be heard throughout the building.
-The staff set the alarm on the north side of the building between 7:00 pm and 9:00 pm and the alarm on the south side of the building around 1:00 am.
-The staff set the north side alarm earlier because those residents went to sleep earlier and those on the south side stayed up and would go outside to smoke up until 1:00 am.
-She would also take Resident #1 on walks, provide activities and one-on-one conversation in efforts to diffuse his anxiety and decrease his risk for elopement.
-She learned to communicate with Resident #1 by using key words that he used and this decreased his anxiety, increased his comfort and provided him a sense of security.
-If these interventions did not work, they had as needed medication they could administer.
-There had been several medication changes made to decrease his anxiety such as clonazepam and sertraline.

Interview with the RCC on 8/24/16 at 3:34 pm revealed:
-She had been employed as the RCC for one week.
-She did not think that the facility actually had a policy for elopement and she had initiated the every thirty minute checks and required that they be done for 24 hours.
-She instructed staff to do the thirty minute checks, document and the checks were to continue this for 24 hours.

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{D 270}	Continued From page 12 -She instructed staff to stop the thirty minute checks when she found out the staff had not stopped them after 24 hours. -She did not think it was necessary to continue thirty minute checks beyond 24 hours because that is what the staff used to do at the facility she worked at before this facility. -She had called the RP several times to discuss alternative placement to a secured facility but had not been able to get in touch with the RP. Review of Resident #1's Thirty Minute Check documentation revealed that Resident #1's location was monitored every thirty minutes from 8/17/16 at 7:00 p.m. through 8/22/16 at 7:00 p.m. Interview with the Business Office Manager (BOM) on 8/25/16 at 11:35 am revealed -She was aware of Resident #1 leaving the facility on 8/17/16 and she understood that the physician had been notified and had recommended a higher level of care. -The Administrator admitted Resident #1 and was told he was not a wanderer and that he was just happily confused. -She thought that the Administrator in training had spoken with the RP and suggested a higher level of care and they were just waiting for her response. -The facility did not have a written policy for a resident walking to the street but they did have a missing resident policy. Interview with the Administrator in Training/Owner on 8/24/16 at 2:42 pm revealed: -The facility had notified the RP that Resident #1 required alternative placement. -He had tried to contact her several times and left at least 3-4 different messages. -The facility never initiated a formal 30 day	{D 270}		

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discharge.
-He expected staff redirect a resident who had eloped back to the facility, notify the RP, and the RCC or himself.
-It was their policy to place a resident who had eloped on thirty minute checks until the behavior subsided or further instruction from a physician.
-He was aware the physician was notified and had requested a new FL2 be completed for Resident #1 so a more secured placement could be obtained.
-It had been his intention to find a more secure placement for Resident #1.

Interview with Resident #1's Nurse Practitioner on 8/24/16 at 12:50 pm revealed:
-The facility did notify her of Resident #1 trying to leave the facility.
-The facility did not notify her when Resident #1 left the facility and went up to the road on 8/17/16.
-Resident #1 was otherwise healthy, but her concern was Resident #1's impaired cognition and the facility's close proximity to the road.
-The facility did tell her they were concerned and they were looking for alternative placement, and she was under the impression they were trying to relocate him to a secured unit.
-She had signed a new FL2 for Resident #1.

Interview with Resident #1's RP on 8/25/16 at 11:20 am revealed:
-She had been notified of Resident #1's exit seeking behavior.
-She had been notified of Resident #1 elopement on 8/17/16.
-She knew he was placed on thirty minute checks, but did not know how long these were to continue or if they had stopped.
-A MA had informed her of this and she had not spoken with the Administrator, the owners of the

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facility, the RCC or the BOM about his safety after the 8/17/16 incident.
-She was aware of his advanced dementia, and thought Resident #1 went to the road because he had been active all of his life and may have just been walking.
-She did not know how to get him qualified for assistance and she could not afford a Special Care Unit.
-She looked into secured units prior to placing him at this facility.
-He did not try to leave the previous facility, but he had to relocate because he had been in an altercation with his roommate.

Based on record review, interview and observation it was determined Resident #1 was not interviewable.

B. 1. Review of Resident #4's current FL2 dated 2/7/16 revealed diagnoses included muscle spasms, chronic obstructive pulmonary disease, anxiety disorder, and bipolar disorder.

Review of a Progress Note for Resident #4 dated 7/21/16 for 3:00 pm-11:00 pm shift revealed:
-Resident #4 was in the sun room watching television and she and another resident were yelling at each other.
-By the time the Medication Aide (MA) and Personal Care Aide (PCA) got to the sunroom, the two residents were physically fighting.
-Resident #4 kicked the other resident.
-The other resident "slid across the floor hitting her head on a glass table."
-Staff called 911 and the police.

Review of an Incident Report dated 7/21/16 revealed:
-At 10:45 pm on 7/12/16 Resident #4 "got into a

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fight with another resident. She was the aggressor."
-Resident #4 had no injuries.
-No documentation of steps taken to prevent recurrence.

Review of a local police report dated 7/21/16 at 22:59 pm revealed:
-A report was called to the local police department at 22:59 pm.
-The responding officer interviewed Resident #4.
-Resident #4 told him she and another resident had gotten into an argument over the television.
-Resident #4 stated the other resident "attacked her twice while she was sitting in her (wheel)chair."
-Resident #4 stated she pushed the other resident to try to get away from her.
-Resident #4 showed the police officer a faint red mark on her chest that she said was a result of her being assaulted by the other resident.
-Resident #4 stated when she pushed the other resident, the resident fell striking her head on the bird cage that was in the corner of the foyer.
-Resident #4 stated the other resident was "drunk", she used the television all of the time, and it was her turn to watch it.
-None of the staff on duty at the time of the altercation had witnessed the occurrence.
-The officer went to the hospital to interview the injured resident.
-The injured resident said Resident #4 was asleep in the sun room when the resident changed the television channel to watch what she wanted to watch.
-Resident #4 awoke and got extremely mad because the other resident had changed the channel.
-The injured resident reported to the officer that Resident #4 got up from her chair and hit her,

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knocking her to the floor and causing her to strike her head on the corner of a glass top table that was located in the foyer.
-The injured resident was noted to have a small laceration to the back of her head and a hematoma to the left forearm.
-Both residents involved were noted to have extreme variations in their sides of the story.
-Both residents were noted to be competent and were advised to seek their own private warrants in the matter for the assault if they felt it was necessary.

Review of a Psychologist visit note dated 3/14/16 revealed Resident #4 tended to be angry, irritated, had verbal outbursts, and friction with peers.

Review of a Psychologist visit note dated 07/19/16 revealed Resident #4 appeared fairly well managed with no changes at that time.

Review of Resident #4's Progress Notes revealed:
-A Progress Note dated 7/22/16 revealed the Resident Care Director (RCD) contacted Resident #4's physician regarding behaviors and requested a review of medications.
-A Progress Note dated 7/23/16 revealed Resident #4 stated she had no concerns about the altercation and had shown no additional signs of behavior issues.
-There was no documentation of other behavioral incidents.
-There was no documentation of increased supervision by staff for Resident #4 following the incident occurring on 07/21/16.

Review of a Nurse Practitioner (NP) note dated 07/22/16 revealed:

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{D 270}	Continued From page 17 -Staff called to report Resident #4 had "gotten into several fights with other residents." -On 7/22/16, Resident #4 struck another resident sending the resident to the emergency room for stitches. -The facility requested a medication review. -The NP ordered to discontinue Lamictal 100 mg (Lamictal is used for seizures and bipolar disorder) one tablet daily. -The NP ordered Lamictal 100mg one tablet every morning and 1/2 tablet every night for one week, then increase to Lamictal 100mg one tablet twice a day. Review of incident reports from 06/01/16 to 08/22/16 revealed no documentation of other incidences of Resident #4 being involved with altercations with other residents. Interview with Resident #4 on 8/25/16 at 1:55 pm revealed: -When asked about the altercation with the other resident on 7/21/16, she stated "we don't talk about that anymore." -The other resident hit Resident #4 and "I hit her back and knocked her out". -She had not been in any further altercations. -She now had a television in her room and did not go to the sunroom to watch television. -She had seen her doctor recently and "I am okay with my current medicines." 2. Review of Resident #6's current FL2 dated 7/22/16 revealed diagnoses included joint pain, cerebrovascular disease, pulmonary vascular disease, lack of coordination, and history of alcohol abuse. Interview with Resident #6 on 8/24/16 at 2:30 pm revealed:	{D 270}		

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{D 270}	Continued From page 18 -She and Resident #4 were in the sunroom and Resident #4 was asleep on the couch and "was snoring." -Resident #4 was not watching television and when she called Resident #4's name, she did not answer her. -Resident #6 turned the television channel and Resident #4 starting yelling "I was watching the [expletive] TV." -The resident responded to Resident #4 "I don't see your name on it." -Resident #4 "backhanded me and I fell on the glass table with a glass top." -"She [Resident #4] wants to be the boss." -Resident #6 had a laceration on the left side of her head. -She was taken to the emergency room and had seven stitches. -There was no staff present during the altercation, but 2 Medication Aides (MA) came into the room when they heard the altercation. -Resident #6 denied drinking prior to the altercation. -There had been no further instances with Resident #4 and no other residents of which she was aware. Review of Resident #6's Emergency Room discharge documents dated 7/21/16 revealed: -Resident #6 was treated for a scalp laceration, scalp hematoma, contusion of left forearm, and alleged assault. -Resident #6 was prescribed hydrocodone-acetaminophen 5-325mg tablet, take one to two tablets by mouth every six hours as needed for pain. Interview on 8/25/16 at 2:30 pm with the Business Office Manager (BOM) revealed: -Resident #6 came to her on 7/22/16 to tell her	{D 270}		

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about the incident that occurred on 7/21/16.
-Resident #4 also came to her on 7/22/16 to inform her about the incident that occurred on 7/21/16.
-She met with both residents to discuss the incident on 7/22/16.
-She met with the Co-Administrator in Training to discuss the incident and to get his approval for the facility to purchase a television for Resident #4 to have in her room.
-The facility purchased a television for Resident #4.
-Resident #4 "does have a temper."
-There had been no further instances of altercations involving Resident #4 or Resident #6.
-She was not aware if staff had been asked to increase supervision of Resident #4 following the incident.

Attempted interview on 8/24/16 with the Medication Aide who completed the Incident Report related to the altercation was unsuccessful.

Interview with a Medication Aide (MA) on 8/25/16 at 9:41 am revealed:
-The facility had placed residents who needed more supervision on 30 minute checks.
-The current Resident Care Director (RCD) said they only did 30 minute checks for 24 hours after an incident.

Interview with a second MA on 8/25/16 at 1:50 pm revealed, to her knowledge, Resident #4 was not on 30 minute checks after the altercation with Resident #6.

Interview with Resident #4's Nurse Practitioner on 08/24/16 at 1:05 pm revealed:
-Resident #4 had not exhibited aggressive

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behaviors previously to her knowledge.
-She was very surprised that Resident #4 had an altercation with another resident.
-She did not know what could have caused the change in Resident #4's behavior.
-She adjusted one of Resident #4's medications when notified by the facility the day after the incident.

Attempted interview with Resident #4's Psychiatric Practitioner on 8/25/16 was unsuccessful.

Interview on 8/25/16 at 2:45 pm with the Co-Owner revealed:
-She was aware of the altercation between Resident #4 and Resident #6.
-The facility could implement 30 minute checks if a resident needed increased supervision.
-To her knowledge, staff had not increased documented supervision of Resident #4 following the incident.
-The Resident Care Director (RCD) position had recently changed which could have been why increased supervision was not implemented.

Review of the facility's "Management of Physical Aggression or Assault by a Resident Policy" dated 10/29/04 revealed:
-Harassment, physical, or verbal abuse of other residents or staff was considered to be inappropriate and unacceptable.
-Residents engaging in inappropriate behavior may be subject to behavioral intervention techniques as deeded necessary by the facility and the resident's physician.
-Depending on the severity of the behavior, and based on the circumstances, the facility would ask all staff to be alert to inappropriate behaviors and report immediately to the supervisor any

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{D 270}	Continued From page 21 maladaptive behaviors. _____ A Plan of Protection was provided by the facility on August 24, 2016 as follows: -Effective immediately, residents with identified needs for increased supervision will be evaluated and identified and interventions as well as increased monitoring will be implemented to ensure safety. -A training program will be implemented to help staff identify residents that need increased supervision. -The Supervisor will ensure designated staff will initiate increased monitoring to ensure resident safety. -The RCC will monitor close supervision and track weekly for two months to ensure proper implementation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 8, 2016.	{D 270}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 276		

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D 276	Continued From page 22 reviews, the facility failed to assure implementation of physician orders for 2 of 5 sampled residents with physician's orders for Finger Stick Blood Sugars (Resident #1) and laboratory work, including a urine drug screen, a 12 panel (to screen for drug usage), and a hemoglobin A1C test (to screen for diabetes) (Resident #4). The findings are: A. Review of Resident #4's current FL-2 dated 2/7/16 revealed diagnoses included chronic obstructive pulmonary disease (COPD), thrombocytopenia, bipolar disorder, and hypothyroidism. Review of Resident #4's physician orders revealed: -A physician's order dated 6/24/16 for a hemoglobin (Hgb) A1C. "Lab will be done by [named company] the next time they come to the facility. No scheduling needed by facility." -A physician's order dated 7/08/16 for a urine drug screen and 12 panel lab due to long term use of medications. "Please have this lab drawn per usual facility procedures." Review of Resident #4's lab results revealed there were no results for a urine drug screen, 12 panel lab or a Hgb A1C. Interview with the medical Nurse Practitioner (NP) on 8/24/16 at 12:58 pm revealed: -She had ordered the Hgb A1C on 6/24/16 for Resident #4 to obtain a baseline level even though Resident #4 was not currently a diabetic. -Resident #4's "sugars" had been okay when checked by routine labs. -"I am sure her A1C will be fine."	D 276		

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-She would re-order the A1C.
-She informed the former Resident Care Director (RCD) on her next visit to the facility 2 weeks later that the A1C had not been obtained.
-The urine drug screen and 12 panel lab ordered 7/8/16 were also a routine test she ordered because Resident #4 was on routine pain medication.
-She did not receive results for the urine drug screen or the 12 panel lab.
-She thought she had informed the RCD she had received results for a routine urinalysis, but it did not include urine drug screen results or the 12 panel lab.
-She thought she informed them 2 weeks after she ordered the tests.

Interview with the former RCD on 8/24/16 at 11:45 am revealed:
-She was employed as the RCD until 7/8/16.
-[Named company] came to the facility routinely and obtained orders for labwork to be drawn.
-[Named company] had a location in the facility where the orders from the medical practitioner were on file for labwork to be completed.
-It was the responsibility of the Medication Aides (MA) or the RCD to ensure lab orders were placed in [named company's] designated location for orders.
-She did not know why [named company] had not completed the drug screen and 12 panel.
-She was contacting another lab company today to obtain the urine drug screen and the 12 panel labs.

Interview with the Co-Administrator in Training on 08/24/16 at 1:05 pm revealed:
-She would have expected the MAs to give her the orders for the labs because they were "in transition with RCD's."

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D 276	Continued From page 24 -She was unaware Resident #4's labs for an A1C, urine drug screen, and 12 panel had not been initiated by staff. -She would provide training to MA's regarding the initiation of orders for labs. Refer to interview with the medical Nurse Practioner on 08/24/16 at 12:50 pm. B. Review of Resident #1's current FL2 dated 5/30/2016 revealed: -Diagnoses included diabetes mellitus type II. -A physician's order for Finger Stick Blood Sugars (FSBS) twice weekly on Monday and Thursday. -A physician's order for metformin 1000mg, 1 tablet twice daily (a medication used to regulate blood glucose) and glyburide 5mg, 1 tablet twice daily (a medication used to regulate blood glucose). Review of Resident #1's record revealed a physician's order dated 6/24/16 to obtain blood pressures daily for two weeks and FSBS daily for two weeks and then resume original orders. Review of Resident #1's June 30, 2016 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry dated 6/24/16 to check blood pressure daily for two weeks and blood pressures were documented as obtained daily at 8:00 am 6/25/16 through 6/30/16 and blood pressures ranges from 100-162 systolic and 67-90 diastolic. -There was a computer generated entry dated 5/31/16 to obtain FSBS twice weekly on Monday and Thursday and FSBS were documented as obtained at 8:00 am on Mondays and Thursday with a range of 80-160. -There was no entry to obtain FSBS daily for two	D 276		

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D 276	Continued From page 25 weeks. Review of Resident #1's July 2016 eMAR revealed: -There was a computer generated entry dated 6/24/16 to check blood pressure daily for two weeks and blood pressures were documented as obtained at 8:00 am 7/01/16 through 7/08/16 and blood pressures ranges from 136-159 systolic and 68-92 diastolic. -There was a computer generated entry dated 5/31/16 to obtain FSBS twice weekly on Monday and Thursday and FSBS were documented as obtained at 8:00 am on Mondays and Thursday with a range of 90-130. -There was no entry to obtain FSBS daily for two weeks. Interview on 8/24/16 at 12:50 pm with the medical Nurse Practitioner (NP) revealed: -She had not recognized the daily FSBS order was not initiated. -She was able to review Resident #1's FSBS which were obtained and she had enough information to evaluate his blood sugars and she found them to be in acceptable range. Interview on 8/24/16 at 11:36 am with a pharmacy representative revealed: -They received an order on 6/24/16 to check blood pressures daily for two weeks and this was entered into the eMAR. -She did see there was an order to obtain FSBS daily for two weeks and this order was not entered into the eMAR. -She did not know why the FSBS was not entered into the eMAR. -She expected the facility to review all the orders and once reviewed the facility staff was to reject or approve the new orders.	D 276		

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D 276	Continued From page 26 -The order to obtain the blood pressures daily for two weeks had been approved. -No one from the facility had notified them via fax or phone that the FSBS order had not been entered. Interview on 8/25/16 at 2:50 pm with a Medication Aide (MA) revealed: -The new orders were to be faxed to the pharmacy and the pharmacy entered the new orders into the eMAR. -MAs were responsible for copying the order and stapling a copy of the order to a new order tracking form. -The new order tracking form was to be filled out by the MA who received the order and the MA who verified the order had been entered correctly by the pharmacy. -Once the order was verified as correct the new order tracking form and the copy of the new order were filed in the new order tracking book and the new order was to be approved in the eMAR. -There was not a tracking order form or a copy of the order in the new order tracking book. Interview with the Resident Care Coordinator (RCC) on 8/24/16 at 3:34 pm revealed: -She had been employed at the facility for a week. -She was not aware Resident #1 had an order for FSBS to be taken daily for 2 weeks that was not initiated. -She had not had a chance to review Resident #1's record. -She did not know if there was a process in place to check and ensure orders were transcribed onto the eMARs correctly and completely. Interview with the Administrator in Training/Owner on 8/24/16 at 2:45 pm revealed:	D 276		

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D 276	Continued From page 27 -He was not aware Resident #1 had an order for FSBS to be taken daily for 2 weeks that was not initiated. -He knew there was a process in place to check and ensure orders were transcribed onto the eMARs correctly and completely but did not know why it was not fully implemented. -He expected the supervisor and RCC to review all new orders and verify they were correct in the eMARs. Based on observation, record review, and interview, it was determined Resident #1 was not interviewable. Refer to interview with the medical Nurse Practioner on 08/24/16 at 12:50 pm. Interview on 8/24/16 at 12:50 pm with the medical Nurse Practitioner (NP) revealed: -She expected all of her orders to be implemented the same day they were ordered. -She visited this facility every two weeks.	D 276		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record	{D 358}		

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{D 358}	Continued From page 28	{D 358}		

review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 2 of 5 sampled residents (#3 and #4) which included errors with administration of divalproex sodium and voltaren gel.

The findings are:

A. Review of Resident #3's current FL2 dated 7/21/16 revealed:
-The diagnoses included schizophrenia.
-A hand written physician's order for divalproex sodium 250mg, 1 tablet twice daily and 3 tablets (750mg) every evening (a medication used to manage symptoms of psychotic mood disorders such as schizophrenia).

Review of a signed Physician Order Sheet dated 7/8/16 from Resident #3's previous facility revealed a computer generated order for divalproex sodium 250mg 1 tablet twice daily and 250mg 3 tablets (750mg) every evening.

Review of Resident #3's Progress Notes revealed an entry dated 7/26/16, staff notified the mental health practitioner and requested a medication review because the resident had been "aggressive and hard to redirect."

Review of Resident #3's July 2016 electronic Medication Administration Record (eMAR) revealed:
-An entry for divalproex 250mg take 2 tablets (=500mg) every night at bedtime and documented as administered every evening at 8:00 pm from 7/21/16 through 7/31/16.
-An entry for divalproex 250mg, 1 tablet twice daily and documented as administered at 8:00 am and 2:00 pm from 7/22/16 through 7/31/16.

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{D 358}	Continued From page 29 Review of Resident #3's August 2016 eMAR revealed: -An entry for divalproex 250mg take 2 tablets (=500mg) and documented as administered every night at bedtime at 8:00 pm from 8/01/16-8/22/16. -An entry for divalproex 250mg 1 tablet twice daily and documented as administered at 8:00 am and 2:00 pm from 8/01/16 through 8/22/16. Interview with a representative from Resident #3's Pharmacy on 8/24/16 at 11:36 am revealed: -The hand written physician's order on the FL2 dated 7/21/16 for divalproex acid 250mg was interpreted divalproex sodium 250mg 2 tablets (500mg) every evening. -They did not receive the Physician Order Sheet which had the computerized order for divalproex sodium 250mg 3 tablets (750mg) every evening. -On 7/28/16 the pharmacy filled 120 tablets of divalproex sodium 250mg 2 tablets (500mg) every evening which was a 30 day supply. -She would have expected the facility to call the pharmacy if they could not interpret the hand written order or if the hand written order was different from the computer generated physician order. -She would have expected the facility to reject the order in the system, call the physician for clarification, and fax the clarification once it had been received. -The pharmacy did not receive a phone call or fax requesting the pharmacy review the discrepancies with the divalproex entry. -The facility accepted the divalproex orders as they were entered and they did not receive any clarification of the order. -The facility approved the order entered for divalproex 250mg 2 tablets (500mg) every	{D 358}		

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{D 358}	Continued From page 30 evening in the electronic MAR system. Observation of the supply of divalproex 250mg revealed: -There were 4 cards of divalproex 250mg filled by the facility's contracted pharmacy on 7/28/16. The first card had 27 tablets of divalproex 250mg remaining. The second had 28 tablets of divalproex 250mg remaining. The third had 21 tablets of divalproex 250mg remaining. The fourth had 30 tablets of divalproex 250mg remaining. -There was one card brought from Resident #3's previous facility and it had 15 tablets of divalproex 250mg remaining. Review of a Release of Responsibility for Medication Form dated 7/21/16 and signed by a facility staff member revealed the previous facility released 125 tablets of divalproex acid 250mg tablets. Review of Resident #3's eMARs from 7/21/16 through 8/22/16 revealed: -158 tablets were needed to administer the medication as ordered. -There was one exception documented as not given on 8/20/16 at 8:42 am because the resident was out of the facility. According to the amount of divalproex acid 250mg dispensed and amounts administered between 7/21/16 to 8/22/16, there should have been 87 tablets remaining and there were 121 tablets remaining. Interview with a Medication Aide (MA) on 8/24/16 at 12:10 pm revealed: -Physician orders were faxed to the pharmacy and the pharmacy keyed the new orders into the electronic MAR.	{D 358}		

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{D 358}	Continued From page 31 -The new orders were flagged and the MAs were responsible for approving all of the orders entered by the pharmacy staff. -The flagged order entries in the eMAR were compared to the actual physician order and the medication label to verify they were all consistent. -She was not working at the time Resident #3 was admitted to the facility. -Resident #3 had not presented with any aggressive behavior she had observed but he was observed constantly pacing the hallways and walkways of the facility. Interview with a second Medication Aide (MA) on 8/25/16 at 2:50 pm revealed: -Physician orders were faxed to the pharmacy and the pharmacy keyed the new orders into the electronic MAR. -The entry should have been compared to the original order which was in the new order tracking book. -The discrepancy between the hand written FL2 order and the computer generated Physician Order Sheet should have been clarified with the physician. -When a MA received new orders they were to place a copy in the new order tracking book along with the new order tracking form and fill out the form as appropriate. -She did not process this admission but was able to tell which MA had admitted Resident #3. -Resident #3 had not presented with aggressive behaviors, but was not always compliant with the hands on care offered by staff. -Resident #3 had not had an occasion to hit or fight since his admission. Interview with a third Medication Aide (MA) on 8/25/16 at 3:10 p.m. revealed: -She did approve the divalproex order that was	{D 358}		

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entered into the electronic MAR system by the pharmacy.
-She did compare the order with Resident #3's FL2 and also thought that the order instructed to give two tablets instead of three because the hand writing was messy.
-She did not see the copy of the Physician Order Sheet behind Resident #3's FL2 and if she seen it, she would have called the physician to clarify the order.
-She had not observed Resident #3 to be aggressive, but had observed him to pace. He was not compliant with care in that he would take off the shoes staff had assisted him to wear. He had not hit or became physically aggressive with staff or residents.

Interview with Resident #3's Primary Care Practitioner on 8/24/16 at 12:50 pm revealed:
-She had signed a Physician Order Sheet for Resident #3.
-She relied on the facilities to make sure the orders on these sheets were accurate and "only glances over them to make sure nothing sticks out that doesn't look right".
-She did not manage his divalproex and that was the responsibility of the psychiatric practitioner.

Attempted interview with Resident #3's Psychiatric Practitioner on 8/25/16 was unsuccessful.

Interview with Resident #3 on 8/25/16 on 12:40 pm revealed:
-He did not know when he was admitted, but thought it may have been about a month ago.
-He walked to get away from voices in his head.
-He did not hear any more voices since being admitted to this facility.
-He liked living at this facility and the staff were

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nice to him.
-He did not have any violent thoughts toward himself or others since being admitted to this facility.

Interview with the Resident Care Coordinator (RCC) on 8/24/16 at 3:34 p.m. revealed:
-She had only been employed at the facility for about one week.
-She was unaware the divalproex acid was being administered incorrectly and was not familiar with the admission process or the processing of new orders.

B. Review of Resident #4's current FL-2 dated 2/7/16 revealed diagnoses included muscle spasms, chronic obstructive pulmonary disease, and bipolar disorder.

Review of a Nurse Practitioner's visit note on 7/8/16 revealed:
-Resident #4 had chronic pain due to history of trauma and surgeries.
-Resident #4 had a recent fall at the facility with no fractures, but complained of right knee pain.

Review of Resident #4's physician's orders revealed:
-A physician's order dated 5/27/16 for Capsaicin Cream (used to relieve muscle or joint pain) apply to affected areas of pain four times daily as needed (may keep at bedside).
-A prescription dated 8/08/16 for Diclofenac Sodium 1% gel (used to treat joint pain) place onto skin four times a day as needed .
(Diclofenac Sodium 1% gel is the generic brand for Voltaren Gel.)
-There was no physician's order the Voltaren Gel could be kept at bedside.

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{D 358}	Continued From page 34 Observation on 8/23/16 at 9:25am revealed: -Resident #4 was lying in bed and appeared to be drowsy. -There was a plastic zip-loc bag lying in a chair beside the bed. -The zip-loc bag contained a labeled box containing a tube of Voltaren Gel 1%. -The instructions on the label read: "Voltaren Gel 1%. Place 4 grams on left hip skin four times a day as needed. -The Voltaren Gel 1% was filled 8/10/16. -A protective glove, with all fingers of the glove pulled up into the glove, was lying beside the plastic bag containing the Voltaren Gel 1%. Interview with Resident #4 on 8/23/16 at 9:28 am revealed: -She did "not usually" apply the Voltaren Gel, "but they were busy this morning so I did it myself." -"I can reach my hip." -She measured four grams by putting the gel in "one of those little cups with marks on it." -"It is about 1/2 an inch." -She could not recall which staff person gave her the Voltaren Gel. -She had applied the medication before, but did not know how often. -The medication had helped her pain "a little" this morning. A second interview with Resident #4 on 8/25/16 at 1:55pm revealed: -The Voltaren gel was the medication she used as needed for pain in her hip. -She measured 4 grams with the cup. -The staff usually applied the Voltaren Gel, but they were busy on Tuesday morning [8/23/16]. -She went to the nurse's station the morning of 8/23/16 and asked for medication cream to apply to her hip.	{D 358}		

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{D 358}	Continued From page 35 -She could not recall who provided her with the Voltaren Gel. -She was unable to walk and had to use a wheel chair for mobility. -She "was lazy" that morning and did not return the medication to the nurses station. -"I don't have the "C" cream [Capsaicin Cream] anymore, because it was empty." -She threw the Capsaicin Cream away about one month ago. -She had not reported to staff she was not using the Capsaicin Cream. -She had not requested staff to refill the Capsaicin Cream for her because she did not think she still needed it. -The cream she had now (Voltaren gel) could not be kept at her bedside. -"I don't want them to get in trouble because I was too lazy to get up and take the cream back to the desk." Observation on 8/24/16 at 10:30 am revealed: -Voltaren Gel was on the medication cart and not in Resident #4's room. -The dispense date on the label of the Voltaren Gel was 8/10/16. -The medication tube was one-third full. Review of prescribing instructions for Voltaren Gel revealed: -A dosing card (provided with the medication) should be used to measure up to the 2 gram or 4 gram line. -The dosing card could be used to apply the gel. -The hands should then be used to gently rub the gel into the skin as ordered. As second interview with the Medication Aide (MA) on 8/24/16 at 10:32 am revealed: -Resident #4 had 2 medications to be applied for	{D 358}		

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pain, Voltaren Gel and Capsaicin Cream.
-The Voltaren Gel was to be applied by the MA and not the resident.
-The Capsaicin Cream could be kept at bedside and Resident #4 could apply it as needed.
-She had observed Resident #4 use gloves when applying the Capsaicin Cream.
-Resident #4 was to inform them when she was out of the Capsaicin Cream.
-She was not aware Resident #4 had the Voltaren Gel in her room on 8/23/16.
-She did not know how Resident #4 would have measured 4 grams because the measuring tool (a small ruler) was kept on the medication cart.
-Resident #4 would not have been able to measure 4 mg's of the Voltaren Gel with a measuring cup.

A second interview with a MA on 8/25/16 at 2:20pm revealed:
-She was unaware Resident #4 had discarded the Capsaicin Cream when she ran out of the medication.
-Resident #4 had not informed staff she was out of the Capsaicin Cream.
-She would order the Capsaicin Cream today from the pharmacy and it would be delivered tonight.

Interview with a former Resident Care Director (RCD) on 8/24/16 at 12:00 pm revealed:
-She was the RCD at the facility until 8/8/16.
-She was aware Resident #4 had a cream ordered she could apply herself, but she was not familiar with the order for the Voltaren Gel and who was to apply it.
-Only medications that were ordered by the doctor to be self-administered were to be kept in a resident's room.

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{D912}	Continued From page 37	{D912}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to ensure supervision for 2 of 5 sampled residents, one resident identified as disoriented and at risk for elopement (#1) and one resident with aggressive behavior (#4) resulting in injury to another resident. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type B Violation)].	{D912}		