STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on August 15-17, 2016.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 2 of 6 sampled staff (A, and E) were tested upon employment for tuberculosis (TB) disease with the two-step TB skin test in compliance with control measures adopted by the Commission for Health Services. The findings are: A. Review of Staff A's personnel file revealed: -Staff A was hired as a Medication Aide (MA) on 7/8/2015. -Documentation a TB test was administered on 6/29/15 and read on 7/1/15 with a negative zero millimeter reading. -There was no documentation a second TB test had been administered. Interveiw on 8/15/16 at 3:30 pm with Staff A revealed she had one TB skin test administered	D 131		

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D 131	Continued From page 1 on 6/29/15 since employment at the facility. Interview on 8/15/16 at 3:00 pm with a facility Nurse revealed: -She administered TB skin tests to staff in March 2016. -She could not find documentation Staff A had a second TB skin test in March 2016. Interview on 8/15/16 at 4:35 pm with the Business Office Coordinator revealed: -She was responsible for making sure all staff TB skin tests were completed and up to date. -She thought the Nurse completed the TB skin test for all staff in March 2016. -She was aware all staff needed two TB skin tests. B. Review of Staff E's personnel file revealed: -She was hired on 07/07/15 as a Medication Aide/Resident Care Associate. -There was documentation Staff E had a TB skin test and it was read on 07/09/15. -There was no documentation Staff E had a second TB skin test. Interview on 08/17/16 at 3:25 pm with Staff E revealed: -She had worked at the facility since last year, July 2015. -Initially, she was hired as a Medication Aide/Resident Care Associate (RA). -Sometimes she worked second shift, but mostly worked third shift as a Medication Aide/Supervisor. -Her duties and responsibilities were administering medications to residents at the facility. -She had a TB skin test upon hire at the facility. -Since employment she have not taken another	D 131		

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D 131	Continued From page 2 TB skin test. -The Business Office Coordinator (BOC) kept up with required trainings and other things needed for employment. -The BOC usually informed staff when trainings or other required documents were needed for employment. Interview on 08/16/16 at 3:50 pm with the Executive Director revealed: -Ensuring staff had TB skin tests was the responsibility of the BOC. -The BOC was to notify the nurse of the staff that needed TB skin tests. -The Nurse would schedule the time for staff to obtain the TB skin test. -She had been in the facility for only two days and was unaware Staff E did not have a second TB skin test. Interview on 03/16/16 at 3:41 pm with the BOC revealed: -Ensuring employees had all required documents for employment was her responsibility. -She informed the nurse when staff needed a follow-up TB skin test. -As of today she was unaware that Staff E did not have a second TB skin test, but she would make sure the TB skin test was done very soon. Interview on 08/16/16 at 4:45 pm with the Nurse revealed: -She no longer worked at the facility. -It was the BOC's responsibility to inform the nurse when staff needed TB skin test. -She was unaware Staff E had not completed a second TB skin test.	D 131		

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D 167	Continued From page 3	D 167		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 11 of 16 days on second shift and 16 of 16 days on third shift from 8/1/16-8/16/16. The findings are: A. Review of Staff F's personnel file revealed: -Staff F was hired as a Medication Aide (MA) on 1/19/16. -Staff F's title was Supervisor/Medication Aide -No documentation in Staff's personnel file of CPR training within the last 24 months.	D 167		

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D 167	Continued From page 4 Review of the staffing schedule dated 8/01/16-8/16/16 revealed: -Staff F worked second shift on 8/1/16-8/3/16, 8/5/16, 8/6/16, 8/15/16 and 8/16/16 and third shift on 8/6/16, 8/7/16 and 8/10/16. -Staff F was not CPR certified based on her staff personnel file. Interview with Staff F, MA on 8/16/16 at 3:05 pm revealed: -She took CPR training and thought her CPR certification expired in September of 2015. -She had worked at the facility since January 2016, but had only been the second shift supervisor for two weeks. -She routinely worked second and third shift. -She did not know if there was anyone else on her shift that was CPR certified. -No resident had required CPR or had an incident of choking during any shifts she had worked at the facility. Refer to interview with the Resident Care Coordinator (RCC) on 8/16/16 at 3:12 pm. Refer to interview with the Business Office Coordinator (BOC) on 8/16/16 at 3:30 pm. Refer to Interview with the Administrator on 8/16/16 at 3:00 pm. B. Review of Staff E's personnel file revealed: -Staff E was hired as a Medication Aide/ Resident Care Associate on 07/07/15. -No documentation of CPR training within the last 24 months. Review of the staffing schedule dated 8/1/16-8/16/16 for Staff E revealed:	D 167		

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D 167	Continued From page 5 -Staff E worked second shift on 8/7/16, 8/8/16, 8/13/16, 8/14/16 and third shift on 8/1/16, 8/2/16-8/5/16, 8/8/16, 8/9/16, and 8/11/16-8/16/16. Interviews on 08/17/16 at 3:25 pm with Staff E revealed: -She had worked at the facility since last year, July 2015. -Initially, she was hired as a Medication Aide/Personal Care Aide (PCA). -Sometimes she worked second shift, but mostly worked third shift as a Medication Aide/Supervisor. -Her duties and responsibilities were administering medications to residents at the facility. -The Business Office Coordinator (BOC) was responsible to ensure staff required trainings and other things needed for employment were done. -The BOC informed staff when trainings or other required documents were needed for employment. -The Resident Care Coordinator did the staffing schedule, and she was not aware of staff that were CPR certified. -No resident had required CPR or had an incident of choking during shifts she worked at the facility. Interview on 08/16/16 at 3:00 pm with the Executive Director revealed: -The Nurse or the Resident Care Coordinator was responsible to ensure CPR certification was done. -BOC was responsible to inform staff if they needed CPR certification. -She had only worked as the Executive Director at the facility for two days, and was not aware Staff E did not have CPR certification.	D 167		

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D 167	Continued From page 6 Refer to interview with the Resident Care Coordinator (RCC) on 8/16/16 at 3:12 pm. Refer to interview with the Business Office Coordinator (BOC) on 8/16/16 at 3:30 pm. Refer to Interview with the Administrator on 8/16/16 at 3:00 pm. _____ Interview with the Resident Care Coordinator (RCC) on 8/16/16 at 3:12 pm revealed: -She was responsible for completing the staff schedule. -She had been doing the schedule for almost a year. -She had been the RCC for a month. -She had worked in the facility for 5 years. -She did not account for CPR certification when formulating the schedule. -They did have a Personal Care Aide (PCA) that was CPR certified that worked on second shift on 8/8, 8/9, 8/10, 8/11 and 8/12/16. -This PCA's CPR would expire in February 2018 (card was provided). -She was not aware this PCA was CPR certified when she made the schedule. Interview with the Business Office Coordinator (BOC) on 8/16/16 at 3:30 pm revealed: -She was responsible for maintaining employee records and had been the BOC for approximately one year. -There was no system in place that indicated who had CPR and when their CPR certification would expire. -The facility did offer CPR classes, but she thought some employees may not have given her a copy of their CPR card. -Some employees obtained their CPR outside of the facility, but they had not provided her a copy	D 167		

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D 167	Continued From page 7 of the card. Interview with the Administrator on 8/16/16 at 3:00 pm revealed: -The RCC or the Registered Nurse were responsible for ensuring one person was CPR certified on each shift. -It was their policy to require all MAs have their CPR certification. -She did not know how long they were scheduling staff without having CPR certification. -She was aware at least one person on each shift were required to be CPR certified. A Plan of Protection was provided by the facility on August 16, 2016 as follows: -An audit on all staff files would be completed by 8/17/16. -CPR training took place on 8/16/16. -The staff schedule would be reviewed for CPR trained associates. -The staff schedule will be reviewed ensuring compliance by the Executive Director or designee. -Another CPR class will be completed no later than 9/09/16. -On going, each new schedule will be reviewed for compliance prior to posting by the Executive Director or designee. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, October 1, 2016.	D 167		
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:	D 276		

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D 276	Continued From page 8 (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 reviews, the facility failed to assure implementation of physician orders for 1 of 5 sampled residents (Resident #2) with physician's orders for laboratory work (Complete Blood Count (CBC) with differential and Comprehensive Metabolic Panel (CMP) with glomerular filtration rate (GFR)). The findings are: Review of Resident #2's current FL2 dated 05/24/16 revealed diagnoses included dementia with behavioral disturbance, vitamin D deficiency, anemia, chronic kidney disease, and joint disease. Review of Resident #2's record revealed: -A physician's order dated 07/12/16 for CBC with diff and CMP with GFR. Based on record review and observation on 08/15/17 Resident #2 was not interviewable. Interview on 08/16/16 at 12:08 pm with the Nurse Practitioner revealed: -The CMP with GFR and CBC with diff were routine labs. -She had the same labs drawn in February 2016, and it was time to have the labs done again.	D 276		

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-She would check her computer to see if the labs were drawn and if she had a copy of the results.
-A check of her computer revealed she did not see where labs were done or that the facility notified her the resident refused to have labs done.
-"Someone at the facility just dropped the ball."

Interview on 08/16/16 at 10:52 am with a representative from the laboratory corporation responsible for drawing Resident #2's blood revealed:
-When a resident had an order for a lab, the facility should notify the laboratory.
-A phlebotomist visited the facility to draw the resident's blood.
-The order for the blood draw and results would be documented in their system.
-If the resident refused to allow the phlebotomist to draw the lab, the refusal would be documented.
-A check of their records revealed there was no documentation Resident #2 had been scheduled for a lab draw.

Interview on 08/16/16 at 12:50 pm with the first shift Medication Aide (MA)/Supervisor revealed:
-If the resident refused to allow the technician to draw the lab, the technician wrote "lab not performed" on their paperwork and would give the facility a copy of the paperwork.
-The MA would document the refusal in the resident's record and notify the Nurse Practitioner to see what she wanted to do.
-A check of Resident #2's record revealed there was no documentation the resident refused.
-She was not sure why Resident #2's lab work was not done, "it must have been missed".
-The Nurse Practitioner visited the facility on Tuesday and the lab technician visited the facility

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D 276	Continued From page 10 every Wednesday. -When lab orders were received the MA wrote down the order on the lab sheet. -The sheet was put in the folder for the lab technician to obtain upon the next visit to the facility. -When the lab technicians came to the facility they review the lab sheet with the resident's name and labs to be drawn. -The Resident Care Coordinator (RCC) received a copy of the lab order and checked to ensure the lab was scheduled. -There was no system of monitoring in place to ensure the labs were implemented as ordered. Interview on 08/16/16 at 3:47 pm with a second first shift MA revealed: -Resident #2's lab should have been written on the lab sheet for the phlebotomist to draw the resident's blood. -Lab draws were done weekly, and a copy was given to the RCC. -If the resident refused the lab draw, the lab draw would have been attempted again the next week. -She checked the orders for Resident #2 and believed the laboratory never got a copy of Resident #2's lab orders.	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	D 358		

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D 358	Continued From page 11 and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 4 residents (#6) for administation of escitalopram and 1 of 5 sampled residents (#1)which included with lorazepam. The findings are: A. Review of Resident #6's current FL2 dated 6/28/16 revealed: -The Diagnoses included Alzheimer's dementia. -A physician's order for escitalopram 30mg daily (a medication used to treat depression and anxiety). Review of Resident #6's Progress Notes revealed: -Resident #6 was sent to a local Behavioral Health hospital for evaluation on 6/01/16. -He returned to the facility on 6/27/16. -There was one entry dated 7/31/16 in regards to a bruise on his toe but no mention of behavioral disturbances. -An entry dated 8/05/16, Resident #6 tried to kick and hit a Personal Care Aide (PCA) while they were trying to assist him. The physician and responsible party were notified. No new medication orders obtained. -An entry dated 8/06/16, Resident #6 was in the hall with another resident's walker. Staff asked him to return the walker and Resident #6, grabbed the staff member around the neck. The staff member removed the resident's hands and	D 358		

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he returned to his room.
-An entry dated 8/07/16, Resident #6 was resting in his bed and "seemed ok at first", the staff member turned around to leave and Resident #6 kicked at the staff member. He continued being aggressive with staff, police were called and Resident #6 was sent to the hospital. He returned 5 and 1/2 hours later.
-An entry dated 8/07/16, Resident #6 was very agitated, threw a glass and broke it on the dining room floor. Resident #6 was removed and taken to his room. Another resident wandered in to his room and laid down on the bed. Resident #6 was observed kicking the other resident on the leg. The responsible parties and the physician were notified.
-An entry dated 8/15/16, staff requested an as needed medication for anxiety/agitation from Resident #6's primary care provider and responsible party was notified.

Review of Resident #6's June 2016 Medication Administration Record (MAR) revealed:
-A hand written entry for escitalopram 10mg take 3 tablets (=30mg) and documented as administered once daily at 8:00 a.m. on 6/29 and 6/30/16.

Review of Resident #6's July 2016 MAR revealed:
-A hand written entry for escitalopram 10mg take 3 tablets (=30mg) and documented as administered once daily at 8:00 a.m. on 7/01-7/05/16.

Review of Resident #6's July 2016 electronic Medication Administration Record (eMAR) revealed:
-A computerized entry for escitalopram 10 mg tablets give 3 tablets once daily and documented as administered from 7/06/16-7/31/16 at 8:00 am.

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D 358	Continued From page 13 Review of Resident #6's August 2016 eMAR revealed: -A computerized entry for escitalopram 10 mg tablets give 3 tablets once daily and documented as administered from 8/01/16-8/16/16 at 8:00 am. Observation during the 8:00 am medication pass on 8/16/16 revealed: -At 7:36 am the Medication Aide (MA) pulled Resident #6's card of escitalopram 10mg tablets from the medication cart. -She put one tablet in the medication cup along with 4 other tablets. -After error identified to the MA, Resident #6 was administered the correct medications with a cup of water and swallowed them without difficulty at 7:41 am. -The MA documented administration immediately after the medication was administered. Interview with the MA on 8/16/16 at 9:04 am revealed: -She had been a MA for two months. -She had been trained and checked off by a Registered Nurse. -She thought she normally put 3 tablets of escitalopram 10mg tablets in this medication cup. -She only put one escitalopram tablet in this morning because she was nervous. Interview with a representative from Resident #6's Pharmacy on 8/16/16 at 9:21 am revealed: -The physician's order for escitalopram was dated 6/27/16 and Resident #6 was to receive 30mg daily. -On 6/27/16 the pharmacy filled 90 tablets of escitalopram 10mg with instructions to take three tablets daily. -They had not refilled this medication since	D 358		

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6/27/16.
-They refilled medications based on the requests from the facility whether via fax or phone.
-They had not received any refill requests from the facility for Resident #6's escitalopram.

Observation of the card of escitalopram 10mg revealed:
-There were 37 of the escitalopram 10mg tablets.
-The medication was filled on 6/27/16.
-There was no additional escitalopram on the medication cart for Resident #6.

Review of the eMARs from June 28, 2016 through August 16, 2016 revealed:
-150 tablets were needed to administer the medication as ordered.
-There were no exceptions documented as medication not given.
According to the amount of escitalopram 10mg dispensed and amounts administered between 6/28/16 to 8/16/16, there would not have been enough escitalopram available to administer as ordered.

Interview with the Resident Care Coordinator (RC) on 8/16/16 at 9:35 am revealed:
-She was not aware Resident #6 was not getting the 30mg dose of escitalopram.
-She was aware Resident #6 had been agitated and had reported this agitation to the prescribing practitioner.
-Resident #6 would get agitated if he did not get what he wanted when he wanted it.
-Resident #6's agitation was often displayed as yelling and shouting profanities.
-Resident #6 was without agitation and anxiety for a while after he returned from the behavioral hospital but had presented with agitation in the last several weeks.

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D 358	Continued From page 15 Interview with the Administrator on 8/16/16 at 12:05 pm revealed: -She had only been the Administrator for this facility for two days. -She was not aware of the escitalopram not being administered according to the physician orders. -She was not aware of why the medication error occurred, but was going to make sure the problem was corrected going forward. Interview with Resident #6's Nurse Practitioner on 8/16/16 at 9:30 am revealed: -They had been calling her about him exhibiting anxiety and requesting as needed medication. -If he had been taking the medication as prescribed it was possible Resident #6 would not have experienced anxiety/agitation as he had been. -There was no adverse clinical consequence of him receiving 10mg daily rather than 30mg daily other than the anxiety. -She had written a recent order for as needed lorazepam (a narcotic medication used to treat anxiety and other psychiatric problems) because it was reported to her Resident #6 was presenting with agitation and aggression. Based on record review, observations and interviews it was determined Resident #6 was not interviewable. Observation on 08/15/16 from 12:00 pm to 1:00 pm of the lunch meal revealed: -At 12:15 pm Resident #6 came into the dinning room and walked directly to a table where a resident was sitting with her private sitter. -Resident #6 grabbed the bottle of water and lunch (sandwich) of the private sitter off the table. -The sitter quickly grabbed the sandwich back	D 358		

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and attempted to grab the bottle of water but Resident #6 pulled away and yelled "No."
-Resident sat down at a table that was not his assigned seat.
-The sitter repeatedly asked Resident #6 for the bottle of water, he continued to yell "No."
-Facility staff eventually got the water from Resident #6, and moved him to his assigned seat.
-Two minutes after sitting down Resident #6 was up again and walking toward the door to exit the dining room.
-The Personal Care Aide (PCA) touched Resident #6's arm and asked him to come back and sit down to eat his meal.
-The resident pulled his arm away from the PCA and yelled "No."
-Resident #6 exited the dining room and did not return during the meal.

Interview on 08/15/16 at 12:43 pm with the private sitter revealed:
-Resident #6 had "behavior problems."
-His assigned seating was behind the resident that she was private sitting for, and she was concerned that Resident #6 would hit her resident, so she had to watch him at every meal.
-She had not observed Resident #6 hit other residents, but he would throw things and yell at other residents.
-This past weekend while in the dinning room, Resident #6 threw a glass and cause it to break.
-She was thankful the glass did not hit another resident.

B. Review of Resident #1's current FL2 dated 6/15/16 revealed:
-Diagnoses included hypertension and dementia.
-A physician's order for Ativan 0.5 mg (a sedative used for reducing anxiety) every 6 hours as

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D 358	Continued From page 17 needed for anxiety. Review of Resident #1's record revealed a signed physician order dated 6/27/16 for Ativan 0.5mg 2 times daily. Review of medications on hand for Resident #1 revealed there was no Ativan 0.5 mg in the medication cart available for administration for Resident #1. Review of Resident #1's August 2016 Electronic Medication Administration Record (eMAR) revealed a computerized entry for Ativan 0.5 mg at 9:00 am and 9:00 pm, with documentation of administration on 8/15/16 at 9:00 am. Review of the facility controlled substance record for Resident #1 revealed: -The Ativan 0.5 mg had been signed out on 8/15/16 at 9:00 am. -The pharmacy generated punch card for Ativan 0.5 mg was empty. -The narcotic ending count for Ativan 0.5 mg was zero, and was correct. Interview on 8/15/16 at 1:00 pm with a Medication Aide (MA) revealed: -She administered the last Ativan 0.5 mg to Resident #1 on 8/15/16 at 9:00 am. -She would re-order Ativan 0.5 mg for Resident #1 on 8/15/16 and the Ativan 0.5 mg would be in the facility prior to Resident #1's next scheduled dose at 9:00 pm. -The facility policy was to reorder resident's medications a week before running out of the medication. -The pharmacy delivered medications nightly to the facility.	D 358		

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D 358	Continued From page 18 Review on 8/16/16 at 9:00 am of medications on hand for Resident #1 revealed there were no Ativan 0.5 mg in the medication cart or in the pharmacy delivery bag. Review of Resident #1's August 2016 eMAR revealed: -A computerized entry for Ativan 0.5 mg at 9:00 am and 9:00 pm. -A computerized entry Ativan 0.5 mg was not administered on 8/15/16 at 9:00 pm. -A computerized entry for Ativan 0.5 mg as administered on 8/16/16 at 9:00 am. Interview on 8/16/16 at 11:30 am with the MA responsible for the medication cart revealed: -She had been in a hurry and accidentally documented the Ativan 0.5 mg as administered on 8/16/16 at 9:00 am for Resident #1. -She had attended a class at the facility after her morning medication pass and did not inform the Resident Care Coordinator (RCC) she had accidentally documented the Ativan 0.5 mg as administered for Resident #1. -Resident #1's Ativan 0.5 mg was out of stock, "so I could not have administered it." Observation on 8/16/16 of Resident #1 revealed she was calm and resting in a recliner in her room with her family present. Interview on 8/16/16 at 12:00 pm with the RCC revealed: -She was aware Resident #1 was out of Ativan 0.5 mg on 8/15/16. -The MAs were to contact the pharmacy when the resident's medications were within a week of running out. -She relied on the MAs to fax or call the physician if residents run out of medications.	D 358		

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D 358	Continued From page 19 -She was unaware Resident #1's Ativan 0.5 mg were not in the facility on 8/16/16. -She knew the MA had faxed the pharmacy on 8/15/16 in regard to Resident #1 out of Ativan 0.5 mg and needed a refill. Further review of the eMAR for Resident #1 revealed the Ativan 0.5 mg could not be re-ordered on the computer due to needing a signed written prescription from the physician. Interview on 8/16/16 at 12:38 pm with the prescribing Nurse Practitioner revealed: -She had seen Resident #1 on 8/16/16, and Resident #1 was calm and resting in the recliner in her room. -She was unaware Ativan 0.5 mg had not been administered to Resident #1 on 8/15/16 at 9:00 pm and on 8/16/16 at 9:00 am. -The two missing doses of Ativan 0.5 mg were not significant when they were not administered to Resident #1. -The facility may have called or faxed to the office a request for renewal of the Ativan 0.5 mg. but the physician's office was closed permanently and all calls and fax were to be re-routed to the new prescribing practice that were taking over the business. -She had a new computer system on 8/15/16 and was unfamiliar with the system. -There were several red flags on the computer for Resident #1, but she was not familiar with what they were, "They could be in reference to the facility contacting me or the office, I just cannot say." -She had written Resident #1 a prescription for Ativan 0.5 mg 2 times daily and contacted the pharmacy on 8/16/16.	D 358		

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D 358	Continued From page 20 A Plan of Protection was provided by the facility on August 29, 2016 as follows: -The Medication Aide making the error was pulled off the medication cart at the time of discovery. -The community will re-evaluate the need for training prior to resuming Medications Aide duties. -The community completed a cart audit on all available medications regarding dosage and available medications with alert notes placed on appropiate card as indicated. -Re-training all medication Aides was completed on 8/16/16 on the 7 rights of medication administration to include noting dosage on hand and order on Medication Administration Record, and will continue as opportunity arise and at monthly meetings. -Meetings weekly, medication audits, checking comparison of medication on hand and available dosage, will start 8/29/16 for appropriate medication dose of administering. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, October 13, 2016.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to	D 468		

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D 468	Continued From page 21 be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on observations, interviews, and review of personnel files, the facility failed to assure 2 of 6 sampled staff (B and E) who were responsible for personal care and supervision within the special care unit completed 20 hours of training specific to the population being served within 6 months of employment. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired as a Personal Care Aide (PCA) on 09/28/15. -Staff B completed 8 hours of Special Care Unit (SCU) orientation training on 10/08/15.	D 468		

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D 468	Continued From page 22 -She had documentation of 30 minutes of additional hours of training specific to SCU per month in January, February, March, April, May, June, and July 2016 for a total 3.5 hours. -Documentation of additional hours of training specific to SCU from an outside agency in June and July 2016 for a total of 2 hours. -She had a total of 5 hours of training specific to the SCU population from May 2016 through July 2016, more than 6 months after hire. -There was no documentation of any other training specific to the SCU population within 6 months of hire, from 09/28/15 - 03/28/16. Observation on 08/15/16 during the survey revealed Staff B worked as PCA on first shift in the SCU from 7:00 am to 3:00 pm. Interview on 08/16/16 at 1:30 pm with Staff B revealed: -She tried to take all training offered by the facility, but did not know how much training was required. -She does not recall specific titles of training offered, but training classes taken are documented in her employee file. -The Business Office Coordinator (BOC) informed staff of needed training. Interview on 08/16/16 at 3:00 pm with the Executive Director revealed: -The BOC was responsible to inform the staff of needed training. -The facility offered training all the time and staff were free to take the training as desired. -She had only worked at the facility for two days and was not aware Staff B did not have the required 20 hours of training. Refer to interview on 08/16/16 at 3:41 pm with the	D 468		

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D 468	Continued From page 23 Business Office Coordinator. 2. Review of Staff E's personnel file revealed: -Staff E was hired as a Medication Aide (MA)/Personal Care Aide (PCA) on 07/07/16. -Staff E completed 8 hours of Special Care Unit (SCU) orientation training on 08/06/15 -She had documentation of 30 minutes of additional hours of training specific to the SCU population each month from January - July 2016 for a total of 3.5 hours. -She had 5.5 hours of training specific to the SCU population in May, June and July 2016, more than 6 months after hire. -There was no documentation of any other training specific to the SCU population within 6 months of hire, from 07/07/15 - 01/07/16. Interview on 08/17/16 at 3:25 pm with Staff E revealed: -She had worked at the facility since last year, July 2015. -Initially, she was hired as a MA/PCA. -Recently, she was promoted to Medication Aide/Supervisor. -Sometimes she worked second shift, but mostly worked the third shift as a Medication Aide/Supervisor. -Her duties and responsibilities were administering medications to residents at the facility. -The Business Office Coordinator (BOC) kept up with required trainings and other things needed for employment. Interview on 08/16/16 at 3:00 pm with the Executive Director revealed: -BOC was responsible to inform of the staff needed training. -The facility offered training all the time and staff	D 468		

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D 468	Continued From page 24 were free to take the training as desired. -She had only worked at the facility for two days and was not aware that Staff B did not have required 20 hours of training. Refer to interview on 08/16/16 at 3:41 pm with the Business Office Coordinator. Interview on 08/16/16 at 3:41 pm with the Business Office Coordinator revealed: -She was unaware staff needed 20 hours of SCU training hours within six months of employment. -Staff B and E might have 20 hours of training specific to SCU, but she would have to go through all their training records.	D 468		
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 observations, interviews, and record reviews, 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 training on cardio-pulmonary resuscitation (CPR) and Medication Administration. The Findings are:	D912		

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D912	Continued From page 25 A. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 11 of 16 days on second shift, 16 of 16 days on third shift from 8/1/16-8/16/16. [Refer to Tag 0167 10A NCAC 13F. 0507 (Type B Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 4 residents (#6) for administation of escitalopram and 1 of 5 sampled residents (#1)which included with lorazepam. [Refer to Tag 0358 10A NCAC 13F. 1004(a) (Type B Violation)].	D912		