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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082014	A. BUILDING: _____ B. WING _____	10/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE HAVEN OF STAR ASSISTED LIVING	327 FREEMAN STREET STAR, NC 27356

(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 September 29, 30 and October 3, 2016.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure storage areas which contained cleaning agents which may be hazardous if ingested, inhaled, or handled were locked and not accessible to residents on the Special Care Unit (SCU). The findings are: Observation on 09/29/16 at 9:25 am during the initial tour on the SCU hall revealed: -A closet labeled "Housekeeping" locked with a keyed deadbolt lock. -An unlocked closet with a single keyed knob located to the left of the housekeeping closet. -One resident was walking down the hallway with no staff visible on the hallway where the storage closet was located.	D 056	DOC attached POC dated 11/7/16	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Quinn — TITLE: Regional — (X6) DATE: November 7th 16

STATE FORM 6899 PNIM11 If continuation sheet 1 of 16

Reviewed + Approved 11/10/16 Darlene K Parr

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D 056	Continued From page 2 -All storage and housekeeping closets were to be locked at all times. -Housekeeping staff accessed the closets with a key. -Chemicals had to be locked because they had confused residents. -The other housekeeper did her training when she was hired in January 2016. -Her training included the storage of chemicals and keeping them locked. Interview on 09/29/16 at 4:45 pm with the Regional Director revealed: -All chemicals were to be stored in locked closets when not in use. -Housekeeping staff were to keep chemicals on the cart and in eyesight when cleaning. -Staff on the SCU had been instructed to check the storage doors routinely during the day to make sure they were all locked. -There had been no incidences of residents obtaining chemicals.	D 056	See attached POC dated 11/7/16.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets (Renal) was served as ordered by the physician for 1 of 5 sampled residents (Resident	D 310		

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D 310	Continued From page 3 #2). The findings are: Review of Resident #2's current FL-2 dated 05/09/16 revealed: -Diagnoses included End-Stage Renal Disease on dialysis and hypotension. -A physician's order for a renal diet. Review of Resident #2's physician's orders revealed: -A physician's order dated 05/17/16 for a renal diet. -A physician's order dated 05/17/16 for dialysis three times weekly. -A physician's order dated 06/22/16 from the dialysis clinic's physician for a renal diet (low sodium/potassium/phosphate) and fluid restrictions 2 liters per day. Review of Resident #2's laboratory results revealed: -Resident #2's Albumin levels (measurement of protein in the blood) were 3.5 (low) on 06/28/16, 3.4 (very low) on 07/26/16, and 3.5 (low) on 08/23/16. -Resident #2's Phosphorous levels were 4.5 on 06/14/16 (normal), 3.9 on 07/12/16 (normal), and 2.8 (low) on 8/09/16. -Instructions for Resident #2 was to increase proteins with his meals. Review of the resident diet list posted in the kitchen on 09/29/16 revealed Resident #2 was on a renal diet. Review of the therapeutic diet spreadsheet for the renal diet lunch meal on 09/29/16 revealed Resident #2 was to be served 3 ounces of beef	D 310	See attached POC dated 11/7/16.	

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D 310	Continued From page 4 patty, 1/2 cup of rice or noodles, 1 wheat dinner roll, margarine, 1 cookie, and 8 ounces of beverage of choice (no milk). Observation on 09/29/16 at 10:15 am revealed: -A "Basic Diet" for Dialysis Patients posted on the refrigerator in the kitchen. -Suggestions for eating proteins, limiting foods with phosphorous, and limiting foods with potassium. Observation of the lunch meal served on the Assisted Living unit (ALU) on 09/29/16 at 12:05 pm revealed: -Resident #2 was served (2) 6 ounce servings of mixed fruit with grapefruit, mango, and mandarin oranges, 6 ounces of country fried steak with gravy, 1/2 cup of mashed potatoes, 1/2 cup of green beans, 1 piece of corn bread, 6 ounces of water and 12 ounces of tea. -Resident #2 ate 6 ounces of the mixed fruit, all of the country fried steak with gravy, all of the mashed potatoes, drank all of the water. -Resident #2 told a staff person he was not supposed to receive tea because "water is all I can have." -Resident #2 did not drink any of the tea. Interview with Resident #2 on 10/03/16 at 1:00 pm revealed: -He received dialysis on Mondays, Wednesdays, and Fridays. -He could only have 32 ounces of fluids a day. -He took his medications in applesauce. -The facility prepared his meals for him, but he also was familiar with foods he should avoid. -He was supposed to eat a lot of protein, including meats and eggs. -He did not measure his fluids because the facility staff kept up with how much he could drink.	D 310	See attached POC dated 11/7/2016.	

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D 310	Continued From page 5 -He had a measuring cup provided by the dialysis center, but he did not use it. -He only drank fluids at meal times. -He only drank cranberry juice and water. -He thought he was "doing pretty good" with regards to his dialysis treatment. Interview with a Personal Care Aide (PCA) on 10/03/16 at 2:15 pm revealed: -She worked on ALU and the Special Care Unit (SCU). -She was responsible for serving meals to residents on therapeutic diets, including Resident #2. -Dietary staff pleted the food for Resident #2 and she served the meal and beverages to him. -Resident #2 was on dialysis and he could only have certain food and beverages on his diet. -He could only have cranberry juice, not orange juice with breakfast. -Resident #2 was on limited drinks and usually drank only water at lunch and supper. -The Medication Aides monitored how much fluids he drank and would sometimes tell the NAs if he could have additional fluids with his meals. Interview with the cook on 09/29/16 at 10:50 am revealed: -She worked full-time as a cook. -The previous cook provided her training when she was hired two months ago. -She had not received training to use a therapeutic diet spreadsheet to prepare meals. -There was not a dietary manager for the facility. -Resident #2 was on dialysis and was on a renal diet. -There was posted information on the refrigerator in the kitchen about what foods Resident #2 could and could not have. -She was told the reference information for	D 310	See attached POC dated 11/7/16	

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D 310	Continued From page 6 Resident #2's diet was provided by the dialysis center. -She did not have a therapeutic diet spreadsheet to refer to for meal preparation of a renal diet. -Resident #2 received double portions of eggs for breakfast and could have no processed meats. -"If he can't have something that is on the menu, I substitute what he can have" based on the posted information from the dialysis center. Interview on 10/03/16 at 2:30 pm with a dietician at Resident #2's dialysis provider revealed: -Resident #2 was on a renal diet and they gave the facility and him information about what foods and beverages he could have and what he needed to avoid. -Bananas, oranges, and potatoes should be limited. -He was now receiving his medications in applesauce instead of water. -He was on a 32 ounce a day fluid restriction. -He was "doing quite well". -She maintained contact with the facility regarding his lab values. Interview with the Regional Director on 09/29/16 at 5:45 pm revealed: -The facility did not have a Dietary Manager. -She did not know who did the training for the cook when she was hired. -The facility did have a Therapeutic Diet Spreadsheet that was to be used when preparing therapeutic diets. -She was aware Resident #2 was on a renal diet. -The MAs monitored his fluid intake as ordered by his physician. -Resident #2 was very knowledgable about the foods he needed to limit. -She would educate the cook on using the therapeutic diet spreadsheet.	D 310	See attached POC dated 11/7/16	

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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 observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents with an order for Vitamin D2 (Resident #3). The findings are: Review of Resident #3's current FL2 dated 11/20/2015 revealed: -Diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia, diabetes mellitus Type II, and esophageal reflux disease. -A physician's order for Vitamin D2 50,000 units take 1 capsule once a week. Review of Resident #3's record revealed no physician's order or laboratory results for a Vitamin D2 level. Review of Resident #3's August 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for Vitamin D2 50,000 units 1 capsule once a week and documentation of administration on 08/19/16, 08/20/16, 08/21/16, 08/25/16,	D 358	See attached POC dated 11/7/16.	

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D 358	Continued From page 8 08/26/16, 08/27/16, 08/28/16, and 08/29/16. Review of Resident #3's September 2016 eMAR revealed: -An entry for Vitamin D2 50,000 units 1 capsule once a week and documentation of administration on 09/01/16, 09/02/16, 09/03/16, 09/08/16, 09/09/16, 09/10/16, 09/17/16, and 09/24/16. Observation of Resident #3's medications on hand on 10/03/2016 at 10:30 am revealed: -A bubble pack with a label identifying Vitamin D2 capsules 50,000 units dispensed with 5 capsules by the pharmacy on 09/14/2016. -Three of the 5 capsules remained in the bubble pack filled on 09/14/2016. Interview on 09/29/16 at 9:32 am with Resident #3 revealed: -She had resided at the facility for "a long time". -Staff administered medications to her each day at the same time and the facility always had medications available for her to take. -She was not aware of the names of any of the medications she was taking. Interview with the contract pharmacy on 10/03/2016 at 11:05 am revealed: -Vitamin D2 was dispensed to the facility for Resident #3 on 08/24/16 for 5 capsules. -There had been no Vitamin D2 dispensed prior to 08/24/16 from this pharmacy. -A facility staff member had called on 09/04/2016 at 7:51 am to request a refill. -The pharmacy would not refill the Vitamin D2 at that time because it was last filled on 08/24/2016. -There had been 5 capsules dispensed on 08/24/16 to the facility and there should have been enough to last a month because Vitamin D2 was ordered to be administered weekly. It was	D 358	See attached POC dated 11/7/16.	

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D 358	Continued From page 9 not yet time for a refill. -The Vitamin D2 was last dispensed for Resident #3 to the facility on 09/14/16 for 5 capsules. -There had been no additional Vitamin D2 dispensed to the facility until 09/14/16 and 5 capsules were sent to the facility at that time. Interview with the Resident Care Coordinator (RCC) on 10/03/2016 at 11:10 am revealed: -Resident #3 was supposed to receive Vitamin D2 once a week every Saturday. -The RCC was not aware Resident #3 received Vitamin D2 more than once a week as ordered. -The RCC would not have given any medication on Saturdays because she did not work on Saturdays. -She could not say whether any of the Medication Aides (MAs) had administered the Vitamin D2 daily in August or not. -There was another MA that had documented administration on the eMAR of Vitamin D2 to Resident #3, but she was not working today. -The facility had switched to the eMAR system in mid-August 2016 and there had been some issues with the new eMAR system. -Since the Vitamin D2 was a weekly medication and not a daily medication, the eMAR would give a daily pop-up alert for the Vitamin D2 and it would not "go away" or you could not go forward unless you initialed it as administered". -The problem with the eMAR system had been fixed now. Interview with a MA on 10/03/2016 at 11:20 am revealed: -She had administered the Vitamin D2 to Resident #3. -She did not remember giving Vitamin D2 to Resident #3 more often than once a week on Saturdays.	D 358	See Attached POC dated 11/7/16.	

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D 358	Continued From page 10 -She was not sure why the Vitamin D2 had been documented as administered daily on the August and September 2016 on the eMAR. -She did recall when the facility began using the eMAR system the Vitamin D2 would give a daily pop-up alert to administer the medication. -"You had to initial the Vitamin D2 as administered to get the pop-up alert to go away". Interview with a second MA on 10/03/16 at 11:25 am revealed: -She had administered Vitamin D2 to Resident #3. -She did not recall administering Vitamin D2 to Resident #3 daily and thought it was ordered to be administered weekly. Interview with a staff person at Resident #3's primary care physician's office on 10/03/2016 at 11:53 am revealed: -Any documentation or orders for Resident #3 were in the resident's record at the facility. -The physician's office did not keep any of the resident's information in the office. Telephone interview with the Nurse Practitioner (NP) from Resident #3's primary care physician's office on 10/03/2016 at 12:03 pm revealed: -The NP was not made aware Resident #3 had been given the Vitamin D2 50,000 units more often than ordered. -Resident #3 was taking Vitamin D2 for Vitamin D deficiency. -The NP would order a Vitamin D2 level to be drawn today. Interview on 10/03/16 at 2:10 pm with the Regional Director revealed: -She was not aware Vitamin D2 had not been administered as ordered to Resident #3.	D 358	See Attached POC dated 11/7/16.	

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D 358	Continued From page 11 -After looking at the eMARs and the information provided by the pharmacy it appeared the Vitamin D2 had been administered daily from 08/25/16 to 08/29/16 and the Vitamin D2 would not have been available for administration again until after 09/14/16.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week. The findings are: Observations in the Special Care Unit at various times revealed: -There were 16 residents residing in the SCU. -There were two Personal Care Aides (PCA) in the SCU on duty on 09/29/2016 and 10/03/2016. -There was no Resident Care Coordinator (RCC) available for the SCU on the above dates. Observations at 9:00 am on 10/03/2016 revealed there was a Medication Aide (MA) from the Assisted Living Unit (ALU) passing medications in the SCU. Interview on 09/29/2016 at 11:15 am with a PCA	D 466	See attached POC dated 11/7/16.	

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D 466	Continued From page 12 in the SCU revealed: -"We do not have a boss over the SCU". -There had never been a RCC for the SCU. -There was one RCC for the entire facility. -The PCAs reported to the supervisor/MA, MAs reported to the RCC, RCC reported to the Executive Director (ED). -There were two PCAs working in the SCU at all times on day shift and night shift. -The MA covered the entire facility and passed medications in the SCU and the ALU. Interview on 09/29/2016 at 11:20 am with a second PCA in the SCU revealed: -There was no RCC for the SCU. -The RCC covered the entire facility. -The MA for the facility covered both the ALU and the SCU. -There were two PCAs in the SCU at all times. -The facility RCC was always available for issues, but did not stay any length of time in the SCU. Observation on 9/29/16 at 3:00 pm in the SCU revealed the RCC and the Regional Director were in the medication room in the SCU. Observation on 09/29/2016 at 3:05-3:15 pm in the ALU revealed: -There was no staff available in the ALU. -At 3:15 pm, the PCA/MA was observed coming in the front door of the ALU from outside of the facility. Interview on 9/29/2016 at 3:15 pm with PCA/MA in the ALU revealed: -She had worked at the facility since May 2016. -She usually worked as the MA in the ALU. -She was performing PCA duties today and the RCC was working as the MA. -She had left the ALU to go to lunch and informed	D 466	See attached POC dated 11/7/2016.	

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D 466	Continued From page 13 the RCC she was taking lunch prior to exiting the building. -The PCA/MA and RCC were the only staff covering the ALU today. -There was usually one PCA and one MA that covered the ALU for both day and night shifts. -The RCC usually worked on day shift as well. Interview on 09/29/2016 at 3:30 pm with the ED revealed: -The ED informed the PCA she was not to leave the ALU without informing someone and the PCA told the ED she had inform the RCC prior to leaving the building for lunch. -The ED was not aware there was no staff available in the ALU. -The RCC was in the SCU passing medications. Interview on 10/03/2016 at 10:32 am with a third PCA in SCU revealed: -The RCC for the ALU was the RCC for the SCU as well. -The RCC covered the entire facility. -The RCC did not stay in the SCU for 8 hours each day. -There was no RCC for the SCU. -The RCC checked in on staff by doing "walk-through's" throughout the day, but did not stay in the ALU. -On the days the RCC performed the duties of the facility MA, she would stay in the SCU longer to complete the medication pass. -The PCA usually worked four 12 hour days and then off 3 days. -The MA that worked in the ALU came to the SCU for each medication pass in the SCU. -If there was a staff call out, the facility tried to cover with staff. If the facility could not find another staff to cover the shift the on call administration would come in to work the shift.	D 466	See Attached POC dated 11/7/2016.	

PRINTED: 10/19/2016
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL062014	A. BUILDING: _____ B. WING _____	10/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE HAVEN OF STAR ASSISTED LIVING	327 FREEMAN STREET STAR, NC 27356

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D 466	Continued From page 14 -Most of the time the ED or the RCC covered the facility when there were staff call outs. Interview on 10/03/2016 at 10:40 am with the RCC revealed: -There was no designated RCC for the SCU. -There was only one RCC for the entire facility. -She was responsible for the SCU and the ALU. -She was not aware of any other facility staff that assumed responsibilities of an RCC for the SCU. -The RCC stayed in the SCU 4-5 hours each day. -She started work at the facility in December 2015 as the RCC. -She usually worked Monday through Friday 8 hours each day. -The RCC's job duties include: record audits every 3 months for both units,resident care plans, LHPS assessments, residents' Activities of Daily Living worksheet, reviewed physician orders, paperwork for new admissions and assessments to the residents. -The RCC did not have an office in the SCU. She worked out of the medication rooms in both the SCU and ALU. -The RCC did MA duties for the ALU and SCU about 2-3 times each week. -During those times when she was in the SCU as the MA, she would be in the SCU for about 1 and 1/2 hours for the three medication passes each day. -If facility staff called out, the on call person was responsible to come in and cover the shift. There were frequent staff call outs. -The RCC, Transportation Staff, and ED were in the on call rotation. -One PCA was on duty in the ALU when the RCC was in the SCU. -She scheduled facility staff as follows: all facility staff worked 12 hour shifts. Shifts consisted of day shift 7am-7pm with one PCA and one MA in	D 466	See Attached POC dated 11/7/2016.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 466	Continued From page 15 the ALU and two PCAs in the SCU. Night shift was from 7pm-7am and consisted of one PCA and one MA in the ALU and two PCAs in the SCU. -The PCAs reported to the MA, MAs reported to the RCC, and the RCC reported to the ED. Interview on 10/03/2016 at 11:20 am MA/Transportation Staff/Activity Coordinator revealed: -She had been employed at the facility since 2014. -Her duties included MA duties, transportation and activities for residents. -There was only one RCC for the entire facility. Interview on 10/03/2016 at 2:05 pm with the current ED and the Regional Director revealed: -The previous ED's last day was 9/30/16. -There were a few staff who had expressed an interest in the SCU RCC position. -There were several staff that acted as RCC including the Activity Coordinator. -The Regional Director was not aware there needed to be a RCC in the SCU for 8 hours a day, 5 days a week. -The Regional Director thought RCC duties for the SCU could be shared by other staff.	D 466	See attached POC dated 11/7/16.	

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Regulatory Areas Cited:

10A NCAC 13F. 0305F (4) Physical Environment
(f) The requirements for storage rooms and closets are:
(4) Housekeeping storage requirements are:
(A) a housekeeping closet, with a mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion therefore; and (b) there shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use.

Plan of Correction:

Immediate & ongoing training with all staff on proper storage of cleaning agents to ensure that housekeeping closets are continued to be kept locked. 9/29/2016

Proper storage and monitoring of cleaning agents will continue to be part of new hire orientation. 9/29/2016 & ongoing

Immediate walk-thru completed by management to assure chemicals were stored properly. 9/29/2016

Monitoring System

Regional Director, Executive Director/Designee will perform weekly random walk-thru's to assure chemicals are monitored while in use and stored properly. 9/29/2016 & ongoing

Any staff found not following proper procedures for chemical storage will be reprimanded to include additional training and/or disciplinary action. 9/29/2016 & ongoing

10A NCAC 13F. .0904 (e) (4)Nutrition and Food Service

(e) Therapeutic Diets in Adult Care Homes: (4) all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

Plan of Correction

- Staff training on proper preparation of meals per the residents diet ordered using the therapeutic diet spreadsheet and therapeutic diet menu. 9/29/2016 & ongoing

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- Re-implementation of dietary staff orientation training sheet to include therapeutic diet menus. 11/7/2016 & ongoing

Monitoring System

- Executive Director/ QA Staff/ designee will perform random meal observation to assure meals are served as ordered per therapeutic diet order weekly x 1 month and then bi-weekly thereafter. 11/7/2016 & ongoing
- Executive Director/QA staff /designee will perform random audits to assure dietary spreadsheet is updated per diets ordered. 11/7/2016 & ongoing
- Regional Director/QA Staff/designee will perform random audits to assure that meal observations are being performed monthly. 10/01/2016 & ongoing
- Any staff found not following proper procedures shall receive additional training and/or disciplinary action. 9/29/2016 & ongoing

10 NCAC 13F .1004(a) 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.

Plan of Correction

- Residents # 3 is received medications as ordered. 10/03/2016 & ongoing
- Staff shall be retrained on administering medications as ordered and assuring documentation reflects medications given as ordered. 9/30/2016 & ongoing

Monitoring System

- Administrator/Regional/ Designee shall preform random medication pass audits monthly and record review to assure that medications are administered as ordered. 11/7/2016 & ongoing

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- Any staff found not following proper medication administration shall be disciplined to include, re-training, written warnings and up to termination from being a medication.

11/7/2016 & ongoing

10 NCAC 13F. 1308(b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in paragraph (a) of this rule for units 15 or fewer residents.

Plan of Correction

- Director shall assure that the SCU coordinator is staffed 8 hours a day 5 days week. If the SCU Coordinator is not available another staff member (who has been trained as SCU Coordinator) shall be staffed in the SCU. 10/1/2016 & ongoing
- Implementation of a staffing log that will show that the SCU was covered by the SCU Coordinator 8 hours a day for 5 days a week. 10/01/2015 & ongoing

- Monitoring System

- Regional Director/Designee shall randomly monitor the SCU to assure that the SCU is staffed with a SCU Coordinator at least 8 hours a day 5 days a week. 10/1/2016 & ongoing
- Regional Director/Designee shall randomly monitor staffing logs to assure coverage is documented. 10/01/2016 & ongoing

Lauren Quinn, Regional
Signature / Regional Director

11/7/2016
Date