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	HAL063011	A. BUILDING: _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARA PLANTATION OF CARTHAGE	820 S. MCNEILL STREET CARTHAGE, NC 28327

(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 October 26-27, 2016.	D 000		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure milk was served at least twice daily to residents in the Special Care Unit facility (SCU). The findings are: Review of the menu dated 10/26/16 revealed residents were to be served milk for lunch and dinner. Observation of the lunch meal on 10/26/16 at 12:15 pm revealed: -Thirty-four residents were served in 2 SCU dining rooms. -Each resident was served water and either sweetened or unsweetened tea. -The beverage cart did not contain any milk. -No milk was offered or served.	D 299		

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D 299	Continued From page 1 Observation of the Supper meal on 10/26/16 at 4:50 pm revealed: -Twenty-nine residents were served in 2 SCU dining rooms. -Each resident was served water and either sweetened or unsweetened tea. -The beverage cart did not contain any milk. -No milk was offered or served. Interviews on 10/27/16 at 9:00 am and 10:30 am with a Care Aide (CA) in the Special Care Unit (SCU) revealed: -She had worked in the SCU for two months. -The residents were served milk with cereal. "Today was a big meal (breakfast), and cereal was not served, so no one was served milk." -The residents "did not get milk often at dinner", and it was not served at the lunch meal. -If milk was served, "some residents would probably drink it". Interview on 10/27/16 at 9:30 am with the Unit Care Coordinator (UCC) revealed: -She had worked at the facility for 5 years, and as the UCC for the last 2 years. -Milk was served "every morning with cereal" in the SCU. -"If anyone requested milk, it would be given to them, even in the SCU". She was not aware if residents in the SCU requested milk. -If milk was served and on the table, a resident could drink it if they wanted to or not. The "feeders" would be served whatever beverage was on the table to be given to the resident. "If milk was served, staff would try to encourage the resident to drink it." Interview on 10/27/16 at 10:35 am with another CA in the SCU revealed:	D 299		

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-She had worked in the SCU for 3 weeks.
-She had seen milk served at breakfast when cereal was served.
-She was not sure if a resident would drink milk if it was served.
-No residents had asked her for milk.
-She was not aware residents should be served milk two times a day.

Interview on 10/27/16 at 10:45 am with a Kitchen Aide revealed:
-Milk was served to residents with cereal.
-A drink cart was sent to the SCU. Milk was not always sent with the other beverages.

Interview on 10/27/16 at 11:10 am with the facility Cook revealed:
-There was plenty of milk available for anyone who wanted it.
-Milk was sent to the SCU on the beverage cart at mealtimes so staff could serve it.
-She expected the SCU staff to serve what was on the menu. Milk was on the menu to be served twice a day, at breakfast and dinner meals.
-Ice cream was not served in place of milk on the 10/26/16 dinner meal, as both were on the menu to be served.

Interview on 10/27/16 at 11:20 am with a SCU Medication Aide (MA) revealed:
-She also worked as a CA, and had worked at the facility for 10 months.
-Milk was not served in the SCU unless cereal was served at breakfast.
-Milk was not served at lunch or dinner meals in the SCU.
-"If milk was served (in the SCU), some residents would drink it."

Interview on 10/27/16 at 2:40 pm with the

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D 299	Continued From page 3 Administrator revealed: -If residents in the SCU asked for milk it would be served, but not all residents could ask for it. -Some residents in the SCU would "possibly drink it if milk was served, but I can't say". -She expected milk to be served if it was on the menu to be served. -She was not aware milk was not served twice a day in the SCU.	D 299		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff documented the administration of medication immediately following administration to the resident and prior to the administration of another resident's medication. The findings are: A. Observation on 10/26/16 of the morning medication pass in the Special Care Unit (SCU) revealed: -At 10:00 am, the Medication Aide (MA) prepared	D 366		

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and administered medications to a resident, returned to the medication cart and prepared and administered another resident's medications.
-The MA did not document administration of the first resident's medications on the Medication Administration Record (MAR).

Interview on 10/26/16 at 10:10 am with the MA revealed:
-She was preparing medications for the last of 34 residents on the medication pass.
-There was a total of two medication carts and two MAR books.
-She planned to document administration of all 34 residents' medications after she completed the medication pass.
-The MA initially stated she "usually" documented administration of all the medications after she completed the entire med pass.
-The MA then stated she "usually" documented administration of the medications "as I go" but it had been really busy today, so she was waiting until she completed the med pass.

Review on 10/26/16 at 10:20 am of the MARs revealed:
-There were 18 residents' medications stored on one medication cart and 16 residents' medications stored on the second medication cart.
-None of the 8:00 am medications for 34 residents were documented as administered for the morning of 10/26/16.

Refer to interview on 10/27/16 at 2:00 pm with the Unit Care Coordinator (UCC).

Refer to interview on 10/27/16 at 2:40 pm with the Administrator.

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D 366	Continued From page 5 B. Observation on 10/27/16 of the morning medication pass in the Assisted Living (AL) revealed: -The Medication Aide (MA) prepared 11 medications for administration to a resident. -The MA documented administration of each medication as she put the medication in the medication cup and before administering the medication to the resident. -The MA then administered the medications to the resident and returned to the medication cart to prepare the next resident's medications for administration. Interview on 10/27/16 at 10:41 am with the MA revealed: -She received her MA training from the Unit Care Coordinator (UCC). -She was trained to document the administration of medications at the time of admission, and clarified that meant when the medication was put in the cup and before taking the medication to the resident. -She stated that process of administering medications was "drilled into our head to do it that way". Refer to interview on 10/27/16 at 2:00 pm with the Unit Care Coordinator (UCC). Refer to interview on 10/27/16 at 2:40 pm with the Administrator. _____ Interview on 10/27/16 at 2:00 pm with the Unit Care Coordinator (UCC) revealed: -Her responsibilities included oversight of the MAs and training of new MAs on both the Assisted Living and Special Care units. -She routinely trained MAs to document the administration of medications immediately after	D 366		

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D 366	Continued From page 6 administering them to the resident and prior to administering another resident's medications. -She was not aware one MA was signing all the MARs at the completion of the entire med pass. -She was not aware one MA was precharting medications. -There was currently no system in place to ensure MAs were documenting the administration of medications after administering the medications to the resident, observing the resident take the medication, and prior to administering medications for another resident. Interview on 10/27/16 at 2:40 pm with the Administrator revealed: -She owned her own consulting company and had developed an extensive MA training program, which far exceeded state requirements. -All MAs were required to complete the extensive training program prior to working as a MA in the facility. -She was not aware one MA was signing all the MARs at the completion of the entire med pass. -She was not aware one MA was precharting medications. -There was currently no system in place to ensure MAs were documenting the administration of medications after administering the medications to the resident, observing the resident take the medication, and prior to administering medications for another resident.	D 366		
D 370	10A NCAC 13F .1004 (m) Medication Administration 10A NCAC 13F .1004 Medication Administration (m) Medication administration supplies, such as graduated measuring devices, shall be available	D 370		

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D 370	Continued From page 7 and used by facility staff in order for medications to be accurately and safely administered. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medication administration supplies were available for facility staff in order for medications to be accurately and safely administered. The findings are: Observations on 10/26/16 and 10/27/16 of the equipment used for crushing medications revealed: -The pill crusher on each medication cart was a brand that required coordinating, thick, plastic pouches in which medications were to be placed. -The plastic pouch of medications was then to be placed vertically between the crushing plate and the base of the crusher. -A handle could then be depressed to crush the medications between the crushing plate and the base of the crusher. -There were no plastic pouches available for use on any of the four medication carts. A. Observation on 10/26/16 of the morning medication pass revealed: -The Medication Aide (MA) prepared a resident's medications to be crushed for administration. -The medications included 6 pills. -The MA placed the pills in a souffle cup. -The MA placed the souffle cup of pills in front of the crushing plate and depressed the handle several times to crush the pills. -The MA opened the crushed cup and inspected the pills, returned the cup to the pill crusher and	D 370		

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depressed the handle several more times.
-The MA repeated this process several times in an attempt to adequately crush the pills.
-At one point, the souffle cup tore and medication powder was observed to leak from the tear in the souffle cup into the base of the pill crusher.
-The MA retrieved a second souffle cup, and placed the torn souffle cup containing crushed medications inside the second souffle cup.
-The MA placed the cups in front of the crushing plate and repeated the process of depressing the handle to crush the medications.
-The MA transferred the medication powder to a plastic medication cup containing applesauce and discarded the souffle cups in the trash.
-Medication powder residue was visible in the pleats and folds of both souffle cups that were discarded.
-The MA administered the medication to a resident.

Refer to interviews on 10/26/16 at 10:15 am and 10/27/16 at 3:02 pm with a Medication Aide.

Refer to interview on 10/27/16 at 10:41 am with a second MA.

Refer to interview on 10/27/16 at 11:05 am with a third MA.

Refer to interview on 10/27/16 at 2:00 pm with the Unit Care Coordinator (UCC).

Refer to interview on 10/27/16 at 2:40 pm with the Administrator.

Refer to telephone interview on 10/27/16 at 3:48 pm with the facility owner's Administrative Assistant.

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D 370	Continued From page 9 B. Observation on 10/27/16 of the morning medication pass revealed: -The Medication Aide (MA) prepared a resident's medications to be crushed for administration. -The medications included 12 pills. -The MA placed the pills in three different souffle cups. -The MA spread open the souffle cup, unfolding the pleats, placed the souffle cup of pills in front of the crushing plate and depressed the handle several times to crush the pills. -The MA emptied the medication powder into a plastic medication cup, discarded the souffle cup in the trash, and proceeded to use the same process to crush the second souffle cup of pills. -At one point, the souffle cup tore and medication powder was observed to leak from the tear in the souffle cup into the base of the pill crusher. -The MA reached across the medication cart, retrieved a second souffle cup, and placed the torn souffle cup containing crushed medications inside the second souffle cup, spilling medication powder on top of the medication cart. -The MA placed the cups in front of the crushing plate and repeated the process of depressing the handle to crush the medications. -The MA transferred the medication powder to a plastic medication cup, discarded the souffle cups in the trash, and proceeded to use the same process to crush the third souffle cup of pills. -The MA added chocolate pudding to the crushed pills in the plastic medication cup and administered the medication to a resident. Refer to interviews on 10/26/16 at 10:15 am and 10/27/16 at 3:02 pm with a Medication Aide. Refer to interview on 10/27/16 at 10:41 am with a second MA.	D 370		

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D 370	Continued From page 10 Refer to interview on 10/27/16 at 11:05 am with a third MA. Refer to interview on 10/27/16 at 2:00 pm with the Unit Care Coordinator (UCC). Refer to interview on 10/27/16 at 2:40 pm with the Administrator. Refer to telephone interview on 10/27/16 at 3:48 pm with the facility owner's Administrative Assistant. _____ Interviews on 10/26/16 at 10:15 am and 10/27/16 at 3:02 pm with a Medication Aide (MA) revealed: -The facility did not have any of the plastic pouches required for the brand of pill crusher being used. -She had worked at the facility since June 2016 and there had been no plastic pouches for the pill crusher since "at least August". -She did not know why there were no plastic pouches and was "just told to do it this way". -She had not reported to management the need for the plastic pouches, she just used the souffle cups as she was instructed to. Interview on 10/27/16 at 10:41 am with a second MA revealed: -She began working as a MA in August 2016. -The facility had been out of the plastic pouches required for their brand of pill crusher "as long as I've been here". -The MA stated she had never seen any of the plastic pouches in the facility. -It was a common occurrence for the souffle cups to tear while attempting to crush medications. -When the souffle cup tore, the MA had to "try to hurry and get another souffle cup underneath so I don't lose that medication".	D 370		

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-She had to turn the cup sideways and manipulate the cup position in an attempt to keep the medication powder from escaping the torn cup.
-The MA stated she believed the residents were getting an accurate dosage of medications, but stated she could not be sure they were getting an accurate dose, but she tried to be very careful to "keep it all".
-She had souffle cups to tear while crushing medications "every day".
-She had souffle cups to tear "about six times" during this morning's medication pass.
-She tried to divide the pills into separate souffle cups to decrease the likelihood of the cup tearing, but the cups still tore.
-She had not discussed the problem of the souffle cups tearing with anyone in management, but she had "let them know" she did not like the souffle cups for use in crushing medications.
-The souffle cups were "fine" for regular pills but "crushing is a problem".

Interview on 10/27/16 at 11:05 am with a third MA revealed:
-She began working at the facility as a Personal Care Aide (PCA) on 12/12/15 and became a MA in August 2016.
-She had seen the plastic medication pouches being used by MAs before, but there had not been any of the pouches since she became a MA in August 2016.
-The MA stated she "just don't feel like they're (residents) are getting all their medication".
-She discussed the issue with the Unit Care Coordinator (UCC), but the UCC said the souffle cups was what the owner preferred them to use.
-The souffle cups tore "every day" and about six times during a single medication pass.
-She routinely separated the pills, putting 2-3 pills

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in one souffle cup, in an attempt to keep the cup from tearing.

Interview on 10/27/16 at 2:00 pm with the UCC revealed:
-The plastic pouches required for their brand of pill crusher had been out since the end of July or the beginning of August.
-Staff were instructed by the Administrator to use the souffle cups in place of the plastic pouches.
-The souffle cups tore "if you put too many (pills) in there".
-She routinely put one big pill with a couple little ones, or 4-5 little pills in one souffle cup at a time.
-When asked if she could ensure accurate dosing of medication, the UCC stated, "No, not if we are losing powder".
-The UCC stated you have to spread the souffle cup open "very gently" and that she could take her time and administer the medications timely and accurately, "but some MAs have not mastered that".
-There was no way to "know how much of a dose you're losing if you don't do it correctly".
-There had been no specific training provided to the MAs regarding the use of souffle cups to crush medications.

Interview on 10/27/16 at 2:40 pm with the Administrator revealed:
-She was aware the facility did not have the plastic pouches required for their brand of pill crusher.
-The facility staff was told by the owner that due to the cost of the plastic pouches, they were to use souffle cups instead.
-The Administrator had received complaints from the MAs about using the souffle cups for crushing medications.
-The MAs did not report they were "losing bits of

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D 370	Continued From page 13 meds", just that the plastic pouches were easier to use and using the souffle cups to crush medications was hard. Telephone interview on 10/27/16 at 3:48 pm with the Owner's Administrative Assistant revealed: -The Owner was not available for interview at this time. -The facility staff had been instructed to use souffle cups for crushing medications because they were not aware the facility used the brand of pill crushers which required the plastic pouches. -The Administrative Assistant stated she did not think the Owner would have instructed the facility to use the souffle cups with that particular brand of pill crusher.	D 370		