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
	HAL026062	A. BUILDING: _____ B. WING _____	04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND VILLAGE ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

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D 000	Initial Comments The Adult Care Licensure Section and the Cumberland County Department of Social Services conducted an annual survey and complaint investigation on 4/26/16 through 4/29/16. The complaint investigation was initiated by the Cumberland County Department of Social Services on 3/24/16.	D 000	POC - See attached	
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the walls, floors and resident bathrooms (shared bathrooms and common bathrooms) were kept clean and in good repair (floors with dirt/grime buildup, broken and missing tile pieces, bathrooms with foul odors, dirty commodes and walls with holes and in need of painting and repairs). The findings are: 1. Observations of the C Hall (resident rooms 18A- 29B) and Hall B (rooms 9 - 16) during the facility tour on 04/26/16 11:00am- 12:15pm revealed: - Room 26 had black dirt stains along the entrance wall. - Room 28 had black dirt stains on the floor tiles along the wall of the entrance doorway and around the bathroom doorway.	D 074		

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

Joyce M. Jr Lucas — Administrator — 06/15/16

STATE FORM 6899 HKIG11 If continuation sheet 1 of 18

acknowledged 6/15/16

Cumberland Village
HAL-026-062
Plan of Correction
DHSR Survey 04/29/2016

10 NCAC 13F .0306(a)(1)-Housekeeping and Furnishings

(a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair.

Plan of Correction

- Walls, ceilings, floors and floor coverings have been cleaned. 6/13/2016
- Repairs have been made to walls, ceilings and floors and floor coverings. 6/13/2016
- Staff received additional training regarding use of maintenance repair log. 4/29/2016
- Administrator and maintenance director retrained on maintenance duty task sheets, documentation of completion of task and follow-up of reported areas. 4/29/2016 & ongoing
- Schedule to be put in place to replace floors as needed by corporate maintenance. 6/3/2016

Monitoring System

- Administrator/designee will perform weekly walk through within the community to assure walls, ceilings, floors and bathrooms are in good repair, including fixtures and appliances 4/29/2016 & ongoing
- Maintenance director/designee will monitor logs on a daily basis and document that follow up was completed. 4/29/2016 & ongoing
- Any staff not complying with policies will be handled on an individual basis to include additional training, disciplinary action or termination. 4/29/2016 & ongoing

10 NCAC 13F. .0902(b) Health Care

(b)the facility shall assure referral and follow up to meet the routine and acute health care needs of residents.

Plan of Correction

- Resident #7 orders for labs are being completed as ordered. 4/29/2016 & ongoing

- Lab order notebook will be implemented for tracking and monitoring of labs and follow up orders of lab results. 04/30/2016 & on-going

- Admin/Regional Director/designee will review lab orders and lab notebook, weekly x4 weeks, and then monthly x4 months and randomly thereafter to ensure compliance. 4/30/2016 & on-going

- Any staff members found not following policy and procedures will receive additional training and/or disciplined up to and including termination. 4/30/2016 & on-going

10A 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 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

- Resident #2 and Resident #7 are receiving medications as prescribed by the physician. 4/29/2016 & ongoing
- RCC/Administrator reviewed records to ensure residents are receiving medications as ordered by their physician. 4/29/2016 & ongoing

- Staff will receive additional training on administering medications per physician's orders and follow up of orders. 4/29/2013 & ongoing as needed

Monitoring System

- Administrator/RCC/Designee will monitor MAR's weekly x2 months, then monthly x4 months and randomly thereafter to insure that all medications have been administered as ordered 4/29/2016 & on-going

- Administrator/RCC/Designee will randomly monitor med passes to ensure that staff is following policies and procedures 4/29/2016 & on-going

- Any staff members found not following policy and procedures will receive additional training/disciplined up to and including termination. 4/29/2016 & on-going

G.S. 131D -21(2)- 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.

- Staff will continue to be trained on residents' rights at hire and annually thereafter.

Prior to 4/30/2016 & ongoing

- Resident Rights training with emphasis placed on the residents rights to receive care and services which are adequate , appropriate and in compliance with relevant federal and state laws and rules and regulations. 4/30/2016

Monitoring System

- Administrator/RCC/Designee will randomly monitor resident's needs based on MAR and chart documentation weekly x2 weeks, then monthly x4 months and randomly thereafter, to ensure resident rights are not being violated. 06/14/2016 & on-going
- Administrator/RCC/Designee will conduct random interviews with resident's weekly x2 weeks, then monthly x4 months and randomly thereafter, to ensure resident rights are not being violated. 06/14/2016 & on-going
- Any staff member found to be in violation of resident rights will receive additional training and/or disciplinary action, up to and including termination. 06/14/2016 & on-going

Joseph Lucas 06/15/16

Signature / Executive Director Date

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D 074	Continued From page 1 - Room 29 had a hole in the wall above the baseboard near the bathroom door. There were black dirt stains in the doorway of the entrance to the room and black dirt stains on both sides of the entrance doorway walls. - Rooms 27 and 29 shared a bathroom. The bathroom floor tiles were covered in black dirt and brown rust stains. The floor of the bathroom around the commode was covered with brown rust and black dirt. - The bathroom in room 9, had several missing tile pieces near the commode. The remaining tile had dirty/grime buildup. The base of the commode was cracked. - The bathroom shared by residents in rooms 10 and 11 had a foul smell of urine. On the floor near the base of the commode was a pool of clear liquid. - The bathroom shared by residents in rooms 12 and 13 had cracked floor tile near the base of the commode. The sealant around the sink was cracked and the commode would not flush. - The bathroom shared by residents in rooms 14 and 15 had a crack on the right side of the wall below the sink. - The community bathroom had a large pool of water on the floor near the shower stall. A microwave oven was on a half wall which separated the shower stalls. - The floor tile near the sink had black dirty/grime buildup. Interview with the facility ' s Resident Care Coordinator on 04/26/16 from 12:30am revealed: - A resident in room 10 frequently urinated on the bathroom floor. - The RCC instructed a housekeeping staff to mop and sanitize the floor immediately. - The housekeeping staff should clean the residents ' bathrooms and the community	D 074		

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D 074	Continued From page 2 bathrooms daily. Observation of the bathroom shared by residents in rooms 10 and 11 on 04/26/16 at 2:00pm revealed the floor near the commode was dry, but the foul smell of urine continued. Refer to interview with a housekeeper on 4/46/16 at 11:10am. Refer to interview with the facility's Administrator on 4/29/16 at 3:30pm. 2. Observations made on E Hall (resident rooms 38A - 49B) and F Hall (resident rooms 50A - 66B) on 04/29/16 12:30pm - 1:15pm revealed: - Community bathrooms on Hall E and F had black dirt buildup on tile around commode, shower stalls, bath tub, and around edges of walls. The walls near the sink were dirty. - A community bathroom on Hall E had multiple tile pieces broken and missing with dirt buildup and rotted exposed wood at doorway. - The floors inside the shower stalls had black dirt/grime buildup on tiles and rust around edged of the commodes. - A second community bathroom on Hall E had a hole in the wall, behind the door, approximately the size of a door knob and paint on the walls were peeling off/bubbling up. - A commode in a community bathroom on Hall F had dried brown material on the seat and half filled with dark foul smelling water/feces. The commode with dried feces above the water level. - Multiple resident room doors on both hallways with dark scuff marks about halfway up the doors and dirt build up on tiles around edges of rooms, near walls.	D 074		

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D 074	Continued From page 3 Refer to interview with a housekeeper on 4/26/16 at 11:10am. Refer to interview with the facility's Administrator on 4/29/16 at 3:30pm. _____ Interview with a housekeeper on 4/26/16 at 11:10am revealed: - Two housekeepers were scheduled to work each shift. - The housekeeper was responsible for cleaning each room and bathroom in the A ,B, C and D hallways every day. - Daily cleaning the rooms consisted of dusting headboards, window sills, window blinds and sweeping and mopping floors. - Each bathroom was cleaned every day, inside and outside of sinks and toilets, with floors swept and mopped each day. - Some of the floor tiles had been retiled about a month ago, there were still some others that need to be retiled. Interview with the facility's Administrator on 4/29/16 at 3:30pm revealed: - The facility had 3 fulltime housekeepers who were responsible for keeping the facility clean, including community bathrooms and resident rooms. - The floor tiles throughout the facility were old and needed replacing. - The facility's "corporate office" was aware of the areas and plan to address the problem. - Someone from the corporate office will be at the facility next week. - The facility has not had a maintenance person	D 074		

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D 074	Continued From page 4 employed for several months, only housekeeping staff. Review of the facility's Plan of Protection dated 04/29/16 revealed: - The Administrator and maintenance will be retrained on maintenance duty task sheets, documentation of completion of task and follow-up of reported areas. - Schedule to be put in place to replace floors as needed by corporate maintenance. - Administrator/designee will complete weekly walk through within the community to assure walls, ceilings, floors and bathrooms are in good repair, including fixtures and appliances starting 04/29/16. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2016.	D 074		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews, observations and record review, the facility failed to coordinate with the Home Health agency to assure Valporic Acid levels were obtained as ordered for 1 of 7 sampled residents (#7).	D 273		

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D 273	Continued From page 5 The findings are: Review of Resident #7's FL-2 dated 08/28/15 revealed: -Diagnoses included unspecified epilepsy, personal history of falls, bipolar disease, and encounter for long term use of anticoagulants, muscle weakness, unspecified anemia, esophageal reflux, and edema. -The Resident was intermittently disoriented. -There was an order for Valproic Acid (a medication to treat seizures and used as a mood stabilizer) 375mg twice daily. Review of Physician Orders for Resident #7 revealed an order dated 09/02/15 to obtain a Valproic Acid level (a test that measures and monitors the amount of Valproic Acid in the blood to determine whether the drug concentration is within a therapeutic range) every 3 months. Review of the lab reports for Resident #7 revealed a Valproic Acid level on 08/05/15 (done prior to the Resident's admission to this facility). Interview with the Resident Care Coordinator (RCC) on 04/29/16 at 11:00am revealed: -The Valproic Acid levels were obtained by the Home Health Nurse. -The first Valproic Acid level was obtained sometime in December 2015 and the next one should be obtained in March 2016. -The home health nurse prior to the current nurse may not have put the order in for the Valproic Acid Level for home health to perform every 3 months. -The RCC did not have a specific system in place to assure labs were done as ordered other than trying to remember when they were due. -She would call the home health agency to see if they had obtained any Valproic Acid levels.	D 273		

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D 273	Continued From page 6 A follow up interview done with the RCC at 11:45am on 04/29/16 revealed: -A call had been placed to the laboratory and no Valproic Acid levels had been obtained for Resident #7. -The home health agency that cared for Resident #7 did not have any Valproic Acid levels drawn for Resident #7. -The RCC was unaware that the Valproic acid levels were never obtained. Interview with the Home Health Nurse on 04/29/16 at 12:05pm revealed: -The home health agency received an order for Valproic acid levels every 3 months on 04/28/16. -The home health agency had obtained labs as ordered by the primary provider and no Valproic Acid levels had been obtained since the resident was admitted to home health care on 09/14/15. -She reviewed the electronic orders in her computer and there was an order for Valproic Acid levels to be drawn every 3 months that began on 01/15/16 and ended on 01/20/16; she was unable to find a note that corresponded with the creation of that order; and no Valproic Acid level was ever obtained. -She was at the facility to obtain a Valproic Acid level for Resident #7. Interview with the Administrator and the Regional Director on 04/29/16 at 4:00pm revealed: -The Home Health Nurse should be exiting with the RCC or the Supervisor in Charge to review the care that was provided. -The Regional Director had set up a lab book and the facility would initiate this log to track when the labs were due.	D 273		

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D 358	Continued From page 7	D 358		
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: TYPE B VIOLATION Based on interview and record review, the facility failed to assure medications were administered as ordered for 2 of 7 sampled residents (Residents #2) who had ordered blood pressure parameters with administration of Metoprolol which was not followed and medication administered when BP was below the paramters (Resident #2) and (Resident #7) who had changed Coumadin doses which was not administered as ordered . The findings are: 1. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 01/29/16. Review of Resident #2's current FL-2 dated 01/16/16 revealed: - Diagnoses included atherosclerotic heart disease, cerebral edema, malignant neoplasm of brain and seizures. - There was an order for Metoprolol tartrate 25mg, by mouth, 2 times a day (used to control high blood pressure). Hold medication if systolic	D 358		

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blood pressure (top reading) is less than 110 or if diastolic blood pressure (bottom reading) is less than 60.

Review of the resident's 6 month order update, dated 2/01/16, revealed order for Metoprolol 25mg, take 1 tablet, 2 times a day at 8:00am and 8:00pm. Hold if systolic blood pressure is less than 110 or diastolic blood pressure is less than 60.

Review of the Resident #2's February 2016 medication administration record (MAR) and blood pressure (BP) logs revealed:
- From 02/1/16 through 02/29/16 the resident's Metoprolol was documented as administered 6 0f 7 times when BP was below parameters and was held 1 time when BP was documented as above parameter.
- On 2/2/16 at 8:00pm, the resident's BP was documented as 102/68 and the Metoprolol was documented as administered.
- On 2/21/16 at 8:00pm, the resident's BP was documented as 95/62 and the Metoprolol was documented as administered.
- On 2/22/16 at 8:00pm, the resident's BP was documented as 100/84 and the Metoprolol was documented as administered.
- On 2/24/16 at 8:00pm, the resident's BP was documented as 108/77 and the Metoprolol was documented as administered.
- On 2/25/16 at 8:00pm, the resident's BP was documented as 79/56 and the Metoprolol was documented as administered.
- On 2/26/16 at 8:00pm, the resident's BP was documented as 95/59 and the Metoprolol was documented as administered.
- On 2/27/16 at 8:00pm, the resident's BP was documented as 113/74 and the Metoprolol was documented as not administered (should have

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D 358	Continued From page 9 been administered). Review of the Resident #2's March 2016 medication administration record (MAR) and blood pressure (BP) logs revealed: - From 3/01/16 through 3/31/16, the resident's Metoprolol was documented as administered 6 of 19 times when BP was below parameters. - On 3/10/16 at 8:00am, the resident's BP was documented as 108/68 and Metoprolol was documented as administered. - On 3/12/16 at 8:00pm, the resident's BP was documented as 102/66 and Metoprolol was documented as administered. - On 3/13/16 at 8:00pm, the resident's BP was documented as 106/74 and Metoprolol was documented as administered. - On 3/20/16 at 8:00pm, the resident's BP was documented as 94/60 and Metoprolol was documented as administered. - On 3/21/16 at 8:00pm, the resident's BP was documented as 103/64 and Metoprolol was documented as administered. - On 3/24/16 at 8:00pm, the resident's BP was documented as 100/63 and Metoprolol was documented as administered. Review of the Resident #2's April 2016 medication administration record (MAR) and blood pressure (BP) logs revealed: - From 4/01/16 through 4/27/16, the resident's Metoprolol was documented as administered 9 of 13 times when BP was below parameters. - On 4/03/16 at 8:00am, the resident's BP was documented as 100/69 and Metoprolol was documented as administered. - On 4/03/16 at 8:00pm, the resident's BP was documented as 90/66 and Metoprolol was	D 358		

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documented as administered.
- On 4/04/16 at 8:00am, the resident's BP was documented as 101/62 and Metoprolol was documented as administered.
- On 4/04/16 at 8:00pm, the resident's BP was documented as 99/68 and Metoprolol was documented as administered.
- On 4/07/16 at 8:00am, the resident's BP was documented as 102/70 and Metoprolol was documented as administered.
- On 4/07/16 at 8:00pm, the resident's BP was documented as 90/59 and Metoprolol was documented as administered.
- On 4/08/16 at 8:00pm, the resident's BP was documented as 100/64 and Metoprolol was documented as administered.
- On 4/09/16 at 8:00am, the resident's BP was documented as 105/69 and Metoprolol was documented as administered.
- On 4/13/16 at 8:00pm, the resident's BP was documented as 94/60 and Metoprolol was documented as administered.

Interview with a 2nd shift medication aide (MA) on 4/27/16 at 3:35pm revealed:
- The MA administered Resident #2's Metoprolol 25mg.
- The MA always checked the resident's BP before administering the medication.
- The BP was documented on the resident's BP log and if below parameters, the medication should not be administered and documented as not administered (circle initial and document on back of MAR reason medication was not administered).
- If the MA did not circle initial or document on back of MAR reason the medication was not administered, the medication was administered.
- At times the resident may have been administered the Metoprolol when her BP was

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D 358	Continued From page 11 below the ordered parameters. Interview with the facility's Resident Care Coordinator (RCC) on 4/28/16 at 9:15am revealed: - She was not aware Resident #2 received Metoprolol when her BP was below the ordered parameters for administering the medication. -The MAs should check the resident's BP before administering the medication, document the BP on the BP log and if below parameters, the medication should be not be administered, the MAs initials should be circled on the date and time not administered and documented on the back of the MAR why the medication was not administered. -The RCC had not reviewed the MARs and was not aware the resident's Metoprolol had been administered multiple times since admission when it should have been held. Interview with Resident #2's primary medical provider on 4/29/16 at 12:00 noon revealed: - The resident's current order was Metoprolol 25mg, 2 times a day. The current parameter needed to be followed by the facility because the resident's BP was unstable and would drop and cause the resident to have hypotension (low BP). - The primary medical provider expected the facility to follow the current BP parameters and to hold the Metoprolol if the resident's systolic BP was below 110 or if the resident's diastolic BP was below 60. - The facility's RCC contacted the primary medical provider on 4/28/16 regarding the current BP parameters, and was advised they needed to adhere to the current orders. - Resident #2 could become weak and dizzy and could fall if attempted to walk if her BP was low and the Metoprolol was administered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026062	A. BUILDING: _____ B. WING _____	04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 12 Interview with Resident #2 on 4/29/16 at 12:15pm revealed: - The MAs administered her BP medication 2 times a day (in the morning and at night). - The MA monitored her BP before administering the medication. - The resident did not know her BP readings and never asked the MA for her readings. - The BP medication was not administered 3 or 4 times this month because of her BP readings. - The resident did not recall being dizzy or weak since admission to the facility, but did roll of her bed 1 time (several weeks ago) and fell 2 times in her bathroom while transferring from wheelchair to the commode). No injuries were sustained. 2. Review of Resident #7's FL-2 dated 08/28/15 revealed: -Diagnoses included unspecified epilepsy, personal history of falls, bipolar disease, and encounter for long term use of anticoagulants, muscle weakness, unspecified anemia, esophageal reflux, and edema. - The resident was intermittently disoriented. -There was an order for Coumadin, generic name Warfarin (an oral, blood thinner medication used to treat and prevent blood clots) 2.5mg daily. -There was an order for a International Normalized Ratio (INR) (a international normalized ratio is a blood serum test to measure how long it takes for the blood to clot with a therpeutic range of 2.0 - 3.0) to be done monthly and as needed. Review of Resident #7's Resident Register revealed an admission date of 09/02/15.	D 358		

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D 358	Continued From page 13 Review of physician orders for Resident #7 revealed an order dated on 09/02/15 for home health nursing services to obtain a INR monthly. Review of the home health agencies In Home INR Results/ Physician's Order Sheet for Resident #7 revealed: -On 04/18/16, lab results: PT-19.5, INR-1.6; current Coumadin dose was 3mg Monday through Friday and 4mg on Saturday and Sunday; Coumadin dose was to increase to 4 mg daily; next INR to be obtained in one week. -On 4/25/16, lab results: PT-40.6, INR-3.4; current Coumadin dose was 4mg daily; Coumadin dose was to remain the same; next INR to be obtained in two weeks. Review of the April 2016 Medication Administration Record (MAR) for Resident #7 revealed: -There was a computerized entry for Warfarin 4mg every day to be given at 5pm along with a handwritten entry that this medication had changed on 03/28/16 and one line was drawn thru the administration row. -There was a handwritten entry dated 03/28/16 for Warfarin 4mg on Saturday and Sunday to be given at 5pm. -There was a handwritten entry dated 03/28/16 for Warfarin 3 mg, Monday thru Friday to be given at 5pm. -The Medication aides documented administration of Warfarin 3 mg at 5:00pm on 04/01/16, 04/04/16-04/08/16, 04/11/16-04/15/16, 04/18/16-04/22/16, and 04/25/16-04/28/16. - The Medication aides documented administration of Warfarin 4 mg at 5:00pm on the following dates: 04/02/16, 04/03/16, 04/09/16, 04/10/16, 04/16/17, 04/17/16, 04/23/16, and	D 358		

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D 358	Continued From page 14 04/24/16. -There was no entry for Warfarin 4mg daily to start as ordered on 04/18/16. Interview with Resident #7 on 04/29/16 at 2:00pm revealed the following: -She was not sure what medications she takes. -Staff come to get her when it was time to take her medications -She had never ran out of any of her medications. Interview with the Resident Care Coordinator on 04/29/16 at 3:36pm revealed the following: -When Coumadin orders were changed, she would fax the order to the pharmacy. -The home health nurse usually obtained the orders for the Coumadin dose along with the time to obtain the next INR for Resident #7 from the primary provider. -The home health nurse was expected to tell her when new or changed orders were received. -It was expected that the home health nurse have a same day case conference concerning the residents seen when home health visits were made to update the facility's staff but she had not been doing this. She was unaware of the Coumadin order for 04/18/16, for Coumadin to be increased to 4 mg daily and was not aware of the order on 4/25/16 to continue the current dose of Coumadin at 4mg. -The home health nurse was filing the orders in the resident's record and not alerting anyone about those orders. -The home health nurse was filing the orders for the Coumadin in two separate areas in the chart. -She would contact the primary provider to inform that the resident had been on the alternating dose of Coumadin and was currently not taking the 4mg daily dose.	D 358		

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D 358	Continued From page 15 Interview with the Administrator and the Regional Director on 04/29/16 at 4:00pm revealed: -The Home Health Nurse should be exiting with the RCC or the Supervisor in Charge to review the care that was provided. -The Home health nurse should not be filing orders into the residents' charts. According to the facility's Plan of Protection dated 4/29/16, the medication staff will be retrained on administering medications as ordered on 4/29/16. A lab notebook will be available for all lab orders to be reviewed by medical provider to notate any changes. The medication administration records will be audited beginning immediately to assure medications are administered as ordered. The Administrator will schedule meetings with outside healthcare agencies to assure the staff is exiting with the facility's RCC/designee for any updates in the resident's care. The Executive Director/RCC to randomly audit MARs to assure medications are being given as ordered. The Executive Director/RCC will randomly observe medication aides during medication passes to assure orders are being followed. Any staff not following orders/procedures will be re-trained and/or disciplined. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2016.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 16 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 ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings and Medications not administered as ordered. 1.Based on observations and interviews, the facility failed to assure the walls, floors and resident bathrooms (shared bathrooms and common bathrooms) were kept clean and in good repair (floors with dirt/grime buildup, broken and missing tile pieces, bathrooms with foul odors, dirty commodes and walls with holes and in need of painting and repairs). [Tag 074, 10A NCAC 13F .0306 Housekeeping and Furnishings (Type B Violation)]. 2. Based on interview and record review, the facility failed to assure medications were administered as ordered for 2 of 7 sampled residents (Residents #2) who had ordered blood pressure parameters with administration of Metoprolol which was not followed and medication administered when BP was below the paramters (Resident #2) and (Resident #7) who had changed Coumadin doses which was not	D912		

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D912	Continued From page 17 administered as ordered [Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		