STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080006	A. BUILDING: _____ B. WING _____	R-C 01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 1/18/17, 1/19/17 and 1/20/17.	{D 000}		
D 253	10A NCAC 13F .0801(a) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure that an initial assessment of each resident was completed within 72 hours of admission using the Resident Register for 3 of 3 Residents (Residents #2, #6, #7) admitted in the past month. The findings are: A. Review of Resident #2's Resident Register revealed: -An admission date of 12/12/16 to a named facility, which was not the current facility. -There were 4 pages to the Resident Register, but the page identified as page 3 was missing. There was a duplicate copy of page 4. -Page 2 was a completed assessment page. -There were 2 signature pages (page 4), exactly the same, except that one was completely blank. -Page 3 was missing. It was an assessment page of Resident #2's "hobbies", "activity interests" and "activities strongly disliked or to be avoided", and included a "Request for Assistance" section with 4 unsigned spaces where the resident's, or their responsible person's, signature should have been placed. -The Declaration of Residents' Rights, the	D 253		

Reviewed
Accepted 3-3-17

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D 253	Continued From page 1 facility's grievance procedures and the facility's willingness to comply with Title VI of Civil Rights Act signature line on page 4 was marked with an X but had not been signed by the resident or his responsible person. -The signature page on page 4 had the Administrator or Supervisor in charge's signature, but was not dated, and had no Resident or Resident's Responsible party's signature. Interview on 1/18/17 at 2:00 pm with the Resident Care Director (RCD) revealed: -Resident #2 had come from a "sister facility" last week. -She had merged "some of that record" into Resident #2's current file. She had been told that "if a resident came from an outside facility, everything (paperwork) should be new, but that if they were from an affiliated facility, she could use the Resident Register, orders and FL2 for this facility. I understood it was acceptable." -After reviewing the facility census roster, she revealed that Resident #2 was admitted 1/10/17. -She would get Resident #2 to sign a new and correct Resident Register. Interview on 1/18/17 at 3:45 pm with Resident #2 revealed he had moved here last week from another facility and did not recall signing any new paperwork after his arrival. Review of Resident #2's record on 1/19/17 at 8:30 am revealed a new Resident Register had been signed and placed in Resident #2's record. Review of Resident #2's Resident Register in the record on 1/19/17 at 8:30 am revealed: -Page one listed the correct named facility and was complete. -The assessment area on page 2 and 3 was	D 253	**All new client registers have been Updated and signed.** **Exhibit A-1**	**1/18/17**

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D 253	Continued From page 2 complete. -The "Request For Assistance" section on page 3 had 4 unsigned spaces where the resident's, or her responsible person's, signature should have been placed. -The "Receipt of Materials" section on page 3 and 4 acknowledging the resident, or responsible person, had received information regarding the resident contract, facility house rules, Declaration of Residents' Rights, the facility's grievance procedures and the facility's willingness to comply with Title VI of Civil Rights Act had not been signed by the resident of his responsible person. -The signature page on page 4 was completed with Resident #2's signature and the Administrator or Supervisor's signature, both dated 1/18/17. Refer to interview on 1/20/17 at 12:50 pm with the Administrator in Training. B. Review of Resident #6's Resident Register revealed: -An admission date of 1/09/17 to the current named facility. -No information for contact person, family, responsible person, person identified by the resident to receive a copy of the discharge notice or the attending physician was completed on page 1. -The Resident assessment on pages 2 and 3 was incomplete and blank. -The "Request For Assistance" section on page 3 had 4 highlighted yellow lines marking where the resident's, or her responsible person's, signature should have been placed. There were no signatures on these lines. -The "Receipt of Materials" section on page 3 and 4 acknowledging the resident, or responsible person, had received information regarding the	D 253	**New Admission package has been developed** **Exhibit A-2**	**1/21/17**

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D 253	Continued From page 3 resident contract, facility house rules, Declaration of Residents' Rights, the facility's grievance procedures and the facility's willingness to comply with Title VI of Civil Rights Act had not been signed by the resident or his responsible person, but was marked with a highlighted yellow line marking the signature line. -The signature page had the Administrator or Supervisor's signature, dated 1/10/17, but had no Resident or Resident's Responsible party's signature. Interview on 1/20/17 at 9:10 am with the Resident Care Director (RCD) revealed: -She was responsible for making sure the Resident Registers were completed and signed. -She had started Resident #6's Resident Register and asked someone else to complete it with the resident's interview information and signatures. -She was not aware it was not completed. Interview on 1/20/17 with Resident #6 was not available. Refer to interview on 1/20/17 at 12:50 pm with the Administrator in Training. C. Review of Resident #7's Resident Register revealed: -An admission date of 1/09/17 to the current named facility. -No information for family, responsible person, person identified by the resident to receive a copy of the discharge notice or the attending physician was completed on page 1. -The Resident assessment on pages 2 and 3 was incomplete and blank. -The "Request For Assistance" section on page 3 had 4 highlighted yellow lines marking where the resident's, or her responsible person's, signature	D 253	**Resident Register completed And signed Exhibit A-3**	**1/21/17**

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D 253	Continued From page 4 should have been placed. There were no signatures on these lines. -The "Receipt of Materials" section on page 3 and 4 acknowledging the resident, or responsible person, had received information regarding the resident contract, facility house rules, Declaration of Residents' Rights, the facility's grievance procedures and the facility's willingness to comply with Title VI of Civil Rights Act had not been signed by the resident or his responsible person, but was marked with a highlighted yellow line marking the signature line. -The signature page had the Administrator or Supervisor's signature, dated 1/10/17, but had no Resident or Resident's Responsible party's signature. Interview on 1/20/17 at 9:10 am with the Resident Care Director (RCD) revealed: -She was responsible for making sure the Resident Registers were completed and signed. -She had started Resident #7's Resident Register and asked someone else to complete it with the resident's interview information and signatures. -She was not aware it was not completed. Interview on 1/20/17 with Resident #7 was not available. Refer to interview on 1/20/17 at 12:50 pm with the Administrator in Training. Interview on 1/20/17 at 12:50 pm with the Administrator in Training revealed: -Resident Registers should be completed, including signatures, within 72 hours of admission in accordance with the regulations. -His RCD was responsible for making sure the Resident Registers were completed. -He was not aware the Resident Registers were	D 253	**Resident Register completed and Signed** **Exhibit A-4**	**1/23/17**

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D 253	Continued From page 5 not being completed.	D 253		
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 observations, interviews, and record reviews, the facility failed to contact the physician for 3 of 5 sampled residents for fingerstick blood sugar (FSBS) results outside the ordered parameters (Resident #4), high blood pressures (Resident #2) and failure to make a physician's ordered gynecological referral (Resident #1). The findings are: A. Review of Resident #4's current FL2 dated 11/10/16 revealed diagnoses included diabetes mellitus. Review of Resident #4's record revealed physician's orders dated 11/18/16 which included the following order: "check blood sugars at meals and every evening for a couple of weeks and if over 200 - please call and will add possibly another oral medication." Review of Resident #4's November 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for FSBS before meals and at bedtime (6:30 am, 11:30 am, 4:30 pm and 9:00 pm) and to call physician if over 200.	D 273		

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D 273	Continued From page 6 -On 11/23/16 at 9:00 pm the FSBS was documented as 216. -There was no documentation indicating the physician had been notified of the elevated blood sugar. -Resident #4's blood sugars ranged from 49-325. Review of Resident #4's December 2016 eMAR revealed: -An entry for FSBS before meals and at bedtime (6:30 am, 11:30 am, 4:30 pm and 9:00 pm) and to call physician if over 200. -On 12/01/16 at 9:00 pm the FSBS was documented as 241. -On 12/02/16 at 9:00 pm the FSBS was documented as 207. -On 12/10/16 at 11:30 am the FSBS was documented as 209. -On 12/14/16 at 9:00 pm the FSBS was documented as 218. -On 12/15/16 at 6:30 am the FSBS was documented as 264. -On 12/17/16 at 11:30 am the FSBS was documented as 229. -There was no documentation indicating the physician had been notified of the elevated blood sugar. -Resident #4's blood sugars ranged from 53-264. Review of Resident #4's January 2017 eMAR revealed: -An entry for FSBS before meals and at bedtime (6:30 am, 11:30 am, 4:30 pm and 9:00 pm) and to call physician if over 200. -On 1/09/16 at 4:00 pm the FSBS was documented as 269. -On 1/09/16 at 9:00 pm the FSBS was documented as 206. -On 1/10/16 at 4:00 pm the FSBS was documented as 203.	D 273		

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D 273	Continued From page 7 -On 1/10/16 at 9:00 pm the FSBS was documented as 223. -On 1/14/16 at 9:00 pm the FSBS was documented as 215. -There was no documentation indicating the physician had been notified of the elevated blood sugar. -Resident #4's blood sugars ranged from 61-223. Review of Resident #4's progress notes revealed there was no documentation indicating the physician had been notified of the elevated blood sugar. Telephone interview with the Registered Nurse at Resident #4's physician's office on 1/19/17 at 9:52 am revealed there were no calls from the facility reporting Resident #4's blood sugars had exceeded 200. Interview with a Medication Aide (MA) on 1/19/27 at 3:11 pm revealed: -The MAs were responsible for calling the resident's physicians if a blood sugar exceeded the ordered parameter. -The MAs were expected to implement the physician's order and document in the progress notes. -She had never observed Resident #4's blood sugar exceed 200. -She did not know why the MAs would not have called Resident #4's physician. Interview with the Resident Care Director (RCD) on 1/19/17 at 10:00 am revealed: -She knew Resident #4 had an order for FSBS and to call the physician if the FSBS exceeded 200. -She did not review the MARs to ensure any results that were outside ordered parameters	D 273		

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D 273	Continued From page 8 were reported to the physicians. -She did not know Resident #4's FSBS had exceeded 200 on several occasions. -She expected the MAs to notify the physician if a FSBS exceeded the ordered parameters. -She did not know why the MAs had not notified the physician or at least reported the result to her so that she could have notified Resident #4's physician. -There was not a system in place to review the FSBS results and ensure results which exceeded the ordered parameters had been reported to the physician. Interview with the Administrator-in-Training (AIT) on 1/19/17 at 10:00 am revealed: -He was not aware Resident #4 had an order for FSBS checks and to call the physician if the FSBS exceeded 200. -He did not know Resident #4's FSBS had exceeded 200 on several occasions and these results were not reported. -He expected that the MAs or the RCD contact the physician if a residents FSBS exceeded the ordered parameters. -He did not know why this did not occur. B. Review of Resident #2's current FL-2 dated 12/22/16 revealed: -Diagnoses included diabetes, hypertension, paranoid schizophrenia, lithium toxicity, and pneumonia. -A physician's order for blood pressure (BP) checked daily. No parameters were ordered for physician notification. -Physician medication orders included lisinopril 10 mg daily (used to treat high BP) and amlopidine 5 mg daily (used to treat high BP). Review of Resident #2's Resident Register revealed an admission date of 1/11/17 to this	D 273	**Employees trained on Diabetes and Insulin Administration 3 hrs CEU Exhibit B-1** **Employees re-trained on BP and FSBS Exhibit B-2** **Employees trained on Alzheimer's Medications Exhibit B-2-a** **FSBS Protocol System developed Exhibit B-3** **RCD is checking Quick Mars daily Exhibit B-4**	**6/8/17** **2/15/17** **2/10/17** **2/15/17** **1/20/17**

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D 273	Continued From page 9 facility. Review of Resident #2's January 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for BP checks daily and documented as performed daily at 7:00 am from 1/11/17 to 1/18/17 with results which ranged from 156/88 to 209/124. No parameters were ordered for physician notification. -A BP result of 209/124 on 1/12/17 and no documentation BP was rechecked or the physician was notified. -A BP result of 205/105 on 1/16/17 and no documentation BP was rechecked or the physician was notified. -A BP result of 195/94 on 1/18/17 and no documentation BP was rechecked or the physician was notified. Review of the facility's "nurses notes" (or 24 hour) log book with vital signs and narrative documentation for January 2017 revealed: -There was documentation on 1/10/17 that Resident #2 was a new admission. The entry documented an admission BP of 189/90. -The logbook contained entries each shift from 1/10/17 to 1/13/17 for Resident #2 being a new resident. -There was no documentation that Resident #2's BP was rechecked or physician was notified that his BP was elevated on 1/12/17, 1/16/17 or 1/18/17. According to the Department of Health and Human Services, National Institute of Health, a blood pressure was considered high if it was greater than 130/80 mm/Hg (millimeters of mercury).	D 273		

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D 273	Continued From page 10 Interviews on 1/18/17 at 3:35 pm and 1/20/17 at 12:10 pm with the Resident Care Director (RCD) revealed: -"If a resident's BP was elevated, the staff should re-check the BP, notify the physician and document in the nurses notes" what was done or said. -She was not aware Resident #2's BP was elevated, and staff had not notified the physician. -Resident #2's physician should have been notified for his BP readings on 1/12/17, 1/16/17, and 1/18/17. -She was uncertain the BP value that would be considered elevated. -She was not aware of a policy for physician notification of BP results that a range was specified. -A policy related to physician notification of BP values could not be provided. Interview on 1/18/17 at 3:45 pm with Resident #2 revealed: -He had lived at the facility for 1 week. -The staff checked his BP daily, and he was aware "it ran high", but reported "I feel normal even when it is high". -He expected the facility to follow his physician's orders. Interview on 1/18/17 at 4:00 pm with a 2nd shift Medication Aide (MA) revealed: -She had worked at the facility for over 2 months. -BP checks were obtained on the first shift by the Personal Care Aides (PCA). Interview on 1/18/17 at 4:30 pm with the Administrator in Training revealed: -If BP's were elevated, the staff were to notify the physician, document and re-check the BP. -He was uncertain the BP value that would be	D 273	**Policy to notify physicians relating to BP values for specific parameters** **Exhibit B-4** **Staff re-training on BP protocal and Protocol sheet in 24 hour note book and hot box charting and on information board** **Exhibit B-2** **Exhibit B-3** **Exhibit B-4** **Exhibit B-5**	**2/1/17** **2/10/17**

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D 273	Continued From page 11 considered elevated. -He was not aware of a policy for physician notification of BP results that a range was specified. Telephone interview on 1/19/17 at 4:00 pm with Resident #2's physician's office representative revealed: -There was no documentation the physician had been notified that Resident #2's BP had been elevated on 1/12/17, 1/16/17 or 1/18/17 when the BP results ranged from 156/88 to 209/124. -There were no parameters in the office records for when the facility was to notify the physician for. -She was "sure the physician would want to know when Resident #2's BP was 'that high'". Interview on 1/20/17 at 11:50 am with a Personal Care Aide (PCA) revealed: -The first shift PCAs checked the BP's and recorded the results on a log sheet which was given to the MA to enter into the electronic MAR (eMAR) system. -"If a BP was elevated, I report the BP to the MA sooner than waiting to finish all the BP checks." -Usually she rechecked a BP if the systolic BP was higher than 170 unless that is the "normal range the resident's BP runs". -She could not state a normal BP value or range. -"The MA notifies the physician if necessary." Interview on 1/20/17 at 11:55 am with a MA revealed: -The PCA's check BP's, documented the results on a log sheet that was turned into the MA for entering into the eMAR system. If the BP was elevated, "usually I let the resident sit for a bit and re-check the BP. If it is still elevated I call the physician."	D 273		

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D 273	Continued From page 12 -She was uncertain what value should be considered a high BP. -She had not taken Resident #2's BP, but would have notified the physician when it was "that high". -"Everyone's BP was different." -She could not state a normal BP value or range. -She was not aware if the facility had a policy for specific parameters for elevated BP to notify a physician. -Documentation of physician notification was recorded in the 24 hour log book kept at the MA station. A policy related to physician notification of BP values could not be provided. Attempted interview on 1/20/17 with a MA responsible for documenting Resident #2's BP on 1/12/17, 1/16/17 and 1/18/17 was not successful. C. Review of Resident #1's current FL-2 dated 10/14/16 revealed: -Diagnoses included bipolar disease, anxiety disorder, colitis, chronic obstructive pulmonary disease (COPD), and pancreatitis. -A physician's order to check blood pressure (BP) and pulse weekly. 1. Review of Resident #1's record revealed: -A physician's order dated 11/11/16 for hydrochlorothiazide 12.5 mg daily (used to treat high BP). Review of Resident #1's November 2016 electronic Medication Administration Record (eMAR) revealed: -An entry to "record BP weekly" and scheduled for 9:00 am on Mondays. -BP results were documented weekly as ordered	D 273		

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D 273	Continued From page 13 and ranged from 119/73 to 176/90. -BP was recorded as 158/77 on 11/07/17 at 9:00 am and no documentation BP was rechecked or the physician was notified. -BP was recorded as 176/90 on 11/14/16 at 9:00 am and no documentation BP was rechecked or the physician was notified. -BP was recorded as 159/76 on 11/21/17 at 9:00 am and no documentation BP was rechecked or the physician was notified. -Three of 4 systolic BP results posted in November 2016 were greater than 150. Review of Resident #1's December 2016 eMAR revealed: -An entry to "record BP weekly" and scheduled for 9:00 am on Mondays. -BP results were documented weekly as ordered and ranged from 131/71 to 157/77. -BP was recorded as 151/77 on 12/05/17 at 9:00 am and no documentation BP was rechecked or the physician was notified. -BP was recorded as 157/77 on 12/12/17 at 9:00 am and no documentation BP was rechecked or the physician was notified. -Two of 4 systolic BP results posted in December 2016 were greater than 150. Review of Resident #1's January 2017 eMAR on 1/20/17 revealed: -An entry to "record BP, pulse and respirations weekly on Mondays" and scheduled for 8:00 am on Mondays. -BP results were documented weekly as ordered and ranged from 118/80 to 182/77. -BP was recorded as 182/77 on 1/09/17 at 8:00 am and no documentation BP was rechecked or the physician was notified. -One of 3 systolic BP results posted in January 2017 were greater than 150.	D 273		

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D 273	Continued From page 14 According to the Department of Health and Human Services, National Institute of Health, a blood pressure was considered high if it was greater than 130/80 mm/Hg (millimeters of mercury). Review of the facility's "nurses notes" (or 24 hour) log book with vital signs and narrative documentation revealed there was no documentation that Resident #1's BP was rechecked on 11/14/16 or 1/09/17 or that her physician was notified of the elevations. Interviews on 1/18/17 at 3:35 pm and 1/20/17 at 12:10 pm with the Resident Care Director (RCD) revealed: -"If a resident's BP was elevated, the staff should re-check the BP, notify the physician and document in the nurses notes" what was done or said. -She was uncertain the BP value that would be considered elevated. -She was not aware of a policy for physician notification of BP results that a range was specified. -A policy related to physician notification of BP values could not be provided. Interview on 1/18/17 at 4:30 pm with the Administrator in Training revealed: -If BP's were elevated, the staff were to notify the physician, document and re-check the BP. -He was uncertain of the BP value which would be considered elevated. -He was not aware if the facility had a policy for physician notification of BP results. Interview on 1/20/17 at 11:50 am with a Personal Care Aide (PCA) revealed:	D 273		

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D 273	Continued From page 15 -The first shift PCAs checked the BP's and recorded the results on a log sheet which was given to the MA to enter into the electronic MAR (eMAR) system. -She could not remember if she had taken Resident #2's BP on the dates they were elevated. -"If a BP was elevated, I report the BP to the MA sooner than waiting to finish all the BP checks." -Usually she rechecked a BP if the systolic BP was higher than 170 unless that was the "normal range the resident's BP runs". -"The MA notifies the physician if necessary." Interview on 1/20/17 at 11:55 am with a MA revealed: -The PCA's check BP's and document the results on a log sheet that was turned into the MA for entering into the eMAR system. If the BP was elevated, "usually I let the resident sit for a bit and re-check the BP. If it is still elevated I call the physician." -She was uncertain what value would be considered a high BP. -"Everyone's BP was different." -She was not aware if the facility had a policy for specific parameters for elevated BP to notify a physician. -Documentation of physician notification was recorded in the 24 hour log book kept at the MA station. Interview on 1/20/17 at 12:00 pm with Resident#1 revealed: -The staff checked her BP every Monday and reported the results to her. It had "never been in the danger zone". -If her BP was elevated, the staff "let me rest then rechecked it. I know the MA is notified". -She was on a medication for her BP.	D 273		

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D 273	Continued From page 16 Interview on 1/20/17 at 12:35 pm with Resident #1's Nurse Practitioner (NP) revealed: -There was documentation in the office files dated 1/06/17 that the physician did an "oversight visit" for notification of elevated BP, and Resident #1 "was also seen by the other NP" on 1/06/17. "Her BP was stable at the visit" with her systolic BP 130. -She would expect the facility to notify the physician or NP if Resident #1's BP was elevated, as her medications might need to be adjusted. 2. Review of Resident #1's record revealed: -A Nurse Practitioner's (NP) order dated 10/28/16 from an onsite visit to "please refer to gynecology for evaluation for pessary due to urinary incontinence". -There was no documentation in the record that the gynecology referral appointment was made. -There was no documentation in the record that Resident #1 was seen by a gynecologist. Interview on 1/20/17 at 10:30 am with the facility transportation staff revealed: -She transported all residents to their off-site appointments. -She had not taken Resident #1 to a gynecology appointment. -"Since Resident #1 sees the NP here, I do not touch those orders. If I take a resident to an appointment, either the resident or I give the orders to a MA" on our return to the facility. -The Resident Care Director (RCD) was responsible for scheduling appointments. Interview on 1/20/17 at 12:00 pm with Resident #1 revealed: -She saw her physician or the NP when they rounded at the facility.	D 273	**Employees trained on new BP Protocol Exhibit B-2** **New BP Protocol System in place Exhibit B-3** **RCD is checking Quick Mar daily Exhibit B-4 Exhibit B-5** **Resident #1-did not have insurance that Would cover the doctor appointment so that it could be done in Rowan County. Resident was waiting to get insurance coverage to cover the cost of the procedure. Insurance has been changed and appointment has already been made Exhibit C-2.** C. I	**2/15/17** **2/15/17** **1/21/17** **1/26/17 1/31/1**

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D 273	Continued From page 17 -She was aware she was to see a gynecologist, but had not seen them yet. -"I think they made an appointment for a gynecologist", but was not sure if the NP or the facility made her appointments. Interview on 1/20/17 at 12:35 pm with Resident #1's NP revealed: -There was a note in the office files that Resident #1 was referred to a gynecologist, but "we do not make appointments". -They expected the facility to follow any physician or NP orders, which included referral appointments. -She was not aware Resident #1 had not been seen by a gynecologist. Interview on 1/20/17 at 12:50 pm with the Administrator in Training revealed: -He expected his staff to follow-up with any appointments ordered by the physician or the NP. -The RCD was responsible for scheduling appointments as ordered. Interview on 1/20/17 at 1:05 pm with the Resident Care Director revealed: -She was not aware of the gynecology referral order. -She had not made an appointment for Resident #1 to be seen by a gynecologist. -She had checked with Resident #1 for her preference for a gynecologist, and reported Resident #1 had not seen a gynecologist since her move to North Carolina a few years ago. -An appointment would be made. -She was responsible for making sure that physician's orders were followed. -She was responsible for making appointments, but had no specific tracking system in place or log book.	D 273		

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{D 276}	Continued From page 20 restricted." -Resident #4 was to restrict fluid as previously directed upon discharge. Review of an emergency room discharge note dated 12/11/16 revealed Resident #4 had a fall secondary to orthostatic hypotension. Review of Resident #4's fluid intake log revealed: -Documentation in the notebook started 10/26/16 through 11/15/16. -The documentation had no shift or daily totals. -The documentation skipped shifts and entire days. -The documentation included non-specific units of measurement including the terms "bottle" and "glass". -The staff documented Resident #4 exceeded the 1500 ml restriction 7 times from 10/26/16 through 11/15/16. -Examples of documentation included: -Documentation on 10/27/16, third shift documented Resident #4 had two cups of coffee. -Documentation on 10/27/16, second shift documented Resident #4 had a half a cup of tea at dinner and 1 cup of water at 8:00 pm. -Documentation on 10/28/16, Resident #4 had 16 ounces of coffee in the morning. -Documentation on 10/29/16, second shift documented Resident #4 had one glass of tea at dinner, one cup of liquid at snack, one bottle of soda at 3:20 pm, one cup of water at 4:00 pm and one cup of water at 8:00 pm. -Documentation on 10/31/16 Resident #4 has 16 ounces of coffee and 5 ounces of orange juice for breakfast, 5 ounces of water at 8:00 am, 8 ounces of tea at lunch, 16 ounces of soda and 6 ounces of punch for 2 pm snack. A total of 56 ounces (1680 ml) on first shift.	{D 276}		

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{D 276}	Continued From page 21 Interview with a Personal Care Aide (PCA) on 11/19/17 at 11:52 am revealed: -She documented what they observed Resident #4 drink. -Resident #4 was no longer on fluid restriction. -There was, at one time, a sign on the refrigerator in the kitchen where staff was to document what they observed him drink. -She did not know how many ounces were in a cup. -She did not know when to offering him fluids she only documented what she observed him drink. -She thought the Medication Aides kept track of what Resident #4 drank in a day and expected they would limit him. Interview with a Dietary Aide on 1/19/16 at 10:52 am revealed: -She was unaware that Resident #4 was on fluid restriction. -She would provide him with unsweet tea because he is on a diabetic diet but she did not document how much she provided him or how much he drank. Interview with two PCAs 1/19/17 at 11:10 am: -No one in the facility was on fluid restrictions. -They remembered when Resident #4 was on fluid restrictions and they would write down what they observed him drinking. -They did not add shift or daily totals. -They did not know what his fluid limit was. -They did not know how many milliliters were in one ounce. Interview with a Medication Aide on 1/19/17 at 3:21 pm revealed: -No one looked at the shift or daily totals of his fluid intake. -They wrote down what they observed him drink.	{D 276}		

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{D 276}	Continued From page 22 -There was no way to know how much he acutally drank in a day. -She did not know how many milliliters were in an ounces or how many ounces would be equal to his daily fluid allotment. Interview with the Resident Care Director (RCD) on 1/19/17 at 8:54 am revealed: -Staff wrote down what they observed Resident #4 drink. -She did not think that Resident #4 was on fluid restrictions anymore. Interview with the Resident Care Director (RCD) on 1/19/17 at 4:26 pm revealed: -There was no plan to divide fluids up throughout the day in efforts to regulate Resident #4's fluid intake. -She and the staff thought Resident #4 was no longer on fluid restriction but she did not have a physician's order to discontinue the fluid restrictions. -She spoke with the social worker today at Resident #4's physician office and the social worker confirmed Resident #4 was still to have fluid restricted to 1500 ml per day. Interview with the Registered Nurse at Resident #4's primary physician's office on 1/20/17 at 11:54 am revealed: -Resident #4's physician fully intended Resident #4 to be on fluid restriction of 1500 ml per day. -The physician was not aware that the facility was not restricting Resident #4's fluid. -Fluid is restricted in patients with hyponatremia in efforts to create a balance between the solute and water in the blood. -Fluid restriction is and sodium supplementation are essential in repairing sodium depletion. -They were unaware of Resident #4 having a	{D 276}		

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{D 276}	Continued From page 23 sodium serum level of 124 on 12/09/16. -Hyponatremia can be one of many causes that cause a drop in blood pressure leading to orthostatic hypotension and falls. -The physician could not say that the fall on 12/11/16 was ultimately related to hyponatremia but it was possible. -Resident #4 had an office visit to have the stitches removed from his head that were the result of the fall on 12/11/16. Interview with the visiting Nurse Practitioner (NP) on 1/20/17 at 11:05 am revealed: -She had just started as the facility's NP. -She had not seen Resident #4. -She could not say that restricting Resident #4's fluids properly or starting the sodium chloride caused the fall but it was possible these things could have contributed to the fall. -The cause of the fall would depend on if the resident had a history of falls or what other factors may have been present to contribute to the fall. -Fluid restriction was very hard to implement in the assisted living setting given the staff could not watch the resident at all times. Observation of Resident #4 on 1/20/17 at 3:30 pm revealed he was outside in the courtyard with a 16 ounces diet soda. Interview with Resident #4 on 1/20/17 at 3:30 pm revealed: -He did not think anyone observed what he had to drink. -He did not monitor his fluid intake. -He would drink what he wanted when he was thirsty. -He "stayed thirsty".	{D 276}		

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{D 276}	Continued From page 24 2. Review of Residents #4's physician's order dated 12/09/16 revealed an order for urine and serum osmolality electrolytes for the diagnosis of hyponatremia and to send the results of the sodium laboratory results to the primary care physician and that Resident #4 was started on sodium chloride tablets. Review of Resident #4's record revealed there were no laboratory results of urine osmolality or urine electrolytes. Review of Resident #4's serum electrolytes dated 12/09/16 revealed a sodium level of 124 (normal range 136-144). Review of an emergency room discharge note dated 12/11/16 revealed Resident #4 had a fall secondary to orthostatic hypotension. Interview with the Registered Nurse at Resident #4's primary physician's office on 1/19/17 at 9:52 am revealed -Their office had not received laboratory results of a urine electrolytes as ordered by the facility physician on 12/09/16. -Hyponatremia can be one of many causes that cause a drop in blood pressure leading to orthostatic hypotension and falls. -The physician could not say that the fall on 12/11/16 was ultimately related to hyponatremia but it was possible. -Resident #4 had an office visit to have the stitches removed from his head that were the result of the fall on 12/11/16. Interview with the Resident Care Director on 1/19/17 at 11:27 am revealed: -There was no process in place to ensure laboratory was obtained and reviewed by the	{D 276}	**Tracking form for New Orders Exhibit C-1**	**1/20/17**

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{D 276}	Continued From page 25 ordering physician. -Laboratory orders were faxed straight from the facility's physician to the facility's laboratory company. -The facility's laboratory company drew blood but did not obtain urine samples. -The facility staff would obtain the urine samples and the facility's laboratory company would process the urine. -She could not find any results for Resident #4's urine electrolytes. -She did not know why the laboratory tests were not obtained. Interview with the Administrator on 1/19/17 at 4:30 pm revealed: -He was not aware of Resident #4's laboratory orders for urine electrolytes or urine osmolality. -He expected the RCD to ensure all lab orders were obtained and filed in the residents records after having been reviewed by the physician. -He did not know why this had not occurred. Interview with Resident #4 on 1/20/17 at 3:30 pm revealed he did recall giving a urine sample at this facility. B. Review of Resident #5's current FL2 dated 9/16/16 revealed diagnoses included mood disorders, borderline personality disorder and lithium toxicity. 1. Review of Resident #5's physician order dated 12/29/16 revealed orders to start depakote 125 mg three times daily and to obtain a valproic acid level in one week (depakote is a medication used to treat a variety of seizure and mood disorders). Review of Resident #5's record revealed there were no results for a valproic acid level (valproic	{D 276}		

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{D 276}	Continued From page 26 acid test is used to measure and monitor the amount of valproic acid in the blood and determine whether the drug concentration is within the therapeutic range). Interview with a Medication Aide on 1/19/17 at 3:21 pm revealed: -The physician's office was to fax all laboratory orders to the facility's contracted laboratory. -The results were faxed to the facility. -There was no system in place to check to ensure all ordered laboratory work was complete and reviewed by the ordering physician. -If she received a laboratory order she made a copy for the resident record and place another copy under the Resident Care Director's door. Interview with the Resident Care Director on 1/19/17 at 11:27 am revealed: -The contracting physician emails all the laboratory orders and the laboratory's phlebotomist comes to the facility and draws the ordered laboratory tests. -The laboratory emailed or faxed the labs to the ordering physician. -She did not see Resident #5's valproic acid order dated 12/29/16. -A copy of the laboratory order was not placed under her office door. -The MAs were responsible for ensuring that the laboratory orders were drawn by the contracted company. -The order for Resident #5's valproic acid level was not in the new order tracking book therefore she did not know who received the order and failed to process it correctly. -There was no system in place to ensure all of the laboratory orders were obtained, processed by the laboratory and reviewed by the ordering practitioner.	{D 276}	**Tracking form put in place Exhibit B-4**	**1/20/17**

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{D 276}	Continued From page 27 -A valproic acid level was not obtained. Interview with a representative from the visiting physician's office on 1/20/17 at 8:53 am revealed: -The visiting practitioner would write orders to have laboratory orders drawn. -She would submit the orders to the contracted laboratory only if she knew that the resident used that laboratory. -Some [illegible] facility is responsible for getting those orders to the home health agency. -She thought Resident #5 was a home health client and did not order Resident #5's laboratory orders through the contracted laboratory. -There is no clear list or method to determine if a resident is on home health or if a resident utilized the contracted laboratory. -A valproic acid level was monitored to ensure the dose prescribed was within therapeutic range. -It was possible to reach toxic levels of the medication and potentially go to the hospital for medication toxicity. Interview with the Administrator on 1/19/17 at 4:30 pm revealed: -He was not aware of Resident #5's laboratory orders for a valproic acid level. -He expected the RCD to ensure all lab orders were obtained and filed in the residents records after having been reviewed by the physician. -He did not know why this had not occurred. The facility provided a Plan of Protection on 1/20/17 as follows: -The facility will immediately refuse all ambiguous or untrackable orders (example fluid restrictions). -The RCD will directly implement all new orders and cancellations for all medicaotn's, laboratory orders, labs and physician office visits on a daily	{D 276}	New Tracking form includes method To co-ordinate resident care with Multiple providers Exhibit B-4	1/20/17

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{D 276}	Continued From page 28 basis. -The facility has promoted a senior medication aide to assist the RCD with the sole duty of reviewing all medication orders, laboratory orders and doctor visits for changes and accuracy on a daily basis. -The RCD will use the tracking form to ensure all laboratory orders and requested doctor visits are completed. -The administrator will review the tracking sheet daily for one month and weekly going forward. -The RCD and assistant RCD will review all current charts to ensure all medication orders, laboratory orders and doctors visits are correct and complete. -The facility will continue to refuse all ambiguous or untrackable orders (example fluid restrictions). -The RCD will continue to directly implement all new orders and cancellations for all medicaotn's, laboratory orders, labs and physician office visits on a daily basis. -The assistant RCD to assist the RCD with the sole duty of reviewing all medication orders, laboratory orders and doctor visits for accuracy. -The RCD will use the tracking form to ensure all laboratory orders and requested doctor visits are completed. -The administrator will review the tracking sheet daily for one month and weekly going forward. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 6, 2017.	{D 276}	**RCD is reviewing all new orders daily** **Exhibit D-1** **Exhibit D-2**	**1/23/17**
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner	D 344		

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D 344	Continued From page 29 for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify and verify medication orders for 1 of 5 sampled residents (Resident #2) within 24 hours of admission who was being administered medications for hypertension, anti-psychotics, and diabetes. The findings are: A. Review of Resident #2's current FL-2 dated 7/05/16 revealed: -It was from a previous facility. -Diagnoses included diabetes, hypertension, paranoid schizophrenia, and lithium toxicity. -The medication area was marked "see attached" but there were no medication orders attached or listed. Review of Resident #2's Resident Register revealed an admission date of 12/12/16 to another facility, but a new Resident Register supplied on 1/20/17 revealed an admission date of 1/11/17 to this facility. Interview on 1/18/17 at 2:00 pm with the Resident	D 344		

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{D 358}	Continued From page 40 -She did not know Resident #4 had an order to hold insulin. -She did have a new order tracking form and order was attached, however the form was not filled out. -She did not know if the order was faxed to the pharmacy. -She expected the MAs to fax the order to the pharmacy and the order be entered by the pharmacy. -MAs were also expected to call the pharmacy and make sure the pharmacy received the faxed order. -There was no system in place to ensure that the new orders faxed to the pharmacy had been entered correctly into the eMAR. Interview with the Administrator-in-Training (AIT) on 1/19/17 at 4:30 pm revealed: -He was not aware Resident #4 had an order to hold Lantus insulin. -He did not know that Resident #4's Lantus insulin had not been held. -He expected that the MAs or the RCD fax the physician orders to the pharmacy and make sure they were correctly entered into the eMAR. -He did not know why this did not occur. 3. Review of a physician's order dated 11/18/16 revealed an order which documented the following: "Please note a few changes now per pharmacy recommendations, decrease aspirin to 81 mg especially with falls." Review of the November, December 2016 and January 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for aspirin 325 mg to be administered daily at 8:00 am. -The aspirin 325 mg was documented as	{D 358}		

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{D 358}	Continued From page 41 administered daily at 8:00 am. Observation of medications on hand on 1/19/17 revealed one bottle of aspirin 325 mg approximately half full, filled 8/17/16. Telephone interview with a representative from the previous contracted pharmacy on 1/20/17 at 10:26 am revealed the pharmacy did not receive an order to decrease aspirin to 81 mg daily. Interview with a Registered Nurse at Resident #4's primary physician's office on 1/19/17 at 9:52 am revealed: -There was a pharmacist consult note with a physician response which included the following, "Please note a few changes now per pharmacy recommendations to 1. hold Lantus, 2 decrease aspirin to 81 mg." -There were no calls from the facility to clarify or verify the orders to decrease the aspirin. -The physician was not aware Resident #4 was receiving aspirin 325 mg daily in November and December 2016 and January 2017. Interview with a Medication Aide (MA) on 1/19/27 at 3:13 pm revealed: -The MAs are expected to implement the physician's order and document in the progress notes. -She never saw the order to decrease aspirin to 81 mg daily. Interview with the Resident Care Director (RCD) on 1/19/17 at 10:00 am revealed: -She did not know that Resident #4 had an order to decrease aspirin to 8 mg daily. -She did have a new order tracking form and that order was attached however the form was not filled out.	{D 358}		

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{D 358}	Continued From page 42 -She did not know if the order was faxed to the pharmacy. -She expected the MAs to fax the order to the pharmacy and the order be entered by the pharmacy. -MAs were also expected to call the pharmacy and make sure the pharmacy received the faxed order. -There was no system in place to ensure that the new orders faxed to the pharmacy had been entered correctly into the eMAR. Interview with the Administrator-in-Training (AIT) on 1/19/17 at 4:30 pm revealed: -He was not aware Resident #4 had an order to decrease aspirin to 81 mg daily. -He did not know that Resident #4's aspirin had not been decreased. -He expected that the MAs or the RCD fax the physician orders to the pharmacy and make sure they were correctly entered into the eMAR. -He did not know why this did not occur. B. Review of Resident #2's current FL-2 dated 12/22/16 revealed: -Diagnoses included diabetes, hypertension, paranoid schizophrenia, lithium toxicity, and pneumonia. -A physician's order for Hydrophilic cream "apply topically to affected area" (a moisturizer used to treat dry skin). -A physician's order for Ketoconazole 2% cream "apply topically to affected area" (an antifungal cream used to treat scaly areas on skin). Review of Resident #2's Resident Register revealed an admission date of 1/11/17 to the current facility.	{D 358}		

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{D 358}	Continued From page 43 Review of Resident #2's record revealed: -A physician's order dated 12/29/16 for "Ketoconazole 2% cream "apply to affected areas daily". -There was no documentation for where the hydrophilic cream or Ketoconazole cream were to be applied. -There was no physician's order for how often the hydrophilic cream was to be applied. -There was no documentation in the record regarding a foot rash, itching complaint or discoloration. Review of Resident #2's January 2017 MAR revealed: -An entry for hydrocerin cream to "apply topically to (left blank) affected areas every day", with a "need clarification on frequency" notation. It was documented as administered daily at 8:00 am from 1/11/17 to 1/18/17. -An entry for Ketoconazole 2% cream "apply topically to (left blank) affected areas every day", with a "need clarification on frequency" notation. It was documented as administered daily at 8:00 am from 1/11/17 to 1/18/17. Observation of Resident #2's medication on hand for administration on 1/18/17 at 4:00 pm revealed: -A 1 pound container of hydrocerin cream dispensed on 7/25/16 from a local government pharmacy with approximately 2 tablespoons removed from the container. The label stated 2 of 3 refills remained. The container lid was labeled with a black marker to "use daily at 8:00 am". -A 60 g tube of Ketoconazole 2% cream dispensed on 8/09/16 from a local government pharmacy with approximately 3/4 of the tube remaining. The label stated 1 of 2 refills remained.	{D 358}		

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{D 358}	Continued From page 44 Interview on 1/18/17 at 8:45 am with Resident #2 revealed "my feet are tore up, they are killing me", and asked that it be investigated. Second interview on 1/18/17 at 3:45 pm with Resident #2 revealed: -He had lived at this facility for 1 week. -He reported the tops of both feet had a rash that itched. -"Back in July they put an ointment on my feet, but it was only one time." -He "had not been getting any ointments (applied) since he had lived at this facility". -He was not aware if he had any ointments or creams ordered, but he had notified the staff that his feet itched. Observation of Resident #2 on 1/18/17 at 3:45 pm revealed: -Resident #2 was sitting in a chair in his room. -He removed his right shoe and sock to show the surveyor his foot rash. -A dark brown area of discoloration on the anterior of his foot with ashy dry skin on the anterior and bilateral sides of his foot was observed with a few red bumps noted on the anterior, upper area of the foot below the ankle. He stated that the area that itched was a band approximately 2 1/2 inches wide across the area immediately below and towards the ankle. There were no broken or open areas noted. -He stated his left foot looked the same. Interview on 1/18/17 at 4:30 pm with the Administrator in Training revealed: -He expected the staff to administer medications as ordered and to clarify orders as necessary. -He expected the staff to administer medications as documented. -Resident #2 often refused baths and assistance,	{D 358}		

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{D 358}	Continued From page 45 and often needed encouragement, so he could understand if a medication, like an ointment, was not given, but then he expected the staff to document a refusal. -He was not aware Resident #2 was not administered his foot medications. Second interview on 1/19/17 at 8:15 am with Resident #2 revealed: -His foot creams had been given to him 1/18/16 by the second shift Medication Aide (MA), and his feet felt much better. -He had not received his medications this morning yet. Interview on 1/19/17 at 8:25 am with a first shift MA revealed: -She had not administered medications 1/18/17, but that MA was not working today. -She had administered medications to Resident #2 since his admission last week. -She tried to administer pills and ointments/creams separately and administered the creams at a later time. -She admitted that she would sign the creams as administered at the same time she signed pill medications as administered, but frequently forgot to administer the creams. -She was aware she should not document a medication until it had been administered. -She thought "maybe the times could be changed so that they would not be administered at the same time as pills", but was not sure if the facility or the pharmacy could make that change. Interview on 1/19/17 at 8:40 am with the Resident Care Director (RCD) revealed: -She checked the MARs for accuracy the first week of every month. -She was not aware the MA were documenting	{D 358}		

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{D 358}	Continued From page 46 Resident #2's foot medications and not administering them. -The staff were to document a medication as administered after it had been administered to the resident. Observation of and interview with Resident #2 on 1/19/17 at 10:15 am revealed: -He was sitting in the chair in his room with his socks and shoes off. His feel were not ashy, had no redness or breakdown. -He confirmed his foot medications had just been applied and "he was letting them soak in before putting his socks and shoes back on". -He stated that his feet already felt better and no longer itched. Attempted telephone interview on 1/19/17 at 10:45 am with Resident #1's a local government pharmacy was not successful. Interview on 1/19/17 with the first shift MA working 1/18/17 was not available. Interview on 1/19/17 at 4:00 pm with Resident #2's physician's office representative revealed: -There had been no request for orders since Resident #2's admission to the facility 1/10/17. -They expected medications to be administered as ordered to Resident #2. C. Review of Resident #1's current FL-2 dated 10/14/16 revealed: -Diagnoses included bipolar disease, anxiety disorder, colitis, chronic obstructive pulmonary disease (COPD), muscle spasms and pancreatitis. -A physician's order for Morphine Sulfate (a narcotic pain medication) extended release (ER) 30 mg every 8 hours and to hold for sedation .	{D 358}		

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{D 358}	Continued From page 47 Review of Resident #1's record revealed: -A hard script dated 10/14/16 and signed by the Nurse Practitioner (NP) for Norco 5/325 mg daily as needed for pain for 14 tablets and no refills (a narcotic pain reliever containing acetaminophen and hydrocodone). -A NP order from a visit dated 10/28/16 to increase the Norco 5/325 to 2 times a day as needed for pain. -A hard script dated 11/11/16 and signed by the NP for Norco 5/325 mg daily as needed for pain not within 1 hour of MS Contin (a narcotic pain medication containing Morphine) for 50 tablets and no refills. Review of Resident #1's pharmacy review dated 12/27/16 revealed no recommendations regarding norco or MS Contin. Review of Resident #1's November 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for morphine sulfate 30 mg ER (also named MS Contin) every 8 hours and to hold for sedation. It was documented as administered as scheduled at 12:00 am, 8:00 am, and 4:00 pm from 11/01/16 to 11/30/16. -An entry for norco 5/325mg "2 times a day as needed for pain- can be given within an hour of Morphine (hold for sedation)" and documented as administered at least daily from 11/01/16 to 11/30/16. The pharmacy transcription was not entered as per the 11/11/16 physician's order for "not within 1 hour of MS Contin", and there was no documentation that the facility corrected the error. -Documentation that norco 5/325 mg was administered more than 2 times a day on 4 of 30 days in November on the following dates :	{D 358}		

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{D 358}	Continued From page 48 11/06/16, 11/07/16, 11/22/16, and 11/30/16. -Documentation that norco 5/325 mg was administered for pain on 11/06/16 at 1:59 am, 1:36 pm, and 7:14 pm. -Documentation that norco 5/325 mg was administered for pain on 11/07/16 at 3:00 am, 11:36 am, and 7:53 pm. -Documentation that norco 5/325 mg was administered for pain on 11/22/16 at 3:04 pm, 1:39 pm, and 9:07 pm. -Documentation that norco 5/325 mg was administered for pain on 11/30/16 at 1:47 am, 1:24 pm, and 10:34 pm. -Documentation that norco 5/325 mg was administered for pain on 11/12/16 at 7:22 am and 11/26/16 at 12:35 am which were within one hour of MS Contin documented administration times of 12:00 am, 8:00 am, and 4:00 pm for a total of 2 times. Review of Resident #1's December 2016 eMAR revealed: -An entry for morphine sulfate 30 mg ER (MS Contin) every 8 hours and to hold for sedation. It was documented as administered as scheduled at 12:00 am, 8:00 am, and 4:00 pm from 12/01/16 to 12/31/16. -An entry for norco 5/325 mg "2 times a day as needed for pain- can be given within an hour of Morphine (hold for sedation)" and documented as administered at least daily from 12/01/16 to 12/03/16. The pharmacy transcription was not entered as per the 11/11/16 physician's order for "not within 1 hour of MS Contin". -An entry dated 12/05/16 for norco 5/325 mg "2 times a day as needed for pain- not to be given within one hour of Morphine (hold for sedation)" and documented as administered at least daily from 12/06/16 to 12/31/16. -Documentation that norco 5/325 mg was	{D 358}		

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{D 358}	Continued From page 49 administered more than 2 times a day on 1 of 31 days in December on 12/07/16. -Documentation that norco 5/325 mg was administered for pain on 12/07/16 at 2:00 am, 1:23 pm, and 8:21 pm. -Documentation that norco 5/325 mg was administered for pain on 12/12/16 at 3:18 pm, 12/25/16 at 7:50 am and 12/28/16 at 8:34 am which were within one hour of MS Contin documented administration times of 12:00 am, 8:00 am, and 4:00 pm for a total of 3 times. Review of Resident #1's January 2017 eMAR revealed: -An entry for morphine sulfate 30 mg ER (MS Contin) every 8 hours and to hold for sedation. It was documented as administered as scheduled at 12:00 am, 8:00 am, and 4:00 pm from 1/01/17 to 1/20/17. -An entry dated 12/12/16 for norco 5/325 mg "2 times a day as needed for pain- not to be given within one hour of Morphine" and documented as administered at least daily from 1/01/17 to 1/19/17. -There was no documentation that norco 5/325 mg was administered more than 2 times a day. -Documentation that norco 5/325 mg was administered for pain on 1/04/17 at 7:27 am, 1/05/17 at 3:26 pm, 1/12/17 at 7:38 am, 1/13/17 at 7:48 am, 1/14/17 at 4:32 pm, 1/17/17 at 7:37 am, and 1/17/17 at 4:11 pm which were within one hour of MS Contin documented administration times of 12:00 am, 8:00 am, and 4:00 pm for a total of 7 times. Review of Resident #1's norco 5/325 mg controlled drug count sheets on 1/20/17 revealed the medications were signed out matching the administration dates and times on the eMAR, and the count was matching the medications on hand	{D 358}		

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(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 358}	Continued From page 50 (33 of 60 tablets dispensed on 1/02/17 were available for administration). Interview on 1/18/17 at 4:30 pm with the Administrator in Training revealed he expected the staff to administer medications as ordered and to clarify orders as necessary. Interview on 1/19/17 at 8:40 am with the Resident Care Director (RCD) revealed: -She checked the eMARs for accuracy the first week of every month. -She had not noticed the "can be given within one hour of Morphine" on the November and December MARs when it should be "not within one hour". Interview on 1/20/17 at 12:00 pm with Resident #1 revealed: -The facility staff administered her medications. -She was on scheduled and as necessary (prn) pain medications. -"I can have my prn (pain medications) 2 times from midnight to midnight. I'm not getting them more often than that." Interview on 1/20/17 at 12:35 pm with Resident #1's Nurse Practioner (NP) revealed: -Resident #1 was seen by the pain clinic who handled her pain medication orders. -She was aware Resident #1 was on hydrocodone and morphine. Attempted telephone interview on 1/20/17 with Resident #1's pain clinic representative was not successful.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080006	A. BUILDING: _____ B. WING _____	R-C 01/20/2017

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{D912}	Continued From page 51 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 2 of 5 sampled residents with physician orders for fluid restriction, urine electrolytes (Resident #4) and valproic acid levels (Resident #5). [Refer to Tag 276 10A NCAC 13F .0902(c 3-4) Health Care (Type B Violation)].	{D912}	**RCD is monitoring all medication and Physician orders daily M-F To assure all changes and new orders Are given properly and in a timely manner Exhibit E-1 Exhibit E-2**	**1/23/17**