STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067004	A. BUILDING: _____ B. WING _____	01/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC COMMUNITY	1241 ONSLOW PINES ROAD JACKSONVILLE, NC 28540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on January 18-20 and January 23-24, 2017.	D 000		
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: Based on observations and interviews, the facility failed to assure the walls and floors in the living room, residents' bedrooms, bathrooms and both resident hallways in the facility (Red and Green hallways) were kept clean and in good repair. The findings are: Observation of the Red hallway on 1/18/17 at 11:00am revealed a 2-foot by 2-foot ventilation grate located on the wall across from the men's common-use bathroom that was separated from the wall at the base and heavily coated with grey dust. Observation of the Resident Room #201 on the Red hallway on 1/18/17 at 11:15am revealed a total of 22 exposed black nails in various locations between 4-feet and 8-feet from the floor on all four walls protruding 1-inch from the walls. Observation of the Green hallway's emergency exit double door and floor on 1/18/17 at 11:25am	D 074	All nails not in use for hanging pictures will be removed from the walls.	3/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dona Burree — TITLE: President — (X6) DATE: 3.10.17

Reviewed and Accepted
Chris Clark MSN RN
Facility Nurse Consultant
3/21/17

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D 074	Continued From page 1 revealed: -The 2 door panels did not align in the center and had a 1/4-inch vertical space gap the length of the doors, and there was sunshine visible through the 3/4-inch gap horizontally at the bottom edge where the doors met in the middle. -The wood paneled double doors were covered with greyish brown stains in the center of the panels, with dark brown smudges covering the entire surface of the doors. -The bottom 2 feet of the paneled doors had gouges in the wood and a black stain along the bottom and side edges next to the door frames. -The flooring tiles 6 feet in front of the emergency exit door at the end of the hallway were stained a dark brownish yellow. -The bottom edges of the door frames, along the bottom edges of the floor molding, and the wall corners had brownish black stains and an accumulation of sticky dust. Observation of Resident Room #102 on the Green hallway on 1/18/17 at 11:50am revealed: -The 18-inch square wall area with missing tiles above the sink in the bedroom. -The sheetrock had 3-inch reddish brown stains along the bottom edge. -The hot and cold water pipes below the sink were coated with rust where they entered the wall. Observation of Resident Room #104A on the Green hallway 1/18/17 at 11:47am revealed: -The tile flooring beneath the bedroom sink was stained a yellowish brown color. -The bottom edge of the room's baseboard was stained a blackish brown color. -The hot and cold water pipes below the sink were coated with rust where they entered the wall.	D 074	Any gaps in outside doors have been repaired All missing tiles have been repaired. Room has been painted and water pipes have been replaced Tile flooring has been replaced. Baseboard has been replaced/repaired. Water pipes have been replaced.	3/30/17 3/30/17 3/30/17

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D 074	Continued From page 2 Observation of Resident Room #104B on the Green hallway 1/18/17 at 11:40am revealed: -The bedroom's floor tiles were stained a yellowish brown color. -The floor tiles in the bathroom were stained a yellowish brown color. -The wall tiles at the water line connectors behind the bedroom sink were cut and broken, having a circular 1/2-inch to 1-inch open ing in the wall. -The floor at the base of the toilet was stained a dark brown color, and the grout was covered with blackish brown stains. -The black toilet seat was covered with a white chalky substance. -The hot and cold water pipes below the sink were coated with rust where they entered the wall. Observation of the living room on the Green hall on 01/18/17 at 11:05 a.m. revealed: -There was a metal drain plate near the center of the tiled floor that was sunk in about ½ inch, leaving the floor uneven and a trip hazard. -There were cracks in the tile around the metal drain plate on the floor. Interview with a resident sitting in the living room on the Green hall on 01/18/17 at 11:10 a.m. revealed: -The floor around the metal drain had been that way a while (could not give timeframe). -He had not tripped over the drain because he would walk around it. Interview with a second resident sitting in the living room on the Green hall on 01/18/17 at 12:06 p.m. revealed: -She had lived at the facility for about 6 months and the metal drain plate had been that way since	D 074	All floor tiles have been replaced. Wall tiles have been repaired/replaced. Pipes were replaced. Room was thoroughly cleaned. Metal drain plate near center of room has been repaired leaving the floor leveled. Tile has been repaired/replaced	3/30/17 3/30/17

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D 074	Continued From page 3 she was admitted. -She had not tripped over the drain and she was not aware of anyone else tripping over the drain. Interview with the Unit Coordinator (UC) on 01/18/17 at 5:20 p.m. revealed: -There was a metal drain plate in the floor of the living room on the Green hall because it used to be a beauty shop several years ago. -No one had tripped over the metal drain plate or had any injuries related to the drain plate to her knowledge. -They hoped to get funds for repairs for this facility once repairs had been completed at the sister facility. Observation of the women's common bathroom on the Green hall on 01/18/17 at 11:51 a.m. revealed: -There was an area of missing floor tile near the sink that was about 1 foot long and 2 inches wide. -There was a tile on the wall at the end of the tub that had two broken edges. Interview with the UC on 01/18/17 at 12:20 p.m. revealed: -She was not aware of the broken tile on the floor in the women's bathroom. -She would check the maintenance log to see if it was on the list to be repaired. Interview with the UC on 01/19/17 at 3:45 p.m. revealed the Maintenance staff person was currently working on patching the floor in the living room on the Green hall. Observation of the living room on the Green hall on 01/19/17 at 4:05 p.m. revealed: -The metal drain plate near the center of the floor had been covered with cement.	D 074	All tile has been repaired in common bathrooms.	3/30/17

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D 074	Continued From page 4 -The cement patch over the metal drain plate was lower than the tile around it which left the floor uneven in that area. Interview with the Maintenance Director on 01/19/17 at 4:10 p.m. revealed: -He had covered the metal floor drain in the living room on the Green hall with cement. -That was about the only thing that could be done without redoing the whole floor. -He was aware the patched area was still lower and uneven that the tile around it. Observation of the living room on the Green hall on 01/24/17 at 4:00 p.m. revealed the cement patch over the floor drain had been covered with tile. Interview with the Maintenance Director on 01/24/17 at 4:05 p.m. revealed he patched the floor in the living room on the Green hall with a new piece of tile yesterday on 01/23/17. Interview with the Maintenance Director on 01/18/17 at 12:49 p.m. revealed: -He had worked at the facility for about 3 years. -The facility had a maintenance log where staff would documented any needed repairs. -He would check the maintenance log every morning and he would do a walk-through of the building each morning. -The facility was an older building and needed repairs. -They had to go through the corporate office to get approval for repairs. -The Executive Assistant usually requested approval for any needed repairs from the owner. -Repairs to the building depended on approval and the budget. -He documented any repairs done on the	D 074	Cement patch has been covered with tile to ensure the area is even.	3/30/17

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D 074	Continued From page 5 maintenance log. Interview with the Executive Assistant (EA) on 01/19/17 at 5:10 p.m. -She usually coordinated with the owner for any needed facility repairs. -If a repair was less than $100, she could usually authorize it depending on the type of repair. -For more expensive repairs, she would usually email the owner the same day the needed repairs were brought to her attention. -She would usually hear back from the owner within 24 hours about authorization for needed repairs. -She was going to suggest to get the floor in the living room on the Green hall retiled. -They were also about to start a remodel project for this facility. -This facility's funds were put on hold because repairs were being done at a sister facility. Interview with the Maintenance Director on 1/19/16 at 2:42pm revealed: -He only repaired items that the manager of the facility and staff inform him about. -He had not observed any repair or maintenance issues with the floors or walls -He had not received any repair or maintenance requests for any floors or walls. -If he identified any repairs, he would inform the Unit Coordinator. -The priority and necessity of the repairs was determined by the Unit Coordinator. -There was no timeframe for any identified repairs listed in the maintenance log book to be performed. Interview with the Unit Coordinator on 8/19/16 at 2:45pm revealed: -She was unaware of the gap at the end of the	D 074	All funds necessary will be given to this facility for needed repairs. we have revamped requested and needed repairs to the building, but will continue to use a maintenance log. Any needs are determined and approved by the Executive Director or Executive Assistant for priority and execution.	3/10/17 3/10/17

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D 074	Continued From page 6 Green hallway door and the open space at the bottom of the door. -The door and baseboard on the Green hallway needed weather stripping to keep out pests. -She was aware that some of the floors and walls were in need of repair. -She did not do a scheduled walk-thru the facility on a regular basis to identify repair needs. -Any areas in need of repair were delegated to the Maintenance Director. -If something needed repair, the facility staff, Unit Coordinator or the Administrator informed to the Maintenance Director who would fix the issue. -There was no timeframe for any identified repairs listed in the maintenance log book to be performed.	D 074	It is everyone's responsibility to notify Maintenance Director through maintenance log or if immediate jeepardy verbalize to Executive Director to ensure speedy repairs.	3/10/17
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to have furniture in good repair in the living room on the Green hall, resident rooms (101, 103, 104, 105, 109, 111) on Green hall and resident rooms (116, 118, 119, 200) on the Red hall. The findings are: Observation of Resident Room #119 on the Red hallway on 1/18/17 at 11:12am revealed:	D 076	All furnishings will either be repaired or replaced to ensure residents have favorable living conditions.	3/30/17

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D 076	Continued From page 7 -There was a missing knob on the top drawer of the dresser. -There was a missing knob on the top drawer of the nightstand. Observation of Resident Room #116 on the Red hallway on 1/18/17 at 11:17am revealed: -There was a loose handle on the left side of the top drawer of the dresser. -There was a leather-covered rocking chair with two torn 2-inch square sections on the left and right upper seat-back top corners. Observation of Resident Room #118 on the Red hallway on 1/18/17 at 11:20am revealed a missing knob on the top drawer of the dresser. Observation of Resident Room #200 on the Red hallway on 1/18/17 at 11:22am revealed a nightstand with a peeling laminate top. Observation of Resident Room #104A on the Green hallway on 1/18/17 at 11:50am revealed: -The small bedside table had a drawer with a missing handle and was covered with scrape marks and black smear marks. -The drawer could not be opened. Observation Resident Room #109 on the Green hallway on 1/18/17 at 12:15pm revealed: -The small bedside 3-drawer chest had scratches in the surface across the top and sides of the chest. -The top drawer handle of the chest was loose and hanging diagonally. -The center drawer's handle was missing. Interview with the Resident of room #109 on 1/18/17 at 12:17pm revealed: -The resident was new to the facility.	D 076		

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D 076	Continued From page 8 -The resident could not use the top two drawers on the small chest. -No one had offered to fix the drawer handles. -The resident did not use the chest for storage as all of her clothing and toiletry items were stored in her closet. Observation of Resident Room #111 on the Green hallway on 1/18/17 at 12:17pm revealed: -The small bedside 3-drawer chest had scratches on the top, front and side surfaces. -The top drawer handle of the chest was loose and hanging. Observation of the living room on the Green hall on 01/18/17 at 11:05 a.m. revealed: -There was a green straight back chair with areas of upholstery rubbed off and rips and tears in the material. -There was a long white streak across the back of the green upholstered chair. -There were 2 wooden end tables with multiple scratches and areas of missing stain, exposing the wood underneath. Observation of Resident Room #105 on 01/18/17 at 11:24 a.m. revealed there was a six drawer wooden dresser with the bottom 2 drawers sticking out that were uneven, loose and off the track. Interview with a resident residing in Room #105 on 01/18/17 at 11:24 a.m. revealed the dresser belonged to another resident and she was not sure how long the bottom drawers had been broken. Interview with the Unit Coordinator (UC) on 01/18/17 at 5:20 p.m. revealed: -She was not aware of any problems with the	D 076		

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D 076	Continued From page 9 furniture in Room #105. -She would check on the dresser drawers. Observation of resident Room #103 on 01/18/17 at 11:30 a.m. revealed: -There was a wooden dresser that had scratch marks, white marks, and missing stain on the sides, top, and the front of the drawers. -There were two chest of drawers on each side of the sink in the bedroom that had multiple scratch marks, white marks, and missing stain on the sides and front. -There was a chest of drawer near the door that was missing the top drawer. -The clothes stored in the second drawer were exposed and could be seen through the hole where the top drawer was missing. Interview with the UC on 01/18/17 at 5:20 p.m. revealed: -She was not aware a drawer was missing from furniture in Room #103. -She was aware some of the furniture in the facility needed replacing. -She hoped to get some of the furniture replaced soon. Observation of resident Room #101 on 01/18/17 at 11:47 a.m. revealed there were 2 wooden dressers with multiple scratch marks and missing stain. Interview with the Maintenance Director on 01/18/17 at 12:49 p.m. revealed: -He had worked at the facility for about 3 years. -The facility had a maintenance log where staff would documented any needed repairs. -He would check the maintenance log every morning and he would do a walk-through of the building each morning.	D 076		

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D 076	Continued From page 10 -Approval for repairs had to go through the corporate office. -The Executive Assistant usually requested approval for any needed repairs from the owner. -He had recently thrown out some furniture that needed repair or replacement. -There was other furniture that needed repair or replacement but they have to get approval. -Repairs to the building depended on approval and the budget. -He marked any repairs done on the maintenance log. Interview with the UC on 01/18/17 at 5:20 p.m. revealed: -She hoped to replace some furniture soon but she did not know a timeframe. -She hoped to get funds for repairs and replacement furniture for this facility once repairs had been completed at a sister facility. Interview with the Maintenance Director on 01/19/17 at 4:10 p.m. revealed he was currently working on replacing knobs on doors and furniture. Interview with the Executive Assistant (EA) on 01/19/17 at 5:10 p.m. -She usually coordinated with the owner for any needed facility repairs. -If a repair was less than $100, she could usually authorize it depending on the type of repair. -For more expensive repairs, she would usually email the owner the same day the needed repairs were brought to her attention. -She would usually hear back from the owner within 24 hours about authorization for needed repairs. -The residents sometimes picked the varnish off of the furniture with their hands.	D 076		

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D 076	Continued From page 11 -They had started replacing some of the damaged or worn out furniture over the past several months. -They were also about to start a remodel project for this facility. -When the hurricane caused damage to a sister facility in October 2016, this facility's funds were put on hold because the damaged facility needed repairs. Interview with the Maintenance Director on 1/19/16 at 2:42pm revealed: -He only repaired items that the manager of the facility and staff informed him about. -He had not observed any repair or maintenance issues with the dressers, nightstands or chairs. -He had not received any repair or maintenance requests for any dressers, nightstands or chairs. -If he identified any items in need of replacement or repairs, he would inform the Unit Coordinator. -The priority and necessity of the repairs was determined by the Unit Coordinator. -Approval for purchases for materials for repairs was needed by the Unit Coordinator. -There was no timeframe for any identified repairs listed in the maintenance log book to be performed. Interview with the Administrator on 1/19/16 at 2:45pm revealed: -She was aware that some of the furniture was in need of repair. -She was unaware of the missing drawer knobs in several of the resident rooms. -She did not do a scheduled walk-thru the facility on a regular basis to identify furniture in need of repair or replacement. -Any furniture in need of repair was delegated to the Maintenance Director. -If any furniture needed repair, the facility staff,	D 076		

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D 076	Continued From page 12 Unit Coordinator or the Administrator informed to the Maintenance Director who would fix the issue. -There was no timeframe for any identified repairs listed in the maintenance log book to be performed. -"It was time for new furniture."	D 076		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure resident living rooms, bathrooms' light fixtures, sinks, tubs, showers, shower chairs, bedside commodes, towel bars, closet doors and ceiling lights were maintained in a clean manner and free hazards for both halls of the Special Care Unit (SCU) facility, the Red and Green Halls. The findings are: Observation of Resident Room #119 on 1/18/17 at 11:05am revealed: -There was an missing light cover over the fluorescent bulb light above the sink. -There was a heavily rusted 3-inch-4-inch overflow drain on the white ceramic sink beneath	D 079		

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D 079	Continued From page 13 the faucet. -The faucet and both water handles were heavily corroded. Observation of Resident Room #115 on 1/18/17 at 11:11am revealed: -There was a heavily rusted 3-inch-4-inch area around the overflow drain on the white ceramic sink beneath the faucet. -The faucet and both water handles were heavily corroded. Observation of Resident Room #118 on 1/18/17 at 11:20am revealed: -There was a heavily rusted 3-inch-4-inch overflow drain on the white ceramic sink beneath the faucet. -The sink was clogged. Observation of Resident Room #116 on 1/18/17 at 11:10am revealed the closet had a missing doorknob. Observation of Resident Room #202 on 1/18/17 at 11:05am revealed there were two sets of towel brackets each with a missing towel bar behind the entry door. Observation of the living room on the Green hall on 01/18/17 at 11:05 a.m. revealed: -There were 3 standard wheelchairs, 1 high back wheelchair, and 1 rolling walker stored in the corners of the living room around the furniture. -There was a metal door stop embedded in the floor beside the two sectional green sofa near a doorway that stuck up about 1 and ½ inches from the tile floor and was a trip hazard. -Both doorways to the living room had missing hardware where doors were previously installed.	D 079	All areas of facility that are in need of replacement/ repair have been completed. The facility staff, Executive Director, Executive Assistant, and Unit Coordinator will continuously monitor for areas of repair and improvement. we are unable to discern the problem with the doorways in this sentence.	3/30/17

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D 079	Continued From page 14 Interview with the Unit Coordinator (UC) on 01/18/17 at 5:20 p.m. revealed: -The living room on the Green hall used to be a beauty shop but was transitioned to a living room several years ago. -The living room should not be used to store residents' wheelchairs or walkers. -Staff were supposed to take the wheelchairs and walkers to each individual residents' rooms. Observation of Resident Room #105 on 01/18/17 at 11:24 a.m. revealed: -The white porcelain sink in the bedroom had multiple rust stains on the back of the sink running down to the metal drain plate. -There were rust stains around the metal drain plate of the sink. -There was a build-up of white corrosion on the faucet and knobs on the sink. Interview with a resident residing in Room #105 on 01/18/17 at 11:24 a.m. revealed: -She had been at the facility about 3 months. -She used the sink in the bedroom occasionally and it had always been rusted. Observation of Resident Room #103 on 01/18/17 at 11:30 a.m. revealed: -The white porcelain sink in the bedroom had multiple rust stains on the back of the sink running down to the metal drain plate. -There were rust stains around the metal drain plate of the sink. -There was a build of white corrosion on the faucet and knobs on the sink. Interview with the UC on 01/18/17 at 5:20 p.m. revealed: -The sinks had been rusted and they had tried to remove the rust with chemicals.	D 079	The facility has designated areas for walkers and wheelchairs. Any and all sinks, faucets, and piping that have rust have been repaired or replaced.	3/10/17 3/30/17

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D 079	Continued From page 15 -The rust would not come off of the sinks. Observation of the women's common bathroom on the Green hall on 01/18/17 at 11:51 a.m. revealed: -The white porcelain sink in the room had multiple rust stains on the back of the sink running down to the metal drain plate. -There were rust stains around the metal drain plate of the sink. -There were rust stains around the base of the faucet running down into the sink. -There was a spray bottle of multi-purpose disinfectant cleaner stored on a high shelf near the walk-in shower. -There was a bedside commode in the walk in shower that was filled with urine. -There was a build-up of white soap scum all around the floor and walls of the walk in shower. -The metal drain in the floor of the walk in shower had areas of cracked cement around it. -There was a large trash bag full of clothing sitting on the floor near the tub. -The tub had dirt and debris and a build-up of yellowish brown stains all over. -The metal drain plate in the tub was rusted. -There were 3 dish pans sitting in the window sill above the tub. -The back of the wooden entrance door to the [redacted] -The trash can was full of trash. Interview with the UC on 01/18/17 at 12:20 p.m. revealed: -They had tried chemicals to remove rust from the sinks but it did not work. -The bag of dirty clothes in the bathroom should be taken to the laundry room and not stored in	D 079	All common bathrooms will constantly be monitored by Executive Director, Executive Assistant, Unit Coordinator to ensure Housekeeping and Maintenance repair and maintain all areas found on date of survey.	3/30/17

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D 079	Continued From page 16 the bathroom. -The disinfectant spray was not supposed to be stored in the bathroom (she removed it). -Staff had given a resident a shower and forgot to empty the urine in the bedside commode in the shower. Interview with the Maintenance Director on 01/18/17 at 12:49 p.m. revealed: -He had worked at the facility for about 3 years. -The facility had a maintenance log where staff would document any needed repairs. -He would check the maintenance log every morning and he would do a walk-through of the building each morning. -The facility was an older building and needed repairs. -They had to go through the corporate office to get approval for repairs. -The Executive Assistant usually requested approval for any needed repairs from the owner. -The doors to the living room on the green hall were removed about 1 and ½ years ago so the metal door stop mounted in the floor was not needed. -Repairs to the building depended on approval and the budget. -He marked any repairs done on the maintenance log. Observation of the women's common bathroom on the Green hall on 01/19/17 at 5:40 p.m. revealed: -The trash can was full of trash. -The urine hat from the bedside commode was empty but laying on the floor of the walk-in shower. -The spray bottle of disinfectant cleaner had been removed.	D 079		

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D 079	Continued From page 17 Interview with the UC on 01/19/17 at 3:45 p.m. revealed: -She was holding a metal door stop in her hand. -The Maintenance staff person had just removed the door stop in the living room on the Green hall. Observation of the living room on the Green hall on 01/19/17 at 4:05 p.m. revealed the metal door stop had been removed and the area was patched with cement. Interview with the Housekeeper on 1/23/17 at 2:15pm revealed: -She cleaned all resident rooms and common-use bathrooms daily. -Many of the ceramic tubs, toilets and sinks were old and had areas of corrosion or staining. -She cleaned with approved disinfectants which did not remove heavy stains. -If she was unable to clean any areas due to staining or corrosion, she would let the Unit Coordinator know. -She did not write down requests for stain or corrosion repair. -She went room to room as she cleaned and emptied bedside commodes if needed. -She did not check bedside commodes specifically until she was cleaning the entire room. -Sometimes other staff would empty the bedside commodes when performing resident care. Interview with the Maintenance Director on 1/19/16 at 2:42pm revealed: -He had observed the rusted sinks and faucets. -He would get approval from the Unit Coordinator to purchase supplies prior to performing repairs. -No major repairs such as sink replacements or faucets were performed without the approval from the Unit Coordinator.	D 079	All bedside resident comodes and urinals will be monitored by all facility staff to ensure they are emptied and cleaned within a timely manner after use	3/10/17

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D 079	Continued From page 18 -He had not received approval to repair the sinks and faucets. -If he identified any items in need of replacement or repairs, he would inform the Unit Coordinator. -The priority and necessity of the repairs was determined by the Unit Coordinator. -There was no timeframe for any identified repairs listed in the maintenance log book to be performed. Interview with the Administrator on 8/19/16 at 2:45pm revealed: -She was aware that some of the sinks, faucets and light covers were in need of repair. -She did not provide a reason for the lack of repairs. -She did not do a scheduled walk-thru the facility on a regular basis to identify furniture in need of repair or replacement. -She would perform a walk-thru and identify any sinks and faucets, as well as other items, in need of repair. -There was no timeframe for any identified repairs listed in the maintenance log book to be performed.	D 079	Has been answered in previous pages	3/30/17
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all plumbing equipment in the women's common bathroom on	D 105		

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D 105	Continued From page 19 the Green hall and a sink in resident room #118 on the Red hall was in a safe and operating condition. The findings are: 1. Observation of Resident Room #118 on 1/18/17 at 11:20am revealed- -The bedroom sink was clogged. -A resident was observed using the sink with the drain open and the water reached the top edge of the sink. -When the resident turned the water off, it took 7.5 minutes for the water to drain. -The resident using the sink was unable to be interviewed. Interview with the Housekeeper on 1/23/17 at 2:15pm revealed: -She was unaware that the sink in Resident Room #118 was clogged. -She would inform the Maintenance Director if she had any clogs she could not fix herself. Interview with the Maintenance Director on 1/19/16 at 2:42pm revealed: -He was unaware that the sink in Resident Room #118 was clogged. -He would have it fixed immediately. -Residents unfortunately were not always able to inform staff if something was clogged or needed repair because the residents have memory issues. Interview with the Administrator on 8/19/16 at 2:45pm revealed: -She was unaware that the sink in Resident Room #118 was clogged. -She would perform a walk-thru and identify any clogged or slow-draining sinks, as well as other	D 105	This was addressed in previous pages.	3/30/17

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D 105	Continued From page 20 items, in need of repair. -There was no maintenance log book to record items to be addressed. 2. Observation of the women's common bathroom on the Green hall on 01/18/17 at 11:51 a.m. revealed: -The toilet in the first stall had a plastic bag wrapped around the bottom of it. -There was a large piece of cardboard taped to the seat of the toilet with black duct tape. -The faucet of the tub had a thick build-up of whitish gray corrosion all over it. -The tub had a thin steady stream of water running from the faucet. -The cold water knob on the tub would turn on and off but the stream of water did not stop running. -The hot water knob on the tub was stuck and would not turn. Interview with the Unit Coordinator (UC) on 01/18/17 at 12:20 p.m. revealed: -The toilet in the women's bathroom had been broken for a couple of days and they had ordered a new one to replace it. -Residents did not use this tub and she was not sure how long it had been out of order. -She would check with maintenance staff. -There were tubs in the other bathrooms on the Red hall the residents could use. Interview with the Maintenance Director on 01/18/17 at 12:49 p.m. revealed: -The flange on the toilet in the women's bathroom on the Green hall was rusted out so the toilet had been broken for about a week. -They ordered a new toilet yesterday, 01/17/17. -They did not use the tub in the women's bathroom on the Green hall so he was not sure	D 105	The problem with bathtub will be assessed and addressed.	3/30/17

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D 105	Continued From page 21 how long it had been leaking. -He marked any repairs done on the maintenance log. Review of the Maintenance Log on 01/18/17 revealed: -On 12/20/16 - the toilet was leaking in women's bathroom on the Green hall. -The Maintenance staff person documented he tightened the toilet on 12/20/16. -On 01/03/17 - the toilet was leaking in women's bathroom on the Green hall. -Repairs to the toilet were documented as completed on 01/03/17. -On 01/10/17 - the toilet was loose in the women's bathroom on the Green hall. -It was documented a new toilet was ordered on 01/10/17. -There was no further documentation about repairs to the toilet in the women's bathroom on the Green hall. Interview with the UC on 01/18/17 at 5:30 p.m. revealed the Executive Assistant usually checked the Maintenance staff person and the maintenance log to make sure repairs were done. Observation of the women's common bathroom on the Green hall on 01/19/17 at 5:40 p.m. revealed: -The toilet in the first staff was still taped up and out of order. -The tub was still running a small steady stream of water. Interview with a resident on 01/18/17 at 11:54 a.m. revealed: -The toilet in the first stall of the women's common bathroom on green hall had been	D 105	Addressed previously.	3/30/17

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D 105	Continued From page 22 broken about 2 or 3 days. -She thought someone was trying to repair it. Interview with the Maintenance Director on 01/19/17 at 4:10 p.m. revealed the toilet for the women's common bathroom on the Green hall had been ordered and it was supposed to come in next week.	D 105		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 5 residents (#2, #5) sampled were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #5's current FL-2 dated 11/08/16 revealed the resident's diagnoses included acute hypoxemic respiratory failure, aspiration pneumonia, urinary tract infection, hypokalemia, dementia, diastolic congestive heart	D 234		

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D 234	Continued From page 23 failure, hypertension, coronary artery disease, mitral regurgitation, and patent foramen ovale. Review of Resident #5's Resident Register revealed she was admitted to the facility on 06/23/15. Review of Resident #5's tuberculosis (TB) information in the record revealed: -One TB skin test placed on 06/17/15 and read as negative on 06/19/15. -There was no documentation of any other TB skin test in the record. Interview with the Unit Coordinator (UC) on 01/24/17 at 8:30 a.m. revealed she could not locate any other TB skin tests for Resident #5. Interview with a medical assistant at the physician's office for Resident #5 on 01/24/17 at 1:05 p.m. revealed they only had one TB skin test on file which was placed on 06/17/15. Refer to interview with the UC on 01/24/17 at 8:30 a.m. 2. Review of Resident #2's current FL-2 dated 02/08/16 revealed the resident's diagnoses included dementia, Alzheimer's with behavioral disturbance, and hypertension. Review of Resident #2's Resident Register revealed he was admitted to the facility on 02/01/13. Review of Resident #2's tuberculosis (TB) information in the record revealed: -One TB skin test placed on 11/28/12 and read as negative on 11/30/12. -There was no documentation of any other TB	D 234	Unit Coordinator will assure all 2 step TB tests are done on each new resident.	3/10/17

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D 234	Continued From page 24 skin test in the record. Interview with the Unit Coordinator (UC) on 01/24/17 at 8:30 a.m. revealed she could not locate any other TB skin tests for Resident #2. Refer to interview with the UC on 01/24/17 at 8:30 a.m. _____ Interview with the Unit Coordinator (UC) on 01/24/17 at 8:30 a.m. revealed: -She had worked at the facility about 4 months. -The UC was responsible for making sure residents had a 2 step TB skin test upon admission. -They did not currently have a system to monitor and assure TB skin tests were on file to her knowledge. -She was working on a system to monitor TB skin tests for residents.	D 234	All residents currently have 2-step TB skin tests.	3/10/17
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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 2 of 5 residents (#2, #5) sampled as related to a resident with a Stage II pressure ulcer on the buttocks and redness and	D 273		

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D 273	Continued From page 25 indentations on the legs from support hose that had not been reported to the physician or treated (#5), a resident with new orders for a diabetic medication and testing supplies and the physician had not been notified regarding clarification of new orders for blood sugar monitoring (#2), and labwork that had not been done on a resident newly diagnosed with underactive thyroid and started a new thyroid medication (#2), and a resident whose high and low blood pressures were not reported to the physician as ordered (#2). The findings are: 1. Review of Resident #5's current FL-2 dated 11/08/16 revealed the resident's diagnoses included acute hypoxemic respiratory failure, aspiration pneumonia, urinary tract infection, hypokalemia, dementia, diastolic congestive heart failure, hypertension, coronary artery disease, mitral regurgitation, and patent foramen ovale. Review of Resident #5's current assessment and care plan dated 10/31/16 revealed: -Resident #5 was non-ambulatory and had a limited range of motion. -The resident was incontinent of bowel and bladder. -The resident was always disoriented and had significant memory loss. -The resident required total assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. -The resident required limited assistance with eating. A. Observation of Resident #5 with 2 personal care aides (PCAs) on 01/20/17 at 9:30 a.m. revealed:	D 273	The UC has established a new form that the staff is to utilize for new orders or order changes. Staff have been in-serviced on how to report changes for residents on the shower sheets. Unit Coordinator responds on the shower sheet the disposition of event and is kept on file.	3/10/17

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D 273	Continued From page 26 -There was a dime-sized reddened open area of skin on the resident's buttocks near the gluteal cleft. -There was no drainage or odor. -The PCAs cleaned the resident's buttocks and changed the incontinence brief. -The PCAs did not apply anything to the resident's buttocks. Interview with a PCA on 01/20/17 at 9:30 a.m. revealed: -Resident #5 could not bear weight and was either in the geri-chair or bed. -The skin breakdown on the resident's buttocks started a few days ago, up to 1 week ago to her knowledge. -The medication aide was aware and the PCA thought they were in the process of getting a patch for the sore. -The aides usually put barrier cream on the resident after each incontinence brief change. Further interview with the PCA on 01/20/17 at 10:37 a.m. revealed: -She was working with another PCA about a week ago when the other PCA found the sore on Resident #5's buttocks. -The other PCA wrote a skin assessment and notified the medication aide on duty last week. -The PCAs usually put the skin assessment forms under the Unit Coordinator's (UC) door for her review. -The sore looked the same this week as last week. -She had not seen any drainage from the sore and it looked the same size. -She forgot to put barrier cream on the resident's buttocks earlier this morning during incontinence care but went back and put it on a few minutes after the observation.	D 273	Addressed on previous page	3/10/17

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D 273	Continued From page 27 Interview with the medication aide (MA) on 01/20/17 at 10:44 a.m. revealed: -One of the PCAs (could not recall which one) reported they saw a sore on Resident #5's buttocks. -The PCA did not report it until yesterday, 01/19/17. -The PCA did not report how long the sore had been there. -A PCA reported she had put barrier cream on it today, 01/20/17. -She denied that staff had reported it to her prior to 01/19/17. -Normally, she would look at the sore and determine if she needed to call the physician to get an order for home health to treat the area. -She had not had a chance to look at Resident #5's sore or to document it was reported to her. -She left work early yesterday so she reported it to the next MA coming on duty. -She did not notify Resident #5's primary care physician (PCP). -She did not know if that MA had looked at it or contacted the physician. -She had not followed up on it today. Interview with the Unit Coordinator (UC) on 01/20/17 at 10:50 a.m. revealed: -She was not aware Resident #5 had any skin breakdown. -No staff had reported any skin breakdown to her. -The PCAs were supposed to notify either her or the MAs of any skin breakdown or changes in residents' conditions. -She was a licensed practical nurse (LPN) so she would have looked at the resident's skin if she had been notified. -If there was open skin, she would contact the physician to get an order for home health to treat.	D 273	Inservices have been given to all Nursing Staff on when, where, and how to report incidents concerning residents from falls to skin condition and other related issues. Unit Coordinator will follow up to ensure Compliance.	3/10/17

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D 273	Continued From page 28 Interview with a second PCA on 01/20/17 at 11:24 a.m. revealed: -She saw the sore on Resident #5's buttocks last week. -The skin was broken and the area was "smaller than a dime". -The other PCA documented on a skin assessment form and they let the MA on duty know about the breakdown. -They reported it to the MA the same day they first saw the sore about a week ago (could not recall exact date). Review of shower assessment forms completed by PCAs for Resident #5 revealed: -On 01/11/17 (7am - 7pm), there was no documentation of any issues on the skin assessment section. -On 01/13/17 (7am - 7pm), staff circled the lower legs and feet area on the skin assessment section and wrote "swelling". No other skin issues were documented. -On 01/16/17 (7am - 7pm), there was no documentation of any issues on the skin assessment section. Interview with the UC on 01/20/17 at 11:30 a.m. revealed: -The PCP's office was closed on Fridays so she had not been able to reach the PCP about the skin breakdown. -The facility's house physician would not give an order since Resident #5 was not one of their patients. -There was a home health nurse (HHN) in the facility seeing other residents so she asked the HHN to look at the sore on Resident #5's buttocks today (01/20/17). -The HHN told them to put Baza cream (standing	D 273	Answer addressed on previous page.	3/10/17

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D 273	Continued From page 29 order) on it until they heard back from the PCP. -She did not know why staff did not document the breakdown on the shower assessment sheets. -The PCAs were supposed to document any skin issues on that form and give them to her. -She would contact the resident's family to get permission to take her to a local urgent care for the skin breakdown. Interview with a HHN on 01/20/17 at 11:38 a.m. revealed: -Resident #5 was not one of their agency's patients. -The UC asked her to look at the resident's buttocks. -Resident #5 had a Stage II pressure ulcer on her sacral area that measured 0.8cm x 0.5cm. -There was no signs of infection in the wound. -The facility was trying to get orders from the PCP for home health treatment of the wound. Interview with the UC on 01/20/17 at 11:55 a.m. revealed: -She contacted Resident #5's family member and it was okay for the facility to take the resident to urgent care. -They planned to take the resident to urgent care today, 01/20/17. Review of a nursing note for Resident #5 dated 01/20/17 revealed: -This was a late entry for 01/19/17 (by a medication aide). -Aide reported resident's buttock was red, reported to next aide to take a look. -They would continue to monitor. Review of a second nursing note for Resident #5 dated 01/20/17 (7am - 7pm) revealed: -Aide asked for Baza cream (barrier cream) to	D 273	Answered / addressed on pg. 29	3/10/17

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D 273	Continued From page 30 apply to resident's buttocks. -The resident's buttocks had a "dime-sized" open wound. -Physician was notified for home health referral. Review of a third nursing note for Resident #5 dated 01/20/17 (no time) revealed Resident #5 was taken to urgent care for sore on buttocks. Review of a clinic visit note from an urgent care center for Resident #5 dated 01/20/17 revealed: -The reason for visit was "sore on buttock". -The Physician Assistant (PA) noted a small 0.5cm erythematous lesion to gluteal cleft. -No discharge or swelling and no signs of necrosis noted. -The diagnoses was pressure ulcer of the buttock. -There was an order for Bactroban 2% topical ointment, apply to affected area 3 times a day for 10 days. -Reposition the resident every 2 hours, ensure incontinence brief is on properly and clean and dry at all times. -Follow with PCP. Review of a nursing note for Resident #5 dated 01/23/17 (8am) revealed: -The facility staff spoke with a nurse at the PCP's office. -PCP's office would send an order for home health to evaluate and treat Resident #5. Interview with the UC on 01/23/17 at 11:00 a.m. revealed: -Resident #5 was taken to an urgent care center on Friday afternoon, 01/20/17. -The provider at the urgent care center would not give an order for home health because he was not the PCP.	D 273	Answer addressed on pg. 28	3/10/17

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D 273	Continued From page 31 -The urgent care provider gave an order for Bactroban cream (topical antibiotic). -She spoke with Resident #5's PCP via phone today, 01/23/17, and he gave an order for home health to evaluate and treat the wound. -The home health nurse would be coming to the facility on tomorrow, 01/24/17, to see the resident. Interview with a PCA on 01/23/17 at 3:35 p.m. revealed: -It was unusual for Resident #5 to have any skin breakdown. -The PCAs report any changes in a resident's condition to the medication aide (MA) on duty. -The MA would assess the resident and then notify the physician and / or the UC. -The MA usually took care of any changes reported by the PCAs. -The MA would document in the nurses' notes but the PCAs could also document in the nurses' notes. Interview with a family member of Resident #5 on 01/23/17 at 5:45 p.m. revealed: -Resident #5 had lived at the facility about 2 years. -Resident #5 can no longer walk and was either in the geri-chair or in the bed. -She saw a sore on Resident #5's buttocks while one of the aides was changing her at the beginning of last week. -The aide told the family member that she had already reported it to the MA and they were taking care of it. -She could not recall which aide she talked with about the sore. -She thought the facility had taken care of the sore until she received a phone call from the facility this past Friday, 01/20/17.	D 273	Response addressed on pg. 26	3/10/17

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D 273	Continued From page 32 -The facility contacted her on Friday, 01/20/17, to ask about taking Resident #5 to an urgent care center to get treatment for the sore. Interview with a second HHN on 01/24/17 at 10:55 a.m. revealed: -She assessed Resident #5's skin breakdown today and she had a Stage II pressure ulcer on her buttocks. -The wound measured 0.7cm x 0.5cm and it was 0.1cm deep. -The wound did not have any signs of infection. -They are going to continue the order for Bactroban cream 3 times a day for 10 days and the use of barrier cream after each incontinence brief change. -HH services would continue for the resident for 4 weeks and then she would reassess the wound. B. Review of a physician follow-up visit form for Resident #5 dated 09/07/16 revealed: -The resident had swelling of foot and exam revealed cellulitis. -An antibiotic was ordered and the resident was to be rechecked the next week. Review of a physician follow-up visit form dated 09/13/16 revealed: -The resident had improved. -Continue antibiotics and stockings suggested. Review of a nursing note dated 09/14/16 for Resident #5 revealed: -Physician faxed order for geri-chair and to continue antibiotic. -Called to see if physician wanted order for TED (thrombo-embolic deterrent) hose, awaiting response. (TED hose are used to treat swelling in the legs and to reduce the risk of blood clots.)	D 273	Response addressed previously pg. 28	3/10/17

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D 273	Continued From page 33 Review of a nursing note dated 10/27/16 for Resident #5 revealed staff documented no order for TED hose received. Review of a note from Resident #5's primary care physician (PCP) dated 11/03/16 revealed: -The resident was seen in the PCP's office today (11/03/16). -After exam, the PCP determined it was best for Resident #5 to be taken to the emergency room due to shortness of breath and swelling. -The resident was transported by ambulance to the hospital. Review of a nursing note dated 11/10/16 (6:37 a.m.) for Resident #5 revealed: -Resident had TED hose still on this morning. -Both feet were extremely swollen and there were red rings around lower knee area. -TED hose were removed and the Unit Coordinator was notified. Review of a communication note to the physician for Resident #5 dated 11/21/16 revealed: -The facility staff requested for resident to wear TED hose due to legs being swollen. (put on in the morning and take off at night) -The physician signed and dated the note on 11/21/16. Review of a form dated 11/23/16 for Resident #5 revealed: -The Unit Coordinator (UC) documented leg measurements for support hose for Resident #5 on the form. -The form was documented as faxed to the primary pharmacy on 11/23/16 at 11:44 a.m. Observation of Resident #5 with 2 personal care aides (PCAs) on 01/20/17 at 9:30 a.m. revealed:	D 273	Each resident in need of TED hose are properly measured by Unit Coordinator or designee to assure the proper ordering of and size of fit — and monitoring there after	3/10/17

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D 273	Continued From page 34 -The resident had on white TED hose on both legs. -When the TED hose were removed, areas of redness and indentation were observed behind the resident's knees. -Both of the resident's feet and ankles were swollen. Interview with a PCA on 01/20/17 at 9:30 a.m. revealed: -Resident #5 could not bear weight and was either in the geri-chair or bed. -The resident's feet and ankles were always swollen but seemed less swollen than normal today. -She had noticed the TED hose usually caused redness and indentations on the resident's legs. -She could not recall if it had been reported to the medication aide or physician. Interview with a pharmacist from the primary pharmacy for Resident #5 on 01/24/17 at 11:15 a.m. revealed: -They dispensed two pairs of TED hose, one on 11/23/16 and one on 12/02/16. -Both pairs of TED hose were the same size based on measurements received on 11/23/16. -They did not dispense any TED hose prior to 11/23/16 for this resident. Interview with a medication aide on 01/23/17 at 4:40 p.m. revealed: -She was not aware Resident #5's TED hose causing any redness to her legs. -No one had reported any redness from the TED hose to her. -The resident had a second pair of TED hose in the medication cart that had not been opened yet. Interview with a family member of Resident #5 on	D 273	Answer addressed on previous page	3/10/17

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D 273	Continued From page 35 01/23/17 at 5:45 p.m. revealed: -Resident #5 had lived at the facility about 2 years. -Resident #5 can no longer walk and was either in the geri-chair or in the bed. -The resident had chronic problems with her legs swelling. -The resident was usually wearing the TED hose when the family member visited. -She had noticed the TED hose made red marks and indentions in the resident's legs at the top just below her knees. -She had not reported it to anyone because she thought facility staff were aware since they put on and remove the TED hose. Interview with a medical assistant at the PCP's office for Resident #5 on 01/24/17 at 1:05 p.m. revealed: -There was documentation from a visit on 09/13/16 where the PCP suggested support hose. -Facility staff contacted the PCP on 09/14/16 to get an order for the TED hose. -She thought there was a delay in getting the TED hose order because it was on hold because the resident had an infection in her legs. -She could not determine when the TED hose order was put on hold or restarted. -There was no documentation that the facility had notified the physician that the TED hose were causing redness or indentations in the resident's skin. Interview with the UC on 01/24/17 at 3:42 p.m. revealed: -She was not sure where Resident #5's TED hose came from prior to the order on 11/21/16. -She was unable to locate an order prior to 11/21/16.	D 273	Answer addressed on previous pg 34	3/10/17

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D 273	Continued From page 36 -She measured the resident for TED hose on 11/23/16 based on the order they received on 11/21/16. -No one reported the redness to the resident's legs caused by the TED hose when it was documented in the nursing notes in November 2016 or any other time. -She had not reported it to the physician because she was unaware of the redness. -She would check the resident and remeasure to see if the resident needed a different size of TED hose. 2. Review of Resident #2's current FL-2 dated 02/08/16 revealed the resident's diagnoses included dementia, Alzheimer's with behavioral disturbance, and hypertension. Review of Resident #2's current assessment and care plan dated 05/20/16 revealed: -The resident was incontinent of bowel and bladder. -The resident required total assistance with toileting, bathing, dressing, and grooming. -The resident required extensive assistance with eating, ambulation, and transferring. A. Review of a hospital emergency room visit dated 11/03/16 for Resident #2 revealed: -The resident was "slumped at the dinner table". -The resident was seen for altered mental status. -The resident's glucose at the hospital was 162. -The clinical impression documented by hospital was dementia. Review of a physician's visit form dated 11/16/16 for Resident #2 revealed: -There was an order for Metformin 500mg every morning. (Metformin lowers blood sugar.) -There was an order for Glucose Gel - use if	D 273		

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D 273	Continued From page 37 blood sugar was lower than 50. (Glucose Gel raises low blood sugar levels.) -There was an order for alcohol pads, safety lancets, and a glucometer kit with strips. Review of Resident #2's November 2016, December 2016, and January 2017 medication administration records (MARs) revealed: -Metformin 500mg was administered daily at 8:00 a.m. from 11/17/16 through 01/18/17. -There was an entry for Glucose Gel use if blood sugar lower than 50 but none was documented as administered. -There was an entry for alcohol pads to use as directed as needed but none were documented as used. -There was an entry for lancets use as directed as needed but none were documented as used. -There was an entry for a glucometer kit system use as directed as needed but it was not documented as used. Observation of medications and supplies on hand for Resident #2 revealed there was no glucometer or diabetic testing supplies on hand for this resident. Interview with a medication aide (MA) on 01/19/17 at 4:48 p.m. revealed: -Resident #2 did not have a glucometer and they were not checking his blood sugar. -She thought the physician had checked the resident's blood sugar during a visit because the resident was getting very lethargic. -She thought the physician had mentioned something about checking the resident's blood sugar in the mornings. -The physician never wrote an order so they had not checked it. -She thought the physician later said it was not	D 273	Each resident has own glucometer to measure/ monitor blood sugar in all diabetics in facility. If results do not meet protocol, appropriate action will be taken. This will be monitored by Unit Coordinator.	3/10/17

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D 273	Continued From page 38 necessary to check the resident's blood sugar. -She did not document any of this information and could not recall the dates or which physician she had discussed it with. Interview with a second MA on 01/23/17 at 4:45 p.m. revealed: -She was aware Resident #2 was receiving Metformin and had an order for Glucose Gel for low blood sugars. -They do not take Resident #2's blood sugar because there was no order to check it. -Resident #2 did not have a glucometer. -They had not given any Glucose Gel because they had no way to check the resident's blood sugar. -Resident #2 saw the house physician who came to the facility every 2 weeks. -She had not spoken with the physician about needing an order to check the resident's blood sugar. -She had not notified the physician that there was no glucometer to check the resident's blood sugar. Interview with the Unit Coordinator (UC) on 01/24/17 at 11:00 a.m. revealed they would be getting a glucometer for Resident #2 tomorrow morning on 01/25/17. Interview with a pharmacist from the primary pharmacy for Resident #2 on 01/24/17 at 11:15 a.m. revealed: -They received the physician's order dated 11/16/16 for Metformin, Glucose Gel, and diabetic testing supplies, including the glucometer. -They dispensed Metformin, Glucose Gel, alcohol swabs, lancets, and a glucometer kit with strips for Resident #2 on 11/16/16. -They had not sent any diabetic supplies since	D 273	Answer addressed on previous page	3/10/17

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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 273	Continued From page 39 11/16/16 because there had been no request for refills. -There was no documentation of the glucometer kit or other diabetic supplies being returned to the pharmacy. Interview with the UC on 01/24/17 at 3:30 p.m. revealed: -The pharmacy delivery sheet noted a glucometer kit and diabetic supplies were delivered to the facility and signed as received by a MA on 11/17/16. -She did not know what happened to the glucometer or other diabetic supplies. -She had searched the facility and medication carts but could not find the glucometer or supplies. Attempt to interview the MA who signed for the delivery of the glucometer and diabetic supplies for Resident#2 on 11/17/16 was unsuccessful. Interview with a physician from the primary care provider's office on 01/24/17 at 10:20 a.m. revealed: -He usually saw residents on mobile visits at the facility. -He had seen Resident #2 during some visits at the facility. -Resident #2 had also been seen by another physician in the practice at times. -Resident #2 had some dizzy spells and high glucose (in the 200s) during a hospital visit. -This triggered the physician to order Metformin, Glucose Gel, and a glucometer with diabetic supplies on 11/16/16. -He did not realize he failed to write an order for how often the facility should check the resident's blood sugar. -It was an oversight and he wanted the resident's	D 273	Answer addressed on previous pg. 38	3/10/17

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D 273	Continued From page 40 blood sugar checked before meals and at bedtime. -He usually made visits to see residents at the facility every 2 weeks. -No one at the facility had notified him that they needed an order to check Resident #2's blood sugar. -He was not aware they did not have a glucometer for Resident #2. -He was concerned that the resident's blood sugar had not been checked. B. Review of a physician visit note dated 10/05/16 for Resident #2 revealed: -The resident's weight gain was likely secondary to hypothyroidism. -The physician wrote an order to start Synthroid and recheck TSH (thyroid levels) in 6 weeks. (Synthroid is used to treat underactive thyroid.) Review of lab reports in Resident #2's record revealed no documented TSH levels. Review of Resident #2's October 2016 - January 2017 medication administration records (MARs) revealed Synthroid 25mcg was documented as administered once daily at 8:00 a.m. from 10/07/16 through 01/18/17. Interview with the Unit Coordinator (UC) on 01/20/17 at 3:05 p.m. revealed: -She was not aware of the order for Resident #2's TSH level to be drawn. -They usually got a lab requisition from the physician and could take residents to the hospital lab to get labwork drawn. -Resident #2's primary care provider (PCP) made visits on-site at the facility every 2 weeks and had a nurse that would draw labs. -Medications aides gave lab orders to the	D 273	with the Unit Coordinator's protocol for review of all orders and signing off on review – no further action should be necessary	3/10/17

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D 273	Continued From page 41 transporter and the transporter would take residents to the hospital for lab draws or MAs would remind in-house providers to draw the labs. -She did not know why Resident #2's TSH lab was not drawn. -She would contact the physician to notify him that the TSH level had not been checked since the resident started taking Synthroid in 11/2016. Interview with the UC on 01/23/17 at 11:00 a.m. revealed: -Resident #2's TSH level would be drawn on Wednesday morning, 01/25/17. -The PCP was going to start bringing a nurse with him for facility visits so blood could be drawn if needed. Interview with the transporter on 01/24/17 at 3:20 p.m. revealed: -If there were orders for labwork, a home health nurse would usually come to the facility to draw the labs. -She thought medication aides would contact HHN to come out and draw labs. Review of a faxed note dated 01/20/17 to the physician for Resident #2 revealed: -Staff notified that the lab for TSH levels ordered on 10/05/16 was not done. -The facility never received a lab requisition and the lab was not drawn. -The physician responded on 01/23/17 that the resident's labs would be drawn on his next routine visit. Interview with the UC on 01/24/17 at 11:00 a.m. revealed: -The HHN in the facility today would not draw labs for Resident #2 because he was not currently their patient.	D 273	Answer addressed on previous page	3/10/17

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D 273	Continued From page 42 -She called a lab company but they would not come to the facility. -She would contact the physician back to get a requisition sheet and take the resident to the hospital lab to have it drawn sooner. Interview with a physician from the primary care provider's office on 01/24/17 at 10:20 a.m. revealed: -He usually saw residents on mobile visits at the facility. -He had seen Resident #2 during some visits at the facility. -Resident #2 had also been seen by another physician in the practice at times. -The other physician in the practice ordered the Synthroid and TSH level. -Their providers could draw labs while at the facility or sometimes a facility would have home health to draw labs. -He was not sure about the TSH levels for Resident #2 since he did not order it. -He would write the facility an order today to go ahead and have home health draw the TSH lab. Attempt to contact Resident #2's other primary care provider was unsuccessful. C. Review of Resident #2's current FL-2 dated 02/08/16 revelaed an order to check blood pressure (BP) once a day at 9:00 a.m. and notify the physician if systolic BP >170 or <80 or if the diastolic BP >90 or <60. Review of a hospital emergency room visit dated 08/31/16 for Resident #2 revealed: -The resident was seen for a BP problem. -The resident had non-specific low BP reading after a dose of Clonidine. (Clonidine lowers blood pressure.)	D 273	Answer addressed on pg. 41	3/10/17

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D 273	Continued From page 43 -Emergency medical personnel reported a BP of 94/58 upon arrival to the facility. Review of a physician visit note dated 10/20/16 for Resident #2 revealed: -The resident's BP was 170/80 and his pulse was 51. -The physician wrote an order to discontinue Clonidine and start Verapamil. (Verapamil lowers blood pressure.) Review of a nursing note for Resident #2 dated 10/26/16 revealed: -The resident was sent to the hospital due to low BP. -The resident was unresponsive. -The resident returned from the hospital and was doing well. Review of a hospital emergency room visit dated 10/26/16 for Resident #2 revealed: -The resident was seen for altered mental status. -The facility reported the resident had low respirations and BP. -Emergency medical personnel reported the resident was at baseline upon arrival to the facility. -The clinical impression was unresponsiveness. Review of a nursing note for Resident #2 dated 12/22/16 revealed: -The resident was sent to the hospital due to high temperature and high BP. -The resident's BP was 180/100, pulse 107, and oxygen level was 85%. -The resident returned to the facility with no new orders. Review of a hospital emergency room visit dated 12/22/16 for Resident #2 revealed:	D 273	All physician orders and requests in handling of blood pressure will be reviewed and all orders will be followed per resident. This will be monitored by the Unit Coordinator.	3/10/17

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D 273	Continued From page 44 -The resident had agitation, fever, and increased BP. -The resident had sinus tachycardia (rapid heartbeat). -The clinical impression was high BP. Review of a nursing note for Resident #2 dated 01/01/17 revealed: -The resident appeared to be having trouble breathing and was taking deep breaths. -The resident's BP was 165/103 and pulse 74. Review of a hospital emergency room visit dated 01/01/17 for Resident #2 revealed: -The resident had a BP problem. -The facility reported resident had low BP and shortness of breath. -Emergency medical personnel reported a BP of 166/98 and an oxygen level of 100% upon arrival to the facility. -The resident's presentation was similar to when seen previously for altered mental status. -The clinical impression was dementia. Review of the November 2016, December 2016, and January 2017 medication administration records (MARs) for Resident #2 revealed: -There was an entry to check blood pressure once a day at 9:00 a.m. and notify the physician if systolic BP >170 or <80 or if the diastolic BP >90 or <60. -The resident's BP was 136/55 on 12/14/16, 124/52 on 12/19/16, and 134/99 on 12/23/16. -The resident's BP was 145/95 on 01/10/17. -There was no documentation the physician was notified of the BPs that were out of the parameters ordered. Review of nursing notes for December 2016 and January 2017 for Resident #2 revealed no	D 273	Answer addressed on previous page.	3/10/17

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D 273	Continued From page 45 documentation the physician was contacted about the resident's BPs that were out of the parameters as ordered. Interview with a medication aide on 01/23/17 at 4:45 p.m. revealed: -Resident #2 had parameters to contact the physician for high and low blood pressures. -If the physician was contacted it would be documented on the MAR. Interview with a physician from the primary care provider's office on 01/24/17 at 10:20 a.m. revealed: -He usually saw residents on mobile visits at the facility. -He had seen Resident #2 during some visits at the facility. -Resident #2 had also been seen by another physician in the practice at times. -He was aware the resident had some hospital visits related to blood pressure problems. -He could not recall if he had been notified by the facility about the resident's blood pressure being out of the ordered parameters. Attempt to contact Resident #2's other primary care provider was unsuccessful. Review of a faxed note dated 01/20/17 to the other primacy care provider for Resident #2 revealed: -The facility asked the physician if he had been notified of the resident's blood pressures that were out of parameters in December 2016. -The physician responded on 01/24/17 and noted he was not notified. -He asked the facility to fax the resident's blood pressures to him.	D 273	Answer addressed on pg. 44	2/10/17

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D 273	Continued From page 46 The facility's failure to contact Resident #5's physician for an untreated Stage II pressure ulcer and to notify Resident #2's physician of high and low blood pressures was detrimental to the health of two residents. The failure of the facility to assure a system for the coordination of health care directly impacted the health and safety of the residents, which constitutes a Type B Violation. Review of the facility's plan of protection dated 01/20/17 revealed: -Residents' physicians will be notified immediately of any changes of condition. -Notifications will be documented. -The facility will develop a system for lab draws and it will be monitored for system accuracy. -Residents will be transported to urgent care if the primary physician can not be reached. -The physician has been notified of the need for blood sugar checks for Resident #2. -Staff will report any changes in condition of any resident to supervisor who will in turn notify the Unit Coordinator (UC) immediately. -UC will then follow-up on all actions noted above.	D 273	The facility and its staff will at all times care for all of the needs of each resident while in their care. Systems are in place to assure those things happen. This is being monitored by facility staff, Unit Coordinator, Executive Assistant, Executive Director and/or designee. We will follow the Plan of Protection dated 1/20/17.	3/10/17
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 282		

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D 282	Continued From page 47 failed to assure the kitchen's reach-in freezer door seals and floor was clean and protected from contamination. The findings are: Observation of the reach-in freezer on 1/19/17 at 10:20am revealed: -The inside seals of both doors were cracking throughout the entire seal. -Both door seals were dirty with a black tarry substance throughout. -The seal at the base of the left door was held on by 8 pieces of black electrical tape. -The inside freezer floor had a corroded section sheet metal panel which did not fully cover the floor, exposing a 26-inch by 4-inch section of yellow foam insulation which covered the refrigeration piping below which was covered in various colored food particles and black tarry sticky drippings. -The thermometer inside the freezer displayed that the freezer was within the proper temperature range. Interview with the Dietary Manager on 1/19/16 at 9:54am revealed: -The freezer left door seal had been taped "for some time now." -She had noticed the freezer floor was separated and the insulation was exposed. -She had not reported the seals or freezer floor issue to maintenance or management. -The county inspector had informed her of the same issues a month ago. -It had not yet affected the freezer's ability to maintain the proper temperature range. -The county inspector advised her that the floor and seals may eventually affect the freezer's ability to maintain a proper temperature.	D 282	Reach-in freezer doors and seals will be repaired and maintained. Executive Director / Executive Assistant will monitor.	3/30/17

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D 282	Continued From page 48 Interview with the Maintenance Director on 1/19/16 at 2:42pm revealed: -He was unaware that the freezer seals and flooring needed repair. -The Unit Coordinator received the building reports which included areas in need of attention within the building. -The Dietary Manager should notify him of any repair needs. -He would ask for approval from the Unit Manager to purchase items for the freezer repair. Interview with the Administrator on 8/19/16 at 3:35pm revealed: -She was unaware that the freezer seals and flooring needed repair. -She had not reviewed the building inspection report previously identifying the same freezer issues. -She expected her Dietary Manager to report any repair issues identified in the kitchen. -She would tell her Maintenance Director to purchase the needed items for repair immediately.	D 282	Answered on previous page.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record	D 310		

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D 310	Continued From page 49 review, the facility failed to assure 3 of 3 Residents (#1, #6 and #8), which were the only residents at the facility with orders for thickened liquids, received honey thickened liquids as ordered by the primary care physician. The findings are: 1. Review of Resident #1's current FL-2 dated 11/2/16 revealed: -The resident's diagnoses included unspecified dementia, hypothyroidism, COPD, hyperlipidemia and hypertension. -The resident's diet order was listed as a regular diet. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 10/15/12. Review of Resident #1's physician orders revealed: -The resident's diet order dated 1/19/17 revealed start nectar-thick liquids to all drinks for all snacks and meals. Observation of Resident #1 on 1/20/17 between 12:35pm and 1:35pm revealed: -The Resident was served 12 oz of water and 12 oz of tea by the dietary aide. -The Resident was served thickened liquids that were not mixed appropriately. -There was another aide assisting the resident with eating. -The resident coughed once clearing his throat at 12:25pm. -The resident was observed drinking both liquids with no issues. Observation of Resident #1 on 1/23/17 between	D 310	Dietary staff have been in-serviced again (with demonstration) ensuring that the appropriate thickened liquids are given as ordered to the appropriate resident. This will be monitored by Executive Director, Unit Coordinator, and Executive Assistant.	3/10/17

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D 310	Continued From page 50 12:15pm and 1:00pm revealed: -The Resident was served 12 oz of water and 12 oz of tea by the dietary aide. -The Resident was served thickened liquids that were mixed appropriately. -There was another aide assisting the resident with feeding. -The resident was observed drinking both liquids with no issues. Refer to interview with Dietary Manager on 1/20/17 at 11:30am. 2. Review of Resident #6's current FL-2 dated 9/28/16 revealed: -The resident's diagnoses included dementia, malignant neoplasm of skin, anemia unspecified, essential hypertension, and history of neck fracture. -The resident's diet order was listed as a regular diet, pureed with nectar thick liquids. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 3/9/14. Observation of Resident #6 on 1/20/17 between 12:33pm and 1:10pm revealed: -The Resident was served 12 oz of water and 12 oz of tea by the dietary aide. -The Resident was served thickened liquids that were not mixed appropriately. -The Resident required no assistance and drank 100% of the water and tea. -The resident was observed drinking both liquids with no issues. Observation of Resident #6 on 1/23/17 between 12:23pm and 12:50pm revealed:	D 310	Answer addressed on previous page.	3/10/17

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D 310	Continued From page 51 -The Resident was served 12 oz of water and 12 oz of tea by the dietary aide. -The Resident was served thickened liquids that were mixed appropriately. -The Resident required no assistance and drank 100% of the water and tea. -The resident was observed drinking both liquids with no issues. Refer to interview with Dietary Manager on 1/20/17 at 11:30am. 3. Review of Resident #8's current FL-2 dated 5/16/16 revealed: -The resident's diagnoses included Alzheimer's, dementia and anxiety. -The resident's diet order was listed as a regular diet, pureed with nectar thick liquids. Review of Resident #8's Resident Register revealed the resident was admitted to the facility on 4/22/13. Observation of Resident #8 on 1/20/17 between 12:35pm and 1:15pm revealed: -The Resident was served 12 oz of water and 12 oz of tea by the dietary aide. -The Resident was served thickened liquids that were not mixed appropriately. -The Resident required no assistance and drank 20% of the water and 100% of the tea. -The resident was observed drinking both liquids with no issues. Observation of Resident #8 on 1/23/17 between 12:25pm and 12:55pm revealed: -The Resident was served 12 oz of water and 12 oz of tea by the dietary aide. -The Resident was served thickened liquids that	D 310	Answer addressed on pg. 50.	3/10/17

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D 310	Continued From page 52 were mixed appropriately. -The Resident required no assistance and drank 50% of the water and 100% of the tea. -The resident was observed drinking both liquids with no issues. Refer to interview with Dietary Manager on 1/20/17 at 11:30am. --- Interview with the Dietary Manager on 1/20/17 at 11:30am revealed: -There were only 3 residents in the facility on thickened liquids as of 1/20/17. -Resident #1, #6 and #8 were on nectar-thickened liquids. -The facility used powdered thickener when preparing thickened liquids. -Currently all 3 residents were in the dining room awaiting their meal. -All 3 residents received 12 oz of water and 12 oz of beverage. -She prepared the thickened liquids for all meals. Observation of Dietary Manager on 1/20/17 at 12:10pm revealed: -She had already prepared the thickening powder in liquids for all 3 residents requiring nectar-thick liquids. -She had placed three 12 oz cups of water and three 12 oz cups of tea on a rolling cart for the dietary aide for serving. -She distinguished the cups with nectar-thickened liquids by placing spoons in the cups for the aides. Interview with Dietary Manager on 1/23/17 at 12:00pm revealed:	D 310	Answer addressed on pg. 50.	3/10/17

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	HAL067004	A. BUILDING: _____ B. WING _____	01/24/2017

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D 310	Continued From page 53 -She only used one teaspoon sized scoop for each cup of thickened liquids. -She could not state the ratio of thickener powder to fluid per manufacturer instruction to obtain nectar-thick liquid. -She could not identify how many ounces of fluid each of the 3 types of plastic cups could hold which were used by the residents. -She had measured the cups and realized she had always been under-thickening the liquids. -The thickener was supposed to be 1 oz of powder to 1 oz of fluid after reading the instructions. -She would mark all cups according to sizes for all staff to identify. -She was the only person that prepared the thickener at the facility. -She would ensure that all dietary employees were trained on how to prepare it in case she was not available. Review of the manufacturer's instructions on each thickener container on 1/23/17 at 12:02am revealed "one teaspoon scoop to one ounce of liquid for nectar-thick consistency." Observation of the Dietary Manager on 1/23/17 at 12:05pm revealed: -She was preparing the water and tea according to glass size and thickener instructions. -The water and tea were nectar thick. -The cups were marked for the dietary aides who brought the cups to the residents. Interview with the Unit Coordinator on 1/23/17 at 1:45pm revealed: -She thought that it was one scoop of powdered thickener per cup of any size. -She read the manufacturer's instructions and would reeducate all staff preparing thickened	D 310	Answer addressed on pg. 50	3/10/17

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D 310	Continued From page 54 liquids to the correct instructions and highlight the instructions on each carton of thickener. Observation of the cartons of thickener for each of the 3 residents on 1/23/17 at 2:45pm revealed all containers had instructions written in black marker on the outside of the container "1 teaspoon scoop to 1 oz ratio for nectar-thick fluids."	D 310		
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 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 observation, interview, and record review, the facility failed to clarify and verify medication orders for 2 of 5 residents (#2, #5) sampled including a resident whose current FL-2, with missing medication orders, had not been clarified after a hospitalization (#5) and a resident whose orders for a blood pressure medication and an anxiety medication had not been clarified (#2).	D 344	All FL-2's either upon admission or readmission will be reviewed by the shift supervisor and/or unit coordinator to ensure all orders are reviewed, clarified, and implemented.	3/10/17

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D 344	Continued From page 55 The findings are: 1. Review of Resident #5's current FL-2 dated 11/08/16 revealed the resident's diagnoses included acute hypoxemic respiratory failure, aspiration pneumonia, urinary tract infection, hypokalemia, dementia, diastolic congestive heart failure, hypertension, coronary artery disease, mitral regurgitation, and patent foramen ovale. Review of Resident #5's current FL-2 dated 11/08/16 after a hospitalization revealed medication orders included: -Aspirin 325mg once a day. (Aspirin is for prevention of heart disease.) -Calcium with Vitamin D (no strength) take 1 tablet twice daily. (Calcium with Vitamin D is a supplement.) -Coreg 6.25mg every 12 hours. (Coreg is for heart / blood pressure.) -Digoxin 0.125mg once daily. (Digoxin is for heart.) -Depakote 125mg EC once daily. (Depakote is for seizures or mood disorders.) -Aricept 5mg at bedtime. (Aricept is for Alzheimer ' s Disease.) -Ferrous Sulfate 325mg once a day. (Ferrous Sulfate is an iron supplement.) -Prilosec 20mg once a day. (Prilosec reduces stomach acid.) -Vitamin B-6 50mg once a day. (Vitamin B-6 is a supplement.) -Lisinopril 5mg daily. (Lisinopril lowers blood pressure.) -Risperidone 0.5mg at bedtime. (Risperidone is an antipsychotic.) Review of the November 2016, December 2016, and January 2017 medication administration	D 344		

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D 344	Continued From page 56 records (MARs) for Resident #5 revealed: -Aspirin 81mg once a day at 8:00 p.m. -Calcium with Vitamin D 600/400 take 1 tablet twice daily at 8:00 a.m. and 7:00 p.m. -Coreg 6.25mg twice a day with food at 8:00 a.m. and 7:00 p.m. -Digoxin 0.125mg at bedtime at 8:00 p.m. -Depakote 125mg EC at bedtime at 8:00 p.m. -Aricept 5mg daily at 8:00 a.m. -Ferrous Sulfate 325mg at bedtime at 8:00 p.m. -Lisinopril 5mg daily at 8:00 a.m. -Risperidone Solution 1mg/ml take 2ml (=2mg) twice a day at 8:00 a.m. and 7:00 p.m. -Vitamin B-6 100mg take 1 & ½ tablets twice daily at 8:00 a.m. and 7:00 p.m. Review of Resident #5's current FL-2 dated 11/08/16 revealed no orders for Bupropion (for depression), Eucerin Cream (moisturizer), Lasix (for swelling), Tylenol (for pain and fever), Triamcinolone Cream (for skin inflammation), Vitamin D3 50,000 units (supplement for Vitamin D deficiency), Ativan (for anxiety), Meloxicam (for pain and inflammation), or Trazodone (for sleep). Review of the November 2016, December 2016, and January 2017 medication administration records (MARs) for Resident #5 revealed: -Bupropion 75mg once a day for dementia with behaviors at 8:00 a.m. -Eucerin Cream apply to affected area daily (mix with 2:1 Triamcinolone cream) at 8:00 a.m. -Lasix 20mg daily at 8:00 a.m. -Tylenol 325mg every morning at 8:00 a.m. -Triamcinolone 0.1% cream apply a thin layer to affected area topically twice a day at 8:00 a.m. and 7:00 p.m. -Vitamin D3 50,000 units once a week at 8:00 a.m. -Ativan 0.5mg twice a day as needed.	D 344	Answer addressed on pg. 55	3/10/17

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D 344	Continued From page 57 -Meloxicam 7.5mg twice a day as needed for pain and inflammation with food. -Trazodone 50mg at bedtime as needed. Review of Resident #5's physician's orders and nursing notes revealed no documentation the physician was contacted to clarify the medications on the FL-2. Interview with a medication aide on 01/23/17 at 4:40 p.m. revealed: -She was unaware of the missing orders with Resident #5's current FL-2 dated 11/08/16. -She administered medications according to the current MARs. -Medication aides would usually get clarifcation of medication orders when needed. -The FL-2 should have been clarified. Interview with a pharmacist from the primary pharmacy for Resident #5 on 01/24/17 revealed: -They never received the 11/08/16 FL-2 for Resident #5 with orders from the hospitalization. -They continued to dispense and print the MARs as the orders prior to 11/08/16. -The most current FL-2 they had on file for Resident #5 was dated 06/17/16. Interview with a medical assistant at the primary care provider (PCP) office for Resident #5 on 01/24/17 at 1:05 p.m. revealed: -No one had contacted them to clarify any physician's orders for Resident #5 prior to 01/24/17. -The most current order they had on file for Aspirin was 325mg once a day. -There was an order on file for Prilosec 20mg once a day. -There was an order on file Vitamin B-6 50mg once a day.	D 344	Answer addressed on pg. 55.	3/10/17

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D 344	Continued From page 58 -There was an order on file for Risperidone 2mg twice a day. -There was an order on file for Bupropion 75mg once daily. -There was an order on file for Lasix 20mg daily. -There was an order on file for Vitamin D3 50,000 units weekly. -There was an order on file for Meloxicam 7.5mg daily. -There was an order for Triamcinolone Cream apply to affected area twice daily. -There was an order for Eucerin cream but no directions listed. -There were "prn" (as needed) orders on file for Ativan and Trazodone. -There was not an order on file for Tylenol. -The PCP was unavailable for interview but he would clarify any orders requested by the facility. Review of clarification orders from the physician for Resident #5 dated 01/24/17 revealed: -Discontinue Aspirin 81mg at bedtime and start Aspirin 325mg once a day. -Prilosec 20mg once a day. -Discontinue Vitamin B-6 100mg 1 and ½ tablet twice a day and start 50mg once day. -Discontinue Vitamin D3 50,000 units once a week and start Vitamin D3 (no strength) 1 tablet twice a day. -Discontinue Risperdal 2ml twice a day and start 0.5mg at bedtime. -Discontinue Bupropion, Eucerin cream, Triamcinolone cream, Lasix, Ativan, Meloxicam, and Trazodone. Refer to interviews with the Unit Coordinator (UC) on 01/24/17 at 8:30 a.m. and 4:12 p.m. 2. Review of Resident #2's current FL-2 dated 02/08/16 revealed the resident's diagnoses	D 344	Answer addressed on pg. 55	3/10/17

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D 344	Continued From page 59 included dementia, Alzheimer's with behavioral disturbance, and hypertension. Review of a physician's order dated 10/20/16 for Resident #2 revealed: -There was an order for Verapamil 40mg by mouth if diastolic blood pressure was >105. (Verapamil lowers blood pressure.) -There was no frequency of how often the Verapamil was to be administered. Review of Resident #2's physician's orders and communication notes revealed no documentation the physician was contacted to clarify the incomplete order. Review of the November 2016, December 2016, and January 2017 medication administration records (MARs) for Resident #2 revealed: -There was an entry for Verapamil 40mg take 1 tablet by mouth as needed for diastolic blood pressure greater than 105. -No Verapamil was documented as administered. -There was a separate entry to check blood pressures once a day and notify the physician if the systolic BP was >170 or <80 or if the diastolic BP was >90 or <60. -The resident's blood pressure ranged from 92/70 - 156/65 from November 2016 - January 2017. -The highest documented diastolic blood pressure was 95. Interview with a medication aide on 01/19/17 at 4:48 p.m. revealed: -She had not noticed there was no frequency on the Verapamil order. -They usually checked the resident's blood pressure once a day. -He was not sure if the resident's diastolic blood pressure had been over 105.	D 344	Facility will assure all orders are clarified and implemented per order.	3/10/17

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D 344	Continued From page 60 Review of a clarification order dated 01/24/17 for Resident #2 revealed: -The physician wrote an order for Verapamil 40mg once a day if diastolic blood pressure was greater than 105. -Check the resident's blood pressure once a day. Refer to interviews with the Unit Coordinator (UC) on 01/24/17 at 8:30 a.m. and 4:12 p.m. --- Interviews with the Unit Coordinator (UC) on 01/24/17 at 8:30 a.m. and 4:12 p.m. revealed: -The medication aide (MA) on duty was responsible for clarifying any medication orders that were unclear or incomplete. -The MA on duty was responsible for clarifying any FL-2 that was unclear or incomplete. -The MA on duty was responsible for faxing any new orders including new FL-2 forms to the pharmacy. -There was currently no system to check behind the MAs to make sure orders were clarified, faxed, or implemented as ordered. -She was working on a system to track and monitor medication orders.	D 344	Answer addressed on previous page.	3/10/17
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 61 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are: Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 2 of 5 residents (#2, #5) sampled as related to a resident with a Stage II pressure ulcer on the buttocks and redness and indentations on the legs from support hose that had not been reported to the physician or treated (#5), a resident with new orders for a diabetic medication and testing supplies and the physician had not been notified regarding clarification of new orders for blood sugar monitoring (#2), and labwork that had not been done on a resident newly diagnosed with underactive thyroid and started a new thyroid medication (#2), and a resident whose high and low blood pressures were not reported to the physician as ordered (#2). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	D912	Each resident of The ARC of Jacksonville will be cared and served for their needs and remain in compliance with relevant federal, state laws, rules and regulations at all times.	