STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL007014	A. BUILDING _____ B. WING _____ MAY 24 2017	R 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA MANOR	1218 PAMLICO STREET WASHINGTON, NC 27889

(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 and the Beufort Count Department of Social Services conducted an annual, follow-up survey, and a complaint investigation on May 3-5, 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 ensure the walls in two resident hallways, the walls and floors in the two common-use bathrooms and two dining room doors were in good repair. The findings are Observation of Bathroom #1 on 5/2/17 at 10.00am revealed: -There was a 4-foot section of baseboard under the sink which had dry rot and was unpainted. -The 3-inch by 12-inch floor vent was rusted. Observation of Bathroom #2 on 5/2/17 at 10:40am revealed: -There was a 2-foot section of baseboard under the sink which had dry rot and was unpainted. -The ceiling light did not work due to a blown light bulb. -There was a 4-inch by 5-foot floor board which ran the length of the shower entrance which had	D 074	The facility will that all hallways, walls and floors are in good repair; The facility will assure that all equipment is in proper usage and in good appearance Assuring all floors are free from any hazards Manager will do weekly walk through. Maintenance Man will do weekly check in on the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diana Jones-Barker

TITLE: Administrator

(X6) DATE: 5/25/17

Reviewed & Accepted By: [illegible]
5/30/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA MANOR	1216 PAMLICO STREET WASHINGTON, NC 27889

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D 074	Continued From page 1	D 074		

dry rot and was unpainted.
-There was a 3-inch by 14-inch metal floor vent completely covered in rust.

Observation of the door at the entrance of the dining room on 5/2/17 at 11:00am revealed the door had to be forced open because of the buckling of the floor where the door rubbed against the tile.

Observation of the door at the entrance of the kitchen from the dining room on 5/2/17 at 11:05am revealed:
-The door had to be forced open because of the buckling of the floor where the door rubbed against the tile.
-The cook had used her shoulder to force open the door when entering the room.

Interview with the cook on 5/2/17 at 11:10am revealed:
-The doors had always stuck since the floors were uneven.
-The administrator had been notified about the doors being stuck.
-They had been stuck for over a year.

Observation of the baseboard heater cover to the right of the entrance door of the dining room at 5/2/17 at 1:00pm revealed the left side had a rusted metal plate measuring 6-inches by 3-inches which protruded outwardly into the pathway of the residents entering the dining room.

Confidential interview with a resident revealed:
-All residents had to force the doors fully open by using their shoulders to open both doors all the way.
-The residents in wheelchairs required staff

6/30/17

The facility will assure that the floors are free from anything that could cause a hazard and are of a smooth surface and no objects or covers in the way of causing harm to anyone - Manager will due walk through weekly and Maintenance Man will do weekly check in on the facility.

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D 074	Continued From page 2 assistance with opening the doors -The doors were usually left open because of the difficulty in opening and closing the doors. -The residents had notified the Administrator of the rusted vents. Attempted interview with the maintenance director on 5/3/17 unsuccessful Interview with the Administrator on 5/2/17 at 1:20pm revealed: -She was aware of the dining room doors inability to completely open. -The dining room doors ability to open was affected "when the floors swell up now and then." -She would put in a maintenance request to have the dining room doors fixed. -She would have the baseboard heater repaired. -She would have the baseboards and rotted wood in the bathrooms repaired. -She was responsible for overseeing all repairs -The facility had access to the maintenance person who could complete any repair request.	D 074		
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 and interviews, the facility failed to assure patio chairs and porch chairs were kept clean and in good repair, including chairs with rips in the fabric on the seat part of the	D 076	The facility will assure that all furniture are clean and in good repair. The facility will assure that chairs are free from cracks and rips. The Manager will walk through weekly and Maintenance Man weekly Check in the facility 5/3/17	

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D 076	Continued From page 3 chair The findings are: Observation of the two outdoor porch chairs on 5/2/17 at 12:00pm revealed: -There were two chairs made of metal bar construction covered in a beige fabric covering. -The fabric on the left chair seat was completely detached on the left and front side causing the fabric to hang downward touching the ground. -The fabric on right chair seat had a 2-foot tear extending from the front center bar of the seat to the rear center bar of the seat exposing the center metal base support which had protruding bolts sticking upwards. -Both chairs were covered in dirt and mildew. -The chairs were not able to be used to sit in or you would fall through them to the ground. Observation of the 5 outdoor patio chairs on 5/2/17 at 12:10pm revealed: -All chairs were made of metal bar construction covered in a beige fabric covering. -One of chairs had torn seat fabric extending from the front bar to the rear bar of the seat, exposing the metal support base. -All chairs were covered in dirt and mildew. -All chairs had spots of rust forming on all parts of the metal bar construction Confidential interviews with 2 residents revealed: -All residents still sat on the chairs but "you had to straddle the bars so you didn't fall through the chairs." -The patio and porch chairs had been in a state of disrepair for over a year. -The fabric is so dry and brittle that residents had to be careful "not to tear the chair more than it already was."	D 076		

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D 076	Continued From page 4	D 076		

-The Administrator was aware of the condition of the chairs.
-The residents had told the Administrator of the condition of the chairs.
-The residents had stopped reporting the need over the past year for replacement chairs because they felt the facility did not place high importance on outdoor furniture.

Interview with the RCC (Resident Care Coordinator) on 5/3/17 at 10:05am revealed.
-The chairs had been identified before as being in need of repair by another agency that visited the facility a month ago.
-The chairs had rips in them for over a year.
-The residents still sit in the chairs but some of the chairs just were not able to support any residents.
-There were no restrictions prohibiting use of the torn chairs.

Attempted interview with the maintenance director on 5/3/17 unsuccessful.

Interview with the Administrator on 5/3/17 at 13:30am revealed:
-The chairs were identified as being in need of repair by another agency a month ago
-The maintenance director dealt with all identified repair needs.
-The maintenance director worked for the owner who was assigned to other properties in addition to the facility.
-The residents had never informed her of the need for the patio and porch chair repairs
-She was unaware of the condition of the chairs
-She would put in a request to the owner to have the chairs repaired or replaced.

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D 079	Continued From page 5	D 079		
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 the facility's walkway railings, the exterior telephone and cable wires by the wooden ramp, and two of the common-use bathroom toilet support railings were in maintained in a clean manner and free of hazards. The findings are: Observation of outdoor ramp on 5/3/17 at 10:00am revealed: -The 16-foot long railings on both sides of the 4-foot wide ramp leading to the side door had rotting wood, 7 loose vertical slats and 12 nails protruding from the top of the railings. -All areas of both railings had wooden splinters and rough edges with peeling paint. -All areas of the ramp and railings were covered in mold. Observation of bathroom #1 on 5/2/17 at 11:12am revealed there was a unstable metal support railing to the left of the toilet which was loosely attached to the wall and floor mounts causing the railing to easily be moved side-to-side	D 079	The facility will assure that all exterior objects or wiring are properly installed to prevent any hazards - The Manager will do weekly walk through and Contact proper Company's regards their exterior equipement that is out of place. Maintanence Man Check in on facility weekly - 5/19/17	

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O 079	Continued From page 6 approximately 1-foot. Observation of bathroom #2 on 5/2/17 at 11:19am revealed there was a unstable metal support railing to the left of the toilet which was loosely attached to the wall and floor mounts causing the railing to easily be moved side-to-side approximately 1-foot Observation of the telephone and cable boxes at the base of the wooden ramp on 5/3/17 revealed: -There was a broken box cover for the telephone wires which was hanging 2 feet exposing approximately 25 wires which went into the facility's exterior wall. -There were exposed sharp metal telephone wire tips near the walk path approximately 4 feet from the ground within reach of residents passing by the phone box. -There were television cable wires that were protruding outwardly towards the walkway approximately 2-feet from an open plastic encasement which was unable to contain the bulky cables. Confidential interviews with 5 residents revealed: -The bathroom bars were unsafe when residents tried to stand up from the toilet. -The residents had notified the Administrator on several occasions but could not recall the dates of the notifications. -The maintenance man had been seen in the facility in the past several months but had not addressed the railings in the bathrooms. -The wooden ramp outside the facility needed repairs. -The ramp was covered in mold and had nails sticking out of the railings. -The ramp had been the same for over a year. -The telephones in the facility often had static.	O 079	The facility will assure that all equipment in use for purpose of disabled are purely in smooth surface and good working condition free from any objection pushing up from wood or metal of any kind. Manager check Weekly and Maintanence check in weekly- 6/30/17	

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D 079	Continued From page 7	D 079		

during the rain because of the exposed phone cables.
-The wires for the telephone and television cables were never fixed even though residents had told the administrator over a year ago.
-There was an occasion that the facility had no telephone service after a rain storm.

Interview with the Maintenance Director on 5/4/17 at 8:45am revealed:
-He had noticed the phone cables and television cables protruding from the facility's exterior.
-He thought it was the responsibly of the phone company and cable company to fix it.
-He had never called the telephone company or cable company to tell them of the protruding cables and broken containment boxes.
-He would call the phone and cable company to have the cables and boxes repaired.

Interview with Resident Care Coordinator (RCC) revealed 5/3/17 at 10:30am revealed:
-The facility did not have a dedicated maintenance person but had shared one maintenance person among the owner's other facilities.
-The loose wires by the walkway and wooden ramp were functional but needed to be repaired.
-No residents had been injured by the exposed wiring.
-Sometimes when it rained, the telephone service had a lot of static

Interview with Administrator on 5/3/17 at 11:45am revealed:
-She was unaware of the phone wire containment box being broken.
-She had not seen the exposed wires.
-She had not seen the exposed television cable wires.

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D 079	Continued From page 8 -She had not been notified by the residents of the phone wires and the television cables at the base of the pathway -She was responsible for overseeing the maintenance of the building -She would notify the maintenance man of the repair needs to the telephone and cable boxes at the base of the ramp	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by Based on observations, interviews, and record reviews, the facility failed to maintain hot water system at a minimum of 100 degrees Fahrenheit hot water to 2 of 7 bathroom fixtures in the common-use bathrooms and a resident's private bathroom. The findings are: Observation of the bathroom sinks and showers at the facility after allowing each faucet to run for a minimum of 10 minutes on 5/2/17 revealed: -Common-use bathroom #2 bathroom sink revealed a water temperatures of 96 degrees	D 113	The facility will assure that the water temperature maintains the recommended desired temperature at all times - Assure that water temp does not exceed to hot or down to cold for resident personal care needs - Manager & staff Check temp on every Shift with the proper instrument to be used - Maintenance Main Check in facility Weekly -	5/11/17

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D 113	Continued From page 9	D 113		

Fahrenheit at 8:10am.
-Common-use bathroom #4 bathroom sinks revealed a water temperatures of 99 degrees Fahrenheit for the sink by the door (4A), and 90 degrees for the second sink (4B) at 8:32am.
-Common-use bathroom #5 bathroom sink revealed a water temperature of 99 degrees Fahrenheit at 8:26am.
-The facility's only private bathroom sink revealed a water temperature of 94 degrees Fahrenheit at 8:50am.

A second observation of the bathroom sinks and showers at the facility after allowing each faucet to run for a minimum of 10 minutes on 5/3/17 revealed:
-Common-use bathroom #4 bathroom sink 4B revealed a water temperature of 94 degrees Fahrenheit at 11.05am.
-The facility's only private bathroom sink revealed a water temperature of 94 degrees Fahrenheit at 11:25am.

Review of the facility's monthly temperature logs for May 1-3, 2017 revealed:
-Bathroom #2 ranged from 101.3 degrees to 110 degrees
-Bathroom #4A ranged from 102.3 degrees to 108.1 degrees
-Bathroom #4B raged from 103 degrees to 110.5 degrees.
-Bathroom #5 ranged from 103.7 degrees to 113.1 degrees.

Observation of the Manager checking the water temperatures on 05/03/17 at 9:00 AM revealed she was using a meat thermometer to check water temperatures.

Confidential interviews with 3 residents revealed:

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D 113	Continued From page 10 -The water had been cold sometimes throughout the day. -Cold water temperatures had occurred several times over the past few months -Each resident had told the Administrator of the cold water issue on each occasion when they experienced cold water temperatures. -The Administrator had told each resident that the water temperature would be addressed after each complaint. -The water temperatures remained the same regardless of the time of day. Interview with the Resident Care Coordinator on 5/2/17 at 10:00am. revealed: -The water heater temperature dial setting had been increased after being informed of cold temperatures earlier that morning. -After adjusting the water heater on 5/2/17 she was able to get temperature readings above 100 degrees Fahrenheit water temperature in all bathrooms using a meat thermometer. -She had not received any complaints related to water temperatures over the last few months -She did keep a log book of water temperature checks at the facility which showed they were in compliance according to the thermometer that they used. -The water temperatures were to be checked daily by staff. Interview with the Administrator on 5/3/17 at 11:45 a.m. revealed: -She would correct the cold water situation immediately -She had already notified the maintenance man to repair the problem. -The residents had not complained about the water temperature. -They did maintain a water temperature log book.	D 113		

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D 113	Continued From page 11 -She would purchase a proper water temperature thermometer. -The water temperatures were checked daily and recorded.	D 113		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial	D 278	The facility will assure that all resident has the proper assessment that is done in a timely manner after admission into facility. The manager will make sure to contact WHS nurse upon arrival of new resident and keep track of time period Nurse has to complete Task and Notify Administrator. 5/31/17	

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ulcer presenting as an abrasion, blister or shallow crater;
(11) inhalation medication by machine;
(12) forcing and restricting fluids;
(13) maintaining accurate intake and output data;
(14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established);
(15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin;
(16) oxygen administration and monitoring;
(17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints;
(18) oral suctioning;
(19) care of well-established tracheostomy, not to include indo-tracheal suctioning;
(20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule);
(21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP);
(22) application of prescribed heat therapy;
(23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity;
(24) ambulation using assistive devices that requires physical assistance;
(25) range of motion exercises;
(26) any other prescribed physical or occupational therapy;
(27) transferring semi-ambulatory or non-ambulatory residents, or
(28) nurse aide II tasks according to the scope of

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practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to assure that 1 of 3 sampled resident (Resident #2) had a computed Licensed Health Professional Support review within 30 days of admission and then quarterly for a resident receiving finger sticks, injectable insulin, and continuous oxygen.

The findings are:

Review of Resident #2's current FL2 dated for 12/18/16 revealed:
-Diagnoses of chronic obstructive pulmonary disease, severe hypoxemia, type 2 diabetes mellitus, situational stress disorder, non-compliance, and venous insufficiency.
-A physician's order for oxygen (used to assist with breathing) 3 liters per nasal cannula.
-A physician's order to check finger stick blood sugar twice per day.
-A physician's order for Humalin N insulin (a medication used to reduce blood sugar) 20 units in the morning and 30 units in the evening via subcutaneous injections.

Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 01/17/17.

Review of Resident #2's record revealed there was no documentation of the Licensed Health Professional Support (LHPS) review completed.

Observation of Resident #2 on 05/02/17 at 9:20

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA MANOR	1219 PAMLICO STREET WASHINGTON, NC 27889

(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 278	Continued From page 14 AM revealed: -There was a tank of oxygen sitting at the resident's bedside. -He was able to place oxygen on his face but did have some trouble cutting the oxygen machine on independently Interview with Resident #2 on 05/02/17 at 9:25 AM revealed: -The staff do not assist him with using his oxygen. -The staff check his finger stick blood sugar twice per day every day. -The Medication Aide gave him his insulin every day. Interview with a Medication Aide on 05/04/17 at 10:30 AM revealed: -The Medication Aide staff were responsible for checking Resident #2's finger stick blood sugar daily. -The Medication Aide staff were responsible for administering Resident #2's insulin daily. -She had helped Resident #2 before with putting on his oxygen. Telephone interview with the Licensed Health Professional Support nurse on 05/04/17 at 10:30 AM revealed: -She was not aware that Resident #2 had not had an LHPS completed since being transferred to this facility. -When Resident #2 was transferred from one facility to another she had forgot to complete the LHPS review. -She would come in a soon as possible and renew Resident #2's LHPS. Interview with the Resident Care Coordinator on 05/04/17 at 10:50 AM revealed: -She was not sure why the LHPS for Resident #2	D 278		

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D 278	Continued From page 15 had not been completed. -The LHPS nurse must have forgot to complete the LHPS for Resident #2. -Resident #2 was new and had only been at the facility since January of 2017. -She would call the LHPS nurse and find out why the LHPS had not been completed for Resident #2.	D 278		
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 failed to ensure the kitchen and dining room areas were free of contaminiation including the kitchen which had dried food particles in multiple areas including around the reach-in freezer and ice machine, an ice machine in need of maintenance and cleaning, rusted refrigerator shelving, a dirty window unit air conditioner and a freezer with a dirty exterior. The findings are: Observation of the ice machine located in the kitchen on 5/2/17 at 10:36am revealed: -The ice machine had greasy substance on the inside lid. -The ice machine had multiple greasy hand prints on the exterior. -The air intake vent had a sticky film covered with	D 282	The facility should assure that the Kitchen dining and food storage areas are clean and well organized and protected from contamination. No area should have signs of unclean stains on its exteriors such as sticky film or spilled liquids. The facility should assure that clean and good repaired shelves and other appliances are cleaned. Manager check daily. 6/30/17	

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D 282	Continued From page 16 dust. Observation of the air conditioner located in the kitchen on 5/2/17 at 10:39am revealed the 2-foot by 3-foot air intake vent was heavily covered in dust. Observation of the reach-in cooler located in the kitchen on 5/2/17 at 10:45am revealed: -The bottom of the cooler had a 2-foot diameter puddle of clear liquid. -The ventilation intake grate at the base of the cooler was covered in dried white liquid spatter. -The front edges of the cooler shelves had several areas of rust beginning to form. -The cooler handle was sticky with dried white spatter around the handle edges. -There were crumbs at the bottom of the handle insert. Interview with the cook on 5/2/17 at 11:45am revealed: There was no cleaning schedule for the cooler or ice machine. -The walk-in cooler racks needed to be replaced. -The cook would clean the refrigerator and ice machine by the end of the day. -The cook would wipe down the exteriors of all the refrigerators and counter surfaces after every meal. Interview with the Resdient Care Coordinator on 5/2/17 at 12:52pm revealed: -She would ensure that the kitchen was cleaned after each meal service -The cook was always working and did not have time to ensure everything was clean and wiped down if the day got busy. -She would create a cleaning schedule for the kitchen.	D 282		

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D 282	Continued From page 17 Interview with the Administrator on 5/2/17 at 10:45am revealed -The kitchen should be cleaned regularly after each meal including floors and walls. -She was going to address the kitchen cleanliness issues. -She was going to create a cleaning schedule for the kitchen. -She was going to alert the maintenance man to clean and repair the ice machine -She was going to alert the maintenance man to clean the air conditioner vent. -She was unaware that the reach-in cooler needed to be cleaned and had rusted shelves.	D 282		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations and interviews the facility	D 317	The facility will assure that all resident activities will equal a total of required 14 hours a week - Activities will be those that are of physical, groups, creative Knowledge and learning skills for the residents. Also community outreaches will be included - Each resident will be encourage and activities will be centered around individual involvement. Manager Monitor weekly and Activity Director Monitor Monthly	6/1/17

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failed to provide 14 hours weekly of planned group activities for 18 of 18 residents

The findings are:

Observations during the survey from 5/2/17 to 5/4/17 revealed:
-The residents were watching television in the living room, asleep, outside on the porch, or by the exit ramp outside smoking
-There were no activities being done during the survey

Review of the May 2017 Activity Calendar from 5/2/17 to 5/4/17 revealed:
-On 5/2/17, from 10am to 11am, "scramble squares" and puzzles were to be offered.
-On 5/2/17, from 6pm to 7pm, a card game was to be offered.
-On 5/3/17, from 10am to 11am, BINGO was to be offered.
-On 5/3/17, from 6pm to 7pm, a board was to be offered.
-On 5/4/17, from 10am to 11am, puzzles were to be offered.

Observation of the activity supplies available at the facility on 5/3/17 at 10:43 p.m. revealed:
-There was a partially assembled puzzle on a table in the living room, two puzzles under the table in boxes.
-There was a closet with a packet of bingo cards and chips, crossword puzzles, coloring books, 2 decks of cards and other random unidentifiable plastic bags of miscellaneous items including cups, small boxes and coloring utensils.

Confidential interview with 5 residents revealed:
-The activities calendar was posted with events but they did not have activities at the posted

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times.
-The only activity in the facility was BINGO and it was never at the posted time.
-There were two puzzles on a table besides bingo that the facility encouraged residents to work on.
-The facility staff did not notify anyone of activities when they were about to begin.
-Most of the activities listed on the calendar were not offered
-Exercise was posted on the activities calendar and no one offered the activity.
-The residents colored and painted as activities "when they wanted to."
-The facility did not take the residents on outings.
-The residents had not told anyone about wanting to go on outings at the facility.
-The Activities Director did not encourage residents to participate in activities.
-BINGO was offered at random times not coinciding with the calendar.
-The facility needed more activities that they residents enjoyed.
-"We get tired of sitting around and watching TV."
-No real activities were done at the facility with residents except for church services by a visiting pastor.
-Different groups from the community came and did church services with the residents about 1 to 2 times per month.

Interview with a Personal Care Aide on 5/3/17 at 2:20pm revealed:
-Personal Care Aides do some activities with the residents on occasion.
-Residents participated in a variety of activities like bingo, word games, coloring, drawing, and playing cards
-She could not recall the last time she had observed or participated in activities with the residents.

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Interview with the Activities Director 5/3/17 at 1:30pm revealed:
-She made the activities calendar every month.
-The residents enjoyed the activities offered.
-She did not call the residents to the activity area when activities started.
-Many residents did not want to participate
-She had not received any complaints from residents related to activities and times of activities.
-Residents enjoyed BINGO and church-related activities.
-All activities were usually at the posted times but sometimes she had to work around the residents time preferences.

Interview with the Administrator on 06/07/16 at 1:15 p.m. revealed:
-The Activities Director kept the posted activities calendar updated.
-She had not received any complaints from the residents.
-The residents enjoyed BINGO and church activities.
-The resident activities included bingo, card games, puzzles, Scrabble and watching television.
-The residents did not like to exercise but it remained on the activities calendar.
-She had no explanation why the activities and times listed on the calendar were not being offered.

D 344 10A NCAC 13F .1002(a) Medication Orders — D 344

10A NCAC 13F .1002 Medication Orders
(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner

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D 344	Continued From page 21 for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 5 residents (#1, #3) sampled including a resident (#3) whose current FL-2 had missing medication orders for a blood pressure medication, a pain medication and an anxiety medication which differed from a hospitalization discharge medication regimen, as well as a resident (#1) with blood sugar control medication had not been clarified. The findings are: 1. Review of Resident #3's current FL-2 dated 4/11/17 revealed the resident's diagnoses included depressive disorder, diabetes, chronic diffuse arthralgia, benign prostate hyperplasia, hypertension, gait instability, toothache and neuro cognitive disorder. Review of a Resident Register revealed that Resident #3 was admitted to the facility on 4/4/17. Review of hospital admission and discharge records for Resident #3 dated 4/11/17 revealed:	D 344	The facility will assume that medication orders are properly clear upon admission or are properly clarified so that resident will receive proper tx without delay. Manager will check chart and med record behind Med-tech. Administrator will follow-up during her monitoring.	6/30/17

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-The resident was taken to the emergency department on 4/4/17.
-The resident was admitted on 4/4/17 for unspecified diagnosis.
-The resident was subsequently admitted to the psychiatric unit within the same hospital on 4/7/11.
-The Resident was discharged from the hospital's psychiatric unit on 4/11/17 with two separate hospital discharge packets, one from the main hospital and one from the psychiatric unit within the hospital.
-The hospital's psychiatric ward discharge packet included "continue oxycodone 10/325mg (pain medication), metoprolol tartrate 25 milligrams (blood pressure medication) and Haldol (for behaviors) as needed" as part of the resident's medication list.
-The main hospital discharge packet did not have oxycodone, metoprolol and Haldol listed in the resident's medication list.

Review of Resident #3's current FL-2 dated 4/11/17 after a hospitalization revealed medication orders omitted oxycodone, metoprolol and Haldol on the medication list.

Review of Resident #3's medical record revealed:
-There were no written orders by Resident #3's medical provider related to the continuance of oxycodone, metoprolol and Haldol.
-There were no notes in the record indicating a verbal order from the doctor was provided after Resident #3 returned to the facility.

Observation of the medication cart containing medications for Resident #3 on 5/4/15 revealed there was a supply of oxycodone, metoprolol and Haldol for the resident.

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Review of the Resident #3's Medication Administration Records admission between 4/4/17 (the resident's admission date) to 5/4/17 revealed:
-The resident had continued receiving his oxycodone 10/325 at 2am, 8am, 2pm and 8pm daily since the resident's return to the facility on 4/11/17.
-The resident had continued receiving his metoprolol tartrate 25mg at 8am each morning since resident's return to the facility on 4/11/17.
-The Haldol (as needed for behaviors) had not been given due to no observed behavior issues since resident's return to the facility on 4/11/17.

Interview with Resident #3 on 5/3/17 at 10:52am revealed:
-The resident had always been taking the same pain medication, blood pressure medication and other medications prior to the admission to the facility and after his admission to the facility.
-The resident had been receiving his pain medications four times a day since he came back from the hospital.
-He couldn't remember what time of day he received his pain medications them but knew it was four times each day.
-He needed his pain medications otherwise he needed to go to the hospital again
-He could not recall any other medications taken but said there were many.
-The staff ensured he received his medications daily

Interview with the Administrator on 5/5/17 at 10:05 am revealed:
-Resident #3 was admitted on 4/4/17 from another facility where the resident had the same medical provider
-A few hours after admission to this facility

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Resident #3 had an anxiety attack and was admitted to the hospital on 4/4/17.
-Resident #3 returned from the hospital with a hospital written FL-2 and signed by a hospital doctor.
-The FL-2 omitted the oxycodone, metoprolol and Haldol.
-Resident #3's medical provider had not reviewed the FL-2 from the hospital.
-Resident #3's medical provider had given a verbal order to the Administrator for Resident #3 to continue the same regimen with oxycodone, metoprolol and Haldol upon his return from the hospital when she was notified that the resident had returned on 4/11/17.
-The Administrator had not clarified the FL-2 from the hospital on paper, but had a verbal order from Resident #3's medical provider that she did not document.

Interview with the Resident #3's medical provider on 5/5/17 at 10:05 am revealed:
-A few hours after admission to this facility Resident #3 had an anxiety attack and was admitted to the hospital on 4/4/17.
-The FL-2 omitted the oxycodone, metoprolol and Haldol.
-She did not catch the omission of the oxycodone, metoprolol and Haldol on the FL-2.
-She wanted the resident to continue taking the oxycodone, metoprolol and Haldol as the resident had been taking prior to admission to the facility
-She had not reviewed the FL-2 from the hospital
-She had given a verbal order to the Administrator for Resident #3 to continue the same regimen with oxycodone, metoprolol and Haldol upon his return from the hospital when she was notified that the resident had returned on 4/11/17.
-Resident #3 could not be without his oxycodone, metoprolol and Haldol because his behaviors

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would increase and the resident would always become defiant.
-She would write the documentation and place it in his chart.
-She did not observe nor was notified of any behaviors requiring administration of Haldol since Resident #3's return from the hospital.
-She wanted to keep the Haldol on-hand even though she was aware Resident #3 had not needed the Haldol since his return from the hospital
-She had sent the oxycodone prescription along with the metoprolol and Haldol directly from her office to the pharmacy on record.
-Resident #3 was on the medications and proper dosages since his return from the hospital and she would update the paperwork in Resident #3's chart to reflect the current orders and medication regimen.

2. Review of Resident #1's current FL-2 dated 1/24/17 revealed the resident's diagnoses included schizophrenia, dementia, obesity, high cholesterol and moderate mental retardation.

Review of Resident Register revealed that Resident #1 was admitted to the facility on 7/13/12.

Review of Resident #1's FL-2 dated 1/24/17 revealed:
-A physician order for one tablet of glipizide 10mg daily (to help control blood sugar)
-A physician order for metformin 500mg two tablets twice daily (to help control blood sugar)

Review of Resident #1's Medication Administration Records between 1/24/17 and 5/4/17 revealed
-There was no documentation of administration of

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glipizide or metformin administered to the resident.
-Glipizide and metformin were not listed on the Medication Administration Record provided by the pharmacy.

Observation of the medication cart revealed there were no medication cards or prescription bottles of glipizide or metformin for Resident #1.

Interview with the Medication Aide on 5/3/17 at 2:00pm revealed:
-She had not given glipizide or metformin to Resident #1 for a long time.
-There was no glipizide or metformin in the cart for Resident #1
-Glipizide and metformin were not listed on the Medication Administration Record to be given to Resident #1

Interview with Resident #1 on 5/2/17 at 1:55pm revealed the resident could not state any medications he received

Interview with Resident #1's medical provider 5/3/17 at 3:05pm revealed:
-Resident #1 should not have been on glipizide or metformin.
-There was an error on the FL-2
-She had not ordered glipizide or metformin for this resident.
-Resident #1's blood sugar readings were ok and glipizide and metformin were not needed since she had signed the FL-2 on 1/24/17.
-She had discontinued glipizide and metformin and had notified the pharmacy who in turn had discontinued the medications.
-When the FL-2 was signed, she had not noticed that the glipizide and metformin had reappeared when signing the form as it was filled out by the

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	HAL007014	A. BUILDING _____ B. WING _____	R 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA MANOR	1218 PAMLICO STREET WASHINGTON, NC 27889

(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 344	Continued From page 27 facility staff. -Resident #1 was currently taking the correct medications. -She would clarify the order on 5/3/17 and send an order to the facility to correct the error on the FL-2 dated 1/24/17. Interview with the Administrator on 5/3/17 at 2:15pm revealed: -She was anticipating a revised order for Resident #1's medication regimen which would reflect the current medication regimen being administered. -She would ensure that all FL-2's would be revlewed in the future for accuracy.	D 344		
D 358	10A NCAC 13F 1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (Resident #3 and Resident #5) including omitting medications scheduled to be administered. The findings are:	D 358	The facility would assure that medications would be properly administered as ordered and prescribed - Staff will have continue training in Administration of Medication and of review. Training was Completed on 5/8/17 by Licensed Pharmacist.	5/8/17

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D 358	Continued From page 28	D 358		

The medication error rate was 6% as evidenced by observation of 2 errors out of 31 opportunities during the 12:00 PM medication pass on 05/02/17 and the 8:00 AM / 9:00 AM med pass on 05/03/17

1. Review of Resident #3's current FL2 dated for 04/11/17 revealed:
-Diagnoses of unspecified depressive disorder, diabetes mellitus, chronic diffuse arthralgia, benign prostate hyperplasia, hypertension, gait instability, toothache, and unspecified neurocognitive disorder.
-A physician's order for Artificial Tears (a lubricating eye drop that helps with dry eyes) 2 drops to both eye's daily.

Observation of the 12:00 PM medication pass on 05/02/17 revealed:
-The Medication Aide pulled out a bottle of eye drops labeled artificial tears 2 drops both eye's daily for Resident #3.
-When all of the other medications that Resident #3 was to receive were administered, the Medication Aide did not administer the eye drops to Resident #3.
-The Medication Aide started pulling medications from the cart for another resident.
-The Medication Aide signed off that the eye drops were administered as ordered.

Interview with the Medication Aide on 05/02/17 at 12:12 PM revealed:
-She had forgot to administer the eye drops to Resident #3
-Since she had to roll the cart down the hallway to him she had forgot that he had not already taken the eye drops.
-She would go and administer the eye drops now.

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D 358	Continued From page 29	D 358		

Observation of the Medication Aide on 05/02/17 at 12:15 PM revealed she administered the eye drops too Resident #3.

Refer to interview with the Administrator on 05/03/17 at 9.50 AM.

2. Review of Resident #5's current FL2 dated for 08/17/16 revealed:
-Diagnoses of hypertension, bilateral leg amputation, and tobacco use, gastro esophageal reflux disorder, chronic pain, hyperlipidemia, and pace maker.
-A physician's order for Citalopram (a mediation used to treat depression) 20 milligrams take 1 tablet by mouth daily.

Observation of the 8:00 AM medication pass at 7:57 AM on 05/02/17 revealed.
-The Medication Aide pulled out a pack of medication labeled Citalopram 20 milligrams 1 tablet daily for Resident #5.
-When all of the other medications that Resident #5 was to receive were administered, the Medication Aide did not administer the Citalopram to Resident #5.
-The Medication Aide started preparing medications from the cart for another resident
-The Medication Aide signed off that the Citalopram was administered as ordered.

Interview with the Medication Aide doing the 8:00 AM medication pass on 05/03/17 at 7:59 AM revealed.
-She was finished with Resident #5 and had administered all of his medications as ordered.
-She was not aware that she had forgotten to place the Citalopram into his medication pill cup.
-She would go back and administer the

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D 358	Continued From page 30 Citalopram to Resident #5 at this time. Observation of the Medication Aide on 05/03/17 at 8:00 AM revealed she administered the Citalopram medication and administered it to Resident #5. Refer to interview with the Administrator on 05/03/17 at 9:50 AM revealed: Interview with the Administrator on 05/03/17 at 9:50 AM revealed: -All Medication Aides received training on medication administration prior to working on the medication cart. -The training was then continued annually for all Medication Aides. -She was not sure when the last training had been done she thought sometime in January or February of 2016 -She would have a pharmacist come and train the Medication Aide staff -She was not aware that the staff members had been omitting medications. -She would be calling today to have a training set up for all of the Medication Aides.	D 358		