Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065020	A. BUILDING: _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPIONS ASSISTED LIVING	1007 PORTERS NECK ROAD WILMINGTON, NC 28411

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D 000	Initial Comments The Adult Care Licensure Section and New Hanover Department of Social Services conducted an annual survey from May 16, 2017-May 18, 2017.	D 000		
D 209	10A NCAC 13F .0604 (2-e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care Other Staffing The following describes the nature of the aide's duties, including allowances and limitations (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure Nurse Aides (NAs) were not routinely assigned to perform food service duties on the Memory Care Unit. The findings are: Observation of the Memory Care Unit (MCU) dining room on 05/16/17 at 11:13am revealed two Nurse Aides (NAs) were placing dishes and silverware on the dining tables. Interview with two NAs on 05/16/17 at 11:13am revealed: -The MCU had two dining rooms. -The NAs were responsible for setting the dining tables for meals.	D 209	Champions Assisted Living acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written assertion of compliance. Champions Assisted Living's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Champions Assisted Living reserves the right to refute and incorporates by reference any rebuttal of any deficiency on this statement of deficiencies that it submits through informal dispute resolution, formal appeal and/or other administrative or legal procedures.	

POC reviewed/accepted 7/31/17
(22)

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D 209	Continued From page 1 -The NAs were responsible for making and serving beverages to the residents. -The dietary staff brought the food and plated the food for the residents; the NAs served the food to the residents. -The NAs were responsible for clearing and cleaning the tables and "scrape plates." -When the NAs were setting the dining tables, activity staff were "usually" with the residents "so they are watched." -While the NAs were serving meals, the residents were eating, so they were monitored. Observation of the breakfast meal in dining rooms A and B of the MCU on 05/17/17 from 7:55am-8:34am revealed: -There were thirteen place settings in dining room A and six place setting in dining room B. -At 7:56am, there were eight residents in the dining room A; two NAs were coming in and out of the food prep area serving food and beverages to the residents. -At 8:05am, there was one dietary staff in the food prep area (located between dining rooms A and B) plating food and one NA in the food prep area; the residents seated in dining rooms A and B were not visible because the doors to the food prep area were both closed. -At 8:20am there were 4 residents in dining room B and one resident walking out of dining room B; there was one NA clearing dishes off the tables and going in and out of the food prep area. -From 8:26am-8:298am, two NAs were cleaning dishes off tables in dining room A and taking them into the food prep area; there were seven residents in dining room A and no staff present when the NAs were in the prep area. -At 8:31am, there were 5 residents in dining room A and two NAs in and out of the food prep area. -At 8:34am there were 5 residents in dining room	D 209	10A NCAC 13F .0604(2-e) Personal Care and Other Staffing Champions will assure that staff will be present in the dining rooms while residents are eating. The doors to the serving pantry will remain open during meal service to ensure staff can see and hear residents while they are in the dining room. Two staff members will remain in the dining room area while other staff will bring residents to the dining room. The Memory Care Coordinator or designee will randomly monitor through observation the dining service on a weekly basis. Alleged completion date is July 15, 2017. 10A NCAC 13F .0904(d)(2) Nutrition and Food Service Champions will assure that memory care residents are offered snacks between meals for a total of three	

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D 209	Continued From page 2 A with zero staff present. Interview with a NA on 05/17/17 at 9:43am revealed NAs were responsible for setting the tables for meals, serving food and beverages, and wiping down the tables. Observation of the MCU on 05/18/17 from 11:44am-12:36pm revealed: -At 11:44am, there were five residents in dining room A and two NAs in the food prep area. -At 11:47am, two NAs came out of the prep area and began placing glasses of water at each of the twelve place settings. -At 11:50, one NA was in dining room A putting glasses of tea on the tables. -At 11:51am, a second NA brought out a tray with six beverages glasses, placed it on the table and walked down the hallway to bring a resident to the dining room. -From 11:50-11:53am, Resident #6 was standing in the hall outside dining room A; she was disoriented and began crying (put her hands over her face and eyes). No staff came to assist or re-direct her. -At 11:55am, a NA came to direct Resident #6 into dining room A. -At 11:58am, Resident #6 began crying again; the two NAs were in the food prep area and did not respond or assist her. -At 11:59am, a Medication Aide came into the dining room and asked Resident #6 what was wrong; the two NAs were still in the food prep area. -At 12:05pm, there were twelve resident in dining room A and two NAs in and out of the food prep area serving food to the residents. -At 12:08pm, Resident #6 left her table and walked to another table; a NA re-directed her back to her seat/table.	D 209	snacks a day. Snacks will be offered mid-morning, mid-afternoon, and after dinner. The Memory Care Coordinator or designee will monitor weekly through observance of snack activity. Alleged completion date is July 15, 2017. 10A NCAC 13F .1002(a) Medication Orders Champions will assure that medication orders are clarified as needed. Orders will be reviewed and transcribed by the receiving staff member. If an order is incomplete or non-specific, the ordering practitioner will be contacted for clarification. A second review of orders and transcriptions will be completed by night staff supervisors to ensure accuracy. The Resident Care Director will conduct random monthly audits of MARs. Any discrepancies will be reported and reviewed monthly by the Pharmacy Committee. A copy of the revised standing orders can be found in Attachment A. Alleged	

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D 209	Continued From page 3 -At 12:10pm, all residents had been served their meal. -At 12:11pm, one NA was clearing salad bowls off the tables. -At 12:12pm, both NAs were in the food prep area; there was no staff in dining room A. -At 12:18pm, Resident #6 put one entire layer of cake measuring ½ inch thick and 2/12-3 inches long into her mouth; there was no staff present in dining room A. -At 12:23pm, Resident #6 began to cry; there was not staff present in dining room A to respond. -At 12:24pm, a NA came into dining room A from the food prep area; a resident sitting at another table was looking at Resident #6 and rolling her eyes at her. -At 12:28pm, one NA began clearing the dishes off the tables. -At 12:29pm, the second NA took Resident #6 out of dining room A to walk in the hallway. -At 12:30pm, there were eleven residents in dining room A; one NA was in the food prep area and one NA was in the hall with Resident #6. -From 12:34pm-12:35pm, there were eight residents in dining room A, one NA walked a resident to their room, and the second NA was across the hall in the common area with Resident #6. -At 12:36pm, the NA told Resident #6 she would be right back then went into dining room A and began clearing tables. Interview with a NA on 05/18/17 at 12:42pm revealed: -Lunch had been busier than usual that day (05/18/17). -"I don't want to say" if personal care was affected by the NAs doing dietary duties. Interview with a housekeeping staff working on	D 209	completion date is July 15, 2017. 10A NCAC 13F .1004(a) Medication Administration Champions will assure that standing orders are administered as ordered. Standing orders have been reviewed and updated to include only over the counter medications (OTC). These OTC medications will be maintained in house stock to ensure availability when needed. Medication technicians will be in-serviced on the revised standing orders and procedure. Revised standing orders will be sent out for physician signatures. Nursing will establish par levels of inventory and will monitor and order monthly or as needed. Alleged completion date is July 15, 2017. 10A NCAC 13F .1004 (n) Medication Administration Champions will assure that medications are administered in	

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D 209	Continued From page 4 the MCU on 05/18/17 at 11:42am revealed: -The NAs were responsible for clearing and washing the dining tables after meals. -The housekeeping staff for responsible for cleaning the floors after meals. Interview with the Dietary Manager on 05/16/17 at 11:40am revealed: -NAs "became wait staff" at meals. -Dietary staff plated the meals; NAs set the dining tables and served food and beverages to the residents. -After meals, the NAs cleared the dishes and cleaned the dining areas and the dietary staff cleaned the steam tables. Interview with the Administrator on 05/18/17 at 11:10am revealed: -NA staff had always set up, served, and cleared the food after meals. -The rule area had not been cited during previous surveys. -The Administrator referred to the North Carolina Department of Health and Human Services rule interpretation document which said bringing plates to tables was an appropriate aide duty.	D 209	accordance with infection control measures that help to prevent the development and transmission of disease or infection. Medication technicians will be in-serviced again on proper hand washing practices regarding the medication pass. Nurse supervisors will conduct random audits through observation on a monthly basis to ensure compliance. Alleged completion date is July 15, 2017.	
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	D 298		

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D 298	Continued From page 5 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure 20 of 20 residents residing in the Memory Care Unit were being offered a snack 3 times a day in between meals. The findings are: Observation of the Memory Care Unit on 05/16/17 from 10:00 AM to 4:00 PM revealed there was only one snacked offered around 3:30 PM to the residents on the Memory Care Unit. Confidential interview with a Memory Care Unit (MCU) staff member revealed: -Residents in the MCU were served snack once daily but they could get a snack whenever they requested it. -A snack was scheduled and served at 3:30 PM daily for residents in the MCU. -There was no snack served in the MCU between breakfast and lunch. -The staff did not think there was a snack scheduled in the MCU after supper. Interview with a resident in the MCU on 05/16/17 at 11:04 AM revealed: -Snacks such as "cookies, drinks, and sweets" were served "sometimes" but not every day. -The resident did not know how often or what time snacks were served. Interview with a second resident on the MCU on 05/17/17 at 1:25 PM revealed: -The staff never came around and offered snacks. -She was not aware of where she could get any snacks. -Her family member would bring her snacks from	D 298		

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D 298	Continued From page 6 time to time to keep in her room. -She would like it if the facility offered snacks throughout the day. Interview with six additional residents in the MCU during the breakfast meal on 05/17/17 at 7:56 AM revealed none of the six residents knew how often snacks were served to them. Interview with the Memory Care Unit Coordinator on 05/17/17 at 10:25 AM revealed: -The only snack offered to the residents on the Memory Care Unit was at 3:30 PM daily. -The second shift staff would set up the snack and give it to the residents on the unit. Interview with the Director of Nursing on 05/17/17 at 10:20 AM revealed the residents in the Memory Care Unit were offered snacks every day but she was not sure how many times per day. Interview with the Administrator on 05/18/17 at 7:55 AM revealed: -The Administrator had spoken with second shift staff employed in the MCU the previous day (05/17/17) and was told by the staff that a snack was offered nightly at 8:00pm to residents in the MCU who were still awake at that time. -Going forward, she would assure snacks were provided three times daily in the MCU. -She was only aware before talking with staff that snacks were offered everyday at 3:30 PM. -She was not aware of any other snacks being offered.	D 298		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with	D 344		

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D 344	Continued From page 7 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 observations, interviews, and record reviews, the facility failed to assure medication orders were clarified for 2 of 7 residents sampled for record review (#3, #6) for a nasal allergy spray (#3) and a topical steroid cream (#6). The findings are: 1. Review of Resident #3's current FI-2 dated 02/14/17 revealed: -Diagnoses included Alzheimer's dementia, hypertension, diabetes mellitus, hypothyroidism, and allergic rhinitis. -There was a medication order for Flonase 50mcg 1-2 sprays in each nostril every morning. (Flonase spray is used to treat the symptoms related to inflammation of the mucus membranes). Review of Resident #3's March 2017 electronic Medication Administration Record (eMARs) revealed: -There was a computer generated entry for Flonase 50mcg "1-2 sprays each nostril" once in	D 344		

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D 344	Continued From page 8 the morning. -Flonase was documented as administered from 03/01/17-03/31/17. Review of Resident #3's April 2017 electronic eMARs revealed: -There was a computer generated entry for Flonase 50mcg "1-2 sprays each nostril" once in the morning. -Flonase was documented as administered from 04/01/17-04/30/17. Review of Resident #3's May 2017 electronic eMARs revealed: -There was a computer generated entry for Flonase 50mcg "1-2 sprays each nostril" once in the morning. -Flonase was documented as administered from 05/01/17-05/16/17. Observation of the medication cart for the Memory Care Unit on 05/17/17 at 9:47am revealed there was one bottle of Flonase 50mcg on hand for Resident #3 that had a dispense date of 04/16/17 on the label and directions which read to administer 1-2 sprays once daily. Interview with a Medication Aide (MA) on 05/17/17 at 9:47am revealed: -The MA did not "really know" how many sprays of Flonase to give Resident #3 because the label and eMAR said to give 1-2 sprays each day. -The order should have been given to the "Nurse" for clarification of how many sprays to give. Interview with the Resident Care Director (RSD) on 05/17/17 at 10:12am revealed: -Any incomplete order was supposed to be clarified by the Clinic Nurse. -Resident #3's Flonase order should have been	D 344		

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D 344	Continued From page 9 clarified. -Physician orders were faxed to the pharmacy and transcribed to the eMARs by the "Clinic Nurse." -A second check of orders on the eMARs was completed by the night shift Supervisor. -A third check was completed on the eMAR orders by the Clinic Nurse. -The eMAR checks assured the eMAR matched the physician order. Interview with the Clinic Nurse on 05/17/17 at 10:35am revealed: -Resident #3's Flonase order "slipped through the cracks" and had not been clarified. -She would get the order clarified "right away." Interview with Resident #3 on 05/16/17 at 11:04am revealed she knew she took medications but was not sure which medications or how often. Telephone interview with Resident #3's physician on 05/18/17 at 8:56am revealed the physician "would hope" the facility would clarify whether Resident #3 was to get 1 spray or 2 sprays of Flonase daily. 2. Review of Resident #6's current FL-2 dated 05/02/17 revealed: -Diagnoses included dementia, depressions with anxiety, and vascular dementia with behavior disturbance. -There was a medication order for "Triamcinolone cream (Kenalog) 0.1%" apply topically twice daily. (Triamcinolone cream is used in the treatment of symptoms to include redness, swelling, discomfort, and itching of the skin). Review of the Resident Register for Resident #6	D 344		

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D 344	Continued From page 10 revealed an admission date to the facility of 05/08/17. Review of the Physician's Orders for Resident #6 dated 05/09/17 revealed an order to "change Kenalog 0.1% cream to twice daily as needed." (Kenalog is the name brand of Triamcinolone). -The order did not contain an indication and/or location for application. -The order was signed by a licensed prescriber on 05/09/17. Observation of the medication cart for the Memory Care Unit on 05/17/17 at 9:50am revealed: -There was one full 80 gram tube of Triamcinolone 0.1% cream with a dispense date of 05/08/17 on hand for Resident #6. -The Triamcinolone label directions read "Apply to affected areas topically twice daily as needed." Interview with a Medication Aide (MA) on 05/17/17 at 9:50am revealed: -The Triamcinolone was supposed to be applied to Resident #6's "skin" but the MA did not know where or why to apply the cream because the label did not have those directions. -Resident #6's electronic Medication Administration Record (eMAR) did not give directions on where to or why to apply the Triamcinolone either. Review of Resident #6's May 2017 eMAR revealed: -There was a computer generated entry for Triamcinolone 0.1% cream twice daily as needed. -"Amount to administer: to cover; topical." -There were no directions on the eMAR related to the location and/or indication for application of the Triamcinolone cream.	D 344		

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D 344	Continued From page 11 -Triamcinolone was not documented as administered to Resident #6 on any dated in May 2017. Interview with the Resident Care Director (RSD) on 05/17/17 at 10:12am revealed: -Physician orders were faxed to the pharmacy and transcribed to the eMARs by the "Clinic Nurse." -A second check of orders on the eMARs was completed by the night shift Supervisor. -A third check was completed on the eMAR orders by the Clinic Nurse. -The eMAR checks assured the eMAR matched the physician order. -Any incomplete order was supposed to be clarified by the Clinic Nurse. Information regarding whether Resident #6's Triamcinolone 0.1% cream order had been clarified was requested on 05/17/17 at 10:35am. Based on observations, interviews, and record reviews, Resident #6 was not interviewable. Attempted telephone interview with Resident #6's Power of Attorney on 05/16/17 at 3:35pm was unsuccessful. Interview with the Resident Services Director (RSD) on 05/18/17 at 8:45am revealed: -The RSD provider information on where to look in the electronic health record for the Resident #6's clarified Triamcinolone order. -The RSD did not know why Resident #6's Triamcinolone order had not been clarified until 05/17/17. Review of electronic documentation in the electronic health record of Resident #6 on	D 344		

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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 344	Continued From page 12 05/18/17 revealed there was documentation dated 05/17/17 of clarification of Resident #6's Triamcinolone 0.1% cream order to apply twice daily in the morning and evening to rash under breast as needed. Observation of Resident #6 on 05/18/17 at 10:10am revealed the skin underneath her breasts was clean, intact, and without rashes or redness. Telephone interview with Resident #6's physician on 05/18/17 at 8:56am revealed: -The physician reviewed the orders for Resident #6 and acknowledged there was no indication for use of the Triamcinolone. -The Nurse Practitioner (NP) should have told in the order where to apply the cream. -The physician expected the facility to have the order clarified on the day the order was written by the NP (05/09/17).	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	D 358		

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	HAL065020	A. BUILDING: _____ B. WING _____	05/18/2017

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D 358	Continued From page 13 medications as ordered for 1 of 7 residents sampled (#3) related to a standing order for a medication to lower blood pressure. The findings are: Review of Resident #3's current FL-2 dated 02/14/17 revealed: -Diagnoses included Alzheimer's dementia, hypertension, and diabetes mellitus. -There was a physician's order to check blood pressure every day. Review of the "Physician's Standing Orders" for Resident #3 dated 02/14/17 revealed "Elevated blood pressure- For BP (greater than) >190/100, give Clonidine 0.1mg PO (by mouth). Retake BP every 12 hrs, (hours) and repeat Clonidine dose if >190/100. Notify physician." (Clonidine is used to treat high blood pressure). Interview with a Personal Care Aide (PCA) on 05/16/17 at 10:50am revealed: -Resident #3 had only lived in the facility about two months. -Resident #3 had been having problems with high blood pressure and thought the Medication Aide (MA) checked her blood pressure every day. Interview with Resident #3 on 05/16/17 at 11:04am revealed: -She had been having "heart spells" and "blood pressure" spells that made her feel bad. -She had seen her doctor about her condition, but was not sure when. -She took medications but was not sure which medications or how often. Telephone interview with Resident #3's Power of Attorney (POA) on 05/17/17 at 1:55pm revealed:	D 358		

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D 358	Continued From page 14 -Resident #3 had a history of high blood pressure and had been to the hospital one time about one month ago. -Resident #3's physician was aware of her high blood pressure and had adjusted her medications to get her blood pressure "regulated." -The POA did not know what medications Resident #3 was taking. -The POA did not have any concerns about the care Resident #3 received at the facility. Review of a physician visit "Progress Notes" for Resident #3 dated 04/05/17 revealed: -Resident #3 was seen by the provider at the staff request for elevated blood pressure with diastolic blood pressure as high as in the '90's. -The resident was asymptomatic; her blood pressure was documented at the visit as 170/100. Review of the electronic "Progress Notes" for Resident #3 revealed: -04/06/17, Resident #3's blood pressure was 174/102 at 6:45pm; when her blood pressure was rechecked at 7:40pm, it was 168/86. -04/09/17 at 1:00am: "Recorded as a late entry on 05/01/17 at 10:33pm" Resident #3 complained to the Nurse Aide(NA) that she did not feel well. Her blood pressure was 243/117 and when rechecked 15 minutes later, her blood pressure was 229/98. An order was obtained from the Nurse Practitioner to send Resident #3 to the hospital for further evaluation. -04/09/17 at 2:20am: When the NA was making rounds, "resident stated she was not feeling well." The Medication Aide (MA) was called and "BP was taken several times." Resident #3's blood pressure was 243/117 and 20 minutes later it was 216/108. The on call provider was contacted and gave orders to send Resident #3 to the hospital.	D 358		

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D 358	Continued From page 15 Review of a hospital Emergency Department note for Resident #3 dated 04/09/17 revealed she was evaluated and discharged on 04/09/17; the diagnosis was documented as essential hypertension. Review of the physician visit "Progress Notes" for Resident #3 dated 04/14/17: -Resident #3 was evaluated for follow up to a hospital visit on 04/09/17 for elevated blood pressure. -Resident #3 did not feel well on 04/09/17; her blood pressure was 243/117 and 216/108 on 04/09/17. -Her blood pressure for 04/14/17 was documented as 180/90 with a notation that her blood pressure dropped significantly from lying to standing positions. Review of the electronic "Progress Notes" for Resident #3 dated 04/16/17 revealed: -At 7:00pm, the Licensed Practical Nurse (LPN) was notified that Resident #3's blood pressure was 190/108 and she was complaining of headache, dizziness, and shortness of breath. Her blood pressure was verified using a manual blood pressure cuff. -Resident #3's 7:00pm scheduled medications to include Lisinopril 10mg. (used to treat high blood pressure) were administered. -The medical provider on call was notified and gave orders to recheck Resident #3's blood pressure in 45 minutes and call her back if the blood pressure was still elevated. -At 7:45pm, Resident #3's blood pressure was 173/83. -At 8:45pm, Resident #3's blood pressure was 136/84 and she reported feeling better. Observation of medication cart on 05/17/17 at	D 358		

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D 358	Continued From page 16 9:47am revealed there was no Clonidine 0.1mg stocked on the medication cart for Resident #3. Interview with a Medication Aide (MA) on 05/17/17 at 9:47am revealed: -Resident #3 had a history of elevated blood pressure; her blood pressure was taken and documented daily. -When Resident #3 did not feel good, she let staff know. -When Resident #3's blood pressure was up, the nurse and physician were notified. -The MA did not know why Resident #3 did not have any Clonidine 0.1mg on hand on the medication cart. Interview with the Memory Care Unit Coordinator (MCC) and Resident Services Director (RSD) on 05/17/17 at 10:30am revealed: -Standing orders were scanned into the computer but were not routinely added to the eMARs; the MAs knew to look for standing orders as needed. -If was facility procedure for the MAs to notify a nurse to assess the need for standing order medications. -Standing orders were only implemented as needed so the medications may not be on hand. -The expectation for receipt of medications listed on standing orders was to obtain the medication from the pharmacy as needed. Interview with the Clinic Nurse/LPN on 05/17/17 at 10:35am revealed: -She was unaware Resident #3 had a standing order for Clonidine. -She did not know why Resident #3 was not given Clonidine per the standing order for her elevated blood pressure. -She would check "now" to see if the physician still wanted Resident #3 to have an order for	D 358		

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D 358	Continued From page 17 Clonidine and if so, would get the medication stocked on the medication cart for Resident #3. Interview with the MCC and Administrator on 05/17/17 at 10:45am revealed: -The policy for standing orders was as follows: when a standing order (that was on file) was needed, the nurse wrote a telephone order, the medication was obtained from the onsite pharmacy or alternate pharmacy as needed, and the physician signed the telephone order. The telephone order also served as physician notification. -In order for Resident #3's Clonidine to be administered per the standing order for elevated blood pressure greater than 190/100, both the systolic and diastolic blood pressure would have to exceed the ordered parameters. -Resident #3 had a history of high blood pressure and had been sent to the hospital once for further evaluation. -Resident #3's physician was aware of her elevated blood pressure and had made multiple medication changes; staff monitored her blood pressure as ordered. -Resident #3's standing order for Clonidine 0.1mg dated 02/14/17 was on file but was considered "inactive" until it was actually used, which was why Clonidine was not stocked on the medication cart. -The facility had a pharmacy on their campus and an alternate pharmacy used after hours. -The facility did not want residents to have to deal with the excess cost of obtaining and keeping standing order medications on hand if the medication was not routinely needed. -Standing order medications were filled/stocked on the mediaction cart when the order was activated/medication was needed. -The MCC did not know why the Clonidine had	D 358		

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D 358	Continued From page 18 not been administered to Resident #3 per the standing order when her blood pressure was outside both of the parameters in the standing order and acknowledged there was not documentation as to why the Clonidine was not administered per the standing order. -The MCC thought maybe the Clonidine was not given 04/09/17 because the medical provider had been contacted and said to send her to the hospital. Telephone interview with a staff member at the office of Resident #3's former primary care provider (who had signed the FL-2 and standing orders dated 02/14/17) on 04/17/17 at 4:22pm revealed: -When Resident #3 moved into the assisted living facility, her medical care had been taken over by another health care provider because their office was more than one hour away from the assisted living facility. -Resident #3 had not been patient in that office since she moved into the assisted living facility and the office did not have any details and could not answer any questions related to her care after the date of her admission to the assisted living facility (02/22/17). Telephone interview with Resident #3's current primary care physician on 05/18/17 at 8:56am revealed: -The facility tried to have a nurse on duty on all shifts. -In general, standing orders were utilized in the facility to give the nurse "options" in case the physician could not be contacted for any reason. -The physician would not expect Clonidine to be administered to Resident #3 unless her systolic blood pressure and diastolic blood pressure were both outside of the parameters.	D 358		

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D 358	Continued From page 19 -The physician would not have expected Clonidine 0.1mg to be administered to Resident #3 per the standing order dated 02/14/17 on 04/09/17 when her systolic blood pressure was greater than 200 mm/Hg and her diastolic blood pressure was greater than 110 mm/Hg because the medical provider had been notified and she was sent to the hospital for further evaluation. -When asked if Clonidine was expected to to be kept in stock for Resident #3, the physician did not provide the expectation.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 Medication Aides (MAs) observed during the medication passes administered medications in accordance with infection control measures to prevent the development and/or transmission of infection and/or disease. The findings are: Observation of the 7:00am medication pass in the Assisted Living Section of the facility on Three North hall on 05/17/17 from 7:16am-7:31am revealed:	D 371		

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D 371	Continued From page 20 -There was no hand sanitizer observed on the medication cart. -The MA prepared then administered six oral medications to a resident at 7:20am. -The MA prepared, mixed in applesauce, and administered twelve oral medications and then donned gloves and administered one eye drop medication to a second resident at 7:31am; she removed the gloves after instilling the eye drops. -The MA touched the computer, outside and inside surface the medication cart and drawers of the medication cart, drawer dividers inside the medication cart, medication bingo cards, disposable medication cups and spoon, and door handles of the residents' rooms while preparing, administering, and documenting administration of the medications for the two residents. -The MA was not observed washing her hands or using hand sanitizer at any time. Interview with the MA on 05/17/17 at 7:32am revealed: -When asked what procedures she used for infection control, the MA said there were wipes on the medication cart that she used to wipe down the medication cart before and after the medication pass. -When asked what her procedure was for infection control for her hands or how often she performed hand hygiene, the MA responded "I'm getting ready to wash them now" (her hands). -The MA acknowledged there was no hand sanitizer on the medication cart. Interview with the Administrator on 05/17/17 at 7:52am revealed: -Hand sanitizer was usually kept on the medication carts and was supposed to be on the medication carts. -She would "check into" the observations	D 371		

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D 371	Continued From page 21 identified during the medication pass on Three North hall earlier that day (03/17/17). Interview with the Resident Care Director/Registered Nurse and Community Trainer on 05/17/17 at 10:12am revealed: -All staff were trained on hand washing and infection control annually. -Infection control measures were expected to be followed to include during medication administration. -The MA had previously received training on infection control and hand washing and had been be "counseled" (that day) about not using infection control measures for her hands during the medication pass that day. -The MA had last completed the state mandated infection control training in May 2017. Review of the MAs personnel record revealed: -The MA was hired 10/17/07 and was currently employed as a MA. -The MA had last completed the state mandated infection control training on 05/02/17.	D 371		