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
	HAL065019	A. BUILDING: _____ B. WING _____	R-C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

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D 000	Initial Comments The Adult Care Licensure Section and New Hanover County Department of Social Services conducted an annual and follow up survey and complaint investigation on 06/01/17 - 06/02/17 and 06/05/17 - 06/06/17.	D 000	Please see the attached POC	8/11/17
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director (2) The activity director hired on or after July 1, 2005 shall have completed or complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. A person with a degree in recreation administration or therapeutic recreation or who is state or nationally certified as a Therapeutic Recreation Specialist or certified by the National Certification Council for Activity Professionals meets this requirement as does a person who completed the activity coordinator course of 48 hours or more through a community college before July 1, 2005. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the current Activity Coordinator (Staff F) completed the basic activity course for assisted living activity directors within nine months of employment or assignment to this position. The findings are:	D 129		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daphne P Shelar-Mason — TITLE: Executive Director — (X6) DATE: 7-18-17

STATE FORM 6899 3LKU11

* The plan of correction with addendum was Reviewed and accepted on 08/23/17. Refer to pages 2, 13, and 31
D. Henry 08/25/17

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D 129	Continued From page 1 Observations made throughout the survey on 06/01/17 through 06/02/17 and 06/05/17 through 06/06/17 revealed Staff F held activities with the residents at the facility. Interview with Staff F on 06/06/17 at 2:00 p.m. revealed: -She had worked at the facility for 1 ½ years as the Activity Coordinator. -The only training she had was internal training that was offered by the facility. -She had not taken a basic activity course for assisted living but was planning to get scheduled into a training. -She did not have a degree or certification related to activity coordination for adult care homes. Review of Staff F's personnel record on 06/06/17 revealed: -Staff F had a hire date of 08/11/15. -Staff F's title was Activity Coordinator. Review of the job description for Activity Coordinator revealed: -The job summary included that the dementia programs would meet the specific needs of each and all residents with the memory care facility, would ensure residents' lives were maintained to the extent possible by providing activities and contact with the community and would ensure residents were treated with respect and dignity, recognizing individual needs and encouraging independence. -The education and experience included a Bachelor's degree (B.A.) in a therapeutic recreation or activities-related field and a minimum of two or more years of direct programming experience with older adults and persons with dementia preferred. -The job description was signed and dated by	D 129 D129	Addendum Per Telephone Conversation with Paula Snoke-Mason On 8/23/17 The Executive Director will monitor the activity Course progress on a weekly Basis by meeting with the Activity Coordinator and on a tracking report which will document progress of the course until the course is completed ESOH Activity Course completion-09/29/17 The Correction date for this Standard of Deficiency will be on 09/29/17 Deborah Hines RN 08/23/17	

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D 129	Continued From page 2 Staff F on 08/10/15. Interview with Business Office Coordinator (BOC) on 06/06/17 at 4:20 p.m. revealed: -Staff F had not completed a basic activity course for an assisted living activity director. -Staff F did not have a degree in recreation administration or therapeutic recreation. -Staff F's promotion was based on years of employment with the company, positions held, and evaluation performances. -If an Activity Coordinator was promoted within the company, another Activity Coordinator from another community would come to train the staff member promoted. Interview with Administrator on 06/06/17 at 8:07 p.m. revealed: -Staff F was trying to take an online course for activities since she missed the local class about 1 year ago. -The District Director of Operations at the corporate office was aware Staff F had not taken the course for basic activity director.	D 129		
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	D 209		

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D 209	Continued From page 3 residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure personal care aides (PCAs) were not routinely assigned to perform food service duties on the Special Care Unit. The findings are: Observation of the dining room revealed there were 2 dining room sections separated by a walled in room that was labeled "private dining". Interview with a cook on 06/01/17 at 11:40 a.m. revealed: -The first section of the dining room was known as the independent side where the independent residents sat to eat their meals. -The second section of the dining room was known as the assisted side where residents who required assistance from staff sat to eat their meals. Observation of a PCA on 06/01/17 at 11:50 a.m. revealed the PCA was folding table cloths and setting up the residents' tables for the lunch meal. Observation of a PCA on 06/02/17 at 8:53 a.m. revealed the PCA was wiping off some of the residents tables after the residents' had finished their meal and had left the dining room. Observation during the lunch meal on 06/05/17 revealed: -At 12:55 p.m. a PCA was removing plates and table cloths from the residents' dining room table. -At 1:14 p.m. there were two aides clearing the residents' dining room tables after the residents had left the dining area by removing glasses,	D 209		

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D 209	Continued From page 4 plates and the table cloths. Confidential interview with a staff member revealed: -All PCAs had assigned tasks during the residents' meals. -Individual PCA assignments depended on what hall the PCA was working on. -The PCA assignments included assisting residents in and out of the dining room, setting up the resident's tables with table cloths, utensils and beverages, passing out the meal courses to the residents, assisting the residents with eating, cleaning up the dirty dishes, cleaning the tables after removing the table cloths and to mop and sweep the dining room floor after each meal. -There was only one cook in the kitchen and the cook mostly stayed in the kitchen. -The staff member felt it was odd for the PCAs to perform dietary responsibilities. -The staff member felt the PCAs' extra dietary responsibilities took the PCAs' attention away from resident care. Interview with Administrator on 06/06/17 at 8:07pm revealed: -When dining starts everything stops, as the expectation is for all staff to help with meals. -The Resident Care Coordinator (RCC) works from 12noon to 8:00pm on Monday, Wednesday, Thursday, and Friday as this allows RCC to help with dinner. -The staff assist with table set up, linens, place setting. -One side cleans (wiping table and chairs), the other side sweeps. -The dietary staff is only responsible for meal preparation.	D 209		

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D 276	Continued From page 5	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure implementation of physician orders for 1 of 5 sampled residents (Resident #2) with physician's orders for daily blood pressure checks. The findings are: Review of Resident #2's current FL-2 dated 4/3/17 revealed: -The resident's diagnoses included Alzheimer's dementia, hypertension, and hypothyroidism. -There was an order to check blood pressure daily. Review of Resident #2's April 2017 Electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry to check blood pressures weekly on the 3-11 shift in the evening every Wednesday related to essential (primary) hypertension. The start date was 03/15/17. -There was no documentation of blood pressure readings the entire month for Resident #2.	D 276		

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D 276	Continued From page 6 Review of Resident #2's May 2017 eMAR revealed: -There was a computer generated entry to check blood pressures weekly on 3-11 shift in the evening every Wednesday related to essential (primary) hypertension. The start date was 03/15/17. -The documentation on the eMAR showed Resident #2's blood pressure was 120/70 on 05/17/17, 110/62 on 05/24/17, and 140/80 on 05/31/17. Review of 05/30/17 pharmacy review for Resident #2 revealed: -There was an order on the FL-2 dated 04/03/17 for daily blood pressures. -Weekly blood pressures were on the MAR. -It was noted to "please correct." Interviews with four different medication aides throughout the survey (06/01/17, 06/02/17, 06/05/17, and 06/06/17) revealed: -The blood pressure readings would be documented on the eMAR. -Resident #2 had an order for blood pressure to be taken weekly and not daily. Telephone interview with the former Resident Care Coordinator (RCC) on 06/05/17 at 11:00 a.m. revealed: -If a resident had specific orders for blood pressures the readings would be documented on the eMAR. -The RCC called Resident #2's physician to inform physician Resident #2's blood pressures were not being done daily as ordered. -There was no documentation of RCC calling Resident #2's physician. -The RCC did not know why Resident #2 had	D 276		

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D 276	Continued From page 7 orders to check blood pressure daily other than the resident was taking a blood pressure medication. Observation of a medication aide taking Resident #2's blood pressure on 06/05/17 at 11:37 a.m. revealed the resident's blood pressure was 110/72 from a sitting position. Interview with a nurse at the physician's office for Resident #2 on 06/05/17 at 3:33 p.m. revealed: -The resident was seen at the physician office on 04/03/17 as a new patient. -The FL-2 signed and dated 04/03/17 showed an order to check blood pressure daily. -The nurse did not have information why Resident #2 had an order to check blood pressures daily. -The nurse did not see an order change for weekly blood pressure checks in the system. -The physician assistant could have signed the physician orders for blood pressure to be check weekly while seeing the resident at the facility. -The expectation would have been for Resident #2 to have blood pressure taken daily as ordered until an order changed to check the blood pressures weekly. Interview with Administrator on 06/05/17 at 6:10 p.m. revealed the blood pressure readings would be documented on the eMAR if a resident had a specific order.	D 276		
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	D 310		

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D 310	Continued From page 8 served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure nutritional supplements were administered as ordered for 1 of 1 resident sampled (#3) who had an order for daily house shakes and had a 10.6 pound weight loss in one month. The findings are: Review of Resident #3's current FL-2 dated 06/21/16 revealed: -The resident's diagnoses included dementia, hypothyroidism, hypertension, colitis, hyperlipidemia, recent fall, subarachnoid hemorrhage, and traumatic brain injury - subdural hematoma. -The resident was constantly disoriented. -The resident required assistance with bathing, dressing, and feeding. Review of Resident #3's assessment and care plan dated 02/03/17 revealed the resident required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. Review of a physician's order dated 01/24/17 for Resident #3 revealed an order for house shakes once daily to prevent weight loss. Review of physician's order dated 02/03/17 for Resident #3 revealed: -There was an order to discontinue pureed diet due to weight loss and the resident's dislike of meal texture.	D 310		

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D 310	Continued From page 9 -There was an order to change diet to chopped meats. Review of Resident #3's April 2017, May 2017, and June 2017 medication administration records (MARs) revealed: -There was no entry on the MARs for house shakes. -There was no documentation the resident had received any house shakes from April 2017 - June 2017. Review of Resident #3's 2017 monthly weight log revealed the following weights: -January: 116.6 pounds. -February: 118.8 pounds. -March: 114 pounds. -April: 120 pounds. -May: 109.4 pounds. Observations of Resident #3 in the dining room revealed: -On 06/01/17, Resident #3 ate at least 90% of her supper meal. -On 06/02/17, Resident #3 ate at least 75% of her lunch meal. -No house shakes were served to the resident. Interview with the Dietary Manager (DM) on 06/06/17 at 10:05 a.m. revealed: -House shakes were milkshakes made by the dietary staff at the facility. -There were no residents currently receiving house shakes. -The DM thought it had been about 4 months since any house shakes were ordered and prepared for any resident. -She was not aware that Resident #3 had a current order for house shakes but would check with her cook who may be preparing the	D 310		

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D 310	Continued From page 10 resident's house shake. Interview with a medication aide (MA) on 06/06/17 at 9:42 a.m. revealed: -House shakes were usually given out by second shift staff at 4:00 p.m. -She did not see house shakes listed on Resident #3's MARs. -If a resident received house shakes, it would be documented on the MARs. -Resident #3's primary care provider (PCP) and hospice provider were aware of Resident #3's weight loss. Interview with a second MA on 06/06/17 at 5:05 p.m. revealed: -The kitchen staff usually served house shakes to residents about 4:00 p.m. -The personal care aides (PCAs) would let the MAs know when the resident drank the house shakes and the MAs would document it on the MARs. -Resident #3 used to get house shakes "about a month or so ago". -She did not know why the resident stopped getting house shakes. -Resident #3's MAR did not have house shakes listed on it. -Resident #3 drank the house shakes when she received them in the past. Interview with a personal care aide (PCA) on 06/06/17 at 5:10 p.m. revealed: -She had worked at the facility over a year. -She did not recall Resident #3 ever receiving house shakes. Interview with a third MA on 06/06/17 at 5:19 p.m. revealed: -House shakes were made by kitchen staff.	D 310		

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D 310	Continued From page 11 -House shakes were usually served around 3:30 p.m. or 4:00 p.m. -Orders for house shakes were usually documented on the MARs. -She did not recall Resident #3 receiving house shakes recently but the resident may have received them in the past. -She had not seen an order for house shakes on Resident #3's MAR. Interview with Resident #3's primary care provider (PCP) on 06/06/17 at 10:56 a.m. revealed: -Resident #3 was a hospice patient. -He did not currently provide services to Resident #3 unless the services needed were outside of the scope of hospice. -Any questions related to Resident #3's care should be addressed with the current hospice provider. Interview with Resident #3's hospice nurse on 06/06/17 at 1:15 p.m. revealed: -There was no order to discontinue Resident #3's order for house shakes to her knowledge. -She was aware of the resident's weight loss because the resident was not eating well. -She was not aware the resident was not receiving house shakes.	D 310		
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	D 358		

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D 358	Continued From page 12 (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 1 of 5 residents sampled (#5) who did not receive an antibiotic as ordered for 10 days for an ear infection. The findings are: Review of Resident #5's current FL-2 dated 03/18/17 revealed: -The resident's diagnoses included cognitive deficit following cerebrovascular accident, dysphagia, aspiration pneumonia, protein calorie malnutrition, vascular dementia, diffuse interstitial pulmonary fibrosis, chronic obstructive pulmonary disease, and type 2 diabetes mellitus. -Resident #5 was constantly disoriented. Review of the Resident Register revealed Resident #5 was admitted to the facility on 2/17/17. Review of a physician's visit form dated 05/18/17 for Resident #5 revealed: -The resident was diagnosed with a draining left ear perforation. -An an antibiotic ear drop was prescribed. Review of a lab report, dated 5/23/17, revealed: -A left ear culture taken on 05/18/17 was positive for methicillin resistant staphylococcus aureus (MRSA) infection. -There was an order written on the lab report for Bactrim DS take 2 tablets twice a day for 10 days. (Bactrim DS is an antibiotic for infection.)	D 358 D358	Addendum Per Telephone Conversation with Paula Sholar-Mason on 8/23/17: All Resident Charts Were reviewed and Checked with the MAR by the Executive Director and the Health and Wellness Director and LPN. The Health and Wellness nurse, LPN will monitor the MARS, checking new order tracking forms, Hot Boxes, Carts (medication) weekly on a random chart Basis. 08/23/17	

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D 358	Continued From page 13 Review of a physician order form for Resident #5 dated 05/24/17 revealed: -There was an order for Bactrim DS 2 tablets twice a day for 10 days. -The order was signed by the physician on 05/25/17. Review of the May 2017 and June 2017 electronic medication administration records (e-MARs) for Resident #5 revealed: -The order for Bactrim DS was not listed on the May 2017 MAR. -The order for Bactrim DS was not listed on the June 2017 MAR when initially reviewed on 06/02/17. Observation of Resident #5's medications on hand on 06/02/17 at 11:30 a.m. revealed: -There was a bubble card with a supply of Bactrim DS tablets dispensed from a local pharmacy on 05/23/17. -There was a total of 40 tablets dispensed with 2 tablets packaged in each bubble for a total of 20 doses of the medication (a 10 day supply). -The instructions on the label were to give 2 tablets twice a day for ear infection for 10 days. -Twelve of the 40 tablets had been used, a 3 day supply. -There were 28 tablets remaining in the bubble card, a 7 day supply on the 10th day after the order was written. Interviews with a medication aide (MA) on 06/02/17 at 11:30 a.m. and 1:55 p.m. revealed: -She did not understand why Bactrim DS was not showing on Resident #5's e-MARs or anywhere in the electronic medication management system. -The Bactrim DS was on the e-MAR when the MA gave the resident the 8:00 a.m. dose that morning	D 358		

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D 358	Continued From page 14 on 06/02/17. -She did not notice this issue before now and had been giving the resident the medication. -She recalled that the resident's family member brought in the Bactrim DS from an outside pharmacy. -Typically when the facility received a signed physician's order, the MA on duty filled out a New Order Tracking form and faxed the order to the pharmacy. -The medication would have been entered in the e-MAR system and would have "popped up" on the MAR. -The new e-MAR system was down for 3 days and just came back up late on 05/31/17. -She recalled giving the resident the Bactrim DS the last 3 days she worked. Interview with a second MA on 06/02/17 at 4:45 p.m. revealed: -Resident #5 did not take Bactrim DS to the MA's knowledge. -A New Order Tracking Form should have been completed by the MA on duty when the facility received the Bactrim DS order. -This would have ensured it was added to the e-MAR. -She was unable to locate a copy of the New Order Tracking form for Bactrim DS. Telephone interview with the former Resident Care Coordinator (RCC) on 06/05/17 at 11:05 a.m. revealed: -Her last day working on-site at the facility was about a week ago. -Resident #5 had been complaining of pain in her ear and she thought the resident might have some wax build up. -The ear, nose, and throat (ENT) physician did a culture on the resident's ear and the resident had	D 358		

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D 358	Continued From page 15 methicillin resistant staphylococcus aureus (MRSA) infection in her ear. -Resident #5's family member had taken her to the ENT physician and the ENT office sent an electronic prescription to a local pharmacy instead of the facility's primary pharmacy. -The local pharmacy called the resident's family member on 05/24/17 and let them know about the prescription. -The family member told the RCC about it and she thought the family brought the Bactrim DS to the facility on 05/24/17 in the afternoon. -The RCC contacted the ENT's office to get an order for the facility's records. -She thought she remembered entering the order for the Bactrim DS for Resident #5 on the e-MAR on 05/24/17. -She also thought she filled out and signed off on a tracking order form for the Bactrim DS, which should be on file at the facility. Interview with the hospice nurse on 06/02/17 at 3:00 p.m. revealed: -Resident #5 was diagnosed with an ear infection in March 2017. -The infection was unsuccessfully treated with Augmentin (an antibiotic). -Resident #5 was subsequently referred to an ENT physician who prescribed Bactrim DS. -She recalled seeing Bactrim DS listed on Resident #5's e-MAR and would try to locate a copy. Interview with Resident #5's family member on 06/05/17 at 11:36 a.m. revealed: -The resident had a history of ear problems prior to moving to the facility in February 2017. -Since being at the facility, the resident developed drainage from her ear, though it was not causing pain.	D 358		

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D 358	Continued From page 16 -The ear was treated and the hospice nurse kept a close eye on it. -The resident was seen by an ENT physician on 05/18/17 and a culture was taken of the ear. -After obtaining the culture results, the ENT prescribed Bactrim DS. -The order was sent to a local pharmacy previously used by the resident, as the resident's file had not been updated with the facility's primary pharmacy information. -The pharmacy contacted the family member to pick up the medication on 05/23/17. -In turn, the family member contacted the Resident Care Coordinator (RCC) on 05/23/17 and was informed that it was okay to pick the medicine up and deliver it to the facility. -The family member delivered the Bactrim DS to the facility and gave it to a MA. -He did not remember the date he delivered the Bactrim DS to the facility or the name of the MA he gave it to, but told the MA that the RCC was aware that he was dropping the medication off. -The family member visited the resident 5-6 days per week and had not seen any more drainage from the resident's ear. Interview with a pharmacist at the local dispensing pharmacy on 06/06/17 at 10:58 a.m. revealed: -The pharmacy received an order from Resident #5's physician's office on 05/23/17 for Bactrim DS 2 tablets twice a day for 10 days. -The pharmacy dispensed 40 tablets of Bactrim DS on 05/23/17. -The medication was picked up by Resident #5's family member on 05/27/17. Interview with the nurse at the ENT physician's office on 06/06/17 at 10:02 a.m. revealed: -Resident #5 was seen on 05/18/17 for draining	D 358		

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D 358	Continued From page 17 left ear perforation, and an ear culture was done. -The results of the resident's ear culture came back showing MRSA. -An order was sent to the local pharmacy listed in Resident #5's record on 05/23/17 for Bactrim DS. -The physician's office received a fax from the facility on 05/24/17 asking the physician to sign a Physician Provider Order Sheet for the Bactrim DS. -The physician signed the order form on 05/25/17 and it was faxed back to the facility. Interview with the Administrator on 06/05/17 at 9:50 a.m. revealed: -Resident #5's Bactrim DS could not be found in the e-MAR system. -The medication could have come off of the e-MAR when the electronic medication management system was recently down for three days. Observation of Resident #5's medications on hand on 06/06/17 at 9:00 a.m. revealed: -The bubble card for Bactrim DS that was dispensed on 05/23/17 was in the medication cart. -There were 24 tablets that had been used or a 6 day supply. (There was a 3 day supply used when the medication was checked on 06/02/17 at 11:30 a.m.) Subsequent review of the June 2017 e-MAR on 06/06/17 revealed: -There was an entry for Bactrim DS take 2 tablets twice a day for ear infection for 10 days. -Bactrim DS was documented as administered starting on 06/04/17 at 8:00 p.m., 06/05/17 at 8:00 a.m. and 8:00 p.m., and 06/06/17 at 8:00 a.m.	D 358		

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D 358	Continued From page 18 Interview with a MA on 06/06/17 at 2:55 p.m. revealed: -The order for Bactrim DS was not initially placed on the MAR after it was brought to the facility's attention on 06/02/17 because the order was almost over, and the facility was waiting for clarification from the prescribing physician. -In the meantime, the corporate nurse instructed the MA to add the current order for Bactrim DS on the June 2017 MAR based on the original order. -Bactrim DS was added to the MAR on 06/04/17 and the facility resumed giving the medication to the resident and documenting it on the MAR with the 8:00 p.m. dose on 06/04/17. Interview with the hospice nurse on 06/05/17 at 11:50 a.m. revealed: -She had a printed copy of Resident #5's e-MAR about 5 days ago and she checked it today (06/05/17) but did not see Bactrim DS on the MAR. -She checked the resident's ear today (06/05/17) and the resident did not complain of pain and there was no drainage from the resident's ear. Interview with the Administrator on 06/06/17 at 4:54 p.m. revealed there was an order clarification was done for the Bactrim DS due to the medication error. Review of a clarification physician's order for Resident #5 dated 06/06/17 revealed: -There was a new order for Bactrim DS take 2 tablets twice a day for 7 days. -Discard the remaining 18 tablets and restart the resident on the above.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 19 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records (MARs) were accurate and complete for 3 of 5 residents sampled (#1, #4, #5) including an antibiotic for an ear infection (#5), a corticosteroid dose pack for inflammation of the skin (#4), and a prn (as needed) pain medication (#1). The findings are: 1. Review of Resident #5's current FL-2 dated 3/18/17 revealed: -The resident's diagnoses included cognitive deficit following cerebrovascular accident,	D 367		

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D 367	Continued From page 20 dysphagia, aspiration pneumonia, protein calorie malnutrition, vascular dementia, diffuse interstitial pulmonary fibrosis, chronic obstructive pulmonary disease, and type 2 diabetes mellitus. -Resident #5 was constantly disoriented. Review of the Resident Register revealed Resident #5 was admitted to the facility on 02/17/17. Review of a physician's order dated 05/23/17 for Resident #5 revealed an order for Bactrim DS take 2 tablets twice daily for 10 days for an ear infection. Review of the May 2017 and June 2017 electronic medication administration records (e-MARs) for Resident #5 revealed: -The order for Bactrim DS was not listed on the May 2017 MAR. -The order for Bactrim DS was not listed on the June 2017 MAR when initially reviewed on 06/02/17. Observation of Resident #5' medications on hand on 06/02/17 at 11:30 a.m. revealed: -There was a bubble card with a supply of Bactrim DS tablets dispensed from a local pharmacy on 05/23/17. -There was a total of 40 tablets dispensed with 2 tablets packaged in each bubble for a total of 20 doses of the medication (a 10 day supply). -The instructions on the label were to give 2 tablets twice a day for ear infection for 10 days. -Twelve of the 40 tablets had been used, a 3 day supply. -There were 28 tablets remaining in the bubble card, a 7 day supply on the 10th day after the order was written.	D 367		

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D 367	Continued From page 21 Interviews with a medication aide (MA) on 06/02/17 at 11:30 a.m. and 1:55 p.m. revealed: -She did not understand why Bactrim DS was not showing on Resident #5's e-MARs or anywhere in the electronic medication management system. -The Bactrim DS was on the e-MAR when the MA gave the resident the 8:00 a.m. dose that morning on 06/02/17. -She did not notice this issue before now and had been giving the resident the medication. -She recalled that the resident's family member brought in the Bactrim DS from a local pharmacy. -When a physician's order was received, the MA on duty would fill out a new order tracking form and fax the order to the pharmacy. -The medication would have been entered in the e-MAR system and would have "popped up" on the MAR for administration. -The new e-MAR system was down for 3 days and just came back up late on 05/31/17. -She recalled giving the resident the Bactrim DS the last 3 days she worked. Interview with second MA on 6/2/17 at 4:45 p.m. revealed: -Resident #5 did not take Bactrim to the MA's knowledge. -A new order tracking form should have been completed by the MA on duty when the facility received the Bactrim order. -This would have ensured it was added to the MAR. -She was unable to locate a new order tracking form for Bactrim DS. Telephone interview with the former Resident Care Coordinator (RCC) on 06/05/17 at 11:05 a.m. revealed: -Resident #5's family member had taken her to the ENT physician and the ENT office sent an	D 367		

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D 367	Continued From page 22 electronic prescription to a local pharmacy instead of the facility's primary pharmacy. -She thought she remembered entering the order for the Bactrim DS for Resident #5 on the e-MAR on 05/24/17. -She also thought she filled out and signed off on a tracking order form for the Bactrim DS, which should be on file at the facility. Interview with the hospice nurse on 06/02/17 at 3:00 p.m. revealed: -Resident #5 was referred to an ear, nose and throat (ENT) physician who prescribed Bactrim DS. -She recalled seeing Bactrim DS listed on Resident #5's e-MAR and would try to locate a copy. Interview with Resident #5's family member on 06/05/17 at 11:36 a.m. revealed: -The resident was seen by an ENT physician on 05/18/17 and a culture was taken of the ear. -After obtaining the culture results, the ENT prescribed Bactrim DS. -The family member delivered the Bactrim DS to the facility and gave it to a MA. -He did not remember the date he delivered the Bactrim DS to the facility or the name of the MA he gave it to, but told the MA that the RCC was aware that he was dropping the medication off. -The family member visited the resident 5-6 days per week and had not seen any more drainage from the resident's ear. Interview with a pharmacist at the local dispensing pharmacy on 06/06/17 at 10:58 a.m. revealed Bactrim DS was picked up by Resident #5's family member on 05/27/17. Interview with the Administrator on 06/05/17 at	D 367		

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D 367	Continued From page 23 9:50 a.m. revealed: -Resident #5's Bactrim DS could not be found in the e-MAR system. -The medication could have come off of the e-MAR when the electronic medication management system was recently down for three days. Interview with the Administrator on 06/05/17 at 12:10 p.m. revealed: -She had spoken with the e-MAR contact person in their corporate office on 06/05/17. -She was told it appeared the order for Bactrim DS was discontinued in their computer system on 06/02/17. -She thought staff may have inadvertently discontinued the order while practicing with the new e-MARs. Observation of Resident #5's medications on hand on 06/06/17 at 9:00 a.m. revealed: -The bubble card for Bactrim DS that was dispensed on 05/23/17 was in the medication cart. -There were 24 tablets that had been used or a 6 day supply. (There was a 3 day supply used when the medication was checked on 06/02/17 at 11:30 a.m.) Subsequent review of the June 2017 e-MAR on 06/06/17 revealed: -There was an entry for Bactrim DS take 2 tablets twice a day for ear infection for 10 days. -Bactrim DS was documented as administered starting on 06/04/17 at 8:00 p.m., 06/05/17 at 8:00 a.m. and 8:00 p.m., and 06/06/17 at 8:00 a.m. Interview with a MA on 06/06/17 at 2:55 p.m. revealed:	D 367		

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D 367	Continued From page 24 -The order for Bactrim DS was not initially entered on the e-MAR after it was brought to the facility's attention on 06/02/17 because the order was almost over, and the facility was waiting for further instructions from the prescribing physician. -In the meantime, the corporate nurse instructed the MA to add Bactrim DS on the June 2017 MAR based on the original order dated 05/23/17. -Bactrim DS was added to the MAR on 06/04/17 and the facility resumed giving the medication to the resident and documenting it on the MAR with the 8:00 p.m. dose on 06/04/17. Interview with the hospice nurse on 06/05/17 at 11:50 a.m. revealed: -She had a printed copy of Resident #5's e-MAR about 5 days ago and she checked it today (06/05/17) but did not see Bactrim DS on the MAR. -She checked the resident's ear today (06/05/17) and the resident did not complain of pain and there was no drainage from the resident's ear. Refer to interviews with 3 MAs between 06/02/17 at 11:30 a.m. and 06/06/17 at 5:20 p.m. Refer to interview with the corporate clinical services nurse on 06/06/17 at 2:00 p.m. 2. Review of Resident #4's current FL-2 dated 1/19/17 revealed: -The resident's diagnoses included Alzheimer's dementia, hypertension, and pneumonia. -The resident was constantly disoriented. Review of a physician visit form for Resident #4 dated 04/27/17 revealed: -The resident was seen for diffuse rash/excoriation.	D 367		

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D 367	Continued From page 25 -A Medrol dose pack was prescribed. (Medrol is a corticosteroid used to treat inflammatory conditions.) Review of a physician's order dated 04/27/17 revealed an order for Medrol 4 mg, 21 tablets, follow instructions on package. Review of the manufacturer's instructions for Medrol 4mg dose pack revealed: -Day 1: take 2 tablets before breakfast, 1 tablet after lunch and after dinner, and 2 tablets at bedtime. -Day 2: take 1 tablet before breakfast, after lunch, and after dinner and 2 tablets at bedtime. -Day 3: take 1 tablet before breakfast, after lunch, after dinner, and at bedtime. -Day 4: take 1 tablet before breakfast, after lunch, and at bedtime. -Day 5: take 1 tablet before breakfast and at bedtime. -Day 6: take 1 tablet before breakfast. Review of the April 2017 and May 2017 electronic medication administration records (e-MARs) for Resident #4 revealed Medrol was not listed on either of the e-MARs Interview with a medication aide (MA) on 06/06/17 at 11:45 a.m. revealed: -She recalled the Medrol dose pack was dispensed from the primary pharmacy and Resident #4 received it. -It was a tapered dose and the resident finished all of the medication. -The Medrol should have been listed on the April and May 2017 MARs. -The MA did not know why the medication was not on the April and May 2017 MARs.	D 367		

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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 367	Continued From page 26 Interview with a representative from the primary pharmacy on 06/06/17 at 12:35 p.m. revealed: -The pharmacy received an order for Medrol Dose Pack 4 mg, 21 tablets for Resident #4 on 04/27/17. -The medication was delivered to the facility on 04/27/17 at 3:00 a.m. -The medication was a tapered dose for 6 days. Review of a new order tracking form dated 04/27/17 revealed: -A MA initiated a new order tracking form for Resident #4's Medrol dose pack on 04/27/17. -The MA initialed and dated the steps completed for the new medication order on the tracking form. -The order was signed and dated from the physician. -The order was faxed to the pharmacy/verified receipt of new order. -The original order was filed in Resident #4's chart. -A copy of the order along with the tracking tool was placed in the designated location. -An entry was placed on the 24-hour shift report. -The form was signed by the MA and the Health and Wellness Director / Registered Nurse (HWD/RN). -The MA did not initial and date indicating the order was transcribed onto the MAR/if the end of the month transcribe to new MAR. Refer to interviews with 3 MAs between 06/02/17 at 11:30 a.m. and 06/06/17 at 5:20 p.m. Refer to interview with the corporate clinical services nurse on 06/06/17 at 2:00 p.m. 3. Review of Resident #1's current FL-2 dated 12/20/17 revealed:	D 367		

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D 367	Continued From page 27 -Diagnoses included dementia unspecified and iron deficiency anemia. -The resident was intermittently disoriented. -The resident was ambulatory and a wanderer. -There was an order for Seroquel 50 mg twice daily (an anti-psychotic medication). -There was an order for Paxil 20 mg at hour of sleep (a medication used for depression). -There was an order for Ativan 0.5 mg daily as needed (a medication used for anxiety). Review of Resident #1's primary care provider visit dated 05/23/17 revealed there was an order for Ultram 50 mg one tablet at 4:00 p.m. (a narcotic pain medication). Review of a subsequent primary care provider order dated 05/30/17 for Resident #1 revealed an order for Ultram 50 mg at 4:00 p.m. scheduled and one tablet twice daily as needed for breakthrough pain. Review of Resident #1's electronic medication administration records (e-MARs) for April and June 2017 revealed: -There was an entry for Ultram 50 mg, give one tablet in the evening for hip pain with a scheduled administration time at 4:00 p.m. -There was not an entry for Ultram 50 mg twice daily as needed for pain. Interview with the Administrator on 06/05/17 at 11:25 a.m. revealed: -The medication could have come off of the e-MAR when the electronic medication management system was recently down for three days. -All of Resident #1's medications had cleared out of the electronic medication management system Saturday (06/03/17) and had to be re-entered by	D 367		

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D 367	Continued From page 28 the Corporate Clinical Services Nurse. Review of the updated e-MAR for June 2017 printed on 06/05/17 at 11:29 a.m. revealed: -There was an entry for Ultram 50 mg, give one tablet by mouth daily as needed for breakthrough pain, give twice daily as needed; scheduled dose at 4:00 p.m., ensure at least 4 hours had passed between administering the as needed (Ultram). -There was no documentation that Resident #1 had required Ultram 50 mg dose scheduled as needed from 06/03/17 through 06/05/17. Refer to interviews with 3 MAs between 06/02/17 at 11:30 a.m. and 06/06/17 at 5:20 p.m. Refer to interview with the corporate clinical services nurse on 06/06/17 at 2:00 p.m. --- Interviews with 3 MAs between 06/02/17 at 11:30 a.m. and 06/06/17 at 5:20 p.m. revealed: -When the facility received a medication order, the MA on duty filled out a new order tracking form and faxed the order to the pharmacy. -The medication was entered into the e-MAR system and "popped up" on the e-MAR. -A copy of the order was stapled to the tracking form and put in the nurse's box for the Resident Care Coordinator (RCC) or Health and Wellness Director / Registered Nurse (HWD/RN). -Once the RCC or HWD/RN signed off on the tracking form, it was given back to the MA and filed in a notebook. -A copy was also filed in the resident's record. -When medication was delivered to the facility, two MAs separated it in totes and checked it against the residents' MARs. -The medications were kept in the totes until placed on the medication carts the next day.	D 367		

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D 367	Continued From page 29 -The e-MAR system was down for 3 days and came back up late on 05/31/17. Interview with the corporate clinical services nurse on 06/06/17 at 2:00 p.m. revealed: -The facility started using an electronic medication management system in March 2017 and the staff were still getting comfortable with it. -She was temporarily assisting the facility until a new HWD/RN was hired. -She was aware that staff were missing a step in ensuring medications were on the e-MAR. -The MAs were required to complete a new order tracking form for all new medication orders that were received during their shift. -The tracking form listed all the necessary steps to ensure new medications were ordered and added to the MAR. -The MAs were required to initial and date each step when it was completed. -Once all the necessary steps were completed and the medication was in the facility, the form was signed and dated by the MA completing it. -A copy of the tracking form was forwarded to the RCC or HWD/RN to review for completeness and accuracy. -It appeared that staff was faxing the order to the pharmacy, but not entering the medication orders into the e-MAR each time. -To help ensure medications were listed on the e-MAR when received, the MAs would have to manually link the medication to an order in the electronic medication management system. -The MAs would soon have scanners that would make this easier.	D 367		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

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D 438	Continued From page 30 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .1001 and .1002 for 1 of 1 resident sampled (#3) with injuries of unknown origin on 3 occasions including a broken wrist, a bruised forehead, and a bruised thumb that were not reported to the Health Care Personnel Registry. The findings are: Review of Resident #3's current FL-2 dated 06/21/16 revealed: -The resident's diagnoses included dementia, hypothyroidism, hypertension, colitis, hyperlipidemia, recent fall, subarachnoid hemorrhage, and traumatic brain injury - subdural hematoma. -The resident was constantly disoriented. -The resident required assistance with bathing, dressing, and feeding. Review of Resident #3's assessment and care plan dated 02/03/17 revealed the resident required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. Review of Resident Log notes for Resident #3 revealed:	D 438 D438	Addendum Per telephone Conversation with Paula Sholar-Mason on 8/23/17: The Executive Director provided training to all Staff regarding the requirements to report abuse, neglect, exploitation OR injuries of unknown origin. The Executive Director or the designee will review Random chart Audits/ER reports on a Weekly basis D.H RN 08/23/17	

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D 438	Continued From page 31 -08/27/16 (11:00 a.m.): The resident had a witnessed fall. The resident was leaning forward and sustained an abrasion on head. The resident was sent to the emergency room (ER). -03/13/17 (6:50 a.m.): Staff found the resident on the floor with a head injuring during rounds. The resident was sent to the ER. Review of an incident / accident report dated 03/13/17 (4:25 a.m.) for Resident #3 revealed: -The resident had an unwitnessed fall with head injury and swelling. -The resident was found with hematoma to left side of forehead. -The resident was sent to the emergency room (ER) for treatment. -The resident returned to the facility with no new orders. Review of a hospital report dated 03/13/17 for Resident #3 revealed: -The resident arrived to the emergency room at 5:14 a.m. -The chief complaint was fall with hematoma to the forehead without loss of consciousness. -The resident had no edema or tenderness in extremities. -The resident had good range of motion in all major joints. -The head scan showed a left frontal scalp hematoma. -The resident was discharged back to the facility. Review of a notification faxed to the primary care provider (PCP) on 03/13/17 revealed: -Resident #3 was found on the floor with a large bump on the left side of her head. -The resident was sent to the emergency room (ER). -The PCP signed the form and no new orders	D 438		

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D 438	Continued From page 32 were noted. Review of physician's orders for Resident #3 revealed an order dated 03/14/17 for a crash pad (fall mat) beside the bed at night. Review of Resident Log notes for Resident #3 revealed: -03/17/17 (7:00 a.m.): The resident was holding her left wrist and expressed pain when touched. The left wrist appeared to be swollen. An incident report was completed. -03/17/17 (10:00): The hospice nurse aware of new pain to wrist with edema. No new orders. Review of a notification faxed to the primary care provider (PCP) on 03/17/17 revealed: -Resident #3's left wrist was swollen and painful to move or touch. -The PCP signed the form and no new orders were noted. Review of Resident Log notes for Resident #3 revealed: -03/22/17 (10:00 p.m.): The resident had an x-ray today that showed an acute fracture to left wrist. The hospice nurse came and the physician ordered for the resident to go to the ER the next morning to have a cast put on the wrist. Review of an incident / accident report dated 03/22/17 (9:50 p.m.) for Resident #3 revealed: -This was an incident of unknown origin. -The resident had a left wrist fracture found on x-ray. -The resident was sent to the ER on 03/23/17 to have a cast applied to left wrist. -An incident report was sent to the Department of Social Services and a 24 hour report was faxed to the state.	D 438		

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D 438	Continued From page 33 Review of a hospital report dated 03/23/17 for Resident #3 revealed: -The resident arrived to the ER at 9:03 a.m. -The chief complaint was wrist injury. -The resident was diagnosed with a left wrist fracture (03/22/17). -The resident had a mechanical fall on 03/13/17 and was evaluated in the ER and cleared. -No new falls were noted. -The resident continued to hold wrist per Emergency Medical Services and an x-ray was performed yesterday (03/22/17). -The resident had mild swelling to her left wrist. -The resident's left wrist fracture required splinting. Review of a 24 hour report to the Health Care Personnel Registry (HCPR) dated 03/23/17 revealed: -Resident #3 had an x-ray done on 03/22/17 and was found to have a left wrist fracture. -There was a fax confirmation sheet stapled to the 24 hour report indicating it was faxed to the HCPR on 03/23/17. Review of Resident #3's record revealed there was no documentation of a 5 day working report being completed or sent to the HCPR for the resident's broken wrist of unknown origin. Review of Resident Log notes for Resident #3 revealed on 03/30/17 (6:00 a.m.), the resident fell at 3:00 a.m., there were no injuries, and hospice was notified. Review of a notification faxed to the primary care provider (PCP) on 03/30/17 revealed: -Resident #3 rolled out of bed and no injuries were noted.	D 438		

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D 438	Continued From page 34 -The PCP signed the form and no new orders were noted. Review of Resident Log notes for Resident #3 revealed: -04/01/17 (6:00 a.m.): The resident rolled out of bed at 11:35 p.m. No injuries were noted. The hospice nurse came to assess the resident. 04/11/17 (6:00 a.m.): The resident appeared to have a small bruise over her right eye and a red mark below her right eye. The resident showed signs of pain in her right shoulder while being dressed. The resident resisted range of motion on her right shoulder. An incident report was completed and all parties were notified. Review of a notification faxed to the primary care provider (PCP) on 04/11/17 revealed: -Staff discovered a bruise and a red mark of unknown origin above and below Resident #3's right eye. -The PCP signed the form and no new orders were noted. Review of Resident #3's record revealed there was no documentation of a 24 hour report or a 5 day working report being completed or sent to the HCPR for the resident's injuries of unknown origin of a bruise over right eye, red mark below her right eye, and pain in shoulder. Review of Resident Log notes for Resident #3 revealed: -04/15/17 (11:30 p.m.): The resident was found on the floor next to her bed at shift change. No injuries. The hospice nurse came to assess the resident. Review of a note by the hospice nurse dated 04/16/17 revealed:	D 438		

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D 438	Continued From page 35 -The nurse visited the resident due to a fall. -The resident rolled out of bed. -The resident had no signs or symptoms of pain or discomfort. -There were no injuries noted at that time. Review of a notification faxed to the primary care provider (PCP) on 04/16/17 revealed: -Resident #3 rolled out of bed onto the floor on 04/15/17 and there were no injuries. -The PCP signed the form and no new orders were noted. Review of a physician's visit form dated 04/20/17 for Resident #3 revealed: -The resident's left wrist fracture was healing well. -The resident was to wear a wrist splint as needed. Observation of Resident #3 on 06/01/17 at 11:15 a.m. revealed: -The resident was lying in a recliner in the common living room. -The resident had a yellowish green bruised area about 1 and ½ inches in diameter on her upper right forehead. -The resident had a purple bruise on the underside of her thumb on her left hand. -The resident mumbled and was unable to answer any questions. Review of Resident Log notes for Resident #3 revealed: -06/01/17 (10:00 p.m.): Resident #3's left thumb was swollen with bruising. The hospice nurse was called to check on it. The hospice nurse put a splint on the resident's thumb. Interview with a personal care aide (PCA) on 06/05/17 at 1:48 p.m. revealed:	D 438		

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D 438	Continued From page 36 -Resident #3 had some falls so they tried to keep her in the common areas during the day. -She did not know how the resident got the bruise on her thumb and she was unsure how long it had been there. -She had not noticed the current bruise on the right side of Resident #3's forehead so she did not know what caused the bruise. Interview with a medication aide (MA) on 06/05/17 at 1:50 p.m. revealed: -She did not know how Resident #3 injured her thumb or forehead. -The resident already had those injuries when she started working at the facility. -She had observed the resident bite on her hand at times and thought that could be what caused the bruise on the resident's thumb. Interview with a second MA on 06/06/17 at 9:42 a.m. revealed: -She did not know what caused the injury to Resident #3's wrist, forehead, or thumb. -Staff were supposed to report any injuries to the MA / supervisor on duty. -The MA was supposed to document the injury and complete an incident report. -The incident reports were usually forwarded to the Health and Wellness Director / Registered Nurse (HWD/RN). Interview with the hospice nurse on 06/05/17 at 11:40 a.m. revealed: -Resident #3 leaned forward due to her posture and she had rolled out of bed at times. -The resident's mattresses had been lowered to the floor and she had a fall mat. -The resident had a fall in March 2017 and hit her head and was sent to the ER. -The hospital did not find anything wrong and sent	D 438		

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D 438	Continued From page 37 the resident back to the facility. -A few days later (could not recall exact timeframe), the resident started complaining of pain in her wrist when she was transferred. -An x-ray was done and the resident's left wrist was broken. -The broken wrist may have been caused by the fall but she was not sure. -She had seen the bruise currently on the right side of the resident's forehead. -She did not know what caused the bruise. -She was aware of the bruise on the resident's thumb. -She thought the resident may have sat on her thumb but she was not sure. Interview with Resident #3's primary care provider (PCP) on 06/06/17 at 10:56 a.m. revealed: -Resident #3 was a hospice patient. -He did not currently provide services to Resident #3 unless the services needed were outside of the scope of hospice. -Any questions related to Resident #3's care should be addressed with the current hospice provider. Telephone interview with Resident #3's family member on 06/06/17 at 1:20 p.m. revealed: -Resident #3 had lived at the facility since 2014. -The resident was currently receiving hospice care. -The facility had notified him of the resident's falls and injuries. -He thought the resident's may have hit her arm during a fall, causing the wrist fracture. Telephone interview with the former Resident Care Coordinator (RCC) on 06/05/17 at 10:55 a.m. revealed: -Resident #3 had fallen "a few times".	D 438		

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D 438	Continued From page 38 -She thought the resident's broken wrist may have been caused by a fall. -She also thought the bruise on the resident's forehead may have occurred after a fall. -The problem with the resident's wrist started with swelling and bruises to the wrist. -She could not recall a timeframe for when the swelling started. -The resident's wrist did not appear broken when the RCC looked at the resident's wrist. -She was surprised when the x-ray showed it was broken. -She completed an incident report and it was forwarded to the HWD/RN. -The HWD/RN or the Administrator would sign off on the incident reports. -She was not aware of the requirement to report injuries of unknown origin to the HCPR. -She had not made any reports to the HCPR. -The HWD/RN position was currently vacant and she did not know if the former HWD/RN made any reports to the HCPR. Interview with the Administrator on 06/06/17 at 2:04 p.m. revealed: -The facility's HWD/RN was responsible for completing the 24 hour report and the 5 day working report to the HCPR for any injuries of unknown origin. -The HWD/RN was supposed to forward copies of both reports to the Administrator. -She did not receive copies of any HCPR forms for Resident #3. -The HWD/RN no longer worked at the facility and the position was currently vacant. -She could not find any documentation of any HCPR reports for Resident #3 other than the 24 hour report for the resident's broken wrist. -She planned to implement a new system to assure any injuries of unknown origin were	D 438		

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D 438	Continued From page 39 reported as required.	D 438		

10A NCAC 13f .0404 Qualifications of Activity Director:

The activity director will enroll in an activity coordinator class on line through the local Community College. She will enroll no later than 08/31/17.

10A NCAC 13f .0902 Health Care:

1. The community will utilize the New Order Tracking Form for new orders.
2. The Medication Aides (MA) will transcribe and/or implement the new order including Medication Orders, orders for lab, consults, etc. and a copy of the new order will be placed into the tracking binder.
3. The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or designee will review the binder twice per day to verify completion of the order.
4. The Executive Director (ED)/designee will review the binder on a weekly basis and as needed to provide additional verification.
5. Medication technicians will be trained on Acute Charting (Hot Box) guidelines.
6. Implementation of new orders will be documented in the resident record. Documentation will be entered on the "Hot Box" tracking form and documentation will be completed for 72 hours or until resolved.
7. The HWD/Designee will monitor the Hot Box tracking form and review charting on a daily basis.
8. The ED/designee will monitor the Hot Box tracking form and review random charts on a weekly basis to verify compliance.

The Date of correction for this standard deficiency will not exceed 08/11/17

10A NCAC 13f. 0904 Nutrition and Service:

1. The community will utilize the New Tracking Order Form for new Orders.
2. The Medication Aides (MA) will transcribe, enter into the eMAR (when available) and/or implement the new medication order and then place a copy of the new order along with the New Order Tracking Form into the Tracking binder.
3. The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or designee will review the binder twice per day to verify completion of the order.
4. The HWD/RCC will enter the supplement into the Nutrition Tracker.
5. The Executive Director (ED)/designee will review the binder on a weekly basis and as needed to provide additional verification.
6. Implementation of new orders will be documented in the resident record. Documentation will be entered on the "Hot Box" tracking form and documentation will be completed for 72 hours or until resolved.
7. The HWD/Designee will monitor the Hot Box tracking form and review charting daily.
8. The ED/designee will monitor the Hot Box tracking form and review random charts on a weekly basis for accuracy.

The date of correction for this standard deficiency will not exceed 08/11/17

10A NCAC 13f .1004 Medication Administration:

9. The community will utilize the New Tracking Order Form for new Orders.
10. The Medication Aides (MA) will transcribe, enter into the eMAR (when available) and/or implement the new medication order and then place a copy of the new order along with the New Order Tracking Form into the Tracking binder.
11. The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or designee will review the binder twice per day to verify completion of the order.
12. The Executive Director (ED)/designee will review the binder on a weekly basis and as needed to provide additional verification.
13. Medication technicians will be trained on Acute Charting (Hot Box) guidelines.
14. Implementation of new orders will be documented in the resident record. Documentation will be entered on the "Hot Box" tracking form and documentation will be completed for 72 hours or until resolved.
15. Lab orders and X-ray orders will be documented in a separate log for follow up.
16. The HWD/Designee will monitor the Hot Box tracking form and review charting daily.
17. The ED/designee will monitor the Hot Box tracking form and review random charts on a weekly basis for accuracy.

The date of correction for this standard deficiency will not exceed 08/11/17

10A NCAC 13f .1205 Health Care Personnel Registry:

1. Reports of abuse, neglect, exploitation or injuries of unknown origin will be reported to the HCPR within 24 hours of notification.
2. The ED/Designee will investigate the event/incident and submit a 5 day working report to the HCPR.
3. The ED will maintain a file of the HCPR reports in the ED office for review by regulatory agencies.

The date of correction for this standard deficiency will not exceed 08/11/17

D209 – 10A NCAC 13F .0604 Personal Care Other Staffing

In accordance with section 10A NCAC 13F .0604, the community will only reassign certified nursing assistants (CNAs) associates to limited periods of providing dining food service or housekeeping assistance during periods of time when the community has more aide staff hours available at a particular time than what the community is required to have on duty to meet the regulatory staffing requirements. The community will document which aides have been temporarily reassigned to food service or housekeeping duties and the amount of time the employee was re-assigned from Aide duties to food service or housekeeping duties. If the community does not have available CNAs to provide temporary food services or housekeeping assistance, the community will utilize only hourly associates who are not direct care staff to provide any necessary, temporary, housekeeping or food service assistance.