STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026052	A. BUILDING: _____ B. WING _____	R 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY PINES ADULT CARE	2521 MURIEL DRIVE FAYETTEVILLE, NC 28306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Division conducted an annual survey on August 22, 2017 and August 23, 2017 with exit by telephone on August 25, 2017.	D 000		
D 163	10A NCAC 13F .0504(c) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff were competency validated to apply Santyl ointment, an enzymatic wound debriding agent, 1 of 3 residents (Resident #1). The findings are: Review of Resident #1's Resident Register revealed an admission date of 06/13/17. Review of Resident #1's current FL-2 dated 06/21/17 revealed: -Diagnoses included paranoid schizophrenia, end stage renal disease, diabetes mellitus (unspecified) and a Stage I decubitus on the right great toe. -There was an order for Santyl ointment, apply "a	D 163		

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D 163	Continued From page 1	D 163		

sufficient amount" to right great toe once a day.

Review of Resident #1's Medication Administration Record (MARs) for June 2017 revealed:
-There was an entry for Santyl ointment, apply "a sufficient amount on toe every day" at 8:00am.
-There was documentation that Santyl ointment was administered on 06/14/17, 06/15/17, 06/18/17, 06/19/17, 06/20/17, 06/21/17, 06/22/17 and 06/28/17.
-There was documentation that the resident refused the Santyl ointment on 06/16/17, 06/17/17, 06/23/17, 06/24/17, 06/25/17, 06/27/17, 06/29/17 and 06/30/17.

Review of Resident #1's Medication Administration Record (MARs) for July 2017 revealed:
-There was an entry for Santyl ointment, apply "a sufficient amount on toe every day" at 8:00am.
-There was documentation the resident refused the Santyl ointment 07/01/17-07/20/17.
-The Santyl ointment was discontinued 07/20/17.

Interview with the Supervisor on 08/23/17 at 3:20pm revealed:
-The Supervisor did not know that Santyl ointment was a debriding agent.
-She did not know that competency verification was required before Santyl ointment was applied by non-licensed staff.
-There was no staff at the facility with required competency verification.

Interview with the Administrator on 08/23/17 at 4:16pm revealed:
-He did not know that Santyl ointment was a debriding agent.
-He "thought it was just another antibiotic

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D 163	Continued From page 2 ointment". -The Administrator did not know that competency verification was required before Santyl ointment was applied by non-licensed staff. Resident #1 refused my request to see his right great toe. Attempted telephone interview with prescribing physician was unsuccessful.	D 163		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure that food (seven boxes of assorted crackers, cereals, cookies and ice cream cones), was stored in manner to prevent contamination. The findings are: Observation of dry storage area in kitchen on 08/23/17 at 10:30am revealed there were 3 boxes of opened cereal, 1 box of ginger snap cookies, 2 boxes of crackers and 1 box of ice cream cones without remaining contents in a sealable food storage bag or other means of preventing contamination. Interview with the Kitchen Manager on 08/23/17 at 10:35am revealed: -She knew that opened dry foods should be	D 283		

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D 283	Continued From page 3	D 283		

stored either in a sealable food storage bag or other air-tight container.
-The Kitchen Manger worked from 6:00am until 2:00pm.
-After 2:00pm, all staff working had access to the kitchen.
-Other staff served afternoon snacks, dinner and bedtime snacks.
-She would post a sign reminding staff how partially used dry foods should be stored as soon as possible.

Interview with a Personal Care Aide (PCA) on 08/23/17 at 3:17pm revealed:
-The PCA did serve snacks during her shift.
-She stored partially used snack foods in zip-lock food storage bags after serving snacks.

Interview with the Supervisor on 08/23/17 at 10:40am revealed:
-After the Kitchen Manager has left for the day, all staff serve snacks.
-Unused portions of crackers, cereals, cookies and other dry foods are placed in either a zip-lock food storage bag or an air-tight container.
-All opened food items are labeled with date opened.
-She would follow-up with the Kitchen Manger.

Interview with the Administrator on 08/23/17 at 4:16pm revealed:
-He stated the proper procedure for storing unused dry foods.
-Unused portions of crackers, cereals, cookies and other dry foods are placed in either a zip-lock food storage bag or an air-tight container
-He did not know who was improperly storing unused dry foods.

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D 358	Continued From page 4	D 358		
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: TYPE B VIOLATION Based on record reviews and interviews, the facility discontinued an antibiotic (Doxycycline) fourteen days early without a physician's order for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's Resident Register revealed an admission date of 06/13/17. Review of Resident #1's current FL-2 dated 06/21/17 revealed: -Diagnoses included paranoid schizophrenia, end stage renal disease, diabetes (unspecified) and hypertension. -Medications on the FL-2 included Doxycycline 100mg, 1 capsule every day by mouth. Review of a physician's order form dated 06/01/17 from a Podiatrist in a local hospital revealed: -There was an order to stop Doxycycline 100 mg twice a day. -There was an order to start Doxycycline 100mg	D 358		

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D 358	Continued From page 5	D 358		

once a day, starting 06/05/17.
-The prescription for Doxycycline was included in Resident #1's admission forms from the hospital.
-There was an order to dispense 30 capsules with 1 refill.

Review of the electronic Medication Administration Record (eMAR) for June 2017 revealed that Doxycycline 100mg was documented given as ordered June 14, 2017 through June 30, 2017.

Review of the eMAR for July 2017 revealed:
-Doxycycline 100mg was documented given as ordered from July 01, 2017 through July 20, 2017.
-A computer generated "DC'd" was printed in the column beside the Doxycycline entry.
-"Stop date July 20, 2017" was printed underneath the entry for Doxycycline.

Review of Resident #1's record did not reveal an order to discontinue the Doxycycline.

Interview with the Supervisor on 08/22/17 at 3:20pm revealed:
-Printed doctor's orders were given to Resident #1 during the visit.
-The new order form did not include the order for the Doxycycline.
-The new orders did not include a discontinuation order for the Doxycycline.
-The new orders were faxed to the facility's providing pharmacy.
-The providing pharmacy discontinued the Doxycycline on 07/20/17.
-The facility did not receive an order to discontinue the Doxycycline.
-The Supervisor did not attempt to clarify the Doxycycline order.

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D 358	Continued From page 6 Review a physician's order form 07/19/17 revealed no information about the Doxycycline order. Telephone interview with the facility's providing pharmacy on 08/23/17 at 9:40am revealed: -The pharmacy had been told by the facility if an order was not on the doctor's order sheet it was no longer active. -The pharmacy did not attempt to clarify the Doxycycline order. -Telephone interview attempts to contact Resident #1's Podiatrist was unsuccessful. _____ The failure of the facility to administer an antibiotic (Doxycycline) as ordered by stopping it fourteen days early without a physician's order was detrimental to the health, safety and welfare of Resident #1 and constitutes a Type B Violation. _____ Review of a Plan of Protection dated 08/23/17 revealed: -The Supervisor or Administrator will review all new MARs. -Any variation from old entries as compared to new entries will be clarified before medications are given. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 10/09/17.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 7 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that 1 of 3 sampled residents (Resident #1) received care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations related to medication administration. The findings are: 1. Based on record reviews and interviews, the facility discontinued an antibiotic (Doxycycline) fourteen days early without a physician's order for 1 of 3 sampled residents (Resident #1). [Refer to tag 0358, 10A NCAC 13F .1004(a) (Type B Violation)].	D912		