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	HAL077010	A. BUILDING: _____ B. WING _____	R 08/31/2017

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HAMLET HOUSE	632 FREEMAN MILL ROAD HAMLET, NC 28345

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 08/30/17 - 08/31/17. {D 273} 10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure physician notification for 4 of 5 residents sampled (#2, #3, #4, #5) including a resident's increased shortness of breath and the need for oxygen and a current order (#5); a resident's increased swelling of legs and use of home remedy treatment (#3); a resident's increased shortness of breath, difficulty breathing while ambulating, and contacting the medical equipment company about problems with portable oxygen (#2); and a resident with over a 40 pound weight loss not receiving a nutritional supplement because it had not been obtained from the pharmacy (#4). The findings are:	{D 000} {D 273}	Responses to the cited deficiency does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set-forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law. An audit was conducted on resident record to identify concerns regarding refferal and follow up. All identified isues were addressed and will be corrected by 9/30/17. Alll Care staff were inserved on 9/1/17 regarding reporting procedures, referral and follow-up and process for managing all physician orders. Physician orders are monitnored weekly by Executive Director or designee to assure prompt attention. Medication Refusal Policy training was conducted on 9/1/17 and med tech signed ackwoledging. On 9/18/17, Resident Rights and effective communication training was conducted for staff by Executive Director. On 9/25/17 Regional Director of Operataions and Nurse Consulatant met with all care staff to review policy and procedures regarding communication with physicians, documentation of medical orders and hotbox charting. On 9/26/17 adjustments made to schedule for 1st and 2nd shift to allow more time for resident care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Jones, RDO — TITLE: RDO — (X6) DATE: 10-4-17

RECEIVED OCT 4 2017 ADULT CARE LICENSURE SECTION RALEIGH

* The plan of correction was reviewed and accepted with addendum on 10/6/17. Refer to addendum on pages 2 and 28 of this Statement of Deficiencies. W. Williams 10/6/17

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{D 273}	Continued From page 1 1. Review of Resident #5's current FL-2 dated 07/16/17 revealed diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Hypothyroidism, Atrial-Fibrillation and Right Hip Replacement. Review of the Resident Register for Resident #5 revealed she was admitted to the facility on 07/16/09. Review of Resident #5's physician's orders revealed there was a prescription dated 06/07/17 for oxygen at 3 liters per minute (L/min) via nasal cannula (NC). Review of Resident #5's discharge summary dated 06/06/17 revealed: -Resident #5 was admitted to the hospital on 05/27/17 with admitting diagnoses of right lower lobe pneumonia and atrial fibrillation with rapid ventricular response. -Resident #5 was discharged back to the facility on 06/06/17. Review of Resident #5's physician's orders signed 07/14/17 revealed an order for oxygen at 3L in nostrils as directed. Review of Resident #5's Licensed Health Professional Support (LHPS) review dated 12/19/16 revealed: -The nurse documented Resident #5 was using oxygen at 2L via NC and her pulse ox (pulse oximetry is a test used to measure the oxygen level of the blood) was 100% on oxygen. -The nurse checked the block indicating the task of oxygen administration and monitoring. -The nurse recommended continuing current plan of care.	{D 273}	Executive Director and Resident Care Manager will monitor missed meds daily while on site for any refusals and/or missed meds. D273 Addendum per telephone with Ms. Betty Kester, BOM/Interim ED on 10/6/17: Reporting procedures include: The PCAs report any changes in condition to the MA on duty. The MA will notify the RCM. The RCM or MA will contact the physician and document in the resident care notes. The staff have meetings each shift to review information including residents' conditions. The RCM reviews care notes daily to assure physician's are notified of changes in condition. W. Williams 10/6/17	

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{D 273}	Continued From page 2 Review of Resident #5's LHPS review dated 07/05/17 revealed: -The nurse documented Resident #5 had oxygen at 3L via NC, continuous. -The nurse checked the box for oxygen administration and monitoring as a marked task. -The nurse documented to continue current plan of care. Review of Resident #5's computer generated July 2017 Medication Administration Record (MAR) revealed: -There was an entry for oxygen at 3L/min via NC. -The original order was 06/06/17. -The stop date was 06/06/27. -The oxygen was scheduled to be checked between 12:00 a.m. to 6:39 a.m., 7:00 a.m. to 2:59 p.m. and 3:00 p.m. to 10:59 p.m. -Staff documented oxygen checks on all 3 shifts from 07/01/17 through 07/31/17. Review of Resident #5's computer generated August 2017 MAR revealed: -There was an entry for oxygen at 3L/min via NC. -The original order was 06/06/17. -The stop date was 06/06/27. -The oxygen was scheduled to be checked between 12:00 a.m. to 6:39 a.m., 7:00 a.m. to 2:59 p.m. and 3:00 p.m. to 10:59 p.m. -Staff documented oxygen checks on all 3 shifts except it was documented as refused on 08/06/17 at the 7 a.m.-2 p.m. shift. Observation on 08/31/17 at 10:30 a.m. of Resident #5 revealed: -The resident was coughing with a noted wet non-productive cough. -The resident had a wheeze that could be heard from a 5-foot distance. -Resident #5's face was flushed.	{D 273}		

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{D 273}	Continued From page 3 -The resident was not wearing any oxygen. -There was no oxygen concentrator or portable tank in Resident #5's room. Interview on 08/31/17 at 10:30 a.m. with Resident #5 revealed: -She had been coughing and short of breath for a few days. -Her cough had gotten worse last night (08/30/17). -She had asked for and was given cough medicine last night (08/30/17) by the medication aide. -She had been using her nebulizer treatments 3 times a day. -She felt she needed oxygen to help her breathe better. -She did not have any oxygen. -She had oxygen until 2-3 months ago. -The oxygen helped her breathe better. -Someone had picked the oxygen up 2-3 months ago. -The previous Resident Care Manager (RCM) had called the medical equipment company, and they picked it up. -She did not know why it was picked up. -A physician or nurse had not come to her room to check on her. -She saw her primary care physician (PCP) in his office on 08/15/17. Interview on 08/31/17 at 10:55 a.m. with the medication aide (MA) revealed: -When a resident had oxygen they would check to make sure the bulb was at the correct setting. -They made sure residents were using the oxygen correctly and then would initial it on the MAR. -She did not know why she had documented oxygen checks for Resident #5.	{D 273}		

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{D 273}	Continued From page 4 -She thought it had been discontinued. -Resident #5 told her this morning (08/31/17) that she needed oxygen. -She had not called Resident #5's physician to report her symptoms or ask about oxygen. Interview with a Personal Care Aide (PCA) on 08/31/17 at 11:00 a.m. revealed: -She helped Resident #5 this morning (08/31/17) because the resident did not feel well. -Resident #5 usually dressed without assistance. -Resident #5 was having a hard time breathing today (08/31/17). -She reported it to the MA. -The MA had checked on the resident. -Resident #5 did not currently have oxygen. -Resident #5 had used oxygen several months ago. -The previous RCM stopped it. -She did not know why it had been stopped. -They would have needed a doctor's order to stop it so there must have been a reason. Interview on 08/31/17 at 11:05 a.m. with the Executive Director (ED), Consultant Nurse and RCM revealed: -The staff were supposed to notify either the RCM or ED and call the resident's PCP if there were any changes in condition. -The PCA was supposed to tell the MA. -The MA would check on the resident, tell the RCM or ED and then call the PCP. -They were not aware of any change in Resident #5's condition. -The check off on the MARs related to the oxygen was to show that the MA had checked the appropriate setting and the resident used it correctly. -They did not know why the MAs would check off on oxygen if they had not physically checked the	{D 273}	NOTE INACCURATE INFORMATION: Interview with the nurse consultant was neither requested nor given at any time during the survey.	

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{D 273}	Continued From page 5 resident's oxygen. Interview on 08/31/17 at 11:36 a.m. with Resident #5 revealed: -The ED told her that her PCP could not see her until next week. -The ED offered for her to go to the emergency room today (08/31/17). -She wanted to go to the emergency room. -When she had oxygen, she did not use it all the time but when she needed it, she used it. -She needed to use it for the last few days. -She needed it at others time since it had been picked up. -She had not told anyone she needed it "because they are the ones that took it from me". -She did not know she could get it back. Observation on 08/31/17 at 11:46 a.m. revealed the transporter had gone into Resident #5's room to take her to the emergency room. Telephone interview on 08/31/17 at 2:07 p.m. with PCP's nurse for Resident #5 revealed: -The facility had called them today (08/31/17) to set up an appointment. -They did not have anything open until next week. -The facility reported they might send Resident #5 out to the emergency room. -She had not heard back from the facility if they had sent Resident #5 out or not. -She could not find documentation that Resident #5's oxygen had been discontinued. -She did not check Resident #5's oxygen levels when she was there on her last visit. -If Resident #5 had worn oxygen to the appointment she would have automatically checked her oxygen levels. Telephone interview on 08/31/17 at 2:15 p.m. with	{D 273}		

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{D 273}	Continued From page 6 a representative in the billing department at the Medical Equipment Company revealed: -They had picked up Resident #5's portable oxygen tank in March 2017 at the resident's request. -They had picked up Resident #5's oxygen concentrator on 05/23/17. -She did not know why it had been picked up. -She did not have a discontinue order on file. Telephone interview on 08/31/17 at 3:20 p.m. with PCP's nurse revealed: -Resident #5 had lung disease. -Resident #5 did not want to have any procedures or testing done. -She did not want to see a pulmonologist. -She had diagnoses of COPD and Pulmonary Fibrosis. -She noted on the PCP's last note on 08/15/17 that resident was on oxygen via nasal cannula. -It did not make sense to her that if Resident #5 was supposed to be on oxygen why she was not wearing it on her last appointment. -The discharge summary from the hospital on 06/06/17 documented that Resident #5 had been on oxygen. -The PCP was not available for interview about the resident's oxygen. Telephone interview on 08/31/17 at 4:41 p.m. with the facility's primary pharmacy revealed: -Resident #5 was deleted from their electronic MAR system when she went to the hospital in May 2017. -When they received new orders for Resident #5 they keyed that information into the electronic MAR system. -They had an order dated 06/06/17 for oxygen at 3L/min via NC. -They had not received any orders to discontinue	{D 273}		

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{D 273}	Continued From page 7 Resident #5's oxygen. Interview on 08/31/2017 at 5:48 p.m. with a second MA revealed: -She had given Resident #5 the house stock of cough syrup per standing orders. -She did not recall what time she gave it. -Earlier in her shift, 7-8 p.m., Resident #5 was having difficulty with a lot of phlegm (the thick viscous substance secreted by the mucous membranes of the respiratory passages). -The cough syrup had helped Resident #5 because when she checked on the resident later she was resting. -She did not document a change in the resident's condition. Interview with the Business Office Manager on 08/31/17 at 5:55 p.m. revealed: -She remembered the oxygen being removed from Resident #5's room, but she was not sure of the date. -She recalled questioning why it was being removed. -She recalled asking the resident why it was being removed. -The resident told her that she had been told they had to take it. -She recalled the resident saying she didn't use it that much anyway. -She recalled the previous RCM had taken care of having the oxygen picked up. -She was never sure why it was taken out. Interview on 08/31/17 at 6:00 p.m. with Resident #5 revealed: -She was at the emergency room all day. -They ran a lot of tests. -They gave her a lot of medicine. -She felt a lot better.	{D 273}		

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{D 273}	Continued From page 8 -She was worried because she still did not have oxygen. -She was told she would have to wait until she saw her doctor next week. -She felt she needed it before then because she was short of breath. Review of Resident #5's hospital discharge papers dated 08/31/17 revealed: -Resident was seen for diagnosis of exacerbation of COPD. -Resident was given an injection of Furosemide (diuretic for to decrease swelling/fluid). -Resident was administered (2) Albuterol (for difficulty breathing) nebulizer treatments. -Resident was given an injection of Prednisone (for inflammation). Review of Resident #5's physician's orders dated 08/31/17 revealed: -Proventil inhaler prn (as needed) for wheezing. (Proventil is for breathing problems.) -Levaquin 500mg for 10 days. (Levaquin is an antibiotic for infection.) -Prednisone 60mg everyday for 5 days. 2. Review of Resident #3's current FL-2 dated 07/13/17 revealed diagnoses of Hypertension (HTN), Hyperlipidemia, Sick Sinus Syndrome Pacemaker, Hypothyroidism, Anemia and Dementia. Review of Resident #3's Resident Register revealed an admission date of 05/02/16. Observation of Resident #3 on 08/30/17 at 10:30 a.m. revealed: -Resident #3 was sitting in a recliner in her room with the leg rest in the up position. - The resident was wearing non-skid socks on	{D 273}		

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{D 273}	Continued From page 9 both feet. -There was aluminum foil wrapped around both of her legs from the area right below her knee down to underneath her socks. Interview with Resident #3 on 08/30/17 at 10:30 a.m. revealed: -Her family member had wrapped gauze, plastic wrap, and aluminum foil around her legs yesterday (08/29/17) because "It pulls fluid off". -Her family member was a nurse and she was experimenting to see if it worked. -Her legs were swollen and "tight feeling". -She could take the wraps off today (08/30/17). Interview on 08/30/17 at 12:19 p.m. with a personal care aide (PCA) revealed: -Resident #3's bath days were Mondays, Wednesdays and Fridays. -Resident #3 needed assistance with putting on her knee highs. -Resident #3 needed assistance with putting on her underclothes. -Resident #3 did not put on pajamas at night because she slept in her recliner. -She had not assisted Resident #3 recently because the medication aides (MA) had been helping her. Interview on 08/30/17 at 1:19 p.m. with a MA revealed: -Resident #3's legs had been swelling. -She was not aware of any non-medical treatment for the swelling in the resident's legs. -She helped Resident #3 with her bath. -The resident did not get a bath as scheduled yesterday (08/29/17). -Resident #3's bath schedule was Tuesday, Thursday and Saturday. -Resident #3 would be getting a bath today	{D 273}		

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{D 273}	Continued From page 10 (08/30/17). -She had not seen aluminum foil on Resident #3's legs. -She had heard about the aluminum foil from another resident. -Resident #3's family member was at the facility on (08/29/17) and she must have put the foil on the resident's legs at that time. Interview on 08/30/17 at 1:24 p.m. with the Resident Care Manager (RCM) revealed: -She was new to her position. -She had been doing training and working on orders and resident records. -She was not familiar with Resident #3's care. -The MA would be able to give information about Resident #3. Interview on 08/30/17 at 1:28 p.m. with the Executive Director (ED) revealed: -Resident #3's family member had used foil one time before and it worked. -Resident #3's family member was a Registered Nurse. -She knew Resident #3's family member tried a home remedy and was not sure what it was, but knew she was doing something. -Resident #3's legs were weeping and the primary care provider (PCP) was called about sending Resident #3 to the emergency room (ER). -Resident #3 did not want to go to the ER. -Resident #3's family member had looked up a home remedy on the internet. -The ED did not feel the home remedy was a medication and therefore she did not know she needed a physician's order. -The PCP saw the swelling and weeping. -She thought Resident #3's family member would have called the PCP about using the home	{D 273}		

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{D 273}	Continued From page 11 remedy. -She had not contacted the PCP to see if Resident #3's family member had discussed the home remedy with the PCP. Interview on 08/30/17 at 1:40 p.m. with a MA revealed: -She had contacted Resident #3's PCP (08/30/17) to notify her of Resident #3 having her legs wrapped in foil today (08/30/17). -The PCP was not aware Resident #3's daughter had tried a home remedy that included wrapping the legs. -The PCP would call Resident #3's family member to discuss. Interview on 08/30/17 at 1:42 p.m. with a second MA revealed: -She heard that Resident #3 had aluminum foil on her legs before. -She thought it was last week. -She did not see the aluminum foil wrapped on Resident #3's legs because she did not look at the residents legs. -She did not check on it or report it to anyone for follow-up. Observation on 08/30/17 at 4:22 p.m. of Resident #3 revealed: -She had yellow non-skid socks on both of her feet. -She did not have any type of wrapping on either leg. -Her lower left leg had an area with pink and red discoloration. Interview on 08/30/17 at 4:22 p.m. with Resident #3 revealed: -The MA had taken the wrappings off her legs prior to her bath on (08/30/17).	{D 273}		

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{D 273}	Continued From page 12 -Resident #3 thought the swelling in her legs looked much better. -She was concerned there was an area on her left lower leg that looked like it might open up. Review of Resident #3's medical record on 08/30/17 revealed: -There was no documentation for Resident #3 to have dressings or wraps on her legs. -There was no order for dressings or wraps for Resident #3's legs. Interview on 08/31/17 at 12:50 p.m. with the PCP revealed: -Resident #3 did not have aluminum foil on her legs on Monday (08/28/17) when she had made her rounds at the facility. -Yesterday (08/30/17) when the MA called her, it was the first she had heard of leg wraps being done to the resident. -She was surprised the family member had done this as she usually called the PCP for everything. -The primary concern she had about the home remedy was if the leg wraps were too tight. -If it had a crinkle in the wrapping, it could cause a sore. -She had never seen Resident #3's legs wrapped. -She had seen Resident #3 with control type knee highs that were too tight and had told the resident they needed to be thrown away. -She had been adjusting Resident #3's Lasix to reduce the swelling. (Lasix is a diuretic used to treat swelling.) -She had not given any non-pharmaceutical treatment orders to any staff related to Resident #3. -She had told the resident and her family member to elevate the resident's legs. -She had not seen Resident #3's legs weeping. -She had not received any call related to Resident	{D 273}		

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(D 273)	Continued From page 13 #3's legs weeping. -If she had known that Resident #3's legs were weeping she would have instructed staff to elevate legs above her head and increased her Lasix. -The resident's last chest x-ray was fine. -If Resident #3's legs were "that bad" her family member would have made the resident go to the emergency room. -She had not ordered compression stockings due to the risk of the smallest crinkle could cause more problems. Telephone interview on 08/31/17 at 3:23 p.m. with Resident #3's family member revealed: -She visited Resident #3 a lot. -She had not tried to get the resident to go to the hospital. -She noticed the increased swelling in the resident's legs for about 3 weeks. -The resident's legs had been cold as ice. -The doctor had already started treatment. -The resident's legs had been leaking fluid. -Resident #3's non-skid socks had been soaking wet. -Another family member had open-heart surgery in 2016 and his legs were swollen and itching and the dermatologist had suggested she rub the family member's legs down in Vaseline, then put gauze on them and cover with saran wrap. -This treatment had worked for the other family member's legs and since Resident #3's legs were swollen and skin irritated she thought she would try it. -She had read on the internet "you could use aluminum foil" instead of plastic wrap. -There was a MA that saw Resident #3's legs the day she applied her home remedy. -The MA went to the ED about Resident #3's legs while she was there.	(D 273)		

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{D 273}	Continued From page 14 -When she was leaving that day the (ED) asked her if she thought Resident #3 should be sent out to the emergency room. -The ED was not a nurse. -She did not think Resident #3 needed to go to the hospital because the PCP had been working on it. -It was a Tuesday night, and she knew the PCP would be coming back on Thursday. -The ED knew she had tried her home remedy on Resident #3's legs. -No one told her she could not try the home remedy on Resident #3's legs. -The PCP told her today (08/31/17) that she had not done anything to hurt Resident #3. -She did not ask anyone prior to doing the home remedy if she could or not. -The first time she had done it was about one and a half weeks ago. -Both legs were swollen. -The left leg did not ever go down. -She told the ED that she had wrapped the resident's legs. -It was not questioned "at all." -The ED knew she was a retired nurse. -She wrapped the resident's legs again because they had been swollen. -She did it on Tuesday (08/30/17). -She was at the facility today (08/31/17) and she thought Resident #3's legs looked better. -She talked to the PCP and knew she was treating the swelling. -She thought on today's visit (08/31/17) Resident #3's legs looked like they were going to "open up" -She hoped the PCP was going to order a cream for it. Interview with a MA on 08/31/17 at 5:51 p.m. revealed: -She heard about Resident #3 having aluminum	{D 273)		

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{D 273}	Continued From page 15 foil on her legs. -She had not seen the foil on Resident #3's legs and did not check to see if there was any type of dressing on Resident #3's legs. -She did not report what she heard to anyone for follow-up. 3. Review of Resident #2's current FL-2 dated 08/03/17 revealed diagnoses of coronary artery disease, chronic obstructive pulmonary disease, chest pain, hypertension, hyperlipidemia, anxiety, insomnia, constipation, and depression. Review of Resident #2's Resident Register revealed an admission date of 05/15/15. Observation of Resident #2 during the initial tour of the facility on 08/30/17 at 10:23 a.m. revealed: -The resident was sitting on the bed wearing oxygen via nasal cannula connected to an oxygen concentrator. -There was a small portable oxygen tank lying on the floor next to the recliner in his room. Review of Resident #2's medical record revealed: -There was a physician's order from the former physician for Resident #2 for portable oxygen to be worn at all times while ambulating dated 6/09/17. -There was a physician's order from the current Nurse Practitioner for Resident #2 for portable oxygen to be worn due to shortness of breath dated 8/24/17. Interview with Resident #2 on 08/30/17 at 10:23 a.m. revealed: -His oxygen concentrator was set on 2 liters per minute. -His portable oxygen tank was not working. -His portable oxygen tank started leaking last	{D 273}		

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{D 273}	Continued From page 16 weekend. -Facility staff were aware and they were ordering an emergency supply of oxygen. -He thought they were waiting on approval for his insurance but he was not sure. -He had that portable oxygen tank when he came to the facility. -He had to take frequent breaks and stop when he was walking from his room to the dining room for meals because he would get short of breath. -He took frequent breaks to rest when walking to the dining room because his room was far away from the dining room. -He did "okay" without his oxygen at meal times. -The facility staff was helping him get more portable oxygen. Observation on 08/31/17 at 10:15 a.m. of Resident #2 revealed: -The resident was seated on a bench near the front entrance of the facility by the dining room area. -The resident was wearing portable oxygen. Interview on 08/31/17 at 12:20 p.m. with Resident #2 revealed: -He had no problems breathing until about a week ago. -He had a portable oxygen carrier since he had been at the facility, but it was broken. -It had been leaking oxygen for about a week and was not working properly. -His portable oxygen was fixed yesterday on 08/30/17 since the state was here. -He used his oxygen in his room and took rest breaks when he needed to go outside of his room. -As of 08/31/17, his oxygen saturation was back up to 90% since he started wearing his portable oxygen after it was fixed.	{D 273}		

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{D 273}	Continued From page 17 -He felt much better now that his portable oxygen was working right. -He didn't want to be a bother so he did not complain about his portable oxygen not working properly. Interview on 08/31/17 at 2:40 p.m. with a personal care aide (PCA) revealed: -She had not seen Resident #2 wearing portable oxygen until two days ago. -Resident #2 took frequent breaks when ambulating because he would become short of breath. -Resident #2 told the PCA last week the resident was short of breath but was waiting to see the doctor about it. -She did not report Resident #2 being short of breath because he said he would be okay. Interview with a medication aide (MA) on 08/31/17 at 2:50 p.m. revealed: -She had not observed Resident #2 using oxygen outside of his room. -Resident #2 began to have difficulty breathing about a week ago, but she was unable to specify what day. -She contacted the primary nurse practitioner (NP) on the same day Resident #2 told the MA about difficulty breathing about a week ago. -She had not documented her notification to the NP made a week ago. -She believed a referral had been made to the pulmonologist for Resident #2. -Resident #2 did appear to be tired and short of breath often, but he did stop and rest when ambulating within the facility. Interview with two Housekeeping Staff on 08/31/17 at 3:00 p.m. revealed: -They both had seen Resident #2 wearing	{D 273}		

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{D 273}	Continued From page 18 portable oxygen for the past couple of days within the facility. -Prior to this, they had only seen Resident #2 wearing oxygen while using the oxygen concentrator in his room. -They had not observed Resident #2 wearing portable oxygen outside of his room prior to a couple of days ago. -Resident #2 seemed to tire easily, even while wearing the portable oxygen, but not as often as he did without it. -Resident #2 would stop and sit down and rest a lot when ambulating within the facility. Review of Resident #2's medical record revealed: -There was no documentation of the former physician or the current Nurse Practitioner (NP) for Resident #2 being notified of issues regarding shortness of breath, difficulty breathing while ambulating within the facility, or issues with portable oxygen. Interview on 08/31/17 at 1:40 p.m. with the Nurse Practitioner (NP) for Resident #2 revealed: -There was a provider available 24-hours a day. -She was aware Resident #2 gets out of breath easily and had oxygen for use in his room. -She was not aware Resident #2 had an order for portable oxygen dated 6/09/17. -She became the primary care provider for Resident #2 in mid-July 2017. -She had not been notified by the facility that Resident #2 did not have his portable oxygen or had difficulty breathing when ambulating. -She had not seen Resident #2 using portable oxygen while ambulating outside of his room. -She completed an order for portable oxygen for Resident #2 on 8/24/17 per Resident #2's request for one. -Resident #2's oxygen level was at 69% on	{D 273}		

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{D 273}	Continued From page 19 8/24/17 but he refused to go to the hospital. -On 8/28/17, during a facility visit, the NP was asked by Resident #2 for a portable oxygen carrier again because he had not received one. -Resident #2 informed the NP on 8/28/17 his current portable oxygen carrier leaked and did not work properly. -On 8/28/17, the Executive Director (ED) notified the NP to add additional wording for Resident #2's portable oxygen to be approved for payment. -Prior to 8/28/17, the NP had not been notified of any issues regarding Resident #2's portable oxygen. -The NP was never informed of Resident #2 not wearing or refusing to use oxygen. -Resident #2's current portable oxygen carrier tubing was repaired by facility staff on 08/29/17. -Resident #2's oxygen saturation was 88% on 08/31/17 at 1:25 p.m. -Resident #2 needed the portable oxygen while ambulating due to his diagnosis. -Due to difficulty breathing and shortness of breath, Resident #2 took frequent breaks to rest when ambulating to various areas within the facility. -She had observed Resident #2 taking rest breaks without wearing portable oxygen. -She was unsure why the facility waited six days from the date of the order completed on 08/24/17 to ensure a portable oxygen carrier was in place for Resident #2 on 08/30/17. Interview on 08/30/17 at 1:24 p.m. with Resident Care Manager (RCM) revealed: -She was new to her position. -She was currently going through training and working on orders and resident records. -She was not familiar with Resident #2's care. -She was not aware of an order for portable oxygen dated 08/24/17 for Resident #2.	{D 273}		

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{D 273}	Continued From page 20 -She had observed Resident #2 taking rest breaks while ambulating to the dining room and other areas in the facility. -She had not contacted the NP regarding Resident #2. Interview on 08/30/17 at 1:28 p.m. with Executive Director (ED) revealed: -She was unaware Resident #2 had a physician's order on 6/09/17 for portable oxygen. -She was aware Resident #2 had a physician's order for portable oxygen written on 8/24/17. -She had contacted the NP to add additional wording on 8/28/17 for the portable oxygen to be approved for payment. -She had observed Resident #2 being short of breath and taking frequent breaks. -She thought the NP was aware of Resident #2's medical concerns. -She would follow-up with the NP for Resident #2, the RCM, and the MA's to develop a system to ensure physician orders were followed up on and the NP was being immediately notified. Attempted telephone interview on 08/31/17 at 5:33 p.m. with responsible party for Resident #3 was unsuccessful. 4. Review of Resident #4's current FL-2 dated 07/13/17 revealed the diagnoses included dementia, acute failure to thrive, history of left breast cancer, depression, anxiety, chronic renal insufficiency, hypophosphatemia, hypokalemia, constipation, osteoarthritis, hypertension, Vitamin B12 deficiency, anemia, irritable bowel syndrome, and iron deficiency. Review of Resident #4's Resident Register revealed: -The resident was admitted to the facility on	{D 273}		

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{D 273}	Continued From page 21 07/04/17. -The resident was lactose intolerant. Review of Resident #4's monthly weight log revealed: -The resident weighed 139.5 pounds on 07/17/17. -The resident weighed 96.8 pounds on 08/14/17. Review of a physician's order dated 07/24/17 for Resident #4 revealed an order for Ensure 1 can 3 times a day for poor po (by mouth) intake. (Ensure is a nutritional supplement used as a meal replacement or to help with weight loss. Ensure contains milk.) Review of a resident care note dated 07/27/17 for Resident #4 revealed the resident stated "she can't drink Ensure". Review of a physician's order dated 07/27/17 for Resident #4 revealed: -There was an order to discontinue Ensure and change to something non-dairy. -Any non-dairy supplement will suffice as resident is lactose intolerant with same frequency as before. Review of Resident #4's July 2017 and August 2017 medication administration records (MARs) revealed: -There was a computer printed entry for Ensure original chocolate liquid take 1 can by mouth 3 times daily as needed for poor intake. -The original date of the order was 07/24/17. -The Ensure was listed as a "prn" (as needed) medication with no scheduled times. -There was no documentation that any Ensure was given to the resident in July or August 2017. Interview with a medication aide (MA) on	{D 273}		

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{D 273}	Continued From page 22 08/31/17 at 2:10 p.m. revealed: -The resident said she was allergic to Ensure and she could not drink it. -The facility got an order for a non-dairy supplement for the resident. -They did not receive a non-dairy supplement from the pharmacy. -She was not sure if it came in a non-dairy formulation. -She had not contacted the pharmacy about obtaining a non-dairy supplement for Resident #4. -Resident #4 was refusing meals frequently and losing weight. -The primary care provider (PCP) was aware of the meal refusals and weight loss. -She had not notified the PCP that Resident #4 was not receiving a non-dairy supplement. -She would contact the pharmacy today (08/31/17) to find out if they had a non-dairy supplement. Review of a care note dated 08/21/17 by Resident #4's PCP revealed: -The PCP spoke with Resident #4's power of attorney (POA) about the resident's refusal of meals and weight loss (decrease from "132 to 96.8 pounds"). -They discussed a feeding tube and supplements but agreed the resident would not allow such. -They discussed considering hospice services. Interview with Resident #4 on 08/31/17 at 12:30 p.m. revealed: -The resident was in her room and had not eaten lunch. -When asked if she was going to eat lunch she did not comment. -She ate meals sometimes but would not comment when asked about Ensure or weight	{D 273}		

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(D 273)	Continued From page 23 loss. Interview with Resident #4's PCP on 08/31/17 at 12:40 p.m. revealed: -She was aware of Resident #4's refusals of meals and her weight loss. -She thought the resident had lost about 40 pounds since the resident was admitted to the facility. -Some of the issue was the resident's dementia and some of it was stubbornness. -She ordered Ensure to because the resident was refusing meals. -She considered poor po (by mouth) intake to be if the resident ate 50% or less of a meal. -She discontinued Ensure and wrote an order for a non-dairy supplement because the resident was lactose intolerant. -She thought the resident had been receiving a non-dairy supplement. -She was not aware the resident never received a non-dairy supplement from the pharmacy and had not been getting any. -She had spoken with the residents POA and they had discussed starting hospice services because of the weight loss and failure to thrive. Interview with a MA on 08/31/17 at 2:40 p.m. revealed: -The MAs would fax orders to the pharmacy when an order was received. -The pharmacy would put the order into the electronic MARs and send the product/medication. -If the order was not entered on the MAR or if a product/medication was not received, the MAs were supposed to contact the pharmacy. -She just spoke with someone at the pharmacy today (08/31/17). -The pharmacy would have to check with their	(D 273)		

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{D 273}	Continued From page 24 purchasing department to see if they could order a non-dairy supplement. Telephone interview with a pharmacy technician at the primary pharmacy on 08/31/17 at 2:48 p.m. revealed: -They received the order to discontinue Ensure and start a non-dairy supplement on 07/27/17. -She did not know why Ensure was not discontinued from the MARs. -It appeared the pharmacy overlooked the order dated 07/27/17. -The pharmacy had not been contacted by the facility prior to today (08/31/17) about obtaining a non-dairy supplement for Resident #4. -She was going to check with the pharmacy's purchasing department to see if a non-dairy supplement could be ordered for the resident. Interview with a second MA on 08/31/17 at 6:15 p.m. revealed: -Resident #4 usually went to the dining room after the other residents left the dining room on second shift. -She did not recall giving Ensure to Resident #4 because the resident ate most of her meals when she was on duty. -She was not aware the order for Ensure had been discontinued because it was still on the MAR. -She was aware Resident #4 had lost weight. Interview with the Executive Director (ED) on 08/31/17 at 2:28 p.m. revealed: -She was not aware Resident #4 had lost about 40 pounds. -She was not aware the resident was supposed to be getting a supplement. -Staff should be using the "hot box" and "bucket system" to track orders.	{D 273)		

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{D 273}	Continued From page 25 -Staff should have notified the PCP that the resident had not been receiving any supplements. -They would reweigh the resident today (08/31/17) to check her weight now. Interview with the first MA on 08/31/17 at 3:14 p.m. revealed: -She just weighed Resident #4 today (08/31/17) a few minutes ago. -Resident #4 weighed 106 pounds today. Attempt to contact Resident #4's POA on 08/31/17 was unsuccessful. --- The facility failed to notify PCPs of Resident #5's increased shortness of breath and the need for oxygen and a current order; of Resident #3's increased swelling of legs and the use of home remedy treatment; of Resident #2's increased shortness of breath, difficulty breathing while ambulating, and contacting the medical equipment company about problems with portable oxygen; of Resident #4 who had over a 40 pound weight loss not receiving a nutritional supplement for over a month. The facility's failure to meet the acute health care needs of 4 of 5 residents resulted in substantial risk of serious physical harm for the residents and constitutes a Type A2 Violation. --- Review of the facility's plan of protection dated 08/31/17 revealed: -An immediate audit will begin on all resident records to identify any issues regarding referral and follow-up. -All identified issues will be addressed immediately. -All care staff will be in-serviced regarding	{D 273}		

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{D 273}	Continued From page 26 reporting procedures, referral and follow-up, and process for managing all physician's orders beginning immediately and to be completed by 09/04/17. -Executive Director (ED) and/or designee will monitor physician's orders on a daily basis for 30 days, then weekly thereafter to ensure prompt attention. -ED and/or designee will monitor the use of the bucket system for physician's orders daily. -All care staff will report and/or document any contact with the physicians and families. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 2017.	{D 273}		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and	D 375	Resident charts reviewed for self administration and orders were obtained from physician if physican agrees resident is capable of administrating medications. Completed by 9/30/17. All med techs were trainined on the self medication policy conducted by Executive Director on 9/1/17. Residents that self administer medications will be reviewed quarterly by Resident Care Manager and Executive Director.	

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D 375	Continued From page 27 interviews, the facility failed to assure 3 of 4 residents sampled (#3, #5, #6) who self-administered medications had physicians' orders to self-administer including a resident with a nebulizer medication for breathing problems (#5); a resident with a topical cream for itching (#3); and a resident with a combination liquid cold medication, a combination medication for pain/inflammation/sleep, a combination medication with a stool softener/stimulant laxative, a medication for pain and inflammation (#6). The findings are: 1. Review of Resident #5's current FL-2 dated 07/16/17 revealed: -Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Hypothyroidism, Atrial-Fibrillation and Right Hip Replacement. -No information was marked related to Resident #5's orientation. Review of the Resident Register for Resident #5 revealed that she had been admitted to the facility on 07/16/09. Review of Resident #5's physician's orders signed 07/14/17 revealed an order for Albuterol Nebulizer treatments to be used every 6 hours while awake. (Albuterol is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs.) Review of Resident #5's physician's order dated 07/17/17 revealed an order Albuterol Nebulizer treatments to be used 4 times per day for 30 days.	D 375 D375	Addendum per telephone with Ms. Betty Kester, BOM / Interim ED on 10/6/17: Any staff who observe medications in a resident's room will report it to the MA / Supervisor on duty. The Supervisor will verify to assure self-administration orders on on file and current. Quarterly audits by the RCM and ED will include checking self-administration orders, checking medications on hand for self-administration, and assessing the resident to assure compliance. Non-compliance with self-administration will be reported to the physician. W. Williams 10/6/17	

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D 375	Continued From page 28 Review of Resident #5's computer generated July Medication Administration Record (MAR) revealed: -There was an entry for Albuterol Sulfate 0.083% 2.5MG/3ML Vial-nebulizer (NEB) scheduled to inhale the contents of 1-vial via hand held nebulizer every 6 hours while awake with a start date of 06/06/17 and stop date of 07/14/17. -Staff documented Albuterol as administered at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. from 07/01/17 through 07/17/17. -There was a second entry for Albuterol Sul 0.083% 2.5MG/3ML Vial-NEB scheduled four times daily with a start date of 07/18/17. -Staff documented Albuterol as administered at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. from 07/18/17 through 07/31/17. Review of Resident #5's computer generated August 2017 MAR on revealed: -There was an entry for Albuterol Sulfate 0.083% 2.5MG/3ML Vial-NEB scheduled four times daily with a start date of 07/18/17. -Resident #5 was signed off on this medication at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. from 08/01/17 through 08/16/17. -There was a handwritten note the medication had been discontinued on 08/16/17. Review of Resident #5's physician's orders revealed: -There were no subsequent orders for Albuterol treatments. -There were no orders to discontinue Albuterol treatments. -There were no orders to self-administer Albuterol treatments. Review of Resident #5's Licensed Health Professionals Support (LHPS) reviews dated	D 375		

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D 375	Continued From page 29 12/29/16 and 07/05/17 revealed: -The nurse documented on 12/29/16 that Resident #5 was taking Albuterol Sulfate via nebulizer while awake. -The nurse documented on 07/05/17 that Resident #5 was to use Albuterol nebulizer while awake. Interview on 08/31/17 at 10:30 a.m. with Resident #5 revealed: -She was using her Albuterol nebulizer treatments. -She used her nebulizer (3) times per day. -She used her nebulizer treatment today (08/31/17). -The MA gave her a box of Albuterol when she needed it. -She had been doing her own Albuterol treatments in her room. Observation on 08/31/17 at 10:30 a.m. revealed Resident #5 had a box of prescribed Albuterol Sulfate 0.083% nebulizer vials on a shelf by her bedside. Interview on 08/31/17 at 11:05 a.m. with the Executive Director (ED), Consultant Nurse and Resident Care Manager (RCM) revealed they were not aware Resident #5 was self-administering medication. Interview with the RCM on 08/31/17 at 11:45 a.m. revealed: -She obtained a physician's order today (08/31/17) for Resident #5 to have her nebulizer treatments at bedside to self-administer. -She had not found any previous order for this resident to self-administer any medications. Interview with a Medication Aide (MA) on	D 375		

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D 375	Continued From page 30 08/31/2017 at 5:48 p.m. revealed: -She was aware that Resident #5 had Albuterol at her bedside. -She thought there was an order for Resident #5 to be able to do this on her own. -She checked on her shifts to make sure Resident #5 had done her nebulizer treatments. Refer to interview with the Executive Director (ED) on 08/30/17 at 12:57 p.m. Refer to the facility's written policy for self-administration of medications. 2. Review of Resident #3's current FL-2 dated 07/13/17 revealed diagnoses of Hypertension (HTN), Hyperlipidemia, Sick Sinus Syndrome Pacemaker, Hypothyroid, Anemia and Dementia. Review of Resident #3's Resident Register revealed an admission date of 05/02/16. Interview on 08/30/17 at 4:22 p.m. with Resident #3 revealed: -She rubbed cream on her legs today (08/30/17). -The cream was for skin protectant. Observation on 08/30/17 at 4:22 p.m. of Resident #3's room revealed a tube of Anti-itch cream (Anti-itch cream is a topical analgesic and skin protectant that contains 2% Diphenhydramine hydrochloride & 0.1% Zinc acetate). Review of Resident #3's physician's orders revealed: -There was no order for an Anti-itch cream on file. -There was no order for Resident #3 to self-administer any medications. Interview with the primary care provider (PCP) on	D 375		

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D 375	Continued From page 31 08/31/17 at 12:50 p.m. revealed she was going to order a cream to be applied to Resident #3's legs. Interview on 08/31/17 at 1:00 p.m. with Resident #3 revealed: -She used her anti-itch cream this morning (08/31/17). -She did not know where she had gotten the tube of Anti-itch cream. -Her family member probably brought it to her. -She thought that because the box said skin protectant that it would help her legs. -She had applied the cream to the red and pink discoloration on her lower left leg. -She had seen her PCP today (08/31/17) and thought the PCP was going to order her something that would work better. Telephone interview on 08/31/17 at 3:23 p.m. with the Resident #3's family member revealed: -She brought Resident #3 the anti-itch cream. -She hoped the PCP was going to order a cream for Resident #3's legs. -She thought she might purchase a different cream to bring to resident. -She did not know she could not bring cream in for Resident #3 to use on her own. -She had not asked anyone if she could bring a cream to Resident #3. Interview with a MA on 08/31/17 at 5:51 p.m. revealed: -She was aware Resident #3 had Anti-itch cream at her bedside. -She helped Resident #3 with applying the cream at her bedside today (08/31/17) at 5pm. -She was not sure if there was an order for the cream. -She was not sure if Resident #3 had an order to have it at bedside and to self-administer it.	D 375		

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D 375	Continued From page 32 Review of Resident #3's physician orders dated 08/31/17 revealed an order to a apply a thin layer of triple antibiotic ointment to the left lower extremity wounds, cover with pad and wrap both legs from knees to toes applying slight compression daily. Refer to Interview with the Executive Director (ED) on 08/30/17 at 12:57 p.m. Refer to the facility's written policy for self-administration of medications. 3. Review of Resident #6's current FL-2 dated 07/13/17 revealed the resident's diagnoses included benign prostatic hypertrophy, hypertension, chronic obstructive pulmonary disease, coronary artery disease, anemia, thrombocytosis, hernia, chronic kidney disease stage III, pulmonary hypertension, hyponatremia, Vitamin B12 deficiency, iron deficiency, gastroesophageal reflux disease, and diverticulosis. Review of Resident #6's current assessment and care plan dated 05/22/17 revealed: -The resident stayed to himself and only came out of his room for meals and physician's appointments. -The resident was sometimes disoriented, forgetful, and needed reminders. Observation during tour of the facility on 08/30/17 at 10:41 a.m. revealed: -Resident #6 had 4 medications sitting on the top of a chest of drawers in his room. -There was an 8 ounce bottle of liquid Severe Cold and Mucus with a combination of medications including Acetaminophen (for	D 375		

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D 375	Continued From page 33 pain/fever), Dextromethorphan (cough suppressant), Phenylephrine (nasal decongestant), Guaifenesin (expectorant), and alcohol 0.5%. -There was less than half of the liquid Severe Cold and Mucus medication left in the bottle. -There was an opened bottle of Aleve 220mg tablets (for pain and inflammation). -There was an opened bottle of Stool Softener with Stimulant Laxative (for constipation) that expired 03/2016. -There was an opened bottle of Advil PM that contained Ibuprofen (for pain and inflammation) and Diphenhydramine (an antihistamine). Interview with Resident #6 on 08/30/17 at 10:41 a.m. revealed: -He did not know how long he had the medications in his room. -He was not sure where he got the medications. -He took the liquid cold medication when he had a cold when he needed. -He could not say how much he took of the liquid cold medication or when he last took any. -He took Advil PM and Aleve when he needed it but he did not know how often he took it. -He did not know how often he took the Stool Softener / Stimulant Laxative. Review of Resident #6's physicians' orders revealed: -There were no orders for Severe Cold and Mucus, Aleve, Advil PM, or Stool Softener/Stimulant Laxative. -There was no order for Resident #6 to self-administer any medications. Interview with a medication aide (MA) on 08/30/17 at 12:48 p.m. revealed: -Resident #6 was not supposed to self-administer	D 375		

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D 375	Continued From page 34 any medications. -Resident #6 should not have any medications in his room. -She was not aware the resident had medications in his room and self-administering them. -The resident may have bought the medications himself or his family may have brought them. Interview with a second MA on 08/30/17 at 12:55 p.m. revealed: -Residents should not have medications in their room. -She was not aware Resident #6 had medications in his room and was self-administering them. -She was not aware of a system to check resident's room for medications. -If staff saw medications in a resident's room, they should report it to the MAs. -She did not know if Resident #6 was capable of self-administering medications. Interview with the Executive Director (ED) on 08/30/17 at 12:57 p.m. revealed: -Staff had cleaned up Resident #6's room over a month ago. -She did not see any medications in the resident's room when they cleaned it. -She was not aware Resident #6 had medications in his room and was self-administering them. -She was not aware of a written facility policy for self-administration of medications but she would check on it. -The facility's procedure was there needed to be an order to self-administer medications. -Staff should check on residents who self-administered "every now and then" but there was no specific time frame of how often the checks should be done. -If there was a change in the resident's cognitive status, staff was supposed to notify the physician.	D 375		

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D 375	Continued From page 35 Refer to interview with the Executive Director (ED) on 08/30/17 at 12:57 p.m. Refer to the facility's written policy for self-administration of medications. Interview with the Executive Director (ED) on 08/30/17 at 12:57 p.m. revealed: -She was not aware of a written facility policy for self-administration of medications. -The facility's procedure was there needed to be an order to self-administer medications. -Staff should check on residents who self-administered "every now and then" but there was no specific time frame of how often the checks should be done. -If there was a change in the resident's cognitive status, staff was supposed to notify the physician. -She would check to see if there was a written policy for self-administration. Review of the facility's written policy for self-administration of medications provided by the ED on 08/30/17 revealed: -Resident will be competent and physically able. -It will be ordered in writing by physician or other legally authorized person to prescribe and kept in the resident's record. -Specific instructions for administration of the medication must be printed on the label. -The physician should be notified if a resident as a change in mental or physical ability or is non-compliant with the physician's orders or facility policies. -A resident has the right to refuse to self-administer any medication within regimen. -This does not imply the resident is unable to self-administer.	D 375		

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{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are: Based on observations, record reviews, and interviews, the facility failed to assure physician notification for 4 of 5 residents sampled (#2, #3, #4, #5) including a resident's increased shortness of breath and the need for oxygen and a current order (#5); a resident's increased swelling of legs and use of home remedy treatment (#3); a resident's increased shortness of breath, difficulty breathing while ambulating, and contacting the medical equipment company about problems with portable oxygen (#2); and a resident with over a 40 pound weight loss not receiving a nutritional supplement because it had not been obtained from the pharmacy (#4). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]	{D912}	Resident Rights training was conducted by Executive Director on 9/18/17. Resident Right policy will be reviewed uopon hire and routinly for all current staff.	