STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045005	A. BUILDING: _____ B. WING _____	10/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCULLOUGH'S REST HOME	720 ORR'S CAMP ROAD HENDERSONVILLE, NC 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Henderson County DSS conducted an annual survey on October 26, 27, and 30, 2017.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by chemicals in the storage room which was not maintained locked because the door lock was not in working order. The findings are: Observation of the storage room on 10/26/17 at 9:55am revealed: -The door was not locked. -Two containers of pest control, 1 container weed killer, 3 cans paint, 1 spray bottle window cleaner, and 1 container house hold cleaner were stored on an open shelving unit. Interview with the Administrator on 10/26/17 at 2:55pm revealed: -The door lock on the storage door had not been	D 079		

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D 079	Continued From page 1 operable for a "few days," time not certain. -She had new door knobs but the maintenance director could not put them on until the following Monday. -She would remove the chemicals and store them in an outdoor building. -The residents did not use or handle the chemicals. Interview with the Maintenance Director on 10/13/17 at 1:45pm revealed he was there to do some maintenance work which included installing the new door knobs on the storage room.	D 079		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure tuberculosis (TB) disease skin testing in compliance with the control measures adopted on the Commission for Health Services testing was completed upon hire for 3 of 4 sampled staff (B, D, and E).	D 131		

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D 131	Continued From page 2 The findings are: A. Review of Staff B's personnel record revealed: -There was no documented date of hire. -There was no documentation of a TB skin test upon hire. Interview on 10/27/17 at 10:00am with Staff B revealed: -She was hired "sometime" at the start of January 2017 as a Medication Aide. -She worked first shift every weekend. -She had a TB skin test done upon hire but the paperwork could not be found. -The TB skin test was negative. -She had another TB skin test done today (10/27/17). Refer to the interview with the Administrator on 10/27/17 at 2:25pm. B. Review of Staff D's personnel record revealed: -The date of hire was 7/31/17. -There was no documentation of a TB skin test upon hire. Telephone interviews on 10/27/17 at 9:20am and 10/30/17 at 12:30pm with Staff D revealed: -She was hired at the end of July 2017 as a Personal Care Assistant. -She worked 20-30 hours per week. -She had not had a TB skin test upon hire. Refer to the interview with the Administrator on 10/27/17 at 2:25pm. C. Review of Staff E's personnel record revealed: -There was no documented date of hire. -There was no documentation of a TB skin test upon hire.	D 131		

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D 131	Continued From page 3 Interview on 10/27/17 at 11:20am with Staff E revealed: -She was hired in February 2017 as a housekeeper. -She had not had a TB skin test upon hire Refer to the interview with the Administrator on 10/27/17 at 2:25pm. _____ Interview on 10/27/17 at 2:25pm with the Administrator revealed: -She knew the staff "needed" the TB skin test upon hire. -The Licensed Health Professional Support (LHPS) nurse was responsible for administering the TB skin tests. -She was not sure why the TB skin tests had not been done. -Some paperwork had been "lost". -She did not have a policy on TB skin testing. -She had been the Administrator for thirty years. _____ The failure of the facility to ensure staff were free from active tuberculosis (TB) disease placed the residents at risk for exposure to TB if staff were working and infected. This failure placed the residents' health, safety, and welfare at risk and constitutes a Type B Violation. _____ A Plan of Protection was provided by the facility on 10/27/17 as follows: -The facility will immediately get TB screenings done on all employees that do not have documentation of TB testing. -The facility will require that the TB screenings	D 131		

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D 131	Continued From page 4 are done on all new hires prior to working. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2017.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure that each staff person had no substantiated findings listed on the North Carolina Health Care Personnel Registry for 3 of 4 sampled staff (A, D, and E). The findings are: A. Review of Staff A's personnel record revealed: -He was hired as a Medication Aide on 6/8/06. -He worked full time. -There was no documentation that a North Carolina Health Care Personnel Registry check had been completed. Interview with Staff A on 10/27/17 at 11:00am revealed he was sure the check had been done.	D 137		

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D 137	Continued From page 5 Refer to the interview on 10/27/17 at 2:25pm with the Administrator. B. Review of Staff D's personnel record revealed: -She was hired on 7/31/17. -There was no documentation that a North Carolina Health Care Personnel Registry check had been completed. Telephone interviews on 10/27/17 at 9:20am and 10/30/17 at 12:30pm with Staff D revealed: -She was hired at the end of July 2017 as a Personal Care Assistant. -She worked part time 20-30 hours per week. -She did not know about the Health Care Personnel Registry check. Refer to the interview on 10/27/17 at 2:25pm with the Administrator. C. Review of Staff E's personnel record revealed: -There was no documented date of hire. -There was no documentation that a North Carolina Health Care Personnel Registry check had been completed. Interview on 10/27/17 at 11:20am with Staff E revealed: -She was hired in February 2017 as a housekeeper. -She did not know about the Health Care Personnel Registry check. Refer to the interview on 10/27/17 at 2:25pm with the Administrator. _____ Interview on 10/27/17 at 2:25pm with the Administrator revealed:	D 137		

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D 137	Continued From page 6 -She did not know why the Health Care Personnel Registry checks had not been done. -She "thought the LHPS nurse was supposed to do that". -She knew some paperwork had been "lost". -She had no written policy on the Health Care Personnel Registry checks. -She would "make sure they get done". _____ The facility failed to ensure 3 of 4 sampled staff (A, D, and E) had a North Carolina Health Care Personnel Registry check prior to date of hire. The facility not knowing if staff had substantiated findings placed all resident at risk for neglect or abuse and constitutes a Type B Violation. _____ A plan of protection was received from the facility 10/27/17 as follows: -A Healthcare Personnel Registry check would be done on all current employees. -A Healthcare Personnel Registry check would be done on all future new hires prior to start date in the facility. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2017.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by:	D 139		

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D 139	Continued From page 7 TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 3 of 4 sampled staff (B, D, and E) had a criminal background screening upon hire. The findings are: A. Review of Staff B's personnel record revealed: -There was no documented date of hire. -There was no documentation that a criminal background screening had been completed. Interview on 10/27/17 at 10:00am with Staff B revealed: -She was hired "sometime" at the start of January 2017 as a Medication Aide. -She worked first shift every weekend. -She did not remember signing a consent for criminal background check. -She did not know if a criminal background check had been completed. Refer to the interview on 10/27/17 at 2:25pm with the Administrator. B. Review of Staff D's personnel record revealed: -The date of hire was 7/31/17. -There was no documentation that a criminal background screening had been completed. Telephone interview on 10/27/17 at 9:20am and 10/30/17 at 12:30pm with Staff D revealed: -She was hired as a Personal Care Assistant. -She worked part time 20-30 hours per week. -She did not know if a criminal background check had been completed or not. -She was sure "one was done at my last place of work".	D 139		

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D 139	Continued From page 8 Refer to the interview on 10/27/17 at 2:25pm with the Administrator. C. Review of Staff E's personnel record revealed. -There was no documented date of hire. -There was no documentation that a criminal background screening had been completed. Interview on 10/27/17 at 11:20am with Staff E revealed: -She was hired in February 2017 as a housekeeper. -She did not know anything about a criminal background screening. Refer to the interview on 10/27/17 at 2:25pm with the Administrator. _____ Interview on 10/27/17 at 2:25pm with the Administrator revealed: -She had been the Administrator for thirty years. -She was sure the criminal background checks had been done. -She was responsible for checking criminal backgrounds. -The paperwork was "lost". -She would make sure to do the criminal background checks again. -There was no written policy on criminal background checks. _____ The failure of the facility to ensure 3 of 4 sampled staff (B, D, and E) had a state-wide criminal background check upon hire resulted in the facility being unaware of any criminal background findings that could be detrimental to the welfare	D 139		

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D 139	Continued From page 9 and safety of the resident. This non-compliance constitutes a Type B Violation. A plan of protection was received from the facility on 10/27/17 as follows: -Criminal background checks would be done on 10/27/17 on all employees without one. -All potential employees would have a criminal background check complete before hire. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2017.	D 139		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (B) were competency validated by a registered nurse by return demonstration prior to performing Licensed Health Professional Support tasks.	D 161		

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D 161	Continued From page 10 The findings are: Review of Staff B's personnel record revealed: -There was no documented date of hire. -There was no Licensed Health Professional Support tasks documentation. Interview on 10/27/17 at 10:00am with Staff B revealed: -She was hired "sometime" at the start of January 2017 as a Medication Aide. -She worked first shift every weekend as a Medication Aide. -Staff B had received her Medication Aide training and testing in 2001. -The facility had a nurse give her a medication test and LHPS check off when she started in January. -The LHPS check off included "general things like taking blood pressures and turning people". Interview on 10/27/17 at 9:45am with the LHPS nurse revealed: -She had previously LHPS validated Staff B. -The paperwork could not be found. -She was scheduling a time to do the LHPS validation again. Interview on 10/27/17 at 10:50am with the Administrator revealed: -She had been the Administrator for thirty years. -The nurse was responsible for the LHPS validations. -She "thought" the nurse had completed it. -No paperwork could be found. -She would have the nurse schedule a time to complete it. -There was no policy on LHPS validations.	D 161		

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D 176	Continued From page 11	D 176		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the Administrator failed to assure the management and overall operations of the facility by failing to meet and monitor rules related to housekeeping and furnishings, other staff qualifications, competency validation for LHPS tasks, health care, medication orders, medication administration, ACH medication aides training and competency, and examination and screening. The findings are: Interview with the Administrator on 10/30/17 at 11:00am revealed: -She had been the Administrator for at least 30	D 176		

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D 176	Continued From page 12	D 176		

years, was there daily, and stayed until 8:00pm or 9:00pm at night.
-She thought things "were being taken care of" by the first shift week-day staff, Staff A.
-Staff A, was responsible for assuring the medications were ordered and documented on the Administration Records (MARs) and that all the medications were available for administration.
-Staff A monitored the medication cart once a week to assure all the medications in the drawer matched the MAR.
-One of their former medication aides, Staff F, used to be responsible for maintaining the personnel and resident records, but she had not worked very much in the past 2 months.
-She planned to have the first shift week-end staff, Staff B, be responsible for assuring all the records including personnel and medication orders were accurate and maintained updated.
-She had no written policies on health care referral, medication management, and personnel qualifications and records.

Non-compliance identified during the survey included the following rule areas.

A. Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by chemicals in the storage room which were not maintained locked because the door lock was not in working order. [Refer to Tag 79, 10A NCAC 13F .0306(a) Housekeeping and Furnishings.]

B. Based on record reviews and interviews, the facility failed to ensure tuberculosis (TB) disease skin testing in compliance with the control measures adopted on the Commission for Health Services testing was completed upon hire for 3 of 4 sampled staff (B, D, and E). [Refer to Tag 131,

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D 176	Continued From page 13 10A NCAC 13F .0406(a) Test For Tuberculosis (Type B Violation).] C. Based on record reviews and interviews, the facility failed to ensure that each staff person had no substantiated findings listed on the North Carolina Health Care Personnel Registry for 3 of 4 sampled staff (A, D, and E). [Refer to Tag 137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation).] D. Based on record reviews and interviews, the facility failed to ensure 3 of 4 sampled staff (B, D, and E) had a criminal background check upon hire. [Refer to Tag 139, 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation).] E. Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (B) were competency validated by a registered nurse by return demonstration prior to performing Licensed Health Professional tasks. [Refer to Tag 161, 10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks.] F. Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for the scheduling of a neurologist appointment, for the refusals of lidocaine patches and ipratropium-albuterol inhaler for 1 of 3 sampled residents (#1). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] G. Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for verification or clarification of orders for Levothyroxine, Metformin, Invokona, Primidone, Prazosin, Lunesta, Ipratropium-albuterol, Benadryl,	D 176		

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D 176	Continued From page 14 Diclofenac Sodium, and Diclofenac Potassium for 1 of 3 sampled residents (#1). [Refer to Tag 273, 10A NCAC 13F .1002(a) Medication Orders (Type B Violation).] H. Based on observations, interviews, and record reviews, the facility failed to assure the accuracy of the Medication Administration Records for 1 of 3 sampled residents (#1) related to documenting the administration of Ketorolac, Risperdal, Benadryl, Klonopin, ipratropium-albuteral inhaler, and Mapap Arthritis, and lidocaine patches and related to documenting the reason for the administration and resulting effect of PRN (as needed) medication orders Mapap Arthritis, Benadryl, Klonopin, and Ketorolac. [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration (Type B Violation).] I. Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled medication aides (Staff B) completed the 15 hour medication training within 6 months of hire as a medication aide. [Refer to Tag 935, G.S. 131D - 4.5B(b) ACH Medication Aides; Training and Competency.] J. Based on record reviews and interviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed for 3 of 3 sampled staff (B, D, and E) who were hire after 10/1/13. [Refer to Tag 992, G.S. 131D - 45(a) Examination and Screening.] _____ The administrator failed to ensure that the management, operations, and policies of the facility were implemented to ensure the services necessary to maintain the residents' physical and mental health were provided as evidenced by the	D 176		

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D 176	Continued From page 15 failure to maintain compliance with the rules and statutes governing adult care homes, which is the responsibility of the Administrator. Failure to ensure all staff requirements were met and documented, that health care referral and follow up was completed, and that all medications were clarified, administered, and documented as ordered was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The Plan of Protection provided by the facility on 10/27/17 revealed: -The Administrator will make all necessary changes to immediately correct rule violations and begin to monitor to assure staff are following procedures properly. -The Administrator will monitor the facility to assure it adheres to State Regulations and the Medication Aides will assist with making sure all regulations are in compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2017	D 176		
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: TYPE B VIOLATION	D 273		

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Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for the scheduling of a neurologist appointment, for the refusals of lidocaine patches and ipratropium-albuterol inhaler for 1 of 3 sampled residents (#1).

The findings are:

Review of Resident #1's hospital discharge generated FL2 dated 10/11/17 revealed diagnoses included schizoaffective disorder, bipolar type, migraines, asthma, bipolar disorder, and chronic obstructive pulmonary disease.

The findings are:

1. Review of Resident #1's hospital discharge records, dated 10/11/17, revealed a physician order for an "injection 15 with PRDH EMG/Botox" at a local neurology physician office on 10/23/17 (used to treat chronic migraines by blocking certain chemical signals the nerves, causing temporary paralysis of the muscles).

Interview with the first shift week-day Medication Aide, Staff A, on 10/30/17 at 10:55am revealed:
-He was not aware Resident #1 had an appointment for the injection on 10/23/17.
-He would call to reschedule the appointment.
-He was responsible for scheduling all physician appointments.

Interview with the Administrator on 10/30/17 at 2:45pm revealed:
-She picked Resident #1 up at the hospital upon discharge but did not read the orders.
-Staff A was responsible for assuring all physician orders were processed which included scheduling

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health care referrals.

-Interview with Resident #1 on 10/30/17 at 2:40pm revealed:
-She routinely had "Botox" injections and she was not aware she had an appointment on 10/23/17.
-She had been having migraine headaches recently, had a bad migraine headache on Thursday, 10/26/17, which was reported to the medication aides.

Telephone interview with a nurse at the Neurologist office on 10/30/17 at 2:17pm revealed:
-Resident #1 was scheduled every 12 weeks to receive a Botox injection and she received the last one on 7/31/17.
-The Botox was prescribed for migraine headaches.
-Routine injections of Botox was prescribed to reduced the severity and frequency of migraine headaches.

Refer to interview with the Administrator on 10/30/17 at 11:15am.

2. Review of Resident #1's current FL2 dated 10/11/17 revealed physician orders included lidocaine 5% patch, use 2 daily every 12 hours then remove (a topical pain reliever).

Review of the 10/1/17 through 10/26/17 Medication Administration Records (MARs) revealed:
-A computer generated entry for lidocaine patches 5%, apply as directed.
- Staff documented the administration of lidocaine patches daily at 8:00am except 10/4/17 through 10/10/17 when Resident #1 was in the hospital.

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D 273	Continued From page 18 Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed: -A box of 60 lidocaine patches were dispensed on 5/17/17 with 12 patches remaining in the box. -No other lidocaine patches were available. -A box of 60 lidocaine patches was a 30 day supply with the current order to use 2 patches daily. Review of Resident #1's record revealed no documentation Resident #1 had refused lidocaine patches Telephone interview with the contract pharmacist on 10/26/17 at 2:41pm revealed: -They dispensed a supply of 60 lidocaine patches for Resident #1 on 5/17/17 and staff had not requested any more. -Facility staff had to request refills for the pharmacist to dispense medications. Interview with Resident #1 on 10/30/17 2:40pm revealed: -She had been refusing the patches for a few months because they felt "weird" on her knees because a metal plate was placed in her knees when she had knee replacement surgery. -She wanted to try using the lidocaine patches again and did not want them discontinued. Interview with the first shift week day Medication Aide, Staff A, on 10/26/17 at 2:25pm revealed: -Resident #1 had been refusing the lidocaine patches. -He did not know why he kept documenting the administration of the patches. -He did call the physician to inform him of Resident #1 refusing the lidocaine patches, but he did not document the refusals nor the contact	D 273		

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with the physician.

Interview with the first shift week-end day Medication Aide, Staff B, on 10/27/17 at 10:00am revealed:
-She had not applied a lidocaine patch on Resident #2 in the past few months.
-She had worked at the facility for 10 months as a Medication Aide.

Attempted telephone interview with Resident #1's primary care physician on 10/26/17 at 3:12pm revealed the physician was not available for interview.

Refer to interview with the Administrator on 10/30/17 at 11:15am.

3. Review of Resident #1's FL2 dated 10/11/17 revealed a physician order for ipratropium-albuterol 20-100 mcg/actuation mist inhaler, inhale 1 puff 4 times a day as needed.

Review of Resident #1's previous FL2 dated 8/11/17 revealed a physician order for Combivent Respimat inhaler (brand name for ipratropium-albuterol) 1 puff 4 times a day.

Review of the October 2017 MAR on 10/26/17 at 11:15am revealed:
-A computer generated entry for Combivent Respimat inhaler, inhale 1 puff 4 times a day.
-Documentation of daily administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm of Combivent Respimat inhaler 1 puff 4 times a day from 10/11/17 through 10/25/17.
-No entry for Combivent Respimat inhaler to be administered as needed.

Observation of medications on hand available for

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administration for Resident #1 on 10/26/17 at 11:15am revealed:
-A Combivent inhaler dispensed on 4/21/17 with directions to administer routinely 4 times per day.
-A second Combivent inhaler dispensed on 7/14/17 with directions to administer routinely 4 times per day.

Telephone interview with the pharmacist on 10/30/17 at 11:48am revealed:
-They dispensed a Combivent inhaler on 7/14/17 with directions to administer routinely 4 times per day and no more had been requested.
-One Combivent inhaler would last 30 days if it was administered routinely 4 times daily.

Interview with the first shift week day Medication Aide, Staff A, on 10/26/17 at 2:25pm revealed:
-Resident #1 had been refusing the Combivent inhaler.
-He documented the administration of the Combivent inhaler in error.
-He had not contacted the physician that Resident #1 was refusing the Combivent inhaler.

Interview with Resident #1 on 10/26/17 at 3:00pm revealed:
-She had not needed the Combivent inhaler and not requested it since she came back from the hospital on 10/11/17.
-She could not remember if she had used the inhaler in the past few months before she went to the hospital.

Review of record revealed no documentation a physician had been contacted that Resident #1 was refusing the Combivent inhaler and no clarification it was to administered as needed or routinely.

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D 273	Continued From page 21 Attempted telephone interview with Resident #1's primary care physician on 10/26/17 at 3:12pm revealed the physician was not available for interview. Refer to interview with the Administrator on 10/30/17 at 11:15am. --- Interview with the Administrator on 10/30/17 at 11:15am revealed: -Another medication aide, Staff F, had not been available in the past 2 months to maintain the files, the medication orders, and assure all medications were administered as ordered. -Staff A was currently responsible for assuring the physicians were contacted if residents refused their medications and if orders were not clear, and was responsible for assuring all medications were available for administration as ordered. -Staff A was currently responsible for assuring all resident medical appointments were scheduled but the Administrator transported them to the appointments. -She was not aware and Staff A had not informed her that Resident #1's had missed a neurologist appointment. -She stated, "I thought everything was being taken care of." -She did not have a written policy on health care referral and follow-up and on medication refusals, but they would follow the licensure rules. --- The facility's failure to assure referral and follow-up resulted in Resident #1 missing an appointment for a neurological physician visit for a Botox injection which was prescribed to reduce the severity and frequency of migraines resulted in Resident #1 experiencing migraines. The	D 273		

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D 273	Continued From page 22 failure to contact Resident #1's physician for refusal or clarification of the order for ipratropium-albuterol inhaler placed the resident at risk for exacerbation of her diagnosis of chronic obstructive pulmonary disease. Failure to contact Resident #1's physician for refusal or clarification of the lidocaine patch 5% for pain management also placed the resident at risk. The failure to provide health care and referral for Resident #1 was detrimental to the health and safety of the resident and constitutes a Type B Violation. The Plan of Correction provided by the facility on 10/27/17 revealed: -The Medication Aides will be responsible for assuring all medical appointments are scheduled as ordered. -The first shift week-end Medication Aide, Staff B, will be given the responsibility of monitoring and maintaining all the orders in the resident records. -Staff B will be responsible for assuring the accuracy of the Medication Administration Records. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2017	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours	D 344		

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of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Type B Violation

Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for verification or clarification of orders for Levothyroxine, Metformin, Invokona, Primidone, Prazosin, Lunesta, Ipratropium-albuterol, Benadryl, Diclofenac Sodium, and Diclofenac Potassium for 1 of 3 sampled residents (#1).

The findings are:

Review of Resident #1's current FL2 dated 10/11/17 revealed:
-Diagnoses included schizoaffective disorder, bipolar type, migraines, asthma, bipolar disorder, and chronic obstructive pulmonary disease.
-The FL2 was generated at the hospital upon discharge on 10/11/17 and was attached to 3 pages of medication and medication discontinue orders.

Review of Resident #1's hospital records, dated 10/3/17 through 10/11/17, revealed:
-Resident #1 "was admitted to the hospital for stabilization of mood.....was initially over sedated due to overmedication and drug drug interaction."
-"Her medications were discontinued and she

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was started on unit recommend, with a much reduced amount of medications at the lowest therapeutic dose."
-The "Patient Active Problem List" diagnoses were "Migraine without aura and without status migrainosus....schizoaffective disorder, bipolar type."

Telephone interview with the contract pharmacist on 10/26/17 at 2:41pm revealed:
-When they received Resident #1's hospital discharge orders dated 10/11/17, the FL2 page was signed by the physician, but the three pages of physician orders were not signed, which the pharmacy required to fill a prescription.
-The pharmacist called the facility to inform them they required a physician's signature on each page of medication orders, but did not have documentation when they called or who they talked to.

Interview with the first shift week-day Medication Aide, Staff A, on 10/26/17 at 2:25pm revealed:
-Resident #1 was treated by a psychiatrist at the hospital in October 2017 and Resident #1 wanted that psychiatrist for her ongoing therapy and now she did not want to go back to her previous mental health provider.
-The day program provided mental health services but she recently refused to attend the day program; therefore the mental health physician would not prescribe or clarify medications because she was discharged from that program after refusing participation.
-A mental health provider who used the services of the hospital psychiatrist was contacted; an intake worker came to the facility on 10/27/17 and met with Resident #1.
-The intake worker started the paperwork to get Resident #1 into the new mental health provider

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system.
-The psychiatrist was going to make a "house call" to complete an assessment on Resident #1, but it usually took about 3 business days to schedule the facility visit, and the provider had not let him know the date.

Telephone interview with the new Mental Health Provider intake worker on 10/30/17 at 2:05pm revealed:
-He verified he met with Resident #1 and filled out the required paperwork.
-The psychiatrist would come out to complete an initial assessment on Resident #1 but he did not know the date.

Telephone interview on 10/30/17 at 11:15am with a social worker at the hospital which provided psychiatric services to Resident #1 in October 2017 revealed:
-The hospital psychiatrist would not discuss Resident #1's medication because he had discharged the resident from the hospital.
-The hospital psychiatrist provided services for a mental health system which offered ongoing outpatient medication management.

Telephone interview with a staff at Resident #1's primary care physician office on 10/26/17 at 3:12pm revealed:
-The physician had reviewed a copy of the hospital discharge medication orders and wanted Resident #1 to be on all the medications which were ordered at the hospital.
-The physician did not want to make any decisions related to any of Resident #1's medications until the resident saw an outpatient mental health provider.

Interview with the Administrator on 10/30/17 at

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D 344	Continued From page 26 11:15am revealed: -The facility did not maintain pharmacy dispensing records. -One of their former medication aides, Staff F, used to be responsible for maintaining the residents' files, the medication orders, and for assuring all medications were administered as ordered, but Staff F had not been available for the past 2 months. -Currently, Staff A was responsible for assuring the medication orders were sent to the pharmacy, that all orders were clarified, and that all medications were available for administration as ordered. -The Administrator was not aware and had not been informed that Resident #1's hospital discharge medication orders had not been filled and administered as ordered. -She stated, "I thought everything was being taken care of." -She did not have written policies and procedures for clarification of medication orders but staff were supposed to follow licensure rules. Interview with Resident #1 on 10/26/17 at 9:45am revealed the facility sometimes ran out of her medications, but did not know which ones or how often. Examples of medications that were included on the hospital discharge physician orders dated 10/11/17 but were not clarified per pharmacy requirements were as follows: 1. Review of Resident #1's FL2 dated 10/11/17 revealed a physician order for Levothyroxine 88 mcg at 6:00am (a thyroid supplement). Review of Resident #1's previous FL2 dated 8/11/17 revealed a physician order for	D 344		

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D 344	Continued From page 27 Levothyroxine 100 mcg. Review of the October 2017 Medication Administration Record (MAR) on 10/26/17 at 11:15am revealed: -Levothyroxine 88 mg daily was not entered on the MAR. -There was a computer generated entry for Levothyroxine 100 mg daily and documented daily at 8:00am except 10/4/17 through 10/10/17 when Resident #1 was in the hospital. Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed Levothyroxine 100 mg daily which were dispensed on 9/29/17. Review of Resident #1's hospitalization records dated 10/11/17 revealed no documentation of thyroid levels. Review of Resident #1's facility record revealed no documentation of thyroid levels. Telephone interview with the pharmacist on 10/30/17 at 11:49am revealed Levothyroxine 100 mg order was on the only order on file and they dispensed 30 doses on 9/27/17. Interview with Resident #1 on 10/30/17 at 2:40pm revealed she took Levothyroxine 100 mg daily. Refer to interview with the Administrator on 10/30/17 at 11:15am. 2. Review of Resident #1's current FL2 dated 10/11/17 revealed: -A physician order for Metformin 1000 mg daily with breakfast (used to control blood sugar levels).	D 344		

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-Check fingerstick blood sugar (FSBS) twice weekly.
-No physician order for Invokana 100 mg before first meal of day (used to control blood sugar levels).

Review of Resident #1's previous FL2, dated 8/11/17, revealed an order for Invokana 100 mg before first meal of day (used to control blood sugar levels).

Observation of medications on hand available for Resident #1 on 10/26/17 at 11:15am revealed:
-Metformin 500 mg take 2 tablets twice daily with dispense date of 9/21/17.
-Invokana 100 mg, take 1 before the first meal of the day with 28 doses dispensed on 9/27/17 with 10 doses remaining.

Review of the October 2017 Medication Administration Record (MAR) on 10/26/17 at 11:15am revealed:
-There was a computer generated entry for Metformin 500 mg take 2 tablets twice daily and documentation of administration daily at 8:00am and 5:00 pm except 10/3/17 through 10/10/17 when Resident #1 was in the hospital.
-There was a computer generated entry for Invokana 100 mg one tablet every day before the first meal of the day and documentation of administration daily at 8:00am and 5:00 pm except 10/3/17 through 10/10/17 when Resident #1 was in the hospital.
-FSBS was documented as checked twice weekly and readings ranged from 82 to 248 (American Diabetes Association (ADA) recommends keeping FSBSs before meals from 80-130 mg/dl.)

Telephone interview with the pharmacist on 10/30/17 at 11:49am revealed:

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-They dispensed Metformin 500 mg, 2 tablets daily, on 9/21/17 with a 30 day supply and the last order was dated 5/19/17.
-They dispensed the Invokana on 9/27/17 but the original order was dated 8/11/17.

Interview with Resident #1 on 10/30/17 at 2:40pm revealed she received Metformin 500 mg 2 tablets twice daily and Invokana 100 mg once daily.

Review of Resident #1's hospital records from 10/3/17 to 10/11/17 revealed no A1C levels (a lab value which indicates the last 90 day average FSBS level) but the serum glucose level was 106.

Review of Resident #1's record revealed no clarification for the following:
-Were both oral diabetic medications, Metformin and Invokana, to be administered.
-The frequency of administration for Metformin 1000 mg, once daily or twice daily.

Refer to interview with the Administrator on 10/30/17 at 11:15am.

3. Review of Resident #1's FL2 dated 10/11/17 revealed a physician order Primidone 50 mg, take 25 mg 4 times per day (an anti-epleptic medication and first-line therapy for essential tremor).

Review of Resident #1's previous FL2, dated 8/11/17, revealed an order for Primidone 50 mg, take 25 mg three times daily.

Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed:
-Primidone 50 mg, take 25 mg three times daily

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and were dispensed on 9/21/17.
-No Primidone 50 mg, take 25 mg four times daily was available for administration.

Review of the October 2017 Medication Administration Record (MAR) on 10/26/17 at 11:15am revealed
-There was a computer generated entry for Primidone 50 mg, take 25 mg three times daily and documented as administered daily at 8:00am, 12 noon, and 8:00pm except from 10/3/17 through 10/10/17 when Resident #1 was in the hospital.
-No entry for Primidone 50 mg, take 25 mg four times daily.

Telephone interview with the pharmacist on 10/30/17 at 11:49am revealed they had on file Primidone 50 mg, take 25 mg three times daily and last date of order was 9/18/17.

Interview with Resident #1 on 10/30/17 at 2:40pm revealed she received the Primidone 25 mg three times per day.

Review of Resident #1's record revealed no clarification whether Primidone 25 mg was to be administered 3 times daily or 4 times daily.

Refer to interview with the Administrator on 10/30/17 at 11:15am.

4. Review of Resident #1's FL2 dated 10/11/17 revealed a physician order Prazosin 5 mg, take 15mg (3 capsules) nightly (used for high blood pressure, anxiety, post traumatic stress syndrome and for nightmares).

Observation of medications on hand available for administration for Resident #1 on 10/26/17 at

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11:15am revealed:
-Prazosin 5 mg, take 2 daily and were dispensed on 9/28/17.
-No Prazosin 5 mg with directions to take 3 daily was available for administration.

Review of the October 2017 Medication Administration Record (MAR) revealed:
-There was a computer generated entry for Prazosin 5 mg, take 2 daily and staff documented daily administration at 8:00am except 10/4/17 through 10/1/17 when Resident #1 was in the hospital.
-No entry for Prazosin 5 mg, take 3 daily.

Telephone interview with the pharmacist on 10/30/17 at 11:49am revealed they had on file Prazosin 5 mg, take 3 daily with order date 8/11/17.

Interview with Resident #1 on 10/30/17 at 2:40pm revealed she received the Prazosin 10 mg (2 five mg capsules) at night but continued to have nightmares occasionally.

Review of Resident #1's record revealed no clarification whether Prazosin should be administered 10 mg daily or 15 mg daily.

Refer to interview with the Administrator on 10/30/17 at 11:15am.

5. Review of Resident #1's FL2 dated 10/11/17 revealed Lunesta, take 3 mg by mouth nightly, but a line had been hand drawn through it and signed by a hospital Registered Nurse (a sedative used to treat insomnia).

Review of Resident #1's record revealed a previous physician order, dated 8/15/17, for

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Lunesta 3 mg as needed for insomnia.

Telephone interview with pharmacist on 10/26/17 at 11:48am revealed their last order for Lunesta 3 mg as needed for insomnia was dated 9/18/17 and they dispensed 30 doses on 9/18/17.

Review of Resident #1's medications on hand available for administration on 10/26/17 at 11:15am revealed Lunesta 3 mg as needed at bedtime for sleep, 28 dispensed on 9/18/17, with 1 remaining.

Review of the September and October 2017 Medication Administration Record (MAR) on 10/26/17 at 11:15am revealed:
-There was a computer generated entry of Lunesta 3mg, 1 tablet at bedtime as needed for sleep.
-Documentation of administration of Lunesta 3mg daily at bedtime from 10/11/17 through 10/25/17.
-Thirty 30 doses Lunesta were documented as administered from 9/18/17 through 10/25/17.

Interview with Resident #1 on 10/26/17 at 3:00pm revealed she did not think she had taken any Lunesta since she returned from the hospital on 10/11/17 and she thought it was discontinued.

Review of Resident #1's record revealed no clarification whether Lunesta 3mg should have been administered routinely or as needed, or discontinued.

Refer to interview with the Administrator on 10/30/17 at 11:15am.

6. Review of Resident #1's FL2 dated 10/11/17 revealed a physician order for ipratropium-albuterol 20-100 mcg/actuation Mist

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inhaler, inhale 1 puff 4 times a day as needed.

Review of Resident #1's previous FL2 dated 8/11/17 revealed a physician order for Combivent Respimat inhaler (brand name for Ipratropium-albuterol) 1 puff 4 times a day.

Review of the October 2017 MAR on 10/26/17 at 11:15am revealed:
-A computer generated entry for Combivent Respimat inhaler, inhale 1 puff 4 times a day.
-Documentation of daily administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm of Combivent Respimat inhaler 1 puff 4 times a day from 10/11/17 through 10/25/17.
-No entry for Combivent Respimat inhaler to be administered as needed.

Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed:
-A Combivent inhaler dispensed on 4/21/17 with directions to administer routinely 4 times per day.
-A second Combivent inhaler dispensed on 7/14/17 with directions to administer routinely 4 times per day.

Telephone interview with the pharmacist on 10/30/17 at 11:48am revealed:
-They dispensed a Combivent inhaler on 7/14/17 with directions to administer routinely 4 times per day and no more had been requested.
-One Combivent inhaler would last 30 days if it was administered routinely 4 times daily.

Interview with Resident #1 on 10/26/17 at 3:00pm revealed she had not needed the Combivent inhaler and not requested it since she came back from the hospital on 10/11/17 and could not remember if she took any in the past

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few months before she went to the hospital.

Review of record revealed no documentation a physician had been contacted to clarify the Combivent inhaler whether it was to administered as needed or routinely.

Refer to interview with the Administrator on 10/30/17 at 11:15am.

7. Review of Resident #1's physician orders dated 10/19/17 revealed orders Resident #1 "may take Benadryl as currently written on MAR."

Telephone interview with the contract pharmacist on 10/30/17 at 11:49am revealed:
-They dispensed 60 doses (120 capsules) Benadryl 50 mg twice daily as needed for itching on 10/23/17.
-They had a previous order for Benadryl 50 mg twice daily as needed for itching and insomnia on 9/5/17.

Review of the October 2017 MAR revealed:
-A computer generated entry for Benadryl 50 mg, 1 capsule every 4 hours as needed for itching and insomnia.
-No documentation of any Benadryl administered, no documentation of the reason it was administered, and no documentation of the effectiveness of the medication.

Observation of medications for Resident #1 available for administration on 10/26/17 at 11:15am revealed:
-A bubble pack of Benadryl 25 mg, 2 capsules twice daily as needed for itching with 120 capsules dispensed on 10/23/17 with 2 capsules in each bubble.
-Five doses (10 Benadryl capsules) were missing

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and 110 capsules (55 doses) remained.

Interview with the Staff A on 10/26/17 at 2:25pm revealed he had administered "some" Benadryl to Resident #1 for insomnia but had forgotten to document the administrations.

Interview with Resident #1 on 10/30/17 at 2:35pm revealed:
-She sometimes takes Benadryl at 8:00am and 8:00pm.
-She asked for it because of itching or when she has insomnia.

Refer to interview with the Administrator on 10/30/17 at 11:15am.

8. Review of Resident #1's FL2 dated 10/11/17 revealed a physician order for Diclofenac Sodium 100 mg every 24 hours (a non-steroidal anti-inflammatory drug used to treat arthritis, headaches, and chronic muscle pain).

Review of physician orders for Resident #1 revealed an order, dated 8/3/17, for Diclofenac Potassium 50 mg, 1/2 50 mg at onset of headache, may repeat every 2 hours.

Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed:
-No Diclofenac Sodium 100 mg was available for administration.
-Diclofenac Potassium 50 mg oral powder, 1/2 50 mg once at onset of headache, may repeat every 6 hours and was dispensed on 8/4/17.

Review of the October 2017 Medication Administration Record (MAR) on 10/26/17 at 11:15am revealed:

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D 344	Continued From page 36 -Diclofenac Sodium 100 mg was not entered on the MAR. -There was a computer generated entry for Diclofenac Potassium 50 mg, take 1/2 tablet every 6 hours as needed for migraine but staff had not documented the administration of any doses administered. Review of Resident #1's record revealed no clarification whether to administer Diclofenac Sodium 100 mg and no clarification whether to administer Diclofenac Potassium 25 mg as needed every 2 hours or every 6 hours. Telephone interview with the contract pharmacist on 10/30/17 at 11:49am revealed Diclofenac Potassium 50, 1/2 50 mg as needed every 6 hours was the most current order on file dated 9/2/17. Interview with Resident #1 on 10/30/17 at 2:40pm revealed the Diclofenac Sodium was discontinued and was not sure how often she received the Diclofenac Potassium. Refer to interview with the Administrator on 10/30/17 at 11:15am. _____ Interview with the Administrator on 10/30/17 at 11:15am revealed: -Another medication aide, Staff F, had not been available in the past 2 months to maintain the files, the medication orders, and to assure all medications were administered as ordered. -Currently, Staff A was responsible for assuring the medication orders were sent to the pharmacy, that all orders were clarified, and that all medications were available for administration as ordered.	D 344		

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D 344	Continued From page 37 -The Administrator was not aware and had not been informed that Resident #1's hospital discharge medication orders had not been filled and administered as ordered. -She stated, "I thought everything was being taken care of." -She did not have a written policy on medication administration or clarification of medication orders, but they were supposed to follow the licensure rules. _____ The facility failed to ensure Resident #1's physicians was contacted to clarify medication orders for Levothyroxine, Metformin, Invokona, Primidone, Prazosin, Lunesta, Ipratropium-albuterol, Benadryl, Diclofenac Sodium, and Diclofenac Potassium. The failure to clarify the Levothyroxine dose placed Resident #1 at risk for symptoms of weight gain, fatigue and depression if the dose was too low and at risk for weak bones, insomnia, breathlessness, and even heart problems if the dose was too high. Resident #1 had a diagnosis of chronic obstructive pulmonary disease (COPD) with a Combivent inhaler order which was not clarified and not administered placing her at rick of exacerbation of COPD symptoms like shortness of breath and lack of energy. Failure to clarify the administration of 2 diabetic medication orders placed her at risk for low blood sugar if overmedicated. The failure to clarify the Prazosin dose which is used to treat nightmares resulted in Resident #1 continuing to have nightmares. The facility's failure to ensure an effective system for the clarification of medications was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____	D 344		

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D 344	Continued From page 38 The Plan of Protection provided by the facility on 10/30/17 revealed: -Physician orders on hospital discharge records will be entered on the Administration Records as soon as the orders are in the facility. -The physician orders will be faxed to the pharmacy when they are brought to the facility. -Upon discharge at the hospital, facility staff will request the physician sign every page of the discharge orders per the pharmacy protocol. -The pharmacy will attach physician orders with the medications if the pharmacy receives any electronic orders. -The Medication Aides will immediately contact the pharmacy if any medications are not dispensed timely. -The Medication Aides will contact the prescribing physician as soon as possible any orders that are not clear. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2017	D 344		
D 367	10A NCAC 13F .1004(j) Medication Administration 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	D 367		

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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:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure the accuracy of the Medication Administration Records for 1 of 3 sampled residents (#1) related to documenting the administration of Ketorolac, Risperdal, Benadryl, Klonopin, ipratropium-albuteral inhaler, and Mapap Arthritis, and lidocaine patches and related to documenting the reason for the administration and resulting effect of PRN (as needed) medication orders Mapap Arthritis, Benadryl, Klonopin, and Ketorolac.

The findings are:

Review of Resident #1's hospital discharge generated FL2 dated 10/11/17 revealed diagnosis which included Schizoaffective disorder, bipolar type, migraines, asthma, bipolar disorder, and chronic obstructive pulmonary disease.

1. Review of Resident #1's FL2 dated 10/11/17 revealed orders for lidocaine 5% patch, use 2 daily every 12 hours then remove (a topical pain reliever).

Review of the 10/1/17 through 10/26/17

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D 367	Continued From page 40 Medication Administration Records (MARs) revealed Staff documented the administration of lidocaine patches daily at 8:00am except 10/4/17 though 10/10/17 when Resident #1 was in the hospital. Observation of medications for Resident #1 available for administration on 10/26/17 at 11:15am revealed: -A box of 60 lidocaine patches were dispensed on 5/17/17 with 12 remaining the box. -No other lidocaine patches were available. -A box of 60 lidocaine patches was a 30 day supply with the current order to use 2 daily. Telephone interview with the contract pharmacist on 10/26/17 at revealed: -They had not dispensed any lidocaine patches for Resident #1 since 5/17/17. -Facility staff had to request refills for the pharmacist to dispense medications. Interview with Resident #1 on 10/30/17 at 2:40pm revealed: -She had been refusing the patches for a few months because they felt "weird" on her knees because she has metal in her knees with the recent knee replacement surgery. -She wanted to try using the lidocaine patches again and did not want them discontinued. Interview with the first shift week day Medication Aide, Staff A, on 10/26/17 at revealed: -Resident #1 had been refusing the lidocaine patches and he did not know why he kept documenting the administration of the patches. -He called the physician to inform him of Resident #1 refusing the lidocaine patches, but he did not document it.	D 367		

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D 367	Continued From page 41 Interview with the first shift week-end day Medication Aide, Staff B, on 10/27/17 at 10:00am revealed: -She had never applied a lidocaine patch on Resident #2. -She thought the lidocaine order was as needed. -She had worked there since January 2017 as a medication aide. Telephone interview with Resident #1's primary care physician on 10/26/17 at 3:12pm revealed the physician was not available for interview. Refer to interview with Staff A on 10/26/17 at 2:25pm. 2. Review of Resident #1's FL2 dated 10/11/17 revealed a physician order, "Stop taking" Ketorolac (a non-steroidal anti-inflammatory medication used short term to treat moderate to severe acute pain). Review of Resident #1's physician orders dated 10/17/17 revealed orders for Ketorolac 10 mg, 1 tablet three times per day as needed for head aches for 3 days. Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed 9 doses of Ketorolac 10 mg were dispensed on 10/17/17 with 1 dose remaining. Review of the 10/1/17 through 10/26/17 Medication Administration Records (MARs) revealed: -There was a hand written entry for Ketorolac 10 mg 1 tablet three times per day for 3 days as needed. -There was no documentation Ketorolac 10 mg	D 367		

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had been administered, no documentation of the reason it was administered, and no documentation of the effectiveness of the medication.

Observation of the 1 dose Ketorolac 10 mg remaining on 10/26/17, review of the label on the medication that it was dispensed on 10/17/17 with 9 doses, and review of the October 2017 MAR, revealed the 8 missing doses had not been documented as administered, not documented with justification of administration, and not documented with the effect of the results of the administration.

Interview with the first shift week day Medication Aide, Staff A, on 10/26/17 at revealed he was not aware the Ketorolac 10 mg was discontinued.

Refer to interview with Staff A on 10/26/17 at 2:25pm.

3. Review of Resident #1's October 2017 MAR revealed:
-A computer generated entry for Risperdal 3 mg at bedtime (an antipsychotic medication).
-Daily documentation of the administration of Risperdal 3 mg at 8:00pm except from 10/3/17 through 10/10/17 when Resident #1 was in the hospital.
-A computer generated entry for Risperdal 1 mg at 8:00am but no documentation of administration after 10/03/17.

Review of Resident #1's current FL2 dated 10/11/17 revealed no physician order for Risperdal 3 mg at bedtime.

Observation of Resident #1's medications on hand available for administration on 10/26/17 at

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D 367	Continued From page 43 11:15am revealed no Risperdal 3 mg and no Risperdal 1 mg. Telephone interview with the contract pharmacist on 10/30/17 at 11:49am revealed the most current order for Resident #1's Risperdal was for 3 mg at bedtime and 1 mg every morning dated 9/27/17 with a 30 day supply dispensed on 9/7/17. Interview with Resident #1 on 10/26/17 at 3:00pm revealed she did not know if she was still taking the Risperdal. Interview with the Staff A on 10/26/17 at 2:25pm revealed he had documented the administration of Risperdal 3mg in error. Refer to interview with Staff A on 10/26/17 at 2:25pm. 4. Review of Resident #1's physician orders dated 10/19/17 revealed orders Resident #1 "may take Benadryl as currently written on MAR." Telephone interview with the contract pharmacist on 10/30/17 at 11:49am revealed: -They dispensed 60 doses (120 capsules) Benadryl 50 mg twice daily as needed for itching on 10/23/17. -They had a previous order for Benadryl 50 mg twice daily as needed for itching and insomnia on 9/5/17. Review of the October 2017 MAR revealed: -A computer generated entry for Benadryl 50 mg, 1 capsule every 4 hours as needed for itching and insomnia. -No documentation of any Benadryl administered, no documentation of the reason it was	D 367		

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administered, and no documentation of the effectiveness of the medication.

Observation of medications for Resident #1 available for administration on 10/26/17 at 11:15am revealed:
-A bubble pack of Benadryl 25 mg, 2 capsules twice daily as needed for itching with 120 capsules dispensed on 10/23/17 with 2 capsules in each bubble.
-Five doses (10 Benadryl capsules) were missing and 110 capsules (55 doses) remained.

Interview with the Staff A on 10/26/17 at 2:25pm revealed he had administered some Benadryl to Resident #1 for insomnia but had forgotten to document the MAR.

Interview with Resident #1 on 10/30/17 at 2:35pm revealed:
-She sometimes takes Benadryl at 8:00am and 8:00pm.
-She asked for it because of itching or when she has insomnia.

Refer to interview with Staff A on 10/26/17 at 2:25pm.

5. Review of Resident #1's FL2 dated 10/11/17 revealed revealed a physician order, dated 10/11/17, for Klonopin 0.5 mg, 1 tablet 2 times a day as needed for anxiety (used to control seizures in epilepsy and for the treatment of panic disorder).

Review of the October 2017 MAR revealed:
-A hand written entry for Klonopin 0.5 mg, 1 tablet 2 times as needed for anxiety.
.-Documentation of administration of Klonopin 0.5 mg 14 times from 10/13/17 through 10/25/17

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with the reason and justification documented on the back of the MAR.

Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed Klonopin 0.5 mg, 1 tablet twice daily as needed for anxiety with 60 doses dispensed on 10/13/17 and 42 doses remaining (18 missing.)

Review of the Controlled Sheet for Klonopin 0.5mg revealed 18 doses Klonopin 0.5 mg were administered form 10/13/17 through 10/25/17.

Review of the Klonopin 0.5 mg Controlled Drug Sheet compared to the documentation on the October 2017 MAR, the reason and the effect for the administration of Klonopin 0.5 mg was not documented 4 times from 10/13/17 through 10/25/17.

Interview with Resident #1 on 10/26/17 at 3:00pm revealed she had been receiving Klonopin 0.5 mg twice daily.

Refer to interview with Staff A on 10/26/17 at 2:25pm.

6. Review of Resident #1's FL2 dated 10/11/17 revealed a physician order for ipratropium-albuterol 20-100 mcg/actuation mist inhaler, inhale 1 puff 4 times a day as needed.

Review of Resident #1's previous FL2 dated 8/11/17 revealed a physician order for Combivent Respimat inhaler (brand name for ipratropium-albuterol) 1 puff 4 times a day.

Review of the October 2017 MAR on 10/26/17 at 11:15am revealed:

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D 367	Continued From page 46 -A computer generated entry for Combivent Respimat inhaler, inhale 1 puff 4 times a day. -Documentation of daily administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm of Combivent Respimat inhaler 1 puff 4 times a day from 10/11/17 through 10/25/17. -No entry for Combivent Respimat inhaler to be administered as needed. Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed: -A Combivent inhaler was dispensed on 4/21/17 with directions to administer routinely 4 times per day. -A second Combivent inhaler dispensed on 7/14/17 with directions to administer routinely 4 times per day. Interview with Resident #1 on 10/26/17 at 3:00pm revealed she had not needed the Combivent inhaler and not requested it since she came back from the hospital on 10/11/17 and could not remember if she took any in the past few months before she went to the hospital. Telephone interview with the contract pharmacist on 10/30/17 at 11:48am revealed: -They dispensed Combivent inhaler on 7/14/17 with directions to administer routinely 4 times per day and facility staff had not requested any more after that was dispensed. -One Combivent inhaler would last 30 days if it was administered routinely 4 times daily. Review of record revealed no documentation a physician had been contacted to clarify the Combivent inhaler whether it was to administered as needed or routinely and no documentation Resident #1 had refused the medication.	D 367		

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D 367	Continued From page 47 Interview with Staff A on 10/26/17 at 3:00pm revealed: -Resident #1 had refused the inhaler but he documented the administration of the inhaler by mistake. -He had not called the physician to clarify the order or inform the physician that she was refusing the Combivent. -He documented the administration of the Combivent inhaler in error. Refer to interview with Staff A on 10/26/17 at 2:25pm. 7. Observation of medications on hand available for administration for Resident #1 on 10/26/17 at 11:15am revealed 30 doses Mapap Arthritis 650 mg every 5 hours as needed was dispensed on 10/9/17 with 21 remaining (pain medication). Review of the October 2017 MAR on 10/26/17 at 11:15am revealed no entry and no documentation of Mapap Arthritis 650 mg every 5 hours as needed, no documentation of the reason it was administered, and no documentation of the effects of the medication. Telephone interview with the pharmacist on 10/30/17 at 11:49am revealed they had an order, dated 10/19/17, for Mapap Arthritis with 30 dispensed on that date. Interview with Resident #1 on 10/30/17 at 2:40pm revealed she had been receiving Mapap Arthritis and sometimes requested it every 6 hours. Review of the remaining Mapap Arthritis doses on hand available for administration and the number	D 367		

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D 367	Continued From page 48 of the Mapap Arthritis dispensed revealed the medication was administered without any documentation. Interview with the Staff A on 10/26/17 at 2:25pm revealed he had overlooked documenting the administration of the Mapap to Resident #1. Refer to interview with Staff A on 10/26/17 at 2:25pm. --- Interview with the first shift week day Medication Aide, Staff A, on 10/26/17 at 2:25pm revealed: -He was responsible for assuring all physician orders were entered on the MAR. -He usually wrote the new medication orders on the MAR as soon as they were ordered. -He knew he was supposed to enter the documentation of a medication immediately after it was administered. -He knew he was supposed to follow-up with the prescribing physician for medications which the pharmacy did not dispense. -He did make some errors in the documentation of the October 2017 MAR. -He was supposed to contact the Administrator or the county Adult Home Specialist if there was a problem with obtaining medications as ordered by the physician. --- The facility's medical and health care providers relied on the accuracy of the Medication Administration Records (MARs) to determine the current medication regiment and how to continue to treat Resident #1. The facility staff relied on the accuracy of the MARs to administer medications, order refills, and determine when as needed medications could be administered within the time	D 367		

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D 367	Continued From page 49 frames. The failure of the facility to ensure the accuracy of documentation of the MARs was detrimental the health and safety of the residents and constitutes a Type B Violation. _____ The Plan of Protection provided by the facility on 10/27/17 revealed: -All medications administered will be properly documented on the Medication Administration Records (MARs). -The reason for the administration and the effectiveness of the as needed medications will be documented. -All the narcotic medications will be documented on the controlled drug sheet and the MARs. -The week-day first shift Medication Aide will monitor the MARs weekly to assure all medications are documented accurately. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2017	D 367		
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, interviews, and record review, the facility failed to assure all residents received care and services which were adequate,	D912		

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appropriate, and in compliance with relevant federal and state laws and rules and regulations related to test for tuberculosis, other staff qualifications, health care, medication orders, medication administration, and management of facilities.

The findings are:

A. Based on record reviews and interviews, the facility failed to ensure tuberculosis (TB) disease skin testing in compliance with the control measures adopted on the Commission for Health Services testing was completed upon hire for 3 of 4 sampled staff (B, D, and E). [Refer to Tag 131, 10A NCAC 13F .0406(a) Test For Tuberculosis (Type B Violation).]

B. Based on record reviews and interviews, the facility failed to ensure that each staff person had no substantiated findings listed on the North Carolina Health Care Personnel Registry for 3 of 4 sampled staff (A, D, and E). [Refer to Tag 137, 10A NCAC .13F 0407(a)(5) Other Staff Qualifications (Type B Violation).]

C. Based on record reviews and interviews, the facility failed to ensure 3 of 4 sampled staff (B, D, and E) had a criminal background check upon hire. [Refer to Tag 139, 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation).]

D. Based on observations, interviews, and record review, the Administrator failed to assure the management and overall operations of the facility by failing to meet and monitor rules related to housekeeping and furnishings, other staff qualifications, competency validation for LHPS tasks, health care, medication orders, medication administration, ACH medication aides training

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D912	Continued From page 51 and competency, and examination and screening. [Refer to Tag 176, 10A NCAC 13F .0601 Management Of Facilities (Type B Violation).] E. Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for the scheduling of a neurologist appointment, for the refusals of lidocaine patches and ipratropium-albuterol inhaler for 1 of 3 sampled residents (#1). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] F. Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for verification or clarification of orders for Levothyroxine, Metformin, Invokona, Primidone, Prazosin, Lunesta, Ipratropium-albuterol, Benadryl, Diclofenac Sodium, and Diclofenac Potassium for 1 of 3 sampled residents (#1). [Refer to Tag 273, 10A NCAC 13F .1002(a) Medication Orders (Type B Violation).] G. Based on observations, interviews, and record reviews, the facility failed to assure the accuracy of the Medication Administration Records for 1 of 3 sampled residents (#1) related to documenting the administration of Ketorolac, Risperdal, Benadryl, Klonopin, ipratropium-albuteral inhaler, and Mapap Arthritis, and lidocaine patches and related to documenting the reason for the administration and resulting effect of PRN (as needed) medication orders Mapap Arthritis, Benadryl, Klonopin, and Ketorolac. [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration (Type B Violation).]	D912		

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D935	Continued From page 52	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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D935	Continued From page 53 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled medication aides (Staff B), completed the 15 hour medication training within 6 months of hire as a medication aide. The findings are: Review of Staff B's personnel record revealed: -There was no documented date of hire. -There was documentation of the Medication Aide Test dated 7/18/01. -There was documentation of Medication Clinical skills dated 1/30/17. -There was documentation of 5 hours of Medication Training dated 1/30/17. -There was no documentation of any other Medication Training hours. -There was no documentation of verification of prior medication aide employment. -There was documentation that diabetic care and infection control training had been completed 9/7/17. Interview on 10/27/17 at 10:00am with Staff B revealed: -She had been hired at the beginning of January 2017. -Staff B worked first shift every weekend as a Medication Aide. -She had received her Medication Aide certification in 2001.	D935		

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	HAL045005	A. BUILDING: _____ B. WING _____	10/30/2017

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D935	Continued From page 54 -The Licensed Health Professional Support (LHPS) nurse had given some training when she started. -Staff B did not know how many hours of training she had. -She knew some of the paperwork was "lost". Interview on 10/27/17 at 9:45am with the facility's LHPS nurse revealed: -She provided the training for the Medication Aides. -Training had been provided to Staff B during the year. -The nurse had no records of the training. -The nurse did not remember how many hours of training were given to Staff B. -She would schedule a time for the training. Review of medication administration records for September and October 2017 revealed Staff B had administered medications to residents in the facility. Interview on 10/27/17 at 10:50am with the Administrator revealed: -The LHPS nurse from the facility's pharmacy did the medication training. -The nurse was responsible for keeping the records. -She did not know why the training was not complete. -Some of the paperwork could not be found. -She would make sure the training would be complete. -There was no policy on training.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for	D992		

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D992	Continued From page 55 the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the	D992		

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D992	Continued From page 56 facility failed to ensure examination and screening for the presence of controlled substances was completed for 3 of 3 sampled staff (B, D, and E) who were hired after 10/01/13. The findings are: A. Review of Staff B's personnel record revealed: -There was no documented date of hire. -There was no documentation of controlled substance screening. Interview on 10/27/17 at 10:00am with Staff B revealed: -She was hired "sometime" at the start of January 2017 as a Medication Aide. -She worked first shift every weekend. -She had not had a drug screen at this facility. -She did not know she "needed one". -She had not been asked by anyone at the facility to get a drug screen. Refer to the interview with the Administrator on 10/27/17 at 2:25pm. B. Review of Staff D's personnel record revealed: -The date of hire was 7/31/17. -There was no documentation of controlled substance screening. Telephone interviews on 10/27/17 at 9:20am and 10/30/17 at 12:30pm with Staff D revealed: -She was hired as a Personal Care Assistant (PCA). -She worked part time 20-30 hours per week. -She had not had a drug screen at this facility. -She knew she had one "at my old place of work". -She had not been asked by anyone at the facility to get a drug screen.	D992		

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D992	Continued From page 57 Refer to the interview with the Administrator on 10/27/17 at 2:25pm. C. Review of Staff E's personnel record revealed: -There was no documented date of hire. -There was no documention of controlled substance screening. Interview on 10/27/17 at 11:20am with Staff E revealed: -She was hired in February 2017 as a housekeeper. -She had not had a drug screen at this facility. -She had not been asked by anyone at the facility to get a drug screen. Refer to the interview with the Administrator on 10/27/17 at 2:25pm. Interview on 10/27/17 at 2:25pm with the Administrator revealed: -There was no policy regarding drug screens. -She did not know that the employees needed a drug screen. -She did not know about the October 2013 controlled substance screening rule. -The employees would get a drug screen. The facility failed to ensure an examination and screening for the presence of controlled substances was performed for 3 out of 3 sampled staff (B, D, and E) hired after 10/1/13. This failure to screen new employees for controlled substances comprimised the health, safety, and welfare of all residents. A plan of protection was received from the facility	D992		

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D992	Continued From page 58 on 10/27/17 as follows: -Controlled substance drug screens would be performed on all employees hired after 10/1/2013. -All future employees would be drug screened before hired. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2017.	D992		