STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	11/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

(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 conducted an annual survey on 11/27/17 and 11/28/17.	D 000		
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 interviews and record reviews, the facility failed to assure 3 of 6 staff sampled (C, D, and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire. The findings are: 1. Review of Staff C's personnel record revealed: -Staff C was hired on 7/30/14 as the Dietary Manager. -There was no documentation of a Health Care Personnel Registry (HCPR) check for Staff C upon hire. Interview with Staff C on 11/28/17 at 3:00 pm revealed: -She was hired as the dietary manager in 2014. -She was unaware what a HCPR check was, or if the facility had obtained one prior to her hire date. -Staff C had worked in assisted living facilities for	D 137		

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D 137	Continued From page 1 14 years prior to working at the current facility. Review of the HCPR for Staff C dated 11/28/17, revealed Staff C had no substantiated findings listed on the HCPR. Interview with the Business Office Manager (BOM) on 11/28/17 at 3:18 pm revealed: -She had reviewed some of the staff records, but had not gotten to Staff C's record. -She was unaware Staff C did not have a HCPR check prior to hire in 2014. Refer to interview with the BOM on 11/28/17 at 3:18 pm. Refer to interview with the Administrator on 11/28/17 at 3:35 pm. 2. Review of Staff D's personnel record revealed: -She was hired on 1/24/17 as a Medication Aide. -There was no documentation of a HCPR check for Staff D being completed upon hire. -There was a HCPR check completed on 11/28/17 that showed no substantiated findings for Staff D. Interview with Staff D on 11/28/17 at 3:30 pm revealed: -She had been hired as a Medication Aide in January 2017. -She was not familiar with the HCPR check requirements. -She had worked at a previous facility for several years. Refer to interview with the BOM on 11/28/17 at 3:18 pm. Refer to interview with the Administrator on	D 137		

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D 137	Continued From page 2 11/28/17 at 3:35 pm. 3. Review of Staff E's personnel record revealed: -He was hired on 6/23/17 as the Transportation provider. -There was no documentation a HCPR check for Staff E was completed upon hire. -There was a HCPR check completed on 11/27/17 that showed no substantiated findings for Staff E. Interview with Staff E on 11/28/17 at 3:45 pm revealed: -He had been hired to provide transportation at the facility. -He was not familiar with the HCPR check requirements. -He currently provided transportation at several different facilities. Interview with the BOM on 11/28/17 at 2:45 pm revealed that during a check of Staff E's record on 11/27/17 she realized he did not have a HCPR check and ran one to put in his file. Refer to interview with the BOM on 11/28/17 at 3:18 pm. Refer to interview with the Administrator on 11/28/17 at 3:35 pm. _____ Interview with the Business Office manager (BOM) on 11/28/17 at 3:18 pm revealed: -She had worked in the facility as the BOM since April 2017. -She was in the process of reviewing all staff records. -She had reviewed some of the staff records but not all of them.	D 137		

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D 137	Continued From page 3 -She was responsible for reviewing staff records, but had not gotten around to checking all the staff folders. -She was responsible for assuring HCPR checks for all staff were completed. Interview with the Administrator on 11/28/17 at 3:35 pm revealed: -She had been employed as the Administrator for 9 months. -The BOM was new to the facility as well as new to the position. -The BOM had reviewed staff records in the facility, but had not reviewed all the staff records. -The BOM was responsible for reviewing all staff records and processing new staff records. The facility failed to assure 3 of 6 staff sampled (C, D, and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire. The failure of the facility not knowing if staff had substantiated findings of neglect or abuse was detrimental to the residents' safety and welfare and constitutes a Type B Violation. The facility provided the following Plan of Protection on 11/28/17: -Immediately the BOM will run a HCPR check for all three staff (C, D, and E). -Any new hires will have HCPR check ran prior to employment. -The BOM will audit files on a monthly basis for compliance. -The Administrator will oversee the BOM for completion of staff reviews monthly, this will be done ongoing.	D 137		

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D 137	Continued From page 4 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, JANUARY 20, 2017.	D 137		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing pratcitioner for 1 of 5 sampled residents (Resident #1) with orders for vitamin B-12 injection. The findings are: Review of Resident #1's current FL2 dated 11/02/17 reveal diagnoses included dementia, hypothyroidism and essential hypertension. Review of Resident #1's record revealed an physician's order dated 11/06/17 for vitamin B-12 1000 mcg (B-12 is used to increase serum B-12 deficiency) inject 1 time weekly for 4 weeks. Review of Resident #1's November 2017	D 358		

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D 358	Continued From page 5 Medication Administration Record (MAR) revealed: -No transcription entry for administration of vitamin B-12. -No documentation of B-12 administration. Interview on 11/28/17 at 10:15 am with Resident #1's physician revealed: -"I ordered the injectable B-12 in early November because her (Resident #1) lab values were low". -"I don't have her chart in front of me, but her lab values must have been pretty low if I didn't order B-12 medication by mouth". -The staff at the facility was not allowed to give intramuscular injections. The injection would have to be performed by myself or by Home Health (HH) staff. -"I have not given any injections for Resident #1". -The facility needs to set up a system so this medication was given as ordered. -"I was not aware the injection had not been given as ordered". -The facility had not notified her of the missed doses of B-12. Interview on 11/28/17 at 10:30 am with the Special Care Unit (SCU) Director revealed: -She thought the physician had administered the vitamin B-12 injection for Resident #1. -The facility had a process for all new orders. -The first step of the process was completed by the Medication Aide (MA) on duty when the order was received, and included transcription of the order to the MAR, faxing the order to the pharmacy and placing the original order in the resident's record. -The second step of the new order process was completed by the next MA on duty, typically on 2nd shift, and the work completed by the first MA was verified and double checked.	D 358		

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D 358	Continued From page 6	D 358		

-The third step of the new order process was c-mpleted by the next MA on duty (typically the 3rd shift when the medication arrived from the pharmacy) and the previous steps were double checked and verified. At this point, the new order process was considered complete.
-The new order process was not followed for the B-12 ordered for Resident #1 on 11/06/17.
-She did not know how the B-12 transcription and administration for Resident #1 was missed by all three shifts of MAs.

Interview on 11/28/17 at 10:45 am with a MA revealed:
-The facility had a 3 step process MAs follow whenever there was a new medication order.
-She was unaware Resident #1 had a physician's order for injectable B-12.
-She was unable to locate the B-12 on the medication cart or any medication storage areas.
-"We don't give that" (in reference to the the B-12 injection).
-The injection was given typically by the physician or HH.
-The medication was ordered from the pharmacy just prior to administration, and that was why there was no injectable B-12 in the facility for Resident #1.

Telephone interview on 11/28/17 at 11:00 am with Resident #1's pharmacy representative revealed:
-The pharmacy received an order from the facility on 11/06/17 for B-12 1000 mcg, inject 1 time weekly for 4 weeks for Resident #1.
-Four doses of B-12 1000 mcg was filled and delivered to the facility on 11/06/17.

Interview on 11/28/17 at 11:30 am with the Resident Service Director (RCD) revealed:
-The facility had a 3 step process for all new

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D 358	Continued From page 7 orders. -The process was not followed for the B-12 order for Resident #1, and the process was not completed. -She did not know what happened or how the double checks for the new order process were missed. -She had searched the medication storage areas and was unable to locate the B-12 for Resident #1. Review of Resident #1's record revealed a B-12 lab value dated 11/03/17 of 172. Normal reference range of the lab result was 211 - 946, as provided on the lab value result. Based on observation, record review and interview, Resident #1 was determined to be not interviewable. Telephone interview on 11/28/17 at 3:15 pm with Resident #1's family member: -Resident #1 had resided at the facility since the spring of 2017. -The family member was unaware of the medications prescribed to Resident #1, "the facility took care of all that". Interview on 11/28/17 at 3:30 with the Administrator revealed: -The facility had a system in place for new orders. -New orders were to be checked 3 times by different MAs before the order entry was considered complete. -She was not aware Resident #1 had not received the B-12 injections as ordered.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 8 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 observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related Other Staff Qualifications Health Care Personnel Registry. The findings are: A. Based on interviews and record reviews, the facility failed to assure 3 of 6 staff sampled (C, D, and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire. [Refer to tag 137,10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)].	D912		