Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055003	A. BUILDING: _____ B. WING _____	C 12/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	7981 OPTIMIST CLUB ROAD DENVER, NC 28037

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D 000	Initial Comments The Adult Care Licensure Section and the Lincoln County Department of Social Services conducted an annual survey on December 19-21, 2017.	D 000	See attached form.	
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure plumbing equipment in 2 of 2 common shower/tub rooms and 1 resident room (Room #18) were maintained in a safe and operating condition. The findings are: Observation of the women's common shower/tub room, on the East Hall on 12/19/17 at 11:15am revealed: -There were 2 shower stalls and one bathtub for the female residents. -The cold water handle was missing from the bathtub. -The shower head was missing from the bathtub. -The spray shower head holder for the spray shower head was broken in the right shower stall. -There was only 1 functional shower available for 30 female residents. Observation of the men's common shower/tub room, on the West Hall on 12/19/17 at 11:20am revealed: -There were 2 shower stalls and one whirlpool	D 105		

Reviewed and Accepted
Date: 2/2/18 cs

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D 105	Continued From page 1 bathtub for the male residents. -The whirlpool bathtub was missing the central control knob between the hot and cold water controls. -The shower lever to control water flow and temperature was missing in the right shower stall. -There was only one functional shower available for 26 male residents. Observation of Room #18 on 12/19/17 at 9:58am revealed: -There were two residents who lived in the room. -There was no handle to control water flow or temperature at the shared sink in the room. -There was a metal bolt visible in the location where the handle was supposed to be attached. Interview with one resident who lived in Room #18 on 12/21/17 at 10:56am revealed: -The faucet in his room had been broken for "months." -He was still able to "put the water on" by manipulating the metal bolt where the faucet handle used to be. Interview with a female resident on 12/20/17 at 2:20pm revealed: -The resident had used the women's common shower on the East Hall. -"I haven't noticed the shower head missing." -"I think they got a new showerhead, but I haven't seen it yet." Interview with a male resident on 12/20/17 at 3:23pm revealed: -The resident had used the men's common shower on West Hall. -"I think the other shower has been broken for about a month." -"I shower 3 times a week."	D 105		

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D 105	Continued From page 2 -"We really could use an extra shower or to get the broken one fixed." Interview with a female resident on 12/20/17 at 3:47pm revealed she only took showers, because the "bathtub was too high to get into." Interview with a Personal Care Aide (PCA) on 12/20/17 at 3:28pm revealed: -The whirlpool in the men's shower/tub room used to work and had not been used in over 1 year. -The whirlpool tub was used for bathing in the past. -There were 2 male residents that took baths currently and had to use the women's bathtub. -She did not know of the missing central control knob on the whirlpool tub. -All female residents in the facility took showers. -She did not know that the spray shower head holder was broken in the women's shower stall. -She was responsible to report any plumbing issues to the office staff. Interview with the housekeeping staff on 12/21/17 at 9:33am revealed: -She did not know of any of the plumbing fixture issues prior to 12/20/17. -"No one uses the tubs." -She had put the missing cold water handle on the women's bathtub on the list for repairs on 12/20/17. -She was responsible for reporting plumbing issues by writing it down in the front office, and the office staff would contact the plumber. Interview with the Administrator on 12/21/17 at 9:30am and 10:15am revealed: -She was responsible for repairs in the facility. -The facility had a contract plumber for needed	D 105		

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D 105	Continued From page 3 repairs. -She knew of the sink faucet handle in Room #8 and had notified the plumber. -She knew of the missing cold water handle on the women's bathtub. -The plumber had been trying to find a replacement for the missing cold water handle in the women's bathtub. -She was unable to give a timeframe for how long these items had not been working. -She did not know of the issues with the men's and women's shower stall fixtures, the missing shower head for the women's tub, and the whirlpool tub control knob in the men's shower/tub room. -"I will just need to check the bathrooms more often." Interview with the contract plumber on 12/21/17 at 12:00pm revealed: -He had recently worked on the women's cold water handle on the women's bathtub, and had trouble finding the part. -He had not been asked to repair the missing sink faucet handle in Room #18. -He had not worked on the showers or whirlpool tub issues. Interview with the contract maintenance person on 12/21/17 at 12:05pm revealed: -He was not responsible for plumbing repairs. -He had worked as a contractor, for the facility for 1.5 years.	D 105		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care	D 285		

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D 285	Continued From page 4 Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to assure there was at least a three day supply of perishable food, including milk, to serve 57 residents according to the menu. The findings are: Interview with the Admissions Coordinator (AC) on 12/19/17 at 9:00am revealed the facility census was 57 residents. Observation of the milk inventory on 12/19/17 at 10:00 am revealed the facility had no milk in the kitchen. Review of the facility's breakfast and dinner menu for 12/19/17 revealed the breakfast and dinner menu included 1 serving of cereal to be served at breafast and one cup of milk to be served at breakfast and dinner.. Interview with the Cook on 12/19/17 at 10:14am revealed: -"We just ran out of milk this morning." -A staff member had "gone out to get some." -"The residents have been eating more cold cereal because they don't like my oatmeal." Observation of the milk inventory on 12/19/17 at 11:30am revealed there 12 gallons of 2% milk in the refrigerator.	D 285		

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D 285	Continued From page 5 Interview on 12/20/17 at 9:00am with a Personal Care Aide (PCA) revealed: -"Sometimes they do run out of milk." -If they run out of milk the supervisors will go out and purchase for the residents. -She thought the facility had changed vendors. -Some residents did complain when they did not have milk with their meal. Interview with one resident on 12/19/17 at 9:35am revealed: -"We ain't [sic] got no milk." -"I love milk every morning." -"Somebody was supposed to go get it." Interview with a second resident on 12/19/17 at 10:25am revealed "They said they didn't have any milk" this morning at breakfast. Interview with two additional residents on 12/20/17 at 12:05pm revealed: -"We did not have milk for breakfast this morning" -"I like to drink milk with my meals, I had to do without" -"They normally don't run out of milk" -"I can usually get milk when I ask for it" Interview with another resident on 12/20/17 at 2:20pm revealed: -"When I am in the dining room, I'm not offered milk. It's not generally something they put out." -"It has happened a few times when I have asked for milk and they didn't have it, but not very often." Interview with another resident on 12/20/17 at 3:23 pm revealed: -"I like to drink milk, but they are out." -"They used to serve milk with the meal, but they don't anymore." -"A lot of people have been asking for milk lately,	D 285		

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D 285	Continued From page 6 but they have been out." Review of facility receipts for milk purchased for November and December 2017 revealed 12 gallons of 2% milk was purchased on 11/10/17, 11/22/17, 12/1/17, 12/6/17, and 12/19/17. 10 gallons of 2% milk was purchased on 11/15/17. Interview with the AC on 12/20/17 at 1:20pm revealed: -She was responsible for purchasing food for the facility. -She ordered milk online weekly from a nearby store. -The facility normally had milk in the building. -The cooks would notify her when they ran out of milk. -She thought the facility always had enough milk for the residents. -If they ran out of milk, she could always purchase more for the facility. -She was not sure why the facility ran out of milk and for how long they were out of milk. Interview with Administrator on 12/20/17 at 1:25pm revealed: -She did not know the facility ran out of milk. -She expected the AC or the Resident Care Coordinator to order milk on Tuesdays and Fridays. -A dietary aide was responsible for picking up the milk from the store. -The facility may begin purchasing milk 3 days per week to ensure adequate supply.	D 285		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310		

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D 310	Continued From page 7 (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered by the physician for 1 of 1 sampled residents who had an order for chopped meats and nectar thickened liquids (Resident #7). The findings are: Review of Resident #7's current FL-2 dated 1/17/17 revealed: -Diagnoses included dementia, chronic obstructive pulmonary disease, hypertension, and history of pulmonary aspiration. -The resident's diet order was listed as regular, mechanical soft, chopped meats. Review of Resident #7's physician's orders dated 2/10/17 revealed a dietary order for regular mechanical soft, chopped meats, and nectar thickened liquids. Review of the current resident therapeutic diet list revealed: -Resident #7 was on a regular, mechanical soft diet with chopped meat and nectar thickened liquids. -He was the only resident ordered a nectar thickened liquids. Review of the Week 3 lunch menu on 12/19/17 revealed reseidents who received a regular diet	D 310		

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D 310	Continued From page 8 were to receive 1 serving of chef's entree of choice, ½ cup (c.) rice or pasta, ½ c. chef's vegetable choice, ½ c. fruit of choice, 1 white/wheat roll. Review of the Week 3 lunch menu on 12/19/17 revealed residents who had physician's orders for a mechanically soft diet were to receive 1 serving of cook's choice entrée (ground meat), ½ cup (c.) rice or pasta, ½ c. chef's vegetable choice, ½ c. fruit of choice, 1 white/wheat roll. Review of the manufacturer's instructions on the thickened liquid product revealed: -Scoop and level off recommended thickener using enclosed spoon. -Slowly add product to the liquid while stirring until thickener has dissolved. -Let thickened liquid stand 30 seconds to 1 minute to achieve desired consistency and serve. -For nectar thickened water, coffee, and tea, use 3-1/2 to 4 teaspoons per 4 fl. oz. Observation on 12/19/17 between 12:15pm and 1:10pm of the lunch meal revealed: -Resident #7 received 1 sandwich with 1 inch of thin shaved roast beef cut into 4 pieces, ½ c. of mashed potatoes, ½ c. carrots, and an individually wrapped Christmas tree cake. -He was also served a 4 ounce (oz.) glass of nectar thickened water and an 8 oz. glass of tea thickened to honey consistency with small pieces of ice visible in the glass with tea. Interview with the Cook on 12/19/17 at 12:30pm: -He had prepared Resident #2's thickened liquid and was aware there was ice in the glass with tea. -The roast beef sandwich was provided by a vendor and he thought it was shaved finely	D 310		

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D 310	Continued From page 9	D 310		

enough to not require the meat to be chopped.
-He checked with management who said it would be ok to serve cut into four pieces since it was shaved very thin.
-He would immediately prepare the nectar thickened tea and water without ice to replace the glasses he had served.
-He would immediately chop the roast beef and replace the sandwich he served.

Observation of Resident #7 on 12/19/17 at 12:35pm revealed:
-Resident #7 received freshly prepared nectar thickened liquids from staff that did not contain ice.
-He also received a sandwich with chopped roast beef cut into four pieces from staff.

Observation of Resident #7 on 12/19/17 at 1:05pm revealed:
-He consumed 100% of the roast beef sandwich, carrots, individually wrapped cake, and water.
-He consumed 25% of the mashed potatoes.
-He ate his food without difficulty and did not choke or cough at any time during the meal.

Interview with a Cook on 12/19/17 at 1:15pm and 12/20/17 at 9:30am revealed:
-He worked in the facility as a cook for 4 years.
-He normally put ice in the thickened liquids he thickened for Resident #7.
-He did not know that the ice would change the consistency of the thickened liquid.
-He was trained by the previous cook for 2 weeks when he first started working.
-He measured the powder and added to drink per the instructions.
-He used the pre-thickened drinks when available and served to Resident #7.
-The facility purchased pre-thickened drinks and

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D 310	Continued From page 10 on 12/19/17 he requested the tea also be purchased pre-thickened. -He was aware of how to properly chop meats, as he used a food processor to chop the meats. -He normally chopped the meats for residents who were ordered a chopped meats diet, but because of the donated meal received on 12/19/17, he was instructed that it was shaved thin enough for resident to eat. -The kitchen is overseen by the Resident Care Coordinator. Interview with a second Cook on 12/20/17 at 9:30am revealed: -She worked in the facility as a cook for 4 ½ months. -She was trained for 1 ½ weeks by two other dietary aides. -She had not completed the food service orientation. -She knew how to prepare thickened liquids according to the instructions. -She normally put ice in the thickened drinks because that's how she was trained. -She did not know that ice would change the consistency of the thickened drinks. -She knew the residents who required chopped meats. -She knew how to properly chop meats using a food processor. Interview on with a Personal Care Aide (PCA) on 12/211/17 at 2:30pm revealed: -Resident #7 was to be served nectar thickened liquids at meals and chopped meats. -His meats were always chopped with the exception of 12/19/17. -His drinks were thickened and his tea usually included ice. -He had never choked and had a good appetite.	D 310		

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D 310	Continued From page 11 -The cooks were responsible for preparing food and drinks. Interview on Resident #7's Primary Care Provider (PCP) on 12/22/17 at 3pm revealed: -She could not remember very much about Resident #7. -She could not recall his diet order and did not think Resident #7 had any difficulty with swallowing. -She had not been contacted about Resident #7 having any problems swallowing the nectar thickened liquids. -The consequences of Resident #7 drinking thickened liquids prepared too thin was aspiration pneumonia; if prepared to thick, he would have dysphasia (difficulty swallowing). -The PCP had the expectation that the facility staff were trained to properly prepare the ordered nectar thickened liquids correctly. -She thought Resident #7 was ordered a chopped meat diet because he had difficulty chewing because he had no teeth. -If resident #7 was able to tolerate his meats not being chopped, it would cause no harm. Interview with another dietary staff member on 12/20/17 at 10:00am revealed: -She had been working at the facility for 17 years. -She received her Safe Serve Training 2 ½ years ago. -She recently trained both cooks for 2 weeks, but couldn't provide a date. -She would provide additional training as needed. -She was not aware ice could not be added to thickened liquids. -She would ensure staff are preparing thickened liquids correctly. -Both cooks were aware of how to properly prepare chopped meats.	D 310		

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D 310	Continued From page 12 Interview with the Resident Care Coordinator (RCC) on 12/20/17 at 10:00am revealed: -She knew Resident #7 had a physician's order for nectar thickened liquids and chopped meats. -She was responsible for overseeing the kitchen. -Another dietary staff member with food service orientation was responsible for providing the training. -She knew ice had been served in Resident #7 thickened drink, but was not aware that it would melt and change the consistency. -She knew that Resident #7 meats were not chopped on 12/19/17, as she thought it was shaved thin enough to not require chopping. Interview on with the Administrator on 12/20/17 at 1:25pm revealed: -She knew Resident #7 had a physician's order for nectar thickened liquids and chopped meats. -The RCC and the Admissions Coordinator (AC) were responsible for handling residents' dietary orders. -The RCC was responsible for training since they had completed the food service orientation. -The RCC was responsible for having staff training on the correct procedures for preparing thickened liquids. -The cooks were aware of how to properly chop meats and always chopped meats for residents with orders. -She would purchase pre-made thickened liquids in the future for residents with orders for thickened liquids.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 13 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (Resident #8) with a Physician's order for Symbicort, that was not available for administration. The findings are: Observation of the medication pass on 12/20/17 at 7:40am revealed: -Resident #8's Symbicort 80-4.5mcg (an inhaled maintenance medication used for shortness of breath) was not on the medication cart. -Symbicort was scheduled to be given twice daily (BID) at 8am and 8pm. Interview with the first shift Medication Aide (MA) on 12/20/17 at 7:40am revealed: -The Symbicort was not available for Resident #8. -There was no back-up supply in the medication room. -The medication was "on order" from the pharmacy. -He was unsure of when the refill request was sent to the pharmacy.	D 358		

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D 358	Continued From page 14 -The medication had not been given "for a few days." Review of Resident #8's record revealed: -A physician's order dated 7/21/17 for Symbicort 80-4.5mcg 2 puffs by mouth BID. -She was admitted to the facility on 3/9/17. Review of Physician's Order Fax Memo sheet dated 9/6/17 for Resident #8 revealed: -Staff reported to the Primary Care Provider (PCP) that Resident #8 was frequently short of breath and was wheezing. -An order dated 9/8/17 to encourage use of albuterol 4 times daily as needed. Review of Resident #8's Medication Administration Record (MAR) for December 2017 revealed: -There was an entry dated 7/21/17 for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration on 12/1 and 12/14 at 8am. -There was documentation that the medication was on order on 12/2, 12/6 and 12/12 for 8pm, 12/3, 12/15, and 12/16 for 8am and 8pm. -An "X" was documented on 12/2, 12/6, and 12/19 for 8am, 12/4, 12/5, 12/7, 12/8, 12/17 and 12/18 for 8am and 8pm, and 12/1, 12/10, 12/13 and 12/14 for 8pm. -There was documentation that the medication was not administered on 12/9 to 12/13 at 8am, and 12/9 and 12/11 at 8pm. -There was documentation on the back of the MAR on 12/1 8pm, 12/2 8am, 12/4 8pm, 12/5 8am, and 12/7 8pm that the medication was "not here" and documentation on 12/9 at 8am and 8pm, and 12/12 at 8pm that the medication was "not given, on order from [named pharmacy]."	D 358		

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D 358	Continued From page 15 Review of Resident #8's MAR for November 2017 revealed: -There was an entry for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration 54 occurrences out of 54 opportunities. -There was documentation that Resident #8 was out of the facility from 12/9 at 8pm to 12/13 at 8am. Review of Resident #8's MAR for October 2017 revealed: -There was an entry for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration 62 occurrences out of 62 opportunities. Review of a Physician's visit note for Resident #8 dated 8/10/17 revealed: -Resident #8 was seen on this visit for occasional shortness of breath upon exertion. -A documented history of reactive airway. -Resident #8 had requested a nebulizer machine. -A pulse oximetry reading of 99% on room air. -Respiratory status documented as "lungs clear to auscultation bilaterally without rales, wheezing, or rhonchi, appears SOB." -Diagnosis of acute shortness of breath. -Resident #8 was to continue her current medications. Interview with the facility's pharmacy provider on 12/20/17 at 2:18pm revealed: -The Symbicort required prior authorization from the PCP because it was non-formulary. -The prior authorization request was sent to the PCP on 12/2/17. A second interview with the first shift MA on	D 358		

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D 358	Continued From page 16 12/20/17 at 2:30pm and 3:50pm revealed: -When a medication ran out, he would peel the label off, place on a sheet of paper and fax to the pharmacy. -The RCC or Admissions Coordinator were responsible for prior authorization requests. Interview with the Admissions Coordinator on 12/20/17 at 2:45pm revealed: -The PCP came to the facility every week. -She kept refill requests in a folder for the PCP. -She was unaware that Resident #8 was out of Symbicort. Interview with the Resident Care Coordinator (RCC) on 12/20/17 at 2:47pm and 3:11pm revealed: -She did not know that prior authorization was needed for Resident #8's Symbicort. -She did not know that Resident #8 was out of Symbicort. -The pharmacy usually sends the prior Authorization form to the PCP's office. -She was going to check with the PCP's office to see if they had the paperwork. -The prior authorization was denied and the PCP would see Resident #8 on 12/21/17 to discuss an alternative. -The facility's policy for obtaining medications was to notify the pharmacy that a medication was needed, if prior authorization was required, a note was written on the MAR and the pharmacy would send the prior authorization paperwork to the PCP from the Resident's insurance provider. -The RCC or Admissions Coordinator were responsible to follow-up with the PCP and pharmacy regarding refills and prior authorization requests. Interview with Resident #8 on 12/20/17 at 3:47pm	D 358		

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D 358	Continued From page 17 revealed: -She was aware that she had not been getting the Symbicort. -She had been more short of breath at night. -The shortness of breath had been worse over the past few weeks. -She had seen the PCP "about 2 weeks ago." Interview with a first shift MA on 12/21/17 at 9:50am revealed: -The Symbicort for Resident #8 had been requested from the pharmacy. -The RCC and Admissions coordinator had been in contact with the pharmacy to get it filled. -The MAs were responsible for faxing refill requests to the pharmacy. -The RCC and Admissions Coordinator were responsible for prior authorization requests. Interview with Resident #8's PCP regarding Symbicort on 12/21/17 at 11:47am revealed: -"My office is handling this." -Being out of Symbicort for the month of December was not detrimental for Resident #8. -Resident # 8 had an as needed inhaler that could be used for shortness of breath due to Symbicort being unavailable. -She did not know that Resident #8 had reported increased shortness of breath at night, for the past few weeks. -She would see Resident #8 on 12/22/17 related to increased shortness of breath at night. Interview with the Admissions Coordinator on 12/21/17 at 10:20am and 2:00pm revealed: -She had talked to the pharmacy "a few times" in December regarding the prior authorization for Resident #8's Symbicort. -She was aware that the prior authorization was needed.	D 358		

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D 358	Continued From page 18 -"I called the pharmacy every couple days." -She did not document the calls to the pharmacy. -She did not notify the PCP. -The PCP "had the prior authorization request and should have been aware of it." -"Once the PCP gets the prior authorization request it's up to them." -She found out that Symbicort was denied yesterday (12/20/17) and was not sure when the PCP's office was notified of the denial. -She and the RCC were responsible for making sure medications were available. -She had requested a refill for the Symbicort on 12/17/17. Interview with the RCC on 12/21/17 at 11:00am revealed she would check the smart pages (notification system used to communicate with the PCP's office) to see if the PCP was notified of the prior authorization. Review of a Notice of Denial of Medicare Prescription Drug Coverage letter dated 12/7/17, for Resident #8 revealed the Symbicort was denied. Interview with the Admissions Coordinator/MA on 12/21/17 at 2:25pm and 3:17pm revealed: -She also worked as a Medication Aide in the facility. -The MA's could have signed the Symbicort and administered ProAir instead from July 2017 to December 2017. -She had documented administration of Symbicort to Resident #8. -She had completed a MAR review on Resident #8's record between 11/28/17 and 12/2/17 and realized the Symbicort was not on the medication cart. -She immediately called the pharmacy (could not	D 358		

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D 358	Continued From page 19 specify date) to request a refill for Symbicort, and was told that prior authorization was required. -She did not notify the PCP. -She did not know Symbicort was not available for Resident #8 prior to the MAR review she did at the end of November 2017. -She performed MAR reviews monthly. -She compared the old MAR, the new MAR, and medications on the medication cart, "I just missed it." -She was responsible for making changes to the MARs when new or changes orders were received. Interview with the facility's pharmacy provider on 12/21/17 at 2:02pm revealed: -The pharmacy had only received a faxed refill request on 12/17/17 for Symbicort 80-4.5mcg. -The 7/21/17 order for Symbicort 80-4.5mcg was written with 11 refills. -Symbicort 80-4.5mcg had never been dispensed to the facility for Resident #8. Interview with the RCC on 12/21/17 at 3:05pm revealed: -She was unable to provide invoices for the Symbicort from the pharmacy for Resident #8. -There was no documentation of communication with the pharmacy or the PCP regarding the medication being unavailable. Review of Resident #8's MAR for September 2017 revealed: -There was an entry for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration of Symbicort for 60 occurrences out of 60 opportunities. Review of Resident #8's MAR for August 2017	D 358		

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D 358	Continued From page 20 revealed: -There was an entry for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration of Symbicort for 62 occurrences out of 62 opportunities. Review of Resident #8's MAR for July 2017 revealed: -There was a handwritten entry dated 7/21/17 for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration of Symbicort for 19 occurrences out of 19 opportunities. Interview with Resident #8 on 12/21/17 at 3:10pm revealed: -"I use an inhaler only when I can't breathe good, maybe 2 to 3 times per week I may ask for it." -"I have been using an inhaler for years, since I've been living here I only use it when needed." -"I used to use an inhaler every day before I lived here." -She had used a different inhaler in the past, but now only used ProAir. -"I have not seen Symbicort, I only think it's ProAir." -"Sometimes I feel like I can't breathe and that's when I ask for my inhaler." -She had never used oxygen in facility. -"The facility always have an inhaler (ProAir)." Interview with the Administrator on 12/21/17 at 3:20pm revealed: -The MAs were responsible to notify the RCC or the Admissions Coordinator if medications were not available. -The RCC or the Admissions Coordinator were expected to notify the pharmacy and the PCP	D 358		

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D 358	Continued From page 21 every 2 days if medications were not sent to the facility. -She was unaware that Resident #8's Symbicort was never sent to the facility. -She could not explain why Symbicort had been documented on the MAR from July 2017 to December 2017. _____ The facility's failure to administer medications as ordered by the licensed prescribing practitioner resulted in Symbicort inhaler, not administered as ordered for 1 resident diagnosed with acute shortness of breath. The failure of not receiving Symbicort as ordered can result in exacerbations of clinical symptoms. The facility failed to administer a routine medication from July 2017 to December 2017, which was detrimental to the health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a Plan of Protection on 12/21/17 as follows: -Contact resident's primary care provider to inform her that meds prior authorization was denied and ask to be advised on changing to different medication. -Ensure resident utilizes as needed medications available to prevent shortness of breath episodes and chest tightness. -Improve communication between pharmacy, facility, and primary care provider. -Medication Aides responsible for checking medications available to residents and ensuring they relay information to staff Resident Care Coordinator and Admissions Coordinator. -Resident Care Coordinator and Admissions Coordinator will assume responsibility for ensuring all residents medications are in the	D 358		

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D 358	Continued From page 22 facility for use. -If prior authorization is an issue, the facility staff will contact the pharmacy immediately and relay information to the primary care provider within 24 hours. -Upon prior authorization decision, the primary care provider will be contacted immediately for other medication, advice, etc. _____ CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2018.	D 358		
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 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).	D 367		

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D 367	Continued From page 23 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the accuracy of the Medication Administration Record (MAR) for 1 of 3 residents (Resident #8), related to documenting administration for Symbicort 82-4.5mcg scheduled for administration. The findings are: Observation of the medication pass on 12/20/17 at 7:40am revealed: -Resident #8's Symbicort 80-4.5mcg (an inhaled maintenance medication used for shortness of breath) was not on the medication cart. -Symbicort was scheduled to be given twice daily (BID) at 8am and 8pm. Interview with the first shift Medication Aide (MA) on 12/20/17 at 7:40am revealed: -The Symbicort was not available for Resident #8. -There was no back-up supply in the medication room. -The medication was "on order" from the pharmacy. -The medication had not been given "for a few days." Review of Resident #8's MAR for December 2017 revealed: -There was an entry dated 7/21/17 for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration on 12/1 and 12/14 at 8am. -There was documentation that the medication was on order on 12/2, 12/6 and 12/12 for 8pm, 12/3, 12/15, and 12/16 for 8am and 8pm. -There was an "X" documented on 12/2, 12/6,	D 367		

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D 367	Continued From page 24 and 12/19 for 8am, 12/4, 12/5, 12/7, 12/8, 12/17 and 12/18 for 8am and 8pm, and 12/1, 12/10, 12/13 and 12/14 for 8pm. -There was documentation that the medication was not administered on 12/9 to 12/13 at 8am, and 12/9 and 12/11 at 8pm. -There was documentation on the back of the MAR on 12/1 8pm, 12/2 8am, 12/4 8pm, 12/5 8am, and 12/7 8pm the medication was "not here" and documentation on 12/9 at 8am and 8pm, and 12/12 at 8pm the medication was "not given, on order from [named pharmacy]." Review of Resident #8's record revealed a physician's order dated 7/21/17 for Symbicort 80-4.5mcg 2 puffs by mouth BID. Interview with the facility's pharmacy provider on 12/21/17 at 2:02pm revealed: -Symbicort 80-4.5mcg had never been dispensed to the facility for Resident #8. -The pharmacy had only received a fax on 12/17/17 requesting a refill of the Symbicort 80-4.5mcg. -The original order dated 7/21/17 for Symbicort 80-4.5mcg was written with 11 refills. Review of Resident #8's MAR for July 2017 revealed: -There was a handwritten entry dated 7/21/17 for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration of Symbicort for 19 occurrences out of 19 opportunities. Review of Resident #8's MAR for August 2017 revealed: -There was an entry for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm.	D 367		

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D 367	Continued From page 25 -There was documentation of administration of Symbicort for 62 occurrences out of 62 opportunities. Review of Resident #8's MAR for September 2017 revealed: -There was an entry for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration of Symbicort for 60 occurrences out of 60 opportunities. Review of Resident #8's MAR for October 2017 revealed: -There was an entry for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration 62 occurrences out of 62 opportunities. Review of Resident #8's MAR for November 2017 revealed: -There was an entry for Symbicort 80-4.5mcg inhale 2 puffs by mouth BID at 8am and 8pm. -There was documentation of administration 54 occurrences out of 54 opportunities. -There was documentation that Resident #8 was out of the facility from 12/9 at 8pm to 12/13 at 8am. Interview with the Admissions Coordinator/MA on 12/21/17 at 2:00pm and 2:25pm revealed: -She and the Resident Care Coordinator (RCC) were responsible for making sure medications were available. -She also worked as a Medication Aide in the facility. -She thought the MA's had signed the Symbicort as administered on the MAR and administered ProAir instead from July 2017 to December 2017. -She had documented administration of	D 367		

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D 367	Continued From page 26 Symbicort to Resident #8. -She had completed a MAR review on Resident #8's record between 11/28/17 and 12/2/17 and realized the Symbicort was unavailable. A second interview with the Admissions Coordinator/MA on 12/21/17 at 3:17pm revealed: -She did not know that Symbicort was not available for Resident #8 prior to the MAR review she did at the end of November 2017. -She performed MAR reviews monthly. -She compared the old MAR, the new MAR, and medications on the medication cart, when she did MAR reviews. -"I just missed it" (Symbicort not being available). -She was responsible for making changes to the MARs when new or changes orders were received. Interview with the Administrator on 12/21/17 at 3:20pm revealed: -The MAs were responsible to notify the RCC or the Admissions Coordinator if medications were not available. -The RCC or the Admissions Coordinator were expected to notify the pharmacy and the PCP every 2 days if medications were not sent to the facility. -She was unaware that Resident #8's Symbicort was never sent to the facility. -She could not explain why Symbicort had been documented on the MAR from July 2017 to December 2017. Review of the facility's Medication Administration Policy revealed: -Medications are administered as ordered by the prescribing practitioner. -All medications will be dispensed at med pass and MAR signed.	D 367		

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D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order. (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. (6) The restraint order shall be kept in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, record	D 485		

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D 485	Continued From page 28 reviews, the facility failed to assure a complete restraint order was obtained and updated every 3 months for 1 of 2 sampled residents (Resident #1) with full side rails and geriatric chair with tabletop. The findings are: Review of Resident #1's current FL2 dated 8/2/17 revealed: -Diagnoses included Alzheimer's Disease and anxiety disorder. -The resident was intermittently disoriented and ambulatory. -The resident was incontinent of bladder and bowel. Review of Resident #1's Face Sheet revealed an admission date of 8/7/17. Review of Resident #1's Care Plan dated 8/9/17 revealed: -The resident required extensive staff assistance with bathing, dressing, and grooming/personal hygiene. -The resident required limited staff assistance with eating, toileting, and transfers. -The resident required staff supervision with ambulation. Review of Resident #1's Licensed Health Professional Support evaluation dated 8/29/17 revealed the tasks provided were medication management and "total care with ADL's (Activities of Daily Living)." 1. Observation of Resident #1 on 12/19/17 at 10:21am revealed: -The resident was in the Activity Room sitting in a geriatric chair with a tabletop attached to the	D 485		

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D 485	Continued From page 29 geriatric chair. -The resident was beating the tabletop with her hands and grasping the sides of the tabletop and tried to move it back and forth. -The resident shifted her bottom in the chair frequently. Observation of Resident #1 on 12/19/17 at from 11:58am to 1:07pm during the lunch meal-service revealed: -At 11:58am, the resident was seated in a geriatric chair with tabletop in the dining room. -From 11:58am to 12:42pm, Resident #1 was observed to constantly wipe the tabletop and intermittently beat the top with her hands. -At 12:42pm, the resident was served a lunch tray and immediately stopped hitting the tabletop and appeared less anxious. -At. 12:43pm, a personal care aide began to provide one on one feeding assistance in a seated position to Resident #1. -At 1:07pm, the resident had completed her meal. Observation of Resident #1 on 12/19/17 at 3:15pm revealed: -The resident was in the Activity Room sitting in a geriatric chair with a tabletop attached to the geriatric chair. -The resident intermittently beat the tabletop with her hands. -The resident intermittently wiped the tabletop with her hands. -The resident shifted her bottom in the chair frequently. -On one occasion, the resident was observed to hit the bottom of the tabletop with her right knee. Interview with one personal care aide on 12/19/17 at 3:23pm revealed: -After lunch, "usually we take her in her room to	D 485		

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D 485	Continued From page 30	D 485		

watch TV."
-"Sometimes if she's not agitated we walk her."
-"We haven't walked her today."
-"She played bingo at 2 o'clock and fell asleep sitting on the couch (in the Activity Room), so we put her back in her chair."

Interview with two additional personal care aides on 12/19/17 3:40pm revealed:
-There were four residents who were restrained in the facility.
-Those residents were released every 2 hours for "bathroom breaks" or incontinent care.
-Resident #1 "gets out of hers" referring to the geriatric chair with the attached table top.
-Resident #1 could tell them when she needed to go to the bathroom.
-"They will get [Resident #1's name] up and walk her, toilet her, and then get her ready for dinner."
-"Her family comes and walks her too. Sometimes 2-3 times a day."
-Resident #1 was supervised frequently by staff.
-"We see her pretty much all day."
-"She stays up near the desk most all day, so we can keep an eye on her."

Observation of Resident #1 on 12/20/17 from 9:21am to 9:24am revealed:
-The resident was walking around the nurses station.
-The resident's gait was stable.
-The resident was clean, well groomed, and appropriately dressed.
-The resident sat for a few minutes in a chair inside the nurses station.
-At 9:24am, a Personal Care Aide (PCA), was observed to verbally encourage Resident #1 to walk with her to the Activity Room.
-Resident #1 walked with the PCA to the Activity Room.

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D 485	Continued From page 31 Observation of Resident #1 on 12/20/17 at 9:32am revealed a PCA walked beside Resident #1 in the East Wing hallway. Observation of Resident #1 on 12/20/17 at 2:16pm revealed the resident was walking by herself in the East Wing hallway. Observation of Resident #1 on 12/20/17 at 5:00pm revealed: -The resident was walking around the nurses station. -The resident's gait was stable. -After walking around the nurses station, the resident ambulated towards the East Wing hallway. Observation of Resident #1 on 12/21/17 at 8:35am revealed: -The resident was walking around the nurses station. -The resident's gait was stable. -After walking around the nurses station, the resident ambulated towards the East Wing hallway. Observation of Resident #1 on 12/21/17 at 9:21am revealed a PCA walked with Resident #1 to her room. Review of Resident #1's physician order dated 9/6/17 revealed: -"Rapid decline noticed please review meds." -"Also may we have geri chair order for meals and [as needed]." -Resident "having difficulty walking." -There was no documentation of a tabletop to be used with the geriatric chair. -There was no documentation as the medical	D 485		

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D 485	Continued From page 32 need for the restraint. -There was no documentation as to the period of time the restraint was to be used. -There was no documentation as to the time intervals the restraint was to be checked and released. -The Nurse Practitioner had signed the order on 9/8/17. Review of Resident #1's prescription order dated 9/8/17 revealed: -An order for a geriatric chair. -Diagnoses listed as to medical need for geriatric chair included: vascular dementia, abnormal gait, and risk for falls/history of falls. -There was no documentation of a tabletop to be used with the geriatric chair. -There was no documentation as to the period of time the restraint was to be used. -There was no documentation as to the time intervals the restraint was to be checked and released. -The Nurse Practitioner had signed the order on 9/8/17. Review of Resident #1's Hospice Communication Notes dated 8/8/17 to 12/11/17 revealed: -On 11/20/17, "Sitting in geriatric chair, awake and alert, fidgeting, trying to get out of chair." -On 12/11/17, "Patient sitting in geriatric chair for lunch, restless, agitated trying to get out of chair." Telephone interview with Resident #1's Nurse Practitioner on 12/19/17 at 4:36pm revealed: -Resident #1 was ordered a geriatric chair with tabletop "for safety." -"She has a history of falls.' -"When I was there last week, she was ambulating with a staff member." -She had never seen her try to get out of the	D 485		

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D 485	Continued From page 33 geriatric chair with tabletop. -She had noticed an improvement in Resident #1's ability to ambulate since coming to the facility. -"She's actually ambulating more now." Telephone interview with Resident #1's family member on 12/20/17 at 9:49am revealed: -"She gets combative and very confused." -"She gets agitated when someone's talking loud or there are loud noises." -"At times, I don't mind the geriatric chair. There's times when she can't walk and is wobbly." -"She will not eat if not in the geriatric chair. She would just walk around." -Resident #1 not being able to "sit still" had gotten worse over the last 3 weeks. -Use of the geriatric chair was "so she won't hurt herself or others." -"I'm pretty sure the doctor and nurse had discussed the risks and benefits with me" of using the geriatric chair with tabletop. -The family member did not remember ever signing a consent form, but would do so. -"I said do it as needed." Interview with a medication aide on 12/21/17 at 8:32am revealed: -"She can get the tabletop off." -"I have seen her do it." -"During meals, she will push on the tabletop to try to get out." -She had never seen Resident #1 try to crawl under or over the tabletop to try to get out. Based on record review and observations on 12/19/17, 12/20/17, and 12/21/17, the resident was determined not to be interviewable. 2. Review of Resident #1's physician order dated	D 485		

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D 485	Continued From page 34 9/19/17 revealed: -"Patient to have Full Side Rails on Bed for patient safety." -There was no documentation as to medical need for full side rails on bed. -There was no documentation as to the period of time the restraint was to be used. -There was no documentation as to the time intervals the restraint was to be checked and released. Observation of Resident #1's bed on 12/20/17 at 2:09pm revealed: -There were full side rails installed on the resident's bed. -The foot of the resident bed was elevated at an approximate 30 degree angle and had a fall mat folded in half lying on the foot of the bed. Telephone interview with Resident #1's family member on 12/20/17 at 9:49am revealed: -"I'm pretty sure the doctor and nurse had discussed the risks and benefits with me" of using the side rails. -The family member did not remember ever signing a consent form for restraint use, but would do so. Interview with Resident #1's roommate on 12/20/17 at 2:10pm revealed: -Staff put up both side rails on Resident #1's bed at night "so she don't fall out." -Resident #1 "tries to get out" from the bed "every night." -"She don't go to sleep until 2 or 3 o'clock in the morning." -"She gets out and goes walking up the hallway." -Staff on all shifts were aware Resident #1 could get out around the side rails.	D 485		

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D 485	Continued From page 35 Interview with a medication aide on 12/21/17 at 8:32am revealed: -She worked as a medication aide on night shift "on Friday and Saturday nights." -Resident #1 "had been all over the place for the last two weeks." -"But she's not like that most of the time." -Resident #1's Nurse Practitioner had just adjusted the resident's medications and "that's supposed to help." -"She doesn't want to stop long enough to sleep sometimes." -Resident #1 was not able to "know to put her light on" if she needed staff assistance to get up out of bed at night. -Resident #1 was able to "get over them" referring to the side rails on the bed. -The staff "were going down there every little bit to check on her, every hour at least, to make sure she was sleeping." -"The bedrails worked for awhile to help keep her from rolling out of bed." Based on record review and observations on 12/19/17, 12/20/17, and 12/21/17, the resident was determined not to be interviewable. _____ The facility failed to assure the order for the restraints was complete. The facility failed to clarify the medical need for the restraints, the type of restraints to be used, the period of time the restraints were to be used, and the time intervals the restraints were to be checked and released. The facility failed to assure the restraint orders were updated by the resident's physician at least every three months following the initial order. This failure was detrimental to the health and welfare of the resident and constitutes a Type	D 485		

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D 485	Continued From page 36 B Violation. The facility provided a Plan of Protection on 12/20/17 as follows: -The Primary Care Provider was contacted regarding geriatric chair order. -The order was changed and staff were now to utilize the geriatric chair during meal times only for a 1 hour period. -Resident #1's bed was replaced with a low bed without side rails. -Staff to monitor Resident #1 every 30 minutes and document checks. -Staff to assess residents in geriatric chairs and side rails to ensure safety and prevention of injury. -Upon evaluation of additional residents trying to climb out of bed or out of geriatric chairs, the Primary Care Provider will be contacted immediately for different restraint alternatives. -Staff to monitor residents every 30 minutes while in bed with side rails and those in geriatric chair to ensure safety. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2018.	D 485		
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.	D912		

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D912	Continued From page 37 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and orders for the use of restraints. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (Resident #8) with a Physician's order for Symbicort, that was not available for administration. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] B. Based on observations, interviews, record reviews, the facility failed to assure a complete restraint order was obtained and updated every 3 months for 1 of 2 sampled residents (Resident #1) with full side rails and geriatric chair with tabletop. [Refer to Tag 485,10A NCAC 13F .1501(d) Use of Physical Restraints and Alternatives (Type B Violation).]	D912		
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.	D935		

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D935	Continued From page 38 (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 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:	D935		

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D935	Continued From page 39 Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled medication aides (Staff C) who administered medications and were hired after October 2013 had completed the 15 hour medication training within 60 days of hire as a medication aide. The findings are: Review of Staff C's personnel record revealed: -There was a hire date of 7/11/17 for the position of Medication Aide (MA). -There was documentation of Medication Clinical skills evaluation dated 7/11/17. -There was documentation of successful completion of the Medication Aide test on 5/26/04. -There was documentation of Licensed Health Professional Support validation on 7/11/17. -There was no documentation of 15 hour medication training. -There was no documentation of prior Medication Aide employment. Review of five sampled residents (Resident #1, #2, #3, #4, #5) Medication Administration Records for 12/1/17 to 12/19/17 revealed: -Staff C had documented administration of medications on 12/1/17, 12/3/17, 12/5/17, 12/8/17, 12/11/17, 12/14/17, 12/15/17,12/17/17, 12/18/17, and 12/19/17. -The types of medications documented as administered by Staff C included oral medications, controlled substances, eye drops, insulin, nasal spray, and topical medications. Interview with Staff C, MA, on 12/19/17 at 3:28pm revealed she worked as a medication aide in the facility.	D935		

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LAKEWOOD CARE CENTER	7981 OPTIMIST CLUB ROAD DENVER, NC 28037

(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
D935	Continued From page 40 Interview with the Resident Care Coordinator (RCC) on 12/21/17 at 10:00am revealed when she had asked Staff C about the 15 hour medication aide training, Staff C had told her she had the 15 medication training class, but she did not have the certificate. Telephone interview with Staff C, MA, on 12/21/17 at 11:30am revealed: -She had the 15 hour medication aide training class "some years ago." -"I didn't get a certificate." -She had worked as a medication aide in another local facility from 2003 to 2006. -She had worked at a private home health service from 2006 until coming to the current facility 7/11/17. Interview with a Registered Nurse contracted by the facility to provide continuing education to the medication aide staff on 12/21/17 at 3:30pm revealed: -She assisted the facility on an as needed basis with their training needs. -She was there to do the required annual 6 hour medication training for all of the facility medication aides. -She was going to complete the 5 hour medication training with Staff C after the 6 hour class was completed. -She would be back on 12/22/17 to finish the 10 hour medication training class with Staff C. Interview with the Administrator on 12/21/17 at 12:05pm revealed: -She was not aware of the 5-10-15 hour medication aide training requirement to be completed within 60 days of hire. -Most of their medication aide staff had been hired before the rule change in October 2013.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 41 -Staff C worked in the facility as a medication aide and was a new employee. -"She just started with us in July." -The RCC was responsible for hiring medication aide staff. -The RCC was responsible for ensuring all training requirements were met before new staff were allowed to administer medications.	D935		

D 105-

Cold water handle and shower head on East Wing tub was purchased and replaced, East Wing tub currently working properly.

Spray shower head in East Wing right shower stall was purchased and replaced, East Wing right shower stall currently working properly.

As of December 26th, there are 3 functioning showers available for 30 female residents.

West Wing bathtub control knobs can no longer be purchased according to facility plumber on January 2, 2018. Office Administrator, [redacted] priced out replacing West Wing bathtub. Co-Administrator, [redacted] signed contract with [redacted] to install a new walk-in tub on January 15, 2018. This new tub should be installed and working properly on or before February 4, 2018. [redacted] informed facility on January 15, 2018 once new walk-in tub was ordered and delivered, the old nonfunctioning bathtub could be removed and new one replaced in less than 36 hours.

Shower lever in West Wing right shower stall was looked at by contract plumber, new part was ordered on January 16, 2018 but has not been delivered as of January 23, 2018 due to the recent snow storm. Contract plumber stated shower fixtures may have to be replaced if lever ordered does not fix the current problem.

As of January 23, 2018, there is 1 functioning shower available for 26 male residents. On or before February 4, 2018 there will be 3 functioning showers available for the male residents.

Facility Manager, [redacted] will work closely with housekeeping and maintenance staffs to ensure all shower facilities are functioning properly. Co-Administrator, [redacted] will check both East and West Wing shower facilities weekly to ensure residents have 6 total functioning shower facilities available for daily use.

Handle for water control in Room #18 was purchased and replaced on December 27th, 2017. Metal bolt is no longer visible as sink is functioning properly with both water control knobs at this time.

Facility Manager, [redacted] will work closely with housekeeping and maintenance staffs to ensure all resident rooms water control handles are functioning properly.

Staff meeting was held on January 2, 2018 to encourage staff to report issues like those mentioned above to office staff or SICs ASAP to help prevent in the future.

D 285

Admissions Coordinator, [redacted] increased the bi-weekly milk order to ensure facility had a 3-day supply at all times. Milk is still ordered bi-weekly on Tuesdays and Fridays but was increased from 12 gallons per week to 16. Dietary staffs were advised to inform AC (MG) when they were down to 4-5 gallons of milk to ensure it was ordered and pick-up arrangements had been made. AC (MG) will work closely with dietary staff to ensure residents always have milk available. AC (MG) will check the kitchen herself every Monday before ordering milk for Tuesday's pickup. AC (MG) will continue to order milk bi-weekly online; and use weekly grocery delivery ([redacted]) as an additional resource when/if milk is needed. Increasing of weekly milk began on December 26 2017.

D310

Facilities dietary staffs are aware of each individual resident's current diet. Dietary staff are made aware of diet changes asap and implement these diet changes for immediate upcoming meal and meals moving forward.

Dietary staff immediately issued a new sandwich with chopped meats and new thickened tea without ice on December 19, 2017.

Dietary staff (TB) who is serv-safe certified sat down with dietary staff on December 20, 2017 to discuss questions and concerns regarding therapeutic diets. Dietary staff (TB) encouraged other staff to ask questions when they were unsure of therapeutic diets. Dietary staff are aware that all meats moving forward, despite the thin or thick texture of the meat, must be chopped finely before serving.

In the case of special meals, like those served on December 19, 2017 from volunteers, etc., for Christmas, other holidays, special occasions, etc., the meat will be finely chopped for those with specific therapeutic diets.

Facility began purchasing thickened tea on December 26, 2017 with the previously ordered thickened water, thickened milk and thickened orange juice each week from [redacted] to avoid dietary staff using thickening powder. Utilizing the pre-made nectar thickened liquids will eliminate this problem moving forward. Dietary staff (TB) had a meeting with staff (KB & ET) to discuss thickened liquids, to ensure they knew ice cannot be added to any type of thickened liquid or thickening product.

Dietary staff is responsible for ensuring resident's diets are correct when serving each meal. Facility Manager, [redacted] and Admissions Coordinator, [redacted] will be responsible for relaying information to dietary staff regarding resident's diet changes.

D358-

Resident's PCP discontinued Symbicort order on December 22, 2017. Resident's PCP also discontinued resident's current PRN Proair order. PCP wrote a new order for resident to begin Proair 90mcg 2 puffs PO QID. Resident began new Proair order on December 22, 2017.

Facility Manager, [redacted] and Admissions Coordinator, [redacted] are responsible for medication orders and changes for residents. WD & MG will be responsible for ensuring ordered medications are received from pharmacy and administered to facility residents in a timely manner. SICs will be responsible for informing both WD & MG of medications not received. WD & MG will contact pharmacy asap regarding medications ordered and not delivered.

If a prior authorization is required, WD & MG will be responsible for contacting ordering physician to ensure PA is being worked on; or, that the ordering physician is changing the medication order. WD & MG will contact pharmacy within 24 hours of medication not arriving. Then, staff will contact ordering physician within 72 hours regarding PA. Staff will remain in contact with pharmacy and ordering physician until PA for medication is approved or medication is changed.

Staff (WD & MG) will be responsible for documenting contact with pharmacy and ordering physicians in these types of cases moving forward. Staff (WD & MG) began completing bi-weekly med cart reviews on Fridays, following cycle delivery, to ensure all medications ordered are in the facility and being administered to resident's as prescribed.

D367-

Resident's PCP discontinued Symbicort order on December 22, 2017. Also, PCP discontinued resident's current PRN Proair order. PCP prescribed for resident to begin Proair 90mcg 2 puffs PO QID. Resident began new Proair order on December 22, 2017.

Admissions Coordinator, [redacted] made these appropriate changes to resident's current December MAR. Staff documented on the back of resident's MAR that medication was never received from pharmacy due to PA and was not administered.

Staff (WD & MG) began completing bi-weekly MAR reviews with med cart on Fridays following cycle delivery to ensure all medications ordered are in the facility and being administered to resident's as prescribed. MAR reviews are completed monthly by Admissions Coordinator, [redacted] to ensure all medication changes made by physicians are relayed to the current and the following months MAR. Administrators, [redacted] review and sign each resident's MAR monthly to help ensure accuracy.

D485-

Facility completed a restraint care plan for resident, including geri-chair with tabletop and full bed rails on December 20, 2017. Restraint care plan was signed by Administrator, Facility Nurse, [redacted] (POA) and RCC on 12-20-17. Resident's restraint assessment care plan (Consent and Physicians Order) was completed in its' entirety. Admissions Coordinator (MG) reviewed care plan with PCP via telephone, PCP verbally accepted. Resident's restraint care plan was reviewed and signed by resident's PCP on 12-22-17.

Suggestion made for facility to try a low PVC bed for resident's safety. Facility had low PVC bed in storage; this was used for one night. [redacted] (POA) did not like the low PVC bed, [redacted]. Staff discussed the risk of her current bed without the bed rails, with [redacted] (POA). He stated, "He is aware of fall risk and would rather her use current bed without rails than low PVC bed." Onsite PCP (EC) and Hospice made aware of [redacted] decision regarding resident's bed choices. PCP & Hospice approved current bed without bedrails; in order to avoid resident getting injured while trying to climb around the bed rails to get out of bed. Hospice wrote order on December 21, 2017 to discontinue bed rails.

Resident is to only utilize geri-chair with tabletop during meals; and PRN for agitation/wandering for one hour periods at a time. Staff is to monitor resident closely while in the geri-chair to ensure resident's safety. Staff is to release resident from geri-chair after a PRN hour usage; and supervise her during ambulation to prevent falls.

Admissions Coordinator (MG) and Facility Manager (WD) will be responsible for communicating with ordering physicians when any type of restraint is ordered. Staff will ensure resident's Restraint Assessment Care Plan (Consent and Physicians Order) includes the required information listed in: 10A NCAC 13F .1501 Use of Physical Restraints and Alternatives (1 (A-D) & 2-6).

Admissions Coordinator (MG) will be responsible for working directly with resident, resident's family/guardian, Administrator, Facility RN, and ordering physician to ensure resident's Restraint Assessment Care Plan (Consent and

Physicians Order) is completed in its entirety every 3 months and signed accordingly.

Co-Administrator (RBC) and Admissions Coordinator (MG) checked each resident's bed for bedrails. For those residents with full bedrails, Admissions Coordinator (MG) will ensure their Restraint Assessment Care Plan (Consent and Physicians Order) is completed in its entirety.

D912- Resident's Rights (Hall & Haddix)

Resident #8's Symbicort order was changed 12-22-2017 to Proair 90mcg. This medication was available 12-22-2017 for resident's usage. This ensures the resident received the care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

Resident #1's Restraint Assessment Care Plan (Consent and Physicians Order) was completed in its entirety on December 20, 2017. Staff spoke directly to physician regarding order and its requirements via telephone on 12-20-17.

Resident's order for bed rails was discontinued; and geri-chair with tabletop order changed to PRN for agitation and meals only (1 hour periods) to ensure the resident receives the care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

Facility staff will work closely together to ensure all resident's rights are being met each day. Admissions Coordinator (MG) and Facility Manager (WD) will ensure all medication orders are followed up on; and administered to residents as prescribed; in order to ensure the resident receives the care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

Admissions Coordinator (MG) and Facility Manager (WD) will ensure all restraints ordered for residents are discussed thoroughly with ordering physician for clarification. The Restraint Assessment Care Plans (Consent and Physicians Order) will be completed in their entirety in a timely manner to ensure the residents receive the care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. Guaranteeing our resident's safety and their rights are Lakewood's #1 priority. The facility staff will work together; by communicating with RNs, Physician's and Home Health staff, etc., to ensure all of our resident's receive the care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

D935-

Staff C completed required 5 hour medication aide training on December 21, 2017 with RN (KS). Staff C attended annual 6 hour medication aide training with other facility staff on December 22, 2017 with RN (CR). Staff C attended Safe Diabetes Care training with other facility staff on December 22, 2017 with RN (CR). Staff C also completed required 10 hour medication aide training on December 22, 2017 with RN (KS). Staff C worked directly with RN (KS) that night distributing medications and reviewing policies and procedures.

Upon hiring new medication aides, Facility Manager (WD) will ensure they have previously worked as a medication aide within the past 2 years. Documentation will be required to prove this work was completed as a medication aide in another facility within the last 24 months prior to hire at Lakewood. RN will be contacted immediately for 5 and 10 hour training if required for new hires. RN's (CR) and (KS) will be utilized for these services since they have completed the trainings in the past for Lakewood. Facility Manager (WD) will ensure these trainings are completed before releasing the medication aides to distribute medications to residents.

Staff C completed 5 hour, annual 6 hour, 10 hour medication aide training and Safe Diabetic Care training by December 23, 2017. Staff C will continue to attend the annual 6 hour medication aide training with other Lakewood facility staff yearly.