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D 000	Initial Comments The Adult Care Licensure Section and the Hoke County Department of Social Services conducted a follow-up survey and complaint investigation from 01/23/18-01/26/18. The complaint investigation was initiated by the Hoke County Department of Social Services on 10/13/17.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure bleaches, cleaners, and disinfectants were stored in a locked area and not accessible to residents in the assisted living side of the facility. The findings are: Observation of the janitorial/housekeeping closet on Townsend Hall (assisted living side of the facility) on 01/23/18 at 10:12 a.m. revealed: -The door to the closet was unlocked. -There was a sign on the outside of the door that read "Janitors' Closet, keep locked." -There were four bottles of liquid solution to the right of the door mounted on the wall.	D 056		

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D 056	Continued From page 1 Observation of the janitorial/housekeeping closet on Townsend Hall on 01/23/18 at 10:56 a.m. revealed the closet was still unlocked. Observation of the housekeeper on 01/23/18 at 10:58 a.m. revealed she entered the closet without using a key and exited less than a minute later. Observation of the housekeeper on 01/23/18 at 10:59 a.m. revealed she entered the closet a second time without using a key. Interview with a housekeeper on 01/23/18 at 11:14 a.m. revealed: -There were some residents on the hall who were not mentally stable. -None of the residents had ever touched the chemicals on her cart in the five years she had worked at the facility. -She kept the janitorial closet unlocked. -She was certain she would see the resident if they attempted to touch her cart or enter the closet. Observation of the janitorial/housekeeping closet on Townsend Hall on 01/23/18 at 11:31 a.m. revealed the closet was still unlocked. Observation of the utility room on Townsend Hall on 01/23/18 at 10:47 a.m. revealed: -There was a biohazard sign on the door. -The door was unlocked. -A housekeeping cart with supplies was stored in the utility room. -There was a large container of bleach wipes and a can of disinfectant spray on top of the housekeeping cart. (Both product labels noted, "hazardous to humans and domestic animals;	D 056		

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causes moderate eye irritation".)
-There was a spray bottle of concentrated disinfectant cleaner sitting on the corner of the sink. (Product label noted to "keep out of reach of children - danger".)

Observation of the utility room on Townsend Hall on 01/23/18 at 10:54 a.m. revealed:
-The housekeeper walked down Townsend Hall to the utility room.
-The housekeeper took the housekeeping cart from the utility room and began performing housekeeping duties in residents' rooms.
-The housekeeper did not lock the utility room door.

Observation on 01/23/18 at 11:30 a.m. revealed the janitorial/housekeeping closet on Jordan Hall (assisted living side of the facility) was unlocked during the tour of the facility.

Interview with a housekeeper on Jordan Hall 01/23/18 at 11:35 a.m. revealed the housekeeping closet was left unlocked all day until her shift ended, and then it was locked.

Interview with the Director of Resident Services (DRS) on 01/23/18 at 11:37 a.m. revealed:
-The housekeeping closets were supposed to be locked on all halls.
-They did not usually lock the utility room on Townsend Hall because it was used for soiled linen.
-The housekeepers were not supposed to store the housekeeping cart in the utility room.
-The housekeeping carts should be locked in the housekeeping closets.
-There were some residents on the assisted living side of the facility who were confused and disoriented at times including one resident who

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D 056	Continued From page 3 wandered and wore a wander guard device. -She would lock the door to the janitorial/housekeeping closet on Townsend Hall. Observation of the janitorial/housekeeping closet on Townsend Hall on 01/23/18 at 11:44 a.m. revealed the door was locked. Interview with a housekeeper on Townsend Hall on 01/24/18 at 10:14 a.m. revealed: -She was not thinking yesterday (01/23/18) when she put the housekeeping cart in the utility room on Townsend Hall. -She was supposed to store the housekeeping cart in a closet on Jordan Hall. Interview with the Administrator on 01/23/18 at 3:00 p.m. revealed: -The housekeeping carts were supposed to be kept in the housekeeping closets not in the utility room. -Housekeeping staff were supposed to keep the housekeeping closets locked.	D 056		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record	D 270		

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reviews, the facility failed to provide supervision for 3 of 9 sampled residents (#1, #3, #6) resulting in two residents eloping from the facility without staff knowledge (#1, #6) and the third resident wandering into other residents' rooms (#3).

The findings are:

1. Review of Resident #6's current FL-2 dated 03/08/17 revealed:
-Diagnoses included Alzheimer's unspecified, cerebral infraction, general anxiety disorder, excessive crying of child, long term use of antithrombotic, and dementia with behavioral disturbances.
-Resident #6 was intermittently disorientated.
-Resident #6 wandered.
-Resident #6 was semi-ambulatory.
-Resident #6 used a wheelchair to ambulate.
-The recommended level of care was marked other SCU (special care unit).

Review of Resident #6's care plan dated 11/14/17 revealed:
-Resident #6 required extensive assistance with toileting, bathing, dressing, transferring, grooming and personal care.
-Resident #6 required limited assistance with eating and ambulating.

Telephone interview with Resident #6's family member on 12/08/17 at 3:06 p.m. revealed Resident #6 constantly tried to get out of the facility even with the wander guard on, therefore she was moved to the Special Care Unit (SCU).

Review of Resident #6's Progress Notes dated 10/19/17 revealed:
-The progress note was completed for the 6am -2pm shift.

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-Resident #6 got out of the facility.
-A former employee saw Resident #6 and brought Resident her back to the facility.
-The special care unit coordinator (SCUC) was not aware Resident #6 had gotten out of the facility until the Administrative Assistant (AA) called and told her.
-The maintenance staff was unaware the top keypad wires had been taken apart on the door alarm to the SCU.

Attempted telephone interview with the former SCUC, (who wrote the progress note dated 10/19/17), on 12/21/17 at 10:09 a.m. and on 12/29/17 at 3:44 p.m. was unsuccessful.

Interview with the PCA (referenced in the 10/19/17 note) on 01/09/17 at 1:40 p.m. revealed:
-The PCA was not aware Resident #6 was out of the facility on 10/19/17.
-The PCA was made aware Resident #6 had left when the former employee brought the resident back to the facility and knocked on the outside of the SCU door.
-No one knew Resident #6 had gotten out of the facility.
-The PCA was not sure of the last time Resident #6 was observed on the SCU (prior to leaving the facility).
-Residents were to be checked every two hours.
-The PCA was not informed the doors to the SCU that lead outside were not working 10/19/17.
-The PCA forgot to tell the former SCUC that Resident #6 had been brought back to the facility.

Interviews with a second PCA on 12/14/17 at 11:15 a.m. and 01/09/17 at 1:55 p.m. revealed:
-The PCA worked on the day (10/19/17) Resident #6 got out of the facility.
-The PCA did not know Resident #6 had gotten

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out of the facility until she was brought back by a former employee.
-Resident #6 was found close to a major highway by a former employee.
- The maintenance staff was working on the door to the SCU.
-The PCA was not sure what the maintenance staff was doing to the door.

Interviews with Director of Resident Services (DRS) on 12/14/17 at 2:15 p.m. and 01/09/17 at 2:30 p.m. revealed:
-The DRS was not aware Resident #6 had gotten out the facility on 10/19/17.
-When staff went out the door on the SCU, Resident #6 followed staff out.
-Resident #6 was in the back-parking lot by the laundry.
-A former employee brought Resident #6 back to the facility.
-When asked why staff would allow a resident to go out the door, the DRS stated "because the staff was not paying attention."

Interviews with the Administrative Assistant (AA) on 12/14/17 at 12:20 p.m., 12/19/17 at 1:50 p.m., and 12/29/17 at 11:50 a.m. .revealed:
-Resident #6 got out of the facility on 10/19/17.
-She did not know Resident #6 had gotten out of the facility until she got a phone call from a former employee between 12:45 p.m. - 1:00 p.m., stating she had brought Resident #6 back to the facility.
-The former employee brought Resident #6 back to the facility to the SCU door.
-When asked how far Resident #6 had gotten away from the facility she responded, she was brought back to the facility from the highway.
-The fire pull station handle was broken during the fire drill on 10/19/17, which automatically unlocked all the doors.

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-The maintenance staff silenced the alarm while he was working to fix the fire pull station handle.
-Upon further investigation the door to the SCU was not latching correctly and the maintenance man had taken the alarm loose.
- The maintenance staff reported to the AA that the alarm on the SCU was not working correctly; the alarm had sounded for at least 15 minutes.
- The AA was not sure why the maintenance staff had taken the wires loose to the SCU.
-The staff on the SCU were not made aware on 10/19/17 that the mag lock on the SCU could not be reset due to the broken fire pull station, even though the alarm had been silenced.

Interviews with the maintenance staff on 12/14/17 at 2:27 p.m. and 01/12/18 at 1:15 p.m. revealed:
-A fire drill was conducted on 10/19/17.
-When the fire alarm handle was pulled, all the locked doors in the facility automatically unlocked.
-The pull on the fire alarm broke when he pulled it, therefore the fire alarm could not be reset to lock any of the doors in the facility.
-He tried to repair the broken fire pull.
-The fire alarm pull station handle was fixed enough so the doors on the SCU would lock for the night
-He reported to the AA that the alarm on the SCU was not working properly.
-A company came in the next day to fix the fire alarm pull.
-On the day of the fire drill the door to the SCU that led outside would not lock or alarm.
-"The aides should have been watching the residents."

Interview with a PCA (referenced in the 10/19/17 note) on 01/09/17 at 1:40 p.m. revealed during a fire drill the PCAs made sure the residents were

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in a safe place, until the fire drill was over.

Telephone interview with Resident #6's family member on 12/08/17 at 3:06 p.m. revealed:
-The family member was informed the maintenance staff was working on the door and Resident #6 just went out of the facility.
-The family member was not sure who brought Resident #6 back to the facility.
-The family member was not sure how long Resident #6 had been gone from the facility.

Interviews with the Administrator on 12/19/17 at 1:50 p.m., 12/29/17 at 12:10 p.m., and 01/09/17 at 3:00 p.m. revealed:
-Resident #6 was moved from the Assisted Living (AL) side of the building to the SCU because of being in and out of another residents' room, and for trying to get out the front door.
-The Administrator was not in the facility on 10/19/17, and was made aware of the incident when she returned to work on 10/23/17.
-The maintenance staff broke the pull station handle during the fire drill on 10/19/17.
-As long as the fire alarm was going off the mag locks on the SCU would not lock.
-The maintenance staff silenced the fire alarm to stop the noise.
-The mag lock on the SCU did not reset when the alarm was silenced.
-A PCA should have been stationed by the door during the fire drill.
-The PCAs on duty that day [10/19/17] had been working at the facility long enough to know what to do during a fire drill.
-The staff on duty that day did not know Resident #6 had left the facility.
-When the fire alarm was broken the staff were to conduct 15-minute checks on the residents.
-She was not sure if 15-minute checks were done

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that day.
-The fire alarm was silenced several times from 11:30 a.m. to 12:21 p.m.
-The staff assumed all doors were okay because the alarm had been silenced.
-"No one is sure what time Resident #6 left the building and how long she had been gone".
-The fire alarm started at 11:30 a.m. and ended at 12:21 p.m., all that time the mag locks had not been engaged, and the door leading outside the SCU was unlocked.

Interview with the Administrator on 01/25/18 at 6:30 p.m. revealed:
-They had a fire drill at the facility on 10/19/17 and the pull station was broken on Jordan Hall on the AL side of the facility.
-When the fire alarm pull station was pulled, the mag locks were not operational.
-A supervisor on the AL side of the facility silenced the alarm so they could repair the pull station and reset the alarm.
-The alarm was pulled at 11:30 a.m. and restored at 12:21 p.m.
-All staff on the SCU were in the dining room feeding residents during the time the alarm was not engaged.
-The former SCUC had gone to the AL side of the facility during that time.
-No staff were stationed at the exit doors in the SCU when the alarm was silenced.
-She did not believe staff in the SCU realized the alarms were not working.
-Resident #6 exited the building when she left the dining room while staff were still in the dining room on 10/19/17.

2. Review of Resident #1's current FI-2 dated 11/01/17 revealed:
-Diagnoses included macular degeneration,

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hypertension, hyperlipidemia, right shoulder arthritis, cognitive deficit and Vitamin D deficiency.
-Resident #1 was constantly disorientated.
-Resident #1 wandered.
-Resident #1 ambulated.
-Resident #1 had functional limitations to her sight.

Review of Resident #1's care plan dated 02/22/17 revealed:
-Resident #1 became confused at times and wanted to leave the facility and walk home.
-Resident #1's vision was very limited.
-Resident #1 was legally blind.
-Resident #1 wore a wander guard to alert staff when she tried to leave the facility.

Review of a note faxed to Resident #1's Primary Care Provider (PCP) dated 12/03/17 revealed:
-The facility had issues with Resident #1 trying to get out of the facility more towards the evening time.
-The PCP had not replied to the fax.

Review of a note faxed to Resident #1's PCP dated 12/07/17 revealed:
-Resident #1 had been agitated for the past three days, trying to leave the facility. "What do you suggest?"
-The PCP responded to the fax on 12/11/17 that Resident #1 needed a visit.

Attempted interview with Resident #1's PCP on 01/24/18 at 8:30 a.m. was unsuccessful.

Review of Resident #1's Progress Notes dated 12/31/17 revealed:
-Resident #1 had gotten out of the side door on the AL side of the facility at 3:49 p.m.

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-Resident #1 was found at a local convenience store.
-The police brought Resident #1 back to the facility at 4:39 p.m.
-A personal care aide (PCA) was in a room on the same hall and failed to respond to the door alarm.
-Resident #1 was now on 15-minute checks.

Review of an incident/accident report dated 12/31/17 for Resident #1 revealed:
-Resident #1 had gotten out of the side door on the AL side of the facility.
-Resident #1 walked away from the facility.
-Resident #1 walked out the door at 3:49 p.m.; at 3:52 p.m. the Supervisor checked the door and the facility for the resident.
-The facility called 911 and notified Resident #1's family.
-At 4:39 p.m. the police brought Resident #1 back to the facility.

Interview with a PCA on 01/24/18 at 9:24 a.m. revealed since Resident #1 eloped, she was placed on 15-minute checks and the PCA's were to walk the halls with her and keep an eye on her.

Interview with a second PCA on 01/24/18 at 3:30 p.m. revealed:
-The PCA worked on the day (12/31/17) Resident #1 eloped from the facility.
-Resident #1 was an exit seeker and was confused at times, which was why she had the wander guard.
-Resident #1 had tried to get out of the facility before the elopement on 12/31/17.

Interview with a Supervisor on 01/24/18 at 2:15 p.m. and on 01/25/18 at 3:00 p.m. revealed:
-The Supervisor had gone to the SCU to make rounds on 12/31/17.

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D 270	Continued From page 12 -While she made rounds, she heard the alarm on the AL sounding. -According to the facility camera, it took the Supervisor 3 minutes to get from the SCU to the AL side of the facility. -The Supervisor immediately went to Resident #1's room because she had tried to get out of the facility for the past 3 days. -Residents with wander guards were checked every 30 minutes. -The Supervisor checked inside and outside the facility and could not locate Resident #1. -Resident #1 was found at the pumping station down the street from the facility by a community member and was taken to the convenient store across the street. -The Supervisor was not sure the last time Resident #1 was seen in the facility before the elopement. -Resident #1 got more confused in the evening between 3:00 p.m. and 5:00 p.m. -Resident #1 had gotten out the other door (she did not get far) on the AL side of the facility a week before the incident on 12/31/17. -Resident #1 should not leave the facility by herself. Interview with the Director of Resident Services (DRS) on 01/24/18 at 4:50 p.m. revealed: -Resident #1 had the wander guard because she would go out the front door and stand there and she tried to leave the facility. -Resident #1 had not gotten away from the facility before the incident on 12/31/17. -Resident #1 was confused. -The PCA were responsible for checking the wander guard twice a week to make sure they were still on the resident and worked properly. -Resident #1 was put on 15-minute checks after she eloped on 12/31/17.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 13 -The DRS was not sure what Resident #1's vision limitations were. Based on observations, record reviews, and interviews, Resident #1 was not interviewable. Telephone interview with Resident #1's family member on 01/25/18 at 9:40 am revealed: -Resident #1 had a mental decline and was confused all the time. -Resident #1 had the wander guard for 8 to 10 months. -Resident #1 needed the wander guard because she would walk out the door if she did not have it on. -It was very cold the evening Resident #1 eloped from the facility. -Resident had on a thin sweater when she eloped from the facility. -When brought back to the facility Resident #1 was clueless as to what happened. -The family member did not know Resident #1 had gotten out of the facility a week earlier. -Resident #1 had limited vision; she could see very little. Observation on 01/26/17 at 2:31 p.m. revealed: -The driving distance to the gas pump station identified as the location Resident #1 was found after leaving the facility unsupervised on 12/31/17 was 0.5 miles from the facility. -The road identified as the one Resident #1 crossed on 12/31/17 was a busy two-lane road. Attempted telephone interview with Resident #1's PCP on 01/24/18 at 8:29 a.m. and 01/24/18 at 2:00 p.m. was unsuccessful. Interviews with the Administrator on 01/09/17 at 2:50 p.m., 01/25/18 at 6:45 p.m., and 01/26/18 at	D 270		

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D 270	Continued From page 14 6:00 p.m. revealed: -When asked why Resident #1 had a wander guard she responded, "we have a problem with Resident #1 trying to get out of the facility." -When Resident #1 was "sun downing, she goes to the front door every 10 minutes in an attempt to leave the facility." -She had talked with the resident's family member about putting the wander guard on the resident because the family wanted the resident to stay on the assisted living side of the facility. -The resident had been more agitated since Thanksgiving. -A MA had written a note to the physician to get medication for agitation. -She was aware Resident #1 left the facility on 12/31/17. -A PCA was in another resident's room on her cell phone and did not respond to the wander guard alarm on 12/31/17. -When asked the protocol for elopement, she responded a physical search was conducted, the family was notified, the Administrator is notified, then the DRS is notified; if the resident is not located, 911 was called. -The resident exited the end door on Jordan Hall on 12/31/17 at 3:49 p.m. -The resident walked to the back of the facility and got to a gas pump on the other side of the road, near the overpass. -A person from the community picked up Resident #1 and took the resident to a convenience store. -The person bought the resident a cup of coffee and called the police. -The resident was returned to the facility by the police at 4:32 p.m. on 12/31/17. -Resident #1 was placed on 15-minute checks after the elopement on 12/31/17.	D 270		

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D 270	Continued From page 15 3. Review of Resident #3's current FL-2 dated 08/29/17 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbance, diabetes mellitus type 2 with diabetic neuropathy, history of falls, and peripheral vascular disease. -The recommended level of care was documented as Special Care Unit (SCU). Review of Resident #3's care plan dated 09/08/17 revealed: -Resident #3 was sometimes disoriented, forgetful, and needed reminders. -Resident #3 wandered at times. -Resident #3 required extensive assistance with toileting and bathing, and limited assistance with ambulation, dressing, grooming and personal hygiene. Review of Resident #3's most current care plan dated 09/20/17 revealed Resident #3 wandered in and out of other residents' rooms. Confidential staff interviews revealed: -Resident #3 "wanders all over the place"; staff did the best they could to watch her. -Resident #3 walked the halls and went into other residents' rooms; staff checked on her every two hours. -Staff had to look for Resident #3 sometimes and would find her in other residents' rooms; staff checked on her every two hours or more because she was frequently walking in the halls. -Resident #3 wandered and walked the halls "a lot"; "We're supposed to be watching her (Resident #3) at all times," but staff had to look for her "at times." -Staff could see and monitor Resident #3 as she walked up and down the halls.	D 270		

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D 270	Continued From page 16 Observation of Resident #3 on 01/25/18 between 11:20 a.m.-11:50 a.m. revealed: -At 11:20 a.m. Resident #3 was seated on the sofa in the day room of the SCU speaking in Spanish with another resident. -A Personal Care Aide (PCA) came into the day room and said "time for lunch" and then motioned with her hands for Resident #3 to go to the dining room. -Resident #3 responded to the PCA loudly using Spanish phrases. -The PCA said "I'm just going to do what I normally do and leave her here when I can't understand her and see if someone else can help her," and then she left the room. -At 11:28 a.m. two other PCAs entered the day room and tried to get Resident #3 to go to the dining room by speaking English and using hand motions. -Resident #3 was speaking to the staff loudly using Spanish phrases. -One PCA said "This happens every day; we don't have a clue what she's trying to tell us". -Another PCA tried to hold Resident #3's hand, but Resident #3 shouted a phrase in Spanish and pulled her hand back and continued to sit on the sofa. -At 11:35 a.m. the housekeeper and another PCA entered the day room and spoke to Resident #3 in English asking her to go to the dining room. -Resident #3 was pointing to her stomach and speaking in Spanish. -At 11:45 a.m. all SCU staff had left Resident #3 in the day room alone; a Supervisor from the Assisted Living (AL) unit came in to speak to Resident #3. -Resident #3 was agitated and speaking loudly in Spanish to the Supervisor. -The Supervisor spoke in English to Resident #3 and told her they would keep her lunch and give it	D 270		

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to her later.
-At 11:50 a.m. all SCU residents were in the dining room eating lunch and Resident #3 was sitting alone in the day room watching TV.

Observations on 01/26/18 between 11:00 a.m.-11:10 a.m. revealed:
-Resident #3 went into a resident's room (that was not hers) and closed the door.
-She left that room and she went into another resident's room.
-No staff intervened or re-directed Resident #3.

Observations on 01/26/18 between 11:20 a.m.-11:46 a.m. revealed:
-Staff were taking residents to the SCU dining room for lunch.
-Lunch was being served by dietary staff; there were two PCAs in the dining room.
-Resident #3 was not in the dining room.
-At 11:46 a.m., Resident #3's room was empty and a third PCA was walking in the hallway; the surveyor asked the PCA where Resident #3 was because she was not in the dining room or her room.
-At 11:47 a.m., the PCA and surveyor found Resident #3 sitting alone in the day room; the PCA used hand gestures to assist Resident #3 to the dining room.

Interview with Resident #3's family member on 01/26/18 at 12:00 p.m. revealed:
-Resident #3's family visited her at least once daily, but usually twice daily (one family member visited in the mornings and the second family member visited in the evenings).
-The family was concerned that the facility was not "keeping an eye on her (Resident #3) like they need to."
-The family was concerned because when the

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family visited Resident #3, the staff did not know where she was.
-"The other day we (staff and the family) could not find her"; the resident was eventually found.
-About one month ago, the staff and family could not find Resident #3 and looked for her; the staff told the family member she was going to activate the alarm, but then Resident #3 was found asleep in another resident's room.
-On another occasion (unsure of the date, but it was recently), the staff did not know where Resident #3 was; she was found in the bathroom and had made a "mess" with the shampoo and it was "everywhere."
-About two months ago, the family member noticed Resident #3 had been urinating in some of the containers that were in her furniture drawers, but the staff were not aware; if the staff were watching her, they would have known.
-"They don't keep enough watch on her"; the family feared staff would not keep a check on her if they did not visit multiple times daily.

Observations on 01/26/18 between 12:04 p.m.-12:16 p.m. revealed:
-At 12:04 p.m., Resident #3's family member pushed the call bell in Resident #3's room.
-At 12:16 p.m., no staff had responded to the call bell; the family left Resident #3's room to look for Resident #3 and staff.

Interview with the Special Care Unit Coordinator (SCUC) on 01/25/18 at 10:35 a.m. revealed:
-Resident #3 wandered the halls, went into other residents' rooms.
-Staff tried to take all residents into the TV room in order to monitor them as much as possible.
-If residents were asleep or in their room, staff monitored them every two hours; if the resident had a restraint, staff monitored the resident every

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30 minutes.
-Some residents were put on 15 minutes checks if they were exhibiting abnormal behaviors, but she did not know if that was a facility policy.
-There were not any residents on the SCU who received special monitoring or additional supervision at that time.

Interview with the Director of Resident Services (DRS) on 01/26/18 at 1:34 p.m. revealed:
-All residents were supposed to be monitored every two hours; if they were in bed or had a restraint, they were monitored every 30 minutes.
-Resident #3 was monitored at least every two hours, if not more.
-She was not aware of any family concerns for Resident #3.
-She was not aware of any instances when staff or family could not find Resident #3.

Interviews with the Administrator on 01/25/18 at 6:55 p.m. and 01/26/18 at 5:05 p.m. revealed:
-Resident #3 was "not always nice" and was a "sundowner."
-Resident #3 hit one resident in the back of the head and slapped another resident.
-She believed Resident #3 had went into another resident's room and purposely unplugged the power cord to the resident's television.
-She had looked at the video surveillance coverage for an incident in which Resident #3 sustained a bruise on her breast, but was not able to find it on video.
-Resident #3 would go into other residents' rooms, which could be why she could not find the incident on video.
-Resident #3's family had requested that her Primary Care Provider (PCP) decrease her medications and her medications had been decreased multiple times.

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D 270	Continued From page 20 -Interventions for Resident #3 including monitoring her like all residents in the SCU such as being in the day room as much as possible for staff monitoring, and having staff in the halls and day room. _____ The facility failed to provide supervision to three residents (#1, #6, #3) who had a history of wandering. Staff failed to supervise Resident #6, who had a diagnosis of Alzheimer's disease and resided in the SCU, after a fire drill and the door in the SCU malfunctioning, resulting in the resident eloping from the facility because staff failed to monitor the malfunctioning door and supervise the resident. Staff failed to supervise Resident #1, who was legally blind, and had a wander guard, resulting in the resident eloping from the facility, walking alone for approximately 0.5 miles, crossing a road, and being found by a member of the community. The facility failed to supervise Resident #3 resulting in the resident wandering into other residents' rooms. The facility's failure to supervise these residents placed the residents at substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ Review of the Plan of Protection submitted by the facility on 01/25/18 revealed: -Training was held with the SCU employees on the limitation of the locking system during fire drills and power outages. -Training was held on the wander guard system. -Emergency procedures were covered during training sessions. -Placement of staff during fire drills and emergencies was discussed and a facility layout was used to show where staff should be stationed to monitor residents. -All facility alarms were reviewed to ensure staff	D 270		

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D 270	Continued From page 21 were familiar with sounds of the alarms to make sure staff would be able to recognize the differences in the alarms. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 23, 2018.	D 270		
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 Based on observations, record reviews, and interviews, the facility failed to assure physician notification and follow- up care for 2 of 7 sampled residents (#2, #11) related to failure to use compression stockings due to swelling (#2) and failure to coordinate follow-up care with the primary eye doctor resulting in the resident missing doses and running out of eye drops for glaucoma (#11). 1. Review of Resident #2's FI-2 dated 04/05/17 revealed: -Diagnoses included Alzheimer's disease, altered mental status, dementia, diabetes mellitus type 2, hypertension, migraines, Vitamin D deficiency, hypercholesterolemia, osteoarthritis, chronic lymphedema, and hiatal hernia. -Resident #2 needed assistance with bathing and	D 273		

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dressing.
-Resident #2 was intermittently disoriented.
-Resident #2's knee-hi compression stockings were to be applied the morning and removed at bedtime. (Compression stockings are used to prevent and decrease the chance of blood clots and treat and decrease swelling).

Review of Resident #2's care plan dated 10/24/17 revealed:
-Resident #2 required daily extensive assistance applying and removing the TED (thromboembolic deterrent hose) compression stockings.
-The TED hose were to be applied in the morning and removed at night.

Review of Resident #2's Licensed Health Professional Support (LHPS) dated 10/19/17 revealed:
-Residents ankles and legs remain edematous (swollen).
-There was an order for TED hose to be put on in the morning and removed at night.
-Resident #2 had complained in the past that the TED hose hurt her legs.
-Resident #2 was not wearing the TED hose at this time.

Review of a fax to Resident #2's Primary Care Provider (PCP) by the former Special Care Unit Coordinator (SCUC) on 10/19/17 and on 11/15/17 revealed:
-The SCUC asked for an order to discontinue the use of the TED hose in the morning and removing at night and asked for an order for a different type and brand of compression stockings (used to help reduce persistent swelling but were not tight on the legs) instead.
-The PCP agreed to the order change on 12/14/17.

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D 273	Continued From page 23 Observation of Resident #2 on 01/23/18 at 11:05 a.m. revealed: -She was in the SCU day room. -She had swelling in both feet. -She was in her wheelchair with her feet on the floor (her lower extremities were not elevated). -She was not wearing any specialty TED hose or compression stockings. Interview with Resident #2 on 01/23/18 at 11:05 a.m. revealed: -When asked if she had swelling in her feet she said "uh-huh." -She did not know how long her feet had been swollen. -She was not hurting anywhere. Interview with the Special Care Unit Coordinator (SCUC) on 1/23/18 at 10:35 a.m. revealed: -Resident #2 was confused at times but could tell you when she was in pain. -Resident #2 sometimes complained of back pain, but had no other complaints of pain. Observation of Resident #2 on 01/25/18 at 9:28 a.m. and at 4:50 p.m. revealed: -Resident #1 was not wearing her compression stockings. -Resident #1 had on regular socks. -Resident #1's feet were both swollen. Review of Resident #2's electronic Medication Administration Record (MAR) for January 2018 revealed: -There was an entry to apply [name brand] stockings in the morning and remove at bedtime. -There was documentation the stockings were applied from 01/01/18-01/24/18 a 9:00 a.m. and removed from 01/01/18-01/24/18 at 9:00 p.m.	D 273		

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D 273	Continued From page 24 -There was documentation the stockings were applied 01/25/18 a 9:00 a.m. Interview with the DRS on 01/25/18 at 4:55 p.m. revealed: -After the compression stockings order was changed (in December 2017), the Administrator ordered the new brand/type of stockings from an online website (no date provided). -Resident #1 should have the compression/TED stockings on. Interview with a Medication Aide (MA) on 01/25/18 at 5:10 p.m. revealed the compression stockings were in Resident #2's room. Observation on 01/25/18 at 5:15 p.m. revealed the compression stockings were located in Resident #2's dresser drawer, folded up. Interview with a Personal Care Aide (PCA) on 01/26/18 at 11:05 a.m. revealed: -The PCAs were responsible for applying and removing Resident #2's compression stockings. -The MAs documented the use of the compression stockings on the MAR. -The PCA knew Resident #1 should have on the compression stockings during the day. -If the compression stockings were not worn, the PCAs were supposed to notify the MA. -The PCA could not get the compression stockings on Resident #2 that morning because the resident's legs were too swollen; the PCA had put big socks on the resident instead of the compression stockings. -The PCA should have notified the Supervisor that she did not apply the stockings, but she forgot. -Resident #2 was to keep her feet propped up as much as possible because of the swelling in her	D 273		

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legs.
-The PCA had documented that the compression stockings were on the resident that day, but they were not actually put on.
-The PCA would try and put the compression stockings on the resident later.

Observation of Resident #2 on 1/26/18 at 11:07 a.m. revealed:
-She had edema in both feet and both lower extremities almost up to her knees.
-When the PCA touched her right foot, and ask it was sore, Resident #2 responded "yea."
-She was not wearing the compression stockings.

Interview with a Supervisor on 1/26/18 at 11:15 a.m. revealed:
-The PCAs were responsible for putting specialty hose and stockings on the residents.
-The MAs were supposed to ask the PCAs if the residents' were wearing the specialty stockings/hose and "lay eyes" on the resident to be sure they were on the resident.
-Documentation of the specialty stockings such as TED hose was kept on the MAR or Treatment Administration Record (TAR).
-The staff that put on and removed the specialty hose were responsible for the documentation of the task being completed.
-The Supervisor was not aware Resident #2 was not wearing the compression stockings that day.
-No staff had reported swelling in Resident #2's legs.
-She would check Resident #2's legs.

Interview with a second MA on 01/26/18 at 11:20 a.m. revealed the MA on the cart for the day was responsible for checking to see if the compression stockings were on the resident.

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D 273	Continued From page 26 Observation on 01/26/18 at 11:35 a.m. revealed Resident #1 was wearing the compression stockings. Attempted telephone interview with Resident #2's PCP on 01/26/18 at 11:50 a.m. was unsuccessful. Review of Resident #2's record of the facility's communication with her Primary Care Provider (PCP) revealed: -There was no documentation the PCP was notified of Resident #2 edema in the feet and lower extremities or complaints of pain dated for January 2018. -There was no documentation the PCP was notified Resident #2 had not been wearing her compression stockings. Observation on 01/26/18 at 5:05 p.m. revealed the Administrator looked through Resident #2's record and did not find any documentation of Resident #2's PCP being notified of her not wearing the hose due to swelling on any date in 2018. Interview with the Administrator on 01/26/18 at 5:05 p.m. revealed: -There was a concern about Resident #2's TED hose not being put on in late summer or early fall (2017). -The facility's Licensed Health Professional Support (LHPS) nurse recommended the[named brand] hose which is when the SCUC contacted the PCP to change the order. 2. Review of Resident #11's current FL-2 dated 08/28/17 revealed: -Diagnoses included Alzheimer's dementia, adult	D 273		

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failure to thrive, persistent mood disorder, dementia with behavioral disturbances, anorexia, hypertension, osteoarthritis, and constipation.
-There was an order for Dorzolamide HCL 2%, instill 1 drop in the right eye twice a day. (Dorzolamide is used to treat glaucoma.)
-There was an order for Lumigan 0.01%, instill 1 drop in each eye at bedtime. (Lumigan is used to treat glaucoma.)

Review of refill authorization reports for Resident #11 revealed:
-There was a refill request from faxed from the pharmacy to the primary eye doctor on 01/23/18 because there were no refills remaining on either prescription.
-The primary eye doctor's office did not authorize any refills and noted they had not seen the resident since 2014.

Observation of Resident #11's medications on hand on 01/26/18 at 9:25 a.m. revealed:
-There was a 10ml bottle of Dorzolamide 2% eye drops that was dispensed on 09/08/17 and was still half full.
-There was a 2.5ml bottle of Lumigan 0.01% eye drops that was dispensed on 09/08/17 and felt empty when shaken.

Interview with the medication aide (MA) on 01/26/18 at 9:25 a.m. revealed:
-The resident refused eye drops at times.
-If the eye drops were refused, it would be documented as refused on the medication administration records (MARs).
-There were no other supplies of these eye drops on hand for the resident.
-She would contact the pharmacy to order more Lumigan eye drops.

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D 273	Continued From page 28 Review of Resident #11's September 2017 - January 2018 MARs revealed: -There was an entry for Dorzolamide 2%, place 1 drop in the right eye twice daily and it was documented as administered at 7:00 a.m. and 7:00 p.m. from 09/01/17 - 01/24/18. -There was an entry for Lumigan 0.01%, place 1 drop in each eye once daily at bedtime and it was documented as administered at 7:00 p.m. from 09/01/17 - 01/23/18. Interview with the Director of Resident Services (DRS) on 01/26/18 at 11:12 a.m. revealed: -She had seen the note on the refill request forms but she had not had a chance to follow up about the eye drops. -At one time, Resident #11 was going to a primary eye doctor in another town. -She could not recall when the resident last went to the primary eye doctor but it had been "years." -She was not sure why the resident had not seen the primary eye doctor unless it was because she was receiving hospice services. -She was not aware the resident was out of Lumigan eye drops. -She would either have to check with the primary care provider or schedule an appointment with the eye doctor to get refills on the eye drops. Interview with the Transporter on 01/26/18 at 11:14 a.m. revealed: -When Resident #11 was put on hospice services, she stopped going to the eye doctor because at that time the resident was not physically able to go. -The resident had improved over time and was able to go currently. -Resident #11 saw an eye specialist (could not recall when) and had surgery on one eye to decrease the pressure in her eye.	D 273		

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-The resident refused to go back and have a second procedure done.
-She did not recall if there was any documentation regarding the eye procedures in the resident's record.

Review of Resident #11's progress notes revealed:
-The resident was seen by the primary eye doctor on 08/19/13 for a follow up on the resident's glaucoma and the eye pressure was under good control.
-The resident was to follow up in 2 weeks.
-There were no other progress notes in the record about eye care for the resident after 08/19/13.

Review of a pharmacy refill report for Resident #11 dated 09/01/17 - 01/26/18 revealed:
-The Dorzolamide and Lumigan eye drops had only been dispensed one other time since the supplies on hand that were dispensed on 09/08/17.
-Dorzolamide 10ml was dispensed on 12/26/17 (100 day supply).
-Lumigan 2.5ml was dispensed on 12/26/17 (25 day supply).
-Both of those supplies were delivered to the facility on 12/28/17.

Observation of medications on hand and review of pharmacy dispensing records for Resident #11 revealed:
-The supply of Dorzolamide dispensed on 09/08/17 was a 100 day supply and would have been used by around 12/16/17 but the bottle was still half full.
-The supply of Dorzolamide dispensed on 12/26/17 and delivered on 12/28/17 was a 100 day supply if used as ordered should have about

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a 70 day supply but none was on hand.
-The Lumigan dispensed on 09/08/17 was a 25 day supply and would have lasted until about 10/02/17 but the bottle was empty.
-The Lumigan dispensed on 12/26/17 and delivered on 12/28/17 and would have lasted until about 01/21/18 and none was on hand.
-There was only a 50 day supply of Lumigan dispensed for 131 day time frame.

Attempted telephone interview with Resident #11's primary eye doctor on 01/26/18 at 1:50 p.m. was unsuccessful.

Telephone interview with a nurse at the eye specialist's office for Resident #11 on 01/26/18 at 1:54 p.m. revealed:
-The resident had not been seen in their office since 2014.
-The resident was released from their services in 2014 and was supposed to follow up with the primary eye doctor.

Attempted telephone interview with Resident #11's hospice provider on 01/26/18 at 4:55 p.m. was unsuccessful.

Interview with Resident #11 on 01/26/18 at 12:14 p.m. revealed:
-She could not see very well.
-She could see shapes and her vision was "just dim".
-She used to go to an eye doctor in another town but it had "been so long" since she had seen the eye doctor.
-"It has been a good while."
-She used to get eye drops in her eyes but she did not get them anymore.
-She could not recall how long it had been since she last got eye drops.

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D 273	Continued From page 31 -Her eyes did not hurt but things she looked at were not clear. Interview with the Administrator on 01/26/18 at 5:50 p.m. revealed: -She had spoken with the hospice provider today on 01/26/18 and the resident should be able to go to an eye care provider. -They had made an appointment for Resident #11 to see a local eye doctor. Interview with the DRS on 01/26/18 at 12:03 p.m. revealed they made an appointment for Resident #11 to be seen by a local eye doctor on 01/29/18 at 11:30 a.m. _____ The facility failed to assure Resident #2, who had diagnoses including Alzheimer's, chronic lymphedema, and diabetes wore compression stockings as ordered and failed to notify the PCP that the compression stockings did not fit the resident and were not worn due to swelling, which resulted in the resident complaining of pain; and the facility failed to assure Resident #11 who had glaucoma and poor vision had follow-up care with a primary eye doctor to monitor the resident's eye pressure and eye medications, resulting in the resident missing doses and running out of glaucoma eye drops. This failure was detrimental to the health and welfare of the residents which constitutes a Type B Violation. _____ Review of the Plan of Protection submitted by the facility on 01/26/18 revealed: -Treatments required to be completed will be documented and checked with staff initials by Supervisors, with RCC and SCUC checking behind randomly residents who have special treatments such as TED hose, ..., bunny boots, and dressings to assure completed.	D 273		

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D 273	Continued From page 32 -Tape will be used to document initials, time, and date on any appliance. -A checklist would be created to document findings and submitted to consulting RN for further follow up or further assessment. -Any further medical requirements needed as decided by RN will be reported to the PCP. -Pharmacy has been contacted to submit a report to the facility indicating medications that have not been ordered in the last 30 days. This report will be used by the RCC and SCUC to double check ordering is completed on third shift. -MARs and TARs are checked randomly for documentation. -Any problems, refusals, or non-compliance of use will be reported to the PCP for any further orders or changes. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2018.	D 273		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure three snacks were served or made available for residents on the Special Care Unit three times daily; failed to	D 298		

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assure appropriate snacks were served for 3 of 5 sampled residents with orders for no concentrated sweets diets (#9, #10, #18); and failed to assure snacks were shown on the menu as snacks.

The findings are:

1. Interview with the Dietary Manger (DM) on 01/24/18 at 9:10 a.m. revealed:
-The facility was on the cycle menu for week one.
-He thought the facility's menus contained snack menus; "let me look at this book."

Observation on 01/24/18 at 9:01 a.m. revealed the DM was looking through a binder of menus and did not find a snack menu.

Review of the "Fall/Winter" Week one cycle menus approved by a Registered Dietician (RD) revealed:
-The menu for week one, days 1-7 contained detailed menus with portion sizes for breakfast, lunch, and dinner.
-There was documentation on each day (1-7) of the week one cycle menu which read "snack of the day."

Interview with the Administrator on 01/24/18 at 5:30 p.m. revealed she would check to see if the facility had snack menus.

A second interview with the DM on 01/25/18 at 9:45 a.m. revealed the current menus were "new"; he would look again for snack menus and provide a copy, if found.

Interview with the Administrator on 01/26/18 at 1:20 p.m. revealed:
-She had contacted the menu provider and

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D 298	Continued From page 34 spoken with a dietician. -The menu provider did not usually provide menus for snacks. 2. Interview with the Dietary Manager on 01/24/18 at 9:10 a.m. revealed snacks and beverages were served three times a day to all residents on the Assisted Living (AL) and Special Care Unit (SCU) at 10:00 a.m., 3:00 p.m., and 8:00 p.m. Observation of the 10:00 a.m. snack service on the SCU on 01/24/18 between 10:02 a.m.-10:20 a.m. revealed: -At 10:02 a.m., a Medication Aide (MA) had the snack cart with a variety of snacks and water at the day room; there were 9 residents in the day room. -At 10:08 a.m., there were 12 residents in the day room eating snacks and 2 staff in the day room; none of the residents had a beverage and beverages had not been offered to the residents. -At 10:09 a.m., there was one Personal Care Aide (PCA) in the hallway going room to room filling cups in the rooms with water. -At 10:10 a.m., the PCA went into resident room #52 and filled the water cup; the resident who was in bed in the room was not offered a snack. -At 10:13 a.m., there were 11 residents in the day room; none had a beverage. -At 10:15 a.m., the PCA went to resident room #49 and filled the resident's water; the resident was offered a choice of snack from the snack tray, but not offered water. -At 10:18 a.m., there were 11 residents in the day room; 11 of 11 residents did not have a beverage. -At 10:20 a.m., the PCA had the snack cart near a door to the day room; no beverages were offered to the residents. Observation of the 3:00 p.m. snack service on the	D 298		

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SCU on 01/24/18 between 3:10 p.m.-3: p.m. revealed:
-Resident were served a popsicle or light applesauce.
-Staff were observed walking down the hall to each residents' room to offer a snack and refill water cups.
-There were no beverages served.

Confidential staff interviews revealed:
-Some residents like to "sleep in" and did not want to get up for snack; the resident could ask for a snack when they woke up.
-"Sometimes" juice was offered with the SCU snacks, but usually the staff just filled the water in the residents' rooms.
-Snacks were served in the SCU on second shift at 3:00 p.m.; if the resident asked for a snack after 3:00 p.m., staff would give them a snack.
-Residents on the SCU were served juice at supper; residents received water at snack time.
-At the 8:00 p.m. snack on the SCU, the residents were not really given anything to eat; staff were just focused on getting them to drink water before bed.
-"Ice pops" were "sometimes" served at the 8:00 p.m. in SCU because the resident did not like to drink.
-Water was kept filled in the residents' rooms in the SCU; beverages were not necessarily offered with snacks because the water was filled and in the rooms for the residents to drink whenever they wanted it, but sometimes juice was served at snack.

Interview with the Special Care Unit Coordinator (SCUC) on 01/24/18 at 10:25 a.m. revealed:
-Snacks and beverages were supposed to be offered to all residents during snack times.
-The kitchen staff prepared the snacks and staff

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served the snacks.
-If the residents were not in the day room during snack times, staff normally went to their rooms to offer snacks and beverages.
-Beverages were supposed to be served with snacks.
-Beverages offered at snack included water and cranberry juice.

Interview with the Administrator on 01/24/18 at 5:30 p.m. revealed:
-Snacks were served or available for all residents three times daily at 10:00 a.m., 3:00 p.m., and 8:00 p.m.
-The dietary staff prepared the snacks and beverage for snacks.
-In the Assisted Living (AL), snacks were served in AL dining room and residents went down to the dining room for snack.
-In the SCU, the residents were served snacks by staff.
-Residents were supposed to be served beverages with snacks.
-The staff rolled the snack carts down the hall and filled the residents' water cups with water.
-Ice pops were sometimes served at snack to encourage hydration.
-Beverages included cranberry juice, water, and other juices.
-If the third snack (8:00 p.m.) snack was not being served on SCU, it was not because the snacks were not available, it was because staff were not going to the kitchen to get the snacks.
-The 8:00 p.m. snack was usually a variety and there were also high protein snack for overnight, such as a sandwich or peanut butter crackers.
-She expected staff to go get the snacks and beverages out of the kitchen and the snacks and beverages to be served to all residents.
-The refrigerator was accessible for staff on all

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shifts and kept stocked with a variety of beverages.
-The dry storage area was kept unlocked and kept stocked with a variety of snacks.

3. Confidential staff interviews revealed:
-The dietary staff prepared the snacks.
-Staff were concerned that residents who had diabetes did not get diabetic appropriate snacks.
-Staff had mentioned to the dietary staff that there were "often" no snacks on the snack carts for diabetics and were told "that's all we have."
-The Administrator was aware of the types of snacks served and lack of diabetic appropriate snacks.
-Diabetic residents were served sugar free ice cream, cake, and fruit at meals and snacks such as chips, cheese puffs, and marshmallow cereal treats for snack.
-Diabetic residents got cookies for snack that a staff thought were sugar free, but the staff was not sure.
-Staff reported examples of snacks included fig cookies, chocolate marshmallow snack pies, marshmallow cereal treats, chocolate sandwich cookies, ice pops, and potato chips; the staff did not know if diabetics were provided with anything different for snacks other than the regular snacks.

Confidential interview with a resident's family member revealed:
-The resident lived in the SCU, was a diabetic, but was not served snacks appropriate for a diabetic diet.
-Staff knew the resident was a diabetic.

Observation during a kitchen tour on 01/24/18 at 8:57 a.m. revealed:
-There was a snack cart in the kitchen with various single packaged snack food items to

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include: chocolate covered marshmallow snack cakes, marshmallow cereal treats, chocolate nut mix, animal cookies, and cereal snack mix.
-In the pantry area, there were two plastic containers with various packaged snack foods to include: single count fortune cookies, chocolate with vanilla sandwich cookies, chocolate covered marshmallow snack cakes, marshmallow cereal treats, chocolate nut trail mix, animal cookies, and cereal snack mix.
-There were not any sugar free snacks on the snack cart or pantry; there was no variety of diabetic appropriate snacks in the pantry on the snack cart.

Interview with the DM on 01/24/18 at 9:00 a.m. revealed:
-He ordered a "variety" of snack foods each week such as cookies, potato chips, juice, popsicles, and sugar free cookies.
-The facility's food supplier delivered the orders each Thursday.
-The facility was "out" of diabetic and sugar free snacks at that time except for sugar free ice cream.
-The facility had been out of sugar free snacks for one week; diabetic/sugar free snacks were expected to be delivered on Thursday (01/25/18).

Interview with a Dietary staff member on 01/24/18 at 2:42 p.m. revealed:
-She did not know what types of snacks were usually put on the snack carts.
-"Somebody" said to put applesauce on the snack carts today (01/24/18).

Interview with the Administrator on 01/24/18 at 5:30 p.m. revealed:
-The facility served fruit in light syrup or water, sugar free cake, and sugar free icing for

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desserts.
-There was usually a variety of snack foods in stock to include high protein snacks for overnight, such as a sandwich or peanut butter crackers that would be appropriate for diabetics.
-The DM tried to order and keep diabetic appropriate (sugar free) snacks stocked, but it was difficult to get individually wrapped sugar free snacks.
-She was not aware the facility was currently out of sugar free snacks except for sugar free ice cream.
-She did not know if the popsicles (ice pops) were sugar free or not.
-Diabetic residents should be getting appropriate snacks for their diet.

a. Review of Resident #10's current FL-2 dated 12/03/17 revealed:
-Diagnoses included insulin dependent diabetes mellitus, hypertension, lower extremity edema, and dementia with behaviors.
-The resident was intermittently disoriented.
-There was an order for a no concentrated sweets (NCS) diet.

Review of a subsequent diet order dated 01/03/18 for Resident #10 revealed an order for a diabetic diet.

Observation of Resident #10 during the 10:00 a.m. snack service on 01/25/18 revealed:
-The resident was in the day room of the SCU.
-At 10:12 a.m., the resident was eating a [brand name] chocolate marshmallow snack pie, which she had already half eaten.
-At 10:17 a.m., Resident #10 had eaten the entire chocolate covered marshmallow snack pie.

Review of the nutritional information label on the

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marshmallow snack pie revealed:
-The serving size was documented a one pie.
-There were 20 grams of sugar and 40 grams of carbohydrates in the snack pie.

Observation of the 3:00 p.m. snack service on the SCU on 01/24/18 from 3:10 p.m.-3:16 p.m. revealed:
-Residents were served a popsicle or light applesauce.
-At 3:12 p.m., staff offered Resident #10 a popsicle; the resident shook her head left to right to indicate 'no' to refuse the popsicle.

Review of Resident #10's blood sugar results revealed:
-Resident #10's blood sugar at 11:15 a.m. on 01/24/18 (after she ate the snack pie) was 151.
-Resident #10's 7:15 a.m. blood sugars from 01/01/18-01/24/18 ranged from 94-359.
-Resident #10's 11:15 a.m. blood sugars from 01/01/18-01/24/18 ranged from 74-269.
-Resident #10's 5:15 p.m. blood sugars from 01/01/18-01/24/18 ranged from 96-419.

Based on observations, interviews and record reviews, Resident #10 was not interviewable.

Interview with Resident #10's family member on 01/25/18 at 1:00 p.m. revealed:
-Resident was a diabetic and was on a diabetic diet.
-"A lot of times" staff said the resident's blood sugars were "high."

Interview with the Special Care Unit Coordinator (SCUC) on 01/24/18 at 10:25 a.m. revealed Resident #10's blood sugars ran high after she had a "sugary snack."

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Attempted telephone interview with Resident #10's Primary Care Provider (PCP) on 01/25/18 at 9:12 a.m. and 01/26/18 at 9:40 a.m. was unsuccessful and messages were not returned prior to survey exit.

b. Review of Resident #18's current FL-2 dated 11/06/17 revealed:
-Diagnoses included hypertension, hypothyroidism, chronic lower extremity edema, diabetes mellitus, and hyperlipidemia.
-There was an order for a no concentrated sweets (NCS) and no added salt diet.

Interview with Resident #18 on 01/23/18 at 9:45 a.m. revealed:
-She was a diabetic.
-Some days she "went to bed hungry because there were no diabetic snacks on the tray."
-Snacks were offered daily at 10:00 a.m., 3:00 p.m. and 8:00 p.m.
-The snacks that were offered had a lot of sugar in them.
-Snacks that were offered included cookies, cereal bars, and chocolate covered marshmallow snack cakes.
-There were no diabetic snacks offered.

Interview with the Dietary Manager (DM) on 01/24/18 at 10:00 a.m. revealed:
-The snacks were put on the AL dining room table for the AL residents to "get what they want".
-Snacks were taken to the residents who were not able to come to the dining room.
-There were no diabetic snacks available at that time (01/24/18).

Observation of the morning snack on 01/24/18 at 10:10 a.m. revealed:
-Cookies, chocolate covered marshmallow snack

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cakes, nut and chocolate snack mix and cereal snack mix were offered as a snack.
-The residents came in and picked up a snack off the tray.
-Resident #18 chose the nut and chocolate snack mix for a snack.

Observation of the nutritional label on the chocolate snack mix Resident #18 chose for snack revealed:
-The serving size per bag was documented as 2.
-The amount of calories per serving was documented as 130, the total number of carbohydrates per serving was documented as 12 grams, and the total amount of sugar per serving was documented as 9 grams.

c. Review of Resident #9's current FL-2 dated 02/21/17 revealed:
-Diagnoses included diabetes, hypertension, and chronic kidney disease stage 1.
-The resident was on a No Concentrated Sweets (NCS) diet.

Interview with Resident #9 on 01/24/18 at 10:07 a.m. revealed:
-She did not usually get a morning snack.
-She only got snacks in the afternoon at 3:00 p.m.
-Typically she was given cereal and marshmallow snack bars or sandwich cookies.
-She did not get a drink with her snack.

Observation of a PCA in the hallway on 01/24/18 at 10:13 a.m. revealed the PCA carried a cereal and marshmallow snack bar into Resident #9's room.

Observation of Resident #9 on 01/24/18 at 10:15 a.m. revealed:
-She had eaten over half of the cereal and

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D 298	Continued From page 43 marshmallow snack bar. -She was not sure what her blood sugar reading was that morning or the evening before. Review of the cereal and marshmallow treat bar nutritional information revealed there were 8 grams of sugar, 17 grams of carbohydrates, and 90 calories in the bar. Review of Resident #9's blood sugars on 01/24/18 at 2:50 p.m. revealed: -Resident #9's blood sugar at 11:00 a.m. on 01/24/18 was 396 after having the marshmallow snack bar. -Resident #9's 7:00 a.m. blood sugars for the month of January ranged from 106-270. -Resident #9's 11:00 a.m. blood sugars for the month of January ranged from 127-251. -Resident #9's 5:00 p.m. blood sugars for the month of January ranged from 133-272. Interview with the Dietary Manager (DM) on 01/24/18 at 10:00 a.m. revealed: -The snacks were put on the dining room table for the AL residents to "get what they want." -There were no diabetic snacks available at that time.	D 298		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 44 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to communicate with 2 of 2 sampled residents (#3, #5) who only spoke Spanish, resulting in the residents reporting feeling lonely, sad, and becoming agitated when unable to communicate their needs to staff due to the language barrier. The findings are: 1. Review of Resident #5's FL-2 dated 08/22/17 revealed: -Diagnoses include: dementia, epilepsy, seizure disorder, osteoporosis, unspecified psychosis, hypertension, hyperlipidemia, and unspecified schizophrenia -Resident #5 was intermittently disoriented. -Resident #5 was incontinent of bladder. Review of Resident #5's pre-screening assessment for the special care unit (SCU) revealed: -There was no date on the pre-screening assessment. -The staff at the facility communicated with Resident #5 by using gestures. -Resident #5 was unable to communicate with staff, because she spoke little English and "spoke a different language." Review of Resident #5's care plan dated 10/16/17 revealed: -Resident #5 spoke Spanish. -Resident #5 used gestures to communicate with staff. Confidential staff interview revealed:	D 338		

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-Resident #5 did not speak English; she only spoke Spanish.
-None of the staff spoke Spanish.
-Staff were not able to communicate with Resident #5; the resident would get "agitated" because staff did not understand her.
-"We don't know what she needs."
-The Administrator was aware Resident #5 only spoke Spanish.
-Staff were "concerned" about not being able to understand what she needed but "afraid" to discuss their concerns with the Administrator.

Review of an appointment note, received from Resident #5's Primary Care Provider (PCP) revealed:
-Resident #5 had a follow up appointment with her PCP on 10/19/17.
-Resident #5 was agitated.
-Resident #5 reported to the staff at the PCP's office that she was upset with the staff at the facility because "she has had the same clothes on for two days, her socks are dirty and the food they give her is nasty and she is lonely because there is no one to translate for her."
-Resident #5 presented with an odor of urine.

Interview on 01/16/18 at 10:00 a.m. with a Medical Assistant (MOA) at Resident #6's PCP office who wrote the note on 10/19/17 revealed:
-Resident #6 was combative because staff could not understand her.
-Resident #6 wanted to go home with the MOA because they could communicate with each other in Spanish.

Interview with the former Special Care Unit Coordinator (SCUC) on 11/02/17 at 2:15 p.m. revealed:
-Resident #5 was combative with staff.

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D 338	Continued From page 46 -It was hard to communicate with Resident #5, because she spoke little English. Telephone interview with Resident #5's family member on 11/16/17 at 2:37 p.m. revealed: -Resident #5 had a long history of mental illness. -Resident #5 never wanted to learn to speak English. -If Resident #5 was not taking her medications, she would not bathe or sleep. -The facility staff often called the family member to translate for Resident #5 over the phone. -Resident #5's family member was not present when Resident #5 was admitted to the facility or admitted to the SCU. Interview with the Director of Resident Services (DRS) on 11/21/17 at 11:52 a.m. and 12/29/17 at 11:20 a.m. revealed: -Resident #5 could understand some English but could not speak or write English. -Resident #5 could say a few words in English like banana. -Resident #5 was moved to the SCU on 08/21/17 because of being in an out of other residents' room. Observation on 12/14/17 at 10:45 a.m. revealed: -Two Personal Care Aides (PCA), a Medication aide (MA) and the kitchen manager were trying to communicate with Resident #5. -Resident #5 ambulated up the SCU hall. -The staff could not verbally communicate with Resident #5. -The staff was using hand gestures to try and communicate with Resident #5. -The staff stated another resident, on the SCU was translating for them, but the other resident had gotten a phone call.	D 338		

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D 338	Continued From page 47 Interview with a PCA on 12/14/17 at 11:15 a.m. revealed: -Resident #5 spoke mostly Spanish, but she could say a few words in English. -No one in the facility could translate Spanish. -The staff could not communicate with Resident #5. -The staff did not know when Resident #5 was hurting. -The past couple of days Resident #5 had been fighting staff and resisting care. Observation on 12/24/17 at 11:29 a.m. revealed another resident who spoke Spanish and English came up the hall, the PCA stated "here's our translator now". Interview with the current SCUC on 12/19/17 at 10:50 a.m. revealed: -The SCUC could not communicate with Resident #5. -Two other [Spanish speaking] SCU residents would let staff know what Resident #5 was saying. -The SCUC was not sure if what the other residents translated was accurate or not. -The SCUC addressed the communication issue with the Administrator before she became the SCUC on 12/01/17. -The SCUC was not sure who said to use residents (Spanish speaking) on the SCU to translate for Resident #5. -The SCUC was not aware of any interventions put in place to communicate with Resident #5 other than the Spanish/English phrase medical print out. Interview with Resident #5 with the help of the Department of Social Services (DSS) translator on 12/29/17 at 10:00 a.m. revealed:	D 338		

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D 338	Continued From page 48 -Resident #5 spoke a little English. -Resident #5 had no one to talk to. -Resident #5 communicated with staff by using gestures. Interview with a Supervisor on 12/29/17 at 10:30 a.m. revealed: -The supervisor could not understand Resident #5 because of the language barrier. -The supervisor paid attention to Resident #5's body cues to determine Resident #5's needs. Interview with another resident (who also resided in the SCU) who translated for the staff on the SCU, (with the DSS translator) on 12/19/17 at 12:00 p.m. revealed: -The resident was asked to translate by all the staff at the facility including the Administrator. -The resident translated to the other residents on a daily basis. -The resident felt there should be someone on duty that spoke Spanish to translate for staff and residents. Interview with the Administrator on 12/19/17 at 2:30 p.m. revealed: -Resident #5 would sometimes speak English. -Resident #5's family member was sometimes called to translate for the facility. -There was a staff member on 2nd shift who spoke some Spanish, but not much. -There were three residents (two of the residents were on the SCU) who communicated with Resident #5 and translated what Resident #5 was saying to the staff. -The Administrator was "ok" with the residents translating for staff and residents. -The three residents had been translating for the staff since Resident #5 was admitted to the facility on 04/24/17.	D 338		

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D 338	Continued From page 49 -She was not sure if what the residents translated to the staff was accurate. -She ordered a medical English/Spanish book so the staff could communicate with Resident #5. -The book was given to the former SCUC. -The book was in the SCU office, and was accessible to all the staff. -The Administrator acknowledged it was a difficult situation, trying to communicate with Resident #5. 2. Review of Resident #3's FL-2 dated 08/29/17 revealed diagnoses included Alzheimer's dementia with behavioral disturbance, diabetes mellitus type 2 with diabetic neuropathy, right shoulder pain, history of falls, osteoarthritis, hiatal hernia, and peripheral vascular disease. Review of Resident #3's pre-screening assessment for the special care unit (SCU) revealed: -The resident was unable to communicate because she spoke mainly Spanish. -The staff at the facility communicated with Resident #3 by using body gestures. -Resident #3 was bladder and bowel incontinent. -Resident #3 required assistance with bathing, oral care, dressing, and hair care. -Resident #3 needed encouragement at times for eating. Review of Resident #3's care plan dated 09/8/17 revealed: -Resident #3 spoke only Spanish. -Resident #3 was sometimes disoriented and forgetful, and needed reminders. -Resident #3 was agitated with staff at times. -Resident #3 required extensive assistance with toileting and bathing, and limited assistance with ambulation, dressing, grooming and personal hygiene.	D 338		

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D 338	Continued From page 50 Review of an updated care plan for Resident #3 dated 09/20/17 revealed: -Resident #3 could communicate with family, but could not communicate with staff because she spoke only Spanish. -The staff used body gestures to try and communicate with Resident #3. -Resident #3 wandered in and out of other residents' rooms. Observation on 01/25/18 at 10:00 a.m. revealed: -Resident #3 was walking in the hallway and a Personal Care Assistant (PCA) told her "let's go to the dining room for a snack". -Resident #3 looked at the PCA but did not respond. -The PCA held Resident #3's hand and walked her to the dining room. -The Administrator was at the dining room door and said "Buenos dias" to Resident #3 and Resident #3 said "Buenos dias". -There was no other verbal communication between Resident #3 and the Administrator. -Resident #3 sat at a table and talked with another resident who spoke Spanish. -The PCA gave Resident #3 an applesauce and water but did not speak to Resident #3. -Resident #3 spoke several Spanish words to the PCA after she received her applesauce, and the PCA looked at her but did not respond. -There was no other verbal communication by any staff with Resident #3. Observation on 01/25/18 between 11:20 a.m. and 11:50 a.m. revealed: -At 11:20 a.m. Resident #3 was seated on the sofa in the day room of the SCU conversing in Spanish with another resident. -Resident #3 smiled and laughed when the other	D 338		

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OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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resident spoke to her.
-A PCA had come into the day room and said "time for lunch" and then motioned with her hands for Resident #3 to go to the dining room.
-Resident #3 responded to the PCA loudly using Spanish phrases.
-The PCA said "I'm just going to do what I normally do and leave her here when I can't understand her and see if someone else can help her", and then she left the room.
-At 11:28 a.m. two other PCAs entered the day room and tried to get Resident #3 to go to the dining room by speaking English and using hand motions.
-Resident #3 was speaking to the staff loudly using Spanish phrases and pointing to her stomach.
-One PCA said "This happens every day; we don't have a clue what she's trying to tell us".
-Another PCA tried to hold Resident #3's hand, but Resident #3 shouted a phrase in Spanish and pulled her hand back and continued to sit on the sofa.
-At 11:35 a.m. the housekeeper and another PCA entered the day room and spoke to Resident #3 in English asking her to go to the dining room.
-Resident #3 was pointing to her stomach and speaking in Spanish.
-The housekeeper said "She knew a few Spanish words but cannot understand what she (Resident 3) is saying".
-At 11:45 a.m. all SCU staff left Resident #3 in the day room alone and a Supervisor from the Assisted Living (AL) unit came in to speak to Resident #3.
-Resident #3 was agitated and speaking loudly in Spanish to the Supervisor.
-The Supervisor spoke in English to Resident #3 and told her they would keep her lunch and give it to her later.

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D 338	Continued From page 52 -At 11:50 a.m. all SCU residents were in the dining room eating lunch and Resident #3 was sitting alone in the day room watching TV. Observation on 01/25/18 at 2:40 p.m. revealed: -Resident #3 was seated on the sofa in the day room of the special care unit conversing with a Spanish/English speaking interpreter from the local county department of social services. -The interpreter asked Resident #3 various questions in Spanish after prompts from survey staff. -Resident #3 started to cry at times. Interview with the interpreter on 01/25/18 at 2:40 p.m. revealed: -Resident #3 was confused at times and responded to the questions he asked her in Spanish by repeatedly voicing concerns over a deceased family member. -At one point when Resident #3 was crying, Resident #3 told the interpreter "there are no people here that speak Spanish". -Resident #3 kept saying she was "scared to be here and nobody understands her here." -Resident #3 told the interpreter she was lonely there and wanted to see and call her family members. Observation on 01/25/18 at 3:20 p.m. revealed: -Resident #3 was in her room and a PCA was speaking in English telling the resident that she needed to change her pants because they were soiled with urine. -The PCA pointed at Resident #3's soiled pants and used hand motions to show the resident to remove her pants. -The resident was speaking in Spanish to the PCA, but the PCA continued to speak in English telling the Resident to remove her pants.	D 338		

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D 338	Continued From page 53 -After 6 minutes the resident removed her pants and the PCA put another pair of pants on her. -The resident responded "gracias" to the PCA. Confidential interviews with 8 staff members on first, second and third shifts of the SCU revealed: -Resident #3 did not speak English; she only spoke Spanish. -None of the staff spoke Spanish. -It was hard for staff to communicate with Resident #3; staff did not understand what the resident was saying or understand what the resident wanted and needed. -The staff could not communicate with Resident #3 verbally. -The staff could communicate some with Resident #3 using hand gestures. -The staff had learned one or two words in Spanish from another resident on the SCU that could speak English and Spanish. -"All I know is gracias is thank you, so I can't tell what she is saying." -Resident #3 became "agitated" because staff could not communicate with her or understand her. -Resident #3 exhibited "yelling" and "crying" when she was "agitated." -There was a print out with Spanish phrases previously hanging on the wall in Resident #3's room but it was not very helpful to staff. -Resident #3's family visited almost every day and assisted with translation while visiting. -There was another resident in the Special Care Unit (SCU) who spoke English and Spanish, and would help translate for Resident #3 and the staff. -The staff had not been trained to speak Spanish or told what to do to communicate with Resident #3. -Five staff reported the Administrator was aware Resident #3 only spoke Spanish and staff were	D 338		

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unable to communicate with Resident #3 in order to understand her needs; the Administrator told staff to use a Spanish Medical Conversion sheet that she had given them.
-The staff could not use the Spanish Medical Conversion sheet because they could not pronounce the Spanish words and could not identify them when Resident #3 spoke.
-Staff were "concerned" about not being able to use the conversion sheet, but they were "afraid" to discuss their concerns again with the Administrator.
-"Once a PCA tried to dress her (Resident #3), but the resident kept talking in Spanish and became agitated when the PCA couldn't understand, so she (Resident #3) then poured urine from the bedside toilet on the PCA."
-"I've asked time and time again how do we communicate with her because we do not know if she's hurting or hungry or needs something else."
-The staff could not understand Resident #3, but could tell when the resident was "upset" by the "tone of her voice."
-"It is very frustrating that we do not know what she (Resident #3) is saying."
-Resident #3 would cry; her family member said she was thinking of a deceased family member.
-"She gets in an uproar. I don't understand Spanish at all but the resident's facial expressions and hand gestures help some."
-When it was time to give Resident #3's medications, one staff member waited until the other Spanish speaking SCU resident or family member could translate to Resident #3 that she needed to take her medications.
-The staff used hand gestures (pointing) to tell Resident #3 when it was time to go to bed.

Interview with the Director of Resident Services (DRS) on 01/25/18 at 6:15 p.m. revealed:

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D 338	Continued From page 55 -She found an application (app) on her cell phone that could be used for translating. -"The staff have never used the app before but we may look into using this for translating with the non-English speaking residents." Interview with the Administrator on 01/25/18 at 6:55 p.m. revealed: -She had placed job ads online for bilingual employees. -She had hired a bilingual employee but the employee quit after about one month. -Resident #3's family were in the facility daily in the mornings and at night and they could translate what the resident was saying to staff. Interview with Resident #3's family member on 01/26/18 at 12:00 p.m. revealed: -Resident #3 only spoke Spanish. -There were no staff in the facility who spoke Spanish. -The family visited Resident #3 at least once daily and assisted the staff and resident with the communication, when they were visiting. -Resident #3 could voice her needs such as when she was hungry, wanted to eat, or wanted to something to drink; "she is just confused sometimes." -If staff spoke Spanish, they may still not understand what she needed at times due to her confusion. _____ The facility failed to assure staff communicated with 2 of 2 sampled residents (#3, #5) who only spoke Spanish, resulting in Resident #3 crying, yelling, and reporting feelings of fear because staff did not understand her and Resident #5 reporting being upset with staff because they did not understand her or assist her with personal care tasks due to the language barrier. This	D 338		

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D 338	Continued From page 56 failure was detrimental to the health, welfare, and safety of the residents and constitutes a Type B Violation. Review of the Plan of Protection submitted by the facility on 01/25/18 revealed: -The facility was currently seeking bilingual employees to include MAs, dietary staff, and activity coordinator. This has been advertised -Cell phone apps were being reviewed that will translate English and Spanish.; will continue to review for use. -The facility always has the opportunity to contact residents' family (and does so often) for help with interpretation. -The facility would continue to try to hire bilingual staff and inservice staff on use of apps for "better communication." THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2018.	D 338		
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:	D 358		

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D 358	Continued From page 57 FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 6 residents (#10, #17) observed during the medication passes including errors with insulin and a topical antifungal powder (#10) and errors with a laxative, a corticosteroid inhaler and a Calcium with Vitamin D supplement; and for 3 of 6 residents (#2, #10, #11) sampled including errors with sliding scale insulin and expired insulin for two residents (#2, #10) and errors with eye drops for glaucoma (#11). The findings are: 1. The medication error rate was 20% as evidenced by the observation of 5 errors out of 25 opportunities during the 8:00 a.m. and 3:00 p.m. medication passes on 01/24/18 and the 10:00 a.m. and 11:15 a.m. medication passes on 01/25/18. a. Review of Resident #10's current FL-2 dated 12/03/17 revealed diagnoses included dementia with behaviors, insulin dependent diabetes mellitus, hypertension, urinary incontinence, glaucoma, lower extremity edema, osteoporosis, and hyperlipidemia. Review of a physician's order dated 01/11/18 for Resident #10 revealed Novolog Flexpen insulin was to be administered according to the following	D 358		

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scale: 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; and greater than 400 = 12 units. (Novolog insulin is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection. The Novolog Flexpen should be primed with a 2 unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)

Review of Resident #10's January 2018 medication administration record (MAR) revealed:
-There was an entry to check the resident's blood sugar 3 times a day and administer Novolog Flexpen.
-The entry include the following sliding scale: 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; and greater than 400 = 12 units.
-It was scheduled to be administered at 7:15 a.m., 11:15 a.m., and 5:15 p.m.
-The resident's blood sugar ranged from 74 - 419 from 01/01/18 - 01/25/18.

Interview with a medication aide (MA) on 01/25/18 at 10:34 a.m. revealed the lunch meal was normally served at 11:30 a.m. in the special care unit (SCU) and she usually started her fingerstick blood sugars and administration of insulin to the residents about 10:30 a.m. every day.

Observation of the 11:15 a.m. medication pass on 01/25/18 revealed:
-The resident's blood sugar was 276 at 10:37 a.m.
-The MA administered 6 units of Novolog insulin into Resident #10's right upper arm at 10:41 a.m.
-The MA performed a 1 unit air shot instead of a 2

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D 358	Continued From page 59 unit air shot prior to dialing up and administering the 6 units of insulin with the Novolog Flexpen. Observation on 01/25/18 revealed Resident #11 was served lunch at 11:31 a.m., 50 minutes after being administered Novolog, a rapid-acting insulin. Interview with the MA on 01/25/18 at 11:55 a.m. revealed: -She had training on diabetes but she did not recall if she had specific training on the use of insulin pens. -She had a book at home about insulin pens that she had read. -She usually did a 1 unit air shot with the insulin pens. -She was not aware a 2 unit air shot was required and she was not sure why the air shot needed to be done. -The facility's policy was to administer insulin about 30 minutes before meals. -The meals in the SCU were usually served on time. -She usually gave lunch time insulin around 10:30 a.m. - 11:00 a.m. because it would pop up on the electronic MARs. Interview with the Special Care Unit Coordinator (SCUC) on 01/25/18 at 12:22 p.m. revealed: -The facility's policy was to administer insulin no more than 30 minutes before a meal. -The MAs had been trained on the facility's policy and on how to use the insulin pens. -The MAs were supposed to do a 2 unit air shot when using insulin pens. Interview with the Director of Resident Services (DRS) on 01/25/18 at 12:45 p.m. revealed: -The facility's policy was to administer insulin 15	D 358		

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minutes prior to a meal.
-Resident #10's insulin was scheduled at 11:15 a.m. because the lunch meal was served at 11:30 in the SCU.
-The MAs had been trained on the policy and the use of the insulin pens.
-She thought the last training was done in October or November 2017.
-The MAs knew they were supposed to do a 2 units air shot with the insulin pens.

Interview with the facility's Licensed Health Professional Support (LHPS) nurse on 01/25/18 at 3:20 p.m. revealed:
-She usually did the diabetes training for staff including training on insulin pens.
-She had test insulin pens that were used for demonstration when she trained the MAs.
-The MAs were aware they needed to do a 2 unit air shot with the insulin pens.
-The MAs were trained to administer insulin just before the food was served.
-She had trained the MA who administered insulin to Resident #10 and the MA knew how to administer the insulin correctly.

Attempted telephone interviews with Resident #10's primary care provider (PCP) on 01/25/18 at 9:12 a.m. and 01/26/18 at 9:40 a.m. were unsuccessful and messages were not returned prior to survey exit.

b. Review of a physician's order dated 12/26/17 for Resident #10 revealed an order for Zeasorb-AF 2% powder apply under breasts and to groin area once daily. (Zeasorb-AF is a topical antifungal used to treat fungal infections of the skin.)

Review of Resident #10's January 2018

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medication administration record (MAR) revealed:
-There was an entry for Zeasorb-AF 2% powder apply under breasts and to groin area daily.
-It was scheduled to be administered at 10:00 a.m.

Observation of the 10:00 a.m. medication pass on 01/25/18 revealed:
-The medication aide (MA) applied Zeasorb-AF powder under Resident #10's breasts.
-The MA did not offer or attempt to apply Zeasorb-AF powder to Resident #10's groin area as ordered.

Interview with the MA on 01/25/18 at 11:55 a.m. revealed:
-She did not see that the instructions on the MAR also indicated the Zeasorb-AF powder should be applied to the resident's groin area.
-She overlooked it and had never applied the Zeasorb-AF powder to the resident's groin.
-She only put the powder under the resident's breasts.
-She had not seen the resident's groin area and she did not know if the resident had a rash on the groin area.

Interview with the Special Care Unit Coordinator (SCUC) on 01/25/18 at 12:22 p.m. revealed:
-The MAs had been trained to read and follow the orders on the MARs.
-Zeasorb-AF powder should have been applied to Resident #10's groin area.
-She last saw Resident #10's groin area about a week ago and the skin appeared to be clear at that time.

Interview with the Director of Resident Services (DRS) on 01/25/18 at 12:45 p.m. revealed:
-The MAs had been trained to read the MARs

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and follow the orders.
-The Zeasorb-AF powder should have been applied to Resident #10's groin as ordered.

Observation of Resident #10 on 01/25/18 at 3:28 p.m.. revealed the skin in resident's groin and skin folds of her abdomen was intact, without breakdown or rash.

Attempted telephone interviews with Resident #10's primary care provider (PCP) on 01/25/18 at 9:12 a.m. and 01/26/18 at 9:40 a.m. were unsuccessful and messages were not returned prior to survey exit.

c. Review of Resident #17's current FL-2 dated 04/04/17 revealed diagnoses included chronic obstructive pulmonary disease, sick sinus syndrome, cardiac pacemaker, heart block, atherosclerotic heart disease if coronary artery without angina pectoris, generalized muscle weakness, difficulty walking, age-related physical debility, and allergic rhinitis.

Review of Resident #17's current FL-2 dated 04/04/17 revealed an order for Miralax give 17 grams by mouth once a day. (Miralax is a laxative used to treat and prevent constipation.)

Review of Resident #17's physician's order sheet signed and dated 01/04/18 revealed an order for Miralax 17 grams of powder into 8 ounces of fluid and drink once a day.

Review of Resident #17's January 2018 medication administration record (MAR) revealed:
-There was an entry for Miralax Powder, mix 17 grams of powder into 8 ounces of fluid and drink every day.
-Miralax was scheduled to be administered at

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D 358	Continued From page 63 8:00 a.m. -Miralax was documented as administered from 01/01/18 - 01/23/18. Observation of the 8:00 a.m. medication pass on 01/24/18 revealed: -The medication aide (MA) administered 8 medications to Resident #17 from 8:35 a.m. to 8:37 a.m. -Miralax was not administered to Resident #17 when the resident was administered her other medications scheduled for 8:00 a.m. -There was no Miralax in the medication cart for Resident #17. Interview with the MA on 01/24/18 at 8:39 a.m. revealed: -She could not find any Miralax in the medication cart for Resident #17. -They were supposed to order the Miralax before it ran out. -She would call the pharmacy to reorder the Miralax today, 01/24/18. -The Miralax would be delivered to the facility tonight around 8:00 p.m. A second interview with the MA on 01/24/18 at 10:40 a.m. revealed: -She called the pharmacy to order the Miralax and it would be delivered to the facility tonight. -The MAs were supposed to order medications 3 to 7 days prior to the medication running out. -She used the last of Resident #17's Miralax yesterday, 01/23/18, and thought she had reordered it at that time. -Resident #17 sometimes complained of constipation. Interview with Resident #17 on 01/24/18 at 10:08 a.m. revealed:	D 358		

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OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 358	Continued From page 64 -She did not take any medication for constipation to her knowledge. -She sometimes had problems with constipation. -Her last bowel movement was yesterday and she was not currently having any problems with constipation. Interview with the Director of Resident Services (DRS) on 01/24/18 at 10:48 a.m. revealed: -She was not aware Resident #17 was out of Miralax. -According to the electronic MAR, Miralax had not been reordered today but she would reorder it now. -Most scheduled medications were sent to the facility on a monthly cycle. -Miralax was not usually sent in the cycle fill so the MAs were supposed to order it when there was a little less than half of the bottle remaining. -She was not aware of Resident #17 having any problems with constipation. Telephone interview with a pharmacist at the primary pharmacy on 01/24/18 at 2:44 p.m. revealed: -There was one 527gm bottle of Miralax dispensed for Resident #17 on 09/20/17, which was a 30 day supply. -Miralax was not reordered again until 01/24/18. Review of Resident #17's September 2017 - January 2018 MARs revealed: -Miralax was documented as administered daily from 09/01/17 - 11/16/17. -The resident was noted to be in the hospital from 11/17/17 - 11/23/17 and refused the Miralax on 11/24/17. -Miralax was documented as administered daily from 11/25/17 - 01/23/18.	D 358		

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D 358	Continued From page 65 Interview with the DRS on 01/24/18 at 3:00 p.m. revealed: -She was not aware only one 30 day supply of Miralax had been ordered for Resident #17 since 09/20/17 until today, 01/24/18. -Staff should not document a medication was administered if there was none available to administer. d. Review of Resident #17's current FL-2 dated 04/04/17 revealed an order for Calcium Carbonate 600mg / Vitamin D 200 units, take 1 capsule by mouth once a day. (Calcium / Vitamin D is used to treat and prevent osteoporosis.) Review of Resident #17's physician's order sheet dated 01/04/18 revealed: -There was an order for Calcium 600 + D tablet, take 1 tablet once a day. -The order did not specify the strength of Vitamin D. Review of Resident #17's physician's orders revealed no documentation the physician was contacted to clarify the Calcium + D order. Review of Resident #17's January 2018 medication administration record (MAR) revealed: -There was an entry for Calcium 600 + D tablet take 1 tablet once a day and it was scheduled to be administered at 8:00 a.m. -There was no strength of the Vitamin D content listed on the MAR. Observation of the 8:00 a.m. medication pass on 01/24/18 revealed: -The medication aide (MA) administered one Calcium 600 + D tablet to Resident #17 at 8:35 a.m. -The label on the medication bubble card did not	D 358		

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D 358	Continued From page 66 specify the strength of Vitamin D in each tablet. Interview with the Director of Resident Services (DRS) on 01/24/18 at 12:52 p.m. revealed: -She was not aware the strength of Vitamin D was not listed on the MAR or medication label for Resident #17's Calcium tablet. -The MAs were supposed to make sure physician's orders were complete including the strength of medication and if not, they should get clarification. -She would contact the physician to clarify the Calcium 600 + Vitamin D order. Telephone interview with a pharmacist with the facility's primary pharmacy on 01/24/18 at 2:44 p.m. revealed: -They recently started servicing the facility and used physician's order sheets from July 2017 for the resident's medication orders which included Calcium 600mg + Vitamin D. -They used the Calcium with Vitamin D product that the pharmacy kept in stock which had 600mg of Calcium and 800 units of Vitamin D. -They did not have an order that indicated the resident was supposed to get 200 units of Vitamin D. -She just checked their vendor supply information and they did not stock a combination product for Calcium 600mg and Vitamin D 200 units for the pharmacy to order. -They could order a combination product with Calcium 600mg and Vitamin D 400 units. -A clarification order from the physician was needed. Interview with the DRS on 01/26/18 at 1:42 p.m. revealed she had not heard back from Resident #17's physician about the clarification for the Calcium 600mg + D and the physician's office	D 358		

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D 358	Continued From page 67 was closed today (on Fridays). e. Review of a physician's order dated 01/04/18 for Resident #17 revealed an order for Breo Ellipta 100-25mcg inhaler, use 1 inhalation by mouth once a day, rinse mouth after each use. (Breo Ellipta is a combination inhaler that contains a corticosteroid and is used for chronic obstructive pulmonary disease. According to the manufacturer, the mouth should be rinsed with water without swallowing after each use of Breo to help reduce the risk of fungal infection of the mouth.) Review of Resident #17's January 2018 medication administration record (MAR) revealed: -There was an entry for Breo Ellipta 100-25mcg inhaler, use 1 inhalation by mouth once a day. Rinse mouth after each use. -Breo Ellipta was scheduled to be administered at 8:00 a.m. Observation of the 8:00 a.m. medication pass on 01/24/18 revealed: -The medication aide (MA) administered 1 inhalation of Breo Ellipta inhaler to Resident #17 at 8:36 a.m. -The MA did not have the resident to rinse her mouth after the use of the inhaler as ordered. Interview with the MA on 01/24/18 at 10:40 a.m. revealed: -The resident sometimes rinsed her mouth out after the use of the inhaler. -She forgot to have the resident rinse her mouth out after using the inhaler that morning, 01/24/18. Interview with the Director of Resident Services (DRS) on 01/24/18 at 10:48 a.m. revealed: -The MAs had been trained on administering	D 358		

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inhalers.
-The MA should have given water to Resident #17 to rinse her mouth after the use of the Breo Ellipta inhaler.

Interview with Resident #17 on 01/24/18 at 10:08 a.m. revealed:
-The inhaler helped with her breathing problems.
-She did not usually rinse her mouth after using the inhaler.
-She was not aware she needed to rinse her mouth after using the inhaler.
-She denied any irritation or infections in her mouth.

2. Review of Resident #11's current FL-2 dated 08/28/17 revealed:
-Diagnoses included Alzheimer's dementia, adult failure to thrive, persistent mood disorder, dementia with behavioral disturbances, anorexia, hypertension, osteoarthritis, and constipation.
-There was an order for Dorzolamide HCL 2%, instill 1 drop in the right eye twice a day. (Dorzolamide is used to treat glaucoma.)
-There was an order for Lumigan 0.01%, instill 1 drop in each eye at bedtime. (Lumigan is used to treat glaucoma.)

Observation of Resident #11's medications on hand on 01/26/18 at 9:25 a.m. revealed:
-There was a 10ml bottle of Dorzolamide 2% eye drops that was dispensed on 09/08/17 and were still half full.
-There was a 2.5ml bottle of Lumigan 0.01% eye drops that was dispensed on 09/08/17 and felt empty when shaken.

[There are approximately 20 drops in 1ml of eye drop solutions. One 10ml bottle of eye drops would provide approximately 200 doses (at 2

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drops per day would equal 100 day supply. One 2.5ml bottle would provide approximately 50 doses (at 2 drops per day would equal 25 day supply).]

Interview with the medication aide (MA) on 01/26/18 at 9:25 a.m. revealed:
-The resident refused eye drops at times.
-If the eye drops were refused, it would be documented as refused on the MARs.
-There were no other supplies of the eye drops on hand for the resident.
-She would contact the pharmacy to order more Lumigan eye drops.

Review of Resident #11's September 2017 - January 2018 medication administration records (MARs) revealed:
-Dorzolamide 2% was documented as administered twice daily at 7:00 a.m. and 7:00 p.m. for 09/01/17 - 01/24/18.
-Lumigan 0.01% was documented as administered once daily at 7:00 p.m. from 09/01/17 - 01/23/18.

Review of refill authorization reports for Resident #11 revealed:
-There was a refill request form faxed from the pharmacy to the primary eye doctor on 01/23/18 because there were no refills remaining on either prescription.
-The primary eye doctor's office did not authorize any refills and noted they had not seen the resident since 2014.

Interview with the Director of Resident Services (DRS) on 01/26/18 at 11:12 a.m. revealed:
-She had seen the note on the refill request forms but she had not had a chance to follow up about the eye drops.

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D 358	Continued From page 70 -At one time, Resident #11 was going to a primary eye doctor in another town. -She could not recall when the resident last went to the primary eye doctor but it had been "years". -She was not sure why the resident had not seen the primary eye doctor unless it was because she was receiving hospice services. -She was not aware the resident was out of Lumigan eye drops. -She was not aware of the resident refusing any eye drops. -There would not have been enough Lumigan eye drops to last from September 2017 until now. -The MAs should not document they were administering medications if none was available to administer. -She did not know why the supply of Dorzolamide eye drops dispensed in September 2017 were still in the cart and half full. -She would either have to check with the primary care provider or schedule an appointment with the eye doctor to get refills on the eye drops. Interview with the Transporter on 01/26/18 at 11:14 a.m. revealed: -When Resident #11 was put on hospice services, she stopped going to the eye doctor because at that time the resident was not physically able to go. -The resident had improved over time and was able to go currently. -Resident #11 saw an eye specialist (could not recall when) and had surgery on one eye to decrease the pressure in her eye. -The resident refused to go back and have a second procedure done. -She did not recall if there was any documentation regarding the eye procedures in the resident's record.	D 358		

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D 358	Continued From page 71 Review of pharmacy refill report for Resident #11 dated 09/01/17 - 01/26/18 revealed: -The Dorzolamide and Lumigan eye drops had only been dispensed one other time since the supplies on hand that were dispensed on 09/08/17. -Dorzolamide 10ml was dispensed on 12/26/17 (100 day supply). -Lumigan 2.5ml was dispensed on 12/26/17 (25 day supply). -Both of those supplies were delivered to the facility on 12/28/17. Observation of medications on hand and pharmacy dispensing records for Resident #11 revealed: -The supply of Dorzolamide dispensed on 09/08/17 was a 100 day supply and would have been used by around 12/16/17 but the bottle was still half full. -The supply of Dorzolamide dispensed on 12/26/17 and delivered on 12/28/17 was a 100 day supply if used as ordered should have about a 70 day supply but none was on hand. -The Lumigan dispensed on 09/08/17 was a 25 day supply and would have lasted until about 10/02/17 but the bottle was empty. -The Lumigan dispensed on 12/26/17 and delivered on 12/28/17 and would have lasted until about 01/21/18 and none was on hand. -There was only a 50 day supply of Lumigan dispensed for 131 day time frame. Attempted telephone interview with Resident #11's primary eye doctor on 01/26/18 at 1:50 p.m. was unsuccessful. Attempted telephone interview with Resident #11's hospice provider on 01/26/18 at 4:55 p.m. was unsuccessful.	D 358		

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D 358	Continued From page 72 Interview with Resident #11 on 01/26/18 at 12:14 p.m. revealed: -She could not see very well. -She could see shapes and her vision was "just dim". -She used to go to an eye doctor in another town but it had "been so long" since she had seen the eye doctor. -She used to get eye drops in her eyes but she did not get them anymore and she could not recall how long it had been since she last got eye drops. -Her eyes did not hurt but things she looked at were not clear. Interview with the DRS on 01/26/18 at 12:03 p.m. revealed they made an appointment for Resident #11 to be seen by a local eye doctor on 01/29/18 at 11:30 a.m. 3. Review of Resident #10's current FL-2 dated 12/03/17 revealed: -Diagnoses included insulin dependent diabetes mellitus, hypertension, lower extremity edema, and dementia with behaviors. -The resident was intermittently disoriented. a. Review of Resident #10's physician orders revealed: -There were orders dated 07/11/17 for finger stick blood sugars (FSBS) three times a day and Novolog Flexpen sliding scale insulin (SSI) according to the following scale: for FSBS result of 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units. (Novolog is rapid-acting insulin used to lower blood sugar.) -There were subsequent orders on Resident #10's current FL-2 dated 12/03/17 for FSBS three	D 358		

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times a day and Novolog Flexpen sliding scale insulin (SSI) according to the following scale: for FSBS result of 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units.

Review of a "Report of Health Services to Residents" form dated 12/12/17 for Resident #10 revealed:
-Documentation on the form included a request for clarification between two different Novolog Flexpen SSI orders for the resident.
-The two sliding scales in need of clarification were documented as follows: the first Novolog Flexpen SSI documented on the form was for Novolog Flexpen 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units; the second Novolog Flexpen SSI documented on the form was Novolog Flexpen SSI 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; greater than 400 = 12 units.
-There was a check mark documented beside the second Novolog Flexpen SSI order with the scale 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; greater than 400 = 12 units; the clarification was signed by the primary care provider (PCP) and dated 12/26/17.
-The was a fax documentation sheet attached to the "Report of Health Services to Residents" form electronically time stamped/dated as 01/05/18 at 13:53 p.m. documenting the form was faxed to the facility's contracted pharmacy at that time (01/05/18 at 13:53 p.m.).

Review of a copy of an electronic physician's order dated 01/11/18 for Resident #10 revealed an order for Novolog Flexpen SSI according to

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D 358	Continued From page 74 the following scale: for FSBS result of 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units. Review of Resident #10's November 2017 Medication Administration Record (MAR) revealed: -There was a computer generated entry for Novolog Flexpen sliding scale insulin to be administered 3 times a day with administration times of 7:15 a.m., 11:15 a.m., and 5:15 p.m. according to the following scale: for FSBS result of 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units. -Resident #10's FSBS was documented as 246 on 11/04/17 at 7:15 a.m. and would have required 4 units of insulin; 6 units were documented as administered. -Resident #10's FSBS was documented as 449 on 11/13/17 at 11:15 a.m. and would have required 12 units of insulin; 4 units were documented as administered. -Resident #10's FSBS was documented as 367 on 11/20/17 at 5:15 p.m. and would have required 10 units of insulin; 6 units were documented as administered. -Resident #10's FSBS was documented as 400 on 11/25/17 at 11:15 a.m. and would have required 10 units of insulin; 12 units were documented as administered. -Resident #10's FSBS was documented as 261 on 11/26/17 at 5:15 p.m. and would have required 6 units of insulin; 4 units were documented as administered. -Resident #10's FSBS was documented as 261 on 11/30/17 at 5:15 p.m. and would have required 6 units of insulin; 3 units were documented as administered.	D 358		

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D 358	Continued From page 75 Review of Resident #10's December 2017 MAR revealed: -There was a computer generated entry for with Novolog Flexpen SSI to be administered 3 times a day with administration times of 7:15 a.m., 11:15 a.m., and 5:15 p.m. according to the following scale: for FSBS result of 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units. -Resident #10's FSBS was documented as 277 on 12/06/17 at 7:15 a.m. and would have required 6 units of insulin; 4 units were documented as administered. -Resident #10's FSBS was documented as 130 on 12/30/17 at 11:15 a.m. and would have required 0 units of insulin; 2 units were documented as administered. -There was no entry on the MAR for the SSI order clarification dated 12/26/17; there were no SSI administration errors between 12/26/17-12/31/17 related to the SSI order clarification/change. Review of Resident #10's January 2018 MAR revealed: -There were two computer generated entries for Novolog Flexpen SSI to be administered 3 times a day with administration times of 7:15 a.m., 11:15 a.m., and 5:15 p.m. according to the following scale: for FSBS result of 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units. -Resident #10's FSBS was documented as 194 on 01/17/18 at 5:15 p.m. and would have required 2 units of insulin; 4 units were documented as administered. -There was no entry on the MAR for the SSI order change from the order clarification signed by the	D 358		

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D 358	Continued From page 76 PCP and dated 12/26/17, which would have been the most current order from 01/01/18-01/11/18, (when the order was changed back on the electronic order dated 1/11/18); there were no SSI administration errors between 01/01/18-01/11/18. Observations of Resident #10's medications on hand on 01/25/18 at 8:34 a.m. revealed: -There was one open Novolog Flexpen stocked on the medication cart with Resident #10's name on the label; the label did not contain the SSI order or scale. -There were three unopened Novolog Flexpens in a plastic bag in the refrigerator; there was a label on the plastic bag with a dispense date of 12/28/17 and SSI orders as follows: 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units. Interview with a Medication Aide (MA) on 01/25/18 at 8:50 a.m. revealed: -The open insulin pens did not have the SSI order on the label. -She thought the SSI orders were on the full bags of insulin. -When administering SSI, the MAs compared the order/scale in the computer and the resident's blood sugar result to determine the amount of insulin to administer. -The MAs documented the amount of units and the site the medication was administered on the MAR. Based on observations, interviews, and record reviews, Resident #10 was not interviewable. Interview with Resident #10's family member on 01/25/18 at 1:00 p.m. revealed: -Resident #10 was a diabetic and was on insulin.	D 358		

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D 358	Continued From page 77 -As far as the family knew, Resident #10 got her medications on time and as ordered by her PCP. Interview with the Director of Resident Services (DRS) on 01/25/18 at 3:15 p.m. revealed: -She and the SCUC checked the MARs monthly for accuracy, including sliding scale insulin documentation. -They discuss the MARs with the Licensed Health Professional Support (LHPS) nurse to review any problems or concerns with the MARs. -They had found some errors recently with sliding scale insulin and they usually discussed it with the MAs. Interview with the LHPS Registered Nurse (RN) on 01/25/18 at 3:20 p.m. revealed: -They "usually" printed the electronic MARs monthly to review them for accuracy. -She and the DRS and the SCUC usually discussed any concerns with the MARs. -They had recently seen some errors with sliding scale insulin and went over it with the MAs. -They had seen a decrease in the errors with sliding scale insulin over the last couple of months. Attempted telephone interview with Resident #10's primary care provider (PCP) on 01/25/18 at 9:12 a.m. and 01/26/18 at 9:40 a.m. was unsuccessful and messages were not returned prior to survey exit. Interview with the Administrator on 01/25/18 at 4:20 p.m. revealed: -All MAs had been trained on medication and insulin administration and were expected to administer medications as ordered. -The MAs who made the medication errors would be removed from the medication cart and	D 358		

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retrained.
-The facility had implemented procedures such as staff training and having the DRS and a LHPS RN review the residents' MARs to assure medications were administered correctly.

b. Review of Resident #10's current physician's orders for insulin revealed there was an electronic physician's order dated 01/11/18 for Novolog Flexpen SSI according to the following scale: for FSBS result of 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units.

Review of Resident #10's Novolog Flexpens on hand on 01/25/18 at 8:34 a.m. revealed:
-There was one opened Novolog Flexpen stocked on the medication cart; there was no sticker, label, or other documentation on the opened pen to indicate when the pen was first opened.
-There were three unopened Novolog Flexpens in a plastic bag in the refrigerator; there was a pharmacy label on the plastic bag with a dispense date of 12/28/17.
-There were bright yellow colored stickers inside the plastic bag with the unopened pens with directions which read: "Refrigerate until pen opened. After initial use, do NOT refrigerate. Expires 28 days after opening."
-The sticker contained a blank line beside of documentation which read "Expiration date."

Review of the manufacturer's prescribing information and storage directions for Novolog Flexpen revealed:
-Novolog Flexpens should be stored at room temperature after being opened.
-Novolog Flexpens should be discarded 28 days after being opened/stored at room temperature.

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Review of Resident #10's current physician's orders for insulin revealed there was order dated 12/11/17 for Novolog Mix 70/30 Flexpen inject 18 units SQ every morning and 20 units every evening. (Novolog Mix 70/30 Flexpen is a combination of rapid and intermediate acting insulins used to lower blood sugar).

Review of Resident #10's Novolog Mix 70/30 Flexpens on hand on 01/25/18 at 8:34 a.m. revealed:
-There was one opened Novolog Mix 70/30 Flexpen stocked on the medication cart; there was no sticker, label, or other documentation on the opened pen to indicate when the pen was first opened.
-There was a plastic bag in the refrigerator that had one unopened Novolog Mix 70/30 Flexpen in it; there was a pharmacy label on the plastic bag with a dispense date of 10/19/17.
-There was a second plastic bag in the refrigerator with two unopened Novolog Mix 70/30 Flexpens in it; there was a pharmacy label on the plastic bag with a dispense date of 12/17/17.
-There were bright yellow colored stickers inside the plastic bags with the unopened Novolog Mix 70/30 Flexpens pens with directions which read: "Refrigerate until pen opened. After initial use, do NOT refrigerate. Expires 14 days after opening."
-The sticker contained a blank line beside of documentation which read "Expiration date."

Review of the manufacturer's prescribing information and storage directions for Novolog Mix 70/30 Flexpen revealed:
-Novolog Mix 70/30 Flexpens should be stored at room temperature and not refrigerated after being opened.
-The storage conditions for Novolog Mix 70/30 Flexpens included a shelf life of 14 days after

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D 358	Continued From page 80 being opened and stored at room temperature. Interview with a Medication Aide (MA) on 01/25/18 at 11:31 a.m. revealed: -The MAs were supposed to use the stickers to initial and date the insulin pens when they were opened. -She thought the MAs usually followed the expiration date on the stickers to know when to discard any expired insulin. -If the insulin was not dated when it was opened, staff would not know when it expired or when to throw it away. Telephone interview with a Pharmacist at the facility's contracted long-term pharmacy on 01/25/18 at 11:52 a.m. revealed: -The pharmacy sent stickers with insulin pens which contained directions related to storing the insulin and the expiration date of the insulin. -The staff were supposed to use the stickers to document when the insulin pens were opened so they would know the expiration date of the insulin. -Novolog Flexpen expired 28 days after being opened. -Novolog Mix 70/30 Flexpen expired 14 days after being opened. -The "effectiveness" of the insulins could be altered after they were opened, stored outside of the refrigerator, and used after the expiration date. Interview with a second MA on 01/25/18 at 3:16 p.m. revealed: -The MAs were supposed to date the insulin bottles and pens and document their initials when opening insulins. -If there were unlabeled insulins, it was "just laziness" of the MA to not to document the date it was opened	D 358		

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D 358	Continued From page 81 -If she noticed an insulin pen without a date, she discarded it and opened a new pen because she could not tell if the insulin was expired without the date on the sticker. -She reported opened/undated insulins to a Supervisor. Interview with a Supervisor on 01/26/18 at 11:05 a.m. revealed: -The MAs were supposed to initial and date the Insulin pens when they were opened. -Staff would not be able to tell if the insulin was expired if it was not dated when it was opened. -She would check the insulin pens that day (01/26/18) and open new insulin pens for any she found opened and undated. Attempted telephone interview with Resident #10's primary care provider (PCP) on 01/25/18 at 9:12 a.m. and 01/26/18 at 9:40 a.m. was unsuccessful and messages were not returned prior to survey exit. Interview with the Administrator on 01/25/18 at 4:20 p.m. revealed: -The MAs were supposed to initial and date the insulin when it was opened. -The MAs were supposed follow the directions related to the expiration/discard dates for insulins. -She was aware the pharmacy sent stickers with the insulins with expiration directions for insulins. -She expected the MAs to date insulins when opened and to follow the directions related to the discard dates for insulins. -She acknowledged if the insulin was not dated when it was opened, there would not be a way of knowing if the insulin was being used past the expiration date. 4. Review of Resident #2's current FL-2 dated	D 358		

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D 358	Continued From page 82 04/05/17 revealed: -Diagnoses included Alzheimer's disease, Altered mental status, Dementia, Diabetes Mellitus Type 2, Hypertension, Migraines, Vitamin D deficiency, Hypercholesterolemia, Osteoarthritis, Chronic lymphedema, Hiatal hernia. -Resident #2 was intermittently disoriented. a. Review of Resident #2's physician's orders revealed there was an electronic physician's order dated 11/20/17 for finger stick blood sugars (FSBS) four times daily at 7:15 a.m., 11:15 a.m., 5:15 p.m., and 8:30 p.m. with Novolog Flexpen sliding scale insulin (SSI) according to the following scale: notify medical doctor (MD) if <70; 0-200= 0 units, 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401-999 = call the MD. Review of Resident #2's December 2017 Medication Administration Record (MAR) revealed: -There was a computer-generated entry for Novolog Flexpen SSI according to the following scale: for FSBS result less than 70, notify the MD; 0-200= 0 units, 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401-999 = call the MD. (Novolog Flexpen is a rapid acting insulin used to lower blood sugar). -Resident #2's FSBS was documented as 242 on 12/16/17 at 7:15 a.m. and would have required 4 units of insulin; 6 units were documented as administered. -Resident #2's FSBS was documented as 255 on 12/24/17 at 7:15 a.m. and would have required 6 units of insulin; 4 units were documented as administered. Interview with the Director of Resident Services (DRS) on 01/25/18 at 3:15 p.m. revealed:	D 358		

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-She and the SCUC checked the MARs monthly for accuracy, including sliding scale insulin documentation.
-They discuss the MARs with the Licensed Health Professional Support (LHPS) nurse to review any problems or concerns with the MARs.
-They had found some errors recently with sliding scale insulin and they usually discussed it with the MAs.

Interview with the LHPS Registered Nurse (RN) on 01/25/18 at 3:20 p.m. revealed:
-They "usually" printed the electronic MARs monthly to review them for accuracy.
-She and the DRS and the SCUC usually discussed any concerns with the MARs.
-They had recently seen some errors with sliding scale insulin and went over it with the MAs.
-They had seen a decrease in the errors with sliding scale insulin over the last couple of months.

Attempted telephone interview with Resident #2's guardian on 01/25/18 at 11:22 a.m. was unsuccessful.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 01/26/18 at 11:50 a.m. was unsuccessful.

Interview with the Administrator on 01/25/18 at 4:20 p.m. revealed:
-All MAs had been trained on medication and insulin administration and were expected to administer medications as ordered.
-The MAs who made the medication errors would be removed from the medication cart and retrained.
-The facility had implemented procedures such as staff training and having the DRS and a LHPS

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D 358	Continued From page 84 RN review the residents' MARs to assure medications were administered correctly. b. Review of Resident #2's current physician's orders for insulin revealed: -There was electronic physician's order dated 12/21/17 to inject Toujeo Solostar 45 units SQ daily. (Toujeo is a long acting insulin used to lower blood sugar). -There was an electronic order dated 11/20/17 for Novolog Flexpen sliding scale insulin (SSI) according to the following scale: for FSBS result less than 70, notify the MD; 0-200= 0 units, 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401-999 = call the MD. Review of Resident #2's medications on hand on the medication cart on 01/26/18 at 11:03 a.m. revealed: -There was an opened Novolog Flexpen stocked on the medication cart with Resident #2's name on the label; there was no sticker or other documentation on the pen to indicate when the pen was first opened. -There was an opened Toujeo pen label with Resident #2's name; the pen did not have a sticker or other documentation on the pen to indicate when the pen was first opened. Review of the manufacturer's prescribing information and storage directions for Novolog Flexpen revealed: -Novolog Flexpens should be stored at room temperature after being opened. -Novolog Flexpens should be discarded 28 days after being opened/stored at room temperature. Review of the manufacturer's prescribing information and storage directions for Toujeo	D 358		

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D 358	Continued From page 85 revealed the pen "must be discarded 42 days after being opened." Attempted telephone interview with Resident #2's guardian on 01/25/18 at 11:22 a.m. was unsuccessful. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 01/26/18 at 11:50 a.m. was unsuccessful. Telephone interview with a Pharmacist at the facility's contracted long-term pharmacy on 01/25/18 at 11:52 a.m. revealed: -The pharmacy sent stickers with insulin pens which contained directions related to storing the insulin and the expiration date of the insulin. -The staff were supposed to use the stickers to document when the insulin pens were opened so they would know the expiration date of the insulin. -The "effectiveness" of the insulins could be altered after they were opened, stored outside of the refrigerator, and used after the expiration date. Interview with the Administrator on 01/25/18 at 4:20 p.m. revealed: -The MAs were supposed to initial and date the insulin when it was opened. -The MAs were supposed follow the directions related to the expiration/discard dates for insulins. -She acknowledged if the insulin was not dated when it was opened, there would not be a way of knowing if the insulin was being used past the expiration date. _____ The facility did not administer sliding scale insulin as ordered and did not follow the facility's policy for expired insulin for two diabetics, Resident #2	D 358		

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D 358	Continued From page 86 and Resident #10, resulting in increased risk for high and low blood sugars for the residents. The facility did not administer medications as ordered for 2 of 6 residents observed during medication passes resulting in 20% error rate including Resident #10 whose rapid-acting insulin was administered 50 minutes prior to a meal and Resident #17 whose Miralax was not administered due to being unavailable, only one 30 day supply of Miralax had been dispensed since 09/20/17, and the resident complained of having symptoms of constipation sometimes. The facility failed to administer Resident #11's glaucoma eye drops as ordered due to missed doses and running out of the medication. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ Review of the Plan of Protection submitted by the facility on 01/25/18 revealed: -Two MAs identified with errors will be removed from medication carts; they will repeat the MA training and diabetic/insulin administration training. -At successful completion of the training, the MAs will work with another MA for at least a two week period to ensure they can successfully medications per orders. -A consulting pharmacist would audit the medication passes on 1/30/18. -A consulting pharmacist would complete medication cart audit on 1/30/18. -Administrative staff would "follow" medication passes beginning the evening of 1/25/18 and continue through 2/01/18. -The contracted long term pharmacy would would additional forms for checklist for insulin and insulin pens.	D 358		

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D 358	Continued From page 87 -A schedule would be created to routinely check the medication carts and insulin for expired or missing medications. -MARS and orders would be reviewed at least twice monthly by the SCUC, DRS, and/or LHPS RN. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2018.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 3 of 3 residents sampled (#13, #14, #15) who self-administered medications had physicians' orders to self-administer including a resident with medications in her room for pain/fever, diarrhea, sore throat, heart disease, pain/inflammation,	D 375		

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sleep, cough, mouth sores, and cold sores (#14); a resident with medications in his room for heartburn and cough/congestion (#13); and a resident with a medicated lotion for dry, flaky skin left in unlabeled clear plastic cups on his night stand (#15).

The findings are:

1. Observations on 01/23/18 at 10:20 a.m. and at 4:12 p.m. revealed:
-Resident #14 had several medications in her room on the night stand.
-Resident #14 did not have a roommate.
-There were 3 bottles of Tylenol 500mg and one bottle had an expiration date of 12/2016. (Tylenol is a pain reliever and fever reducer.)
-There was 1 box of Loperamide 2mg tablets and 1 empty box. (Loperamide is used to treat diarrhea.)
-There were 2 boxes of Cepastat Lozenges and 1 box of Chloraseptic Lozenges. (Cepastat and Chloraseptic Lozenges are used for sore throat.)
-There was a bottle of Aspirin 325mg that had an expiration date of 09/2017. (Aspirin is used to help prevent heart disease.)
-There was a bottle of Motrin 200mg tablets that had an expiration date of 08/2003. (Motrin is for pain and inflammation.)
-There was a bottle of Melatonin 5mg tablets. (Melatonin is used for insomnia.)
-There was a bottle of Magic Mouthwash. (Magic Mouthwash is used to treat mouth sores.)
-There was a bottle of Campho Phenique Liquid. (Campho Phenique is used to treat cold sores.)
-There was one jar of Vick's Vaporub. (Vick's Vaporub is a topical cough suppressant.)

Review of Resident #14's current FL-2 dated 08/25/17 revealed the resident's diagnoses

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included type 2 diabetes, hypertension, hypothyroidism, hyperlipidemia, acute chronic diastolic congestive heart failure, obstructive sleep apnea, acute chronic obstructive pulmonary disease, coronary artery disease, history of falls, muscle weakness, difficulty walking, and displaced fracture of olecranon.

Review of Resident #14's current assessment and care plan dated 08/25/17 revealed:
-The resident was oriented and had adequate memory.
-The resident required limited assistance with toileting, bathing, dressing, and transferring.
-The resident was independent with eating, ambulation, and grooming.
-There was no documentation regarding self-administration of medications.

Interviews with Resident #14 on 01/23/18 at 10:20 a.m. and 4:12 p.m. revealed:
-Her medications came from an outside pharmacy.
-Resident #14 took the medications sparingly, she did not take them every day.
-The facility staff was aware the medications were in the room.
-She took Tylenol about once a week when her arthritis flared up.
-She used the sore throat lozenges "once in a while".
-She sometimes had problems with diarrhea and she last took the Loperamide 2 to 3 days ago.
-She did not know the last time she had taken any of the Aspirin or Motrin.
-She had not taken Melatonin in a while because she was not having any current sleep problems.

Review of Resident #14's physician's orders revealed:

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-There were no orders for Tylenol, Loperamide, Cepastat, Chloraseptic, Motrin, Melatonin, Magic Mouthwash, Campho Phenique, or Vick's Vaporub.
-There was an order on the current FL-2 dated 08/25/17 for Aspirin EC 81mg 1 tablet every day.
-There were no orders for the resident to self-administer any of these medications.

Interview with the Director of Resident Services (DRS) on 01/23/18 at 4:55 p.m. revealed:
-Resident #14 did not have orders to self-administer those medications.
-Resident #14 would call an outside pharmacy to order things for her family to bring her.
-Resident #14 had medications in her room in the past but they had been removed because the resident did not have orders to self-administer.
-She could not recall when the medications were removed from the resident's room in the past.
-She was not aware Resident #14 had any medications in her room currently.
-Staff should notify her if they see medications in a resident's room.

Interview with the DRS on 01/25/18 at 12:53 p.m. revealed she had sent a fax to Resident #14's physician to request self-administration orders for some of the resident's medications.

Review of signed self-administration orders dated 01/26/18 for Resident #14 revealed orders for only medications including Tylenol 500mg, Melatonin 5mg, Cepastat Lozenges, and Vaporub.

Refer to interview with the DRS on 01/23/18 at 4:55 p.m.

Refer to the facility's written policy for

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self-administration of medications.

2. Observation on 01/23/18 at 4:37 p.m. revealed:
-Resident #3 had 3 small clear plastic cups of a white substance on his night stand.
-Resident #3 was sitting in a chair beside the night stand.

Interview with Resident #15 on 01/23/18 at 4:37 p.m. revealed:
-The plastic medication cups contained lotion.
-He did not know what kind of lotion was in the plastic medication cups.
-Staff brought the lotion to his room every morning and left for him to put the lotion on.
-He usually put the lotion on his lowers legs and feet himself.
-The lotion sometimes made his skin burn.

Observation of Resident #15's right lower leg and foot revealed the resident's skin was intact, not flaky, and had no redness or irritation.

Review of Resident #15's current FL-2 dated 04/21/17 revealed the resident's diagnoses included history of cerebrovascular accident, hyperlipidemia, history of bilateral pulmonary embolism, and history of deep vein thrombosis.
-There was an order for Ammonium Lactate 12% lotion, apply every day from toes to knees. (Ammonium Lactate lotion is used to treat dry, scaly skin and itching associated with that condition.)
-There was no order for the resident to self-administer any medications, including the Ammonium Lactate 12% lotion.

Review of Resident #15's current assessment and care plan dated 04/19/17 revealed:

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D 375	Continued From page 92 -The resident was oriented and had adequate memory. -The resident required limited assistance with bathing. -The resident was independent with eating, ambulation, toileting, dressing, grooming, and transferring. -There was no documentation regarding self-administration of medications. Interview with a medication aide (MA) on 01/23/18 at 4:45 p.m. revealed: -The only lotion Resident #15 had an order for was Ammonium Lactate 12% lotion and it was scheduled to be administered on first shift. -For any resident with orders for creams or lotions, she would always apply it to the resident. -Resident #15 did not have an order to self-administer to her knowledge. -The lotion should not be left in the resident's room for the resident to apply. Interview with a second MA on 01/26/18 at 9:40 a.m. revealed: -She usually applied the Ammonium Lactate lotion to Resident #15 in the mornings when she worked. -She was not sure if other MAs were applying the lotion. Review of Resident #15's January 2018 medication administration record (MAR) revealed: -There was an entry for Ammonium Lactate 12% lotion, apply every day from toes to knees. -It was scheduled to be applied on first shift between 6:00 a.m. - 2:00 p.m. -Ammonium Lactate 12% lotion was documented as administered from 01/01/18 - 01/23/18. -There was no documentation that the resident was to self-administer the lotion.	D 375		

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D 375	Continued From page 93 Interview with the DRS on 01/23/18 at 4:55 p.m. revealed: -Resident #15 did not have orders to self-administer any medications. -The MAs should apply all creams and lotions to residents unless they had an order to self-administer. -The MAs should not leave the lotion in Resident #15's room to self-administer because the resident would need assistance applying the lotion. Interview with the DRS on 01/25/18 at 12:53 p.m. revealed she had notified the MAs to apply the lotion for Resident #15 and not leave it in the resident's room. Refer to interview with the Director of Resident Services (DRS) on 01/23/18 at 4:55 p.m. Refer to the facility's written policy for self-administration of medications. 3. Observations of Resident #13's room on 01/23/18 at 4:12 p.m. revealed: -There was an almost full bottle of "12 hour cough relief" (Guaifenesin Dextromethorphan) syrup on the night stand. (12 hour cough relief is an over the counter medication used to temporarily treat congestion, loosen mucus in the airways, and suppress coughing). -There was an almost full bottle of "heartburn relief chews" (calcium carbonate chews) on the night stand. (Heartburn Relief Chews are over the counter chews used to treat indigestion and heartburn by lowering the amount of acid in the stomach). Review of Resident #13's current FL-2 dated	D 375		

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04/27/17 revealed:
-Diagnoses included delirium, hypertension, benign prostate hypertrophy (BPH), history of constipation, and gastroesophageal reflux disease (GERD).
-The resident was intermittently disoriented.

Interview with Resident #13 on 01/23/18 at 4:12 p.m.revealed:
-The cough syrup and heartburn relief chews on his night stand belonged to him.
-He administered the cough syrup or heartburn chews to himself; staff did not administer the medications to him.
-He took the cough syrup "sometimes" for "cough"; he did not answer when asked the last time he took the cough syrup.
-He took the heartburn relief chews for "indigestion"; he did not answer questions related to how often he took the chews or the last time he took the chews.
-After answering a few questions, he looked away and said his medications "were not on display."

Review of Resident #13's physician's orders revealed:
-There was an order on his FL-2 dated 04/27/17 for Tussin DM syrup 5ml (milliliters) every 6 hours as needed for cough. (Tussin DM is Guaifenesin Dextromethorphan, which is the same cough syrup found in Resident #13's room).
-There were subsequent orders dated 07/13/17 and 01/02/18 for Tussin DM syrup 5ml (1 teaspoon) every 6 hours as needed for cough.
-There were no physician orders for Heartburn Relief Chews.
-There were no physician orders for Resident #13 to self-administer any medications.

Interviews with the Director of Resident Services

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D 375	Continued From page 95 (DRS) on 01/23/18 at 4:30 p.m. and 4:55 p.m. revealed: -Resident #13 was usually oriented. -She was not aware of any physician orders for him to self-administer his medications. -Resident #13's family may have brought in the medications. Review of Resident #13's current care plan dated 07/17/17 revealed: -The resident was oriented. -Resident #13's memory assessment was documented as "adequate." -There was no documentation related to the resident self-administering any of his medications. Interview with the DRS on 01/25/18 at 12:53 p.m. revealed she had sent a fax to Resident #13's physician to request self-administration orders for the heart burn relief chews and the cough syrup. No further information was received from the facility regarding self-administration orders for Resident #13. Refer to interview with the DRS on 01/23/18 at 4:55 p.m. Refer to the facility's written policy for self-administration of medications. _____ Interview with the Director of Resident Services (DRS) on 01/23/18 at 4:55 p.m. revealed: -Only one resident in the facility had an order to self-administer an inhaler. -No other residents had orders to self-administer any medications. -Staff should notify her if they see medications in	D 375		

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D 375	Continued From page 96 a resident's room. -They should have physician's orders to self-administer medications. Review of the facility's written policy for self-administration of medications revealed: -Resident will be competent and physically able. -It will be ordered in writing by a physician or other legally authorized person to prescribe and kept in the resident's record. -Specific instructions for administration of the medication must be printed on the label. -The physician should be notified if a resident has a change in mental or physical ability or is non-compliant with the physician's orders or facility policies.	D 375		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential	D 482		

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D 482	Continued From page 97 decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were used only after an assessment and care planning process had been completed through a team process and used only with a	D 482		

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D 482	Continued From page 98 written order from a physician for 2 of 4 residents (#11, #20) sampled who had full bilateral bed rails. The findings are: 1. Review of Resident #11's current FL-2 dated 08/28/17 revealed: -Diagnoses included Alzheimer's dementia, adult failure to thrive, persistent mood disorder, dementia with behavioral disturbances, anorexia, hypertension, osteoarthritis, and constipation. -The resident was intermittently disoriented. -The section for restraints was blank. Review of Resident #11's Resident Register revealed the resident was admitted to the facility on 09/10/07. Review of a physical restraint consent form revealed the family signed consent for the use of bed rails on 12/19/14. Review of physician's orders for Resident #11 revealed: -There were restraint orders for bed rails signed and dated by the physician on 12/31/14 and 03/09/15. -The restraint was to be used anytime the resident was left unattended and their safety might be jeopardized. -The resident was unable to be in charge of her well-being due to mental/physical capacity. -There was a history of falls or the resident was a wanderer. -The restraint was to be checked every 30 minutes and released every 2 hours. -There were no restraint orders for the bed rails after 03/09/15.	D 482		

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Review of Resident #11's current resident care plan signed and dated 10/09/17 revealed:
-The resident was oriented to person, time, and place.
-The resident had poor vision.
-The resident required limited and extensive assistance with each task of bathing, grooming, toileting and dressing.
-The resident required limited assistance with ambulation, transferring, and eating.
-The resident was noted to have physical restraint daily but no other details were provided regarding the restraint.

Review of Resident #11's Licensed Health Professional Support (LHPS) review dated 12/21/17 revealed:
-The marked LHPS tasks were ambulation with assistive device, transferring, and physical restraints.
-The resident used a wheelchair for locomotion and was wheeled and transferred by staff.
-The resident required the use of side rails when in her bed to help prevent falls and injury.
-No recent falls were noted.
-The nurse's recommendation was to follow facility/state protocols for residents with physical restraints.

Review of a progress note dated 05/16/17 for Resident #11 revealed:
-The resident was sent to the hospital for a fall with complaint of right hip pain.
-The resident returned to the facility on 05/16/17 with a pelvic fracture.
-No surgery was needed, weight bearing as tolerated.

Observation of Resident #11's room on 01/23/18 at 10:32 a.m. revealed:

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D 482	Continued From page 100 -The resident was sitting in a wheelchair beside her bed. -The resident's bed was pushed against the wall and had bilateral full bed rails. -The bed rail next to the wall was in an up position. -The bed rail on the other side of the bed was in the down position. Interview with Resident #11 on 01/23/18 at 10:32 a.m. revealed: -Both bed rails were sometimes up when she was in bed. -"It's in the way, bothers me more than helps." (Referring to the bed rail on the side of the bed opposite the wall). -Staff had to put the bed rail down and she could not get out of the bed until it was put down. -She did not recall having any falls out of the bed or from the wheel chair. Interview with a personal care aide (PCA) on 01/23/18 at 10:40 a.m. revealed: -Resident #11 could transfer herself from the bed to the wheel chair and toilet herself. -She was not aware of Resident #11 having any recent falls. -Staff kept both bed rails up when the resident was in bed for safety. Interview with a medication aide on 01/26/18 at 1:03 p.m. revealed: -Resident #11 could transfer herself from the bed to the wheelchair. -The resident would get out of bed because she liked to pray on her knees. -The resident could not get up from her knees without assistance from staff. -The resident tried to toilet herself but she was unsteady.	D 482		

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-The resident had no recent falls to her knowledge.
-Staff kept the resident's bed rails up when she was in bed to keep her from rolling out of bed and falling.
-The bed rails were supposed to be up anytime the resident was in bed.
-The resident could not let the bed rails down herself.
-When staff put the bed rails up, the resident would say "I ain't no baby".

Interview with a second PCA on 01/25/18 at 8:35 a.m. revealed:
-Resident #11 could sit up in bed and transfer from the bed to the wheel chair by herself.
-The bed rail beside the wall was always up.
-Staff put the other bed rail up at night but leave it down during the day because the resident liked to get out of bed to pray.

Review of Resident #11's personal care service (PCS) logs for November 2017 - January 2018 revealed:
-There was an entry for hospital bed with rails, check every 30 minutes.
-The checks were scheduled for every 30 minutes.
-The checks were scheduled for each shift, 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m.

Review of a physical restraint assessment and care plan form for Resident #11 dated 12/19/14 revealed:
-Alternatives to restraints being used were bowel and bladder training every 2 hours, snacks 3 times a day, fluids every 2 hours while awake, and activities.
-The medical symptoms for the restraint were

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change in mental status and loss of mobility.
-Sections of the form were left blank including how often the symptoms occurred and the resident's response to the restraints.
-The form was signed by the Director of Resident Services (DRS) and the former Special Care Unit Coordinator (SCUC).
-There was no documentation a Registered Nurse (RN) participated in the assessment and care plan process for the restraints
-The section for the RN Consultant to sign was blank.

Interview with the Director of Resident Services (DRS) on 01/26/18 at 8:30 a.m. revealed:
-Resident #11 could sit up, transfer, and toilet herself.
-She had not updated the restraint order for Resident #11's bed rails since 2015 because she did not think the bed rails were being used anymore.
-The resident got the bed rails when she was first on hospice, then she was discharged from hospice, and recently put back on hospice.
-The resident had no recent falls.
-She had told staff after the resident was discharged from hospice the first time (could not recall date) not to use the bed rails anymore.
-She told staff not to use the bed rails anymore because the resident was trying to go around the bed rails to get out of the bed and that was more dangerous than not using the rails.
-She was not aware staff were still using the bed rails.
-When Resident #11's restraint assessment was done in 2014, the facility did not have a nurse so that was why a nurse did not participate in the assessment.
-She had not noticed the LHPS nurse documented the resident was still using the bed

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	HAL047012	A. BUILDING: _____ B. WING _____	R-C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(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 482	Continued From page 103	D 482		

rails.
-She would get with the facility's LHPS nurse to do a reassessment of the bed rails to determine if they were the least restrictive alternative for the resident.
-She thought it might be safer to use a bed alarm for the resident.

Observations of Resident #11 on 01/26/18 at 1:17 p.m. and 2:17 p.m. revealed the resident was asleep in bed with both bed rails in the up position.

Attempted telephone interview with Resident #11's hospice provider on 01/26/18 at 4:55 p.m. was unsuccessful.

2. Review of Resident's #20 FL-2 dated 07/27/17 revealed:
- Diagnoses included: urinary tract infection, restlessness and agitation, Type 2 diabetes, sepsis, Vitamin D deficiency, mixed hyperlipidemia, Alzheimer's disease and metabolic encephalopathy.
-Resident #20 was constantly disoriented.
-Resident #20 was total care.

Review of Resident #20's addendum to the Resident Register revealed:
-There was no date on the resident register
-Resident #20 required assistance with getting in and out of the bed and with transferring to and from the bed.

Review of Resident #20's care plan dated 08/15/17 revealed the resident required extensive assistance with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene and with transferring.

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D 482	Continued From page 104 Review of the physical restraint assessment dated 08/03/17 revealed: -Resident #20 had Alzheimer's disease that warranted the use of a physical restraint. -Resident #20 was unable to walk, feed himself, and unable to perform any of his activities of daily living (ADLs) Review of a consent form for Physical Restraints use revealed Resident #20's responsible party signed the consent on 08/03/17. Review of Resident #20's physician orders on 12/14/17 revealed there was no physician's order for bed rails. Interview with the Director of Resident Services (DRS) on 12/14/17 at 2:07 pm revealed: -After reviewing Resident #20's record, the DRS could not find a physician's order for bed rails to be used. -The DRS was not sure why the order was not in the record; the order had been faxed over previously to Resident #20's Primary Care Provider (PCP). -The DRS would call Resident #20's PCP to see if the order was still at the PCP's office. Review of Resident #20's physician's orders on 01/26/18 revealed: -There was a physician's order for the use of bed rails signed on 12/18/17. -The bed rails were to be used for Resident #20's safety. -There was no signed physician's order for the use of the bed rails prior to 12/18/17. Interview with a PCA on 01/12/18 at 3:50 p.m. revealed Resident #20 used the bed rails because he tried to get out of the bed without	D 482		

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D 482	Continued From page 105 assistance. Observation of Resident #20 on 01/26/18 at 2:18 p.m. revealed the resident was asleep in bed with both bed rails in the up position.	D 482		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding adult care homes as related to health care, resident rights, and medication administration. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to assure physician notification and follow- up care for 2 of 7 sampled residents (#2, #11) related to failure to use compression stockings due to swelling (#2) and failure to coordinate follow-up care with the primary eye doctor resulting in the resident missing doses and running out of eye drops for glaucoma (#11). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		

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D912	Continued From page 106 2. Based on observations, record reviews, and interviews, the facility failed to communicate with 2 of 2 sampled residents (#3, #5) who only spoke Spanish, resulting in the residents reporting feeling lonely, sad, and becoming agitated when unable to communicate their needs to staff due to the language barrier. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 6 residents (#10, #17) observed during the medication passes including errors with insulin and a topical antifungal powder (#10) and errors with a laxative, a corticosteroid inhaler and a Calcium with Vitamin D supplement; and for 3 of 6 residents (#2, #10, #11) sampled including errors with sliding scale insulin and expired insulin for two residents (#2, #10) and errors with eye drops for glaucoma (#11). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect as related to supervision.	D914		

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D914	Continued From page 107 The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 9 sampled residents (#1, #3, #6) resulting in two residents eloping from the facility without staff knowledge (#1, #6) and the third resident wandering into other residents' rooms (#3). [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914		