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C 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services conducted an annual and follow-up survey from 01/26/18 - 01/28/17 and 01/30/18 - 02/01/18 with an exit conference conducted by telephone on 02/01/18.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure the walls and floors were kept clean and in good repair in 2 resident rooms, a shared restroom and the common bathroom. The findings are: Observation during the facility tour on 01/26/18 between 9:45 a.m. to 10:00 a.m. revealed the Live-In Personal Care Aide (PCA) was mopping in the residents' rooms and the common bathroom. Observation of the first resident room on the right side of the hallway on 01/26/18 at 9:48 a.m. revealed there was a build-up of brown and black colored stains along all edges of the floor.	C 074		

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C 074	Continued From page 1 Observation of the shared restroom for the first and last resident room on the right side of the hallway on 01/26/18 at 9:48 a.m. revealed the outer sheetrock type wall under the window had one hole on the left side and three holes with a black colored square pattern mark around the holes and splitting in the wall's material. Observation in the last resident room on the right side of the hallway on 01/26/18 at 10:15 a.m. revealed: -There was a build-up of black and brown colored grime along the edges of the room's floor and the baseboards. -There were scattered rust colored stains on the floor in front of and on the side of a wooden nightstand located on the left side of the bedroom entrance. -There were approximately 10 square floor tiles with multiple scratches and a worn surface that exposed the floor's dull grey under layer surface. -The lower section of the bedroom door had a black colored scuff mark across the width of the door and a blue colored scuff mark that was approximately two 2 feet long. Observation of the common bathroom on 01/26/18 at 9:59 a.m. revealed: -There was an uneven surface of a thick and cracked black/gray colored hard rubber type material along the edges of the right and back corners of the tiled shower stall floor that extended upward along the right and back side of the tiled shower stall walls that varied in height from approximately 4 inches to 24 inches from the floor. -The same black/gray hard rubber type material covered the edges of the tiled floor between the bathtub and outer wall of the shower stall and extended approximately 4 inches up the wall.	C 074		

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C 074	Continued From page 2 -There was a build-up of a grey and white material or substance scattered across the base of the sink's metal type faucet. Review of a facility inspection report from the local Environmental Health Services dated 12/13/17 revealed: -The facility received an "A" status code. -The facility received 1 demerit for walls and ceilings. -There was documentation in the comment section of the report that the shower area wall/floor junction should be in good repair. Interview with Resident #1 on 01/30/18 at 9:28 a.m. revealed: -The PCAs "mopped her room a lot". -The stains in the corner of her bedroom floor had been there "a long time". Interview with Resident #2 on 01/26/18 at 10:44 a.m. revealed: -The resident had lived at the facility for 3 to 4 years. -The black and grey material had been on the shower stall floor in the common bathroom for about 2 months and was placed there to stop a water leak. -He did not know how long the stains had been on the floor edges and baseboards and had not noticed the scratches on the floor. Interview with the Live-In PCA on 01/26/18 at 10:00 a.m. revealed: -She had worked at the facility for about 8 months. -She was not sure how long the black/grey material had been around the shower stall and along the bathroom wall in the common bathroom.	C 074		

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C 074	Continued From page 3 -She cleaned the faucet in the common bathroom today (01/26/18), however, each time the sink's faucet was cleaned, the grey and white stains "would just come right back". -She just mopped the first and the last resident rooms on the right side of the hallway, however, the stains around the floors edges and baseboards could not be removed. -She was responsible to report any needed repairs to the Administrator, however, she was not sure if she had reported the stains on the floors, or the faucet in the bathroom unless she had reported those issues when she first started. Interview with a second Live-In PCA on 01/30/18 at 9:25 a.m. revealed: -She had worked at the facility for one year and 2 months. -The black and grey material around the shower stall and floor in the common bathroom was a sealant that she bought from a local store and had applied it about a year ago to stop the shower stall from leaking. -The shower stall had not leaked since she had applied the sealant. -The facility had hard water which had caused the grey and white build-up on the sink's faucet in the common bathroom and had to be scrubbed with a steel wool pad to remove it. -The stains on the floors in the first and last resident room on the right side of the hallway was wax build-up and thought the floors needed to be stripped and buffed to remove the stains. -She was not sure when the floors in the facility were last stripped and buffed and the floors had looked the same since she had worked at the facility. -The scuff marks on the door of the last resident room on the right side of the hallway had occurred "over time" and was caused by Resident	C 074		

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C 074	Continued From page 4 #2's wheelchair bumping against the door. Interview with the Supervisor-in-Charge (SIC) on 01/26/18 at 5:07 p.m. revealed: -She had not noticed the grey and white build-up on the sink's faucet in the common bathroom, -She thought it was possible that something used to clean the sink's faucet caused the build-up. -The black and grey material in the shower stall and along the wall in the common bathroom had been there for about 1 to 2 months and was applied to stop a leak. -The facility did not have a repairman, however, an outside repairman provider had been contacted to complete the repair to the shower stall and the bathroom wall but she was unsure when the repair would be completed and the Administrator "would know more about that". -The Live-In PCA's were responsible to report any needed repairs in the facility to her or the Administrator. -The floors in the first and last resident room on the right side of the hallway had looked the same since she started working at the facility. -Resident #2 had caused the scuff marks over time on the bedroom door with his wheelchair. Telephone Interview with the Administrator on 01/26/18 at 5:07 p.m. revealed: -She thought the tile in the shower stall had to be retiled and would have the repair work done in the next couple of months. -She performed a walk- through of the facility twice weekly to observe the overall cleaning needs and had told the Live-In PCAs that they needed to do a more detailed cleaning of the floors.	C 074		

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C 076	Continued From page 5	C 076		
C 076	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the furniture in two resident rooms and the common living area were in good repair. The findings are: Observation of the first resident room on the right side of the hallway on 01/26/18 at 9:45 a.m. revealed: -There was a 4 drawer chest of drawers with multiple areas of missing stain on the wood that exposed the under layer color of the wood and one dangling knob on the left side of the third drawer. -There was a nightstand table with scratches and missing wood stain on the drawer and base of the table. Interview with Resident #1 on 01/30/18 at 9:55 a.m. revealed the chest of drawers belonged to the facility. Observation of the third resident room on the left side of the hallway on 01/30/18 at 9:51 a.m. revealed: -There was a nightstand table with missing wood stain in various places on the table with a heavier concentration across the top of the table that	C 076		

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exposed the under layer color of the wood.
-There was a 4 drawer chest of drawers that was missing 2 of 6 knobs.

Observation in the common living room on 01/26/18 at 9:30 a.m. revealed there was a brown colored recliner with vinyl type covering with multiple cracks over the back, seat and armrests of the chair's covering.

Interview with a Live-In Personal Care Aide (PCA) on 01/26/18 at 10:00 a.m. revealed:
-The Administrator and the Supervisor-in-Charge (SIC) would walk through and monitor the home every week for needed repairs.
-She was not sure if she had reported any furniture repair needs but she was supposed to report repair needs to the Administrator and or the SIC.

Interview with a second Live-In PCA on 01/30/18 at 9:28 a.m. revealed:
-She had worked at the facility for one year and 2 months.
-The chair in the common living room had been cleaned so many times with a household cleanser that over time, the cleanser caused the chair's covering to crack.

Confidential interview with staff revealed the facility had furniture in a storage building on the facility's property and thought the furniture in the third resident room on the left side of the hallway and the first resident resident room on the right side of the hallway should have already been replaced.

Interview with the SIC on 01/26/17 at 11:10 a.m. revealed:
-Monitoring of needed repairs was done by her

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C 076	Continued From page 7 two times a week by performing a walk-through of the home. -The furniture would be replaced or repaired. Telephone interview with the Administrator on 02/01/18 at 7:00 p.m. revealed: -She last performed a walk-through of the home "sometime in January" 2018, however, she mostly observed for cleanliness and did not notice the furniture in the first resident room on the right side of the hallway and the third resident room on the left side of the hallway. -Staff normally told her or the SIC when there were repairs needed for the furniture, however, she had not been told about the chest of drawers and the nightstand in the first resident room on the right side of the hallway and in the third resident room of the left side of the hallway. -She had not noticed the cracked areas in the brown colored recliner with vinyl type covering in the common living area, but the chair had not been in the facility that long. -She would have the furniture repaired or replaced.	C 076		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: The facility failed to assure a national criminal history record check was completed as required for 2 of 3 sampled staff (Staff A and Staff C) who	C 147		

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C 147	Continued From page 8 resided outside of this State. The findings are: Review of the personnel record for Staff A (Live-In staff) revealed: -A hire date of 5/5/17. -She was hired for the position of Personal Care Aide/Live-In staff. -According to the address provided on the application dated 5/4/17 Staff A did not live in this state. -Staff A resided in a neighboring state. -A state criminal background check was completed on 5/9/17. -There was no documentation of a national criminal history check available. Review of the personnel record for Staff C (Medication Aide) revealed: -A hire date of 4/18/14. -She was hired for the position of Personal Care Aide/Live-In staff. -According to the address provided on the application dated 4/18/14 and photo identification Staff C did not live in this state. -Staff C resided in a neighboring state. -A state criminal background check was completed on 6/27/14. -There was no documentation of a national criminal history check available. Interview with the Administrator on 1/30/18 at 6:00pm revealed: -She had just learned in the last week a national criminal history check was required for employees who had lived in this state for less than 5 years. -She had the paperwork ready to give Staff A and Staff C so that fingerprints and a national criminal	C 147		

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C 147	Continued From page 9 history check could be completed. Interview with Staff C on 2/1/17 at 5:30pm revealed: -She did not recall having fingerprints completed for a national criminal history check when she started her current employment. -The Administrator completed orientation and all paperwork with Staff C when she was hired. -She was not aware of needing a national criminal history check.	C 147		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .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 B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 resident with a documented history of altered mental status from crossing a busy highway unsupervised by staff. The findings are: Review of Resident #1's current FL-2 dated 10/30/17 revealed: -Diagnoses included schizophrenia/depression, altered mental status, asthenia, hypothyroidism, hypertension and chronic kidney disease stage 4. -There was an unreadable handwritten entry beside the constantly disoriented section of the	C 243		

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C 243	Continued From page 10 FL-2. Review of Resident #1's Resident Register revealed an admission date of 12/07/15. Review of Resident #1's current assessment and care plan dated 09/20/17 revealed: -The resident was oriented and her memory was adequate. -There were no supervision interventions to address the resident's safety. Review of Resident #1's Home Health visit note dated 01/24/18 revealed: -There was documentation by the nurse that staff had reported the resident almost got hit by a car a couple of days ago. -Staff had reported the resident left the building and was walking across the street and walked out in front of a car. -The resident was being seen by mental health provider (named) weekly. -The resident had been told multiple times, not to cross the street, but due to the resident's mental status, the resident did not comply. -The resident had a history of doing the same and went outside naked and tried to flag down cars. -The resident's medications had been adjusted multiple times. -The nurse talked to the resident about leaving the premises and walking across the street and this had been discussed on previous occasions with the Supervisor in Charge (SIC) and staff about the resident being placed in a locked down unit for safety reasons. -The mental health provider had been made aware of the resident's actions and safety concerns. Telephone interview with Resident #1's Home	C 243		

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Health Nurse on 01/31/18 at 4:56 p.m. revealed:
-When she made her visits she would always talk with staff.
-When she made her visit last week a staff reported to her that the resident had left the building to go to the facility across the street and a car had to slam on brakes to keep from hitting her.
-She was not sure if that staff had reported the incident to anyone else.
-She was concerned because that was not the first incident and she knew of numerous incidences of the resident crossing the road.
-She had talked with staff for the last 3-4 months about the resident's safety concerns.
-Staff would tell the resident not to cross the road unattended, however, she was concerned because the resident would not follow directions.

Review of Resident #1's Home Health visit notes from 08/23/17 through 01/10/18 revealed:
-The resident was documented as having impaired decision making on each Home Health visit note.
-On 08/23/17, there was documentation the resident was becoming more manic and sexual to male residents. Psychology had been notified of the behavior. The Home Health Nurse (HHN) provided teaching to staff regarding constant supervision in order to keep the resident safe.
-On 08/29/17, there was documentation the resident continued to strip off clothes and walk outside. Staff had also reported that the resident was crossing the highway. Staff reported that the primary care provider (PCP) was aware and had given the resident a new medication, the HHN provided staff teaching on the importance of monitoring the resident closely.
-On 09/21/17, there was documentation the resident had been flagging down cars that passed

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the facility with the last episode occurring yesterday (09/20/17). The resident had also been going to male residents rooms and getting in their bed. The HHN talked to the Supervisor In Charge (SIC) about the resident's behavior. The SIC reported that psychiatry had increased the resident's Haldol, but per the SIC this did not seem to be helping. The resident had been on Haldol injections (an antipsychotic medication used for severe behaviors and decreases excitement in the brain) and that seemed to stabilize the resident's behavior, however, it was discontinued during a hospital stay. The Psychiatrist reported that he would not place the resident back on the injections because the resident stated she did not want to take it. The HHN talked with the SIC about possibly sending the resident to a facility that had a locked down unit for safety reasons. The SIC reported that she agreed, the Administrator was aware but no decision had been made yet. The HHN discussed with the SIC about monitoring the resident and not allowing her to cross the street unattended.
-On 10/12/17, there was documentation staff had reported that the resident's behavior had been escalating over the past week. The HHN provided staff teaching regarding the need for constant supervision and medication compliance.
-On 11/03/17, there was documentation the resident had been admitted to a local hospital for observation after being involuntarily committed on 10/27/17 and was discharged back to the facility. Staff reported that the resident's behaviors had been uncontrolled, Haldol injections had been ordered monthly, the resident received an injection yesterday by the mental health provider, however, had uncontrolled behavior since that time. Staff reported the resident was outside of the facility knocking on windows at 1:00 a.m.
-On 11/22/17 there was documentation staff had

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reported that the resident started to wander at night again, behaviors beginning to escalate. Trazodone (used for sleep) had been prescribed by the PCP. The HHN provided teaching in regards to the new medication and need for supervision at night.
-On 11/28/17, there was documentation staff had reported that the resident continued to wander during the night. The HHN provided staff education regarding the importance of constant supervision.
-On 12/08/17 there was documentation that the HHN spoke with the Psychiatrist about the recent uncontrolled behaviors. The Psychiatrist felt that the resident may need to be in a memory care unit but would try increasing one of the resident's medication (named).
-On 12/27/18, there was documentation staff had reported the resident had received her Haldol injection 2 days ago. Staff reported that the resident's behavior was uncontrolled at that time. She was hyper and making irrational choices. The HHN taught staff the resident's need for constant supervision to prevent injury.
-On 01/10/18, there was documentation the resident appeared to be having difficulty standing still. Staff had reported that the resident continued to make unsafe decisions such as crossing the road. The HHN taught staff the importance of constant supervision to prevent the resident from being injured.

Confidential interview with a staff revealed:
-The staff feared that something was going to happen to Resident #1 crossing the street.
-The road Resident #1 went across was a very busy highway and Resident #1 crossed the street in a blind section due to the trees behind the facility and beside the road.
-The staff was cleaning up the dining room "just

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yesterday" and Resident #1 was out the door in the next sister facility located on the same side of the road before she even knew she was gone, "she moves quick". The staff estimated this happened within a 2 minute time frame.
-It was impossible to supervise Resident #1 in the environment she was in to keep her safe because she needed more frequent monitoring than could be done at the facility.
- The staff thought it was impossible to "tend to other residents", wash clothes, cook and watch Resident #1 at the same time, "you can't take your eyes off of her".
-The staff felt the resident needed to be in a locked unit to protect her safety.
-There were no staff at night to supervise the resident because staff slept at night and could not supervise her during that time.
-Staff at the other building could not watch Resident #1 when she went there because they had their own residents to care for.

Review of Resident #1's progress notes written by the Live-In staff revealed there was documentation dated 09/22/16 to 06/04/17 of Resident #1 crossing the road 21 times.

Review of Resident #1's progress notes documented by the SIC revealed:
-On 08/24/17, there was documentation that included the resident had went across the road "today".
-On 08/30/17, there was documentation that included the resident "waited until all the office staff left and walked across the road".
-09/05/17, there was documentation the resident had walked across the street.
-On 09/07/17, there was documentation that included the resident was walking across the street. The resident was walked back across the

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street.
09/08/17, there was documentation the SIC was told by staff that the resident walked across the road about 7:30pm last night.
-On 10/25/17, there was documentation the resident came across the street twice yesterday, stopping cars and asking for money. The SIC called the mental health provider however no one called back.
-On 10/26/17, there was documentation that included the resident came across the road begging for cigarettes, The SIC called the mental health provider but the mental health nurse was in a meeting and she left a message to return the call regarding the resident.
-On 11/28/17, there was documentation that the resident got her Haldol injection today.
-On 11/29/17, there was documentation the resident came across the street twice today and had to be taken back across the street.
-On 11/30/17, there was documentation that included the SIC was told by staff that the resident crossed the street last night around 630pm and walked across the road this morning around 2am trying to stop cars.
-On 12/04/17, there was documentation the resident came across the road twice and the SIC walked her back.
-On 12/05/17, there was documentation the resident walked across the street twice.
-On 12/06/17, there was documentation the resident walked across the road at night.
-On 12/13/17, there was documentation, the resident walked across the road. The SIC told her that the mental health nurse said if she kept coming across the road she would not be able to go on the outing and to the dinner.
-On 12/19/17, there was documentation that included the mental health provider came to see the resident and she had just came from across

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the road.
-On 12/20/17, there was documentation the resident came across the road twice today looking for another resident and cigarettes.
-On 12/29/17 there was documentation there was a meeting with the resident's guardian, the local Ombudsman, Administrator and the SIC about the resident's safety and crossing the street.
-On 01/01/18, there was documentation the resident did not cross the road all weekend.
-On 01/05/18 there was documentation of a late entry for 01/04/18 that the resident walked across the street with no shoes on in the cold and snow.

Interview with Resident #1 on 01/30/18 at 9:28 a.m. revealed:
-She crossed the road to go see the other residents at the other building (sister family care home owned by the facility).
-She did not cross the road unless someone was with her now.

Telephone interview with the local Ombudsman on 02/01/18 at 10:49 a.m. revealed:
-The Ombudsman participated in a meeting with the Administrator, the SIC and Resident #1's guardian around Christmas 2017.
-The meeting was held for safety concerns for Resident #1 crossing the street.
-During the meeting there was discussion of possible safety issues of the resident crossing the street and staff were concerned that the resident kept going across the street before they even knew she had gone.
-The group discussed possibly having a schedule of when the resident could go across the street with staff assisting her across and assisting her back across when she returned to the facility.

Interview with a Live-In Personal Care Aide (PCA)

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C 243	Continued From page 17 on 01/30/18 at 10:00 a.m. revealed: -Resident #1 was not supposed to go across the street when "she hasn't got no business crossing the yard". -Resident #1 had not crossed the road unattended in the last 2 weeks that the staff knew of. Interview with a second Live-In PCA on 01/30/18 at 4:30 p.m. staff revealed: -Resident #1 had to be watched more to keep her calm and because she would try to cross the road by herself. -Staff tried to keep the resident's cigarettes so she would not cross the road. -When Resident #1 tried to go across the street alone, the staff was able to catch her. -Staff were supposed to go to the road and help the resident get across the road. Telephone interview with the SIC on 01/31/18 at 2:30 p.m. revealed: -The facility had put a plan in place about 2 months ago for Resident #1 crossing the street. -The plan included staff were supposed to call "mostly her" and meet the resident at the road to assist her to cross the street and when Resident #1 was ready to go back across the road staff called and arranged for someone to meet her to assist the resident back across the road. -The plan had been in place for a month or 2 months because there were safety concerns with Resident #1 crossing the road alone. -Staff were aware of the plan for Resident #1 which was shared with them verbally by her and the Administrator. -The SIC had never been informed that the resident was almost been hit by a car and she would have expected staff to notify her or the Administrator if this occurred.	C 243		

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C 243	Continued From page 18 Interview with the Administrator on 01/30/18 at 5:25 p.m. revealed: -She was not surprised that Resident #1 had crossed the street, but had not been told she was almost hit by a car, "no one has reported that to me". -The resident's behaviors had improved since she had restarted injections for her behavior. -The Administrator was concerned a few months ago for the resident's safety and wanting to go across the street because she had a staggering, slow gait and wasn't crossing the road in a timely manner. -The Administrator had a meeting with Resident #1's family member and the Ombudsman. -A plan was put into place to have staff assist the resident to cross the road and when the resident was ready to come back to the facility, staff from the other home would call and have staff from the facility meet the resident at the road to assist her to cross back over the highway. -Door alarms were used at night to wake staff up if a door was opened. -Resident #1's family member had spoken with the resident about crossing the road, but she did not know how much the resident comprehended. -The mental health team was very involved and tried reinforcements with the resident to encourage her not to cross the road. Telephone interview with a Registered Nurse at Resident #1's mental health provider on 02/01/18 at 9:40 a.m. revealed: -He visited Resident #1 to administer her Haldol injections. -There had been some safety concerns with the resident crossing the highway unattended. -Over this past year, the resident had several psychiatric issues and it seemed like she was	C 243		

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more stabilized but then the past few months she had become worse.
-Medication adjustments were made with Haldol and when that did not help they thought she was having some dementia and she was started on a medication to help with that in January 2018.
-Since the resident had started on the medication for dementia, the resident had been better per staff reports and not trying to cross the road so much as she was for a while.
-There had been no recent reports of almost getting hit by a car recently.
-His last visit to the facility was 01/30/18.
-He thought staff tried to supervise the resident, however, they could get distracted from Resident #1's supervision by other residents.
-There were concerns for her safety due to her behaviors that were unsafe and that was why they were trying to decide if the resident had some dementia or other cause for her safety.
-There had been discussion with the Administrator at one time that the resident's needs would be better met in a memory care unit, however, her behavior had improved since then.
-He thought there would have been a supervision intervention plan in place at the facility to assure her safety was maintained at all times.

Telephone interview with Resident #1's Psychiatrist on 02/01/18 at 9:45 a.m. revealed:
-He thought that the resident was showing signs of a "fair amount of dementia"
-He had talked with a nurse on his last visit to the facility on 01/18/18 but could not recall the "nurses" name that the resident may needed to be moved to a memory care unit to maintain her safety.

_____

The facility failed to provide supervision for Resident #1 who had a documented history of

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C 243	Continued From page 20 altered mental status and crossing a busy highway unsupervised by staff. The facility's lack of supervision was detrimental for Resident #1's safety and welfare and constitutes a Type B Violation. _____ Review of a Plan of Protection dated 01/26/18 revealed: -From 7:00 p.m. to 10:00 p.m. staff would perform every 15 minute checks. -Alarm set at 10:00 p.m. nightly (all door alarms were set to notify staff of residents attempting to exit building). -Initiate plan of protection for safety concerns regarding protection of resident to include education of expectation of staff and documentation of whereabouts of resident to ensure safety. -Staff to assist resident with crossing the road. -Once the resident was ready to come back, staff called worker in resident's home and make aware to meet at road to ensure safety back across the road. -Notify doctor with any further concerns of safety/supervision with all residents by the Administrator/Supervisor in Charge (SIC) immediately. -If the resident is unable to redirect or not responding to staff, the Administrator or SIC to notify mental health provider (named) immediately and staff would remain with the resident to provide 1 on 1 supervision until further assistance arrived -Continue with every 15 minute checks from 7am to 10 pm ongoing. -If during the night, alarm goes off staff were to immediately assess all residents and ensure safety, notify administrator with any problems or concerns immediately. -Initiate a safety plan with residents depending on	C 243		

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C 243	Continued From page 21 need. -Educate staff would start immediately 01/30/18 and continue until all staff rotation was completed 02/05/18 by Administrator/SIC. -SIC would monitor for compliance daily throughout the day. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 18, 2018.	C 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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: Based on interviews and record reviews, the facility failed to assure contact was made with the Primary Care Provider (PCP) for 1 of 3 residents (#1) related to multiple elevated blood pressures. The findings are: Review of Resident #1's current FL-2 dated 10/30/17 revealed: -Diagnoses included schizophrenia/depression, altered mental status, asthenia, hypothyroidism, hypertension and chronic kidney disease stage 4. -There was no order for blood pressure checks. Review of a January 2018 blood pressure log for Resident #1 revealed: -There was documentation at the top of the form that the blood pressure was ordered daily. -The resident's systolic blood pressure reading (the top number of a blood pressure is the	C 246		

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pressure in the blood vessels when the heart beats with a normal systolic reading of 120mmHg or less) was documented as 143mmHg -198mmHg from 01/01/18 - 01/26/18 with an exception on 01/03/18 with a systolic blood pressure reading of 128mmHg.
-The resident's diastolic blood pressure reading (the bottom number of a blood pressure reading is the pressure in the arteries when the heart rests between beats with a normal reading of 80mmHg or less) was documented as greater than 100 with a range of 101mmHg - 109mmHg eight times from 01/11/18 - 1/25/18 and 90mmHg and greater with a range of 90mmHg - 99mmHg 12 times.

Review of Resident #1's record revealed there was not a blood pressure log for December 2017.

Review of a November 2017 blood pressure log for Resident #1 revealed:
-There was documentation at the top of the form that the blood pressure was ordered daily.
-The resident's systolic blood pressure reading was documented as 160mmHg or greater with a range of 164- 198 mmHg sixteen times between 11/03/17 - 11/29/17.
-The resident's diastolic blood pressure was documented as 90mmHg or greater with a range of 91mmHg - 99mmHg nine times from 11/07/17 - 11/26/17, and greater than 100mmHg ten times with a range of 101 mmHg - 111mmHg from 11/03/17 - 11/29/17.
-There was an undated blood pressure entry of 206/111 between the dates of 11/13/17 and 11/14/17 and a blood pressure entry of 207/101 on 11/27/17.

Review of an October 2017 blood pressure log for Resident #1 revealed:

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C 246	Continued From page 23 -There was documentation at the top of the form that the blood pressure was ordered daily. -The resident's systolic blood pressure was documented as 160mmHg or greater with a range of 160mmHg - 194mmHg eighteen times from 10/04/17 - 10/31/17 and no readings documented on 10/05/17, 10/06/17, 10/26/17 and 10/27/17. -The resident's diastolic blood pressure was documented as 90mmHg or greater with a range of 90mmHg - 116mmHg sixteen times from 10/04/17 - 10/31/17 and no readings documented on 10/05/17, 10/06/17, 10/26/17 and 10/27/17. According to the US Department of Health and Human Services, National Institute of Health, a normal blood pressure is 120/80mmHg (millimeters of mercury). Review of Resident #1's progress notes revealed there was no documentation any blood pressures that had been reported to the Supervisor in Charge (SIC) or the primary care provider (PCP). Interview with a Live-In Personal Care Aide (PCA) on 01/30/18 at 4:30 p.m. revealed: -Resident #1's blood pressures were high some days. -He notified the Medication Aide (MA) or SIC when he thought Resident #1's blood pressure results were high but had never been told what blood pressure reading would be considered high for the resident; and did not answer what he thought a high blood pressure reading was. -He had documented the blood pressure reading of 171/104 for Resident #1 on 01/14/18 and was sure that he reported that reading to the MA or the SIC but was not sure if he documented that in the progress notes. -The MAs reviewed the blood pressure logs every	C 246		

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C 246	Continued From page 24 day when medications were given. Interview with the SIC on 01/30/18 at 12:00 p.m. revealed: -The Live-In PCAs were responsible for taking the residents' blood pressures. -The SIC had reviewed Resident #1's January 2018 blood pressure logs the first part of the month, however, no follow up was done with the PCP for any elevated blood pressure results. Telephone interview with the SIC on 01/31/18 at 2:30 p.m. revealed: -The SIC thought a blood pressure over 160/90 would be high and concerning for Resident #1. -Staff were expected to inform her if a high blood pressure result was obtained for any resident, however, she had not received any notification from staff regarding Resident #1's blood pressures. -She usually checked the blood pressure logs "randomly". -She had not called and reported any blood pressure readings for Resident #1 to the PCP. Interview with the Administrator on 01/30/18 at 11:58 a.m. revealed: -The facility took all of the residents' blood pressures daily. -The facility did not have a policy or procedure for blood pressure checks. -No blood pressure parameters had been given to staff and when to report an elevated or low blood pressure, however, some of the staff would know what blood pressure readings to report because of past experience or training. -The residents' blood pressure logs were reviewed by the PCP when the residents were seen by her. -The Live-in PCAs used an automatic arm cuff to	C 246		

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C 246	Continued From page 25 take the residents' blood pressures. Telephone interview with the Administrator on 02/01/17 at 7:10 p.m. revealed: -The Administrator expected the SIC to follow up with the PCP with any blood pressure results with a systolic blood pressure reading greater than 180 or a diastolic reading over 100. -The Administrator monitored the residents' blood pressure logs, however, mostly just looked through the logs to make sure they were done and did not monitor the logs closely. Telephone interview with the PCP on 01/31/18 at 11:30 a.m. revealed: -The resident's latest blood pressure results taken in her office was 161/80. -She had discussed with the Administrator last night (01/30/18) about possibly having the residents' blood pressure logs faxed weekly for review and establishing blood pressure parameters for all residents.	C 246		
C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure foods were stored in a manner to prevent contamination as evidenced by food not labeled with contents and date opened; and leaving expired foods stored in the refrigerator.	C 257		

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C 257	Continued From page 26 The findings are: Observation of the refrigerator door's storage area on 01/26/18 at 11:06 a.m. revealed: -There was half of an onion stored in a re-sealable bag with no labeled date. -There was an opened 24 ounce jar of pasta sauce with no labeled date opened, an opened package of chicken bologna containing approximately 5 slices that was stored in a re-sealable plastic bag with no date opened, stored on the second shelf. -There was an opened container of cake frosting with no opened date and labeled directions to cover and refrigerate any remaining frosting for up to 2 weeks, an opened 16 ounce bottle of ranch dressing with approximately 75% of the dressing remaining with a stamped "best when used by" date of 11/30/17, stored on the third shelf of the refrigerator's door. -There was an opened package of spaghetti noodles with no labeled date opened and an opened box of raisins with approximately 75 percent of the raisins remaining labeled "best before 11/21/17", stored on a small third shelf . Observation of the storage shelving in the refrigerator on 01/26/18 at 11:19 a.m. revealed: -There was a yellow lid container of vegetable soup with no opened date, stored in the back section of the second storage shelf of the refrigerator. -There was a blue lid container of a beige colored chunky liquid that was not labeled with the contents and not dated, stored in the back section of the third storage shelf of the refrigerator. Observation of a middle storage bin of the refrigerator on 01/26/18 at 11:21 a.m. revealed:	C 257		

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C 257	Continued From page 27 -There were two slices of cooked deli ham and a folded and opened package of chicken bologna stored inside the original packaging of the cooked ham that was not a labeled with the contents or a date opened. -There was an opened package of hot dogs with no opened date and approximately 4 hotdogs remaining with the package folded over, not sealed and leaked liquid when the package was picked up. -There was a small whole cooked ham wrapped in aluminum foil that was not labeled with the contents or an opened date. Observation of a lower storage bin in the refrigerator on 01/26/18 at 11:30 a.m. revealed there was a plastic bag containing a head of iceberg lettuce that had several orange and brown discolored areas. Interview with the Live-In Personal Care Aide (PCA) on 01/26/18 at 11:24 a.m. revealed: -She was not sure how long the iceberg lettuce had been in the refrigerator, however, it looked like it needed to be thrown away. -She had opened the small, whole ham in the refrigerator last week but could not place it back into its original container and wrapped it in the aluminum foil. -She was trained at another facility to label all repackaged or opened foods with a date and contents, however, she did not have any re-sealable bags last week when she opened the small, whole ham. -She had not served any of the other opened foods to the residents. -She did not remember seeing the container of vegetable soup or the container of the beige, chunky liquid in the refrigerator when she worked last week.	C 257		

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C 257	Continued From page 28 -The facility did not have a cleaning scheduled, however, she last cleaned the refrigerator out in November or December of 2017. -She did not "pay any attention" to expiration dates when she cleaned the refrigerator, however, looked for the expiration date on all foods before serving it to the residents. -The Supervisor-in-Charge (SIC) looked at the foods stored in the refrigerator every 2 weeks to check for labeling and dating. Interview with the SIC on 01/26/18 at 5:07 p.m. revealed: -The Live-In PCAs were responsible to make sure all foods opened and repackaged were labeled with the contents and date the food product was opened and monitored this at least weekly. -She looked in the refrigerator earlier this week and saw foods that were opened and not labeled with a date and told the Live-In PCA to throw those items in the trash. -Staff were responsible to wipe down the inside of the refrigerator daily and clean out the refrigerator weekly which included disposal of expired foods. Interview with the Administrator on 01/26/18 at 7:13 p.m. revealed: -All staff had been trained and knew her expectation for labeling and dating foods and food packaging when opened. -Staff were responsible to check for expired foods weekly and discard that food immediately.	C 257		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service	C 284		

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C 284	Continued From page 29 (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure therapeutic diets were served as ordered for 2 of 2 residents who had physician's orders for a no concentrated sweets diet (NCS) (#1, #3). The findings are: 1. Review of the facility's therapeutic menus revealed a No Concentrated Sweet (NCS) diet menu was included. a. Review of Resident #1's current FL-2 dated 10/30/17 revealed: -Diagnoses included chronic kidney disease stage 4. -There was no diet order listed. Review of a clarification diet order dated 01/31/18 revealed a No Concentrated Sweet (NCS) diet. Review of the facility's therapeutic diet list revealed Resident #1 was on a NCS diet. Review of the "Week One Menu Cycle, Friday" therapeutic spreadsheet menus for supper meal on 01/26/18 revealed: -There was a column labeled "No Concentrated Sweets" (NCS). -The supper meal menu included: 3 ounces of chicken salad on lettuce, 1 cup of vegetable soup, 1 cornbread, and ¼ cup of congealed (named) salad with fruit, 1 tsp. of margarine, one cup of milk and one cup of coffee/tea/water.	C 284		

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C 284	Continued From page 30 -The spreadsheet included directions that a NCS diet followed a regular diet, however, no sugar and unsweetened fruit for dessert. Observation of Resident #1 during the supper meal on 01/26/18 at 5:41 p.m. revealed: -The resident was served chicken salad on one leaf of iceberg lettuce, approximately one cup of vegetable soup, one serving of cornbread, approximately ½ cup of applesauce, approximately 6 to 8 ounces each of a pink colored liquid and plain water. -The resident ate 100 percent of her applesauce and drank all of the pink colored liquid. Observation of the refrigerator on 01/26/18 at 11:16 a.m. revealed there was a pitcher of tea that was labeled unsweetened tea and a second pitcher of a pink colored liquid that was not labeled. Observation in the kitchen of the applesauce served for the supper meal on 01/26/18 at 5:44 p.m. revealed: -The opened applesauce in the refrigerator was "Original Applesauce" with labeled ingredients that included apples and high fructose corn syrup as the first 2 ingredients. -The serving size on the label was 2/3 cup with a sugar content of 22 grams per serving. Interview with Resident #1 on 01/26/18 at 5:49 p.m. revealed she was not sure what the pink colored liquid was but it was good and tasted sweet. Review of the "Week Two Menu Cycle, Tuesday" therapeutic spreadsheet menus for the lunch menu on 01/30/18 revealed: -There was a column labeled "No Concentrated	C 284		

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C 284	Continued From page 31 Sweets". -The lunch meal menu included: 3 ounces of sliced turkey, ½ cup of sweet potatoes, ½ cup of green beans, 1 biscuit, ½ cup of unsweetened pineapple, 1 tsp of margarine, and once cup of coffee/tea/water. -The spreadsheet included directions that a NCS diet followed a regular diet, however, no sugar and unsweetened fruit for dessert. Observation of Resident #1 during the lunch meal on 01/30/18 at 12:07 p.m. revealed: -The resident was served three thin slices of turkey with gravy, approximately ½ cup of corn, ½ cup of sweet potatoes, one biscuit, ½ cup of pears canned in heavy syrup, approximately 6 to 8 ounces each of unsweetened tea and water. -The resident ate 75 percent of her food and only one slice of pear. Observation in the kitchen of the pears used for the lunch meal on 01/30/18 at 12:08 p.m. revealed -The pears were packed in heavy syrup and ingredients included pears, water, corn syrup and sugar. -There was 19 grams of sugar in ½ cup serving of the pears. Interview with Resident #1 on 01/30/18 at 12:12 p.m. revealed the resident did not eat all of her pears because she "don't want to be a diabetic". Review of Resident #1's blood sugar logs for January 2018 revealed: -The resident's blood sugars were done three times a week. -The resident's blood sugars ranged from 101-278.	C 284		

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Review of a laboratory report for Resident #1 dated 10/19/17 revealed:
-The resident's hemoglobin A1C (HgbA1C) (A blood test used to determine the control and average of blood sugar levels with a normal laboratory value range of 4.7- 5.6) was 5.9.

Telephone interview with Resident #1's primary care provider on 01/31/18 revealed:
-The resident was new under her care.
-The resident had a history of diabetes and expected her diet orders to be followed.

Refer to the interview with the Live-In Personal Care Aide (PCA) on 01/26/18 at 11:16 a.m.

Refer to interview with the second Live-In PCA on 01/26/18 at 5:50 p.m.

Refer to the interview with the Live-In PCA on 01/30/18 at 12:11p.m.

Refer to the Interview with the Administrator on 01/26/1 at 7:13 p.m.

b. Review of Resident #3's current FL-2 dated 7/19/17 revealed:
-Diagnoses included schizoaffective disorder and diabetes mellitus.
-There was an order for a diet no added salt and no concentrated sweet (NCS) diet.

Review of a clarification diet order dated 01/31/18 revealed a No Concentrated Sweet (NCS) diet.

Review of the facility's therapeutic diet list revealed Resident #3 was on a NCS diet.

Review of the "Week One Menu Cycle, Friday" therapeutic spreadsheet menus for supper meal

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C 284	Continued From page 33 on 01/26/18 revealed: -There was a column labeled "No Concentrated Sweets" (NCS). -The supper meal menu included: 3 ounces of chicken salad on lettuce, 1 cup of vegetable soup, 1 cornbread, and ¼ cup of congealed (named) salad with fruit, 1 tsp. of margarine, one cup of milk and one cup of coffee/tea/water. -The spreadsheet included directions that a NCS diet followed a regular diet, however, no sugar and unsweetened fruit for dessert. Observation of Resident #3 during the supper meal on 01/26/18 at 5:45 p.m. revealed: -The resident was served chicken salad on one leaf of ice berg lettuce, approximately one cup of vegetable soup, one serving of cornbread, approximately ½ cup of applesauce, approximately 6 to 8 ounces each of a pink colored liquid and plain water. -The resident ate 100 percent of his applesauce and drank all the pink colored liquid. Observation of the refrigerator on 01/26/18 at 11:16 a.m. revealed there was a pitcher of tea that was labeled unsweetened tea and a second pitcher of a pink colored liquid that was not labeled. Observation in the kitchen of the applesauce served for the supper meal on 01/26/18 at 5:44 p.m. revealed: -The opened applesauce in the refrigerator was "Original Applesauce" with labeled ingredients that included apples and high fructose corn syrup as the first 2 ingredients. -The serving size on the label was 2/3 cup with a sugar content of 22 grams per serving. Review of the "Week Two Menu Cycle, Tuesday"	C 284		

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C 284	Continued From page 34	C 284		

therapeutic spreadsheet menus for the lunch menu on 01/30/18 revealed:
-There was a column labeled "No Concentrated Sweets".
-The lunch meal menu included: 3 ounces of sliced turkey, ½ cup of sweet potatoes, ½ cup of green beans, 1 biscuit, ½ cup of unsweetened pineapple, 1 tsp of margarine, and once cup of coffee/tea/water.
-The spreadsheet included directions that a NCS diet followed a regular diet, however, no sugar and unsweetened fruit for dessert.

Observation of Resident #3 during the lunch meal on 01/30/18 at 12:10 p.m. revealed:
-The resident was served three thin slices of turkey with gravy, approximately ½ cup of corn, ½ cup of sweet potatoes, one biscuit, ½ cup of pears canned in heavy syrup, approximately 6 to 8 ounces each of unsweetened tea and water.
-The resident ate 95% percent of his food and only one slice of pear.

Observation in the kitchen of the pears used for the lunch meal on 01/30/18 at 12:08 p.m. revealed
-The pears were packed in heavy syrup and ingredients included pears, water, corn syrup and sugar.
-There was 19 grams of sugar in ½ cup serving of the pears.

Based on an attempted interview with Resident #3 on 01/30/18 at 5:45 p.m. revealed the resident would not engage in conversation.

Review of Resident #1's blood sugar logs for January 2018 revealed:
-The resident's blood sugars were done daily.
-The resident's blood sugars ranged from

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C 284	Continued From page 35 107-289. Telephone interview with Resident #3's primary care provider on 01/31/18 revealed she expected diet orders to be followed as ordered. Refer to the interview with the Live-In Personal Care Aide (PCA) on 01/26/18 at 11:16 a.m. Refer to interview with the second Live-In PCA on 01/26/18 at 5:50 p.m. Refer to the interview with the Live-In PCA on 01/30/18 at 12:11p.m. Refer to the Interview with the Administrator on 01/26/1 at 7:13 p.m. Interview with the Live-In Personal Care Aide (PCA) on 01/26/18 at 11:16 a.m. revealed the pink colored liquid had been sweetened with sugar and the tea was unsweetened in the refrigerator. Interview with the second Live-In PCA on 01/26/18 at 5:50 p.m. revealed: -His shift started at 3:00 p.m. today (01/26/18). -He served the "Original Applesauce" and the pink colored liquid in the refrigerator to all of the residents at the supper meal. -He did not realize the pink colored liquid had been sweetened with sugar. -When he prepared meals for the resident's he went by the therapeutic menu spreadsheets, however, he did not think about the applesauce that was served having added sugar. Interview with the Live-In PCA on 01/30/18 at 12:11 p.m. revealed: -She knew the pears were in syrup and that was	C 284		

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C 284	Continued From page 36 why she "drained the juice". -There were other fruits canned fruits available with natural juice and packed in water, however, she thought it would be the same by draining the juice from the fruit before serving. Interview with the Administrator on 01/26/18 at 7:13 p.m. revealed: -She expected the Live-In PCAs to follow the menus as directed. -The facility menus specified to "modify the desserts". -The facility purchased unsweetened fruits and desserts for the diabetic residents, however, she had to send another worker this week to the grocery store who might not have picked up the unsweetened fruits that were normally purchased. -Residents on a NCS diet should have unsweetened beverages and if they desired sweetener then an artificial sweetener should have been added to their beverage.	C 284		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and	C 330		

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C 330	Continued From page 37 interviews the facility failed to assure medications were administered as ordered for 2 of 3 sampled residents (#3,#1) as evidenced by Resident #3 not receiving medications as ordered, an anticoagulant and Resident #1 an anticoagulant, a medication used to treat side effects of psychiatric drugs, an anticonvulsant, a blood thinner, pain/fever reducer, and a vitamin supplement as ordered for at least 26 days. The findings are: 1. Review of Resident #3's current FL2 dated 7/19/17 revealed: -Diagnoses included Schizoaffective disorder, diabetes mellitus, hypertension, hypothyroidism, hyperlipidemia, and gastroesophageal reflux disease. -He was ambulatory and continent of bowel and bladder. Review of a hospital history and physical dated 10/6/17 for Resident #3 revealed: -A bare metal stent (a tiny tube inserted into a narrowed or blocked artery that does not have a coating that would release a drug over time to reduce narrowing of the stented area of the artery. The stent is used to treat heart disease by keeping arteries open) was placed. -Cardiology recommended he be started on Brilinta (Brilinta is an antiplatelet drug used to prevent heart attack or stroke after heart surgeries such as stent placement) 90mg twice daily for 4-6 weeks. Review of a physician order dated 10/6/17 revealed: -A new order for Brilinta 90mg twice a day. -The order was a photo copy and the print was very faint, but was legible.	C 330		

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C 330	Continued From page 38 Review of a physician note dated 1/10/18 revealed: -A subsequent order to stop Brilinta 90mg twice daily. -An order to begin Plavix 75mg daily (Plavix is an antiplatelet drug used to prevent heart attack and also used to keep blood vessels open after procedures such as cardiac stent placement). Review of the October 2017 medication administration record (MAR) for Resident #3 on 1/30/18 revealed: -Brilinta 90mg twice daily was transcribed to the MAR. -The order for Brilinta was handwritten on the MAR and started with the 8pm dose on 10/6/17. -Brilinta was documented as administered twice a day from 10/7/17 - 10/31/17. Review of the November 2017 MAR for Resident #3 on 1/26/18 revealed: -Brilinta 90mg twice daily was transcribed on the MAR and was handwritten. -There was no documentation that Brilinta had been administered from 11/1/17 - 11/30/17. Review of the December 2017 MAR for Resident #3 on 1/30/18 revealed. -Brilinta 90mg twice daily was transcribed to the MAR and was handwritten. -Brilinta 90mg twice daily was documented as administered twice daily from 12/1/17 - 12/31/17. Review of the January 2018 MAR for Resident #3 on 1/30/18 revealed there was no order for Brilinta 90mg on the MAR. Interview on 1/30/18 at 2:40pm with a registered nurse (RN) from the cardiology office revealed:	C 330		

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C 330	Continued From page 39 -Resident #3 had diagnoses of heart artery disease and leg artery disease. -Resident #3 was scheduled to have a cardiac catheterization completed at the local hospital on 10/5/17. -The procedure revealed he had a blockage, so a stent was placed and resident spent one night in the hospital. -He was started on Brilinta 90mg twice a day due to the stent being a bare metal stent. -If resident was not administered the Brilinta as ordered the stent could have "blocked back up" or the resident could have formed another blockage. -If this occurred it could cause an occlusion, chest pain, heart attack or stroke. -The only way to determine if this occurred would be to perform another cardiac catheterization. A Follow up interview on 2/1/18 at 11:30am with a registered nurse (RN) from the cardiology office revealed: -There were no concerns noted from the facility and no reports of resident not receiving Brilinta. -If the facility had contacted the cardiology office requesting a copy of the order for Brilinta it would have been provided. -The physician would have to determine if a re-catheterization would need to be completed for Resident #3. Attempted telephone interview on 2/1/18 at 11:30am with the Cardiologist was unsuccessful. Attempted telephone interview on 1/31/18 at 2:35pm with the primary care physician was unsuccessful. Interview on 1/31/18 at 1:20pm with a representative at the contracted pharmacy revealed:	C 330		

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C 330	Continued From page 40 -Brilinta 90mg had never been filled for Resident #3. -A faxed prescription was received, but was not legible due to being a poor copy. -The copy was so bad the date could not be read. -Pharmacy staff had been trying to obtain clarification of the order for a couple of months. -Several messages had been left with nurses at the hospital (date unknown), but clarification of the order was never received. -The facility was made aware at the time the fax was received that the order could not be read. -The contact person at the facility was the Supervisor-in-Charge (SIC) and pharmacy staff asked the SIC for assistance with obtaining clarification. -Pharmacy staff did not know if the SIC worked on getting clarification, but clarification was never received. Interview on 1/31/18 at 2:40pm with the SIC revealed: -The SIC received a faxed order for Brilinta 90mg twice daily for Resident #3 on 10/6/17, the same day he returned from the hospital. -The order was faxed to the pharmacy the same day it was received. -The copy faxed was legible and the SIC used the copy of the order to transcribe Brilinta 90mg twice daily to the MAR. -Pharmacy staff notified the SIC the same day the order was faxed that pharmacy staff could not read the order. -The facility never received Brilinta 90mg for Resident #3. -The SIC did not contact the cardiology office to request a copy of the Brilinta order. -The SIC did not contact the cardiology office to make the physician aware Brilinta was not administered to Resident #3.	C 330		

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C 330	Continued From page 41 -The SIC did not contact the primary care physician to notify her of issues with obtaining Brilinta 90mg for Resident #3. -The SIC did not attempt to hand deliver a copy of the order that was legible to the facility contracted pharmacy. -The SIC did not inform the Administrator of problems with getting Brilinta 90mg filled until after 1/26/18. -The SIC did not know what type of medication Brilinta 90mg was, or why it was ordered for Resident #3. -She should have contacted the cardiologist for Resident #3 when the medication was not filled and she should have informed the Administrator. -The SIC did not know why the MAR had been signed indicating Brilinta was administered for Resident #3. -All medication aides (MAs) were aware they were not to document medication as administered if it was not administered. Interview on 1/30/18 at 3:55pm with the Administrator revealed: -She did not become aware until 1/26/18 that the Brilinta ordered in October 2017 for Resident #3 was never filled. -The SIC informed the Administrator on 1/26/18 of the issue. -The Administrator had heard in October 2017 that there was some clarification needed for Resident #3 and pharmacy staff was making contact with the physician. -The Administrator did not hear any more about the issue and thought the medication was filled. -The SIC was responsible for sending new orders to the pharmacy and assuring medication was available for residents. -If the SIC had a problem getting medication she was expected to discuss with the Administrator.	C 330		

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-The Administrator would complete a medication error report and send to both the primary care physician and the cardiologist for Resident #3.

Interview on 2/1/18 at 5:30pm with a MA revealed:
-She recalled seeing Brilinta order on the MAR for Resident #3.
-Resident #3 never had the medication available.
-She asked the SIC one time about the Brilinta, but did not recall what the SIC said.
-She was not sure why the Brilinta was not available.
-The SIC was her supervisor and was responsible for communicating with the pharmacy.
-She did not recall documenting Brilinta was administered.
-She only documented on the medications that were administered.

Interview on 1/31/18 at 4:15pm with Resident #3 revealed:
-He had an operation due to his heart blockage.
-He did not know what else was done or if stents were placed.
-He was started on new medication, but did not know the name of medication or what it was for.
-He took the medication administered to him and thought he was given what was ordered by the physician.

2. Review of Resident #1's current FL-2 dated 10/30/17 revealed:
-Diagnoses included schizophrenia/depression, altered mental status, asthenia, hypothyroidism, hypertension and chronic kidney disease stage 4.
-There was an order for Benztropine (used to treat side effects of psychiatric drugs) 1 mg twice daily, Oxcarbazepine (used to treat seizures) 300mg daily, Plavix (used to keep blood vessels

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open to prevent heart attacks and strokes) 75 mg daily, Aspirin (used as a blood thinner) 81 mg daily, Acetaminophen (used for pain or fever) 325 mg take 2 tablets every 6 hours as needed for pain or fever, Oncovite (used a vitamin supplement) one tablet daily.

Interview with a Live-In Personal Care Aide (PCA) on 01/30/18 at 12:25 p.m. revealed:
-She witnessed the resident having a seizure about 2 weeks ago that lasted about 5 minutes.
-The staff reported the seizure activity to the Supervisor-in-Charge (SIC).

Review of Resident #1's December 2017 handwritten Medication Administration Record (MAR) revealed:
-There was a handwritten entry for Aspirin 81 mg daily with an administration time of 8:00 a.m.
-Aspirin 81 mg was documented as administered daily from 12/01/17-12/31/17.
-There was a handwritten entry for Benztropine 1 mg twice daily with an administration time of 8:00 a.m. and 8:00p.m.
-Benzotropine 1 mg was documented as administered twice a day from 12/01/17-12/31/17.
-There was a handwritten entry for Plavix 75 mg daily to be administered at 8:00 a.m.
-Plavix 75 mg was documented as administered daily from 12/01/17-12/31/17.
-There was a handwritten entry for Oxcarbazepine 300 mg daily to be administered at 8:00 a.m.
-Oxcarbazepine 300 mg was documented as administered daily from 12/01/17-12/31/17.
-There was a handwritten entry for a Therapeutic Multivitamin (Oncovite) daily to be administered at 8:00 a.m.
-The Therapeutic Multivitamin (Oncovite) was documented as administered daily from

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C 330	Continued From page 44 12/01/17-12/31/17. Review of Resident #1's computer generated January 2018 MAR revealed: -There were 1 of 2 pages of computer generated medications listed for Resident #1. -There was a third page that included one handwritten medication entry. -There were no an entries for Acetaminophen 325 mg, Aspirin 81 mg, Benzotropine 1 mg, Plavix 75 mg, Oxcarbazepine 300 mg, or Oncovite. Interview with the SIC on 01/26/18 at 6:10 p.m. revealed: -Resident #1 was receiving pharmacy services from another pharmacy provider however she was switched over to a new pharmacy in December of 2017. -The previous pharmacy provider was sending Resident #1's medication in "bubble packs" with medications placed together for a scheduled time and then her medications were changed and dispensed in bottles. -Because Resident #1 was having so many medication changes, she was switched to the facility's contracted pharmacy provider since medications were dispensed individually on a blister pack card. -When Resident #1 changed pharmacies, the previous pharmacy provider "switched everything". -She sent Resident #1's FL-2 by fax to the new contracted pharmacy provider but was not sure of the date this was done. -Resident #1's MAR for January 2018 came to the facility from the new contracted pharmacy provider the end of December 2017 and at that time she compared the medications listed on the MAR with her current orders to assure the MAR was correct and that all medications were listed.	C 330		

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C 330	Continued From page 45 -It was questionable and she was not sure if Resident #1 had received Acetaminophen 325 mg as needed, Aspirin 81 mg, Benzotropine 1 mg, Plavix 75 mg, Oxcarbazepine 300 mg, or the Oncovite supplemental vitamin for the month of January 2018. -She thought Resident #1 was "missing some MARs". Observation of the medications on hand for Resident #1 on 01/26/18 at 6:55 p.m. revealed: -There was a unit dose of Plavix 75 mg dispensed on 01/26/18 with a quantity of 30 tablets with no tablets removed from the unit dose blister pack. -There was a unit dose of Benztropine 1 mg dispensed on 01/26/18 with a quantity of 10 tablets with a handwritten entry "owe 50 tabs", with no tablets removed from the unit dose blister pack. -There was an over the counter bottle of Aspirin 81 mg with greater than 10 tablets remaining in the bottle. -There were 2 cards of medications containing blister packs of scheduled/timed medication dosing for morning and bedtime administration with a dispensed date of 10/07/17. -There were other medications dispensed from Resident #1's current pharmacy provider dispensed in a one unit dose with a date of 12/29/17 that had several doses removed from the single dose packaging. -There was no other unit dose packaging for Acetaminophen 325 mg as needed, Aspirin 81 mg, Benzotropine 1 mg, Plavix 75 mg, Oxcarbazepine 300 mg, or the Oncovite supplemental vitamin. Interview with the Administrator on 01/26/18 at 7:00 p.m. revealed:	C 330		

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C 330	Continued From page 46 -The SIC was responsible for reviewing all new MARS with the resident's medication orders and medications on hand. -She would contact and would explain to the Primary Care Provider (PCP) that the Resident #1's ordered Benzotropine 1 mg, Plavix 75 mg, Oxcarbazepine 300mg, Acetaminophen 325 mg, Aspirin 81 mg, and Oncovite supplemental vitamin was not listed on the available MARs for January 2018 and not known if the resident received the medications since January 1, 2018 and would clarify on how to proceed with these medications by making contact tonight (01/26/18). -The SIC was responsible for faxing the current FL-2 and all medication orders to the resident's new contracted pharmacy at the time the pharmacy provider was switched. Telephone interview with a pharmacy technician from Resident #1's previous pharmacy provider on 01/30/18 at 9:05 a.m. revealed: -The resident's medications were transferred to another pharmacy provider on 12/08/17. -The resident was receiving her dispensed medication in bottle form for the last 2 months of service from them. -The last medications they dispensed was on 12/06/17 and the remainder of the refills were transferred to another pharmacy. -The SIC from the facility called and requested to have the resident's medications transferred to a different pharmacy. -She would fax the last 2 months (November and December 2017) dispensing records for the resident. -No dispensing records were provided by the previous facility pharmacy for Resident #1 by the exit date on 02/01/18. Observation of Resident #1's medications on	C 330		

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C 330	Continued From page 47 hand on 01/30/18 at 10:36 a.m. revealed: -There were 3 unit dose cards of Benztropine 1 mg, dispensed on 01/26/18 with a quantity of 20 tablets, a handwritten entry "1/2" on the label with no doses removed. The second unit dose card of Benztropine 1 mg, dispensed on 01/26/17 with a quantity of 10 in the blister packs with no doses removed. The third unit dose card of Benztropine 1 mg, dispensed on 01/26/18 with a quantity of 30 tablets and a handwritten entry on 2/2 on the label with no doses removed. -There was a unit dose of Plavix 75 mg dispensed on 01/26/18 with a quantity of 30 tablets with no tablets removed from the unit dose blister pack. -There were 8 blue colored bottles of medication dispensed from the previous pharmacy with a last dispensed date around 12/05/17, however, none of these medication bottles contained Plavix 75 mg, Benztropine 1 mg, Oxcarbazepine 300mg, or Oncovite vitamins. Interview with the Administrator on 01/30/18 at 10:56 a.m. and at 11:45 a.m. revealed: -She had spoken with the PCP yesterday and it was discussed that the resident had not had any seizures and the PCP ordered to stop Oxcarbazepine, however, after the Administrator reviewed Resident #1's record further and seen that the resident had been on this medication for an extended time she had placed another call to the PCP before discontinuing the medication. -The PCP did not "say anything" when she told her about Resident #1's Plavix, Benztropine, and Aspirin but had placed another call to the PCP. -All of Resident #1's medications should have been started back on Saturday (01/27/18). -She was not sure why none of the 30 tablets of Plavix 75 mg dispensed on 01/26/18 or the Benztropine had not been removed from the	C 330		

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blister pack when Resident #1's medications were rechecked on 01/30/18.
-They never found a missing MAR for Resident #1 for January 2018 and "don't know what to say".
-She had spoken with the SIC regarding the importance of making sure the residents' medications listed on the new MARS were checked off with the current orders and that everything matched with the medications on hand.
-The pharmacy sends the residents new MARS each month around the 20th for the following month.
-She performed medication record reviews but "not like I should" and had intentions to review Resident #1's medications comparing her medications on hand with the current orders since she had so many medications changes in the last few months.

Interview with the SIC on 01/30/18 at 11:15 a.m. revealed:
-She did not save the fax confirmation when she initially sent Resident #1's current FL-2 to the new contracted pharmacy provider.
-She was not sure when she sent Resident #1's current FL-2 to the pharmacy, however, she knew it was not at the same time when Resident #1 was switched to the new contracted pharmacy.

Telephone interview with a Pharmacy Technician at Resident #1's current contracted pharmacy provider on 01/30/18 at 11:43 a.m. revealed:
-He had spoken with the Administrator yesterday (01/29/18) regarding Resident #1's medications.
-The pharmacy did not receive any documentation from the facility when the resident's medications were moved in December 2017 and only received information from the

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previous pharmacy provider.
-He "assumed" there could have been some medications that the previous pharmacy was providing that did not have refills and that could have been the reason those medications were not filled from them (current pharmacy) and sent to the facility.
-They did not receive the current FL-2 from the facility until the first of January 2018.

Review of dispensing records from Resident #1's current contracted pharmacy provider revealed:
-The medication profile of dispensed medication was from 12/01/17-01/30/18.
-Benztropine 1 mg, with a quantity of 60 tablets was dispensed on 01/26/18.
-Oxcarbazepine 300 mg, with a quantity of 30 tablets was dispensed on 01/27/18.
-Plavix 75 mg, with a quantity of 30 tablets was dispensed on 01/26/18.
-Tylenol 325 mg, with a quantity of 60 tablets was dispensed on 01/26/18.
-Oncovite (Certa-vite) vitamin, with a quantity of 30 tablets was dispensed on 01/29/18.
-Aspirin 81 mg had not been dispensed from 12/01/17-01/30/18.

Telephone interview with the SIC on 01/31/18 at 2:30 p.m. revealed:
-She had not been told Resident #1 had a seizure in the last 2 weeks.
-Resident #1 had not had any seizures in a couple of months.
-She had never seen Resident #1 have a seizure.

Telephone interview with a Medical Assistant from Resident #1's Neurologist's office on 02/01/18 at 10:37 a.m. revealed:
-The resident was taking Oxcarbazepine to control seizures.

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C 330	Continued From page 50 -Without medications to control seizures the resident was at an increased risk for seizures and possible injury if a fall occurred because of seizure activity. Telephone interview with Resident #1's Registered Nurse from the mental health provider on 02/01/18 at 9:40 a.m. revealed: -He was not aware that the resident had not received Benztropine for the month of January 2018. -Benztropine was prescribed to the resident to decrease the side effects of other medications she was on and the medication could help decrease hyperactivity. Telephone interview with Resident #1's Psychiatrist on 02/01/18 at 9:45 a.m. revealed the resident was on a lot of psychiatric medications and was prescribed Benztropine for some of the side effects of those medications. Telephone interview with Resident #1's PCP on 01/31/18 at 11:22 a.m. revealed: -She was contacted by the Administrator about Oxcarbazepine and could not be certain but did not think the Administrator mentioned Plavix, Benztropine, and Aspirin. -She had limited information on Resident #1 and had only seen her one time in November of 2017. -She had requested records from the resident's previous PCP but never received any information. -The resident had a history of a stroke from medical information she had obtained and definitely needed to continue Plavix. -She would call the Administrator to make sure Plavix had been restarted. -The resident needed to continue Plavix for stroke prevention. -She did not know there had been reports of the	C 330		

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C 330	Continued From page 51 resident having a seizure and would call and would advise the Administrator to restart Oxcarbazepine. Based on observations of the medications on hand, review of the current FL-2, medication orders, dispensing records from the current contracted pharmacy provider, the MARS and no other additional MARs available with documentation Plavix 75 mg, Benztropine 1 mg, Oxcarbazepine 300 mg, Oncovite (Certa-vite) vitamin, and Aspirin 81 mg administered, and it could not be determined if the above medications had been administered as ordered for Resident #1. The facility failed to assure medication was administered as ordered for 2 of 3 sampled residents as evidenced by a resident not receiving an anticoagulant for months after a cardiac stent was placed (Resident #3) and a resident not receiving medications for the control of seizures, an anticoagulant to prevent a stroke, a medication to help with side effects of antipsychotic medications, an as needed pain reliever, a supplemental vitamin and a medication used to thin the blood for at least 26 days (Resident #1). The facility also failed to notify the physician of the unavailability of medications and of medications not administered as ordered. These failures by the facility resulted in serious neglect and physical harm for residents which constitutes a Type A1 Violation. Review of a Plan of Protection dated 01/26/18 with addendum dated 01/30/18 revealed: -Notify the doctor of medication concerns for January with the identified residents by the Administrator (01/26/18). -Review medications monthly to ensure current	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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
C 330	Continued From page 52 medications, compare to Medication Administration Record (MAR) for accuracy for all residents by the Administrator/Supervisor-in-Charge (SIC) 01/26/18. -Contact the primary care provider with any discrepancies. -Obtain needed medication immediately to make available for resident/clarify with MD for further instructions. -Medications would be ordered by the SIC/Medication Aide. -Administrator/SIC would monitor medications monthly for accuracy with the FL-2, medications on hand, and orders. -Administrator/SIC would compare to MAR for accuracy and to ensure all residents receiving appropriate medications. -Administrator would monitor random medication passes for accuracy. Addendum: -Any new medication orders or clarification would be immediately faxed and processed to pharmacy and follow up if medications were not in the facility within 24 hours. -Educate staff regarding medication documentation documented and no given with completion of administration of medication. -Medications should only be documented as given when they were actually administered. -Medication error form would be completed and sent to the doctor by fax by the Administrator immediately as well as immediate contact on 01/30/18. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 03, 2018.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 912	Continued From page 53	C 912		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration and supervision. The findings are: 1. Based on observations, record reviews, and interviews the facility failed to assure medications were administered as ordered for 2 of 3 sampled residents (#3,#1) as evidenced by Resident #3 not receiving medications as ordered, an anticoagulant and Resident #1 an anticoagulant, a medication used to treat side effects of psychiatric drugs, an anticonvulsant, a blood thinner, pain/fever reducer, and a vitamin supplement as ordered for at least 26 days. [Refer to Tag 0330 10A NCAC 13G .1004 (a)(1)(2) Medication Administration (Type A1 Violation).] 2. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 resident with a documented history of altered mental status from crossing a busy highway unsupervised by staff. [Refer to Tag	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 912	Continued From page 54 0243 10A NCAC 13G .0901(b) Personal Care And Supervision (Type B Violation).]	C 912		