

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/13/2018
NAME OF PROVIDER OR SUPPLIER CHATHAM COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST CHATHAM STREET CARY, NC 27512		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up survey and complaint investigation on February 6-9, and 12-13, 2018.	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 a cabinet, one janitorial closet, and the laundry room containing hazardous materials were locked and not accessible to residents. The findings are: Observation of the men's shower room on 02/06/18 at 2:51 p.m. revealed: -There was a cabinet to the left of the bathtub containing three liquids in spray bottles. -The green liquid was labeled as a neutral cleaner with "do not drink" written on both sides of the bottle. -The yellow liquid was labeled as disinfectant with "do not drink" written on both sides of the bottle. -The white spray bottle's label was covered in red tape.	D 056		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 056	Continued From page 1 Observation of the women's shower room on 02/06/18 at 2:54 p.m. revealed there was another bottle of a yellow liquid on the laundry cart in the shower room. Interview with the Administrator on 02/06/18 at 5:24 p.m. revealed: -The chemicals in the men's shower room should have been locked away. -She would remove the liquids from the shower room. Observation of the men's shower room on 02/09/18 at 10:10 a.m. revealed the same liquids were still unlocked in the cabinet. Observation of the men's shower room on 02/09/18 at 10:22 a.m. revealed: -The Clinical Support Specialist removed the liquids from the cabinet. -The key hanging beside the cabinet was broken. Observation of the women's shower room on 02/09/18 at 10:22 a.m. revealed: -The yellow liquid had been removed from the room. -The cabinet of chemicals in the shower room was locked. Observation of the 100 hall on 02/09/18 from 11:47 a.m. to 11:58 a.m. revealed: -The janitorial closet was unlocked with several chemicals exposed. -The janitorial closet was directly across the hall from a resident's room. -The resident wandered the hall and walked by the closet three times but did not enter. Interview with the Resident Care Coordinator on	D 056		

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D 056	Continued From page 2 02/09/18 at 11:58 a.m. revealed: -The janitorial closet should have been closed and locked. -The housekeeper was busy getting rooms ready for new admissions and probably overlooked closing the door. Observation of the laundry room on the 200 hall on the assisted living (AL) side of the facility on 02/06/18 at 9:38 a.m. revealed: -The laundry room door was unlocked. -There was a 5 gallon bucket of liquid de-stainer / bleach sitting on top of one of the washing machines. ("Danger- keep out of the reach of children. Avoid contact with eyes, skin, or mucous membranes. Flush thoroughly with water.") -The bucket was over half full of de-stainer/bleach. -There was a container of solid laundry detergent in a dispenser on the wall above the washing machines. ("Caution, keep out of reach of children. May be harmful if swallowed.") -Multiple residents were walking up and down the 200 hall during this time. Interview with the Administrator on 02/06/18 at 5:30 p.m. revealed: -She just started working at the facility on 01/22/18. -All chemicals should be locked up. -The laundry room should always be locked.	D 056		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings	D 074		

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D 074	Continued From page 3 (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings, and floors were kept clean and in good repair in the assisted living and special care unit for 3 common bathroom/shower rooms, 12 private or adjoining resident bathrooms, 18 resident rooms, 2 hallways, and a resident lounge room. The findings are: Observation of the shared bathroom between Resident Room 111 and Resident Room 109 on 02/06/18 at 9:49 a.m. revealed there was a basketball sized area of round plaster on the wall to the right of the toilet. Observation of Resident Room 111 on 02/06/18 at 9:50 a.m. revealed: -There was a two inch scrape on the corner of the wall to the right of the closet door near the bathroom. -There were multiple black marks on the wall to the right of the closet near the bathroom. Observation of shared bathroom between Resident Room 107 and Resident Room 105 on 02/06/18 at 10:12 a.m. revealed: -There was a three inch area of baseboard to the left of the door that was rusted. -There was a quarter sized hole in the closet door to the right of the main entrance.	D 074		

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D 074	Continued From page 4 Observation of the shared bathroom between Resident Room 107 and Resident Room 105 on 02/06/18 at 2:56 p.m. revealed: -There was a foot long black scrape to the right of the bathroom door. -There were two round water stains on the ceiling. Observation of Resident Room 105 on 02/06/18 at 3:02 p.m. revealed: -There were multiple black marks and scrapes on the wall to the left of the bathroom door. -There was a foot long scrape to the right of the main entrance. -There were two triangular areas of missing paint and drywall on the wall to the right of the main entrance. Observation of Resident Room 103 on 02/06/18 at 10:26 a.m. revealed: -There was a foot long area of missing drywall on the wall to the left of entrance. -There were multiple black and white scrapes on the wall to the left of the entrance. -Behind the door, there were black smudges and scrapes on the wall. -There were multiple black smudges and chipped paint on the wall to the right of the bathroom door. Observation of the women's shower room on the 100 hall 02/06/18 at 2:48 p.m. revealed: -There was a vent on the ceiling with brown spots and rust. -The exhaust fan had dirt in the grates and was covered in brown and black smudges. Observation of the men's shower room on 02/06/18 100 hall at 2:53 p.m. revealed: -The exhaust fan had rust around the sides of the	D 074		

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D 074	Continued From page 5 grate and brown smudges. -There were two brown water marks on the ceiling surround the smoke detector. Observation of the resident lounge room on the 100 hall on the assisted living (AL) side of the facility on 02/06/18 at 10:55 a.m. revealed: -There was dirt and debris and black streaks in multiple areas all over the floor. -There were cracks and gaps in the ceiling around two electrical outlets near the window. -There was a crack in the ceiling that was approximately 1 to 2 feet long that had been plastered but was reopening through the plaster. -There was ceiling vent with a thick layer of dust. Interview with a resident in the lounge room on 02/06/18 at 10:55 a.m. revealed: -There was only one housekeeper for the facility but he did not clean at all. -The resident had seen the housekeeper mop with dirty water. -They had another housekeeper who cleaned the rooms every day but she left about 4 to 6 weeks ago. -The resident's roommate had to sweep the floor in their room. -The resident did not know when the lounge room had last been cleaned. Observation of the ceiling near the men's shower room on the 100 hall in the AL side of the facility on 02/06/18 at 11:22 a.m. revealed: -There was a crack running down the ceiling from the attic access door that was approximately 2 to 3 feet long. -The crack had plaster or paint over the top of it but the crack had reopened. -There was a crack running down the ceiling from a light fixture in the hallway that was	D 074		

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D 074	Continued From page 6 approximately 3 to 4 feet long. Observation of resident Room 209 in the AL side of the facility on 02/06/18 at 9:40 a.m. revealed: -There was plastic round plate approximately 4 inches in diameter attached to the wall near the closet that was dented and cracked in the center. -There were missing paint, dark yellow tape and plaster on the wall around the round plate. -The bottom edge of the wall near the closet had dent marks with missing paint and chipped off sheetrock. -There was a buildup of black stains all over the floor of the bedroom with dirt and debris scattered on the floor around the room. -There were 5 black streaks/scratch marks ranging from 3 to 5 inches on the floor near the head of the bed on the left. -There were multiple cracks around the molding at the edge of the ceiling around the perimeter of the room. Observation of the bathroom in resident Room 209 in the AL side on 02/06/18 at 9:44 a.m. revealed: -There was a long piece of toilet paper and toilet paper wrapping on the floor near the sink. -There were dark yellow and brown stains on the floor all around the toilet. -The wall beside the toilet had a thick buildup of dark yellow stains running down the wall. -There were dried brown stains running down the wall behind the toilet. -There were at least 6 small holes in the wall near the toilet paper holder. -There was missing paint and rust at the bottom of the door casing on both sides. Interview with a resident in Room 209 on 02/06/18 at 9:48 a.m. revealed he did not know	D 074		

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D 074	Continued From page 7 when the room or bathroom was last cleaned. A second observation of resident Room 209 on 02/06/18 at 2:45 p.m. revealed the room had not been cleaned and it was in the same condition as noted on 02/06/18 at 9:40 a.m. A second observation of the bathroom in resident Room 209 on 02/06/18 at 2:48 p.m. revealed the bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 9:44 a.m. A third observation of resident Room 209 on 02/08/18 at 4:21 p.m. revealed the room had not been cleaned and it was in the same condition as noted on 02/06/18 at 9:40 a.m. A third observation of the bathroom in resident Room 209 on 02/06/18 at 4:21 p.m. revealed the bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 9:44 a.m. Observation of resident Room 205 on the AL side of the facility on 02/06/18 at 9:53 a.m. revealed: -There was a buildup of black stains all over the floor of the bedroom with dirt and debris scattered on the floor around the room. -There were black scratch marks on the bottom half of the wall near the entrance to the bathroom Observation of the adjoining bathroom between Room 205 and 207 on 02/06/18 at 10:08 a.m. revealed: -The towel bar on the wall beside the sink was missing with just a metal bracket on the right and a piece of metal bar sticking out about 2 inches on the right. -There were dark yellow and brown stains on the floor all around the toilet. -There was dirt a debris build up on the floor,	D 074		

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D 074	Continued From page 8 especially in the corner near and around the toilet. -The wall beside the toilet had a thick buildup of dark yellow stains running down the wall. -There were at least 4 small holes in the wall near the toilet paper holder with missing paint near the holes. -There were 2 small holes in the wall above the paper towel dispenser. -There was missing paint and rust at the bottom of the door casing on both sides. -There was a black scratch mark on the wall behind a portable toilet chair that was approximately 3 feet long. Interview with a resident in Room 205 on 02/06/18 at 9:53 a.m. revealed: -The bedroom and the bathroom needed cleaning. -It had been about a week since the room and bathroom were last cleaned. Interviews with a second resident in Room 205 on 02/06/18 at 9:58 a.m. and 10:08 a.m. revealed: -The housekeeper used to clean their room and bathroom every day but now they only get cleaned about once a week. -It was last cleaned about a week ago. A second observation of resident Room 205 on 02/06/18 at 2:55 p.m. revealed the room had not been cleaned and it was in the same condition as noted on 02/06/18 at 9:53 a.m. A second observation of the adjoining bathroom between Room 205 and 207 on 02/06/18 at 2:56 p.m. revealed the bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 10:08 a.m.	D 074		

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D 074	Continued From page 9 A third observation of resident Room 205 on 02/08/18 at 4:17 p.m. revealed the room had not been cleaned and it was in the same condition as noted on 02/06/18 at 9:53 a.m. A third observation of the adjoining bathroom between Room 205 and 207 on 02/08/18 at 4:17 p.m. revealed the bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 10:08 a.m. Observation of resident Room 206 on the AL side of the facility on 02/06/18 at 10:10 a.m. revealed: -There were scratch marks and missing paint on the door casing around the closet on the right. -There was a buildup of black stains all over the floor of the bedroom with dirt and debris scattered on the floor around the room. -There were at least 4 small clumps of a brown substance in the middle of the floor between the two beds. -There were 2 small white pieces of paper and 1 small pink piece of paper on the floor in the middle of the room. -There were pinkish red stains on the floor between the dresser and the foot of the bed on the left. -There were flakes of cigarette tobacco on the floor near the head of the bed and the oxygen concentrator. -There was a cigarette butt on the floor near the closet on the left. -There were two cigarette butts on the floor under the bed on the left. -There was a cigarette butt on the floor under the oxygen concentrator beside the bed on the left. -There was a cigarette butt in an open bag of clean incontinence briefs. Observation of the adjoining bathroom between	D 074		

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D 074	Continued From page 10 Room 206 and 208 on 02/06/18 at 10:24 a.m. revealed: -The toilet paper holder had 2 pieces of metal sticking out of the wall about 3 inches without a roll holder attached. -The bottom third of the walls in the bathroom beside and behind the toilet had peeling paint. -There were dark yellow and brown stains on the floor all around the toilet. -There were small pieces of toilet paper and toilet paper wrapping on the floor beside the toilet. -There was a hole about one inch in diameter and missing paint near the soap dispenser. -There were 2 small holes and missing paint on the wall above the paper towel dispenser. -There were 3 small holes in the wall near the door adjoining Room 206. -There were black scratch marks running along the bottom of the wall near the sink. -There was a buildup of yellow stains on the floor. -There was a crack in the ceiling along the edge of the ceiling exhaust fan/light. Interview with a resident in Room 206 on 02/06/18 at 10:10 a.m. revealed: -The housekeeper was supposed to clean the room every day. -"They don't clean it." -He kept his own broom and he would sweep the room himself which was difficult because the resident was a double amputee and had to use a wheelchair. -It had been about a week since staff had cleaned his room or bathroom. -His roommate would bring in cigarette butts from outside and there were always cigarette butts on the floor. -The toilet paper holder had been broken for a while (could not specify how long).	D 074		

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D 074	Continued From page 11 A second observation of resident Room 206 on the AL side of the facility on 02/06/18 at 2:50 p.m. revealed the room had not been cleaned and it was in the same condition as noted on 02/06/18 at 10:10 a.m. A second observation of the adjoining bathroom between Room 206 and 208 on 02/06/18 at 2:52 p.m. revealed the bathroom had not been cleaned and it was in the same condition as noted on 02/06/18 at 10:24 a.m. except the toilet paper roll holder was attached to the bars on the wall with an empty roll of toilet paper. Interview with a resident in Room 206 on 02/06/18 at 2:50 p.m. revealed his room nor the bathroom had been cleaned today, 02/06/18. A third observation of resident Room 206 on the AL side of the facility on 02/08/18 at 8:54 a.m. revealed: -The small clumps of a brown substance in the middle of the floor between the two beds had been removed. -Everything else was in the same condition as noted on 02/06/18 at 10:10 a.m. A third observation of the adjoining bathroom in Room 206 on 02/08/18 at 8:54 a.m. revealed the bathroom had not been cleaned and it was in the same condition as noted on 02/06/18 at 10:24 a.m. except the toilet paper roll holder was attached to the bars on the wall with a roll of toilet paper. Interview with a resident in Room 206 on 02/08/18 at 8:54 a.m. revealed he thought staff did some cleaning in the bathroom last night on 02/07/18.	D 074		

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D 074	Continued From page 12 Interview with a resident in Room 208 on 02/08/18 at 8:56 a.m. revealed he thought staff usually cleaned the bathroom about every other day. Interview with a visitor in Room 206 on 02/07/18 at 1:22 p.m. revealed: -There had been an ongoing problem with cleanliness of the room. -The floors were dirty and there were cigarette butts on the floor all of the time. -The bathroom always needed cleaning. Observation of resident Room 201 on the AL side of the facility on 02/06/18 at 10:41 a.m. revealed: -There were two brown cigarette butts on the floor beside the bed on the left. -There was a buildup of black stains and dirt and debris on the floor throughout the room. -There were 4 small holes and missing paint on the wall beside the headboard of the bed to the right. Observation of the adjoining bathroom between Room 201 and 203 on 02/06/18 at 10:47 a.m. revealed: -There were dark yellow and brown stains on the floor all around the toilet. -There was dirt and debris scattered all over the floor. -There were small pieces of toilet paper scattered in several areas on the floor. -There were 3 small holes in the wall below the soap dispenser. -There were 3 small holes and missing paint on the wall above the paper towel dispenser. -There were 4 small holes and missing paint on the wall near the toilet paper holder. -There were 5 small holes on the wall near the entrance to Room 203.	D 074		

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D 074	Continued From page 13 -There were scratch marks and missing paint at the bottom of the door casing on both sides. -There was missing paint and plaster on the wall behind the sink. Interview with a resident in Room 201 on 02/06/18 at 10:49 a.m. revealed: -The facility did not have a housekeeper anymore. -She could not recall how long the housekeeper had been gone. -She did not know when the room or the bathroom was last cleaned. Interview with a visitor on 02/06/18 at 3:00 p.m. revealed he had to clean the room every day because it was usually not clean. Observations of resident Room 303 on the AL side of the facility on 02/06/18 at 4:31 p.m. and on 02/07/18 at 8:27 a.m. revealed: -There was a thick buildup of black stains all over the floor of the bedroom with dirt and debris scattered on the floor around the room. -There was a hole near the bottom of the wall beside the closet that had wall putty with a hole in the middle about 1 inch in diameter that went all the way through to the closet. Interview with a resident in Room 303 on 02/06/18 at 4:31 p.m. revealed: -The floors "have been this way". -"They don't mop." Interview with a visitor in Room 303 on 02/06/18 at 3:03 p.m. revealed: -Her family member had just moved into the facility a couple of days ago. -"The floor looks bad." Observations of resident Room 303 on the AL	D 074		

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D 074	Continued From page 14 side of the facility on 02/06/18 at 4:31 p.m. and on 02/07/18 at 8:27 a.m. revealed: -There was a thick buildup of black stains all over the floor of the bedroom with dirt and debris scattered on the floor around the room. -There was a hole near the bottom of the wall beside the closet that had all putty with a hole in the middle about 1 inch in diameter that went all the way through to the closet. Interview with a resident in Room 303 on 01/06/18 at 4:31 p.m. revealed: -The floors "have been this way". -"They don't mop." Interview with a visitor in Room 303 on 02/06/18 at 3:03 p.m. revealed: -Her family member ahd just moved into the facility a couple of days ago. -"The floor looks bad." Observation of the bathroom in room 309 on 02/07/18 at 8:05 a.m. revealed: -There were two 1 foot long purple stains on the floor beside the toilet. -The toilet lid had yellow/brown stains on the top and bottom of the lid. Observation of room 307 on 02/07/18 at 8:12 a.m. revealed: -There was small pieces of paper and trash all of the floor of the room. -There was black scuff marks on the floor near the entry door of the room. Observation of room 308 on 02/07/18 at 8:15 a.m. revealed there were black foot prints all over the floor of the room. Observation of the bathroom in room 308 on	D 074		

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D 074	Continued From page 15 02/07/18 at 8:17 a.m. revealed: -There was a yellow film on the floor around the toilet. -There were 2 broken towel racks on the wall of the bathroom. -The floor was sticky all over when walked on. Observation of room 304 on 02/07/18 at 8:20 a.m. revealed: -There were black stains all over the floor and on the front sides of the bathroom door. -There were black stains all around the beds. -There were small dirt particles and grass all over the floor of the room. Observation of the bathroom in room 304 on 02/07/18 at 8:25 a.m. revealed: -There were 2 of 4 walls that had cracked and peeled paint on them. -There was a toilet that had yellow stains all over the front and sides. Observations on 2/06/17 during the tour from 10:20 a.m. to 11:00 a.m. of the 400 Hall, Special Care Unit (SCU). Observation on 02/06/17 at 10:25 a.m. of the bathroom in resident room #421 revealed: -There were 1/2 inch uncovered holes and indentations in the wall above the toilet paper holder. -There were dark brown and light brown smears of an unknown substance on the wall beside the toilet. -There was a 6 inch x 2 inch scraped mark and a 1-1/2 inch scraped mark having missing paint under the liquid soap dispenser on the wall beside the sink. -There were dark brown stains in the grout at the base of the toilet.	D 074			

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D 074	Continued From page 16 -There was a build up of dark brown dirt around the base of the door frame at the floor. -There were 3 horizontal scrape lines 12 inches above the bottom edge of the bathroom door. -There were multiple 1/2 inch sized brown spots on the floor in the center of the bathroom. -There were dark brown, orange brown, and black stains on 1 foot sections of the ceiling crown molding at the corner of the wall next to the door. Observation on 02/06/17 at 10:31 a.m. of the bathroom in resident room #414 revealed: -There were yellow stains in the flooring of the bathroom. -There were dark brown stains around the base of the toilet. -There were 5 uncovered 1/2 inch holes in the wall surrounding the toilet paper holder. -There was a build up of dark brown dirt around the base of the door frame at the floor. -There were 2 uncovered 1/2 inch holes in the wall, 1 under each end of the towel bar. Observation on 02/06/18 at 10:46 a.m. of the bathroom in resident room #401 revealed: -There were dark brown and black stains in the flooring surrounding the toilet base. -There was a build up of dark brown dirt on the floor and on top of the floor molding in the corner beside the sink. -There was paint missing on the bottom 2 feet of the bathroom door frame. -There was 2 inch towel bar end piece sticking out from the wall beside the sink. Observation on 02/06/18 at 10:51 a.m. of the 400 Hall Men's Shower Room revealed: -There were brown stains in the tile flooring of the open shower area.	D 074		

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D 074	Continued From page 17 -There were yellow and brown stains on the lower tile walls and floor molding. -There were black and dark brown stains on the wall tiles at the right back corner of the shower. -There were dark yellow and brown stains on the wall tiles below the shower faucet. -There were dark brown and black stains on the tile grout of the floor molding all around the Shower Room. -The water sprinkler nozzle, in the ceiling, across from the ceiling vent was loose from the ceiling. - The walls in the room had dark blue and brown marks and smears in the paint. Observation on 02/06/18 at 4:15 p.m. of resident room #401 revealed: -There were dark brown smears and 1 inch horizontal lines on the wall beside the door. -There was missing paint on the bottom 3 feet of the room's door frame. Observation on 02/06/18 at 4:18 p.m. of resident room #402 revealed there were 4 horizontal 3-1/2 feet long x 1-1/2 inches wide white stripes with missing paint, above the resident's bed, on the back wall of the room. Observation on 02/06/18 at 4:22 p.m. of resident room #405 revealed: -There was a torn off 6 x 6 inches section of paint, on the outside wall beside the door, that had no name plate. -There were numerous brown splotches on the flooring throughout the room. -The ceiling coating on the right side of the room had brownish yellow stains, was cracked, and separating from the ceiling. -The ceiling molding had a build up of brown dust in the corners and along the bottom edge. -There were light brown stain marks on the walls	D 074			

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D 074	Continued From page 18 of the room. -The room and bathroom doors had horizontal scrape marks along 6 inches from the floor. Observation on 02/06/18 at 4:28 p.m. of resident room #407 revealed: -There were yellow brown stains on the flooring throughout the room. -The ceiling crown molding had cracking and separating paint throughout the room. Observation on 02/06/18 at 4:30 p.m. of resident room #410 revealed: -There were black scrape marks on the walls 1-1/2 feet up from the floor. -There was a build up of dark brown dirt at the corners of the room. -The room's tile flooring was covered with brown stains and dried liquid drip marks. Observation on 02/06/18 at 4:32 p.m. of resident room #414 revealed there were yellow brown smears on the rooms walls and on the flooring throughout the room. Observation on 02/06/18 at 4:36 p.m. of resident room #415 revealed there were yellow brown smears on the rooms walls and on the flooring throughout the room. Observation on 02/06/18 at 4:38 p.m. of the SCU hallway flooring revealed there were black and dark brown scuff marks, a large dark brown shoe print, and a trail of nickel sized dried drops of a grey brown liquid down the center 3 feet of the hallway. Interview on 2/06/18 at 4:50 p.m. with the Administrator after a tour of the SCU revealed: -She was aware of the scrapes on the walls.	D 074		

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D 074	Continued From page 19 -There were repairs that needed to be done in the SCU. Interview with the Housekeeper on 02/06/18 at 3:13 p.m. revealed: -He had been the only housekeeper at the facility since October 2017. -They had hired a housekeeper on 01/12/18 and another one on 01/24/18 but both only filled out initial paperwork and did not return to the facility. -He had one interview later today with a potential housekeeper. -He was the only housekeeper for the entire facility and it was too much for one person. -He tried to at least clean the common hallways and bathrooms and 6 resident rooms in the AL and 6 resident rooms in the SCU each day. -He was not always able to accomplish that because he also did some maintenance work like changing light bulbs. -He also did laundry because they did not currently have a laundry person at the facility. Interview with the Administrator on 02/06/18 at 5:30 p.m. revealed: -She just started working at the facility on 01/22/18. -There had only been one housekeeper at the facility since October 2017. -The one housekeeper was responsible for keeping the entire facility clean, including the assisted living (AL) and the special care unit (SCU). -The housekeeper also helped with small maintenance issues. -The housekeeper also helped with the laundry because the facility did not currently have a laundry staff person. -One housekeeper was not enough to keep the facility clean and maintained.	D 074		

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D 074	Continued From page 20 -The housekeeper "needs more help". -The housekeeper should make a round in the facility when he got to work each morning to try to identify problems areas. -The housekeeper should take care of cleaning the problems areas first. -At a minimum, the housekeeper should clean common areas every day, including common bathrooms and emptying the trash. -Some resident rooms needed to be cleaned more often than others. -She was aware all resident rooms were not being cleaned daily because it was too much for one person. -Some of the rooms had not been mopped "in a while". -She was in the process of trying to hire another housekeeper. -She was aware some repairs were also needed in the facility and she would work with the corporate office to get those repairs done.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that 3 private or adjoining resident bathrooms (209, 205/207, 206/208) on the 200 hall of the facility had no chronic unpleasant odors as related to strong odors of	D 075		

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D 075	Continued From page 21 urine. The findings are: Observation of the bathroom in resident Room 209 in the assisted living (AL) side on 02/06/18 at 9:44 a.m. revealed: -The trash can was overflowing with incontinence briefs. -There were dark yellow and brown stains on the floor all around the toilet. -There was a soiled toilet plunger stored on the floor under the sink. - There were multiple dried yellow stains around the toilet seat and the back of the toilet. -There was an empty plastic urine collection hat propped against the wall on top of the hand bar beside the toilet. -There was an empty foley catheter bag with tubing wrapped around the hand bar on the wall beside the toilet. -The wall beside the toilet had a thick buildup of dark yellow stains running down the wall. -There was a strong odor of urine in the bathroom. Interview with a resident in Room 209 on 02/06/18 at 9:48 a.m. revealed the resident would not speak to answer questions but indicated by nodding his head that the bathroom smelled like urine. A second observation of the bathroom in resident Room 209 on 02/06/18 at 2:48 p.m. revealed: -The bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 9:44 a.m. -There was a strong odor of urine in the bathroom.	D 075		

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D 075	Continued From page 22 A third observation of the bathroom in resident Room 209 on 02/06/18 at 4:21 p.m. revealed: -The bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 9:44 a.m. -There was a strong odor of urine in the bathroom. Observation of the adjoining bathroom between Room 205 and 207 on 02/06/18 at 10:08 a.m. revealed: -There were dark yellow and brown stains on the floor all around the toilet. -There were multiple dried yellow stains around the toilet seat and the back of the toilet. -There was an empty plastic urine collection hat propped against the wall on top of the hand bar beside the toilet. -There was an empty foley catheter bag with tubing wrapped around the hand bar on the wall beside the toilet. -The wall beside the toilet had a thick buildup of dark yellow stains running down the wall. -The trash can was over 3/4ths full trash, including incontinence briefs. -There was a strong odor of urine in the bathroom. Interview with a resident in Room 205 on 02/06/18 at 9:53 a.m. revealed: -The bathroom needed cleaning. -It had been about a week since the bathroom was last cleaned. -The bathroom smelled like urine all the time. Interviews with a second resident in Room 205 on 02/06/18 at 9:58 a.m. and 10:08 a.m. revealed: -The housekeeper used to clean their room and bathroom every day but now they only get cleaned about once a week.	D 075		

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D 075	Continued From page 23 -It was last cleaned about a week ago. -The bathroom smelled like urine. -The urinary catheter bag and tubing in the bathroom belonged to him. -Facility staff helped him with the catheter and they stored it in the bathroom. A second observation of the adjoining bathroom between Room 205 and 207 on 02/06/18 at 2:56 p.m. revealed: -The bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 10:08 a.m. -There was a strong odor of urine in the bathroom. A third observation of the adjoining bathroom between Room 205 and 207 on 02/08/18 at 4:17 p.m. revealed: -The bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 10:08 a.m. except the plastic urine collection hat had been moved to the towel bar behind the toilet. -There was still a urine odor in the bathroom. Observation of the adjoining bathroom between Room 206 and 208 on 02/06/18 at 10:24 a.m. revealed: -There were two towel bars on the wall opposite the toilet that each had an empty male urinal hanging on the towel bars. -There were dark yellow and brown stains on the floor all around the toilet. -There were multiple dried yellow stains around the toilet seat and the back of the toilet. -The toilet seat was up and there was dark yellow urine in the toilet bowl. -There were dried yellow and brown stains splattered on the front of the toilet. -There was a strong odor of urine in the	D 075		

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D 075	Continued From page 24 bathroom. Interview with a resident in Room 206 on 02/06/18 at 10:10 a.m. revealed: -The housekeeper was supposed to clean the room every day. -"They don't clean it." -His roommate usually messed up the bathroom and it always smelled like urine in the bathroom. -He could not use the bathroom in his room because it was too "messed up" and it smelled bad. -It had been about a week since staff had cleaned his room or bathroom. -The male urinal on the towel bar closest to his room was the one he used. A second observation of the adjoining bathroom between Room 206 and 208 on 02/06/18 at 2:52 p.m. revealed: -The bathroom had not been cleaned and it was in the same condition as noted on 02/06/18 at 10:24 a.m. except the toilet had been flushed. -There was a strong odor of urine in the bathroom. Interview with a resident in Room 206 on 02/06/18 at 2:50 p.m. revealed his room nor the bathroom had been cleaned today, 02/06/18. Interview with a visitor in Room 206 on 02/07/18 at 1:22 p.m. revealed: -The bathroom always smelled like urine. -The bathroom always needed cleaning. A third observation of the adjoining bathroom in Room 206 on 02/08/18 at 8:54 a.m. revealed the bathroom had not been cleaned and it still had an odor of urine	D 075		

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D 075	Continued From page 25 Interview with a resident in Room 208 on 02/08/18 at 8:56 a.m. revealed: -Staff usually cleaned the bathroom about every other day. -The urinal always hung on the towel bars. -The bathroom always smelled like urine. Interview with the Housekeeper on 02/06/18 at 3:13 p.m. revealed: -He had been the only housekeeper at the facility since October 2017. -They had hired a housekeeper on 01/12/18 and another one on 01/24/18 but both only filled out initial paperwork and did not return to the facility. -He had one interview later today with a potential housekeeper. -He was the only housekeeper for the entire facility and it was too much for one person. -He tried to at least clean the common hallways and bathrooms and 6 resident rooms in the AL and 6 resident rooms in the SCU each day. -He was not always able to accomplish that because he also did some maintenance work like changing light bulbs. -He also did laundry because they did not currently have a laundry person at the facility. -The trash cans needed to be emptied twice a day but there was not enough staff to get it done. -He was aware there were some urine odors in some of the resident bathrooms on the 200 hall. -He did not have enough help to keep the bathrooms clean every day. Interview with the Administrator on 02/06/18 at 5:30 p.m. revealed: -She just started working at the facility on 01/22/18. -There had only been one housekeeper at the facility since October 2017. -The housekeeper also helped with small	D 075		

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D 075	Continued From page 26 maintenance issues. -The housekeeper also helped with the laundry because the facility did not currently have a laundry staff person. -One housekeeper was not enough to keep the facility clean. -The housekeeper "needs more help". -The housekeeper should made a round in the facility when he came to work each morning to try to identify problems areas. -The housekeeper should take care of cleaning the problems areas first. -At a minimum, the housekeeper should clean common areas every day, including common bathrooms and emptying the trash. -Some resident rooms needed to be cleaned more often than others. -She was aware all resident rooms were not being cleaned daily because it was too much for one person. -She was in the process of trying to hire another housekeeper.	D 075		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have furniture in good repair in 12 residents' bedrooms and the resident lounge room and men's shower room on the 100 Hall including chest of drawers, night stands/bedside	D 076		

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D 076	Continued From page 27 tables, dressers, chairs, sofas, and a shower chair. The findings are: Observation of Resident Room #111 on 2/6/18 at 9:52 a.m. revealed there were two missing knobs on the top drawer of the dresser. Observation of Resident Room #107 on 2/6/18 at 10:13 a.m. revealed there were missing knobs on the top right drawer of the dresser. Observation of Resident Room #105 on 2/6/18 at 3:03 p.m. revealed there was a dresser missing a knob on the top drawer. Observation of Resident Room #103 on 2/6/18 at 10:37 a.m. revealed there were two broken drawers on the nightstand. Observation of Resident Room #101 on 2/6/18 at 10:49 a.m. revealed there was a missing knob on the top drawer of the dresser. Observation of the men's shower room at 2/6/18 at 2:54 p.m. revealed there was a broken shower chair. Observation of the resident lounge room on the 100 hall on the assisted living (AL) side of the facility on 02/06/18 at 10:55 a.m. revealed: -There was a small table with drawers beside a straight back chair near the soda machine that had dust and multiple dried flower petals and greenery on top of it. -The small table was missing 2 knobs on the drawers. -There were 3 upholstered sofas with multiple brownish black stains on the arms and back of	D 076		

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D 076	Continued From page 28 the sofas. -There was an orange recliner with fabric ripped and hanging off the side of the arm of the chair. Interview with a resident in the lounge room on 02/06/18 at 10:55 a.m. revealed: -The furniture had been dirty for a long time. -The back of the sofas were soiled because residents would lay their heads on it. -There was only one housekeeper for the facility but he did not clean at all. -They had another housekeeper who cleaned the rooms every day but she left about 4 to 6 weeks ago. Observation of resident Room 206 on the AL side of the facility on 02/06/18 at 10:10 a.m. revealed the dresser on the left side of the room was missing 3 knobs on the top right drawer. Interview with a resident in Room 206 on 02/06/18 at 10:10 a.m. revealed he was not sure how long the knobs had been missing on the dresser. Observation of resident Room 201 on the AL side of the facility on 02/06/18 at 10:41 a.m. revealed there was a missing knob on the top left dresser drawer. Interview with a resident in Room 201 on 02/06/18 at 10:49 a.m. revealed she did not know how long the knob had been missing from the dresser. Observation of resident Room 303 on the AL side of the facility on 02/06/18 at 4:31 p.m. revealed: -There was a dresser with 4 knobs missing on the top right drawer and 4 knobs missing on the top left drawer, leaving no knobs for these 2 drawers	D 076			

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D 076	Continued From page 29 to be opened. -There was a knob missing on the top drawer of a nightstand. Interview with a resident in Room 303 on 02/06/18 at 4:31 p.m. revealed he was not sure how long the knobs had been missing from the furniture. Observation on 2/06/18 at 4:15 p.m. of resident room #401 revealed: -The 2 drawers of the bedside chest were angled crookedly and would not close. -The top drawer of the bedside chest had a missing pull knob. -The top 2 drawers of the large 6 drawer chest were missing 6 pull knobs. Observation on 2/06/18 at 4:22 p.m. of resident room #405 revealed there were pull knobs missing on 3 drawers of the 6 drawer chest; 3 on the top right drawer, 3 on the top left drawer, and 1 on the bottom left drawer. Observation on 2/06/18 at 4:32: p.m. of resident room #412 revealed: -There was a beige upholstered arm chair with brown stains along the top edge of the back and arm rests. -The back rest and top of the arm rests were covered with a bright pink stain. -The seat of the chair was covered with a grey blue stain. Observation on 2/06/18 at 4:36 p.m. for resident room #415 revealed: -The 2 drawer bedside chest had scrapes and scratches on the top, top edges, and front, that had removed the wood stain, revealing the white wood underneath.	D 076		

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D 076	Continued From page 30 -The bottom drawer's face plate was hanging at a crooked angle. Interview with the housekeeper on 02/09/18 at 8:50 a.m. revealed: -He was aware there was some furniture that needed cleaning and repair. -He was aware of missing knobs on the furniture. -He had some extra knobs in his supplies and he tried to replace missing knobs when he was cleaning. -He had not replaced any missing knobs recently because facility was short staffed. -He was the only housekeeper for the entire facility and there was not enough time to replace the missing knobs and clean all of the furniture. -He was aware that some of the furniture in the facility was soiled and needed cleaning or replacing. -He used some cleaning solution to try to clean the fabric on the furniture but it did not remove the stains. Interview on 2/06/18 at 4:52 p.m. with the Administrator revealed: -Furnishings needed to be repaired. -The knobs on the drawers needed to be replaced. -The stained upholstered chair needed to be removed and replaced.	D 076		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and	D 079		

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D 079	Continued From page 31 hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was uncluttered, clean and orderly in 2 common resident bathrooms/shower rooms, 5 resident rooms, and 5 private or adjoining resident bathrooms on the 100 and 200 halls of the facility. The findings are: Observation of the women's shower room on 2/6/18 at 2:38 p.m. revealed: -The detachable shower head was leaking. -There was a brown rim around the base of the toilet. -There were various pieces of toilet paper scattered on the floor. Observation of the men's shower room on 2/6/18 at 2:53 p.m. revealed: -There was a brown rim around the base of the toilet. -The toilet bowl was covered in black streaks. -There was dust and trash around the base of the walls. -The sink had strands of hair on the sides and in the basin. -There was a black rim around the interior of the tub. -There were various pieces of toilet paper scattered on the floor throughout the bathroom. -The trash was full and had not been emptied.	D 079		

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D 079	Continued From page 32 Observation of Resident Room #101 on 2/6/18 at 10:49 a.m. revealed the trash can was full and had not been emptied. Observation of Resident Room #105 on 2/6/18 at 3:00 p.m. revealed there were multiple, dried brown stains on the flooring in the doorway. Observation of the shared bathroom between Resident Room 107 & Resident Room 105 on 2/6/18 at 3:03 p.m. revealed there was a dried, yellow stain on the floor to the right of the toilet. Observation of resident Room 209 in the assisted living (AL) side of the facility on 02/06/18 at 9:40 a.m. revealed the trash can was full with paper and plastic sticking out over the top rim of the trash can. Observation of the bathroom in resident Room 209 on 02/06/18 at 9:44 a.m. revealed: -The trash can was overflowing with incontinence briefs. -There was a long piece of toilet paper and toilet paper wrapping lying on the floor near the sink. -There was a soiled toilet plunger stored on the floor under the sink. - There were multiple dried yellow stains around the toilet seat and the back of the toilet. -There was a piece of rolled up material with a blue stripe lying on the floor in the left corner beside the toilet. -There was an empty plastic urine collection hat propped against the wall on top of the hand bar beside the toilet. -There was an empty foley catheter bag with tubing wrapped around the hand bar on the wall beside the toilet. -The catheter bag and tubing were touching the wall beside the toilet.	D 079		

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D 079	Continued From page 33 Interview with a resident in Room 209 on 02/06/18 at 9:48 a.m. revealed: -The resident indicated by nodding his head that the catheter bag in the bathroom belonged to him. -He would not answer any other questions. A second observation of resident Room 209 in the AL side of the facility on 02/06/18 at 2:45 p.m. revealed the room had not been cleaned and it was in the same condition as noted on 02/06/18 at 9:40 a.m. A second observation of the bathroom in resident Room 209 on 02/06/18 at 2:48 p.m. revealed the bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 9:44 a.m. A third observation of resident Room 209 in the AL side of the facility on 02/08/18 at 4:21 p.m. revealed the room had not been cleaned and it was in the same condition as noted on 02/06/18 at 9:40 a.m. A third observation of the private bathroom in resident Room 209 on 02/06/18 at 4:21 p.m. revealed the bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 9:44 a.m. Observation of the adjoining bathroom between Room 205 and 207 on 02/06/18 at 10:08 a.m. revealed: -There were multiple dried yellow stains around the toilet seat and the back of the toilet. -There was an empty plastic urine collection hat propped against the wall on top of the hand bar beside the toilet. -There was an empty foley catheter bag with	D 079		

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D 079	Continued From page 34 tubing wrapped around the hand bar on the wall beside the toilet. -The catheter bag and tubing were touching the wall beside the toilet. -The trash can was over 3/4ths full of trash and there was a strip of toilet paper on the floor near the trash can. -There were brown stains and dirt and debris in and around the sink. -There was an open tube of skin protectant ointment on the floor under the sink. A second observation of the adjoining bathroom between Room 205 and 207 on 02/06/18 at 2:56 p.m. revealed the bathroom had not been cleaned and was in the same condition as noted on 02/06/18 at 10:08 a.m. Interview with a resident in Room 205 on 02/06/18 at 9:53 a.m. revealed: -The bedroom and the bathroom needed cleaning. -It had been about a week since the room and bathroom were last cleaned. Interviews with a second resident in Room 205 on 02/06/18 at 9:58 a.m. and 10:08 a.m. revealed: -The housekeeper used to clean their room and bathroom every day but now they only get cleaned about once a week. -It was last cleaned about a week ago. -The urinary catheter bag and tubing in the bathroom belonged to him. -Facility staff helped him with the catheter and they stored it in the bathroom. A third observation of the adjoining bathroom between Room 205 and 207 on 02/08/18 at 4:17 p.m. revealed the bathroom had not been cleaned and was in the same condition as noted	D 079		

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D 079	Continued From page 35 on 02/06/18 at 10:08 a.m. except the plastic urine collection hat had been moved to the towel bar behind the toilet. Observation of resident Room 206 on the AL side of the facility on 02/06/18 at 10:10 a.m. revealed there was a trash can filled with soiled incontinence briefs that were hanging over the sides of the trash can beside the bed on the right. Observation of the adjoining bathroom between Room 206 and 208 on 02/06/18 at 10:24 a.m. revealed: -There were two towel bars on the wall opposite the toilet that each had an empty male urinal hanging on the towel bars. -There were multiple dried yellow stains around the toilet seat and the back of the toilet. -The toilet seat was up and there was dark yellow urine in the toilet bowl. -There were dried yellow and brown stains splattered on the front of the toilet. Interview with a resident in Room 206 on 02/06/18 at 10:10 a.m. revealed: -The housekeeper was supposed to clean the room every day. -"They don't clean it." -The housekeeper usually emptied the trash every day but it was not emptied this morning, 02/06/18. -He changed his own incontinence briefs but the trash can was full and needed emptying. -His roommate usually messed up the bathroom and it always smelled like urine in the bathroom. -He could not use the bathroom in his room because it was too "messed up" and it smelled bad. -It had been about a week since staff had cleaned his room or bathroom.	D 079		

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D 079	Continued From page 36 -The male urinal on the towel bar closest to his room was the one he used. A second observation of resident Room 206 on the AL side of the facility on 02/06/18 at 2:50 p.m. revealed the room had not been cleaned and it was in the same condition as noted on 02/06/18 at 10:10 a.m. A second observation of the adjoining bathroom between Room 206 and 208 on 02/06/18 at 2:52 p.m. revealed the bathroom had not been cleaned and it was in the same condition as noted on 02/06/18 at 10:24 a.m. except the toilet had been flushed. Interview with a resident in Room 206 on 02/06/18 at 2:50 p.m. revealed his room nor the bathroom had been cleaned today, 02/06/18. A third observation of resident Room 206 on 02/07/18 at 1:22 p.m. revealed: -There was still some dirt and debris on the floor. -The two cigarette butts were still on the floor under the bed on the left. -There was still a cigarette butt on the floor under the oxygen concentrator. -The red stains on the floor at the end of the bed on the left were still there. -The trash can had been emptied. Interview with a visitor in Room 206 on 02/07/18 at 1:22 p.m. revealed: -There had been an ongoing problem with cleanliness of the room. -The floors were dirty and there were cigarette butts on the floor all of the time. -The bathroom always needed cleaning. Observation of resident Room 201 on the AL side	D 079		

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D 079	Continued From page 37 of the facility on 02/06/18 at 10:41 a.m. revealed: -There was a pile of clothes, bed coverings, and plastic bags stacked beside the bed on the left. -There was plastic bottle of soda sitting on the floor near the bed on the left. -The top of the nightstand on the left was cluttered and covered with items such as fast food styrofoam cups, drink cans, lotion, empty candy boxes, emptied potato chip bags, paper receipts and napkins. -The trash can was overflowing with trash with pieces of paper on the floor near the trash can. -There was a tall antique white chest of drawers on the left that had piles of clothes, bags, a cardboard box, and a stuffed animal stacked in front of it on the floor and at the end of the bed. -The top of nightstand on the right had a basket that was cluttered and overflowing with styrofoam cups, toiletry items, and napkins. -There were 3 pairs of shoes piled on the floor beside the bed on the right just in front of the nightstand. -There was a laundry basket overflowing with clothes, and a cardboard box with bags of incontinence supplies on the floor in front of the dresser on the right. -There were 18 broken slats on the window blind that were falling sideways allowing a large opening in the middle of the window. Observation of the adjoining bathroom between Room 201 and 203 on 02/06/18 at 10:47 a.m. revealed: -There were multiple dried yellow stains on the back of the toilet. -There was a large dried brown spatter stain on the left side of the sink. -There were small pieces of toilet paper scattered in several areas on the floor.	D 079		

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D 079	Continued From page 38 Interview with a resident in Room 201 on 02/06/18 at 10:48 a.m. revealed she thought the stain on the sink in the bathroom was hot chocolate. Interview with a second resident in Room 201 on 02/06/18 at 10:49 a.m. revealed: -The window blinds had been broken for "a long time" but she could not specify a time frame. -The facility did not have a housekeeper anymore. -She could not recall how long the housekeeper had been gone. -She did not know when the room or the bathroom was last cleaned. Interview and observation of a visitor on 02/06/18 at 3:00 p.m. revealed: -The visitor was walking toward Room 201 with an empty trash can. -The visitor emptied the trash can himself. -He had to clean the room every day because it was usually not clean. Interview with the Housekeeper on 02/06/18 at 3:13 p.m. revealed: -He had been the only housekeeper at the facility since October 2017. -They had hired a housekeeper on 01/12/18 and another one on 01/24/18 but both only filled out initial paperwork and did not return to the facility. -He had one interview later today with a potential housekeeper. -He was the only housekeeper for the entire facility and it was too much for one person. -He tried to at least clean the common hallways and bathrooms and 6 resident rooms in the AL and 6 resident rooms in the SCU each day. -He was not always able to accomplish that because he also did some maintenance work like	D 079			

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D 079	Continued From page 39 changing light bulbs. -He also did laundry because they did not currently have a laundry person at the facility. -The trash cans needed to be dumped twice a day but there was not enough staff to get it done. -He did not have enough help to keep the bathrooms clean every day. Interview with the Administrator on 02/06/18 at 5:30 p.m. revealed: -She just started working at the facility on 01/22/18. -She was brought to this facility to help get systems in place but she had not been at the facility long enough to get it under control. -There had only been one housekeeper at the facility since October 2017. -The one housekeeper was responsible for keeping the entire facility clean. -The housekeeper also helped with small maintenance issues. -The housekeeper also helped with the laundry because the facility did not currently have a laundry staff person. -One housekeeper was not enough to keep the facility clean. -The housekeeper "needs more help". -The housekeeper should made a round in the facility when he came to work each morning to try to identify problems areas. -The housekeeper should take care of cleaning the problems areas first. -At a minimum, the housekeeper should clean common areas every day, including common bathrooms and emptying the trash. -Some resident rooms needed to be cleaned more often than others. -She was aware all resident rooms were not being cleaned daily because it was too much for one person.	D 079		

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D 079	Continued From page 40 -She was in the process of trying to hire another housekeeper.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interview and record reviews, the facility failed to maintain hot water temperatures between 100 - 116 degrees Fahrenheit (F) for 4 of 4 fixtures in the Special Care Unit's (SCU) Women's Shower Room and Men's Shower Room. The findings are: Observation on 02/06/18 revealed at 10:36 a.m. the water temperature at the sink faucet in the SCU Women's Shower Room was 118 degrees F. Observation on 02/06/18 revealed at 10:38 a.m. the water temperature at the shower faucet in the SCU Women's Shower Room was 126 degrees F.	D 113		

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D 113	Continued From page 41 Observation on 02/06/18 revealed at 10:42 a.m. the water temperature at the sink faucet in the SCU Men's Shower Room was 118 degrees F. Observation on 02/06/18 of the water temperature at 10:42 a.m. at the sink faucet in the SCU Men's Shower Room revealed a temperature of 118 degrees F. Observation on 02/06/18 of the water temperature at 10:44 a.m. at the shower faucet in the SCU Men's Shower Room revealed a temperature of 126 degrees F. Interview on 02/06/18 at 10:50 a.m. with a SCU Medication Aide (MA) revealed: -She was not aware the water at the sink and shower in the Women's Shower Room was too hot. -She was not aware the water at the sink and shower in the Men's Shower Room was too hot. -She was not sure what the water temperature range was supposed to be for the residents' shower rooms. -Maintenance checked the water temperatures in the SCU frequently, but could not remember when the water temperatures were checked last. -No one reported that the water temperatures were too high in the resident's shower rooms. -She was not aware of any residents reporting the water was too hot in the SCU shower rooms. Interview on 02/06/18 at 10:55 a.m. with a 1st shift SCU Personal Care Aide (PCA) revealed: -She was not aware the Women's Shower Room's water at the sink and shower was too hot. -She was not aware the Men's Shower Room water at the sink and shower was too hot. -If the hot water was too hot at the sinks or	D 113		

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D 113	Continued From page 42 showers, she mixed it with cold water. -She was not sure who checked the water temperatures in the residents' shower rooms; she had not seen anyone check those rooms on her shift. -She had not given any residents a shower in the Women's or Men's Shower rooms so far today; she had given a couple of residents sponge baths in their rooms. -She was not aware of any residents complaining about the water being too hot. Interview on 02/06/18 at 11:06 a.m. with the Administrator revealed: -She was not aware the hot water temperatures in the Women's and Men's shower rooms were too hot. -She had been the Administrator since 1/22/18, and had not received any reports from staff or residents that the hot water was too hot. -Maintenance staff made weekly checks of the water temperatures in resident areas and recorded them in a log. -She would post signs in the SCU Women's and Men's Shower rooms to not use the hot water. - The facility had a contracted maintenance staff; she would contact the maintenance staff to adjust the hot water temperatures. Observation on 02/06/18 at 2:52 p.m. of the SCU Women's Shower Room revealed there was a notice posted on the wall above the sink and shower faucets: DO NOT USE, WATER TEMP EXCEED(S) 116, DO NOT USE Recheck of the water temperatures on 02/06/18 at 2:55 p.m., in the SCU Women's Shower Room, at the sink faucet revealed: -The water temperature at the sink was 126 degrees F.	D 113		

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D 113	Continued From page 43 -The water temperature at the shower was 126 degrees F. -The water was producing steam at the faucets. Observation on 02/06/18 at 3:00 p.m. the Maintenance Staff using his thermometer to check the SCU Women's Shower Room water temperatures revealed: -The water temperature at the sink faucet was 126.4 degrees F. -The water temperature at the shower faucet was 126 degrees F. -The water coming from the faucet was producing steam. Observation on 02/06/18 at 3:08 p.m. of the SCU Men's Shower Room revealed there was a notice posted on the wall above the sink and shower faucets: DO NOT USE, WATER TEMP EXCEED(S) 116, DO NOT USE Obgservation of the water temperatures on 02/06/18 at 3:10 p.m. in the Men's Shower Room water temperatures revealed: -The water temperature at the sink faucet was 126 degrees F. -The water temperature at the shower faucet was 126 degrees F. -The water was producing steam at the faucets. Observation on 02/06/18 at 3:12 p.m. with the Maintenance Staff using his thermometer to check the SCU Men's Shower Room water temperatures revealed: -The water temperature at the sink faucet was 126 degrees F. -The water temperature at the shower faucet was 126 degrees F. -The water was producing steam at the faucets.	D 113		

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D 113	Continued From page 44 Interview on 02/06/18 at 3:15 p.m. with the Maintenance Staff revealed: -He made random weekly checks of resident area bathrooms' and shower rooms' water temperatures. -He documented in a log the dates, rooms, and water temperatures he obtained on a weekly basis. -The last check was done this morning about 7:30 a.m. of resident room bathrooms. -He did not check the SCU Women's and Men's Shower Rooms' water temperatures. -He had not had any complaints about the SCU shower rooms' water being too hot. -Today was the first time he was told the hot water in the SCU Women's and Men's Shower Rooms was too hot. -He adjusted the water temperature mixing valve earlier after being told by the Administrator the water temperatures were too hot in the SCU Women's and Men's Shower Rooms. -Maybe there was a problem with the water heater mixing valve and it needed to be replaced. -He was told by his supervisor the range for water temperatures was supposed to be from 105 degrees F. to 115 degrees F. Interview on 02/06/18 at 4:40 p.m. with a MA revealed: -The Women's and Men's shower hot water was too hot this morning.. -The water felt too hot to use to give a resident a bath. -The water felt too hot to her skin through her gloves if she did not mix it with cold water. -After cutting on the hot water, she would move the faucet water control halfway back to the cold water to make the temperature comfortable for the residents to bathe. -She was not sure how long the showers' water	D 113		

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D 113	Continued From page 45 temperatures had been too hot; she was used to adjusting the hot water with the cold. -She had not reported the hot water being too hot to anyone, she adjusted the temperature with cold water. -She did not know if the Women's and Men's Shower Rooms' water temperatures were checked. Interview on 02/07/18 at 7:50 a.m. with the Special Care Coordinator (SCC) revealed: -Resident showers were done mostly on 1st and 2nd shifts. -No staff had notified her of the shower rooms' water temperatures were too hot. -She did not know how often the water temperatures were checked, but they were supposed to be checked by maintenance staff. -She had not seen anyone check the water temperatures in the Women's and Men's Shower Rooms. Observation on 02/07/18 at 8:45 a.m. of the Senior Maintenance Staff checking the Men's Shower Room hot water temperatures revealed: -The hot water temperature at the sink faucet was 102 degrees F. -The hot water temperature at the shower faucet was 96 degrees F. Observation on 02/07/18 at 8:55 a.m. of the Senior Maintenance Staff checking the Women's Shower Room hot water temperatures revealed: -The hot water temperature at the sink faucet was 109 degrees F. -The hot water temperature at the shower faucet was 100 degrees F. Interview on 02/07/18 at 9:00 a.m. with the facility's Senior Maintenance Staff revealed:	D 113		

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D 113	Continued From page 46 -The hot water temperature gauge for the SCU Women's Shower Room and Men's Shower Room had now been set for 113-114 degrees F. -The hot water heater control gauge set yesterday for the SCU shower rooms was reset on the wrong gauge. -There would need to be adjustments made at each sink to ensure hot water temperatures were maintained at the correct range. Review of the facility's Month/Room # Water Temperature logs from 12/26/17 to 02/06/18 for the SCU revealed: -On 02/26/17, two resident rooms' hot water from the faucet was documented as 109.9 and 110.9 degrees F.; there was no documentation for hot water temperatures for the Women's Shower Room and the Men's Shower Room. -On 01/04/18, two resident rooms' hot water from the faucet was documented as 106.7 and 110.1 degrees F.; there was no documentation for hot water temperatures for the Women's Shower Room and the Men's Shower Room. -On 01/09/18, two resident rooms' hot water from the faucet was documented as 109 and 110 degrees F.; there was no documentation for hot water temperatures for the Women's Shower Room and the Men's Shower Room. -On 01/19/18, two resident rooms' hot water from the faucet was documented as 109.8 and 112 degrees F.; there was no documentation for hot water temperatures from the faucet for the Women's Shower Room and the Men's Shower Room. -On 01/30/18, two resident rooms' hot water from the faucet was documented as 111.1 and 112.2 degrees F.; there was no documentation for hot water temperatures for the Women's Shower Room and the Men's Shower Room. -On 02/06/18, two resident rooms' hot water from	D 113			

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D 113	Continued From page 47 the faucet was documented as 111.2 and 112.8 degrees F.; there was no documentation for hot water temperatures for the Women's Shower Room and the Men's Shower Room. Interview on 02/07/18 at 3:56 p.m. with the Administrator revealed: -Maintenance staff was responsible for checking water temperatures in all resident areas of the facility. -Maintenance was called in to adjust the hot water temperatures for the SCU Women's and Men's Shower Rooms. -The water temperatures were not adjusted correctly and the water remained too hot; she left the hot water signs posted in the shower rooms. -She called the regional maintenance staff to come in and check the hot water temperatures and to make adjustments. -She was not aware the maintenance water temperature logs did not show any entries for the SCU Women's and Men's Shower Rooms' water fixtures. -There was a different log available for documenting facility water temperatures that would now be used to ensure resident areas' water temperatures were between 100 - 116 degrees F. _____ The facility's failure to ensure the hot water temperatures at the sinks and showers in the SCU Women's and Men's Shower Rooms were maintained between 100 and 116 degrees Fahrenheit, the highest hot water temperature was 126 degrees, was detrimental to the health and safety of residents having Alzheimer's disease by placing residents at a potential risk for burns. This constitutes a Type B Violation.	D 113		

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D 113	Continued From page 48 Review of the facility's Plan of Protection dated 02/06/18 revealed: -(The) Administrator immediately posted signs stating water temperature was too hot and not to use. -Contacted maintenance, requested water temperature be adjusted (decreased). -Maintenance personnel immediately adjusted the (water) temperature. -Hot water use in the SCU will be supervised by designated staff until consistent compliance is achieved. -Signs will remain posted until hot water temperatures consistently in compliance, -Hot water temperatures will be monitored daily until consistent compliance achieved, then routinely thereafter. -The frequency determined and specified in the Plan of Correction (POC). THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2018.	D 113			
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902	D 131			

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D 131	Continued From page 49 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure all staff had completed a two-step TB skin test in accordance with state guidelines including 2 of 6 sampled staff (Staff D and Staff F), not having a second step TB skin test completed. The findings are: 1. Review of Staff D's personnel file revealed: -Staff D was hired at the facility on 08/24/18 as a Personal Care Aide and Medication Aide. -Staff D completed a TB skin test on 08/11/17 with a negative reading. -There was no documentation of a second step TB skin test. Telephone interview with Staff D on 02/08/18 at 12:00 p.m.revealed: -He had completed the TB skin test since he was in school. -He would not be able to obtain any copies and bring them in since he was out of town. -He had given copies of the TB skin test to the Business Office Manager (BOM) when he was hired. -He was not sure why they were not in his personnel file. Refer to interview with the BOM on 02/08/18 at 10:00 a.m. Refer to interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. 2. Review of Staff F's personnel file revealed: -Staff F was hired at the facility on 05/18/16 at a	D 131		

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D 131	Continued From page 50 Personal Care Aide and Medication Aide. -Staff F had completed a TB skin test on 06/30/17 with a negative reading. -There was no documentation of Staff F completing a second TB skin test. Telephone interview with Staff F on 02/08/18 at 10:35 a.m. revealed: -She had completed a second TB skin test since she had been working at the facility. -She was not sure why the second TB skin test was not in her personnel file. -She could not remember when she had completed the second TB skin test and did not have any records. -She would continue to go through her records to see if she could locate the TB skin test. Refer to interview with the BOM on 02/08/18 at 10:00 a.m. Refer to interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. Interview with the Business Office Manager on 02/08/18 at 10:00 a.m. revealed: -She was responsible for going through and making sure that staff had completed all requirements. -She could not find the second TB skin test for Staff D or Staff F. -She thought they had been completed but she could not locate them. -The staff would be scheduled to get a second TB skin test completed as soon as possible. Interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. revealed: -The Executive Director or the BOM are responsible for making sure all staff qualifications	D 131		

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D 131	Continued From page 51 are completed. -The BOM is to audit 10 percent of the charts quarterly to assure staff records have all completed qualifications. -The first TB skin test should be completed prior to hire. -The second test should be completed within a few weeks of the first or within the first year of hire. -The BOM should have notified the Executive Director or the Licensed Health Professional Support Nurse if the TB skin test are not completed. -The facility will make sure that Staff F and Staff D complete a second step TB skin test as soon as possible.	D 131		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;	D 164		

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D 164	Continued From page 52 (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to assure that 2 of 5 sampled staff (B, F) had completed diabetes training prior to administering insulin. The findings are: 1. Review of Staff B's personnel file revealed there was no documentation that Staff B had completed diabetic care training. Review of 2 residents December 12-31, 2017 Medication Administration records revealed Staff B administered medications to residents on the Special Care Unit on December 13-15, 18-20, 22-26, and 28-29, including a resident who was receiving insulin. Review of 2 residents January 2018 Medication Administration records revealed Staff B administered medication on 2-3, 5-7, 9-11, 15, 17, 20-22, 25-27, and 29-30, including a resident who was receiving insulin. Review of 2 residents February 1-9, 2018 Medication Administration records revealed Staff B administered medication on 2-4, and 6-7, including a resident who was receiving insulin. Interview with Staff B on 02/08/18 at 10:20 a.m. revealed:	D 164		

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NAME OF PROVIDER OR SUPPLIER CHATHAM COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST CHATHAM STREET CARY, NC 27512		
(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 164	Continued From page 53 -She had been working at the facility for about 3 years. -She started as a Personal Care Aide but had been working for the last few months as a Medication Aide. -She started as a Medication Aide sometime in October of 2017 but was not sure of the exact date. -She was not aware of receiving any additional training in diabetic care. Interview with the Business Office Manager on 02/08/18 at 10:00 a.m. revealed: -She was responsible for going through and making sure that staff had completed all requirements. -Staff B had no documentation of completing the diabetic care training. -She thought the training had been completed but she could find the certificate of completion. -Staff B would complete the training as soon as possible. Refer to interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. 2. Review of Staff F's personnel file revealed there was no documentation that Staff F had completed diabetic care training. Telephone interview with Staff F on 02/08/18 at 10:35 a.m. revealed: -She had completed some diabetic care training but she was not sure when she had done that training. -The management staff should have a copy of the training in her personnel file. Interview with the Business Office Manager on 02/08/18 at 10:00 a.m. revealed:	D 164		

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D 164	Continued From page 54 -She could not find diabetic care training for Staff F. -She thought the training had been completed but she could find the certificate of completion. -Staff F would complete the training as soon as possible. _____ Interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. revealed: -The Executive Director and the BOM are responsible for making sure all staff training and requirements are completed. -The BOM is to audit at least 10% of staff charts each quarter. -She was not aware that diabetic care training had not been completed. -She would make sure training was scheduled for both staff members as soon as possible.	D 164			
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census	D 201			

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D 201	Continued From page 55 or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure aide hours met the minimum requirements on 19 of 21 shifts resulting in inadequate staff to meet the needs of residents. The findings are: Interview with a resident on 02/06/18 at 9:37 a.m. revealed: -There was a lot of staff turnover in the building. -"Everyone seems to come and go." -There were not enough staff working and she had waited two hours for assistance a few months ago. -They were always short staffed in the building. Interview with two residents on 02/06/18 at 9:57	D 201		

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D 201	Continued From page 56 a.m. revealed: -There was not enough help in the building. -The same staff seemed to work all the time. -Staff response depended on who was working and how many people were working. -Last night there was one medication aide for the entire building on 02/05/18. -There were no personal care aides working on the 100 hall. Interview with a fourth resident on 02/06/18 at 10:28 a.m. revealed: -The facility was always short staffed. -There was only one medication aide in the building the night of 02/05/18. -She was scheduled to get medication at 7:00 p.m. but she did not receive those medicines until 9:30 p.m. -She was scheduled to get a shower that night but was unable to do so if there were no personal care aides working. -When there were no aides available she would give herself a sponge bath despite paralysis on her left side. Interview with a fifth resident on 02/06/18 at 11:15 a.m. revealed there was only one medication aide for the entire building last night. Interview with a Personal Care Aide (PCA) on 02/06/18 at 11:12 a.m. revealed: -They needed more help at the facility. -She often worked 12 to 16 hour shifts. -She last worked a double shift that past weekend. -There was often only one medication aide (MA) in the building. -There was usually only one PCA and one MA working in assisted living.	D 201		

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D 201	Continued From page 57 Interview with the Resident Care Coordinator (RCC) on 02/07/18 at 9:52 a.m. revealed she was helping on the floor that day 2/7/18 with residents along with one PCA. Interview with a Medication Aide (MA) on 02/08/18 at 10:10 a.m. revealed: -The facility had been shorthanded for four to five months. -They used to have two medication aides and two personal care aides working each shift in assisted living. -She had worked as the only MA in the building more than once. -She believed the last time she was the only MA in the building was back in October or November. -She had worked 24 hours straight twice back in December. Interview with a PCA on 02/09/18 at 2:15 p.m. revealed: -She was the only PCA working on the assisted living side. -At least twice a week, she would be the only PCA working on the assisted living side. Confidential interview with a Medication Aide revealed she was only working on the Assisted Living side that day "cause y'all were here to look like we have enough staff." Review of first shift staff time records and the facility census for 02/01/18 - 02/07/18 revealed: -The census documented 44 residents in the assisted living side of the facility on 02/01/18 - 02/07/18 which required 24 aide hours for first shift. -The staff time card records documented 21 hours and 50 minutes of aide hours on 02/01/18, leaving the facility short 3 hours and 10 minutes	D 201		

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D 201	Continued From page 58 of aide hours. -The staff time card records documented 22 hours and 45 minutes of aide hours on 02/02/18, leaving the facility short 1 hour and 15 minutes of aide hours. -The staff time card records documented 20 hours and 53 minutes of aide hours on 02/03/18, leaving the facility short 3 hours and 7 minutes of aide hours. -The staff time card records documented 21 hours and 25 minutes of aide hours on 02/04/18, leaving the facility short 3 hours and 35 minutes of aide hours. -The staff time card records documented 18 hours and 13 minutes of aide hours on 02/05/18, leaving the facility short 5 hours and 47 minutes of aide hours. -The staff time card records documented 17 hours and 22 minutes of aide hours on 02/06/18, leaving the facility short 6 hours and 38 minutes of aide hours. -The staff time card records documented 22 hours and 27 minutes of aide hours on 02/07/18, leaving the facility short 2 hours and 33 minutes of aide hours. Review of second shift staff time records and the facility census for 02/01/18 - 02/07/18 revealed: -The census documented there were 44 residents in the assisted living side of the facility on 02/01/18 - 02/07/18 which required 24 aide hours for second shift. -The staff time card records documented 16 hours and 34 minutes of aide hours for second shift on 02/01/18, leaving the facility short 7 hours and 26 minutes of aide hours. -The staff time card records documented 22 hours and 27 minutes of aide hours for second shift on 02/02/18, leaving the facility short 1 hour and 33 minutes of aide hours.	D 201		

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D 201	Continued From page 59 -The staff time card records documented 13 hours and 22 minutes of aide hours for second shift on 02/03/18, leaving the facility short 10 hours and 3 minutes of aide hours. -The staff time card records documented 11 hours and 51 minutes of aide hours for second shift on 02/04/18, leaving the facility short 12 hours and 9 minutes of aide hours. -The staff time card records documented 6 hours and 11 minutes of aide hours for second shift on 02/05/18, leaving the facility short 18 hours and 49 minutes of aide hours. Review of third shift staff time records and the facility census for 02/01/18 - 02/07/18 revealed: -The census documented there were 44 residents in the assisted living side of the facility on 02/01/18 - 02/07/18 which required 16 aide hours for second shift. -The staff time card records documented 14 hours and 29 minutes of aide hours for third shift on 02/01/18, leaving the facility short 1 hour and 31 minutes of aide hours. -The staff time card records documented 15 hours and 22 minutes of aide hours for third shift on 02/02/18, leaving the facility short 38 minutes of aide hours. -The staff time card records documented 12 hours and 54 minutes of aide hours for third shift on 02/03/18, leaving the facility short 3 hours and 31 minutes of aide hours. -The staff time card records documented 7 hours and 44 minutes of aide hours for third shift on 02/04/18, leaving the facility short 8 hours and 16 minutes of aide hours. -The staff time card records documented 14 hours and 6 minutes of aide hours for third shift on 02/05/18, leaving the facility short 1 hour and 54 minutes of aide hours. -The staff time card records documented 9 hours	D 201		

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D 201	Continued From page 60 and 10 minutes of aide hours for third shift on 02/06/18, leaving the facility short 15 hours and 50 minutes of aide hours. -The staff time card records documented 12 hours and 24 minutes of aide hours for third shift on 02/07/18, leaving the facility short 3 hours and 36 minutes of aide hours. Interview on 02/07/18 at 7:55 a.m. with the Business Office Manager (BOM) revealed: -She did not do the scheduling of staff for the facility; the (SCU) Special Care Coordinator (SCC) managed the scheduling for the Assisted Living and Memory Care units. -The BOM kept the "punch" time records for facility staff; she had a computer program that was used for keeping records of staff working times. Interview on 02/07/18 at 8:15 a.m. with the Special Care Coordinator (SCC) revealed: -The SCC was responsible for managing the facility staffing schedule, the assisted living side and the (SCU) Memory Care unit. -She made out the schedule according to the resident census. -If there was a call-out or she did not have a staff position matched with a name, she would check with other staff to see if they could work in that slot. -If she could not find another staff to work in the vacant slot, she would work in place of other staff in order to cover resident care. -She would often work additional shifts, besides her own, and on weekends to help with staffing coverage. -The SCC had just been given access to the facility's hiring website in order to assist with interviewing and hiring new employees. -She was in the process of interviewing 3 new staff for the facility.	D 201		

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D 201	Continued From page 61 -Staff worked together to provide personal care to staff. Interview on 02/09/18 at 4:22 p.m. with the Administrator revealed: -The company sent her to this facility because some systems were not working. -There was not enough staff for the assisted living or the SCU. -They needed to recruit experienced staff and provide training to the current staff. _____ The facility's failure to ensure adequate staffing for 19 of 21 shifts resulted in inadequate staff to respond to the daily personal care and supervision needs of residents. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ Review of the facility's plan of protection dated 02/09/18 revealed: -Executive Director (ED) / designee will review schedule daily to ensure sufficient staff are scheduled for all shifts beginning 02/09/18. -Qualified management staff will provide all needed coverage while replacement staff are obtained for call outs, etc. -Staff from sister communities will be utilized to assist while new staff are hired and trained. -ED / designee will continue to review schedule on a daily basis to ensure adequate coverage. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2018.	D 201			

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D 254	Continued From page 62	D 254		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 2 of 5 sampled residents (#2, #3) had a care plan completed within 30 days of admission (#3) and annually (#2) thereafter. The findings are: 1. Review of Resident #3's current FL-2 dated 12/12/17 revealed diagnoses included schizophrenia, abnormal posture, left wrist contracture, traumatic brain injury, arthrosclerosis heart disease.	D 254		

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D 254	Continued From page 63 Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 12/14/17. Review of Resident #3's record revealed there was no documentation that a care plan had been completed within 30 days of admission. Interview with the Resident Care Coordinator (RCC) on 02/08/18 at 9:00 a.m. revealed: -The RCC and Administrator were responsible for making sure that all care plans had been completed. -She was not able to find a completed care plan for Resident #3. -She was not aware that Resident #3 did not have a completed care plan since she had only been here 2 weeks. -She would make sure to have a care plan completed for Resident #3 as soon as possible. Interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. revealed: -The RCC and the Administrator were responsible for getting care plans completed on residents. -They prepared a care plan for Resident #3 and the doctor was going to sign the care plan today. -She did not usually work in that building so she did not know about the care plan not being completed. 2. Review of Resident #2's current FL-2 dated 06/20/17 revealed: -Diagnoses included mental retardation, hypothyroidism, hypertension, and pituitary prolactinoma. -Resident #2 was intermittently disoriented and ambulatory. -Resident #2 was admitted on 07/01/09.	D 254		

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D 254	Continued From page 64 Review of Resident #2's record revealed the last Care Plan was completed 10/14/16. Review of Resident #2's Care Plan dated 10/14/16 revealed: -She required limited assistance with bathing, ambulation, and toileting. -She required extensive assistance with dressing. -She was seen by a mental health provider. -Resident #2 had a developmental disability and wandering behavior. Interview with a personal care aide (PCA) on 02/07/18 at 10:07 a.m. revealed she assisted Resident #2 with bathing by monitoring her showers. Interview with a Medication Aide (MA) on 02/08/18 at 2:33 p.m. revealed: -She assisted Resident #2 with applying lotion to her legs. -Resident #2 was able to get dressed on her own and take her compression hose on and off independently. Interview with a second PCA on 02/08/18 at 2:38 p.m. revealed: -Resident #2 was forgetful. -Resident #2 wore incontinent briefs but usually went to the bathroom on her own. -She had seen MAs assist Resident #2 with applying lotion to her legs. Interview with a second MA on 02/09/18 at 2:02 p.m. revealed: -MAs were supposed to assist Resident #2 with taking her compression hose off at night by washing them and hanging them up to dry. -Mas were also supposed to apply lotion to	D 254		

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D 254	Continued From page 65 Resident #2's legs twice daily. -Staff also encouraged Resident #2 to sit with her legs elevated several times a day to reduce the swelling. Interview with the Resident Care Coordinator (RCC) on 02/07/18 at 9:52 a.m. revealed: -Resident #2's care plan was out of date. -She was working on getting the care plan updated and signed by the physician. Interview with the RCC on 02/09/18 at 12:40 p.m. revealed: -She was new to the position and had only worked at the facility for about three weeks. -She was responsible for doing care plans. -She planned to get a system in place to organize care plans and ensure they were completed timely. Interview with the Clinical Support Specialist on 02/08/18 at 3:55 p.m. revealed: -A care plan had been started for Resident #2 but not signed by the doctor. -The RCC was responsible for completing care plans for all residents.	D 254			
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION	D 273			

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D 273	Continued From page 66 Based on observations, interviews, and record reviews, the facility failed to coordinate the healthcare needs for 2 of 5 residents sampled (#1, #2) including a resident with chronic lymphedema that resulted in an untreated leg edema placing the resident at risk for infection (#2); and a resident whose physician was not notified of blood sugars greater than 400, a missed cardiology appointment and an echocardiogram with doppler, and labwork for a complete blood count and lipid panel was not done (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 06/20/17 revealed: -Diagnoses included mental retardation, hypothyroidism, hypertension, and pituitary prolactinoma. -Resident #2 was intermittently disoriented and ambulatory. Review of Resident #2's Assessment & Care Plan dated 02/09/18 revealed: -Resident #2 had an order to have compression hose that should be worn daily. -Resident #2 required extensive assistance with compression hose. -Resident #2 required extensive assistance with putting on and removing clothing, socks, and shoes. Observation of Resident #2 on 02/06/18 at 9:15 a.m. revealed: -The resident's legs had significant swelling. -The resident was not wearing compression hose. -The resident walked with a shuffling gait.	D 273		

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D 273	Continued From page 67 Interview with Resident #2 on 02/06/18 at 10:14 a.m. revealed: -She needed "hose for my legs." -Staff told her the hose would be in next week. -Her last pair of hose had gotten too small. -Her legs were hurting and she took fluid pills to help with the swelling. Observation of Resident #2 on 02/07/18 at 9:54 a.m. revealed: -Resident #2 was seated with her feet elevated. -Both of Resident #2's legs were noticeably swollen. -Resident #2 was not wearing compression hose. Interview with a Medication Aide on 02/07/18 at 10:00 a.m. revealed: -Resident #2 lost her last pair of compression hose. -She was not sure when Resident #2 lost the hose. -She had witnessed Resident #2 take the hose off on her own. -She believed a new pair had been ordered last week. Interview with a Personal Care Aide (PCA) on 02/07/18 at 10:07 a.m. revealed: -Resident #2's legs were swollen. -Resident #2 usually wore compression hose but she had recently misplaced them. -She believed the resident last wore the hose that past weekend but was not sure. -The hose were tight on the resident's legs and she often complained to staff that the hose were too tight. -She believed a new pair of TEDS were ordered for the resident but she was not sure.	D 273		

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D 273	Continued From page 68 Interview with a second Medication Aide on 02/08/18 at 2:33 p.m. revealed: -Staff knew when Resident #2's legs were hurting if she said she was going to sit down or she leaned against the front reception area. -She was unsure when the resident last wore her compression hose. -She thought she might have seen Resident #2 wearing the compression hose yesterday. -She had witnessed Resident #2 taking the compression hose on and off on her own. -She had not heard Resident #2 complain that the hose were too tight. -Resident #2's legs and ankles were currently swollen and usually were always swollen. Interview with a third Medication Aide on 02/08/18 at 2:02 p.m. revealed: -Resident #2 often complained that her compression hose were too tight. -Medication Aides were supposed to remove the hose at night and hang them up to dry. -She had heard the RCC call the pharmacy that day 2/8/18 to check the status of Resident #2's hose. -She believed the resident's legs looked more swollen in the last few weeks. -Resident #2's ankles appeared "more puffy than usual." Interview with the Resident Care Coordinator on 02/07/18 at 10:48 a.m. revealed: -Resident #2 lost her compression hose last week. -Physical therapy took measurements for new hose on 01/31/18. -The RCC faxed the order to the doctor for the first time on 2/2/18 and the second time on 02/07/18 for signature. -She was not sure the last time Resident #2 had	D 273		

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D 273	Continued From page 69 worn the compression hose. -She planned to fax the order to the pharmacy as soon as she obtained the doctor's signature. Review of the order for replacement compression hose for Resident #2 revealed: -Physical therapy had taken measurements for new compression hose and left the order with the RCC on 1/31/18. -The primary care physician signed this order on 02/02/18. Telephone interview with the pharmacy on 02/07/18 at 11:59 a.m. revealed they had not received any orders for compression hose for Resident #2 since 11/16/17. Review of the physical therapy daily treatment note for 02/07/18 revealed: -The Physical Therapist had spoken with the RCC regarding the delay with the compression hose and provided measurements again. -She was told by the RCC that the order for the compression hose had been refaxed to the pharmacy. Interview with the Physical Therapy Rehab Director on 02/07/18 at 12:37 p.m. revealed: -Resident #2's physical therapist took new measurements for compression hose on 01/31/18. -Those measurements were given to the facility on 01/31/18. -Resident #2 was being seen three times weekly for physical therapy. -Resident #2 was wearing her compression hose on 01/25/18 and 01/29/18. -Resident #2 was first noted to be without her compression hose on 01/31/18.	D 273		

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D 273	Continued From page 70 Review of the physical therapy-therapist progress note dated 12/13/17 revealed: -Resident #2 measured 21.5 inches at the calf, 15 inches at the ankle, and 10.5 inches at the foot. -Staff did not don the resident's hose on this day 12/13/17 -With consistent stocking use, the resident had measured 14.5 inches at the ankle. Review of the physical therapy-therapist progress note dated 01/05/18 revealed Resident #2's ankle measurement decreased by one inch while wearing the compression hose as ordered. Review of the physical therapy-therapist progress note dated 01/23/18 revealed: -Resident #2's calf and ankle measurements decreased by half an inch while wearing the compression hose as ordered. -Resident #2's calf now measured 21 inches and her ankle now measured 14 inches. Interview with the RCC on 02/08/18 at 2:25 p.m. revealed: -She had received a fax from the pharmacy that they were unable to order compression stockings in 10-15 compression. -The pharmacy could provide 20-30 or 30-40 compression in the stockings. -She faxed the request to the primary care physician for guidance. Interview with the Physical Therapist on 02/09/18 at 8:50 a.m. revealed: -Resident #2 initially measured 23 inches at the calf, 15.5 inches at the ankle, and 11 inches at the foot on 11/21/17. -Resident #2 measured 21.5 inches at the calf, 14.5 inches at the ankle, and 10.5 inches at the	D 273		

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D 273	Continued From page 71 foot on 02/09/18 without her compression hose. -She had informed the medication aide and also the RCC that Resident #2 lost her stockings on 01/31/18. -She also left a note with the new order and measurements for compression hose with the RCC on 01/31/18. -The order for compression hose needed to be signed by the doctor. -She suggested to the RCC that medication aides store Resident #2's compression hose on the cart overnight to prevent them being misplaced in the future. -Resident #2 had been 100% compliant with wearing her compression hose prior to losing them this time. -Compression hose were important to keep the resident from developing fibrosis on the ankle as a result of chronic swelling. -Chronic swelling would "overwhelm the lymph system and cause weeping or drainage from the leg placing the resident at risk of cellulitis or infection." -Resident #2 had not had any open areas or drainage from her legs since receiving physical therapy. Observation of Resident #2 on 02/08/18 at 4:15 p.m. revealed: -The resident was seated in the day room with her swollen legs elevated. - Resident #2 had 4+ non-pitting edema with skin folds around the ankles Interview with Resident #2's family member on 02/09/18 at 10:00 a.m. revealed: -She visited Resident #2 at the facility earlier last month. -Resident #2 was wearing her compression hose but in the past she had not been wearing them	D 273			

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D 273	Continued From page 72 when she visited. -She thought the staff sometimes forgot to put the compression hose on Resident #2. Interview with the primary care physician (PCP) on 02/09/18 at 9:33 a.m. revealed: -She had last seen Resident #2 on 01/26/18. -Resident #2 was seen by the Physician's Assistant (PA) on 01/30/18. -Resident #2 had chronic lymphedema and swelling. -She was currently receiving physical therapy services. -Resident #2 was compliant with the compression stockings. -She was not aware that Resident #2 had not been wearing the stockings since misplacing them. -She signed the order for new compression hose on 02/02/18 thinking it was for a new size. -She was made aware that the pharmacy could not fill the requested compression level for the stockings that morning 02/09/18. -Resident #2's swelling went up and down. -She recommended staff have the resident sit as often as possible with her legs elevated. -Resident #2 needed to wear her compression hose daily to prevent further swelling. -She was unaware the PA had changed the order for Resident #2 to wear the compression hose to every other day and planned to change the order so that Resident #2 wore the stockings daily. Interview with the RCC on 02/09/18 at 4:00 p.m. revealed: -She was unable to locate the signed order with the selected compression level for Resident #2's compression hose. -She would have to fax the pharmacy request to the doctor again.	D 273		

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D 273	Continued From page 73 -She was working on the floor that day and had not spoken with the doctor prior to leaving. 2. Review of Resident #1's current FL-2 dated 06/21/17 revealed diagnoses included bradycardia, bilateral shoulder pain, and diarrhea - resolved. a. Review of physician's orders dated 06/22/17 revealed: -There was an order to check fingerstick blood sugar (FSBS) 4 times a day before meals and at bedtime. -There was an order for Novolog sliding scale insulin before meals and at bedtime: 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than (>) 400 = 12 units; call physician if FSBS > 400 or less than (<) 40. (Novolog is rapid-acting insulin used to lower blood sugar in diabetics.) Review of the December 2017 - February 2018 medication administration records (MARs) for Resident #1 revealed: -There were entries for the Novolog sliding scale insulin on each MAR including instructions to call the physician if the blood sugar was >400 or <40. -The resident's FSBS was checked at 7:00 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. -The resident's FSBS was 410 on 12/25/17 at 7:00 a.m. but there was no documentation the physician was notified of the FSBS >400. -The resident's FSBS was 433 on 01/02/18 at 8:00 p.m., 451 on 01/05/18 at 11:30 a.m., 423 on 01/15/18 at 8:00 p.m., and 476 on 01/22/18 at 11:30 a.m. -There was no documentation the physician was contacted about any of the FSBS >400 on the MARs.	D 273		

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D 273	Continued From page 74 Review of Resident #1's handwritten progress notes revealed there was no documentation the physician was contacted for any FSBS >400. Interview with the Clinical Support Specialist on 02/09/18 at 1:15 p.m. revealed: -They found an electronic charting note that Resident #1's physician was contacted for the FSBS of 476 on 01/22/18 and they rechecked the FSBS as ordered. -They could not find any documentation of the physician being notified for the other 4 times the resident's FSBS was >400. Review of charting notes for Resident #1 dated from 10/01/17 - 02/09/18 revealed: -01/22/18 at 1:39 p.m., the resident's blood sugar at 1pm was 476 and 12 units of Novolog were administered. Physician notified and stated if blood sugar not down after recheck in 30 minutes to call back. Blood sugar rechecked at 1:38 p.m. and was 395. -There was no other notes of the physician being contacted regarding the other 4 times the resident's blood sugar was >400. Interview with a medication aide (MA) on 02/09/18 at 6:35 p.m. revealed: -She did not recall contacting Resident #1's physician for any FSBS >400. -If the physician was contacted, it would be documented on the MARs or in the resident's progress notes in the record. Interview the Special Care Coordinator (SCC) on 02/09/18 at 4:20 p.m. revealed: -The MAs were responsible for either calling or faxing the physician for blood sugars outside the ordered parameters. -The MAs should document contact with the	D 273		

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D 273	Continued From page 75 physician on the MAR or in the charting notes. Telephone interview with a nurse at Resident #1's primary care provider's (PCP) office on 02/09/18 at 4:37 p.m. revealed he could not find any documentation the physician was notified about the FSBS > 400 on 12/25/17, 01/02/18, 01/05/18, or 01/15/18. Interview with Resident #1 on 02/09/18 at 7:08 p.m. revealed: -His blood sugar was checked about twice a day. -His blood sugar "runs high a little bit". -He was not sure if his PCP was aware of his high blood sugars. b. Review of visit notes with Resident #1's primary care provider (PCP) dated 10/27/17 revealed: -The resident's list of issues included high blood pressure, coronary artery disease, pacemaker, hyperlipidemia, history of stroke, chronic kidney disease stage 3, and diabetes mellitus. -The resident's blood pressure was 168/78 and his pulse was 50. -The resident was scheduled for a visit with a cardiologist and an echocardiogram with doppler on 12/08/17. Review of Resident #1's record revealed: -There was no documentation of the resident seeing a cardiologist on 12/08/17. -There was no documentation of the resident having an echocardiogram with doppler on 12/08/17. Interview with the Resident Care Coordinator (RCC) on 02/09/18 at 6:50 p.m. revealed: -She was new at the facility and they were working on getting systems in place for referrals	D 273		

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D 273	Continued From page 76 and other appointments. -If there were referrals, staff were supposed to give the paperwork to the facility's transporter and they transporter would set up the appointments and note in the appointment book. -She was not aware Resident #1 had missed any appointments or procedures. -She was not sure what systems the facility had in place prior to her working there. Telephone interview with a nurse at a cardiologist's office for Resident #1 on 02/12/18 at 8:00 a.m. revealed: -The resident was last seen in their office in August 2017. -Their records showed the resident's last pacemaker check was on 12/08/17. -The resident did not see the cardiologist on 12/08/17 and she was not sure why. -She did not see a record of the resident having an echocardiogram with doppler test. -The resident was currently scheduled for a pacemaker check on 02/27/18 and a cardiologist visit on 03/19/18. -The resident was also seen by a second cardiologist but she was unsure why. Telephone interview with a nurse at a second cardiologist's office for Resident #1 on 02/12/18 at 11:30 a.m. revealed: -They started seeing the resident in their practice on 02/17/17 and a pacemaker check was done at that time. -The cardiologist ordered the echocardiogram with doppler because during a hospitalization some cardiomyopathy was noted. -The resident did not show up for an appointment with the cardiologist on 12/08/17. -The resident was a "no show" and the echocardiogram with doppler was not done.	D 273		

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D 273	Continued From page 77 -A follow-up visit with the cardiologist and for the echocardiogram with doppler had not been made. -The resident had an appointment scheduled for 03/09/18 for a pacemaker check. Interview with the Clinical Support Specialist on 02/09/18 at 5:32 p.m. revealed: -She contacted Resident #1's cardiologist and the appointment scheduled for 12/08/17 had been canceled but they did not know who canceled it. -Resident #1 was rescheduled to see the cardiologist on 03/09/18 for an echocardiogram and a pacemaker check. Interview with the Administrator on 02/09/18 at 1:15 p.m. revealed: -The facility had problems with Resident #1's family taking him to appointments and not sharing any paperwork from the visits with the facility. -She had just started working at the facility recently and as not aware Resident #1 had missed any appointments, or procedures. Telephone interview with Resident #1's family member on 02/09/18 at 4:55 p.m. revealed: -She usually took Resident #1 to his doctor's appointments. -She provided paperwork to the facility staff after each appointment. -She thought the facility staff lost his paperwork. -The resident went to the cardiologist's office in December 2017 to get a pacemaker check. -The resident had not had an echocardiogram in over a year to her knowledge. -She was not aware of any missed appointments. Interview with Resident #1 on 02/09/18 at 7:08 p.m. revealed: -His family member usually took him to appointments.	D 273		

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D 273	Continued From page 78 -He thought his family member gave paperwork to the facility when he returned from appointments. -His pacemaker was checked about 2 months ago. -He could not recall when he last saw a cardiologist. -He was not aware of any missed appointments. -He had not experience any heart problems "lately" to his knowledge. c. Review of Resident #1's physician's orders dated 10/17/17 revealed orders for Hemoglobin A1C, lipid panel, complete blood count (CBC) with differential, and comprehensive metabolic panel (CMP). Review of Resident #1's lab work revealed: -There were results for a CMP dated 10/27/17. -There were results for a Hemoglobin A1C dated 10/27/17. -There was no documentation of a CBC or lipid panel being done as ordered on 10/17/17. Interview with the Resident Care Coordinator (RCC) on 02/09/18 at 6:50 p.m. revealed: -She was new at the facility and they were working on getting systems in place for lab work. -Staff were supposed fax orders for labs to the lab company and then the lab company would come to the facility to draw the blood for the labs. -She was not aware Resident #1 had missed any lab work. -She was not sure what systems the facility had in place prior to her working there. Telephone interview with a nurse at Resident #1's primary care provider's (PCP) office on 02/09/18 at 4:37 p.m. revealed: -The last lab work they had on file for the resident	D 273			

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D 273	Continued From page 79 was a BMP and a Hemoglobin A1C on 10/27/17. -The last CBC and lipids lab work they have on file was done on 06/19/17. Interview with the Clinical Support Specialist on 02/09/18 at 5:32 p.m. revealed: -She attempted to contact the lab used by the facility but was unable to reach anyone. -She could not find that the CBC or lipid panel were done for the resident. -She did not know why the lab work was not done. Interview with the Administrator on 02/09/18 at 1:15 p.m. revealed she had just started working at the facility recently and was not aware Resident #1 had missed any lab work. Interview with Resident #1 on 02/09/18 at 7:08 p.m. revealed: -He thought he had some lab work done about 2 weeks ago but he was not sure. -He could not recall when he last saw his PCP. The facility failed to obtain compression stockings for Resident #2 who had chronic lymphedema which resulted in untreated leg edema placing the resident at risk for infection. The facility failed to notify Resident #1's physician of blood sugars greater than 400 on 4 occasions as ordered. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. Review of the facility's plan of protection dated 02/07/18 revealed: -All resident records will be audited beginning on 02/10/18 to identify any issues requiring referral or follow-up. -All identified issues will be addressed	D 273			

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NAME OF PROVIDER OR SUPPLIER CHATHAM COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST CHATHAM STREET CARY, NC 27512		
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D 273	Continued From page 80 immediately. -Executive Director (ED) will ensure all audits are completed and all identified issues corrected. -ED / Resident Care Coordinator (RCC) / Special Care Coordinator (SCC) / designee will complete chart audits a minimum of 5 per week ongoing to ensure appropriate referral and follow-up promptly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2018.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure an order for twice blood pressure and pulse twice monthly was implemented for 1 of 6 sampled residents (#2) with a diagnosis of hypertension. The findings are: Review of Resident #2's current FL-2 dated 10/14/16 revealed: -Diagnoses included mental retardation,	D 276		

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D 276	Continued From page 81 hypothyroidism, hypertension, and pituitary prolactinoma. -There was an order for blood pressure and pulse twice montly. Review of Resident #2's Monthly Weight and Vital Signs for 2017 revealed: -Resident #2's blood pressure and pulse were last taken on 9/12/17. -There were no subsequent readings. Interview with a Medication Aide on 2/8/18 at 2:33 p.m. revealed: -She had never taken Resident #2's blood pressure or pulse. -She was not aware there was an order to do so. Interview with a second Medication Aide on 2/9/18 at 2:02 p.m. revealed: -She had never checked Resident #2's blood pressure or pulse. -The order was not on the Medication Administration Record (MAR) and therefore she had not done it. Interview with the Resident Care Coordinator (RCC) on 2/9/18 at 12:40 p.m. revealed: -Orders were faxed to the pharmacy once signed by the doctor. -The pharmacy then added it electronically to the MAR once the facility approved the change. -She was not aware Resident #2 had an order for blood pressure and pulse checks twice monthly. -She would have to call the doctor and clarify the order. Interview with the Clinical Support Specialist on 2/8/18 at 3:55 p.m. revealed: -She was not sure why there were no readings for Resident #2's blood pressure or pulse after	D 276		

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D 276	Continued From page 82 9/12/17. -She would contact the doctor to see if the order was discontinued. Interview with the primary care physician (PCP) on 2/9/18 at 9:33 a.m. revealed: -She had ordered blood pressure and pulse checks twice monthly for Resident #2. -Resident #2 had a history of a high heartrate. -Resident #2's blood pressure was usually normal when she checked it. -She expected the order for blood pressure and pulse twice monthly to be carried out to ensure Resident #2 was monitored.	D 276			
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 6 of 7 residents (#1, #6, #8, #9, #10, #11) observed during the medication passes including errors with insulin (#1, #8, #10, #11), a mood stabilizer, a blood	D 358			

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D 358	Continued From page 83 pressure medication, an allergy nasal spray (#6), and an iron supplement (#9); and for 1 of 5 residents sampled (#3) who had not received a medication for seizures since it was ordered in December 2017, over 7 weeks ago. The findings are: 1. The medication error rate was 25% as evidenced by the observation of 9 errors out of 35 opportunities during the 7:00 a.m./8:00 a.m., 11:00 a.m./11:30 a.m., and 2:00 p.m. medication passes on 02/07/18. a. Review of Resident #8's current FL-2 dated 06/25/17 revealed: -Diagnoses included type 2 diabetes mellitus, chronic kidney disease - stage 3, hypertension, hypothyroidism, weakness, multiple myeloma, and osteoarthritis. -There was an order for fingerstick blood sugars (FSBS) before meals and at bedtime. -There was an order for Novolog insulin according to the following scale: 150 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; 401 - 500 = 6 units; notify physician if less than 60 or greater than 500. (Novolog is rapid-acting insulin used to lower blood sugar.) Review of Resident #8's February 2018 medication administration record (MAR) revealed: -There was an entry for Novolog insulin before meals and at bedtime according to the following scale: 150 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; 401 - 500 = 6 units; notify physician if less than 60 or greater than 500. -Novolog sliding scale insulin was scheduled to be administered at 7:00 a.m., 11:30 a.m., 4:30	D 358		

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D 358	Continued From page 84 p.m., and 8:00 p.m. -The resident's blood sugar ranged from 120 - 394 from 02/01/18 - 02/08/18. Interview with the medication aide (MA) on 02/07/18 at 8:05 a.m. revealed breakfast was served to the residents in the assisted living (AL) side at 7:30 a.m. Observation of the morning medication pass on 02/07/18 revealed: -The MA checked Resident #8's FSBS at 8:07 a.m. and it was 234. -The resident told the MA that her FSBS was high because she had already eaten breakfast. -The MA administered 2 units of Novolog insulin at 8:14 a.m. after the meal instead of before the meal as ordered. Interview with the same MA on 02/07/18 at 8:15 a.m. revealed: -She was aware that Resident #8 had already eaten breakfast before she checked the resident's FSBS and administered the insulin. -The FSBS and the insulin were both supposed to be done prior to the meal. -Some residents went into the dining room and ate breakfast before she could get to them. -She was the only MA administering medications to all 44 residents on the assisted living side of the facility. -It was not unusual for some residents to get their FSBS and insulin after meals due to the facility being short staffed. Interview with the same MA on 02/07/18 at 12:45 p.m. revealed lunch was served to the residents in the AL side at 12:00 p.m. Observation of the lunch time medication pass on	D 358		

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D 358	Continued From page 85 02/07/18 revealed: -The MA checked Resident #8's FSBS at 1:13 p.m. and it was 286. -The resident had already eaten lunch. -The MA administered 3 units of Novolog insulin at 1:15 p.m. after the meal instead of before the meal as ordered. Interview with the same MA on 02/07/18 at 1:20 p.m. revealed: -She was aware that Resident #8 had already eaten lunch before she checked the resident's FSBS and administered the insulin. -The FSBS and the insulin were both supposed to be done prior to the meal. -She was running late with the morning medication which caused her to start late on the lunch time medication pass. -The Special Care Coordinator (SCC) came to help the MA administer the medications but the residents had already started eating when the SCC arrived to help. -It was not unusual for some residents to get their FSBS and insulin after meals due to the facility being short staffed. Interview with the Resident Care Coordinator (RCC) on 02/07/18 at 1:33 p.m. revealed: -FSBS should be checked 30 minutes before the meal and insulin should be administered before the meal, just after the FSBS was checked. -She was not aware FSBS and insulin were being administered after residents had eaten. -If a MA was running behind with the medication pass, the MA was supposed to inform her or the Administrator. -If help was available, they would get help for the MA. -Some MAs had voiced concerns about being able to finish the medication pass on time.	D 358		

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D 358	Continued From page 86 -They were in the process of trying to hire more MAs. Interview with Resident #8 on 02/08/18 at 4:25 p.m. revealed: -She sometimes had her FSBS checked and received insulin after her meals. -Her blood sugar ran high if she "cheats" on her diet. b. Review of Resident #6's current FL-2 dated 11/20/17 revealed diagnoses included Alzheimer's dementia, difficulty walking, dysphagia - oropharyngeal phase, cognitive communication deficit, abnormal posture, and stress fracture of the hip. Review of Resident #6's physician's order dated 12/12/17 revealed an order for Depakote 125mg twice a day (Depakote is used to treat mood disorders.) Review of subsequent physician's orders for Resident #6 revealed: -There was an order dated 12/20/17 to increase Depakote 125mg to 1 capsule 3 times a day. -There was an order dated 02/02/18 to change to Depakote 125mg take 2 capsules in the morning and at 2:00 p.m. and take 1 capsule at 8:00 p.m. Observation of the morning medication pass on 02/07/18 8:44 a.m. revealed: -The MA administered 1 Depakote 125mg capsule to Resident #6 instead of 2 capsules as ordered. Review of Resident #6's February 2018 medication administration record (MAR) revealed: -There was an entry for Depakote 125mg 1 capsule 3 times a day at 8:00 a.m., 2:00 p.m.,	D 358		

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D 358	Continued From page 87 and 8:00 p.m. and it was discontinued on 02/03/18. -There was an entry for Depakote 125mg take 2 capsules (250mg) twice a day at 8:00 a.m. and 2:00 p.m. starting on 02/04/18. -There was a second entry for Depakote 125mg daily at 8:00 p.m. starting on 02/04/18. Observation of medications on hand on 02/07/18 revealed: -The supply of Depakote in the medication cart was dispensed on 01/16/18 and the instructions on the medication card were to take 1 capsule 3 times a day for mood stabilization. -There was no direction change sticker on the label. Interview with the MA on 02/07/18 at 10:50 a.m. revealed: -She went by the label in the Depakote bubble card when she administered 1 capsule that morning on 02/07/18. -She had not noticed the MAR indicated to administer 2 capsules at 8:00 a.m. and 2:00 p.m. -She did not notice the order changed so she had continued to administer 1 capsule instead of 2 capsules to the resident. -Resident #6 was combative with staff and she had not noticed the resident's behavior was any different than usual. -She would put a direction change sticker on the resident's supply of Depakote in the medication cart. Review of pharmacy dispensing records for Resident #1 revealed: -There were 90 Depakote 125mg capsules dispensed on 12/20/17 (30 day supply). -There were 90 Depakote 125mg capsules dispensed on 01/16/18 (30 day supply).	D 358		

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D 358	Continued From page 88 -There were 150 Depakote 125mg capsules dispensed on 02/03/18 (30 day supply). Interview with the Special Care Coordinator (SCC) on 02/07/18 at 11:00 a.m. revealed: -The MA who administered the Depakote had only been administering medications for 3 months. -The MA had been trained to read the MARs and the labels to make sure everything matched. -The MA should let her know if something did not match. -Resident #6 could get combative with staff and she had noticed a change in the resident's mood. Interview with the facility's contracted primary care provider (PCP) on 02/09/18 at 9:14 a.m. revealed: -Resident #6 was being combative with staff so she increased the Depakote dose on 02/02/18. -She was not aware facility staff was not implementing the dose increase for the Depakote. -It was important because if the resident was still having behaviors, she would have increased the dose again thinking the previous change did not help the resident. -Staff was probably seeing no change in the resident's behavior because the Depakote was not increased as ordered. -She assumed Resident #6 was getting her medications as ordered and as indicated on the MARs. Based on observation, interview, and record review, Resident #6 was not interviewable. c. Review of Resident #6's current FL-2 dated 11/20/17 revealed an order for Hydralazine 25mg take 1.5 tablets twice a day. (Hydralazine lowers	D 358			

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D 358	Continued From page 89 blood pressure.) Observation of the morning medication pass on 02/07/18 at 8:44 a.m. revealed: -The MA administered ½ of a Hydralazine 25mg tablet to Resident #6 instead of 1 and ½ tablets as ordered. -The resident received 12.5mg of Hydralazine instead of 37.5mg as ordered. Observation of medications on hand on 02/07/18 revealed: -The only card of Hydralazine 25mg in the active medication cart was dispensed on 12/19/17 and each bubble contained a half tablet only. -There was no card in the active medication cart with any Hydralazine 25mg whole tablets. -The instructions on the label were to take 1.5 tablets (37.5mg) twice daily, "note dose" and it was pack 3 of 4. Interview with the MA on 02/07/18 at 10:50 a.m. revealed: -She had not noticed the instructions on the label and on the MAR for the Hydralazine was to take 1.5 tablets. -She had been administering the ½ tablet in the bubble card in the medication cart. -She would check the back-up supply to see if there was any other Hydralazine on hand. Observation of the back-up medication supply for Resident #6 on 02/07/18 revealed: -There were 2 bubble cards of whole Hydralazine 25mg tablets in each bubble. -One card was dispensed on 12/19/17 and was noted to be card 1 of 4 and still had all 30 whole tablets in the card. -The other card was dispensed on 01/12/18 and still had all 30 whole tablets in the card.	D 358		

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D 358	Continued From page 90 Review of pharmacy dispensing records for Resident #1 dated 08/01/17 - 02/07/18. -There were 90 Hydralazine 25mg tablets dispensed on 11/22/17 (30 day supply). -There were 90 Hydralazine 25mg tablets dispensed on 01/12/18 (30 day supply). [Each dispensing included 2 cards with 30 whole tablets each (60 whole tablets total) and 2 cards with 30 half tablets each (which were 30 whole tablets already cut in half by the pharmacy) which totaled 90 whole tablets.] Review of Resident #6's December 2017 - February 2018 medication administration records (MARs) revealed: -There were entries on each MAR for Hydralazine 25mg take 1.5 tablets (37.5mg) twice daily at 8:00 a.m. and 8:00 p.m. -Hydralazine 25mg 1.5 tablets was documented as administered twice daily from 12/01/17 - 02/07/18 (8:00 a.m.) with only 1 refusal during this time period. Interview with the Special Care Coordinator (SCC) on 02/07/18 at 11:00 a.m. revealed: -The MA who administered the Hydralazine had only been administering medications for 3 months. -The MA had been trained to read the MARs and the labels and administer the medications as ordered. -She would look for the resident's monthly blood pressures and she would have staff check it today, 02/07/18. Review of Resident #1's monthly vital signs log revealed: -The resident's blood pressure (BP) was 143/74 on 11/27/17.	D 358		

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D 358	Continued From page 91 -The resident's BP was 181/81 on 12/03/17. -The resident's BP was 114/89 on 01/05/18. -The resident's BP was 164/84 on 02/07/18. Interview with the facility's contracted primary care provider (PCP) on 02/09/18 at 9:14 a.m. revealed: -She was concerned that staff was not administering the Hydralazine as ordered and as noted on the MAR because she could change a dosage based on the inaccurate documentation. -The resident's blood pressure was 110/64 during her visit last week so she would probably have the facility check the resident's blood pressure daily since the medication was not administered as ordered. Based on observation, interview, and record review, Resident #6 was not interviewable. d. Review of Resident #6's current FL-2 dated 11/20/17 revealed an order for Flonase Nasal Spray, 2 sprays in each nostril daily. (Flonase is used to treat allergy symptoms.) Observation of the morning medication pass on 02/07/18 at 8:45 a.m. revealed: -The medication aide (MA) administered Flonase 1 spray in each nostril to Resident #6 instead of 2 sprays in each nostril as ordered. -The MA did not offer or attempt a second spray in either nostril. Observation of medications on hand for Resident #6 on 02/07/18 revealed; -There was one bottle of Flonase nasal spray dispensed on 01/02/18 with instructions to use 2 sprays in each nostril daily (a total of 4 sprays needed per day). -The bottle of Flonase contained 120 doses and	D 358			

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D 358	Continued From page 92 would have lasted 30 days with 2 sprays in each nostril daily (4 sprays per day). -The bottle of Flonase was over 3/4th full. Review of Resident #6's December 2017 - February 2018 medication administration records (MARs) revealed: -There were entries on each MAR for Flonase Nasal Spray 50mcg, spray 2 sprays into each nostril every day. -Flonase 2 sprays was documented as administered daily at 8:00 a.m. from 12/01/17 - 02/07/18. Interview with the MA on 02/07/18 at 10:50 a.m. revealed: -The resident was supposed to get 2 sprays of Flonase in each nostril. -She only gave 1 spray that morning on 02/07/18 because the resident would sometimes swing at staff. Review of pharmacy dispensing records for Resident #1 dated 08/01/17 - 02/07/18. -There was one Flonase nasal spray with 120 metered doses dispensed on 11/22/17 (30 day supply). -There was one Flonase nasal spray with 120 metered doses dispensed on 02/06/18 (30 day supply). Interview with the Special Care Coordinator (SCC) on 02/07/18 at 11:00 a.m. revealed: -The MA who administered the Flonase had only been administering medications for 3 months. -The MA had been trained to read the MARs and the labels and administer the medications as ordered. -Resident #6 had not complained of any allergy symptoms.	D 358		

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NAME OF PROVIDER OR SUPPLIER CHATHAM COMMONS			STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST CHATHAM STREET CARY, NC 27512		
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D 358	Continued From page 93 -She was not aware of Resident #6 refusing the Flonase nasal spray. Interview with the facility's contracted primary care provider (PCP) on 02/09/18 at 9:14 a.m. revealed: -She assumed Resident #6 was getting her medications as ordered and as indicated on the MARs. -She expected Resident #6 to get 2 sprays of Flonase in each nostril daily as ordered. Based on observation, interview, and record review, Resident #6 was not interviewable. e. Review of Resident #9's current FL-2 dated 01/17/17 revealed: -Diagnoses included dementia with behavioral disturbance, rheumatoid arthritis, osteoarthritis, osteoporosis with history of fracture, constipation, dysfunction of gait, hypothyroidism, and anxiety disorder. -There was an order for Ferrous Sulfate 325mg 1 tablet daily. (Ferrous Sulfate is used to treat iron deficiency anemia. Ferrous Sulfate is enteric coated and should be not be crushed or chewed.) Review of Resident #9' standing orders dated 08/10/17 revealed all medications (if not enteric coated or time released) may be given by mouth and/or crushed (check do not crush list) and placed in applesauce/pudding unless otherwise noted. Observation of the morning medication pass on 02/07/18 revealed: -The medication aide (MA) crushed all of Resident #9's oral pills, including Ferrous Sulfate, and administered them in applesauce to the resident at 8:35 a.m. (Ferrous Sulfate was	D 358			

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D 358	Continued From page 94 enteric coated and should not be crushed.) -The MA did not use a do not crush (DNC) list to determine which medications could be crushed. Review of Resident #9's February 2018 medication administration record (MAR) revealed: -There was an entry for Ferrous Sulfate 325mg every day at 8:00 a.m. -Ferrous Sulfate was documented as administered daily from 02/01/18 - 02/07/18. -There was no documentation on the MAR related to crushing the resident's Ferrous Sulfate. Observation of Resident #9's medications on hand on 02/07/18 revealed: -There were two supplies of Ferrous Sulfate, one dispensed on 12/28/17 and the second bubble card was dispensed on 01/21/18. -Both cards had a sticker that read, "Do Not Chew or Crush, Swallow Whole". Interview with the MA on 02/07/18 at 10:40 a.m. revealed: -She had not seen a DNC list at the facility. -She remembered talking about it when she was trained. -She would contact the pharmacy to get a DNC list. -She had not noticed there was a label on the Ferrous Sulfate bubble card indicating the pill should not be crushed. Interview with the Special Care Coordinator (SCC) on 02/07/18 at 10:45 a.m. revealed: -They used to have a DNC list that was kept on the medication carts. -The MAs were supposed to use the DNC list when crushing medications. -The MAs were also supposed to check the MARs and the medication labels for information	D 358		

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D 358	Continued From page 95 about crushing the medications. -She would get a new DNC list from the pharmacy. Interview with the Administrator on 02/07/18 at 2:05 p.m. revealed: -The MAs had been trained to read the MARs. -They should administer the medications as ordered. -The MAs had been trained to use direction change stickers on the medication labels when there was an order change. -She had gotten a DNC list from the pharmacy on Monday afternoon, 02/05/18. -She had not had a chance to put a copy of the DNC list on the medication carts yet. Based on observation, interview, and record review, Resident #9 was not interviewable. Review of a fax to Resident #9's primary care provider dated 02/07/18 revealed a request to get a liquid order for Ferrous Sulfate. f. Review of Resident #10's current FL-2 dated 02/10/17 revealed: -Diagnoses included diabetes mellitus type II, schizophrenia, dementia, tardive dyskinesia, hypertension, anxiety, chronic obstructive pulmonary disease, hyperlipidemia, and fatty liver. Review of Resident #10's physician's order dated 12/05/17 revealed an order for Novolog insulin 3 units 3 times a day before meals. (Novolog is rapid-acting insulin used to lower blood sugar in diabetics.) Observation of the 11:30 a.m. medication pass on 02/07/18 revealed:	D 358		

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D 358	Continued From page 96 -The medication aide (MA) checked Resident #10's FSBS at 12:50 p.m. and it was 283. -The resident stated she had already eaten lunch. -The MA indicated the resident was supposed to receive 3 units of Novolog insulin. -The MA could not find any Novolog insulin on hand for Resident #10. -The resident did not receive any Novolog insulin due to the medication being unavailable. Interview with the MA on 02/07/18 at 12:55 p.m. revealed: -She could not find Resident #10's Novolog insulin vial. -She thought the resident had some that morning. -Then she thought she may have used it all earlier that morning on 02/07/18. -She forgot to reorder the insulin. -She would contact the pharmacy to try to get some Novolog insulin from the back-up pharmacy. -She was running late with the lunchtime blood sugars and insulin because her morning medication pass was very late. -The Special Care Coordinator (SCC) came over to help her but it was after the residents had already started eating their lunch meal. Review of Resident #10's February 2018 medication administration record (MAR) revealed: -There was an entry for Novolog insulin 3 times daily before meals, hold if blood sugar less than 100. -Novolog was scheduled to be administered at 6:30 a.m., 11:30 a.m., and 4:30 p.m. -The resident's blood sugar ranged from 153 - 338 from 02/01/18 - 02/08/18. Interview with the MA on 02/07/18 at 1:00 p.m. revealed:	D 358		

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D 358	Continued From page 97 -She had contacted the pharmacy and the Novolog would be filled by the backup pharmacy now. -The backup pharmacy would let the facility know when the Novolog was ready to be picked up. -She would contact Resident #10's primary care provider (PCP) about the missed dose of Novolog insulin. Review of a physician's order dated 02/07/18 at 3:47 p.m. for Resident #10 revealed: -If the resident was feeling fine, check blood sugar at dinner before meal and administer Novolog as ordered. Interview with Resident #10 on 02/08/18 at 4:31 p.m. revealed: -Her FSBS was checked about 2 or 3 times a day. -She sometimes received insulin after she ate her meals instead of before her meals. -She did not know if the facility had run out of her insulin. Interview with the facility's contracted primary care provider (PCP) on 02/09/18 at 9:14 a.m. revealed: -She was aware the facility ran out of Resident #10's Novolog insulin on 02/07/18. -She expected the facility to have insulin for Resident #10 on hand and available at the facility to be administered as ordered. g. Review of Resident #1's current FL-2 dated 06/21/17 revealed diagnoses included bradycardia, bilateral shoulder pain, and diarrhea - resolved. Review of Resident #1's physician's orders dated 06/22/17 revealed:	D 358		

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D 358	Continued From page 98 -There was an order to check fingerstick blood sugar (FSBS) 4 times a day before meals and at bedtime. -There was an order for Novolog sliding scale insulin before meals and at bedtime: 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than (>) 400 = 12 units; call physician if FSBS > 400 or less than (<) 40. (Novolog is rapid-acting insulin used to lower blood sugar in diabetics.) Review of Resident #1's February 2018 medication administration record (MAR) revealed: -There was an entry for Novolog insulin before meals and at bedtime according to the following scale: less than 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 12 units and call physician if greater than 400 or less than 40. -Novolog sliding scale insulin was scheduled to be administered at 7:00 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. -The resident's blood sugar ranged from 65 - 316 from 02/01/18 - 02/08/18. Interview with the medication aide (MA) on 02/07/18 at 12:45 p.m. revealed lunch was served to the residents in the assisted living (AL) side at 12:00 p.m. Observation of the lunch time medication pass on 02/07/18 revealed: -The MA checked Resident #1's FSBS at 1:25 p.m. and it was 371. -The resident was in his room and had already eaten lunch. -The MA administered 10 units of Novolog insulin at 1:27 p.m. after the meal instead of before the meal as ordered.	D 358		

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D 358	Continued From page 99 Interview with the MA on 02/07/18 at 1:28 p.m. revealed: -She was aware that Resident #1 had already eaten lunch before she checked the resident's FSBS and administered the insulin. -The FSBS and the insulin were both supposed to be done prior to the meal. -She was running late with the morning medication which caused her to start late on the lunch time medication pass. -The Special Care Coordinator (SCC) came to help the MA administer the medications but the residents had already started eating when the SCC arrived to help. -It was not unusual for some residents to get their FSBS and insulin after meals due to the facility being short staffed. Interview with the Resident Care Coordinator (RCC) on 02/07/18 at 1:33 p.m. revealed: -FSBS should be checked 30 minutes before the meal and insulin should be administered before the meal, just after the FSBS was checked. -She was not aware FSBS and insulin were being administered after residents had eaten. -If a MA was running behind with the medication pass, the MA was supposed to inform her or the Administrator. -If help was available, they would get help for the MA. -Some MAs had voiced concerns about being able to finish the medication pass on time. -They were in the process of trying to hire more MAs. Interview with Resident #1 on 02/09/18 at 7:08 p.m. revealed: -His blood sugar was checked about twice a day. -His blood sugar "runs high a little bit".	D 358		

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D 358	Continued From page 100 -He sometimes got insulin after his meals instead of before his meals. h. Review of Resident #11's current FL-2 dated 01/24/18 revealed: -Diagnosis included diabetes mellitus. -There was an order for Novolog insulin 3 times daily according to the following scale: 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; call physician if less than 70 or greater than 400. (Novolog is rapid-acting insulin used to lower blood sugar in diabetics.) Observation of the lunch time medication pass on 02/07/18 revealed: -The Special Care Coordinator (SCC) checked Resident #11's FSBS at 1:16 p.m. and it was 186. -The MA did not administer any Novolog insulin to the resident. Interview with the Resident #11 on 02/07/18 at 1:14 p.m. revealed he had already eaten lunch and ate carrots and rice. Interview with the SCC on 02/07/18 at 1:16 p.m. revealed: -The resident required 2 units of insulin based on his sliding scale. -Resident #11 had just gotten insulin at 11:44 a.m. -She would call the doctor to clarify if it was too close to administer another dose of insulin. Review of Resident #11's February 2018 medication administration record (MAR) revealed: -There was an entry for Novolog insulin 3 times daily according to the following scale: 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 =	D 358			

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D 358	Continued From page 101 10 units; call physician if less than 70 or greater than 400. -Novolog sliding scale insulin was scheduled to be administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -The resident's blood sugar ranged from 109 - 167 from 02/01/18 - 02/08/18. -The resident's blood sugar was 122 at 8:00 a.m. on 02/07/18. -No Novolog sliding scale insulin was documented as administered on 02/07/18 and it was noted to be withheld per physician's orders (sliding scale 0 - 150 = 0 units). Interview with the MA on 02/07/18 at 4:36 p.m. revealed: -She checked Resident #11's 8:00 a.m. FSBS at 11:44 a.m. that day on 02/07/18 because she was running late with the morning medication pass. -She did not administer any Novolog insulin because the FSBS was below the sliding scale. -She then documented the Novolog was withheld per doctor's orders. -The SCC checked the resident's FSBS scheduled for 2:00 p.m. -She was not sure why the SCC held the insulin for Resident #11 because no insulin had been administered at 11:44 a.m. Interview with the SCC on 02/08/18 at 12:23 p.m. revealed: -She had not yet received a call back from Resident #11's physician. -She would check to see if any new orders had come in for the resident. Interview with Resident #11 on 02/08/18 at 4:35 p.m. revealed: -His FSBS was checked 2 to 3 times a day. -His FSBS had been running high, "in the 200's".	D 358		

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D 358	Continued From page 102 -He sometimes received his insulin after he had already eaten his meals. Interview with the facility's contracted primary care provider (PCP) on 02/09/18 at 9:14 a.m. revealed: -Fingerstick blood sugars should be checked before meals. -Insulin should be administered before meals. -Checking blood sugar and administering insulin late, especially after meals, can cause the blood sugar to get higher and puts residents at risk of going into a diabetic coma. 2. Review of Resident #3's current FL-2 dated 12/12/17 revealed: -Diagnoses included schizophrenia, abnormal posture, left wrist contracture, traumatic brain injury, arteriosclerosis heart disease. -There was a physician's order for Depakote 500mg 2 tablets daily. (Depakote is used to treat seizures and bipolar disorders.) Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 12/14/17. Review of clarification orders from the physician dated 12/17/17 revealed an order for Depakote DR 500mg 2 tablets at bedtime. Review of Resident #3's December 14-31, 2017 medication administration record (MAR) revealed: -There was no documentation that Resident #3 had received Depakote DR 500mg. -Depakote DR 500mg was not listed on the MAR. Review of Resident #3's January 2018 MAR revealed: -There was no documentation that Resident #3	D 358		

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D 358	Continued From page 103 had received Depakote DR 500mg. -Depakote DR 500mg was not listed on the MAR. Review of Resident #3's February 1-8, 2018 MAR revealed: -There was no documentation that Resident #3 had received Depakote DR 500mg. -Depakote DR 500mg was not listed on the MAR. Observation of the medication cart on 02/07/18 at 1:20 p.m. revealed Resident #3 did not have any Depakote on hand. Interview with the Resident Care Coordinator (RCC) on 02/08/18 at 9:00 a.m. revealed: -She was unable to find any discontinue orders for the Depakote for Resident #3. -She was not aware why it had not been received from the pharmacy since she had only been working at the facility for about 2 weeks. -She called the pharmacy on 02/07/18 and they will be filling the Depakote today and sending in on the truck tonight. -When an order comes into the facility it is placed in a bucket and then whoever received the order is to fax it to the pharmacy. -After it has been faxed, the facility will make sure it is put on the electronic MAR system and the RCC or the Special Care Coordinator (SCC) are responsible for checking the order to make sure it matches. -Once the medication was received and had been checked off by the RCC or SCC then it could be taken out of the bucket list and placed into the resident record. -She notified the primary care physician about the Depakote being missing and was told once the medication arrived to resume administering the medication as ordered.	D 358			

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D 358	Continued From page 104 Telephone interview with a Pharmacist on 02/08/18 at 9:20 a.m. revealed: -The pharmacy did receive the FL-2 form the facility on 12/14/17. -The pharmacy needed clarification on the Depakote order and faxed the facility a request for a clarification. -They never received a response from the facility until 02/07/18 and that is when the Depakote was processed to be filled. -The medication will be filled today and sent to the facility on their shipment tonight. -They faxed the facility on 12/19/17 and 12/20/17 for the clarification order but never received any clarification. Interview with the primary care physician on 02/09/18 at 9:00 a.m. revealed: -She was not aware the medication had not been administered until she received a call from the facility on 02/07/18. -She would have expected the facility to follow-up with the orders to make sure the resident was receiving his medications. -She had received a request back in December 2017 to clarify the Depakote and she sent the facility an order. -She was not sure if the order had ever been sent to the pharmacy. -She had not received any calls from the pharmacy about the Depakote. -Resident #3 was taking the Depakote for seizures but had not had any seizures so she did not feel it had affected him missing the medication. -The medication had been ordered and she did want him to start back taking it as soon as possible. -She had checked a Depakote level last week sometime and it was sub-therapeutic but did not	D 358			

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D 358	Continued From page 105 concern her at the time. Interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. revealed: -When an order comes into the facility it is placed in a bucket and then whoever received the order is to fax it to the pharmacy. -After it has been faxed, the facility will make sure it is put on the electronic MAR system and the RCC or the Special Care Coordinator (SCC) are responsible for checking the order to make sure it matches. -Once the medication was received and had been checked off by the RCC or SCC then it could be taken out of the bucket list and placed into the resident record. -She usually did not work at the facility and was unaware that Resident #3 was not receiving his Depakote. -She would make sure the Depakote was received from the pharmacy and was started for Resident #3 tonight. Observation of the medication cart on 02/09/18 at 11:00 a.m. revealed Resident #3 had a packet of pills labeled, "Depakote DR 500mg 2 tablets at bedtime". The facility had a 25% medication error rate which included 5 errors with the administration of insulin. Resident #10 did not receive scheduled Novolog insulin at lunch time on 02/07/18 because the insulin was unavailable; Resident #8 and Resident #1 both received insulin after their meals on 02/07/18 instead of before the meals; and Resident #11 did not receive Novolog sliding scale insulin on 02/07/18 as ordered. Resident #6 received 1/3rd of the dose of Hydralazine ordered due to staff failing to read the MARs and medication labels resulting in a high blood	D 358			

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D 358	Continued From page 106 pressure reading on 02/07/18. The facility failed to implement an order for Resident #3's Depakote, a seizure medication, when it was ordered on 12/17/17 resulting in the resident not receiving the medication for over 7 weeks and putting the resident at risk for having seizures. The facility's failure to administer medications as ordered to the residents resulted in substantial risk of serious physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ Review of the facility's plan of protection dated 02/07/18 revealed: -Executive Director (ED) or designee will begin immediate audit of all medication orders and ensure medications are available for administration. -Registered Nurse (RN) will begin training (beginning tomorrow 02/08/18) for all medication aides (MAs) including but not limited to medication administration process, insulin administration, medication schedules, and documentation. -ED or designee will ensure medication pass observations are conducted at least weekly by a licensed nurse (Licensed Practical Nurse or RN) or pharmacist to include all MAs on all shifts. -Follow-up training will be provided for all identified issues. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 15, 2018.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 364		

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D 364	Continued From page 107 (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for at least 24 residents in the assisted living side of the facility on 02/07/18 and 7 residents in the special care unit on 02/08/18 resulting in several medications ordered multiple times a day for 9 of the 31 residents (#3, #11, #12, #13, #14, #15, #16, #17, #18) being administered too close to the next scheduled administration time. The findings are: 1. Review of the facility's resident census reports dated 02/01/18 - 02/07/18 revealed there were 44 residents on the assisted living (AL) side of the facility. Interview with 4 residents on the AL side of the facility on 02/06/18 revealed: -Medications were administered late in the facility. -There were not enough medication aides (MAs). -There was one MA working last night on 02/05/18 for the whole building. -A resident was supposed to get medications at 7:00 p.m. but did not receive them until 9:30 p.m. on 02/05/18. -A second resident did not receive 8:00 p.m. medications on 02/05/18 until sometime between 10:00 p.m. and 11:00 p.m. while watching the news.	D 364		

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D 364	Continued From page 108 -A third resident did not receive 8:00 p.m. medications last night on 02/05/18 until 11:00 p.m. Interview with a MA on 02/07/18 at 10:00 a.m. revealed: -She was the only MA for two medication carts in the AL side of the facility. -She was unable to do much resident care because she was so busy passing medications. Interview with the same MA on 02/07/18 at 10:12 a.m. revealed: -She had 11 residents that still needed medications on one side of the hall and "about the same or more" who still needed medications on the other side of the hall. -No other staff had offered to assist her. -She was normally finished with the medication pass by 10:30 a.m. and was behind schedule today. Interview with the same MA on 02/07/18 at 11:26 a.m. revealed: -Staff were aware that she was behind on the medication pass but she had not reported this to anyone that day. -When she asked for help in the past, she did not get help. -She was still passing 8:00 a.m., 9:00 a.m., and 10:00 a.m. medications. -Medications were passed late almost every day. -She was usually the only MA on the AL side daily. -Staff often interrupted her during the medication pass and also when the doctor came it made the medication pass longer. -She had administered morning medications (scheduled between 7:00 a.m.- 9:00 a.m.) to 10 residents from 10:15 a.m. - 11:15 a.m.	D 364			

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D 364	Continued From page 109 -There were 14 residents left who still needed their morning medications. Interview with the Administrator on 02/07/18 at 11:30 a.m. revealed: -She normally staffed the AL side with one MA and two personal care aides (PCAs). -The MA working that day, 02/07/18, had complained before that the medication pass on the AL side was too much for one person. -She had also received the same complaint from other MAs. -She had considered adding another MA to the first shift. -She had also considered changing the administration times of the medications. -If a MA needed assistance, she was expected to notify the Resident Care Coordinator (RCC) or the Administrator. -Either the RCC or the Administrator would then assist with the medication pass. -She was not aware of any other medication passes when 8:00 a.m. medications were given at 11:30 a.m. -This was the first time, to her knowledge, that the morning medication pass had been this late. -She had received complaints from several residents about getting their medications late. Observation of the AL side of the facility on 02/07/18 from 11:49 a.m. to 11:58 p.m. revealed: -There was one MA on the medication cart passing medications. -The RCC walked by the medication cart and entered the special care unit (SCU). Interview with the same MA on 02/07/18 at 12:09 p.m. revealed: -She still needed to give two residents their medications.	D 364			

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D 364	Continued From page 110 -She was finishing up her morning medications specifically nose sprays, eye drops, and lotions. -She had not been offered any help from other staff. -She had not yet done fingerstick blood sugars scheduled for lunch time. -She estimated she had about four to five finger-stick blood sugars to do before lunch. Interview with the same MA on 02/07/18 at 12:17 p.m. revealed: -The Special Care Coordinator (SCC) was coming to assist with the medication pass. - "I really needed the help earlier." Interview with the same MA on 02/07/18 at 12:19 p.m. revealed she had just finished the morning medication pass. Observation on 02/07/18 at 12:46 p.m. revealed the SCC came to the AL side of the facility and started administering medications for one of the medication carts. Interviews with the Administrator on 02/07/18 at 2:05 p.m. and 2:12 p.m. revealed: -She had spoken with the facility's primary care provider (PCP) office about the late medications. -The PCP said "this is unacceptable". -For anyone who missed 12:00 noon medications, they were supposed to wait and give those medications at 4:00 p.m. today (02/07/18). Interview with the facility's contracted primary care provider (PCP) on 02/09/18 at 9:14 a.m. revealed: -The facility's Administrator contacted her on 02/07/18 about the morning medications being administered late. -This was the first time anyone had made her of	D 364		

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D 364	Continued From page 111 any problems with medications being administered late other than a snow day recently when the facility was short staffed due to the weather. -She was concerned about the medications being administered late especially medications given multiple times a day. -There was potential for side effects if the doses of medications were administered too close together. Review of the February 2018 medication administration records (MARs) on the AL side revealed: -All 24 residents had morning medications scheduled for 8:00 a.m. -All 24 residents had medications ordered more than once a day, some with multiple administration times. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.] -Eight of the 24 residents had medications that were scheduled 3 or 4 times a day in which doses were administered too close together due to the 8:00 a.m. medication pass being late on 02/07/18. a. Review of Resident #14's current FL-2 dated 11/14/17 revealed diagnoses included bipolar disorder, edema, rheumatoid arthritis, mononeuropathy, and idiopathic acute pancreatitis without necrosis or infection. Review of Resident #14's February 2018 medication administration record (MAR) revealed: -There were at least 15 medications scheduled to be administered at 8:00 a.m. -There were 4 medications scheduled twice a day at 8:00 a.m. and 8:00 p.m.	D 364		

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D 364	Continued From page 112 -There was 1 medication scheduled twice a day at 8:00 a.m. and 2:00 p.m. -There were 4 medications scheduled for 3 or 4 times a day. -There were entries for Furosemide 40mg 1 tablet at 8:00 a.m. and 2:00 p.m. (Furosemide is a diuretic used to treat swelling/edema.) -There was an entry for Benztropine 1mg 3 times a day and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Benztropine is used to treat side effects of antipsychotic medications such as tremors.) -There was an entry for Ferrous Sulfate 325mg 3 times a day and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Ferrous Sulfate is used to treat iron deficiency anemia.) -There was an entry for Oxycodone 5mg take 1.5 tablets 4 times daily and it was scheduled to be administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. (Oxycodone is a narcotic used to treat moderate to severe pain.) -There was an entry for Metoclopramide 5mg before meals and at bedtime and it was scheduled to be administered at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. (Metoclopramide increase the motility of the stomach to help prevent stomach symptoms like nausea, vomiting, and heartburn.) Review of med pass detail forms dated 02/07/18 for Resident #14 revealed: -The 8:00 a.m. doses of Furosemide, Benztropine, and Ferrous Sulfate were documented as administered at 11:18 a.m. -The 2:00 p.m. doses of Furosemide, Benztropine, and Ferrous Sulfate were documented as administered at 1:57 p.m. -The 8:00 a.m. and 2:00 p.m. doses of Furosemide, Benztropine, and Ferrous Sulfate were administered only 2 hours and 39 minutes	D 364		

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D 364	Continued From page 113 apart. -The 8:00 a.m. dose of Oxycodone was documented as administered at 11:18 a.m. and the 12:00 p.m. dose was documented at 1:57 p.m., only 2 hours and 39 minutes apart. -The 7:00 a.m. dose of Metoclopramide was documented as administered at 11:18 a.m. and the 11:00 a.m. dose was documented at 1:57 p.m., only 2 hours and 39 minutes apart. Interview with Resident #14 on 02/09/18 at 9:20 a.m. revealed: -She was in pain and her knee was aching. -She was "still waiting for medicine." -She was supposed to get her medicines at 8:00 a.m. but her medicines were "usually late." -"All I want is my medicine on time." -Her roommate had gotten her medicines already. -Staff told her they were going to give the medicine but had not done so. -She did not think the staff listened because they were too busy. b. Review of Resident #3's current FL-2 dated 12/12/17 revealed diagnoses included schizophrenia, atherosclerotic heart disease, history of traumatic brain injury, contracture of left wrist, and abnormal posture. Review of Resident #3's February 2018 medication administration record (MAR) revealed: -There were at least 15 medications scheduled to be administered at 8:00 a.m. -There were 5 medications scheduled twice a day at 8:00 a.m. and 8:00 p.m. -There were 2 medications scheduled for 3 times a day. -There were entries for Gabapentin 100mg 2 capsules at 8:00 a.m., 1 capsule at 12:00 p.m.,	D 364		

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D 364	Continued From page 114 and 2 capsules at 8:00 p.m. (Gabapentin is used to treat seizures and mood disorders.) -There was an entry for Topiramate 50mg 3 tablets 3 times daily and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Topiramate is used to treat seizures and mood disorders.) Review of med pass detail forms dated 02/07/18 for Resident #3 revealed: -The 8:00 a.m. dose of Gabapentin was documented as administered at 12:08 p.m. and the 12:00 p.m. dose was documented at 2:24 p.m., only 2 hours and 16 minutes apart. -The 8:00 a.m. dose of Topiramate was documented as administered at 12:08 p.m. and the 2:00 p.m. dose was documented at 2:24 p.m., only 2 hours and 16 minutes apart. Interview with the Administrator on 02/07/18 at 11:30 a.m. revealed: -She was not aware the medication aide (MA) on the AL side was currently still administering the 8:00 a.m. medications at 11:30 a.m.. -The MA should have let her or the Resident Care Coordinator (RCC) know that she was running late with the medication pass. -She would have gotten another MA to help her finish the medication pass if she had known. -The MA had mentioned to her in the past that it was "a lot" for one medication aide to administer all of the 8:00 a.m. medications on the AL side. -She had been looking at staffing patterns to see if they could increase their staffing to have an additional MA. -She had also thought about changing the times of administration so the times would be staggered. -This was the first time she was aware of the MA still passing 8:00 a.m. medications at 11:30 a.m. -They usually had 1 MA in the AL side and 1 MA	D 364		

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D 364	Continued From page 115 in the SCU on first and second shifts. -They tried to have 1 MA in the AL side and 1 MA in the SCU on third shift but sometimes there was on 1 MA for both sides on third shift. -She would get someone to help the MA with the rest of the morning medications on the AL side. -She would contact the facility's contracted primary care provider (PCP) regarding the late medications. c. Review of Resident #12's current FL-2 dated 07/10/17 revealed diagnoses included hypertension, chronic kidney disease - stage III, gastrointestinal bleed, and anemia. Review of Resident #12's February 2018 medication administration record (MAR) revealed: -There were at least 10 medications scheduled to be administered at 8:00 a.m. -There were 3 medications scheduled twice a day at 8:00 a.m. and 8:00 p.m. -There were 2 medications scheduled for 3 or 4 times a day. -There was an entry for Hydralazine 10mg 4 times a day and it was scheduled for 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. (Hydralazine lowers blood pressure.) -There was entries for Sodium Chloride 1gm 2 tablets at 8:00 a.m., 1 tablet at 12:00 p.m., and 2 tablets at 8:00 p.m. (Sodium Chloride is used to treat low sodium levels.) Review of med pass detail forms dated 02/07/18 for Resident #12 revealed: -The 8:00 a.m. doses of Hydralazine and Sodium Chloride were documented as administered at 10:33 a.m. -The 12:00 p.m. doses of Hydralazine and Sodium Chloride were documented as administered at 12:45 p.m.	D 364		

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D 364	Continued From page 116 -The 8:00 a.m. and 12:00 p.m. doses for both medications were administered only 2 hours and 12 minutes apart. Interview with Resident #12 on 02/09/18 at 9:10 a.m. revealed: -She did not receive her medications on time. -On Monday 02/06/18 or Tuesday 02/07/18, she did not get her night medications until 10:30 p.m. -On most nights she got medications around 9:00 p.m. or a little after. d. Review of Resident #11's current FL-2 dated 01/24/18 revealed diagnoses included insulin dependent diabetes mellitus, hypertension, osteoarthritis, paranoid schizophrenia, gout, and history of agitation. Review of Resident #11's February 2018 medication administration record (MAR) revealed: -There were at least 16 medications scheduled to be administered at 8:00 a.m. -There were 4 medications scheduled twice a day at 8:00 a.m. and 8:00 p.m. -There were 2 medications scheduled for 3 or 4 times a day. -There was an entry for Tylenol 500mg 3 times a day and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Tylenol is for pain and fever.) -There was an entry for Combivent Respimat inhaler, inhale 1 puff 4 times daily and it was scheduled at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. (Combivent Respimat is used to treat breathing problems.) Review of med pass detail forms dated 02/07/18 for Resident #11 revealed: -The 8:00 a.m. dose of Tylenol was documented as administered at 11:57 a.m. and the 2:00 p.m.	D 364		

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D 364	Continued From page 117 dose was documented at 1:23 p.m., only 1 hour 26 minutes apart. -The 8:00 a.m. dose of Combivent Respimat was documented as administered at 11:57 a.m. and the 12:00 noon dose was documented at 1:23 p.m., only 1 hour 26 minutes apart. e. Review of Resident #15's current FL-2 dated 01/17/18 revealed diagnoses included fibromyalgia, status post cerebrovascular accident, depression, bipolar disorder, anxiety, vitamin D deficiency, gastric ulcer, and hypertension. Review of Resident #15's February 2018 medication administration record (MAR) revealed: -There were at least 13 medications scheduled to be administered at 8:00 a.m. -There were 5 medications scheduled twice a day at 8:00 a.m. and 8:00 p.m. -There were 2 medications scheduled for 3 times a day. -There were entries for Gabapentin 300mg 2 capsules at 8:00 a.m. and 12:00 p.m. and 3 capsules at 8:00 p.m. (Gabapentin may be used to treat nerve pain or mood disorders.) -There was an entry for Tylenol 325mg 3 times daily and it was scheduled to be administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Tylenol is for pain and fever.) Review of med pass detail forms dated 02/07/18 for Resident #15 revealed: -The 8:00 a.m. dose of Gabapentin was documented as administered at 10:52 a.m. and the 12:00 p.m. dose was documented at 1:50 p.m., only 2 hours and 58 minutes apart. -The 8:00 a.m. dose of Tylenol was documented as administered at 10:52 a.m. and the 2:00 p.m. dose was documented at 1:50 p.m., only 2 hours	D 364			

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D 364	Continued From page 118 and 58 minutes apart. f. Review of Resident #16's current FL-2 dated 09/08/17 revealed diagnoses included debility, hypertension, dementia, and abnormality of gait. Review of Resident #16's February 2018 medication administration record (MAR) revealed: -There were at least 9 medications scheduled to be administered at 8:00 a.m. -There were 2 medications scheduled twice a day at 8:00 a.m. and 7:00 p.m. or 8:00 p.m. -There were 3 medications scheduled for 3 times a day. -There was an entry for Hyoscyamine Sulfate 0.125mg 3 times daily for secretions and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Hyoscyamine is used to treat stomach disorders but may also be used to dry up secretions.) -There was an entry for Robafen 100mg/5ml liquid 20mls 3 times daily and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Robafen is an expectorant used to treat congestion.) -There was an entry for Mintox suspension 10ml 3 times daily with meals and it was scheduled for 7:00 a.m., 12:00 p.m., 5:00 p.m. (Mintox is for heartburn and indigestion.) Review of med pass detail forms dated 02/07/18 for Resident #16 revealed: -The 8:00 a.m. doses of Hyoscyamine and Robafen were documented as administered at 10:57 a.m. -The 2:00 p.m. doses of Hyoscyamine and Robafen were documented as administered at 1:39 p.m. -The 8:00 a.m. and 2:00 p.m. doses for Hyoscyamine and Robafen were administered only 2 hours and 42 minutes apart. -The 7:00 a.m. dose of Mintox was documented	D 364			

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D 364	Continued From page 119 as administered at 10:57 a.m. and the 12:00 p.m. dose was documented at 12:47 p.m., only 1 hour and 50 minutes apart. g. Review of Resident #13's current FL-2 dated 07/25/17 revealed diagnoses included vascular dementia with behavioral disturbances, diabetes mellitus type 2, chronic obstructive pulmonary disease, hypertension, anxiety, gastroesophageal reflux disease, hyperlipidemia, and vitamin D deficiency. Review of Resident #13's February 2018 medication administration record (MAR) revealed: -There were at least 13 medications scheduled to be administered at 8:00 a.m. -There were 2 medications scheduled twice a day at 8:00 a.m. and 8:00 p.m. -There was 1 medication scheduled twice a day at 8:00 a.m. and 5:00 p.m. -There was 1 medication scheduled for 3 times a day. -There was an entry for Lamotrigine 100mg 3 times a day and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Lamotrigine is used for mood stabilization.) Review of med pass detail forms dated 02/07/18 for Resident #13 revealed: -The 8:00 a.m. dose of Lamotrigine was documented as administered at 11:41 a.m. -The 2:00 p.m. dose of Lamotrigine was documented as administered at 2:10 p.m. -The 8:00 a.m. and 2:00 p.m. doses for both medications were administered only 2 hours and 29 minutes apart. h. Review of Resident #17's current FL-2 dated 02/26/17 revealed diagnoses included schizophrenia, type 2 diabetes mellitus, essential	D 364			

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D 364	Continued From page 120 hypertension, dyslipidemia, and right fourth finger cellulitis. Review of Resident #17's February 2018 medication administration record (MAR) revealed: -There were at least 14 medications scheduled to be administered at 8:00 a.m. -There were 6 medications scheduled twice a day at 8:00 a.m. and 8:00 p.m. -There was 1 medication scheduled at 7:30 a.m. and 5:30 p.m. -There was 1 medication scheduled for 3 times a day. -There was an entry for Divalproex Sodium 500mg 3 times daily and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Divalproex Sodium is used to treat mood disorders.) Review of med pass detail forms dated 02/07/18 for Resident #17 revealed: -The 8:00 a.m. dose of Divalproex Sodium was documented as administered at 11:03 a.m. -The 2:00 p.m. dose of Divalproex Sodium was documented as administered at 1:42 p.m. -The 8:00 a.m. and 2:00 p.m. doses Divalproex Sodium were administered only 2 hours and 39 minutes apart. Refer to interview with the Administrator on 02/07/18 at 11:30 a.m. Refer to interview with the Clinical Support Specialist on 02/08/18 at 10:00 a.m. 2. Review of the facility's resident census reports dated 02/01/18 - 02/07/18 revealed there were 30 residents in the special care unit (SCU). Observation in the SCU on 02/08/18 at 9:14 a.m. revealed:	D 364		

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D 364	Continued From page 121 -The Special Care Coordinator (SCC) was at the far end of the 400 hall administering medications to residents. -There was no one else administering medications in the SCU. Interview with the SCC on 02/08/18 at 9:16 a.m. revealed: -She started the morning medication pass in the SCU at 7:05 a.m. -All of the morning medications for all of the residents in the SCU were scheduled for 8:00 a.m. -She was the only staff administering medications to the residents in the SCU. -The SCU was at capacity with 30 residents. -She still had 7 residents left to administer their 8:00 a.m. medications. -She was aware she was running behind the allowed time frame to administer the medications. -She usually finished the medications between 8:45 a.m. and 8:50 a.m. but she usually started earlier. -She was running behind with the medication pass this morning because she provided incontinence care to one resident earlier in the morning because both personal care aides (PCAs) were in the dining room passing out breakfast trays. -The third PCA did not come into work until 7:00 a.m. -There was no medication aide (MA) assigned in the SCU this morning except for her. -It was not unusual for her to administer medications in the SCU even though she was the SCC. -The facility was "short staffed". Observation of the SCC on 02/08/18 revealed she finished administering the medications	D 364			

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D 364	Continued From page 122 scheduled for 8:00 a.m. at 9:55 a.m., 55 minutes beyond the allowed time frame. Review of the February 2018 medication administration records (MARs) in the SCU revealed: -All 7 residents had morning medications scheduled for 8:00 a.m. -All 7 residents had medications ordered more than once a day, one with multiple administration times. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.] -One of the 7 residents had medications that were scheduled 3 times a day in which doses were administered too close together due to the 8:00 a.m. medication pass being late on 02/08/18. a. Review of Resident #18's current FL-2 dated 12/26/17 revealed diagnoses included dementia of Alzheimer's disease with behavioral disturbance, major depressive disorder, arthritis, hypertension, gastroesophageal reflux disease, hypothyroidism, and cataract. Review of Resident #18's February 2018 medication administration record (MAR) revealed: -There were at least 11 medications scheduled to be administered at 8:00 a.m. -There were 2 medications scheduled twice a day at 8:00 a.m. and 8:00 p.m. -There were 2 medications scheduled for 3 times a day. -There was an entry for Levetiracetam 250mg 3 times daily and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Levetiracetam is used for mood disorders.) -There was an entry for Seroquel 25mg 1 tablet 3	D 364			

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D 364	Continued From page 123 times daily and the bedtime dose taken with 50mg tablet and 100mg tablet for dose of 175mg and it was scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. (Seroquel is an antipsychotic.) Refer to interview with the Administrator on 02/07/18 at 11:30 a.m. Refer to interview with the Clinical Support Specialist on 02/08/18 at 10:00 a.m. Interview with the Administrator on 02/07/18 at 11:30 a.m. revealed: -They usually had 1 MA in the AL side and 1 MA in the SCU on first and second shifts. -They tried to have 1 MA in the AL side and 1 MA in the SCU on third shift but sometimes there was on 1 MA for both sides on third shift. Interview with the Clinical Support Specialist on 02/08/18 at 10:00 a.m. revealed they would look at staggering the administration times for the morning medications to make sure the medications were administered on time. There was one medication aide (MA) administering morning medications in the assisted living (AL) side of the facility with a census of 44 residents on 02/07/18. The MA administered 8:00 a.m. medications late to 24 residents in the AL side from 10:15 a.m. until 12:19 p.m. on 02/07/18. At least 8 of those residents had medications with multiple administration times that were administered too close together including but not limited to narcotic pain medication, blood pressure medication, seizure medications, a diuretic for swelling, medications for mood disorders, and an inhaler for breathing problems. The Special Care	D 364		

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D 364	Continued From page 124 Coordinator (SCC) was the only MA administering morning medications in the special care unit (SCU) with a census of 30 residents on 02/08/18. The MA administered 8:00 a.m. medications late to 7 residents in the SCU from 9:15 a.m. until 9:55 a.m. on 02/08/18. One of those 7 residents had two medications with multiple administration times including an antipsychotic and a medication for mood disorders. The facility's failure to administer medications within one hour before or after the scheduled time was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. <u>Review of the facility's plan of protection dated 02/07/18 revealed:</u> -Beginning immediately, two medication aides (MAs) will be assigned to administer medications on the assisted living (AL) unit and 1 MA on the special care unit (SCU) to ensure 8:00 a.m. medications were administered within one hour of ordered administration times. -Executive Director (ED) or designee will immediately begin process of changing medication administration times to a staggered system. -ED or designee will monitor medication pass start and end times daily to ensure ongoing compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2018.	D 364		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and	D 406		

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D 406	Continued From page 125 documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow-up on medication review recommendations for 2 of 8 residents (#1, #4) sampled for review related to medications for cough and diarrhea (#1) and medications for mild pain or fever and diarrhea (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 06/21/17 revealed diagnoses included bradycardia, bilateral shoulder pain, and diarrhea - resolved. -There was an order for Questran (4gm) 1 packet once daily as needed. (Questran may be used to treat diarrhea.) -There was an order for Robitussin 10ml 6 hours as needed and a second order for 10ml 3 times a day as needed for cough. (Robitussin is used for cough and congestion.) Review of subsequent physician's orders for Resident #1 revealed: -There was an order dated 08/28/17 for Questran 1 packet once daily. -There was an order dated 01/25/18 for Tessalon Perles 200mg 3 times a day as needed for cough. (Tessalon Perles are used to treat cough.) -There was an order dated 09/27/17 for Robitussin with Codeine syrup, 5ml twice daily as needed for cough. (Robitussin with Codeine is a narcotic used to treat cough.) Review of Resident #9's medication review dated	D 406			

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D 406	Continued From page 126 11/09/17 revealed: -The pharmacist noted the Questran as changed to a scheduled order but the prn (as needed) order was still on the MAR. -The pharmacist recommended verifying the continuation of the prn order or if it should be discontinued. -The pharmacist noted the resident had duplicate therapy with Robitussin, Tessalon Perles, and Robitussin with Codeine. -The pharmacist recommended they have the physician re-evaluate the need for multiple agents and to consider discontinuing some of the orders. -The section for the physician's response and signature were blank. Review of the December 2017 through February 2018 medication administration records (MARs) revealed: -Questran was documented as administered once daily at 8:00 a.m. each month. -Questran 4gm 1 packet every day as needed was still printed on all 3 MARs but none was documented as administered. -Robitussin 10ml every 4 hours was printed on all 3 MARs but none was documented as administered. -Robitussin with Codeine 5ml twice daily as needed for cough was printed on all 3 MARs but none was documented as administered. -Tessalon Perles 200mg 3 times daily as needed was printed on all 3 MARs but none was documented as administered. Review of Resident #1's physician's orders revealed: -There was no documentation the pharmacist's recommendations had been forwarded to the physician. -There was no documentation of clarification for	D 406		

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D 406	Continued From page 127 any of the orders recommended by the pharmacist. Interview with a medication aide on 02/09/18 at 6:35 p.m. revealed Resident #1 had not complained of coughing or diarrhea to her. Interview with Resident #1 on 02/09/18 at 7:08 p.m. revealed: -He coughed "pretty often" and he sometimes got cough medicine. -He was not sure what kind of cough medicine he received or when he last got it. -He denied any current problems with diarrhea. Refer to interview with the Clinical Support Specialist on 02/09/18 at 10:30 a.m. 2. Review of Resident #4's current FL-2 dated 11/07/17 revealed: -Diagnoses included Alzheimer's disease without behavioral disturbances, diabetes Type II, depression, dysfunction of gait. -The resident was constantly disoriented, ambulatory using a wheelchair, and incontinent of bowel and bladder. -There was a medication order for Acetaminophen 650 mg., suppository, unwrap and insert 1 suppository rectally every 4 hours as needed for fever. -There was a medication order for Loperamide HCL 2 mg. capsule, take 1 capsule by mouth as needed for diarrhea, do not exceed 8 doses in 24 hours. Review of the facility pharmacy's Consultation Report for November 9 - November 13, 2017 revealed: -The pharmacist's Comment: Resident #4 receives potentially duplicate therapy with 2	D 406		

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D 406	Continued From page 128 Acetaminophen suppository orders on MAR and 2 Loperamide orders on the MAR. -The pharmacist's Recommendation: please d/c (discontinue) duplicate order. -There was no signature on the line below the recommendation for the facility's RCC (Resident Care Coordinator) and CC (Memory Care Manager). Review of Resident #4's MARs for December 2017 through February 2018 revealed: -There was a duplicate order for Acetaminophen 650 mg., suppository, unwrap and insert 1 suppository rectally every 4 hours as needed (prn) for fever on the December, 2017 MAR -There were no MA initials indicating administration of either order for the prn Acetaminophen 650 mg. in December, 2017. -There was a duplicate order for Acetaminophen 650 mg., suppository, unwrap and insert 1 suppository rectally every 4 hours as needed for fever on the January, 2018 MAR and Loperamide HCL 2 mg. capsule, take 1 capsule by mouth as needed for diarrhea, do not exceed 8 doses in 24 hours on the January 2018 MAR. -There were no MA initials indicating administration of either order for the prn Acetaminophen 650 mg. in January, 2018. -There was a duplicate order for Acetaminophen 650 mg., suppository, unwrap and insert 1 suppository rectally every 4 hours as needed for fever and Loperamide HCL 2 mg. capsule, take 1 capsule by mouth as needed for diarrhea, do not exceed 8 doses in 24 hours on the February, 2018 MAR. -There were no MA initials indicating administration of either order for the prn Acetaminophen 650 mg. in January, 2018. -There was a duplicate order for Loperamide HCL 2 mg. capsule, take 1 capsule by mouth as	D 406		

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D 406	Continued From page 129 needed for diarrhea, do not exceed 8 doses in 24 hours on the December, 2017 MAR. -There were no MA initials indicating administration of either order for the prn Loperamide HCL 2 mg. in December, 2017. -There was a duplicate order for Loperamide HCL 2 mg. capsule, take 1 capsule by mouth as needed for diarrhea, do not exceed 8 doses in 24 hours on the January, 2018 MAR. -There were no MA initials indicating administration of either order for the prn Loperamide HCL 2 mg. in January, 2018. -There was a duplicate order for Loperamide HCL 2 mg. capsule, take 1 capsule by mouth as needed for diarrhea, do not exceed 8 doses in 24 hours on the February, 2018 MAR. -There were no MA initials indicating administration of either order for the prn Loperamide HCL 2 mg. in February, 2018. Interview on 2/09/18 at 9:50 a.m. with the SCU 1st shift MA revealed: -There were duplicate orders currently on Resident #4's MAR for Acetaminophen 650 mg., suppository, unwrap and insert 1 suppository rectally every 4 hours as needed for fever and Loperamide HCL 2 mg. capsule, take 1 capsule by mouth as needed for diarrhea, do not exceed 8 doses in 24 hours. - There were no initials indicating administration of the prn medications. -She did not know why there were duplicate orders for the medications. -Pharmacy recommendations for the visiting physician were to be placed in the physician's box to be picked up and reviewed. -The Special Care Coordinator (SCC) received the recommendations and was responsible for placing them in the physician's box for review.	D 406			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/13/2018
NAME OF PROVIDER OR SUPPLIER CHATHAM COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST CHATHAM STREET CARY, NC 27512		
(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 406	Continued From page 130 Interview on 2/09/18 at 10:00 a.m. with the SCC revealed: -She was unaware Resident #4 had duplicate medication orders. -The Pharmacy Consult documents would be received by the SCC, reviewed, and placed in the physician's box for review. -She did not know if the November 2017 pharmacist's recommendations for Resident #4 had been placed in the physician's box; she was not the (SCC) at the time, she started in the position in January, 2018. Interview on 2/09/18 at 10:08 a.m. with Resident #4's primary care physician (PCP) revealed: -She was not aware there were duplicate orders on the MARs for the Acetaminophen 650 mg., suppository, and Loperamide HCL 2 mg. capsule. -The resident could have had an overdose of the medications if the duplicate orders had been administered; there were no concerns for Resident #4 since the prns were not administered. -She had not received the pharmacy Consultation Report report recommending the discontinue of the duplicate orders. -The MA or the SCC were to put the recommendations in her box so she could pick them up when coming to see residents. -If there were still duplicates of orders on the MAR for Resident #4, she had not received the recommendation to check on the orders. Attempted interview on 02/09/18 at 10:28 a.m. with the Administrator was unsuccessful. Refer to interview with the Clinical Support Specialist on 02/09/18 at 10:30 a.m.	D 406		

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D 406	Continued From page 131 Interview with the Clinical Support Specialist on 02/09/18 at 10:30 a.m. revealed: -When the Pharmacy Consultation Report was finished, the report was sent to the Administrator, the Resident Care Coordinator (RCC), and the SCC for review. -The facility PCP came twice a week to see residents. and to pick up communications. -There was a box in the SCU for staff to place reports for the PCP to review. -The PCP could agree or disagree with the pharmacist's recommendations, make new orders. -The managers were responsible for sending the changes to the Pharmacy. -She did not know why the pharmacist's recommendations for Resident #4 were not processed, the facility has 14 days to complete recommendations. -Staff who would have been responsible for processing the recommendations from 11/2017 were no longer employed at the facility.	D 406		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by:	D 465		

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D 465	Continued From page 132 TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of 30 residents residing in the Special Care Unit (SCU) for 21 of 21 shifts sampled from 02/01/18 through 02/07/18. The findings are: Interview with a medication aide (MA) on 02/06/18 at 11:25 a.m. revealed: -First shift staff hours were from 6:00 a.m. to 2:00 p.m. -Second shift staff hours were from 2:00 p.m. to 10:00 p.m. -Third shift staff hours were from 10:00 p.m. to 6:00 a.m. Review of the Daily Census Report dated 02/01/18 - 02/07/18 revealed: -The census for the special care unit (SCU) on each day was 30 residents. -30 hours of staff time was required for first and second shift. -24 hours of staff time was required for third shift. Review of the daily staff schedules for the SCU dated 02/01/18 - 02/07/18 revealed: -The computer printed form had a section for all 3 shifts for assignments for staff in the SCU. -For first shift, there were 3 spaces to handwrite a supervisor on duty and two personal care aides (PCAs). -For second shift, there were 3 spaces to handwrite one MA and 2 PCAs. -For third shift, there were 2 spaces to handwrite 2 PCAs. -On 4 of 7 days, there was only 1 staff name	D 465			

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D 465	Continued From page 133 written under the third shift column for the SCU. Review of the staff schedule and the "Punch Detail" timecard reports dated 02/01/18 revealed: -There were 23.28 staff hours provided on first shift but 30 hours were required. -There were 26.00 staff hours provided on second shift but 30 hours were required. -There were 8.53 staff hours provided on third shift but 24 hours were required. Review of the staff schedule and the "Punch Detail" timecard reports dated 02/02/18 revealed: -There were 23.33 staff hours provided on first shift but 30 hours were required. -There were 19.28 staff hours provided on second shift but 30 hours were required. -There were 9.63 staff hours provided on third shift but 24 hours were required. Review of the staff schedule and the "Punch Detail" timecard reports dated 02/03/18 revealed: -There were 23.27 staff hours provided on first shift but 30 hours were required. -There were 25.32 staff hours provided on second shift but 30 hours were required. -There were 16.95 staff hours provided on third shift but 24 hours were required. Review of the staff schedule and the "Punch Detail" timecard reports dated 02/04/18 revealed: -There were 23.93 staff hours provided on first shift but 30 hours were required. -There were 23.63 staff hours provided on second shift but 30 hours were required. -There were 8.70 staff hours provided on third shift but 24 hours were required. Review of the staff schedule and the "Punch Detail" timecard reports dated 02/05/18 revealed:	D 465		

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D 465	Continued From page 134 -There were 19.22 staff hours provided on first shift but 30 hours were required. -There were 15.27 staff hours provided on second shift but 30 hours were required. -There were 20.02 staff hours provided on third shift but 24 hours were required. Review of the staff schedule and the "Punch Detail" timecard reports dated 02/06/18 revealed: -There were 22.80 staff hours provided on first shift but 30 hours were required. -There were 16.43 staff hours provided on second shift but 30 hours were required. -There were 11.43 staff hours provided on third shift but 24 hours were required. Review of the staff schedule and the "Punch Detail" timecard reports dated 02/07/18 revealed: -There were 24.42 staff hours provided on first shift but 30 hours were required. -There were 17.77 staff hours provided on second shift but 30 hours were required. -There were 16.52 staff hours provided on third shift but 24 hours were required. Interview on 02/07/18 at 8:15 a.m. with the Special Care Coordinator (SCC) revealed: -She had worked at the facility as the SCC for 2 to 3 months. -The facility had been short staffed in the SCU since last month when the capacity became full with 30 residents. -She was responsible for managing the facility staffing schedule including staffing for the SCU. -She made out the schedule according to the resident census. -If there was a call-out or she did not have a staff position matched with a name, she would check with other staff to see if they could work in that slot.	D 465		

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D 465	Continued From page 135 -If she could not find another staff to work in the vacant slot, she would work in place of other staff in order to cover resident care. -She would often work additional shifts, besides her own, and on weekends to help with staffing coverage. -The SCC had been given access to the facility's hiring website about 3 weeks ago in order to assist with interviewing and hiring new employees. -She was in the process of interviewing 3 new staff for the facility. -Staff worked together to provide personal care to staff. Interview with the Administrator on 02/07/18 at 11:30 a.m. revealed: -They usually tried to have 1 MA and 3 PCAs on first and second shifts in the SCU. -They usually tried to have 1 MA and 2 PCAs on third shift in the SCU but sometimes there was only 1 MA on third shift to share between the SCU and the AL side. A second interview with the Administrator on 02/09/18 at 4:22 p.m. revealed: -There was not enough staff for the facility including the SCU. -They needed to recruit experienced staff and provide training to the current staff. A telephone interview with the SCC on 02/12/18 at 9:03 a.m. revealed: -There had been some staff interviews and 1 new staff started as a PCA in the SCU the week before last. -The SCC's schedule was 8:00 a.m. to 5:00 p.m. during the week. -If she needed to replace a staff, she would work as floor staff instead of the SCC and would come	D 465		

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D 465	Continued From page 136 in early on 1st shift at 6:00 a.m. -She helped out as floor staff (MA, PCA) on week days and on weekends. -She worked 1 or 2 days during 2 to 3 weekends each month. The facility failed to assure the minimum number of staff were present at all times on all 3 shifts to meet the needs of residents residing in the Special Care Unit (SCU) for 21 of 21 shifts from 02/01/18 - 02/07/18. First shift was staffed with less than 24 of the 30 required hours on 6 of the 7 days. Second shift was staffed with less than 20 hours of the required 30 hours on 4 of the 7 days. Third shift was staffed with less than half of the required 24 hours on 3 of the 7 nights. The facility's failure to provide sufficient staffing to meet the needs of the residents in the SCU was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 02/09/18 revealed: -Executive Director (ED) or designee will review schedule daily to ensure sufficient staff are scheduled for all shifts beginning 02/09/18. -Qualified management staff will provide all needed coverage while replacement staff are obtained for call outs, etc. -Staff sister communities will be utilized to assist while new staff are hired and trained. -ED / designee will continue to review schedule on a daily basis to ensure adequate coverage. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2018.	D 465		

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D912	Continued From page 137	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to other requirements, personal care and other staffing, health care, medication administration, special care unit staffing, adult care home medication aides training and competency, and implementation. The findings are: 1. Based on observations, interview and record reviews, the facility failed to maintain hot water temperatures between 100 - 116 degrees Fahrenheit (F) for 4 of 4 fixtures in the Special Care Unit's (SCU) Women's Shower Room and Men's Shower Room. [Refer to Tag D113, 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure aide hours met the minimum requirements on 19 of 21 shifts resulting in inadequate staff to meet the needs of residents. [Refer to Tag D201, 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type	D912		

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D912	Continued From page 138 B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to coordinate the healthcare needs for 2 of 5 residents sampled (#1, #2) including a resident with chronic lymphedema that resulted in an untreated leg edema placing the resident at risk for infection (#2); and a resident whose physician was not notified of blood sugars greater than 400, a missed cardiology appointment and an echocardiogram with doppler, and labwork for a complete blood count and lipid panel was not done (#1). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 6 of 7 residents (#1, #6, #8, #9, #10, #11) observed during the medication passes including errors with insulin (#1, #8, #10, #11), a mood stabilizer, a blood pressure medication, an allergy nasal spray (#6), and an iron supplement (#9); and for 1 of 5 residents sampled (#3) who had not received a medication for seizures since it was ordered in December 2017, over 7 weeks ago. [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for at least 24 residents in the assisted living side of the facility on 02/07/18 and 7 residents in the special care unit on 02/08/18 resulting in several medications ordered multiple times a day for 9 of the 31 residents (#3, #11, #12, #13, #14, #15, #16, #17, #18) being administered too close to the next	D912		

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D912	Continued From page 139 scheduled administration time. [Refer to Tag D364, 10A NCAC 13F .1004(g) Medication Administration (Type B Violation)]. 6. Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of 30 residents residing in the Special Care Unit (SCU) for 21 of 21 shifts sampled from 02/01/18 through 02/07/18. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)]. 7. Based on interviews and record reviews, the facility failed to assure that all Medication Aides had completed the Medication Aide qualifications to administer medications including 2 of 5 sampled staff (Staff B and Staff F) that had not completed the 15 hours of Medication Aide training and 1 of 5 sampled staff (Staff B) who had not completed the state required medication exam. [Refer to Tag D935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides, Training and Competency Requirements (Type B Violation)]. 8. Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility met and maintained rules related to water temperatures, housekeeping and furnishings, physical environment, staff qualifications and training, resident assessments and care plans, health care, medication administration, pharmaceutical care, and staffing requirements. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A2 Violation)].	D912		
D935	G.S. § 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935		

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D935	Continued From page 140 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered	D935			

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D935	Continued From page 141 by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure that all Medication Aides had completed the Medication Aide qualifications to administer medications including 2 of 5 sampled staff (Staff B and Staff F) that had not completed the 15 hours of Medication Aide training and 1 of 5 sampled staff (Staff B) who had not completed the state required medication exam. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired at the facility on 03/03/15 as a Personal Care Aide. -Staff B received the initial 5 hours of Medication Aide training on 10/11/17. -Staff B was competency validated with a medication clinical skills checklist on 10/11/17. -There was no documentation that Staff B had completed the additional 10 hours of Medication Aide training. -There was no documentation that Staff B had taken and passed the state Medication Aide exam. Review of 2 residents December 12-31, 2017 Medication Administration records revealed Staff B administered medications to residents on the Special Care Unit on December 13-15, 18-20, 22-26, and 28-29.	D935		

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D935	Continued From page 142 Review of 2 residents January 2018 Medication Administration records revealed Staff B administered medication on 2-3, 5-7, 9-11, 15, 17, 20-22, 25-27, and 29-30. Review of 2 residents February 1-9, 2018 Medication Administration records revealed Staff B administered medication on 2-4, and 6-7. Observation of Staff B administering medications in the Special Care Unit on 02/07/18 revealed: -Staff B made 4 medication errors during the morning medication pass observed on 02/07/18. -Staff B administered the wrong amounts of medications for mood disorder, high blood pressure, and a nasal spray for one resident. -Staff B crushed and administered an iron supplement that should not be crushed to a second resident. Interview with Staff B on 02/08/18 at 10:20 AM revealed: -She had been working at the facility for about 3 years. -She started at a Personal Care Aide but had been working for the last few months as a Medication Aide. -She started as a Medication Aide sometime in October of 2017 but was not sure of the exact date. -She had not taken the state test but was scheduled to take it on 02/15/18. -She had previously scheduled the test but never received a test date and when she called they told her that something had not been filled out correctly on her application. -She was aware that she was not to pass medications anymore after a certain period and had told the Special Care Coordinator. -The management continued to put her on the	D935			

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D935	Continued From page 143 schedule to work the medication cart. -She had only taken a Medication Aide course when she was first checked off to pass medications and had not received any additional training. Interview with the Business Office Manager on 02/08/18 at 10:00 a.m. revealed: -She was responsible for going through and making sure that staff had completed all requirements. -She could not find the Medication Aide training for Staff B. -Staff B had no documentation of completing the state medication exam. -She thought the training had been completed but she could find the check-offs. -Staff B would complete the training as soon as possible. Refer to interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. 2. Review of Staff F's personnel file revealed: -Staff F was hired at the facility on 05/18/16 as a Personal Care Aide. -Staff F was competency validated with a Medication Clinical Skills Checklist on 09/08/17. -Staff F had taken and passed the state medication exam on 09/15/17. -There was no documentation that Staff F had completed any of 15 required hours of Medication Aide training. Telephone interview with Staff F on 02/08/18 at 10:35 a.m. revealed: -She had received some Medication Aide training when she was first put on the medication cart. -She took a 24 hour course on Medication Aide training.	D935		

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D935	Continued From page 144 -She was not sure when exactly she had taken the class. -The management should have a copy of the training in her personnel file. Interview with the Business Office Manager on 02/08/18 at 10:00 a.m. revealed: -She was responsible for going through and making sure that staff had completed all requirements. -She could not find the Medication Aide training for Staff F. -She thought the training had been completed but she could not find the check-offs. -Staff F would complete the training as soon as possible. Interview with the Clinical Support Specialist on 02/09/18 at 8:45 a.m. revealed: -The Executive Director and the BOM are responsible for making sure all staff training and requirements are completed. -The BOM is to audit at least 10% of staff charts each quarter. -She was aware that Medication Aides were not allowed to administer medication after 60 days until all requirements had been met. -Staff B will be pulled off of the medication carts until all requirements have been met. -Staff B was scheduled to take her exam on 02/15/18. -Staff F will be pulled off of the medication carts until all requirements have been met. -She would make sure training was scheduled for both staff members as soon as possible. The facility failed to assure that Staff B and Staff F had completed all requirements to administer medications including 15 hours of Medication Aide training and passing the state medication	D935		

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D935	Continued From page 145 exam. Staff B was observed during the morning medication pass in the special care unit on 02/07/18 and Staff B made 4 medication errors by administering the wrong amount of 3 different medications and crushing and administering a fourth medication that should not have been crushed. The failure of the facility to have medication aides complete required training was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. <u>Review of the facility's Plan of Protection dated 02/08/18 revealed:</u> -(The) ED (Administrator)/BOM designee will begin an immediate (2/09/18) audit of all MA personal files to ensure all staff administering meds have met all qualifications to administer meds. -Beginning immediately, all medications will be administered by qualified MAs only. --(The) ED (Administrator)/BOM will maintain (a) perpetual staff log to ensure all staff qualifications are met prior to performing assigned duties (beginning 02/09/18). CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2018.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.	D980		

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D980	Continued From page 146 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility met and maintained rules related to water temperatures, housekeeping and furnishings, physical environment, staff qualifications and training, resident assessments and care plans, health care, medication administration, pharmaceutical care, and staffing requirements. The findings are: Interview on 02/09/18 at 4:22 p.m. with the Administrator revealed: -She started working at the facility on 12/15/18 part-time, and on 1/22/18 full-time. -Her schedule was from 8 a.m. or 9 a.m. until 5 p.m. or 6 p.m. Monday through Friday and sometimes on weekends. -Her company sent her to this facility because systems were not working for medication administration, training, staff qualifications, the number of staff, and housekeeping; she was brought in to address problems not handled by the previous Administrator. -New staff needed to be hired, and current staff needed more training. -The facility had an on-line hiring service and needed to "use it to get people in here to train, needed to assign the Resident Care Coordinator and the Memory Care Manager to use the hiring service". -The Business Office Manager needed to keep up with the personnel files and staff training. -The Resident Care Coordinator was new and needed training.	D980		

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D980	Continued From page 147 - "I am in the beginning of my improvement process; it will take a while to get things into compliance; we have a lot to do, we need to build our team." 1. Based on observations and interviews, the facility failed to assure a cabinet, one janitorial closet, and the laundry room containing hazardous materials were locked and not accessible to residents. [Refer to Tag D056, 10A NCAC 13F .0305(f)(4) Physical Environment]. 2. Based on observations and interviews, the facility failed to assure the walls, ceilings, and floors were kept clean and in good repair in the assisted living and special care unit for 3 common bathroom/shower rooms, 12 private or adjoining resident bathrooms, 18 resident rooms, 2 hallways, and a resident lounge room. [Refer to Tag D074, 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings] 3. Based on observations and interviews, the facility failed to assure that 3 private or adjoining resident bathrooms (209, 205/207, 206/208) on the 200 hall of the facility had no chronic unpleasant odors as related to strong odors of urine. [Refer to Tag D075, 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings]. 4. Based on observations and interviews, the facility failed to have furniture in good repair in 12 residents' bedrooms and the resident lounge room and men's shower room on the 100 Hall including chest of drawers, night stands/bedside tables, dressers, chairs, sofas, and a shower chair. [Refer to Tag D076, 10A NCAC 13F .0306(a)(3) Housekeeping and Furnishings]. 5. Based on observations and interviews, the	D980			

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D980	Continued From page 148 facility failed to assure the facility was uncluttered, clean and orderly in 2 common resident bathrooms/shower rooms, 5 resident rooms, and 5 private or adjoining resident bathrooms on the 100 and 200 halls of the facility. [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings]. 6. Based on observations, interview and record reviews, the facility failed to maintain hot water temperatures between 100 - 116 degrees Fahrenheit (F) for 4 of 4 fixtures in the Special Care Unit's (SCU) Women's Shower Room and Men's Shower Room. [Refer To Tag D113, 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)]. 7. Based on interviews and record reviews, the facility failed to assure all staff had completed a two-step TB skin test in accordance with state guidelines including 2 of 6 sampled staff (Staff D and Staff F), not having a second step TB skin test completed. [Refer to Tag D131, 10A NCAC 13F .0406(a) Test for Tuberculosis]. 8. Based on interviews and record reviews the facility failed to assure that 2 of 5 sampled staff (B, F) had completed diabetes training prior to administering insulin. [Refer to Tag D164, 10A NCAC 13F .0505 Training on the Care of Diabetic Residents]. 9. Based on observations, interviews and record reviews, the facility failed to assure aide hours met the minimum requirements on 19 of 21 shifts resulting in inadequate staff to meet the needs of residents. [Refer to Tag D201, 10A NCAC 13F .0604(e), Personal Care and Other Staffing]. 10. Based on interviews and record reviews, the	D980		

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D980	Continued From page 149 facility failed to assure 2 of 5 sampled residents (#2, #3) had a care plan completed within 30 days of admission (#3) and annually (#2) thereafter. [Refer to Tag D254, 10A NCAC 13F .0801(b) Resident Assessment]. 11. Based on observations, interviews, and record reviews, the facility failed to coordinate the healthcare needs for 2 of 5 residents sampled (#1, #2) including a resident with chronic lymphedema that resulted in an untreated leg edema placing the resident at risk for infection (#2); and a resident whose physician was not notified of blood sugars greater than 400, a missed cardiology appointment and an echocardiogram with doppler, and labwork for a complete blood count and lipid panel was not done (#1). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 12. Based on observations, interviews and record reviews, the facility failed to assure an order for twice blood pressure and pulse twice monthly was implemented for 1 of 6 sampled residents (#2) with a diagnosis of hypertension. [Refer to Tag D276, 10A NCAC 13F .0902(c)(3-4) Health Care] 13. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 6 of 7 residents (#1, #6, #8, #9, #10, #11) observed during the medication passes including errors with insulin (#1, #8, #10, #11), a mood stabilizer, a blood pressure medication, an allergy nasal spray (#6), and an iron supplement (#9); and for 1 of 5 residents sampled (#3) who had not received a medication for seizures since it was ordered in December 2017, over 7 weeks ago. [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication	D980		

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D980	Continued From page 150 Administration (Type A2 Violation)]. 14. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times for at least 24 residents in the assisted living side of the facility on 02/07/18 and 7 residents in the special care unit on 02/08/18 resulting in several medications ordered multiple times a day for 9 of the 31 residents (#3, #11, #12, #13, #14, #15, #16, #17, #18) being administered too close to the next scheduled administration time. [Refer to Tag D364, 10A NCAC 13F .1004(g) Medication Administration (Type B Violation)]. 15. Based on record reviews and interviews, the facility failed to follow-up on medication review recommendations for 2 of 8 residents (#1, #4) sampled for review related to medications for cough and diarrhea (#1) and medications for mild pain or fever and diarrhea (#4). [Refer to Tag D406, 10A NCAC 13F .1009(b) Pharmaceutical Care]. 16. Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of 30 residents residing in the Special Care Unit (SCU) for 21 of 21 shifts sampled from 02/01/18 through 02/07/18. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staff (Type B Violation)]. 17. Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to other requirements,	D980		

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D980	Continued From page 151 personal care and other staffing, health care, medication administration, special care unit staffing, adult care home medication aides training and competency, and implementation. [Refer to Tag D912, G.S. 131D-21(2) Declaration of Resident Rights (Type B Violation)]. 18. Based on interviews and record reviews, the facility failed to assure that all Medication Aides had completed the Medication Aide qualifications to administer medications including 2 of 5 sampled staff (Staff B and Staff F) that had not completed the 15 hours of Medication Aide training and 1 of 5 sampled staff (Staff B) who had not completed the state required medication exam. [Refer to Tag D935, G. S. 131D-4.5B(b) Ach Medication Aides, Training and Competency (Type B Violation)]. The Administrator failed to assure the management, operations, and policies of the facility were implemented by not ensuring appropriate care and services were provided to all residents. The Administrator failed to main substantial compliance with rules and statutes related to water temperatures, housekeeping and furnishings, storage of cleaning chemicals, staff testing for Tuberculosis, staff training in medication administration and diabetes care, pharmaceutical care, resident assessment and care plans, health care, and staffing requirements in the assisted living area and in the special care unit. The failure to implement rules and regulations resulted in serious neglect to all residents, which constitutes a Type A2 Violation. The Plan of Protection submitted by the Administrator on 02/09/18 reveled: -An experienced, licensed Administrator has been hired to oversee day-to-day operations of (the)	D980		

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D980	Continued From page 152 facility. -A Manager-on-duty program will be implemented beginning 02/10/18 to ensure a manager/department head on site daily. -Administrator will be available at all times by phone for all questions/concerns. -New Resident Care Manager was hired, as well, to assist with day to day operations. -Above interventions will remain in place indefinitely to ensure proper management on-site and available to ensure resident care and staff support. CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED MARCH 15, 2018.	D980		