STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028001	A. BUILDING: _____ B. WING _____	02/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 and the Dare County DSS conducted an annual survey on February 05, 2018 through February 09, 2018.	D 000		
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 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 1 of 5 staff (E) sampled was tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Staff E's personnel file revealed: -Staff E was hired as a personnel care aide (PCA) on 11/3/10. -Staff E was rehired as a PCA on 12/1/15. -There was no terminiation date noted after Staff E was hired on 11/3/10. -There was a tuberculosis (TB) skin test placed on 10/16/10 and read as negative on 10/18/10. -There was a TB skin test placed on 11/1/10 and	D 131		

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D 131	Continued From page 1 read as negative on 11/3/10. -There was no documentation of any other TB skin test for Staff B. Interview with the Assistant Resident Care Coordinator (ARCC) on 2/8/18 at 10:10am revealed: -She was not aware that Staff E did not have a current TB test in her file. -Staff E was hired in November 2010 and left (could not recall date) and was rehired in December 2015. -All new hires are to complete a 2-step TB test before hire. -The Business Office Manager was responsible for the personnel files and making sure the staff met the qualifications. -She checked Staff E's personnel file and could not find any documentation that a TB test was completed upon rehire on 12/1/15. Interview with the Business Office Manager on 2/9/18 at 11:30am revealed: -She was not aware that Staff E did not have a current TB test in her file. -Since Staff E had a TB test on file for 2010, it may have been overlooked when she was rehired in December 2015. -She was responsible for the personnel files and making sure the staff met the qualifications. -She checked Staff E's personnel file and could not find any documentation that a TB test was completed upon rehire on 12/1/15.	D 131		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents	D 164		

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D 164	Continued From page 2 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; (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 ensure 1 of 4 medication aides sampled (Staff B) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 11/30/16 as a Personal Care Aide (PCA). -Staff B had passed the Medication Aide test on 6/9/17.	D 164		

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D 164	Continued From page 3 -There was no documentation Staff B had completed diabetic care training. Review of facility's medication administration records (MARs) revealed Staff B documented administering insulin to 2 residents on 1/21/18. Interview with the Business Office Manager (BOM) on 2/9/18 at 9:30am revealed: -Staff B started working as a Medication Aide (MA) on 6/9/17 but she did not start administering medications at the facility until 7/3/17. -Staff B was in nursing school and Staff B told the BOM that all of her diabetic care training was completed through her nursing program. -The facility did not have a copy of Staff B's diabetic care training she received through her nursing school program. -The facility did not provide diabetic care training for Staff B because she thought Staff B was covered since she was in nursing school. Interview with the Executive Director (ED) on 2/9/18 at 10:50am revealed she was not aware Staff B had not completed diabetic care training and the ED would follow-up with the BOM to see what could be done. Interview with the Executive Director (ED) on 2/9/18 at 11:20am revealed: -Staff B had not received any diabetic care training through the facility. -Diabetic care training may have been provided through Staff B's nursing school program. -The facility had no documentation of diabetic care training in Staff B's personnel record. Interview with the BOM on 2/9/18 at 11:30am	D 164		

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D 164	Continued From page 4 revealed: -Staff B passed the Medication Aide exam on 6/9/17 but she did not starting administering medications at the facility until 7/3/17. -The BOM was not aware training on care of diabetic residents was required for the MAs prior to administering insulin. -The facility contracted with a pharmacist to perform the diabetic training. -The BOM maintained all training records for non-clinical training. -The Resident Care Coordinator (RCC) and ED maintained all training records for clinical training. -The process for assuming diabetic training received for newly hired MAs was that the BOM would inform the RCC and ED of the new hire and the RCC or ED would determine if the diabetic training was needed. -The RCC and the ED were aware that Staff B had been working as a MA. -The BOM could not find any documentation to support that Staff B had completed training of care of diabetic residents. Interview with Staff B on 2/9/2018 at 12:43pm revealed she had completed all required training at school and not at the facility.	D 164		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of	D 234		

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the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 2-step tuberculosis (TB) testing had been completed upon admission in compliance with the control measures adopted by the commission for Health Services for 2 of 6 sampled residents (Residents #1, #6).

The findings are:

1. Review of Resident #1's current FL-2 dated 8/20/17 revealed diagnoses of hypertension, hyperlipidemia, osteoarthritis, benign prostatic hyperplasia, and peptic ulcer disease.

Review of Resident #1's Resident Register revealed an admission date of 9/14/17.

Review of Resident #1's Report of Tuberculosis (TB) Screening Evaluation form revealed:
-There was documentation of a TST administered to Resident #1 on 8/30/17 and read as negative on 9/1/17.
-There was no documentation of a 2nd TST being administered to Resident #1 since he was admitted to the facility on 9/14/17.

Interview with the Assistant Resident Care Coordinator on 2/6/18 at 3:30pm revealed:
-She was not aware Resident #1 had not had a second TST since his admission.
-The Resident Care Coordinator (RCC) was responsible for keeping up with what residents needed the 2nd step TST.
-The RCC was not available to this week due to

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illness.
-She would follow-up with the Executive Director (ED) to see what needed to be done.

Interview with Resident #1 on 2/6/18 at 4:05pm revealed he did not remember having 2nd TST since he was admitted to the facility in September 2017.

Interview with the ED on 2/7/18 at 3:45pm revealed:
-She was not aware that Resident #1 had not had his 2nd TST completed.
-The RCC was responsible to make sure newly admitted residents got their TSTs done.
-"The facility had an old RCC who just quit without notice and the new RCC started in her position in September 2017."
-"Some things may be out of whack because the new RCC was playing catch up and she was learning her new role and now she was out sick."
-She would contact the corporate nurse to see what was the policy was for the second TST after admission since the RCC was unavailable.

2. Review of Resident #6's current FL-2 dated 11/20/17 revealed diagnoses of chronic constipation, chronic obstructive pulmonary disease, abdominal aortic aneurysm, low back pain, chronic kidney disease, macular degeneration, and hyperlipidemia.

Review of Resident #6's Resident Register revealed an admission date of 11/21/17.

Review of Resident #6's record revealed:
-Resident #6 was brought to the hospital by Emergency Management Services (EMS) on 11/13/17 for a complaint of weakness and was

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given a chest x-ray.
-The result of the chest x-ray was "possibly mild cardiomegaly; no active lung disease."
-There was no documentation that a TST had been administered.

Review of a facility medical history form signed and dated by the physician on 11/16/17 revealed a note initialed by the physician that read "Tuberculosis screening - please do upon arrival."

Review of facility standing physician's orders signed and dated by the physician on 11/16/17 revealed an order for tuberculin skin test; step 1 and step 2 for move in to be administered by nurse, home health or health department.

Interview with the Assistant Resident Care Coordinator on 2/7/18 at 8:00am revealed:
-She was not aware Resident #6 had not had received the two-step TST.
-The process was that the resident should receive the 1st step TST prior to admission and two weeks later the 2nd step TST.
-"Resident #6 had a chest x-ray one week prior to admission, so maybe they were thinking we could use that."

A second interview with the Assistant Resident Care Coordinator on 2/8/17 at 10:10am revealed:
-The RCC was responsible for following up on resident TSTs.
-In the absence of the RCC, the Nurse Consultant would follow-up.
-The RCC was not available this week due to illness.
-She would follow-up with the Executive Director (ED) to see what needed to be done.

Interview with the ED on 2/8/18 at 12:10pm

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D 234	Continued From page 8 revealed: -She thought the chest x-ray that Resident #6 had a week prior to admission was sufficient since it revealed no active lung disease. -The process was the RCC completed the pre-assessment of the resident prior to admission. -In the absence of the RCC, the Assistant RCC or the ED would complete the pre-assessment. -The RCC would send the completed assessment to the physician for signature and the resident would be given the TST step one. -The RCC would insure the first TST was read before admission. -The RCC was responsible for making sure the second step TST was completed. -The RCC was not available due to illness. -She would follow-up with the Assistant RCC to insure Resident #6 received the two step TST.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 1 sampled resident (Resident #8) who eloped from the Special Care Unit (SCU).	D 270		

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D 270	Continued From page 9 The findings are: Review of Resident #8's current FL-2 dated revealed: -Diagnoses included dementia and anxiety. -The resident was intermittently disoriented. Review of Resident #8's Resident Register revealed date of admission as 10/23/17. Review of Resident #8's Care Plan dated 11/06/17 revealed: -The resident was sometimes disoriented. -The resident was forgetful and need reminders. -The resident has a history of wandering. Review of a progress note by a Licensed Heath Professional Support nurse dated 11/08/17 revealed that Resident #8 was oriented to self but not to place or time. Confidential interview with a staff member revealed: -Resident #8 got out with another resident's family member a "few days ago". -Family members of the residents have the security code to the electronic door lock on the special care unit (SCU). -The resident walked up to a PCA who was pumping gas at a local gas station. -The PCA was on her lunch break. -The PCA returned Resident #8 to the facility. Interview with a personal care aide (PCA) on 2/8/18 at 7:15pm revealed: -Resident #8 needed reminders to perform such things as dressing and bathing. -The resident was constantly wandering, looking for her husband. -The resident frequently asked to leave.	D 270		

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D 270	Continued From page 10 Interview with a second PCA on 2/8/18 at 7:27pm revealed: -Resident #8 was constantly exit seeking. -She would stand at the windows looking out. -The resident would go to doors and "jiggle" the handles trying to get out. Interview with a medication aide (MA) on 2/8/18 at 7:20pm revealed: -The resident was always looking for her husband. -The resident's husband usually visited several times a week. -The resident's husband was receiving medical care out of state and had not visited in over a month. A second confidential staff interview: -When the family member of another resident opened the locked door from the assisted living side, Resident #8 was standing there and went out while the door was open. -Resident #8 was wearing a hat and the family member thought that she was another visitor. -A staff member found the resident during the staff member's lunch break. A third confidential interview with a staff member revealed: -Most family members have the security code to the locked door for the SCU. -Last week a family member was entering the SCU and a resident left while the door was open. -The family member thought the resident was a visitor because she was wearing a hat. -The resident "made it all the way" to a local gas station approximately 1.75 miles from the facility. -The resident walked up to a staff member from the facility who was getting gas.	D 270		

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D 270	Continued From page 11 -The staff member called back to the facility and asked the supervisor in charge (SIC) what to do. -The facility did not know the resident had eloped. -The staff member was instructed to return the resident to the facility. -The incident occurred between 10:30am and 11:00am on 2/1/18. Interview with the Assistant Resident Care Coordinator (ARCC) and the Executive Director (ED) on 2/8/18 at 6:30pm revealed: -Neither the ARCC or the ED had been told Resident #8 had eloped on 2/1/18 until 2/2/18. -The first shift (7:00am - 3:00pm) SCU Supervisor was told about the incident when she reported to work on 2/2/18. -The Supervisor reported the incident to the resident care director (RCC) and ARCC on 2/2/18 who then relayed the information to the ED. -The incident occurred on 2/1/18 at approximately 10:30am while the RCC, ARCC and the ED were in a closed door meeting in the facility. -Staff reported that Resident #8 probably was let out the door of the SCU accidentally by a visitor who did not realize Resident #8 was a resident. -A staff person saw Resident #8 wandering in the parking lot at the gas station down the street on 2/1/18. -Staff brought Resident #8 back inside the facility through the back door of the SCU but no staff on who worked in the SCU on 2/1/18. -No staff had informed the RCC, ARCC or ED that Resident #8 had eloped on 02/01/18. -There had been no interventions or increased monitoring of Resident #8 since the elopement on 2/1/18. -The SCU staff still only checked on residents in the SCU every 2 hours. Interview with the ED on 2/8/18 at 6:50pm	D 270		

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D 270	Continued From page 12 revealed: -On 2/2/18, she interviewed 3 staff members who worked in the SCU on 2/1/18 when the incident occurred. -"The 3 staff members had not reported Resident #8's elopement on 2/1/18 because they did not think it was that big of a deal." -The ED did not know if an incident report or a care note was completed regarding Resident #8's elopement. -The normal process was an incident report was completed for any elopements, falls, or injuries. -The ED had interviewed and had obtained written statements from the 3 staff members who worked 1st shift in the SCU on 2/1/18 and the staff member who reported the incident on 2/2/18. -When the ED was asked who she had notified, she stated "no one". -The RCC and ED was not aware if the family of Resident #8 was aware of the resident's elopement on 2/1/18. -All of the SCU residents' family members had the code for the SCU entry doors so they could get into the SCU without staff assistance. -There was no monitoring of the SCU door 24/7 by staff. -She had not given any new instructions or interventions to the staff on frequency of monitoring residents or dealing with elopement situations since she became aware of Resident #8's elopement. -The ED had tried to get Resident #8 an ankle bracelet through a security company and would talk with Resident #8's family before moving forward. -The only corrective measure that had been done since Resident #8's elopement on 2/1/18 was the ED placed a call to a "wander guard" company to inquire about the product.	D 270		

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D 270	Continued From page 13 Review of the facility's elopement policy titled "Missing Resident Policy" revealed: -The family of the missing resident was to be notified. -An incident report was to be completed. -Persons notified of the elopement was to be documented in the resident's chart. Telephone interview with the RCC on 2/8/18 at 7:23pm revealed: -She had not been told about Resident #8 eloping until the next day (2/2/18). -The Supervisor who worked in the SCU on 1st shift on 2/1/18 was new and must not have realized that the incident should have been reported immediately. -The RCC had received a call on 2/1/18 from a family member of another SCU resident who stated at the call, "I'm sorry I let Resident #8 out of the SCU, I didn't know she was a resident". -The RCC did not know that the family member was referencing to Resident #8's elopement. -"I thought the caller meant Resident #8 had just walked through the SCU doors to the Assisted Living (AL) side of the facility". -The RCC did not notify anyone of Resident #8's elopement on 2/01/18 because she was waiting on "next steps (directions)" from the ED. -I was not told by any staff on 2/1/18 that Resident #8 had eloped from the facility. -The RCC had been on sick leave since 2/2/18. Observation of the location of the local gas station revealed: -The local gas station was 1.75 miles from the facility. -The road in front of the facility was a four lane highway that passed by a multi grade school complex on the way to the gas station.	D 270		

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D 270	Continued From page 14 -The gas station was located at an intersection of the 4 lane highway and 6 lane main highway. -The traffic on the 4 lane road was intermittently heavy. -The traffic on the 6 lane highway was constantly heavy. Interview with the ED on 2/9/18 at 9:02am revealed: -The security code to the SCU was changed last night (2/8/18). -Staff had been instructed not to give the code to any family member. -A letter will be mailed today (2/9/18) to all family members/responsible parties notifying them of the new policy. -A staff member will escort visitors to the SCU and the staff member will enter the security code for them to enter the SCU. _____ The facility failed to provide required supervision to Resident #8, with a diagnosis of dementia with a history of exit seeking behaviors and of being disoriented, eloped from the facility alone and walk over a mile on a busy highway before being discovered by chance. This failure to provide supervision resulted in a substantial risk of serious physical harm and constitutes a Type A2 violation. _____ Review of a Plan of Protection dated February 08, 2018 revealed: -A staff member will sit at the SCU door and monitor those who enters and leaves until maintenance can change the security code . -Once the security code has been changed, only staff members will have access to the code. -All guest will be escorted to and from the SCU.	D 270		

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D 270	Continued From page 15 -Staff will be notified of the procedure change as they come on shift beginning immediately. -A letter will be sent on 02/09/18 to family members of the residents of the SCU. -The security code will be changed quarterly and as needed. THE CORRECTION DATE OF THIS A2 VIOLATION SHALL NOT EXCEED MARCH 11, 2018.	D 270		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that snacks were made available or offered to all residents three times per day. Observation of snack area near the library on 02/06/18 at 10:30am revealed: -There was a tiered fruit stand on a table at the entrance of the library. -Three cereal bars were in the top basket. -Eight apples and 2 bananas were in the bottom basket. -There was a 64 ounce pitcher approximately 2/3 full of water and a stack of disposable cups. Interview with a resident on 2/5/18 at 11:50am	D 298		

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revealed:
-Staff did not go around and offer snacks to the residents in the facility.
-Snacks were left out in the community areas and residents could go and get a snack at any time.
-Community areas were located in the dining room and the living room by the front lobby.

Interview with a second resident on 2/5/18 at 12:15pm revealed:
-The resident stayed mostly in her room for her meals and snacks.
-Staff did not offer snacks to her.
-"Sometimes, I think the staff forget that I am in here".
-If she asked for a snack, staff would get it for her.

Observation of the snack area near the library on 02/07/18 at 10:20am revealed:
-There were 2 cereal bars, 6 individual packages of animal crackers and 8 apples available.
-There was a pitcher of water.

Interview with a PCA on 02/07/18 at 11:15am revealed:
-Snacks are put on a table near the library.
-The activity director takes snack to resident's rooms.
-The PCA doesn't offer snacks, but if a resident asks for one, she will get something for the resident.

Interview with the activity director on 02/07/18 at 3:09pm revealed:
-She has a "snack and chat cart" to she uses to visit with residents that do not get out of their room as much when she can.
-The snack and chat cart is not part of her daily routine.

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D 298	Continued From page 17 Interview with the Kitchen Manager on 02/06/18 at 11:05am revealed: -Snacks are available the in library at all times. -She stated that she did not know how residents who were confined to their rooms got a snack. -She was not sure if every resident was offered a snack.	D 298		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain an accurate and current list of residents with physician-ordered therapeutic diets for 1 of 1 (#4) sampled residents for guidance of food service staff. The findings are: Review of Resident #4's current FL-2 dated 07/13/17 revealed: -Diagnoses included dementia and hypertension. -The resident was on a regular diet. Review of an order written by the primary care provider (PCP) for Resident #4 (without a date) revealed: -The order was signed by the PCP. -The order instructed to "thicken liquids" without a specified consistency. -The order was faxed to the pharmacy on	D 309		

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D 309	Continued From page 18 01/25/18. Review of the dietary list posted in the SCU revealed: -The list had been updated 01/09/18. -Resident #4 diet was listed as "regular" with no liquid consistency specified. Interview with medication aide (MA) on 02/08/18 at 12:10pm revealed: -The MA had not mixed any thickened liquids for Resident #4 today. -Resident #4 did not come to breakfast today. -The resident had not been given any medication since 6:00am on 02/08/18. Interview with a personal care aide (PCA)/MA on 02/08/18 at 11:35am revealed: -She did not know that Resident #4 was to receive thickened liquids. -The MA usually mixed the thickened liquids for residents. -The PCA/MA worked in the SCU regularly and had never mixed thickened liquids for the resident. Interview with the Assistant Resident Care Coordinator (ARCC) on 02/08/18 revealed: -The PCP was scheduled in the facility today (02/08/18) and the ARCC would obtain a complete order. -The diet list in the SCU would be updated as soon as the order was obtained. Telephone interview on 02/09/18 at 12:43pm with the MA that documented administration of tbe thickener powder was unsuccessful. Review of an order written by Resident #4's PCP on 02/08/18 revealed "please thicken liquids to	D 309		

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D 309	Continued From page 19 nectar consistency."	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to add thickeners to all liquids as ordered by the primary care provider for 1 of 1 (Resident #4) of sampled residents. The findings are: Review of Resident #4's current FL-2 dated 07/13/17 revealed: -Diagnoses included dementia and hypertension. -The resident was on a regular diet. Review of Resident #4's Resident Register revealed an admission date of 11/04/13. Review of an order written by the primary care provider (PCP) without a date revealed: -The order was signed by the PCP. -The order instructed to "thicken liquids" without a specified consistency. -The order was faxed to the pharmacy on 01/25/18. Observation of the kitchen area in the special care unit on 02/08/18 at 9:30am revealed: -There was a container of thickener on the	D 310		

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counter with Resident #4's name on it.
-The directions on the pharmacy label on the thickener instructed "provide patient with Thickened Liquids".

Review of the dietary list posted in the SCU on 02/08/18 revealed:
-The list had been updated 01/09/18.
-Resident #4 diet was listed as "regular" with no liquid consistency specified.

Interview with medication aide (MA) on 02/08/18 at 12:10pm revealed:
-The MA had not mixed any thickened liquids for Resident #4 today.
-Resident #4 had not come to breakfast today.
-The resident had not been given any medication since 6:00am on 02/08/18.

Interview with a personal care aide (PCA)/MA at 11:35am revealed:
-She did not know that Resident #4 was to receive thickened liquids.
-The MA usually mixed the thickened liquids for residents.
-The PCA/MA worked in the SCU regularly and had never mixed thickened liquids for the resident.

Observation in the SCU dining room on 02/08/18 at 11:50am revealed:
-Resident #4 was seated at a table with water, juice and milk in front of her.
-All liquids were unthickened.
-The resident began drinking the juice.
-No coughing was noted as the resident drank.
-The PCA removed all liquids from the table in front of the resident.

Interview with the Assistant Resident Care

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D 310	Continued From page 21 Coordinator (ARCC) on 02/08/18 revealed: -The PCP that wrote the order for Resident #4's Thick-It came to the facility each Thursday. -The ARCC worked with the PCP when seeing residents and did not "catch" that the date and consistency was missing from the order. -New orders were usually faxed to the pharmacy and entered into the eMAR system by the third shift (11:00pm to 7:00am) MA. -New orders were considered "pending" until the medication was received by the facility and checked into the system. -The thickener for Resident #4 was received on 01/26/18 and checked in during second shift. -The thickener would have been available for the resident on 01/27/18. -The ARCC was "positive" the resident had not received any thickened liquid since the order was written. -The PCP was scheduled in the facility today (02/08/18) and the ARCC would obtain a complete order. -The diet list in the SCU would be updated as soon as the order was obtained Review of an order written by Resident #4 PCP on 02/08/18 revealed "please thicken liquids to nectar consistency."	D 310		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by:	D 345		

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Based on observations, interviews and record reviews, the facility failed to assure medication orders for hypertension, overactive bladder, constipation, cholesterol, nutritional supplement, pain relief, and self-administration of medications orders for 2 of 3 sampled residents (#1 and #6) were maintained in the residents' records.

The findings are:

1. Review of Resident #6's current FL-2 dated 11/20/17 revealed:
-Diagnoses included chronic constipation, chronic obstructive pulmonary disease (COPD), abdominal aortic aneurysm, low back pain, chronic kidney disease, macular degeneration, and hyperlipidemia.
-There were medication orders for Amlodipine 2.5 mg 1 tablet by mouth daily, Linzess 145 mcg 1 capsule by mouth daily, Metoprolol Succinate ER 50 mg 1 tablet by mouth daily, and Atorvastatin 10 mg 1 tablet by mouth daily at night. (Atorvastatin is for treating high cholesterol. Linzess is for chronic constipation and irritable bowel syndrome. Amlodipine is for high blood pressure. Metoprolol is for blood pressure/heart.)
-There was no order to self-administer medications.

Review of physician's orders in Resident #6's record revealed a medication order dated 1/16/18 for Flaxseed oil 1000 mg capsule take one by mouth daily. (Flaxseed oil may be used for many different medical conditions such as high cholesterol and dry eyes.)

Observation of medications in Resident #6's room on 2/6/18 at 11:15am revealed:
-A bottle of Tylenol 500mg (OTC), bottle of Vitamin B12 1000mcg (OTC), a bottle of

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D 345	Continued From page 23 Atorvastatin 10mg, two bottles of Norvasc 2.5mg tablets, and a bottle of Atorvastatin 20mg -There was no Linzess, Metoprolol, or Flaxseed found in Resident #6's room. Review of Resident #6's record revealed there were no medication orders for Tylenol 500mg or Vitamin B12 1000mcg. Interview with Resident #6 on 2/6/18 at 11:25am revealed: -She took Norvasc 2.5mg twice day and she Atorvastatin 10mg every morning and one table from the second Atorvastatin bottle in the evening. -She was not sure what the current doses of Norvasc or Atorvastatin were. -The dosages for Norvasc and Atorvastatin would have to be verified with her family because her family had an updated medication lists for Resident #6. -Her family handled all of the new medications orders for Resident #6. -"I never read any of my prescription labels; I just do what I am told to do by the doctor (referring to taking her medications)". -The medications in the room were all the medications that she was taking. Interview with the Assistant Resident Care Coordinator (ARCC) on 2/7/18 at 4:15pm revealed: -She was not sure what Resident #6's medications order were or how Resident #6 was supposed to be taking her medications. -She would have to contact Resident #6's primary care provider for any updated medication lists and an order to allow Resident #6 to self-administer her own medications.	D 345		

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D 345	Continued From page 24 2. Review of Resident #1's current FL-2 dated 8/20/17 revealed: -Diagnoses included hypertension, hyperlipidemia, osteoarthritis, benign prostatic hyperplasia, and peptic ulcer disease. -There was no physician's order for Resident #1 to self-administer his medications. Observation of medications in Resident #1's room on 2/6/18 at 4:30pm revealed there were 2 bottles of Vitamin E - 200 international units on hand for self-administration (Vitamin E is a nutritional supplement). Review of physician's orders for Resident #1 revealed there was no documentation of orders for Resident #1 to self-administer his medications or for the Vitamin E supplements. Interview with the Assistant Resident Care Coordinator on 2/7/18 at 10:30am revealed: -She did not realize the order for Resident #1 to self-administer his medication was not on the FL-2 when Resident #1 was admitted to the facility in September 2017. -The physician's order for Resident #1 to self-administer his medications should have been obtained with the original assessment self-medication assessment done by the Resident Care Coordinator. -She did not know how this order was overlooked. -She would contact Resident #1's physician for an order for Resident #1 to self-administer his medications and clarification of order for Vitamin E. Review of subsequent physician's orders for Resident #1 revealed: -A physician's order dated 2/7/18 was written for Resident #1 to self-administer his medications.	D 345		

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D 345	Continued From page 25 -A physician's order dated 2/8/18 was written for Vitamin E 200 international units once daily. Interview with Resident #1 on 2/6/18 at 4:05pm revealed: -He self-administered all of his medications. -He was unsure of how long he had been taking the Vitamin E but it had been greater than 3 months. -"I just take the medications that I am prescribed by my doctor". Interview with the Assistant Resident Care Coordinator (ARCC) on 2/8/18 at 9:20am revealed: -She did not know Resident #1 did not have an order for his Vitamin E. -She would contact his primary care provider for the medication order. Review of subsequent physician's orders for Resident #1 revealed: -A physician's order dated 2/7/18 was written for Resident #1 to self-administer his medications. -A physician's order dated 2/8/18 was written for Vitamin E 200 international units once daily.	D 345		
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.	D 358		

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This Rule is not met as evidenced by:
Based on interverviews and record reviews, the facility failed to administer a pain medication (Norco 10-325) as ordered to 1 of 5 residents sampled resident (Resident #5). The findings are:

Review of Resident #5's current FL-2 dated 3/30/17 revealed diagnoses included osteoporosis, history of fractured right femur and presence of right artificial hip joint.

Review of physician's orders revealed:
-There was an order dated 05/31/17 for Norco 10-325 to be given 4 times a day at 10:00am, 2:00pm, 6:00pm and 10:00pm.
-There was an order dated 04/05/17 for an evening coctail, a maximum of 2, to be administered by staff.
-There was an order dated 08/10/2017 that pain medication and alcoholoic beverages must be at least 4 hours apart.

Review of Resident #5's electronic medication administration record (eMAR) for February 2018 revealed:
-There was an entry for Norco 10-325, 1 tablet four times a day to be given at 10:00am, 2:00pm, 6:00pm and 10:00pm.
-There was documentation Norco 10-325 was administered as ordered from 2/1/18 to 2/5/18 with one resident refusal at 10:00pm on 2/1/18.
-There was an entry for alcohol, "patient may have an evening cocktail, staff to administer, maximum of 2 per evening at 5:00pm daily.
-There was documentation the cocktail was given at 5:00pm daily from 2/1/18 to 2/5/18.

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D 358	Continued From page 27 Review of Resident #5's eMAR for January 2018 revealed: -There was an entry for Norco 10-25, 1 tablet four times a day to be given at 10:00am, 2:00pm, 6:00pm and 10:00pm. -There was documentation Norco 10-325 had been given as ordered from 1/1/18 to 1/31/18 with one resident refusal at 6:00pm on 1/28/18. -There was an entry for alcohol, patient may have an evening cocktail, staff to administer, maximum of 2 per evening. -There was documentation that the cocktail was given daily at 5:00pm from 1/1/18 to 1/31/18. Review of Resident #5's eMAR for December 2017 revealed: -There was an entry for Norco 10-325, 1 table four times a day to be given at 10am, 2:00pm, 6:00pm and 10:00pm. -There was documentation that Norco 10-325 had been given daily as ordered from 12/1/17 to 12/31/17 with two refusals on 12/8/17 at 10:00pm and 12/21/17 at 6:00pm. -There was an entry for alcohol, patient may have an evening cocktail, staff to administer, maximum of 2 per evening. -There was documention that the cocktail was given daily at 5:00pm from 12/1/17 to 12/31/17. Interview with a medication aide (MA) on 2/6/18 at 10:20am revealed: -Sometimes Resident #5 refused her pain medication. -The MA could not remember the resident refusing her evening cocktail. -The MA used the resident's personal jigger to measure 1 ½ ounces of gin. -The resident kept a supply of tonic water in her room and would mix her own cocktail.	D 358		

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D 358	Continued From page 28 -The resident would "sip" her cocktail "all night long" some days. -The resident "sipping" her cocktail "made it hard" to determine when the pain medication should be held. Interview with Resident #5 on 2/6/18 at 10:07am revealed: -The resident's pain "came from her back and her hip". -She always had an evening cocktail before dinner. Interview with the Assistant Resident Care Coordinator (RCC) on 2/6/18 at 10:28am revealed: -She knew of Resident #5's pain medicine schedule and the resident's evening cocktail schedule. -It was hard to time the consumption of the alcohol by the resident since sometimes the resident would put it in her refrigerator "for later". -The assistant RCC would contact the resident's primary physician for clarification of orders for the evening cocktail and pain medication. Attempted interview with Resident #5's primary care physician by telephone on 2/6/18 were unsuccessful. Review of an order written by the primary care physician revealed that the 6:00pm dose of Norco 10-325 was discontinued; continue the other scheduled doses.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 366		

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D 366	Continued From page 29 (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to observe of 1 of 8 sampled resident (#7) take her medication as evidenced by staff leaving medications with the resident in the dining room unattended. The findings are: Review of Resident #7's current FL-2 dated 2/8/18 revealed: -Diagnoses included dementia, aortic stenosis, and history of pulmonary embolus. -Medications included Docusate 100mg, Senna Lax 8.6mg, and Xarelto 20mg (Docusate and Senna Lax are used to treat constipation and Xarelto is used to prevent blood clots). Review of the Resident Register for Resident #7 revealed an admission date of 1/29/16. Review of the Resident #7's care plan dated 2/28/17 revealed the resident was sometimes disoriented. Observation of the dining room on 02/08/2018 at 8:40am revealed: -Eight residents were in the dining room area for breakfast. -No medication aides (MAs) were present in the	D 366		

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dining room.
-Resident #7 was sitting alone at a table with 3 pills on a napkin near her coffee cup on the right side of the table.
-Three medications on Resident #7's napkin included one tan round tablet, one triangular shaped reddish-brown tablet, and a red gel capsule.
-An empty white paper medication cup was on the table next to the napkin.
-The MA returned to the dining room area after approximately 8-10 minutes after the observation of the 3 tablets on Resident #7's napkin.

Interview with Resident #7 on 2/8/18 at 8:43am revealed:
-"I'm slow taking my medications".
-The medication aide left the medications in the medicine cup with Resident #7 on 2/8/18.
-She was not sure what medications had been left in the medicine cup by the MA.
-The MA often left her medications with Resident #7 to take because the MA trusted Resident #7 to take her medications unassisted.
-The MA left medications with Resident #7 "to take on her own quite often if the MAs got too busy on the floor".
-Resident #7 was not able to specify how often the MAs left medications with her unattended or identify who the MAs were.
-The MA did come back sometimes and asked Resident #7 if she had taken the medications left for Resident #7 to take.
-"The MA this morning checked on me, but she did not ask if I took my medicine".
-She was not sure how much time passed from when the MA left the medications with her and when the MA came back to the dining room to check on her.
-Resident #7 did not recall any problems with

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other residents trying to get her medications when the MA left the medications with her unattended.

Interview with the MA on 2/8/18 at 10:35am revealed:
-She had been working at the facility as a MA for about 4 years.
-She had left Resident #7's stool softeners, blood thinner, and pain medications in a medicine cup at the tablet with Resident #7 during breakfast on 2/8/18 because "Resident #7 was busy chewing and eating".
-"I didn't want to give Resident #7 her medications while she was in the middle of eating her breakfast because I didn't want to stop Resident #7 from eating her breakfast in the dining room".
-She left the 3 pills in a medicine cup at the table with Resident #7 but she did not give Resident #7 any instructions to take the medications in the medicine cup.
-She was going to return to administer the medications in the medicine cup later after she administered medications to another resident.
-When she returned to the dining room area, the MA noted Resident #7's medicine cup was empty.
-She did not verify if Resident #7 had taken the medications in the medicine cup.
-"I don't think any of the other residents in the dining room took Resident #7's medications because that was not their medications".
-The MA acknowledged that the facility had 2 or 3 disoriented residents who ate their meals in the dining room.
-She had been trained that medications were not to be left unattended with residents if the medications were not being self-administered.
-"I left the medications with Resident #7 because I knew I wouldn't be gone that long".

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D 366	Continued From page 32 -"I won't be leaving any medications unattended with any residents again". Interview with a second MA in the Special Care Unit on 2/8/18 at 10:45am revealed: -She had been working at the facility as a MA for about 7 ½ years. -It was part of the facility's medication administration policy that staff should witness residents taking their medications. Interview with the Assistant Resident Care Coordinator on 2/8/18 at 10:20am revealed: -She was not aware the MA had left medications in a medicine cup for Resident #7 to self-administer during breakfast on 2/8/18. -The facility did have a "bedside medication policy" that allowed the medication aides to leave medications unattended for residents to self-administer. -The facility process was that a physician's order was required to leave medications at the bedside for a resident. -If there was an order, the MA would leave the medication at the bedside and go back later to see if the resident took it. -If it was meal time, the MA would leave the medication at the dining room table with the resident. -If there was not an order to leave medications at the bedside, then the process was that the MA would wait for the resident to swallow the medication before leaving the resident. -All MAs had been trained on the process and were expected to administer medications per the process. -She was not sure if Resident #7 had an order for self-administration of bedside medications. -She would have to review Resident #7's records for her physician's orders.	D 366		

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D 366	Continued From page 33 -"I can understand the concerns with leaving the medications unattended in the dining room with the other residents who wandered in and out of the dining room". -She would talk with the Executive Director and review their "bedside medication policy". Review of the facility's medication administration policy revealed that bedside medications are not permitted, except when specifically ordered by the resident's physician. Interview with the Executive Director (ED) on 02/08/18 at 12:10pm revealed: -The MAs should not be leaving medication at a resident's bedside or at the dining room table while the resident is eating unless there was a physician's order allowing it. -"We do whatever the doctor orders." -If there was not a physician's order to leave the medication with the resident, the MAs should make sure the resident swallowed the medication and document that the medication was given. -She was not aware that the MAs were not allowed to leave medication at a resident's bedside even if there were a physician's order and will contact our corporate nurse to clarify about leaving medications with residents. Interview with the Executive Director on 2/8/18 at 1:15pm revealed: -She had spoken with their corporate nurse and the facility would no longer use the "bedside medication policy". -The MAs would not be allowed anymore to leave medications to be administered at the bedside or table for any residents. -All MAs would be re-educated to ensure they observed residents taking their medications during their administration.	D 366		

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D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure compliance with the facility's policies and procedures for the self-administration of medications for 3 of 3 sampled residents (#1, #3, and #6). The findings are: Review of the facility's policies and procedures for self-administration for medications revealed: -The resident must have an order from their private physician that "Resident may self-administer medications". -The order must be updated at least quarterly. -The physician must write an order for every medication the resident is taking, prescription and over-the-counter. -The resident must keep medications in an area	D 376		

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D 376	Continued From page 35 which is not accessible to other residents and there must be a locked door, cabinet or drawer between the medications and other residents. -At least quarterly, the Resident Care Coordinator must check the resident's medication for signs that medications may not be taken properly. In North Carolina, a weekly count has to be made. -If such signs are found, the resident's physician and responsible party should be notified immediately. -It should be documented in the resident care notes what was found each time there was a check for appropriate self-administration, and any follow-up contacts. -If the physician and/or the family member insists that the resident should continue taking their own medications after they have been notified of the concern, a Shared Risk Agreement must be completed. 1. Review of Resident #6's current FL-2 dated 11/20/17 revealed: -Diagnoses included chronic constipation, chronic obstructive pulmonary disease (COPD), abdominal aortic aneurysm, low back pain, chronic kidney disease, macular degeneration, and hyperlipidemia. -There were medication orders for Amlodipine 2.5 mg 1 tablet by mouth daily, Linzess 145 mcg 1 capsule by mouth daily, Metoprolol succinate ER 50 mg 1 tablet by mouth daily, Myrbetriq 50 mg 1 tablet by mouth daily for 90 days, Tramadol 50 mg 1 tablet by mouth every 6 hours as needed, Uloric 40 mg 1 tablet by mouth daily, and Atorvastatin 10 mg 1 tablet by mouth daily at night. (Atorvastatin is for treating high cholesterol. Uloric is for excess uric acid in the blood. Tramadol is a narcotic used for moderate to severe pain. Myrbetriq is for symptoms of overactive bladder. Linzess is for chronic	D 376		

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constipation and irritable bowel syndrome. Amlodipine is for high blood pressure. Metoprolol is for blood pressure/heart.)
-There was no order to self-administer medications.

Review of Resident #6's Care Plan dated 1/16/18 revealed:
-Resident #6 self-administered her medications.
-Resident #6 was alert and used glasses.

Review of the Self-Administration Medication Review Form dated 2/7/18 for Resident #6 revealed:
-The resident was assessed for medication self-administration.
-The assessment was completed by the Registered Nurse Consultant.
-There was a score of satisfactory beside each of the applicable questions.
-The resident was able to state the correct does of each medication.
-It was noted that resident was not feeling well so she "took time to respond and think."
-The resident was approved to self-administer medications.

Review of physician's orders in Resident #6's record revealed a medication order dated 1/16/18 for Flaxseed oil 1000 mg capsule take one by mouth daily. (Flaxseed oil may be used for many different medical conditions such as high cholesterol and dry eyes.)

Interview with Resident #6 on 2/6/18 at 10:59am revealed:
-She has been at the facility for a couple of months but she was unsure of how long.
-She had always self-administered her own medications and she kept her medications in her

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room.
-She had her own private room but she did not lock the door of her room at any time.
-"I don't live behind locked doors".
-She kept her medications on the counter by the sink and the nightstand by her bed.
-She kept the medications by her bedside because she used them either first thing in the morning before she got out bed or they were the last medications she had to take at night.
-She kept her morning medications in a brown basket beside the sink and her evening medications were on the countertop in front of the basket.
-She kept her medications arranged like this in her room because she was blind in her left eye and her vision was severely impaired in her right eye from macular degeneration.
-"It's easier for me to keep up with taking my medications this way".

Observation of medications in Resident #6's room on 2/6/18 at 11:15am revealed:
-A bottle of Tylenol 500mg (OTC) was on the left backside of the sink and countertop areas.
-A brown wicker basket contained a bottle of Vitamin B12 1000mcg (OTC), a sample bottle of Uloric 40mg with no name label or dosage instructions, a bottle of Atorvastatin 10mg, and a bottle labeled Tramadol 50mg was filled with Tylenol 500mg capsules.
-A bottle of Norvasc 2.5mg with no name label or dosage instructions, a sample bottle of Myrbetriq 50mg with no name label or dosage instructions, and a bottle of Atorvastatin 20mg dated 2012 had faded, unreadable dosage instructions.
-There was no Linzess, Metoprolol, or Flaxseed found in Resident #6's room.

Review of Resident #6's record revealed there

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D 376	Continued From page 38 were no medication orders for Tylenol 500mg or Vitamin B12 1000mcg. Interview with Resident #6 on 2/6/18 at 11:25am revealed: -She did not know what happened to the Tramadol. -She did not remember taking the Tramadol or putting any Tylenol in the Tramadol prescription bottle. -"I thought the Tramadol was still in the bottle but my family may have taken it out; I don't know". -She was responsible for ordering her own medication until 2 months ago when her health went down and her family started ordering her medications from the pharmacy. -The facility staff did not do anything pertaining to her medications. -No staff ever came to check to ask if she took her medications or to check the counts of her medications. -She was not sure what the current doses of Norvasc or Atorvastatin were. -The dosages for Norvasc and Atorvastatin would have to be verified with her family because her family had an updated medication lists for Resident #6. -Her family handled all of the new medications orders for Resident #6. -"I never read any of my prescription labels; I just do what I am told to do by the doctor (referring to taking her medications)". -The medications in the room were all the medications that she was taking. Interview with a family member of Resident #6 on 2/6/18 at 11:35am revealed: -The self-administration medication order originated from Resident #6's physician when Resident #6 lived out of state.	D 376		

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D 376	Continued From page 39 -The family member had taken over with ordering Resident #6's medications when the resident got sick in November 2017. -She tried to help Resident #6 keep track of her medications but sometimes Resident #6 just did her medications her own way based off old instructions from her doctor and it concerned the family member. -The family member had not voiced any of her concerns with the facility staff. -Resident #6 self-administered her own medications. -She had the medications separated between morning medications and evening medications. -She was not aware that Resident #6 was taking Norvasc and Atorvastatin in the mornings and evenings. -She would have to recheck Resident #6's current medication list to verify the medications that Resident #6 should be taking. -Resident #6 may have taken the Tramadol and just forgot she took it. -The family member could not remember how much Tramadol was brought in the facility when Resident #6 was admitted. -The family member could not remember if staff counted the Tramadol or any of Resident #6's other medications when the resident was admitted. -"Staff here doesn't do anything for Resident #6's medications; I don't even think they asked her if she takes her medications". -"The staff never asked for an updated medication list for Resident #6 but I share the list that I get when I take Resident #6 to her doctor's appointments". -Resident #6 kept her room door unlocked because Resident #6 was not able to see well enough to manage unlocking her room door manually with a key.	D 376		

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-Resident #6 used a magnifying glass to read fine print like on her prescription labels.
-She was not aware that it was an issue that Resident #6 had unlabeled prescription medications or illegible prescription labels.
-"We will have to straighten that out so there is no confusion on what Resident #6 should be taking".
-"I am going to just take Resident #6's Tramadol bottle with me since the Tramadol is all gone".

Observation on 2/6/18 at 11:55am revealed:
-The family member dumped the Tylenol capsules from the Tramadol bottle into the Tylenol bottle on the backside of the sink.
-The family member took the empty Tramadol bottle and put it with the family member's personal items.

Interview with a medication aide (MA) on 2/6/18 at 10:50am revealed Resident #6 self-administered her medications but did not keep her room door locked because she could not maneuver the key to unlock her room door.

Interview with a second MA on 2/6/18 at 4:00 p.m. revealed:
-She did not assist Resident #6 with her medications since she was allowed to self-administer.
-She was not trained on any self-administration of medication procedures and was not aware of any policy for that.

Interview with a third MA on 2/7/18 at 8:40am revealed:
-"Resident #6 had Tramadol in her room in a brown wicker basket on her countertop".
-Resident #6 did not lock her room door.
-"Resident #6 has the Tramadol in her room because I counted it last week and Resident #6

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had about 100 Tramadol pills".
-She did not document when she counted the Tramadol in Resident #6's room.

Interview with the Assistant Resident Care Coordinator (ARCC) on 2/7/18 at 4:15pm revealed:
-She was not sure what Resident #6's medications order were or how Resident #6 was supposed to be taking her medications.
-She would have to contact Resident #6's primary care provider for any updated medication lists and an order to allow Resident #6 to self-administer her own medications.
-She would follow-up with Resident #6's family member about the Tramadol.
-She did not recall if Tramadol was on Resident #6's medication profile when she was admitted to the facility.

Interview with Resident #6's physician's registered nurse (RN) on 2/7/18 at 4:40pm revealed:
-The physician was out of the office and not available to talk.
-Resident #6 was seen by the physician on 12/3/17, 1/2/18 and 1/31/18.
-There was a note on the care plan dated 1/16/18 and signed by the physician that Resident #6 self-administered her medications.
-There was no record of another order for Resident #6 to self-administer medications.
-There had been no calls or correspondence from the facility regarding Resident #6's compliance with self-administration of medications.

Review of Resident #6's care notes revealed there was no documentation showing that the resident's medications were checked quarterly for appropriate self-administration that included a

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D 376	Continued From page 42 weekly count of all medications. Interview with the Executive Director (ED) on 2/8/18 at 12:10 p.m. revealed: -She was not aware that Resident #6 did not have an order to self-administer order. -She did not know that Resident #6 did not lock her medications and pre-poured her medications leaving them on the counters in her room. -The RCC was responsible for monitoring the medication self-administration process. Observation of Resident #6's room on 2/9/18 at 12:15pm revealed: -Resident #6's room door was unlocked. -Resident #6's medications were on the countertop and sink areas by the entrance of her room. Refer to interviews with two medication aides (MAs) on 2/5/18 at 5:00pm. Refer to interview with a third MA on 2/6/18 at 10:50am. Refer to second interview with a MA on 2/7/18 at 8:40am. Refer to interview with the ARCC on 2/8/18 at 9:20am. Refer to interview with the Executive Director (ED) on 2/8/18 at 12:12pm. 2. Review of Resident #3's current FL-2 dated 4/26/17 revealed Review of Resident #3's current FL-2 dated 4/26/17 revealed: -Diagnoses included hypertension, atrial	D 376		

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fibrillation, hypothyroidism, arthritis and gastroesophageal reflux disease (GERD).
-The resident self-administers medications.
-There were 5 medication orders, one of which was a narcotic.

Review of physician's orders for Resident #3 revealed:
-There were 5 orders for additional medications.
-There was an order dated 10/30/17 for resident may self administer meds.

Review of Resident #3's Care Plan dated 6/6/17 revealed:
-Resident #3 self-administered her medications.
-Resident #3 was alert and used glasses.

Review of the Resident #3's Self-administration Medication Review Forms dated 5/5/17, 2/6/18 and 2/7/18 revealed the following on each:
-The resident was assessed for medication self-administration.
-There was a score of satisfactory beside each of the applicable questions.
-The resident was approved to self-administer medications.

Review of Resident #3's care notes revealed there was no documentation showing that the resident's medications were checked quarterly for appropriate self-administration that included a weekly count of all medications.

Interview with Resident #3 on 2/5/18 at 12:15pm revealed:
-She self-administered some of her medications because it was easier to do it that way.
-She self-administered her thyroid medication and she had narcotic pain medication that she kept in her room.

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D 376	Continued From page 44 -A family member brought her narcotic pain medication in from an outside pharmacy. -She kept her room door unlocked except for when she left her room and then she locked the door. Interview with Resident #3 on 2/6/18 at 12:00 p.m. revealed: -The staff had not asked her if she had taken her medications, nor had they counted her medications she kept in her room. -She used all of her oxycodone 5mg tablets and her family member brought her in a few 10 mg tablets that the family member broke in half so she could use those until he gets hers refilled on 2/13/18. -She took the oxycodone 1-2 times per day for pain. -All her medications are kept in a wicker basket on a bedside table, except the oxycodone that she kept in her purse at her side at all times. -She locked her room at night and if she left her room. Observation of medications in Resident #3's room on 2/6/18 at 12:15pm revealed: -All medications were in a wicker basket sitting on the resident's bed, except for oxycodone which was in her purse. -The medications in the basket included: Eliquis 2.5 mg tablets, Coreg 6.25 mg tablets, Synthroid 88 mcg tablets, Prilosec 20 mg capsules and Trandolapril 2mg tablets. -Resident #3 showed a prescription bottle labeled 120 Oxycodone 5 mg tablets dispensed on 9/28/17 that she had in her purse. -The resident opened the bottle of Oxycodone and there were approximately 10-15 pills that were cut in half.	D 376		

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D 376	Continued From page 45 Interview with a MA on 2/6/18 at 4:00pm revealed: -She did not assist Resident #3 with her medications since she was allowed to self-administer. -She was not trained on any self-administration of medication procedures and was not aware of any policy for that. -She was aware that Resident #3 got her medications from her family member and some were sent to the facility. -She saw Oxycodone on the MAR but did not know that the resident kept it with her. Attempted interview with Resident #3's family member on 2/6/18 at 4:20pm was unsuccessful. Attempted interview with another family member of Resident #3 on 2/6/18 at 4:30pm was unsuccessful. Interview with the practice manager of Resident #3's physician's office on 2/7/18 at 4:30pm revealed: -The physician was unavailable for interview. -Resident #3 was last seen by the physician on 4/25/17 when he completed paperwork for her to be admitted to the facility. -Resident #3 had an order on her FL-2 dated 4/26/17 to self-administer her medications. -The resident had an appointment with the physician on 3/9/18 to follow-up on any medication refills. -There had been no calls or correspondence from the facility regarding Resident #3's compliance with self-administration of medications. Refer to interviews with two medication aides (MAs) on 2/5/18 at 5:00pm.	D 376		

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D 376	Continued From page 46 Refer to interview with a third MA on 2/6/18 at 10:50am. Refer to second interview with a MA on 2/7/18 at 8:40am. Refer to interview with the Assistant Resident Care Coordinator (ARCC) on 2/8/18 at 9:20am. Refer to interview with the Executive Director (ED) on 2/8/18 at 12:12pm 3. Review of Resident #1's current FL-2 dated 8/20/17 revealed: -Diagnoses included hypertension, hyperlipidemia, osteoarthritis, benign prostatic hyperplasia, and peptic ulcer disease. -Medication orders included Aspirin 81mg once daily, Calcium 600 with Vitamin D3 1 tablet once daily, Centrum multivitamin 1 tablet once daily, Lisinopril 20mg 1 tablet once daily, Lorazepam 0.5mg 1 tablet twice daily as needed for anxiety, Finasteride 5mg once daily at bedtime, Timoptic 0.5% 1 drop each eye once daily at bedtime (Centrum and Calcium are supplements. Ativan is used to treat anxiety. Lisinopril is used to treat hypertension. Aspirin is used to prevent heart attack and stroke. Finasteride is used to benign prostatic hyperplasia. Timoptic solution is used to treat open-angle glaucoma and other causes of high pressure inside the eye.). -There was no physician's order for Resident #1 to self-administer his medications. Review of Resident #1's Care Plan dated 9/29/17 revealed: -Resident #1 self-administered his medications. -Resident #1 was alert and had adequate vision. Observation of medications in Resident #1's room	D 376		

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D 376	Continued From page 47 on 2/6/18 at 4:30pm revealed there were 2 bottles of Vitamin E - 200 international units on the countertop next to the microwave (Vitamin E is a nutritional supplement). Review of physician's orders for Resident #1 revealed prior to 2/7/18 there were no orders for Resident #1 to self-administer his medications or for the Vitamin E supplements. Interview with the Assistant Resident Care Coordinator on 2/7/18 at 10:30am revealed: -She did not realize the order for Resident #1 to self-administer his medication was not on the FL-2 when Resident #1 was admitted to the facility in September 2017. -Resident #1's current care plan acknowledged Resident #1 self-administered his medications but that was not a clear physician's order for the resident to self-administer his medications. -The physician's order for Resident #1 to self-administer his medications should have been obtained with the original assessment self-medication assessment done by the Resident Care Coordinator. -She did not know how this order was overlooked. -She would contact Resident #1's physician for an order for Resident #1 to self-administer his medications and clarification of order for Vitamin E. Review of subsequent physician's orders for Resident #1 revealed: -A physician's order dated 2/7/18 was written for Resident #1 to self-administer his medications. -A physician's order dated 2/8/18 was written for Vitamin E 200 international units once daily. Interview with Resident #1 on 2/6/18 at 4:05pm revealed:	D 376		

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-He self-administered all of his medications.
-He kept his medications next to the microware, in his nightstand drawer, and in his medicine cabinet.
-All of his medications, except his vitamins and over-the-counter medications, were refilled through the facility pharmacy.
-He let the staff know if he needed to reorder any of his medications.
-No staff at the facility asked if there were changes in his medications.
-He was unsure of how long he had been taking the Calcium, Centrum, and Vitamin E but it had been greater than 3 months.
-"I just take the medications that I am prescribed by my doctor".
-He did know not if he had ever been assessed by staff to see if he could self-administer his medications.

Review of the Self-Administration Medication Review Forms for Resident #1 revealed:
-The resident was assessed for medication self-administration on 9/13/17, 2/6/18, and 2/7/18
-There was a score of satisfactory beside each of the questions on the all forms for all assessment dates.
-There was no documentation that Resident #1 was assessed at least quarterly for continued self-administration of medications per the facility policy.
-There was no documentation that Resident #1's medications were counted weekly per facility policy.

Refer to interviews with two medication aides (MAs) on 2/5/18 at 5:00pm.

Refer to interview with a third MA on 2/6/18 at 10:50am.

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D 376	Continued From page 49 Refer to second interview with a MA on 2/7/18 at 8:40am. Refer to interview with the Assistant Resident Care Coordinator (ARCC) on 2/8/18 at 9:20am. Refer to interview with the Executive Director (ED) on 2/8/18 at 12:12pm. _____ Interview with a medication aide (MA) on 2/5/18 at 5:00pm revealed: -The facility had about 5 or 6 residents in the facility who self-administered their medications. -Any residents had to have an order to self-administer their medications from their physician. -The MAs did not monitor daily any residents who self-administered their medications to see if their medications were administered. -The MAs documented daily that these residents self-administered their medications on the electronic MAR. Interview with a second MA on 2/5/18 at 5:00pm revealed: -The medications aides checked about once a month with residents who self-administered their medications to see if any medications needed to be reordered. -The MAs were not sure how often residents were reassessed for competency to continue to self-administer their medications. -They did not know what the self-administration policy was specifically for the facility. Interview with a third MA on 2/6/18 at 10:50am revealed: -There were about 5 or 6 residents who self-administered medications in the facility.	D 376		

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D 376	Continued From page 50 -The MAs in the facility did not routinely monitor any of the residents who self-administered their own medications except about once a month to see if any medications needed to be reordered. -Most residents who self-administered their medications kept their room doors locked when they left the rooms except there were 1 or 2 residents who did not routinely lock their room doors who self-administered their medications. -She did not know what the facility's policy was on medication storage and residents who self-administered their medications. Interview with a MA on 2/7/18 at 8:40am revealed: -Residents who self-administer their medications are monitored once a month to check to see if any medications need to be reordered from the pharmacy. -The MAs do not count the narcotics or keep any control logs for residents who self-administer their medications. -All of the residents' rooms were equipped with locked storage boxes that could be used to lock up narcotics and store other medications. -There about 3 or 4 residents who self-administered who did not lock their room doors and their medications were kept at their bedside or out in the open on their countertops. Interview with the Assistant Resident Care Coordinator (ARCC) on 2/8/18 at 9:20am revealed: -The process for medication self-administration was that the Resident Care Coordinator (RCC) would perform a pre-assessment with the resident to assess if they were capable of performing self-administration. -The physician would write the order on the FL-2 or a separate order.	D 376		

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D 376	Continued From page 51 -The order should not be written on the care plan, there should be a separate order. -The resident should be able to name the medications and dosages and how to take them. -If the resident could not self-administer according to guidelines, then the physician and family would be notified. - A self-administration medication review is completed quarterly. -The staff would not check with the resident to see if the medications are taken according to schedule. -"I know the policy states to count the medications weekly, but we aren't and didn't know that until I just saw the policy today." -The staff would just check on the resident each day to see if they were "doing good". Interview with the Executive Director (ED) on 2/8/18 at 12:12pm revealed: -The RCC was responsible for monitoring the medication self-administration process. -The previous RCC quit without notice in September 2017, and the new RCC was out. -The new RCC came from the SCU and did not have residents who self-administered medications. -"We have not been following the self-administration of medication policy since the RCC quit back in September 2017." -She had the ARCC complete the current resident assessments on 2/6/18 and then the RN consultant completed the assessments again on 2/7/18 to "get caught up and to have them signed by an RN". _____ The facility's failure to assure compliance with their medication self-administration policy resulted in 2 residents being allowed to self-administer their own medications prior to the	D 376		

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D 376	Continued From page 52 facility obtaining orders from the physician, the omission of quarterly nursing re-assessments to evaluate the continued competency of 2 residents for the self-administration of medications, failed to assure 1 resident followed their facility's policy to ensure self-administered medications, including narcotics, 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 for 2/8/18 revealed: -Residents who self-administer medications will have documented competency to self-administer updated quarterly and as needed. -Our policy on self-administration of medications will be reviewed with med aides annually and as needed. -We will complete a review of all current self-administration residents including all medications they are taking including both prescription and over the counter and verify with their doctors quarterly and as needed. -Medication aides will be re-educated on increased awareness of medications residents may be taking or using on their own annually and as needed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 26, 2018.	D 376		
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	D912		

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	HAL028001	A. BUILDING: _____ B. WING _____	02/09/2018

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D912	Continued From page 53 regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, self-administration of medications, and medication aide training. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 1 sampled resident (Resident #8) who eloped from the Special Care Unit (SCU). [Refer to Tag D270, 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A2 Violation)] 2. Based on observations, record reviews, and interviews, the facility failed to assure compliance with the facility's policies and procedures for the self-administration of medications for 3 of 3 sampled residents (#1, #3, and #6). [Refer to Tag D376, 10A NCAC 13F .1005(b) Self-Administration of Medications (Type B Violation)] 3. Based on interviews and record reviews, the facility failed to ensure that 1 of 4 medication aides (Staff B) had completed the 15 hour state approved medication administration training courses and completed medication administration competency prior to performing unsupervised medication aide duties including administering insulin. [Refer to Tag D935, G.S. 131D-4.5B (b)	D912		

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D912	Continued From page 54 Medication Aide Training and Competency (Type B Violation)]	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide mandatory, annual state approved infection prevention training for 1 of 4 medication aides (B) sampled that had been employed for more than one year. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 11/30/16 as a Personal	D934		

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D934	Continued From page 55 Care Aide (PCA). -Staff B had passed the Medication Aide (MA) test on 6/9/17. -Staff B began working as a MA on 7/11/17. -There was no documentation Staff B had completed the mandatory state approved infection control training since she was hired on 11/30/16. Review of facility's medication administration records (MARs) revealed: -Staff B documented administering medications a total of 20 days from 12/1/17 through 2/8/18. -Staff B documented administering insulin to 2 residents on 1/21/18. Interview with the Business Office Manager (BOM) on 2/9/18 at 9:30am revealed: -Staff B started working at the facility on 11/30/16 as Personal Care Aide (PCA). -Staff B passed the Medication Aide exam on 6/9/17 but she did not starting administering medications at the facility until after 7/3/17. -"Staff B worked a 'casual' schedule at the facility, sometimes many days over a few months and then no days for the next few months because she was in nursing school". -"Staff B's nursing school schedule made it hard to get Staff B scheduled for the infection control training". -New staff usually received the infection control training within 3-6 months of their hire date. -"The next infection control training class was scheduled for April 2018 and the facility would try to arrange for Staff B to get the training then". -Staff B last worked as a MA on 2/7/18 at the facility. Interview with the Executive Director (ED) on 2/9/18 at 10:50am revealed she was not aware	D934		

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D934	Continued From page 56 Staff B had not completed annual infection control training and the ED would follow-up with the BOM to see what could be done. Interview with Staff B on 2/9/18 at 12:43 p.m. revealed: -Staff B had completed her Nurse Aide II (NA II) training and was a certified NA II. -Staff B had passed the required medication exam and she worked as a MA at the facility.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (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	D935		

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D935	Continued From page 57 individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure that 1 of 4 medication aides (Staff B) had completed the 15 hour state approved medication administration training courses and completed medication administration competency prior to performing unsupervised medication aide duties including administering insulin. The findings are: Review of a personnel record for Staff B on 2/8/18 revealed: -Staff B was hired on 11/30/16 as a Personal Care Aide (PCA). -Staff B had passed the Medication Aide test on 6/9/17. -Staff B began working as a MA on 7/11/17. -There was no documentation Staff B had	D935		

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D935	Continued From page 58 completed the 15 hour state approved medication administration course or had medication administration clinical skills checklist that validated her medication administration competency. Interview with the Business Office Manager (BOM) on 2/8/18 at 6:30pm revealed: -The copy of the 15 hour of medication administration course training and the medication clinical skills checklist was supposed to be in Staff B's personnel record. -She would have to try to find out why the information was not in Staff B's personnel record. Second interview with the BOM on 2/8/18 at 7:30pm revealed: -She has spoken with Staff B and Staff B had the documentation of completing her 15 hours medication administration training and her medication administration clinical skills checklist. -Staff B would drop off a copy of the information to the facility on her way home from school on 2/8/17. Third interview with the BOM on 2/8/18 at 9:20pm revealed: -Staff B did not have a copy of the information requested. -"Staff B was in nursing school and according to Staff B all of her medication administration training and skills competency was completed through her nursing school". -"Staff B had spoken (time not specified) with the state board of nursing and verified Staff B could use her nursing school courses as her medication administration training for the facility". -"Staff B would bring the medication administration information from the nursing board to the facility on 2/9/18".	D935		

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D935	Continued From page 59 Review of facility's medication administration records (MARs) revealed: -Staff B documented administering medications a total of 20 days from 12/1/17 through 2/8/18. -Staff B documented administering insulin to 2 residents on 1/21/18. Fourth interview with the BOM on 2/9/18 at 9:30am revealed: -Staff B had not brought in the requested information for the medication administration training. -Staff B was told by the state board of nursing she was approved to pass medications. -The BOM had called the state board of nursing on 2/9/18 and was waiting to see if the board of nursing could fax any supporting documentation for Staff B. -Staff B passed the Medication Aide exam on 6/9/17 but she did not starting administering medications at the facility until 7/3/17. -"Staff B worked a 'casual' schedule at the facility, sometimes many days over a few months and then no days for the next few months because she was in nursing school". -The process for validating medication aide training for new hires was that the BOM would print a copy of the certificate from the registry showing that the MA had passed the medication exam. -The BOM then confirmed the MA had completed the 15 hour medication administration training and scheduled the MA with the LHPS nurse who completed the medication skills checklist with the MA. -The BOM confirmed Staff B passed the medication exam, but did not confirm Staff B had completed the 15 hour medication administration training or the medication skills checklist because	D935		

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D935	Continued From page 60 Staff B said she was approved to pass medications by the state board of nursing. Interview with the Executive Director on 2/9/18 at 9:45am revealed: -She had already spoken with the BOM on 2/9/18. -"Staff B was supposed to have received the 15 hour state medication aide training through her nursing school program". -"Staff B only worked at the facility on a "casual" basis and was supposed to graduate from nursing school in August 2018 as licensed practical nurse (LPN). -She did not know Staff B had not completed her medication administration clinical skills checklist and she would follow-up on that. -She contacted her corporate office and corporate nurse on 2/9/18 to see what could be worked about Staff B and the medication administration training/checklist. -The BOM was waiting for the state board of nursing to call her back for the verification that Staff B had spoken about. Interview with Staff B on 2/9/2018 at 12:43 p.m. revealed: -Staff B had completed her Nurse Aide II (NA II) training and was a certified NA II. -Staff B had passed the required medication exam. -Staff B was told by the Board of Nursing that she had completed the required training to pass medications. -"I am approved through the accredited nursing program I am currently enrolled in." The facility failed to assure 1 of 4 medication aides had received proper medication administration training and skills validation prior to assuming unsupervised medication aide duties, including insulin administration, placed all	D935		

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D935	Continued From page 61 residents at the facility at risk of medication errors. The facility's failure to ensure medication aides are qualified to administer medications 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 for 2/9/18 revealed: -Staff B will not be able to pass medications until she has completed the required 15 hour medication administration training and completed the medication administration skills checklist for medication aides. -Any employee who administers medication will have documentation of completing the 15 hour medication aide training and successfully completed the medication administration skills checklist prior to administering medications. -Any employee who has not completed the 15 hour training and the medication administration skills checklist will be removed from the medication cart immediately. -All medication aides at the facility will have documentation of completing the 15 hour medication administration training and have successfully completed the medication administration skills checklist prior to administering medications. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 29, 2018.	D935		