STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL052007	A. BUILDING: _____ B. WING _____	C 03/06/2018

RECEIVED APR 27 2018 ADULT CARE LICENSURE SECTION RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA COTTAGE CARE BLDG #3	5643 HWY 70 DOVER, NC 28526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 2/28/18, 3/5/18 and 3/6/18.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to notify the Primary Care Provider (PCP) of acute health care concerns for 1 of 3 sampled residents (#3), related to Resident #3 having a spongy left heel that was a purple red color, a reddened area on the inner left knee, raw areas on skin folds bilaterally from the axilla area to the waist and an itchy rash on her entire back. The findings are: Review of Resident #3's current FL-2 dated 6/16/17 revealed diagnoses included Dementia, Seizures, Fever and Abdominal Pain, Hyponatremia, Hypoalbuminemia, Left Knee Pain, Hypomagnesemia and Hypokalemia. Review of Resident #3's current care plan dated 7/31/17 revealed Resident #3 was non-ambulatory and dependent on staff for assistance with toileting, bathing, transfers and ambulation. Interview with Resident #3 on 02/28/18 at 2:43	C 246	C 246: * All staff provided in service or notification of changes in patient status. Staff are to immediately contact Administrator or Nurse via phone, text or in person as soon as changes occur. Administrator/Nurse will confirm information as it is received. * Policy added to Policy/Procedure manual. * Based on assessment, consult or visit w/ PCP will be arranged if needed. * An intake note book will be available for Administrator/Nurse to record/document issues. * Physician notification/treatment will be charted in patient record. * Administrator or Nurse will interview daily residents, family or caregivers for concerns. * All shift documentation will be reviewed weekly by Admin. or Nurse * Any refusal of services	3/2/18

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/6/18

STATE FORM 6899 8TK211 If continuation sheet 1 of 20

Reviewed and accepted 15 May 2018 RN CONSULTANT

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C 246	Continued From page 1 p.m. revealed: -She had lived at the facility for 4 to 5 years. -She was not able to walk and that was one reason she no longer was able to live at her own home. -She had pain "every now and then" but her main complaints was her skin. -Her skin stayed dry and itched a lot. -She wore heel protectors all the time and was not sure why. -She did not have any sores on her body. Observation of Resident #3 on 02/28/18 at 2:43 p.m. revealed: -The resident was lying in bed. -The resident had cloth type padded heel protectors on both of her lower feet. -The resident's heels were not elevated and were in contact with the mattress. Observations on 3/6/18 at 9:35am of Resident #3's skin revealed: -The entire left heel was dark purple-red in color with a dime sized calloused area at the center of the heel. -The left heel area was spongy as the Medication Aide (MA) touched the area. (According to the National Pressure Ulcer Advisory Panel a spongy or boggy heel is suspect for deep tissue injury which is a type of pressure ulcer.) -There were skin folds approximately one to two inches in depth at her bilateral breast line, rib area, waist and front pelvic area that were dark pink, raw with a white substance and foul odor. -There was reddened area on Resident #3's left inner knee. -There were raised red patches from pea to nickel sized on her back from her shoulders to her sacral area.	C 246	will be documented in patient chart at time of occurance (cont.) 3/8/18 Administrator/Nurse will monitor effectiveness of system in place + review monthly (more frequently if deemed necessary) 3/15/18 C 246: Patient #3 was seen initially on 1/8/18 by PCP and complained on dry skin but no issue at that time. * PCP contacted regarding skin irritation to back, possible yeast under breast/skin folds 3/5/18 * Received Nystatin Cream from pharmacy (CPM) per new physician order; requested appropriate dose of PCP - initial 3/6/18 * Requested order for air mattress to PCP - 3/6/18 * Responded 3/8/18 Air mat added; appointment scheduled on ~~3/8~~ 3/14/18 w/ PCP for skin check 3/8/18 * Visit w/ PCP on 3/14/18 revealed NO ulcer foot or heel + NO issue related to foot/heel - He states to continue Nystatin cream 3/14/18	

Sherry Dyer Administrator 4/6/18

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C 246	Continued From page 2 Interview with the MA on 3/6/18 at 9:35am revealed: -She thought Resident #3's heels "looked good," she did not see any evidence of skin breakdown and had not reported any concerns for the resident's left heel to the facility nurse and/or Administrator. -Resident #3 wore heel booties for protection from skin breakdown everyday. -Resident #3 had the raw areas on her skin folds on and off since November 2017 when the MA started working at the facility. -The rash on the resident's back had been there since the MA returned from leave on 1/23/18. -Resident #3 asked staff for lotion for her back which her family member put on for her. -The lotion was for dry skin. -She did not think the resident had been seen by her Primary Care Provider (PCP) for her left heel, left inner thigh, the raw areas on her skin folds or the rash on her back since the MA had been back to work on 1/23/18. -There were no prescriptions creams, powders or lotions used for Resident #3, the staff just tried to keep the areas clean and dry. -Staff used a barrier cream on Resident #3's perinael area and buttocks at each incontinence change to prevent skin breakdown. Interview with Resident #3 on 3/6/18 at 9:35am and 5:15pm revealed: -She did not know her left heel was a purplish-red color and spongy because she could not see her heels. -She did not know she had a reddened area on her left inner knee because her legs were usually covered and staff bathed and dressed her. -The raw areas were sore, especially the one under her left breast area. -She did not know how long she had had the rash	C 246	added twice a day to rash; Complete skin check per PCP * Claiped cream to be applied to skin folds + back * added Benadryl 25 mg TID/prn/ itching * follow up in one month 5/5/18 w/ PCP	cnt. 3/19/18

Sherry Hyatt administrator 4/6/18

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C 246	Continued From page 3 on her back and her back was very itchy. -Lotion helped the itching and staff would put lotion for dry skin on her back. Interview with Resident #3's Power of Attorney (POA) on 3/6/18 at 12:04pm revealed: -The facility took Resident #3 to her doctor's appointments. -Resident #3 had issues with dry skin and had lotion in her closet for her dry skin. -He was not aware of any visits for Resident #3 to a doctor for her skin. Review of staff log note dated 2/22/18 (no time) revealed the Administrator documented "please keep the pads/covers under (Resident #'s name) straight - no wrinkles, need air to skin, prevent skin breakdown." Interview with the Administrator on 3/5/18 at 11:22am revealed: -She had written the note in an effort to prevent any skin breakdown. -The rash was an off an on thing since and she thought the rash might be related to medication changes. -The PCP had weaned Resident #3 off of Vimpat (used to treat seizures) and increased doses of Keppra (used to treat seizures) right around the time the rash had started (November 2017). -She was going to make sure Resident #3 was seen by the PCP for her skin issues. Review of a staff log note dated 3/1/18 from 7:00pm to 7:00am revealed staff documented Resident #3's "breakout looks horrible, regular lotions you just can't use." Review of staff log notes, physician's orders sheets and notes for Resident #3 dated 8/2/17	C 246	all page 2 + 3	

Sherry Gift administrator 4/6/18

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C 246	Continued From page 4 through 3/5/18 revealed there was no documentation the resident's Primary Care Provider was notified of Resident #3's spongy left heel, reddened left inner knee, areas of raw skin on her skin folds and rash to her back. Attempted interviews with Resident #1's Primary Care Provider (PCP) on 3/1/18 at 9:48am, 3/2/18 at 4:45pm and 3/6/18 at 12:08pm and 4:33pm were unsuccessful. Interview with the facility Licensed Practical Nurse (LPN) on 3/5/18 at 11:22am and 3/6/18 at 5:45pm (with the Administrator present) revealed: -She was not aware Resident #3 had a discolored spongy left heel, reddened left inner knee, and raw and foul smelling areas on her skin folds. -She did not regularly look at Resident #3's skin, but relied on staff to inform her if there were concerns. -Staff had not reported any concerns about Resident #3's skin to her. -Staff were expected to call the Administrator for any change in a resident's condition and she and the Administrator would come to the facility to assess the resident. -She rounded daily at the facility for staff to be able to inform her of any resident concerns such as the condition of Resident #3's skin. -The last time she had taken Resident #3 to a doctor's appointment, the resident only had dry skin issues. -The red patches on Resident #3's back would appear, disappear and then reappear again, but it had not been as bad as it was on 3/6/18. -It seemed the rash started when Resident #3 had some medication changes (November 2017). -She could not remember if Resident #3's PCP had been notified about the rash. -She would normally contact the PCP and get an	C 246	C 246: on pg 2+3	

Sherry Gipp administrator 9/6/18

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C 246	Continued From page 5 order or schedule an appointment for any resident concerns reported by staff. -If the concern was acute, she would call 911 and send the resident to the emergency room. -She kept her own notes of when she contacted a resident's PCP, but she did not document notes in the resident's record. -She did not have her notes available for review. -The PCP's office would have a record of when she contacted the PCP regarding a resident. -She had contacted Resident #3's PCP on 3/6/18 after she and the Administrator checked Resident #3's left heel, left inner knee, skin folds and back on 3/6/18. Review of a Physician's Order sheet dated 3/6/18 for Resident #3 revealed there was an order for Nystatin topical cream to affected areas three times daily for rash and skin irritation signed by the PCP. (Nystatin is an antifungal used to treat fungal infections.) The facility's failure to notify Resident #3's Primary Care Provider (PCP) for a spongy left heel that was a purple red color as well as multiple areas of skin irritation and breakdown present since November 2017, placing the resident at increased risk for infection and decubitus ulcers which was detrimental to the health, safety and wellbeing of Resident #3 and constitutes a Type B Violation. The Plan of Protection submitted by the facility on 3/6/18 revealed: -Staff are to notify the Administrator and/or nurse immediately of resident health care issues. -Resident health care issues will be noted in the resident's chart if there is a need to consult with the Primary Care Provider (PCP) and if the PCP's office is notified.	C 246	C 246 C 246 completed 3/5/18 thru 3/14/18	3/14/18

Sherry Hoyle Administrator 4/6/18

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C 246	Continued From page 6 -Staff were advised on 3/2/18 to contact the Administrator and/or nurse via telephone and voice mail if no answer. -The Administrator and/or nurse will provide a follow up call (to staff) to ensure correct exchange of information. -An intake/call notebook will be available for the Administrator and/or nurse to record all calls regarding residents' status or changes. -PCP notification notes and/or treatment notes will be documented in the resident's chart by the Administrator and/or nurse. -The Administrator and/or nurse will continue a daily walk through and calls to staff. -The Administrator and/or nurse will review staff shift notes weekly. -The Administrator and/or nurse will document any resident refusal of services. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2018.	C 246	C246: all systems stated in left column are in placed - Daily walk thru on Mons or calls daily - - Monthly review of service delivery to be reviewed by Administrator/ Nurse C 246 corrected! C246: PCP visit completed in Patient #3 - no issue related to foot/ nail per PCP	3/9/18 3/15/18 3/16/18 3/14/18
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer two eye	C 330		

Sherry Hyp Administrator 4/6/18

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C 330	Continued From page 7 drops as ordered for 1 of 3 residents (#2). The findings are: Review of Resident #2's current FL-2 dated 6/1/17 revealed: -Diagnoses included Altered Mental Status, Dementia and Hypertension. -Medication orders included Maxitrol eye drops two drops four times daily and Altachlore one drop four times daily. (Maxitrol is used to treat swelling of the eye and prevent infection; Altachlore is used to treat corneal edema.) 1. Review of Resident #2's December 2017, January, February and March 2018 Medication Administration Records (MARs) revealed: -There was a preprinted entry for Maxitrol 0.1% two drops in each eye four times daily. -Staff documented the Maxitrol was administered four times daily at 8:00am, 12:00pm, 4:00pm and 8:00pm from 12/1/17 through 3/5/18. Observation of medications on hand for Resident #2 on 3/6/18 at 9:10am revealed there was a 7.5ml bottle of Maxitrol eye drops approximately one half full with a pharmacy label which had Resident #2's name and indicated the bottle was dispensed on 5/26. (The year of the dispense date was not legible.) Interview with the Administrator on 3/6/18 at 9:10am revealed she was not sure the dispense date on Resident #2's Maxitrol bottle was accurate because she was certain Medication Aides (MAs) administered the eye drops as ordered by the doctor. Telephone interview with the Pharmacist on 3/6/18 at 9:17am revealed:	C 330 C 330-	C330: Consult w/ PCP regarding change in patient status + gradual decline. BOM eye drops were discontinued on 3/19/18. Due to patient being now total bed patient, PCP sees her "as needed" + at least annually. Annual visit is scheduled for 4/12/18	3/19/18

Sherry Hoff administrator 4/6/18

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C 330	Continued From page 8 -The current prescription order dated 5/3/17 for Resident #1's Maxitrol was for two drops in each eye four times daily. -Maxitrol was last dispensed on 5/5/17 and it was difficult to say how long one bottle would last. -Maxitrol was used to treat inflammation and infection in the eye. As a general rule there are 20 drops per one ml. A Maxitrol 7.5ml bottle equals 150 drops and two drops in each eye (four drops each dose) four times per day (16 drops per day) would have been a nine day supply. Review of pharmacy orders and dispensing records for Resident #2 revealed -There was a copy of an FL-2 dated 5/3/17 for Resident #2 with an order for Maxitrol two drops four times daily. -There was a notation by the pharmacist that Maxitrol was last dispensed on 5/5/17 for Resident #2. Telephone interview with Resident #2's PCP's Medical Assistant on 3/6/18 at 4:33pm revealed hospital discharge instructions dated 6/16/17 had the most recent order for Maxitrol two drops four times daily. 2. Review of Resident #2's December 2017, January, February and March 2018 MARs revealed: -There was a preprinted entry for Altachlore 5% two drops in each eye twice daily. -Staff documented the Altachlore was administered twice daily at 8:00am and 4:00pm from 12/1/17 through 3/5/18. Observation of medications on hand for Resident #2 on 3/6/18 at 9:10am revealed there was a	C 330		

Sherry Hyatt Administrator 4/6/18

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C 330	Continued From page 9 15ml bottle of Altachlore eye drops that was nearly full with a pharmacy label which had Resident #2's name and indicated the bottle was dispensed on 11/17/17. Interview with the Administrator on 3/6/18 at 9:10am revealed she was not sure the dispense date on Resident #2's Altachlore bottle was accurate because she was certain MAs administered the eye drops as ordered by the doctor. Telephone interview with the Pharmacist on 3/6/18 at 9:17am revealed: -The current prescription order dated 5/8/17 for Resident #1's Altachlore was for two drops in each eye twice daily. -Altachlore was last dispensed on 11/17/17 and it was difficult to say how long one bottle would last. -Altachlore was used to treat corneal edema by decreasing fluid pressure in the eye. As a general rule there are 20 drops per one ml. An Altachlore 15ml bottle equals 300 drops and two drops in each eye (four drops each dose) two times per day (8 drops per day) would have been a 37 day supply. Review of pharmacy orders and dispensing records for Resident #2 revealed -There was a copy of a Primary Care Provider (PCP) prescription order dated 5/8/17 for Resident #2 with an order for Altachlore use as directed. -There was a notation by the pharmacist that Altachlore was last dispensed on 11/17/17 for Resident #2. Telephone interview with Resident #2's PCP's Medical Assistant on 3/6/18 at 4:33pm revealed	C 330		

Stacy Lipp Administrator 4/6/18 4/6/18

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C 330	Continued From page 10 the eye drops were originally ordered by the eye doctor in 2011, but hospital discharge instructions dated 6/16/17 had the most recent order for Altachlore two drops four times daily. Interview with a MA on 3/6/18 at 2:50pm revealed: -Resident #2 was supposed to receive both of her eye drops (Altachlore and Maxitrol) four times daily and that was how she administered the eye drops. -She did not know about the orders because the MAs did not handle physician's orders, the facility nurse and/or Administrator took care of the orders.	C 330		
	Interview with the facility nurse on 3/5/18 at 11:22am revealed: -She observed staff administering medications to residents randomly throughout the week while she was in the facility. -She observed to assure staff prepared medications properly, administered medications to residents, observed residents take medications and documented medications administered on the MAR. -She and the Administrator were responsible for reviewing, faxing, transcribing and implementing PCP orders for the residents. -She and the Administrator were responsible for contacting the PCP if FL-2's or PCP orders were unclear or incomplete. -She kept her own notes of when she contacted a resident's PCP, but there were no notes documented in the resident's record. -Her notes were not available for review. -The PCP's office would have a record of when she contacted the PCP regarding a resident. -She and the Administrator reviewed the medication and the order whenever a new	C 330 C 330	C 330: Med pass observations to occur weekly by nurse or Administrator C 330 - new FL-2 on patient #2 obtained * MAR reviewed for accuracy	3/15/18 ~~3/15/18~~ 4/3/18 4/3/18 4/3/18

Sherry Gift Administrator 4/6/18

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C 330	Continued From page 11 medication was delivered. -She and the Administrator were responsible for checking MARs for accuracy every month and whenever there were new orders. -She and the Administrator were at the facility every week to check medications and MARs. Interview with the Administrator on 3/2/18 at 5:20pm revealed staff were expected to triple check the medication bubble pack against the MAR before they punched the medication out of the bubble, punch the dose, administer the medication and then document on the MAR after observing the resident take the medication. Based on observations, interviews and record reviews, Resident #2 was not interviewable. Attempted interviews with Resident #2's Primary Care Provider (PCP) on 3/1/18 at 9:48am, 3/2/18 at 4:45pm and 3/6/18 at 12:08pm and 4:33pm were unsuccessful.	C 330	C 330: C 330 * Staff were in-serviced on medication Administration 3/1/18 * Notify Administrator/Nurse when meds need to be refilled or new order is needed. 3/2/18 * Administrator/Nurse to check med cart + meds on hand weekly 3/8/18 3/8/18	
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have a readily retrievable record of a controlled drug (Ativan) used to treat anxiety and agitation for 1 of 3	C 367	C367: C 367 All staff in serviced/ Trained on Control count + documentation on control sheet. 3/9/18 Control sheet count for incoming/outgoing staff developed 3/9/18	

Sherry Gipp Administrator 4/6/18

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	FCL052007	A. BUILDING: _____ B. WING _____	C 03/06/2018

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C 367	Continued From page 12 sampled residents (#3). The findings are: Confidential interview with a staff revealed: -Things were not right at the facility, especially with medications. -Residents were given as needed controlled drugs when they did not need the medication. -The Administrator had instructed staff to give certain residents as needed controlled drugs to keep the resident from getting up and going to the door all the time. Review of Resident #3's current FL-2 dated 6/16/17 revealed: -Diagnoses included Dementia, Seizures, Fever and Abdominal Pain, Hyponatremia, Hypoalbuminemia, Left Knee Pain, Hypomagnesemia and Hypokalemia. -Medication orders included Ativan 0.5mg every six hours as needed (PRN) for agitation. (Ativan is a Benzodiazepine use to treat anxiety and agitation.) Review of prescription renewal orders from the pharmacy for Resident #3 revealed there were orders for Ativan 0.5mg twice daily (60 tablets) and every six hours PRN for agitation (30 tablets), dispense as 90 tablets (total) and with two refills available on 12/6/16, 3/24/17, 9/14/17 and 11/14/17. Review of Resident #3's pharmacy dispensing record revealed Ativan 0.5mg every six hours PRN was dispensed on 12/15/16 for 30 tablets, on 3/27/17 for 30 tablets, on 9/14/17 for 30 tablets and 11/15/17 for 30 tablets. Review of Resident #3's December 2017 MAR	C 367	C 367 C 367: A comprehensive monthly tabbed notebook has been developed to keep documented receipt of all control sheets, MAR's, + a Pharmacy delivery book to show delivery + removal of all medications and/or controls — 3/9/18 * Policy revision made to ensure proper receipt of all materials — 3/9/18	cwm 4/6 3/9/18

Sherry Cope Administrator 4/6/18

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C 367	Continued From page 13 revealed: -There was a preprinted entry for Ativan 0.5mg four times daily PRN agitation. -Staff documented Resident #3's Ativan was administered on nine occasions between 12/1/17 and 12/31/17. Review of Resident #3's January 2018 MAR revealed: -There was a preprinted entry for Ativan 0.5mg four times daily PRN agitation. -Staff documented Resident #3's Ativan was administered on two occasions between 1/1/18 and 1/31/18. Review of Resident #3's February and March 2018 MAR revealed there was a preprinted entry for Ativan 0.5mg four times daily PRN agitation and there were no doses documented as administered. Review of a controlled drug record dated 12/7/16 for Resident #3 revealed: -There was a pharmacy label on the controlled drug record with Resident #3's name and instructions for Ativan 0.5mg every six hours PRN. -The pharmacy label indicated 60 tablets were dispensed on 12/7/16. -Staff documented 46 tablets were accounted for from 2/24/17 at 1:30pm through 1/10/17 at 9:00am leaving 14 tablets unaccounted for. Upon request on 3/5/18 and 3/6/18, there was no controlled drug record dated 12/15/16 for 30 tablets of Ativan 0.5mg for Resident #3. Interview with a Medication Aide (MA) on 3/6/18 at 7:20pm revealed: -When she administered controlled drugs to	C 367 C367-	The new system in place allows for easy retrivable records + accurate reconciliation Control Sheet Daily Count for AM/PM staff established (morning/oncoming staff to sign) All med carts have been checked for accuracy on labels, all items expired were removed. Staff trained/inserviced on appropriate way to waste/destroy meds/ ~~Controlled~~ Controls that are dropped. Pharmacy contacted on 3/8/18. They recommend an agent called "Drug Buster" Destroyer add to carts for disposal. All carts have "Drug Destroyer" bottle for disposal of meds dropped ~~that~~ or wasted	3/9/18 3/9/18 3/20/18 3/9/18 3/9/18

Shelly [illegible] administrator
4/6/18

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C 367	Continued From page 14 residents, she first checked the MAR to make sure she had the right resident and the right medication. -She would then administer the medication, sign the MAR and sign the controlled drug record. -Controlled drug counts were done at the end of the shift and in the morning by looking at the controlled drug bubble packs and the controlled drug sheets. -The outgoing MA usually wrote on a sticky note that the controlled drug count was done and the MA coming on duty would check behind the outgoing MA. -The completed controlled drug records were kept in the MARs book until the Administrator took the sheet out of the book. -Any remaining tablets were taken care of by the Administrator, the MA did not have anything to do with returns to the pharmacy. Interview with the Administrator on 3/6/18 at 6:40pm revealed: -She did not know why there would have been 14 tablets remaining on the controlled drug record dated 12/7/16. -Usually, the controlled drug records balanced out. -The 14 tablets might have been expired and returned to the pharmacy. Telephone interview with a Pharmacist on 3/6/18 at 11:55am revealed: -He could not say why the control sheet was dated 12/7/16 and the dispense date was 12/15/16. -It may have to do with billing and delivery dates. Telephone interview with a second Pharmacist on 3/6/18 at 2:30pm revealed: -There was no record of returns of Ativan tablets	C 367	see page 13, 14 - new system in place for Reconciliation of controls 3/9/18 C367 Staff have daily AM/PM control count sheet 3/9/18 C367: Weekly Control Sheets checked by Administrator/Nurse - Kept in notebook upon monthly completion 3/9/18	

Sherry Dyl — Administrator
4/6/18

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C 367	Continued From page 15 for Resident #3. -If the facility had completed a duplicate return sheet, there should have been a copy at the facility. Review of a controlled drug record dated 9/14/17 for Resident #3 revealed: -There was a pharmacy label on the controlled drug record with Resident #3's name and instructions for Ativan 0.5mg every six hours PRN. -The pharmacy label indicated 30 tablets were dispensed on 9/14/17 and the remaining count was 30 tablets. Observation of medications on hand for Resident #3 on 3/6/18 at 2:35pm revealed: -There was a bubble pack with a pharmacy label that had Resident #3's name and instructions for Ativan 0.5mg every six hours PRN for agitation. -The pharmacy label indicated 30 tablets were dispensed on 9/14/17 and 30 tablets remained. Based on review of Resident #3's December 2017 and January through March 2018 MARs, the controlled drug record dated 12/7/16 and pharmacy dispensing records, there were 14 tablets dispensed on 12/7/16, 30 tablets dispensed on 12/15/16, 30 tablets dispensed on 3/27/17 and 30 tablets dispensed on 11/15/17 that were not accounted for. Interview with Resident #3 on 3/6/18 at 5:15pm revealed she did not know what Ativan was or if she was supposed to be taking Ativan, she just took the medications the staff gave to her. Interview with the Administrator on 3/6/18 at 11:51am and 1:45pm revealed: -MARs and controlled drug sheets prior to	C 367	C367 C367: Notebook w/ all delivery + returns developed to read all copies	3/9/18

Administrator 4/6/18

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C 367	Continued From page 16 December 2017 had been shredded, the facility only maintain three months of MARs and controlled drug records. -She did not know the facility was to maintain controlled drug records for a minimum of three years. -There had been returns of controlled drugs to the pharmacy whenever a resident died or was discharged. -She did not have a record of any returns for Resident #3's PRN Ativan. Attempted interviews with Resident #3's Primary Care Provider (PCP) on 3/1/18 at 9:48am, 3/2/18 at 4:45pm and 3/6/18 at 12:08pm and 4:33pm were unsuccessful.	C 367	Annual records now in place, tabbed w/ monthly divider maintained by Administrn. Nurse/Administrn pull monthly MAR/Control sheets & place in binder - end of each month after last MAR documentation for the month	3/9/18
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services of an accident/incident for 1 of 1 resident (#1) sampled that required referral for emergency evaluation for a fall.	C 444 C 444!	C444: a form is now in place to send to DSS in event of accident/injury resulting in emergency evaluation/ treatment. Confirmed that form is appropriate to send (NO standard form on-line available) the form includes: Date/Time of AI; Report filed date; Person completing form	3/15/18

Sherry Ogg — administrator
9/6/18

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C 444	Continued From page 17 The findings are: Review of a Resident #1's current FL-2 dated 01/25/18 revealed: -Diagnoses included dementia, hypertension, hypersensitivity lung disease, insomnia, and atrial fibrillation. -The resident was ambulatory with the use of a walker. Review of a facilty form labeled for orders revealed there was an entry for Resident #1 dated 02/11/18 with a handwritten entry signed by the Administrator "Transported and admitted to hospital". -The form was not signed by the resident's physician. Interview with the Administrator on 03/06/18 at 10:55 a.m. revealed: -Resident #1 had a walker and often needed reminders to use her walker. -Resident #1's family had visited her on 02/11/18. -Resident #1 and her family member walked to the facility's sister home to visit Resident #1's family member. -Resident #1's family member left, however, the resident wanted to stay at the home longer and visit with her family member. -Resident #1 got up from a seated position and walked over to assist another resident without her walker and fell. -The Administrator called 911 to have Resident #1 transported to the hospital and notified the resident's family. -The resident had fractured "the head of her femur or joint itself". -The resident underwent surgery and was currently in a rehabilitation center. -There was no additional documentation related	C 444 C444	- description of A/I; degree of A/I; plan of treatment - Signature of administrator/ Nurse / SIC - File Kept in Administrator file - Nurse note / progress note in chart to add additional notes	cont. 3/15/18 3/15/18

Administrator 4/6/18

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C 444	Continued From page 18 to Resident #1's fall. -She did not do an incident and accident report. Telephone interview with the local adult home specialist on 03/06/18 at 12:59 p.m. revealed: -She had been in her position since December 2017. -She had not received any incident or accident reports. -She was not aware that Resident #1 had fallen on 02/11/18. Interview with Resident #1's health care power of attorney (HCPOA) on 03/06/18 at 11:04 a.m. revealed: -She and another family member had visited Resident #1 on 02/11/18 and went over to the sister facility with the resident to visit another family member. -The resident requested to stay longer at the sister facility to visit after the HCPOA and the other family member left. -The HCPOA was contacted by the Administrator shortly after the HCPOA and the other family member left the facility and was told the resident had fallen. -The HCPOA was told that the resident stood up without her walker attempting to help another resident and fell. -The resident suffered a right hip fracture. -The HCPOA knew of one previous fall prior to 02/11/18, however, the resident was not injured and did not require any medical evaluation. A second interview with the Administrator on 03/06/18 at 5:40 p.m. revealed: -She was not sure "what qualified" for reporting accidents and was not sure what the process was for reporting incidents and accidents. -There were "few falls" and falls were "not a big	C 444	C444: C444: Form is placed and has been utilized sent as Accident/Injury occurs to DSS. Maintained in Administrator file	3/15/18

Shirley Gp Administrator 4/6/18

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C 444	Continued From page 19 issue" at the facility that required medical attention.	C 444		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, 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 related to health care. The findings are: Based on observations, interviews and record reviews, the facility failed to notify the Primary Care Provider (PCP) of acute health care concerns for 1 of 3 sampled residents (#3), related to Resident #3 having a spongy left heel that was a purple red color, a reddened area on the inner left knee, raw areas on skin folds bilaterally from the axilla area to the waist and an itchy rash on her entire back. [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]	C 912 C 912	C 912: (reference C 246) p. 1, 2, 3, 6, 7, Follow up appointment + consults were completed for patient # 3. PCP did not see any issues related to heel/foot " stated "NO ulcers", additionally, creams + medication was ordered for rash itching, Air mattress also provided. - "stretchy" fabric ordered to place in folds to reduce moisture	3/14/18 4/5/18

Shirley Hayes Administrator 4/6/18