STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034019	A. BUILDING: _____ B. WING _____	06/11/2018

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C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on June 6-8, 2018, and June 11, 2018.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure walls, ceilings, and floor coverings were kept clean and in good repair regarding missing tiles at the bottom of the wall and floor in 1 of 4 common bathrooms; shower walls with holes in 1 of 4 common bathrooms; blistered, cracked and peeling walls around the shower unit in 1 of 4 common bathrooms; and a peeling ceiling area in the common dining room. The findings are: Observations of 1 of 4 common bathrooms during the tour on 06/06/18 at 9:57 am revealed: -The shower had 3 walls which was formed and in one piece. -When facing the shower unit, the left wall of the shower had 6 holes at the bottom approximately ½ inch in diameter scattered about with multiple small holes and cracks.	D 074		

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D 074	Continued From page 1 -Each of the 3 walls of the shower unit had previously been patched. -The left side shower wall was attached to a supporting wall that was 6 inches thick. -There were 2 tiles missing from an 8 inch tall by 4 inch wide area missing from the bottom of the wall where it joins the floor at the shower. -Above the missing tile area was a 4 inch by 4 inch tile which was cracked from top to bottom and the top right corner of that tile was missing. -Grout was missing from around the tiles and some other chips were missing from the tile on the side. -The area missing the tile had a depth to it with multiple cracks and looked like some of the underlying wall structure was missing. -The wall, just above the back wall of the shower unit, was bubbled up and peeling. -The wall, just above the right shower wall, was bubbled, peeling and swelled from water damage. Observations of the common dining room during the tour on 06/06/18 at 10:28 am revealed: -The ceiling to the dining room was coated with a popcorn texture. -Some of the popcorn coating had peeled. -The peeled area was approximately 18 inches by 24 inches. Review of the sanitation report dated 11/22/17 revealed: -The sanitation score was 91. -The shower walls and the walls around the shower needed to be repaired. -The ceiling in the dining room needed to be repaired from a previous leak in the roof that had been repaired. Interview with the Maintenance Supervisor (MS) on 06/07/18 revealed:	D 074		

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D 074	Continued From page 2	D 074		

-The Administrator had reported the missing tile, in the common bathroom, to him "last Wednesday".
-He thought the tiles were replaced on 06/06/18 because he had left instructions for the work to be completed by his staff.
-The tile work had not been completed because a different glue was needed to keep the tile adhered to the wall.
-The Administrative Assistant (AA) was responsible for purchasing the glue.
-He had not looked for a different type of glue because the AA was looking for some glue.

Interview with the AA on 06/07/18 at 12:06 pm revealed:
-He was aware the shower wall was missing tile and the walls above the shower were damaged.
-"It just happened about a day or two ago".
-He was aware the dining room ceiling was peeling off.
-Maintenance was responsible completing the repairs.
-The damage was not reported by anyone; maintenance noticed it on his rounds.
-The shower tiles had been broken in the past, about 9 months ago, by wheelchairs hitting the wall.
-Expectations was that if someone saw or broke anything, they report it.
-There were not any policies to refer to.
-There were not any written work orders, just verbal ones.
-Repairs were usually completed the same day when reported or found.
-Repairs of the shower tiles had not been completed because they were looking for a different glue.

Interview with the Administrator on 06/07/18 at

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D 074	Continued From page 3 12:02 pm revealed: -She did not know when the bathroom shower tile had been broken. -She saw the broken areas last week. -She reported the damage to the MS but he was already aware of it. -She is ultimately responsible for making sure the repairs were completed and that the facility followed all state regulations.	D 074		
D 093	10A NCAC 13F .0306(b)(8) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading. This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure there was a light overhead of the bed with a switch within reach of residents lying in bed or a bedside lamp for 7 of 20 residents' rooms (Rooms #105, #112, #116, #117, #118, #136, and #139). The findings are: 1. Observations of the right side of the facility on 06/06/18 between 10:00 am and 11:00 am revealed 4 resident rooms with 1 or no lamps (Rooms #112, #116, #117, and #118) and each	D 093		

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D 093	Continued From page 4	D 093		

resident room had a light switch next to the door of the room to turn on and off the ceiling light were as follows:

a. Resident room #112 was occupied by 2 residents.
-No lamps were observed in the room for the residents to use when in the bed.
-Neither bed was within reach of the overhead light switch.

Refer to interview with Administrative Assistant (AA) on 06/08/18 at 11:12 am.

Refer to interview with Administrator on 06/08/18 at 11:36 am.

b. Resident room #116 was occupied by 2 residents.
-No lamps were observed in the room for the residents to use when in the bed.
-Neither bed was within reach of the overhead light switch.

Based on observations and attempted interviews on 06/11/18 at 3:05 pm, it was determined the residents in the room were not interviewable.

Refer to interview with Administrative Assistant (AA) on 06/08/18 at 11:12 am.

Refer to interview with Administrator on 06/08/18 at 11:36 am.

c. Resident room #117 was occupied by 1 resident.
-No lamp was observed in the room for the resident to use when in the bed.
-The resident's bed was not within reach of the overhead light switch.

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D 093	Continued From page 5 Interview with a resident that resided in room #117 on 06/11/18 at 3:00 pm revealed: -She would like to have a lamp. -She had never asked for a lamp. -She likes to read and do puzzles. Refer to interview with Administrative Assistant (AA) on 06/08/18 at 11:12 am. Refer to interview with Administrator on 06/08/18 at 11:36 am. d. Resident room #118 was occupied by 2 residents. -There were no lamps observed in the room for the residents to use when in bed. -Neither bed was within reach of the overhead light switch. Interview with a resident that resided in room #118 on 06/11/18 at 3:05 pm revealed: -She would like to have a lamp. -She has never had a lamp in her room. -She did not know she could ask for a lamp. Refer to interview with Administrative Assistant (AA) on 06/08/18 at 11:12 am. Refer to interview with Administrator on 06/08/18 at 11:36 am. 2. Observations of the left side of the facility on 06/06/18 between 10:10 am and 10:18 am revealed 3 resident room with 1 or no lamps (room # 105, #136, and #139) and each resident's room had a light switch next to the door of the room to turn on and off the ceiling light. a. Observation of resident room #105 on	D 093		

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06/06/18 at 10:10 am revealed:
-There were two residents who resided in the room.
-There was one lamp on a nightstand that was not located in the center of the two beds.
-The lamp was on a nightstand that was located near one resident's bed.
-Neither bed was within reach of the overhead light switch.

Refer to interview with Administrative Assistant (AA) on 06/08/18 at 11:12 am.

Refer to interview with Administrator on 06/08/18 at 11:36 am.

b. Observation of resident room #136 on 06/06/18 at 10:17 am revealed:
-There was one resident who resided in this room.
-There were no lamps in this room.
-Neither bed was within reach of the overhead light switch.

Refer to interview with Administrative Assistant (AA) on 06/08/18 at 11:12 am.

Refer to interview with Administrator on 06/08/18 at 11:36 am.

c. Observation of resident room #139 on 06/06/18 at 10:18 am revealed:
-There were two residents who resided in the room.
-There was on lamp on a nightstand that was located near one resident's bed.
-Neither bed was within reach of the overhead light switch.

Refer to interview with Administrative Assistant

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D 093	Continued From page 7 (AA) on 06/08/18 at 11:12 am. Refer to interview with Administrator on 06/08/18 at 11:36 am. Interview with the Administrative Assistant on 06/08/11 at 11:12 am revealed: -He was aware that each resident was supposed to have a bedside lamp if the overhead light switch was not within reach. -Lamps were purchased for each resident in the past. -Some resident's had broken their lamps but he did not know what happened to the other lamps that were missing. -He wished the resident would have to pay for their own lamp. -It was not economically feasible to have to continue to purchase lamps for each resident. -He had researched various types of lamps for the residents rooms but had not found anything that would have worked. -He was responsible for purchasing the lamps for each resident. -It would not have done the facility any good to have replaced the lamps. -He "guessed" it would be best for each resident to have had their own lamp. Interview with the Administrator on 06/08/18 at 11:36 am revealed: -She was aware that each resident was supposed to have a bedside lamp if the overhead light switch was not within reach. -She was aware that some residents were missing lamps. -Some residents had broken their lamps but she did not know how. -She was responsible for making sure the facility followed state regulations.	D 093		

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D 093	Continued From page 8 -She did not have a reason as to why the lamps had not been replaced.	D 093		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure heat/air conditioning (AC) units had knobs for controlling the temperature coming from the unit for 3 of 20 resident rooms (Room #119, #120, and #140). The findings are: Observations during the initial tour of the facility on 06/06/18 from 10:00 am to 11:00 am revealed the heat/AC unit in the following resident rooms were missing control knobs: 1. Resident room #119: The heat/AC unit was an individual unit mounted to the wall. -The unit was not on as observed from no sounds or breezes coming from the unit. -There was no knob to control the temperature or the air flow. -There was a slender dark grey piece of metal sticking up from the place where the control knob should have been located. -There was no way for the resident residing in the room to determine the temperature setting of the unit or to adjust the temperature setting to their comfort level.	D 105		

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D 105	Continued From page 9 Interview on 06/11/18 at 10:42 am with the resident in room #119 revealed: -The resident did not know what happened to the control knobs on the heat/AC units. -She was unable to maneuver the controls on the unit without staff assistance. -Staff used a pair of pliers to turn the dark grey piece of metal sticking up, to adjust the temperature and air flow of the unit. 2. Resident room #120: The heat/AC unit was an individual unit mounted to the wall. -The unit was not on as observed from no sounds or breezes coming from the unit. -There was no knob to control the temperature setting. -There was a slender dark grey piece of metal sticking up from the place where the control knob should have been located. -There was no way for the resident residing in the room to determine the temperature setting of the unit or to adjust the temperature setting to their comfort level. Based on observations and attempted interviews on 06/11/18 at 10:48 am, it was determined the residents in the room were not interviewable. Refer to interview on 06/08/18 at 11:12 am with the Administrative Assistant (AA). Refer to interview on 06/08/18 at 12:12 pm with the Maintenance Supervisor (MS). Refer to interview on 06/08/18 at 11:36 am with the Administrator. 3. Observation of the air conditioning unit attached to the wall in room #140 on 06/06/18	D 105		

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D 105	Continued From page 10 10:15 am revealed: -The air conditioning unit was missing two knobs. -The two areas on the air conditioning unit with missing knobs were to control the temperature of the air and the air flow. Interview with the resident in room #140 on 06/11/18 at 2:46 pm revealed: -The resident resided in the facility for two years. -The resident stayed in the same room during the past two years. -The air conditioning unit never had knobs on it to adjust the temperature or air flow. -The resident had to find the maintenance staff in order to have the temperature or air flow adjusted. -The resident often went to a day program and returned tired and warm. -The resident did not request a temperature adjustment because of fatigue and just wanted to sleep. -The resident just dealt with the room temperature being set at an uncomfortable temperature after he attended the day program. -The maintenance staff used pliers to adjust the air conditioning unit. Refer to interview on 06/08/18 at 11:12 am with the Administrative Assistant (AA). Refer to interview on 06/08/18 at 12:12 pm with the Maintenance Supervisor (MS). Refer to interview on 06/08/18 at 11:36 am with the Administrator. _____ Interview on 06/08/18 at 11:12 am with the Administrative Assistant (AA) revealed: -He knew there were some knobs missing but had not looked to see which rooms was missing	D 105		

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D 105	Continued From page 11 knobs. -The facility replaced all the knobs in 2016. -"I had to go to Pluto to get those knobs." -Maintenance was responsible for ensuring the knobs were on the heat/air units. Interview on 06/08/18 at 12:12 pm with the Maintenance Supervisor (MS) revealed: -He was responsible for ensuring the heat/ac units was in proper working order. -He was aware pliers were used to adjust the heat/ac units because knobs were missing. -It was very hard to find replacement knobs. -The AA was responsible for purchasing replacement knobs. Interview on 06/08/18 at 11:36 am with the Administrator revealed: -The facility replaced all the control knobs on the heat/ac units in 2016. -She was aware some units were still missing control knobs -She did not know what happened to the missing knobs other than that some were "stripped". -No resident had requested replacement knobs. -The AA was responsible for purchasing replacement knobs.	D 105		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff	D 139		

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D 139	Continued From page 12 C) had a criminal background check completed in accordance with G.S. 114-19-10 and 131D-40. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 06/21/11. -There was no documentation of a criminal background check in the record. -There was documentation of a consent for a criminal background check signed on 06/21/11 by Staff C. Interview with Staff C on 06/11/18 at 10:30 A.M. revealed: -She was hired as a PCA. -She recalled a criminal background check was completed in 1977 when she was first hired by the facility. -She had left employment at the facility several times and returned. -She did not recall signing a consent for criminal background check in 2011. -She did not recall a criminal background check being completed in 2011. Interview with Administrator on 06/11/18 at 3:54 pm revealed: -Staff C had worked for the facility on and off for years. -She was not able to locate a criminal background check for Staff C. -She was responsible for hiring staff for the facility. -She was responsible for the paperwork completed upon hire.	D 139		

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D 161	Continued From page 13	D 161		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 2 of 3 sampled staff members [Staff A, medication aide (MA) and Staff C, personal care aide (PCA)] were competency validated for Licensed Health Professional Support (LHPS) tasks related to blood glucose monitoring, transferring residents from bed to chair, and use of assistive devices for ambulation. The findings are: 1. Review of Staff C's (PCA) personnel record revealed: -Staff C was hired by the facility on 06/21/11 as a PCA. -There were no documentation of LHPS competency validations in the record. Observation of a resident in the hallway on	D 161		

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C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

(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 161	Continued From page 14 06/07/18 at 12:00 pm revealed: -The resident was sitting in an arm chair. -The resident was assisted by Staff C to stand and sit in a wheelchair. Interview with Staff C on 06/11/18 at 3:54 pm revealed: -Staff C worked for the facility for several years on and off. -Staff C worked as a PCA. -She assisted with meals, personal care and transfers of residents to and from bed and chair. Refer to interview on 06/08/18 at 12:10 pm with the Administrative Assistant. Refer to interview on 06/11/18 at 3:43 pm with the Administrator. 2. Review of Staff A's (administrator) personnel record revealed: -Staff A was hired in June 1995 as the director of the facility. -Staff A passed the medication aide test on 08/30/00. -There were no documentation of LHPS competency validations in the record. Review of a resident's June 2018 medication administration record (MAR) revealed that Staff A had checked a finger stick blood sugar and had administered insulin 5 times in June 2018. Refer to interview on 06/08/18 at 12:10 pm with the Administrative Assistant (AA). Refer to interview on 06/11/18 at 3:43 pm with the Administrator.	D 161		

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D 161	Continued From page 15 Interview with the Administrative Assistant on 06/08/18 at 12:10 pm revealed: -The facility did not have a LHPS Nurse contracted. -He did not know the last date the LHPS Nurse was in the facility. -The Administrator was responsible for ensuring the LHPS competency validations was completed for employees, by a licensed nurse. Interview with the Administrator on 06/11/18 at 3:43 pm revealed: -The facility had a LHPS Nurse in the past. -A LHPS Nurse had not completed any LHPS competency validations since 2016. -She planned to contract with a company for another LHPS Nurse. -She contacted a company on 06/08/18 to speak with a representative but did not give the name of the company. -She had not taken care of this issue because of staffing shortages and working as a medication aide (MA). -The facility staff were unable to locate LHPS competency validations for Staff A and Staff C.	D 161		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator	D 176		

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for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record review, the Administrator failed to assure the management and overall operations of the facility by failing to meet and monitor rules related to housekeeping and furnishings, physical environment, other requirements, other staff qualifications, competency validation for LHPS tasks, TB test, medical examinations, resident assessments, personal care, food and nutrition, medication orders, medication administration, and pharmaceutical care.

The findings are:

Interview with the Administrator on 06/11/18 at 3:30 pm revealed:
-She had been the Administrator for several years, was there daily on Monday through Friday, and stayed until 7:00 pm or 8:00pm at night.
-She was responsible for the overall operation of the facility.
-The Administrative Assistant (AA) had assumed responsiblity for processing paperwork for new admissions, and maintaining the records for employees more than one year ago.
-She was responsible for assuring the medications were administered as ordered, and LHPS services were contracted and completed.
-She and the AA were jointly responsible for

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assuring residents were seen by their providers and all FL2s, care plans, TB tests, and medical examinations were completed in the required time frames.
-She had no written policies on resident care, medication management, and personnel qualifications and records available for review.

Non-compliance identified during the survey included the following rule areas:

1. Based on observations, interviews, and record reviews, the facility failed to provide feeding assistance in a manner that promoted resident dignity and respect for a resident (#3), who needed prompting to use a fork or spoon related to eating non-finger foods with his hands and dropping food, and a resident (#1), who was assessed for needing feeding assistance. [Refer to Tag D0312, 10A NCAC 13F .0904(f)(2) Nutrition and Food Service (Type B Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 8 residents (#7, #8, and #10) observed during the medication passes, including multiple errors with the administration of a steroid nasal spray, laxatives, and thyroid medication (#7), oral inhaler and topical antifungal/steroidal cream (#8), and 2 opthalmic drops for glaucoma (#10); and for 2 of 3 residents sampled (#1 and #2) for errors with thyroid medication (#1), and a sleep medication and vitamin D2 supplement (#2). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

3. Based on observations, record reviews, and interviews, the facility failed to assure walls, ceilings, and floor coverings were kept clean and

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in good repair regarding missing tiles at the bottom of the wall and floor in 1 of 4 common bathrooms; shower walls with holes in 1 of 4 common bathrooms; blistered, cracked and peeling walls around the shower unit in 1 of 4 common bathrooms; and a peeling ceiling area in the common dining room. [Refer to Tag D0074, 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings].

4. Based on observations and interviews, the facility failed to assure there was a light overhead of the bed with a switch within reach of residents lying in bed or a bedside lamp for 7 of 20 residents' rooms (Rooms #105, #112, #116, #117, #118, #136, and #139). [Refer to Tag D0093, 10A NCAC 13F .0306(b)(8) Housekeeping and Furnishings].

5. Based on observations and interviews, the facility failed to assure heat/air conditioning (AC) units had knobs for controlling the temperature coming from the unit for 3 of 20 resident rooms (Room #119, #120, and #140). [Refer to Tag D0105, 10A NCAC 13F .0311(a) Other Requirements].

6. Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff C) had a criminal background check completed in accordance with G.S. 114-19-10 and 131D-40. [Refer to Tag D0139, 10A NCAC 13F .0407(a)(7) Other Staff Qualifications].

7. Based on observations, record reviews, and interviews, the facility failed to assure 2 of 3 sampled staff members [Staff A, medication aide (MA) and Staff C, personal care aide (PCA)] were competency validated for Licensed Health Professional Support (LHPS) tasks related to

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blood glucose monitoring, transferring residents from bed to chair, and use of assistive devices for ambulation. [Refer to Tag D0161, 10A NCAC 13F .0504(a) Competency Validation for Licensed Health Professional Support Task].

8. Based on record reviews and interviews, the facility failed to assure 2 of 3 residents sampled (#2, and #3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag D0234, 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Examinations, and Immunizations.]

9. Based on record reviews and interviews, the facility failed to assure 1 of 3 residents sampled (#3) had an annual FL2 that was signed by their primary care provider (PCP). [Refer to Tag D0235, 10A NCAC 13F .0703(b) Tuberculosis Test, Medical Examinations, and Immunizations].

10. Based on observations, interviews, and record reviews, the facility failed to complete an annual Care Plan for 1 of 3 sampled residents (#3) with a change in assistance with eating. [Refer to Tag D0254, 10A NCAC 13F .0801(b) Resident Assessment].

11. Based on observations, record reviews, and interviews, the facility failed to assure quarterly on site Licensed Health Professional Support (LHPS) evaluations by a Registered Nurse for 3 of 3 sampled residents (Residents #1, #2, and #3) with LHPS tasks of medications administration through injections, finger stick blood sugar (FSBS) checks, transferring semi-ambulatory residents, and ambulating using devices that requires physical assistance. [Refer to Tag D0280, 10A NCAC 13F .0903(c) Licensed

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D 176	Continued From page 20 Health Professional Support]. 12. Based on observations and interviews, the facility failed to assure 25 of 25 residents were served one cup (8 ounces) of milk at least twice daily. [Refer to Tag D0299, 10A NCAC 13F .0904(d)(3)(A) Nutrition and Food Service]. 13. Based on record review and interview, the facility failed to assure all current orders for medications or treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 7 of 7 sampled residents (#2, #5, #6, #7, #8, #9, and #10). [Refer to Tag D0349, 10A NCAC 13F .1002(f) Medication Orders]. 14. Based on observations, interviews, and record reviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 2 of 2 residents (#5, and #6) during the 8:00 am medication pass on 06/07/18. [Refer to Tag D0363, 10A NCAC 13F .1004(f) Medication Administration]. 15. Based on record reviews and interviews, the facility failed to follow-up on medication review recommendations for 3 of 4 sampled residents (#3, and #6) related to updating FL2s over 1 year old for Resident #3 and Resident #6. [Refer to Tag D0406, 10A NCAC 13F .1009(b) Pharmaceutical Care]. _____ The Administrator failed to ensure that the management, operations, and policies of the facility were implemented to ensure the services necessary to maintain the residents' physical and mental health were provided as evidenced by the	D 176		

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D 176	Continued From page 21 failure to maintain compliance with the rules and statutes governing adult care homes, which is the responsibility of the Administrator. Failure to ensure all staff requirements were met and documented, resident rights were protected, personal care was provided, FL2, medication orders, and assessments were current, and that all medications were administered as ordered was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/08/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 26, 2018.	D 176		
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 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 of 3 residents sampled (#2, and #3) were tested upon admission for	D 234		

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tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.

The findings are:

1. Review of Resident #3's current FL2 dated 10/21/16 revealed diagnoses included non-Hodgkin's lymphoma, weakness of both legs, onychomycosis, schizophrenia, and Parkinson Disease (chronic).

Review of Resident #3's Resident Register revealed an admission on 08/06/14.

Review of Resident #3's record revealed:
-There was one TB skin test placed on 07/23/14 and read as negative on 07/25/14.
-There was no documentation of any other TB skin tests in the record.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

Interview on 06/11/18 at 1:15 pm with the Administrative Assistant revealed:
-He assisted the Administrator with the various paperwork requirements for residents.
-He was responsible for setting up residents' records for newly admitted residents.
-He looked for the resident's TB skin test but did not notify the Administrator that the resident did not have both of the 2 step TB test.

Interview on 06/11/18 at 4:15 pm with the Administrator revealed:
-Residents admitted to the facility should have documentation for a second TB skin test if the resident came from another facility, or the

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resident should have a second TB skin test completed by the facility.
-She and the Administrative Assistant were responsible for assuring residents admitted to the facility had a TB skin test documented prior to admission or the 2 step TB testing was completed at admission.
-She did not know Resident #3 had no documentation for a second TB skin test.

2. Review of Resident #2's current FL-2 dated 7/25/17 revealed diagnoses included diabetes mellitus, hyperlipidemia, hypertension, myocardial infarction, stroke.

Review of Resident #2's Resident Register revealed an admission date of April 2017, no specific date was given.

Review of Resident #2's record revealed:
-A TB skin test was administered on 03/21/17 by a Registered Nurse (RN).
-The TB skin test, result on 03/23/17 was negative.
-There were no other TB skin tests documented in the record.

Interview with Resident #2 on 06/08/18 at 10:00 am revealed:
-He had resided at the facility for "a little over a year".
-He had TB skin tests completed in the past before being admitted from the hospital.
-He had not had a TB skin test completed while residing at the facility.
-He did not know his past TB skin test results.

Interview with the Administrative Assistant on 06/08/18 at 12:10 pm revealed:

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D 234	Continued From page 24 -He and the Administrator shared the task of completing the admission process and paperwork. -A resident was not admitted to the facility without documentation of a TB skin test. -He completed Resident #2's admission and he thought he had documentation of a completed TB skin test. -He did not know that Resident #2 did not have documentation of a second TB skin test. -He did not know to schedule Resident #2 for a step 2 TB test. -He did not audit resident records. Interview with the Administrator on 06/11/18 at 3:54 pm revealed: -Residents were not admitted unless there was documentation of a TB skin test. -She did not know that Resident #2 did not have documentation of a second TB skin test. -She did not audit of Resident #2's record. -She had not completed an audit for some time due to staffing shortages.	D 234		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the	D 235		

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D 235	Continued From page 25 following: This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 residents sampled (#3) had an annual FL2 that was signed by their primary care provider (PCP). The findings are: Review of Resident #3's current FL2 dated 10/21/16 revealed diagnoses included non-Hodgkin's lymphoma, weakness of both legs, onychomycosis, schizophrenia, and Parkinson Disease (chronic). Review of Resident #3's Resident Register revealed an admission on 08/06/14. Review of Resident #3's record revealed there was no FL2 dated after 10/21/16. Review of Resident #3's record revealed a signed medication clarification dated 02/16/18 ordering Resident #3's current medications. Review of a Quarterly Medication Review for Resident #3 dated 02/28/18 revealed the Pharmacist documented Resident #3's FL2 was due. Telephone interview on 06/11/18 at 12:30 pm with the primary care provider that signed Resident #3's last FL2 dated 10/21/16 revealed: -There was no documentation for a more current FL2 than 10/21/16 on file for Resident #3 in the clinic's records. -Resident #3's last documented visit to the clinic was 07/25/17 for allergy symptoms. -Resident #3 would need to be seen in the clinic	D 235		

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D 235	Continued From page 26 in order to complete an assessment and FL2. -The facility would be responsible to arrange the clinic visit for updating the FL2. Interview on 06/11/18 at 3:50 pm with the Administrator revealed: -Some of the residents had physicians that were slow to respond to the request for FL2s. -Resident #3's primary care provider was at a local clinic and it was "hard" to get a FL2 signed by providers at the clinic because the practitioners did not respond to request. -She used to have a flow chart for tracking when residents' FL2s were due to be renewed, however she had not used the tracker in the last 2 years. -She had delegated part of the monitoring of residents' required updates, like FL2s, Care Plans, as well as processing new admissions to the Administrative Assistant. -She had not audited residents' records for current FL2 in at least a year due to additional duties, including staffing as a medication aide, due to staff turnover. -She was in the process of hiring a company to assist with auditing the residents' records for compliance with requirements. Based on observations, interviews, and record reviews on 06/08/18 and 06/11/18, it was determined Resident #3 was not interviewable.	D 235		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument	D 254		

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approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to complete an annual Care Plan for 1 of 3 sampled residents (#3) with a change in assistance with eating.

The findings are:

Review of Resident #3's current FL2 dated 10/21/16 revealed:
-Diagnoses included non-Hodgkin's lymphoma, weakness of both legs, onychomycosis, schizophrenia, and Parkinson Disease (chronic).
-Resident #3 was incontinent for bladder and bowel.
-Resident #3 required personal care assistance with bathing and dressing.
-Resident #3 was ambulatory.

Review of Resident #3's Resident Register revealed an admission on 08/06/14.

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D 254	Continued From page 28 Review of Resident #3's care plan records revealed: -The last Care Plan was completed 10/21/16. -There was no documentation a more current Care Plan or assessment had been completed. Review of the Care Plan dated 10/21/16 revealed: -Resident #3 was independent with tasks of eating, -Resident #3 was totally dependent for staff assistance with toileting, bathing, dressing, and grooming. -Resident #3 needed limited assistance with ambulation/locomotion and extensive assistance with transferring. -Resident #3 was sometimes disoriented, and forgetful (needs reminders). Observation on 06/11/18 at 2:45 pm of Resident #3 revealed: -Resident #3 was lying in his bed. -A personal care aide (PCA) entered his room and assisted Resident #3 with getting out of his bed. -The PCA used both hands holding Resident #3's hands and assisted Resident #3 physically and verbally to stand upright from the side of the bed. The resident was able to pivot with cues, and turn to sit in his wheelchair. -The PCA rolled the resident into the hall and to the Nurse's desk where other residents were seated. Telephone interview with Resident #3's Power of Attorney (POA) and family member on 06/08/18 at 1:05 pm revealed: -The family member saw the resident as recent as this week. -Resident #3 required assistance with bathing,	D 254		

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toileting, grooming, ambulating wheelchair, and dressing.
-Resident #3 sometimes eats with his hands if he was not reminded to use fork or spoon.
-Resident #3's care needs had not changed much in the last 12 months, except when the family member visited at meal time he noticed Resident #3 often ate with his hands.

Interview on 06/08/18 at 8:28 am with the Administrator revealed:
-Resident Care Plans were supposed to be done annually.
-She and the Administrative Assistant were responsible to assure resident's Care Plans were updated annually.
-She did not know Resident #3's last Care Plan was dated 10/21/16.

Telephone interview on 06/11/18 at 12:30 pm with the primary care provider that signed Resident #3's last Care Plan dated 10/21/16 revealed:
-There was no documentation for a more current Care Plan than 10/21/16 on file for Resident #3 in the clinic's records.
-Resident #3's last documented visit to the clinic was 07/25/17 for allergy symptoms.
-Resident #3 would need to be seen in the clinic in order to complete an assessment and Care Plan.
-The facility would be responsible to arrange the clinic visit for Care Plans.

Interview on 06/11/18 at 3:50 pm with the Administrator revealed:
-Some of the residents had physicians that were slow to respond to the request for care plans.
-Resident #3's primary care provider was at a local clinic and it was hard to get a care plan signed by providers at the clinic.

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D 254	Continued From page 30 -She used to have a flow chart for tracking when residents' Care Plans were due to be renewed, however she had not used the tracker in the last 2 years. -She had delegated part of the monitoring of residents' required updates, like FL2s, Care Plans, as well as processing new admissions to the Administrative Assistant. -She had not audited residents' records for current Care Plans in at least a year due to additional duties, including staffing as a medication aide, due to staff turnover. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	D 254		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the	D 280		

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resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure quarterly on site Licensed Health Professional Support (LHPS) evaluations by a Registered Nurse for 3 of 3 sampled residents (Residents #1, #2, and #3) with LHPS tasks of medication administration through injections, finger stick blood sugar (FSBS) checks, transferring semi-ambulatory residents, and ambulating using devices that requires physical assistance.

The findings are:

1. Review of Resident #3's most current FL2 dated 10/21/16 revealed diagnoses included non-Hodgkin's lymphoma, weakness of both legs, onychomycosis, schizophrenia, and Parkinson Disease (chronic).

Review of Resident #3's Resident Register revealed an admission on 08/06/14.

Observation on 06/06/18 at 5:05 pm of Resident #3 revealed:
-Resident #3 was seated in a regular chair outside the dining room door.
-The Administrator moved Resident #3's wheelchair in front of the resident.
-The Administrator extended both arms out to the resident who grasped one arm with each hand.

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-The Administrator verbally coached and physically assisted the resident to rise to a slumped over standing position.
-Resident #3 was able to pivot and sit in his wheelchair with the one person assistance provided.

Observation on 06/11/18 at 2:45 pm of Resident #3 revealed:
-Resident #3 was lying in his bed.
-A personal care aide (PCA) entered his room and assisted Resident #3 with getting out of his bed.
-The PCA used both hands, holding Resident #3's hands, and assisted Resident #3 physically and verbally to stand upright from the side of the bed. The resident was able to pivot with cues, and turn to sit in his wheelchair.
-The PCA rolled the resident into the hall and to the Nurse's desk where other residents were seated.

Review of the facility's LHPS for residents revealed Resident #3 did not have a LHPS completed in 2017 or 2018 for tasks of assisting with transfers and ambulation using assistive devices that require physical assistance.

Based on observations, interviews, and record reviews on 06/08/18 and 06/11/18, it was determined Resident #3 was not interviewable.

Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant.

Refer to interview on 06/11/18 at 3:50 pm with the Administrator.

2. Review of Resident #2's current FL-2 dated 7/25/17 revealed diagnoses included diabetes

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mellitus, hyperlipidemia, hypertension, myocardial infarction, stroke.

Review of Resident #2's Resident Register revealed an admission date of April 2017, no specific date was given.

Review of Resident #2's record revealed:
-A physician's order dated 01/25/18 for finger sticks for blood sugar testing daily.
-A physician's order dated 04/25/18 for finger sticks for blood sugar testing daily.
-A physician's order dated 04/25/18 for diabetic supplies to include: lancets, strips, and alcohol pads was sent to the pharmacy.
-There was no documentation of LHPS reviews.

Review of Resident #'2's current care plan dated 07/25/17 revealed Resident #2 was assessed and needed a rollanator walker for ambulation.

Observation of Resident #2's room in the facility on 06/06/18 at 10:18 am revealed a rollanator walker was beside Resident #2's bed.

Observation of Resident #2 in the hallway near the dining hall on 06/07/18 at 7:40 am revealed
-Resident #2 was using a rollanator walker to ambulate.
-Resident #2 had a finger stick performed by a Medication Aide near the medication cart.

Interview with Resident #2 on 06/11/18 at 2:50 pm revealed:
-The staff performed his finger sticks to test his blood sugar.
-He needed to use the rollanator walker for ambulation because he became easily fatigued and weak due to his history of strokes and falls.

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D 280	Continued From page 34 Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant. Refer to interview on 06/11/18 at 3:50 pm with the Administrator. 3. Review of Resident #1's FL2 dated 04/05/18 revealed: -Diagnoses included hypertension, hyperlipidemia, hypothyroidism, diabetes, advanced dementia, altered mental status, and thyroid cancer/status post thyroid resection. -An NCS diet order. -An order for finger stick blood sugars (FSBS) before breakfast on Tuesday, Thursday, Saturday and Sunday. -An order for FSBS before supper on Monday, Wednesday, and Friday. -An order for Lantus (a long acting insulin used to treat high blood sugar in person's with diabetes) give 8 units subcutaneously every night at bedtime. -An order for Novolin R (a short acting insulin used to treat high blood sugar in persons with diabetes) give subcutaneously per sliding scale. Review of Resident #1's Assessment and Care Plan dated 04/05/18 revealed: -The staff was monitoring blood sugar levels via FSBS. -Insulin injections were administered per the physician's orders. Review of Resident #1's most recent LHPS evaluation dated 07/07/14 revealed: -LHPS personal care tasks provided were collecting and testing of fingerstick blood sugars and medication administration through injection. -Assisting with transfers/ambulation. -There were no further LHPS evaluations from	D 280		

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D 280	Continued From page 35 07/07/14 to 06/07/18 available for review. Review of Resident #1's medication administration record (MAR) for May 2018 on 06/07/18 revealed: - An entry for Lantus give 8 units subcutaneously every night at bedtime. -Documentation of Lantus being administered per order. -An entry for Novolin R give subcutaneously per sliding scale. -An entry for FSBS before breakfast on Tuesday, Thursday, Saturday and Sunday. -An entry FSBS before supper on Monday, Wednesday, and Friday. -Documentation of Novolin R being administered as ordered. Review of Resident #1's MAR for June 2018 on 06/07/18 revealed: - An entry for Lantus give 8 units subcutaneously every night at bedtime. -Documentation of Lantus being administered per order. -An entry for Novolin R give subcutaneously per sliding scale. -An entry for FSBS before breakfast on Tuesday, Thursday, Saturday and Sunday. -An entry FSBS before supper on Monday, Wednesday, and Friday. -Documentation of Novolin R being administered as ordered. Based on observations, interviews, and record reviews on 06/06/18 and 06/07/18, it was determined Resident #1 was not interviewable. Interview on 06/11/18 at 3:50 pm with the Administrator revealed there was no LHPS assessments available for review for Resident #3	D 280		

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D 280	Continued From page 36 (any previous LHPS reviews must have been thinned and were filed in a storage building outside.) Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant. Refer to interview on 06/11/18 at 3:50 pm with the Administrator. Interview on 06/11/18 at 1:15 pm with the Administrative Assistant revealed: -He was not responsible for arranging for the LHPS nurse to come to the facility for the LHPS reviews. -The Administrator was responsible for contacting the contract LHPS nurse for completion on LHPS. -He did not know how often the LHPS reviews should be done. Interview on 06/11/18 at 3:50 pm with the Administrator revealed: -She knew residents with LHPS tasks should have LHPS reviews done quarterly by a Registered Nurse. -The facility had not had contracted a LHPS Registered Nurse review since 2016. -The facility had contracted a LHPS Nurse for 2016 LHPS reviews but the Nurse left the position (date not specified) and did not provide the facility with a copy of the LHPS reviews preformed. -Because of financial constraints, she had not contracted another LHPS Nurse for the Quarterly LHPS reviews.	D 280		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 299		

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D 299	Continued From page 37 (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure 25 of 25 residents were served one cup (8 ounces) of milk at least twice daily. The findings are: Review of the Spring/Summer Cycle Menu week #5 revealed 1 cup (8 ounces) of milk was supposed to be served with breakfast and 1 cup (8 ounces) was supposed to be served with dinner. Observation of the milk supply located in the kitchen refrigerator on 06/06/18 at 10:40 am revealed a 3/4 gallon of whole milk. Observation of the lunch meal service in the dining room on 06/06/18 at 12:00 pm revealed 25 residents were in the dining room and none of the residents were offered or given milk and there was no milk observed sitting anywhere in the serving or dining are. Observation of the dinner meal service in the dining room on 06/06/18 at 5:00 pm revealed 25 residents were in the dining room and none of the residents were offered or given milk and there	D 299		

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was no milk observed sitting anywhere in the serving or the dining area..

Interview with a resident on 06/11/18 at 12:44 pm revealed:
- The staff sometimes asked if he wanted milk with breakfast.
-He would drink milk with other meals if it were available.

Interview with a second resident on 06/11/18 at 12:46 pm revealed:
-She liked milk.
-Staff sometimes asked if she wanted milk.
-She did not know she could request milk.
-She would drink milk more often if it were available.

Interview with a third resident on 06/11/18 at 2:58 pm revealed:
-She "never" gets served milk in the dining room unless cereal is being served.
-She had never asked for milk.
-She would drink milk more often if it were available.
-She did not know that she could request milk.

Interview on 06/11/18 at 1:48 pm with a fourth resident (#8) revealed:
-She liked to have milk with meals.
-The facility served milk at breakfast on most days.
-The facility did not routinely serve milk at the other meals.
-She would drink milk more often if it was served.

Interview with a dietary aide on 06/06/18 at 10:45 am revealed:
-She worked in the kitchen assisssting to prepare meals.

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D 299	Continued From page 39 -Her job duties included helping to set the table for the residents. -Milk was not routinely set out for the residents. -Milk was usually given to residents at breakfast if they had cereal. -Milk was not usually served at other meals (no reason given, she just smiled and walked off). Interview with the Dietary Manager (DM) on 06/07/18 at 9:22 am revealed: -She knew that residents were supposed to be served milk twice a day. -Milk was typically served with the evening meal. -She gave the residents juice instead of milk so that it was not wasted. -She did not know why milk was not offered with dinner on 06/06/18. Interview with the Administrator on 06/07/18 at 10:39 am revealed: -She knew that milk was supposed to be served two times a day. -Residents are not always given milk (no explanation given). -Her expectation was for residents to be offered milk every time it was on the menu (twice daily). -She did not know why the residents are not given milk two times a day. -She was responsible for ensuring that the facility follows state regulations.	D 299		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the	D 312		

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assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to provide feeding assistance in a manner that promoted resident dignity and respect for a resident (#3), who needed prompting to use a fork or spoon related to eating non-finger foods with his hands and dropping food, and a resident (#1), who was assessed for needing feeding assistance.

The findings are:

1. Review of Resident #3's current FL2 dated 10/21/16 revealed:
-Diagnoses included non-Hodgkin's lymphoma, weakness of both legs, onychomycosis, schizophrenia, and Parkinson Disease (chronic).
-Resident #3 was ambulatory.
-Resident #3 was ordered a regular diet.

Review of Resident #3's record revealed:
- There was no current FL2 after 10/21/16.
-There was no documentation a more current Care Plan or assessment had been completed than 10/21/16.

Review of Resident #3's care plan dated 10/21/16 revealed Resident #3 was assessed as independent with eating.

Observation on 06/06/18 from12:10 pm to 12:33 pm of the lunch meal revealed:
-Resident #3 was in a wheelchair and seated at a table in the dining room.

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-Resident #3 had a large cloth bib attached around his neck to protect his shirt.
-At 12:10 pm, Resident #3 was served a compartmented tray with lasagna, green beans, tossed salad with thousand island dressing, croissant roll, and 3 sugar wafers along with 12 ounces of water and 10 ounces of tea.
-Resident #3 fiddled with his food for several minutes, but was not eating the food.
-No staff checked on or assisted Resident #3 from 12:10 pm to 12:22 pm.
-At 12:18 pm, Resident #3 picked up the sugar wafers, one by one, and ate the wafers.
-At 12:19 pm, Resident #3 ate the croissant roll, and took a sip of tea.
-The Administrator/medication aide was observed inside the dining room, with the medication cart, administering medications to residents as they completed their meal.
-At 12:25 pm, Resident #3 used his left hand and picked up a piece of lasagna (approximately 2 inches by 3 inches) covered with lasagna sauce. The resident moved the lasagna toward his mouth, smearing sauce all over his chin and left thumb and first 3 fingers, sucked on the lasagna and bit off a small piece. He returned his hand to the plate still holding the piece of lasagna with his left hand.
-From 12:26 pm to 12:33 pm, Resident #3 repeated feeding himself lasagna with his left hand, and added a few pieces of dressing covered lettuce.
-A personal care aide (PCA) was observed feeding 3 residents seated at a table in the front side of the dining room.
-The Administrator continued to administer medication, and dining room staff were attending to residents at the tables other than the table where Resident #3 was seated.
-Resident #3's left hand, mouth, and chin, as well

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as the cloth covering his chest, the table, and left side of his wheel chair had lasagna sauce and salad dressing smeared on the surfaces from his attempts to feed himself.

Interview with a family member of a female resident seated at the same table as Resident #3 on 06/06/18 at 12:34 pm revealed:
-She visited the female resident occasionally.
-Resident #3 ate with his hands sometimes when she visited her relative, and sometimes with his fork or spoon.
-Staff did not check on Resident #3 most of the times she had been at the facility.
-She wished staff would assist Resident #3 to pick up his fork or spoon.
-The resident "looked like a young child trying to eat".

Continued observation of Resident #3 on 06/06/18 from 12:35 pm to 12:57 pm revealed:
-At 12:35 pm, Resident #3 continued to pick up pieces of lasagna, and salad with his left hand.
-No staff were in the general area of Resident #3, and the Administrator was still administering medications in the dining room.
-At 12:36 pm, Resident #3 placed his left hand in his mouth and sucked the first 3 fingers to remove the lasagna sauce.
-At 12:38 pm, Resident #3 consumed 100% of the lasagna, and pushed his tray away toward the right side of the table; no staff had come to the table.
-At 12:39 pm, Resident #3 was observed sucking the lasagna sauce of his left hand.
-At 12:40 pm, Resident #3 used his right hand to slowly pick up a paper napkin on the table, wiped his left hand and chin, and wiped one pass across the table.
-At 12:42 pm, a PCA came to the table, moved

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Resident #3's tray back in front of him, placed his fork in his right hand and walked away.
-From 12:44 pm to 12:55 pm, Resident #3 consumed 100% of the tossed salad with dressing and green beans with the fork in his right hand.
-At 12:57 pm, the Administrator came from across the dining room, removed the resident's bib, wiped his hands with the bib, released the brake on the wheelchair and rolled the resident toward the dining room exit to the hallway. The resident's mouth was wiped by the Administrator.

Observation on 06/06/18 of the evening meal from 5:07 pm to 5:32 pm revealed:
-Resident #3 was assisted by staff in his wheelchair to the same table in the dining room he sat at during lunch.
-At 5:10 pm, Resident #3 was served cream of potato soup, egg salad croissant, green peas, 4 saltine crackers, and pineapple chunks on a compartmented tray.
-Resident #3 used his right hand and the spoon to eat 50% of the soup; he used his right hand and the fork to remove the top croissant layer and consumed 100% of the egg salad; he ate 20% of the green peas with his fork.
-At 5:32 pm, Resident #3 completed his dinner and wiped his face with a napkin; no staff assisted the resident with any prompting or feeding.

Interview on 06/06/18 at 5:40 pm with the Administrator revealed:
-Resident #3 routinely ate on his own; staff did not assist the resident.
-Resident #3 had some days when he seemed to not be able to function as well as other days.
-Staff did not assist Resident #3 because he usually was able to consume most of his food.

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D 312	Continued From page 44 Interview on 06/07/18 at 10:39 am with the Administrator revealed: -The staff watched the residents daily to see what they did or did not do (in regards to eating). -"That was how the facility determined who needed feeding assistance". -She did not see Resident #3 eating with his hands (although she was in the dining room passing medications on 06/06/18). -She was responsible for updating any diet orders or care plans for feeding assistance. Observation on 06/08/18 at 12:15 pm of the lunch meal revealed: -Resident #3 was seated at a front table in the dining room along with 3 other residents. -There was a staff member seated at the table, feeding 2 residents. -At 12:15 pm, Resident #3 was staring at his food. -Resident #3 was verbally prompted to use his fork by a staff. -Resident #3 started eating. Telephone interview with Resident #3's Power of Attorney (POA) and family member on 06/08/18 at 1:05 pm revealed: -The family member had visited with the resident as recent as this week. -Resident #3's care needs had not changed much in the last 12 months, except when the family member visited at meal time, he noticed Resident #3 often ate with his hands. -When he was there, during a meal time, he reminded the resident to use his fork or spoon. -He had not spoken to the staff about Resident #3 needing assistance with eating. Interview on 06/11/18 at 3:50 pm with the	D 312		

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D 312	Continued From page 45 Administrator revealed: -The Administrator was responsible to identify any changes to residents' care needs -Resident #3 had been moved in the dining room to the front table with residents that required feeding assist. -Resident #3 was eating on his own without assistance, with a fork or spoon. -Resident #3 received a cue to start eating if needed. -Resident #3 had an appointment scheduled with his primary care provider for 06/12/18 and the resident had a new assessment and updated care plan to be reviewed by the provider. Based on observations, interviews, and record review, Resident #3 was not interviewable. 2. Review of Resident #1's FL2 dated 04/05/18 revealed: -Diagnoses included hypertension, hyperlipidemia, hypothyroidism, diabetes, advanced dementia, altered mental status, and thyroid cancer/status post thyroid resection. -Resident #1 required personal care assistance with feeding at all times. -Resident #1 was constantly disoriented and dependent on staff for total care. Observation in the dining room on 06/06/18 at 12:12 pm revealed: -Resident #1 was seated in a wheelchair at a table with three other residents. -Resident #1 was served lasagna, green beans, salad, and pineapple; all of which had been pureed. -She was also served tea and water. -A personal care aide (PCA) was seated to the right of the resident. -The PCA fed the resident the pureed lasagna,	D 312		

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green beans, salad, and pineapple prior to offering her anything to drink.
-In between feeding bites of food, the PCA had a sheet of paper in which she wrote down the percentage of food consumed by the other residents in the dining room.
-The PCA assisted the resident to drink her tea only after she had fed the resident all her pureed food.
-The PCA did not speak to the resident while feeding her meal except to call her name on 3 occasions.
-The resident ate 100% of her meal and drank a full glass of tea.

Review of Resident #1's care plan dated 04/05/18 revealed the resident was totally dependent with eating.

Interview with the PCA on 06/11/18 at 3:27 pm revealed:
-Her duties included feeding residents.
-She fed Resident #1 most of the time.
-She typically fed the resident all her food first, prior to giving her anything to drink.
-She believed the resident had a tendency to get full quickly so she gave her the food first.
-No one instructed her to feed the resident all her food prior to giving her anything to drink.
-She knew she was supposed to alternate bites of food with something to drink so that the resident did not get choked.
-She did not have a reason as to why she did not speak with the resident.

Interview with the Administrator on 06/11/18 at 3:46 pm revealed:
-She was not aware the PCA had fed Resident #1 all her food prior to giving the resident her tea.
-The PCA was not instructed to feed the resident

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D 312	Continued From page 47 her food first. -She was responsible for ensuring the facility followed all state regulations. _____ The facility's failure to assure dignity and respect was provided for a resident (#3), who needed prompting to use a fork or spoon related to eating non-finger foods with his hands and dropping food on himself, the table and wheelchair in front of other residents and visitors; and alternate bites of food with something to drink for a resident (#1), who was assessed for needing feeding assistance was detrimental to the welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/08/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 26, 2018.	D 312		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure all current orders for medications	D 349		

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or treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 7 of 7 sampled residents (#2, #5, #6, #7, #8, #9, and #10).

The findings are:

1. Review of Resident #5's current FL2 dated 10/16/17 revealed:
-Diagnoses included cognitive impairment, diabetes, and hypertension.
-There was an order for amlodipine (used to treat high blood pressure) 5 mg daily.
-There was an order for triamterene-hydrochlorthiazide (used to treat high blood pressure) 37.5/25 mg daily.

Review of Resident #5's Resident Register revealed the resident was admitted to the facility 10/12/17.

Record review revealed no six month updated review of all medications and treatments prescribed for Resident #5 was found after 10/16/17.

Observation of Resident #1's medications for administration on the facility's medication cart on 06/07/18 revealed there was amlodipine 5 mg and triamterene-hydrochlorthiazide 37.5/25mg on hand for administration.

Telephone interview on 06/08/18 at 11:24 am with Pharmacist at Resident #5's local pharmacy revealed:
-There were no discrepancies between the current FL2 medication orders and the pharmacy updates for the Resident #5.
-Resident #5's physician often submitted orders for medications via electronic prescription.

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-The pharmacy contacted the resident's prescribers when a medication needed to be updated for filling.
-The pharmacy did not receive 6 month medication updates for Resident #5.

Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant.

Refer to interview on 06/11/18 at 4:00 pm with the Administrator.

2. Review of Resident #6's current FL2 dated 05/27/16 revealed:
-Diagnoses included mild mental retardation and schizophrenia paranoid type.
-There was an order for paroxetine hydrochloride 20 mg (used to treat depression) every morning.
-There was an order for haloperidol 20 mg (used to mental disorders) three times a day.
-There was an order for benzotropine mesylate 2 mg (used to muscle twitches) twice a day.
-There was an order for trazadone 50 mg (used to treat depression) one tablet at bedtime.
-There was an order for olanzapine 20 mg (used to treat mental disorders like schizophrenia) one tablet at bedtime.

Review of the Resident #6's record revealed:
-There was no six month updated review of all medications and treatments prescribed after 05/27/16.
-There was an "examination or contact by physician" sheet documenting Resident #6's mental health provider visits with "continue current medications" documented on 07/24/17, 10/16/17, 03/07/18, and 05/01/18.

Telephone interview on 06/07/18 at 3:20 pm with the Pharmacist at the facility's contracted

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pharmacy revealed:
-There were no discrepancies between the current FL2 medication orders and the pharmacy updates for the Resident #6.
-The pharmacy did not rely on the facility to obtain medication updates; the pharmacy's computer automatically generated a medication request and sent a fax to the prescriber when a resident's medication needed refills.
-The facility was responsible to send new orders to the pharmacy but not refill or medication update information.

Observation of Resident #6's medications for administration on the facility's medication cart on 06/07/18 revealed there was paroxetine hydrochloride 20 mg, haloperidol 20 mg, benzotropine mesylate 2 mg, trazadone 50 mg, and olanzapine 20 mg on hand.

Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant.

Refer to interview on 06/11/18 at 4:00 pm with the Administrator.

3. Review of Resident #9's current FL2 dated 09/06/17 revealed:
-Diagnoses included schizophrenia paranoid type and chronic back pain.
-There was an order for Advair 250-50 diskus(used to treat breathing problems) one puff two times a day.
-There was an order for amlodipine Besylate 10 mg (used to treat high blood pressure) one tablet daily.
-There was an order for dorzolamide-timolol eye drops (used to treat ocular pressure) one drop in each eye two times a day.
-There was an order for haloperidol 10 mg (used

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to treat mental disorders like schizophrenia) one tablet 2 times a day.
-There was an order for haloperidol 5 mg one tablet 2 times a day.
-There was an order for ibuprofen 200 mg (used to treat pain) one tablet 3 times a day, if needed.
-There was an order for lisinopril 40 mg (used to treat high blood pressure) one tablet daily.
-There was an order for metoprolol tartrate 25 mg (used to treat blood pressure and elevated heart rate) one tablet 2 times a day.
-There was an order for Pataday 0.2% eye drops (used to treat allergy) one drop in each eye daily.
-There was an order for Proair HTA 90 mcg (used to improve breathing) 2 puffs every 4 to 6 hours as needed.
-There was an order for quetiapine ER 300 mg (used to treat mental disorders like schizophrenia)one tablet in the evenings.
-There was an order for stool softener 100 mg one capsule daily.

Record review revealed there was no six month updated review of all medications and treatments after 09/06/17.

Telephone interview on 06/07/18 at 2:50 pm with medication technician at Resident #9's local pharmacy revealed:
-There were no discrepancies between the current FL2 medication orders and the pharmacy updates for the Resident #9.
-The order haloperidol 5 mg one tablet 2 times a day was discontinued on 02/13/18.
-There was an order for dorzolamide-timolol eye drops discontinued on 01/07/18.
-There was an order for Spiriva 18 mcg oral inhaler (used to help breathing) once daily dated 03/05/18.
-The pharmacy primarily used electronic

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prescriptions for resident's medication.
-The pharmacy contacted the physician for refills electronically when the computer automatically generate a request and faxed the request to the physician.
-The pharmacy did not generate a 6 month medication renewal/authorization for the facility.

Observation of Resident #9's medications for administration on the facility's medication cart on 06/07/18 revealed Advair 250-50 diskus, amlodipine besylate 2.5 mg, haloperidol 10 mg, ibuprofen 200 mg, lisinopril 40 mg, metoprolol tartrate 25 mg, Pataday 0.2% eye drops, Proair HTA 90 mcg, quetiapine ER 300 mg, Spiriva 18 mcg, and stool softener 100 mg were available for administration.

Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant.

Refer to interview on 06/11/18 at 4:00 pm with the Administrator.

4. Review of Resident #2's current FL-2 dated 7/25/17 revealed:
-Diagnoses included diabetes mellitus, hyperlipidemia, hypertension, myocardial infarction, and stroke.
-There was an order for aspirin 325 mg (used to prevent strokes) one tablet daily.
-There was an order for cholecalciferol/vitamin D3 (used to treat or prevent conditions caused by a lack of vitamin D) one tablet at bedtime.
-There was an order for Plavix 75 mg (used to prevent heart attack and stroke) one tablet daily.
-There was an order for ergocalciferol vitamin D2 50,000 (used to treat vitamin D deficiency) one capsule each week.
-There was an order for lisinopril 20 mg (used to

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treat high blood pressure) one tablet daily.
-There was an order for metoprolol tartrate 25 mg (used to treat high blood pressure) one tablet twice a day.
-There was an order for vitamin B12 1000 mcg (used to treat vitamin B12 deficiency) one tablet daily.
-There was an order for amlodipine besylate 10 mg (used to treat high blood pressure) one tablet daily.
-There was an order for Humalog 75-25 18 units (used to treat diabetes mellitus) twice a day with meals.
-There was an order for Ambien 5 mg (used to treat insomnia) one tablet at bedtime as needed.
-There was an order for acetaminophen 160mg/5ml 20.3 (used to treat pain) every six as needed.
-There was an order for atorvastatin 80 mg (used to treat high cholesterol) one tablet daily.

Review of Resident #2's record revealed no six month updated review of medications and treatments prescribed after 07/25/17.

Observation of Resident #2's medications on the facility's medication cart on 06/07/18 revealed:
-Acetaminophen liquid, ergocalciferol vitamin D2, and Ambien were not available for administration.
-There was aspirin, cholecalciferol/vitamin D3, Plavix, lisinopril, metoprolol tartrate, vitamin B12, amlodipine besylate, Humalog, and atorvastatin available for administration.

Telephone interview with a pharmacy technician at Resident #2's local pharmacy on 06/11/18 at 10:02 am revealed:
-There were no discrepancies between the current FL-2 medication orders and the pharmacy updates for the Resident #2.

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-Resident #2's physician often submitted orders for medications via electronic prescription.
-The pharmacy contacted the resident's prescribers when a medication needed to be updated for filling.
-The pharmacy did not receive 6 month medication updates for Resident #2.

Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant.

Refer to interview on 06/11/18 at 4:00 pm with the Administrator.

5. Review of Resident #7's current FL-2 dated 09/13/17 revealed:
-Diagnoses included schizoaffective disorder bipolar type with exacerbation of mixed features, non-insulin dependent diabetes mellitus, hypothyroidism, seasonal allergies, hypertriglyceridemia, and gastro-esophageal reflux disease (GERD).
-There was an order for melatonin 3 mg (used to treat insomnia) at bedtime.
-There was an order for Tylenol 1000mg (used to treat pain) every six hours as needed.
-There was an order for calcium carbonate 1000 (used to treat GERD) every six hours as needed.
-There was an order for Valium 10 mg (used to treat anxiety) at bedtime and every twelve hours as needed.
-There was an order for hydroxyzine 25 mg (used to treat allergies) every four hours as needed.
-There was an order for trazadone 100 mg (used to treat insomnia) at bedtime as needed.
-There was an order for loratadine 10 mg (used to treat allergies) daily.
-There was an order for Clozaril 200 mg (used to treat schizophrenia) at bedtime.
-There was an order for metoprolol tartrate 25 mg

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(used to treat high blood pressure) twice a day.
-There was an order for lithium 450 mg (used to treat bipolar disorder) twice a day.
-There was an order for Geodon 20 mg (used to treat bipolar disorder) every eight hours as needed.
-There was an order for insulin glargine 12 units (used to treat diabetes mellitus) at bedtime.
-There was an order for Miralax 17 grams (used to treat constipation) daily.
-There was an order for senna R 5 mg (used to treat constipation) at bedtime.
-There was an order for bisacodyl 5 mg (used to treat constipation) twice a day as needed.
-There was an order for ferrous sulfate 325 mg (used to treat iron deficiency) daily.
-There was an order for Flonase 50 mcg (used to treat allergies) daily.
-There was an order for protonix delayed release 40 mg (used to treat GERD) daily.
-There was an order for Synthroid 100 mcg (used to treat hypothyroidism) daily.
-There was an order for Theragran M (used to treat vitamin deficiency) one tablet daily.

Review of Resident #7's record revealed no six month updated review of medications and treatments prescribed after 09/13/17.

Telephone interview with a pharmacy technician at Resident #7's local pharmacy on 06/11/18 at 9:46 am revealed:
-There were no discrepancies between the current FL-2 medication orders and the pharmacy documentation for medications.
-The pharmacy sent a fax to Resident #7's physician when there were no refills remaining for medications.
-If the pharmacy did not receive a medication renewal order from Resident #7's physician, the

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pharmacy telephoned the physician to request a medication renewal order.
-The pharmacy did not receive 6 month medication updates for Resident #7.

Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant. .

Refer to interview on 06/11/18 at 4:00 pm with the Administrator.

6. Review of Resident #8's current FL-2 dated 09/11/17 revealed:
-Diagnoses included chronic schizophrenia disorder, dementia, type II diabetes, history of colon polyps, blind in right eye from motor vehicle accident at age 18, and chronic obstructive pulmonary disease (COPD).
-There was an order for docusate sodium 100 mg (used to treat constipation) one capsule daily.
-There was an order for vitamin D3 1000 units (used to treat vitamin D deficiency) one tablet daily
-There was an order for ferrous sulfate 325 mg (used to treat iron deficiency) one tablet daily with food.
-There was an order for Spiriva 18 mcg (used to treat COPD) one capsule daily
-There was an order for loxapine 25 mg (used to treat schizophrenia) one capsule twice a day.
-There was an order for metformin 500 mg (used to treat diabetes) one tablet twice a day.
-There was an order for clotrimazole-betamethasone (used to treat fungal infections) apply twice a day.
-There was an order for alendronate sodium 70 mg (used to treat osteoporosis) one tablet before breakfast.
-There was an order for melatonin 1 mg (used to treat insomnia) one tablet at bedtime.

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-There was an order for divalproex 500 mg (used to treat bipolar disorder) one tablet at bedtime.
-There was an order for polyethylene glycol 3350 (used to treat constipation) daily as needed.

Review of Resident #8's record revealed no six month updated review of medications and treatments prescribed for Resident #8 was found in the resident's record after 09/11/17.

Telephone interview with a pharmacy technician at Resident #8's local pharmacy on 06/06/18 at 3:15 pm revealed:
-There were no discrepancies between the current FL-2 medication orders and the pharmacy medication updates for Resident #8.
-The majority of medication orders for Resident #8 did not come from the FL-2 but from prescriptions from Resident #8's physician.
-When Resident #8 needed a medication refill, the pharmacy telephoned the physician's office.
-The pharmacy did not receive 6 month medication updates for Resident #8.

Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant.

Refer to interview on 06/11/18 at 4:00 pm with the Administrator.

7. Review of Resident #10's current FL2 dated 08/11/17 revealed:
-Diagnoses included schizophrenia, legally blind, hypertension, and hyperlipidemia.
-There was an order for aspirin 81 mg (used to help circulation) enteric coated daily.
-There was an order for vitamin D 3 (a vitamin supplement for low vitamin D) 2000 international units daily.
-There was an order for lithium carbonate 300 mg

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D 349	Continued From page 58 (used to treat mental disorders like schizophrenia) twice a day, after meals. -There was an order for tamsulosin 0.4 mg (used to treat an enlarged prostate) one capsule daily. -There was an order for latanoprost 5% (used to treat glaucoma) one drop in both eyes at bedtime. -There was an order for timolol maleate 0.05 % (used to treat glaucoma) one drop in both eyes at bedtime. -There was an order for acetaminophen 325 mg (used to treat pain) two tablets every six hours as needed. Review of Resident #10's record revealed no six month updated review of medications and treatments after 08/11/17. Refer to interview on 06/11/18 at 1:15 pm with the Administrative Assistant. Refer to interview on 06/11/18 at 4:00 pm with the Administrator. _____ Interview on 06/11/18 at 1:15 pm with the Administrative Assistant revealed: -He helped the Administrator with resident admissions, setting up residents' records, organizing the records, and assuring the Resident Register was completed and signed. -He was not responsible for the residents' 6 month medication updates. -The Administrator was responsible for assuring medication updates were current.. Interview on 06/11/18 at 4:00 pm with the Administrator revealed: -She was responsible for assuring residents had current medications updated at least every 6 months. -She was working as a daytime shift medication	D 349		

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D 349	Continued From page 59 aide due to staffing shortages and high turnover. -Some residents had their medications updated using the "Medication Clarification" form the facility typed and sent with a resident on physician visits. -She used to use a spread sheet for tracking when residents' FL2s, Care Plans, Licensed Health Professional Support, and medication renewals were due, however she had not used the system in a long time because of the staff shortages and her increased medication aide responsibilities. -She did not have a system in place currently to keep track of which resident needed their medication orders reviewed by their physician.	D 349		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 8 residents (#7, #8, and #10) observed during the medication passes, including multiple errors with the	D 358		

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administration of a steroid nasal spray, laxatives, and thyroid medication (#7), oral inhaler and topical antifungal/steroidal cream (#8), and 2 opthalmic drops for glaucoma (#10); and for 2 of 3 residents sampled (#1 and #2) for errors with thyroid medication (#1), and a sleep medication and vitamin D2 supplement (#2).

The findings are:

1. The medication error rate was 21% as evidenced by the observation of 8 errors out of 37 opportunities during the 12:00 pm medication pass on 06/06/18 and the 8:00 am medication pass on 06/07/18.

a. Review of Resident #10's current FL2 dated 08/11/17 revealed:
-Diagnoses included schizophrenia, legally blind, hypertension, and hyperlipidemia.
-There was an order for aspirin 81 mg (used to help circulation) enteric coated daily; an order for vitamin D3 2000 international units daily(a vitamin supplement for low vitamin D); and an order for lithium carbonate 300 mg (used to treat mental disorders like schizophrenia) twice a day, after meals.

Review of Resident #10's physician's order dated 02/13/18 revealed orders for Cosopt (used to treat ocular pressure) opthalmic drops one drop in each eye twice a day, and Brimonidine 0.2% (used to treat ocular pressure) one drop in each eye 3 times a day.

Observation of medication administration during the morning medication pass on 06/07/18 at 8:48 am by the Administrator revealed:
-The medication cart was set up just outside the dining room.

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-The Administrator was preparing and administering medication to residents as the residents finished with breakfast.
-The Administrator prepared 3 oral medications for Resident #10.
-The Administrator administered the medications and documented administration on the medication administration record (MAR) at 8:50 am.
-Resident #10 received no additional medication.

Review of Resident #10's June 2018 medication administration record (MAR) revealed on 06/07/18 at 11:38 am revealed:
-There was an entry for Cosopt opthalmic drops one drop in each eye twice a day, scheduled for administration at 8:00 am and 8:00 pm daily, and documented as administered on 06/07/18 at 8:00 am (not observed as administered during the 8:00 am medication pass).
-There was an entry for Brimonidine 0.2% one drop in each 3 times a day, scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily, and documented as administered at 8:00 am (not observed as administered during the 8:00 am medication pass).

Observation of Resident #10's medications on hand for administration on 06/07/18 at 11:45 am revealed Cosopt and Brimonidine 0.2% eye drops were available for Resident #10.

Interview on 06/07/18 at 8:00 am with the Administrator revealed:
-She had been working as a medication aide (MA) with scheduled 12 hour day shifts for several weeks, due to staff turnover.
-She was also responsible for residents' health care and coordinating physician visits.
-She administered all the residents' medication in

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the morning, at lunch, and the evening medications when she worked.

Interview on 06/07/18 at 3:20 pm with the Administrator revealed she administered Resident #10's eye drops later in the morning, after he got to his room from breakfast.

Interview on 06/08/18 at 3:45 pm with Resident #10 revealed:
-He was aware he took eye drops in the morning, after lunch, and in the evening.
-He did not receive his morning eye drops on 06/07/18; he did receive one eye drop later after lunch.

b. Review of Resident #7's current FL2 dated 09/13/17 revealed:
-Diagnoses included schizoaffective disorder bipolar type with exacerbation of mixed features, non-insulin dependent diabetes mellitus, hypothyroidism, seasonal allergies, hypertriglyceridemia, and gastro-esophageal reflux disease (GERD).
-There were orders for loratadine 10 mg (used to treat allergies) daily; ferrous sulfate 325 mg (used to treat iron deficiency) daily; metoprolol tartrate 25 mg (used to treat high blood pressure) twice a day; lithium 450 mg (used to treat bipolar disorder) twice a day; and Theragran M (used to treat vitamin deficiency) one tablet daily.
-There were also orders for Miralax 17 grams (used to treat constipation) daily, Flonase 50 mcg (used to treat allergies) daily, and Synthroid 100 mcg (used to treat hypothyroidism) daily.

Interview with the pharmacy technician at Resident #7's local pharmacy on 06/07/18 at 3:50 pm revealed there was an order for milk of magnesia 30 ml daily dated 09/13/17.

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D 358	Continued From page 63 Observation of medication administration on 06/07/18 at 8:35 am by the Administrator revealed: -The Administrator prepared five oral medications for Resident #7. -The Administrator administered and documented the five oral medications for Resident #7 at 8:38 am. -Resident #7 received no additional medications. Observation of Resident #7's medications on the medication cart on 06/07/18 at 3:00 pm revealed all the medications ordered on the current FL-2 were available for administration. Review of Resident #7's June 2018 medication administration record (MAR) on 06/07/18 at 11:00 am revealed: -There was an entry for fluticasone propionate 50 mcg one spray each nostril every day, scheduled for administration at 8:00 am, and not documented as administered on 06/07/18 at 8:00 am (not observed as administered during the 8:00 am medication pass). -There was an entry for milk of magnesia suspension 30 ml every day, scheduled for administration at 8:00 am, and not documented as administered on 06/07/18 at 8:00 am (not observed as administered during the 8:00 am medication pass). -There was an entry for levothyroxine 100 mcg one tablet every day before breakfast, scheduled for administration at 8:00 am, and documented as administered on 06/07/18 at 8:00 am (not observed as administered during the 8:00 am medication pass). -There was an entry for polyethylene glycol mix one capful with eight ounces of water every day, scheduled for administration at 8:00 am, and not	D 358		

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documented as administered on 06/07/18 at 8:00 am (not observed as administered during the 8:00 am medication pass).

Interview on 06/07/18 at 2:40 pm with Resident #7 revealed:
-She did not receive Miralax, milk of magnesium, or Flonase this morning (06/07/18).
-She had not received Miralax in a long time because she has not asked for the medication.
-She did not receive her thyroid medication (Synthroid) today.
-She routinely received all her medications, including thyroid medication, together at the same time in the mornings.

Interview on 06/07/18 at 4:20 pm with the Administrator revealed:
-She was working as a medication aide (MA) on the day shift due to staffing shortages.
-She overlooked administering Resident #7's Flonase, Miralax and milk of magnesium during the 8:00 am medication pass.
-Resident #7 was administered thyroid medication separately before her other 8:00 am medications; she did not know why Resident #7 did not remember receiving the thyroid medication.

c. Review of Resident #8's current FL2 dated 09/11/17 revealed:
-Diagnoses included chronic schizophrenia disorder, dementia, type II diabetes, history of colon polyps, blind in right eye from motor vehicle accident at age 18, and chronic obstructive pulmonary disease (COPD).
-There were orders for docusate sodium 100 mg (used to treat constipation) one capsule daily; ferrous sulfate 325 mg (used to treat iron deficiency) one tablet daily with food; loxapine 25

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mg (used to treat schizophrenia) one capsule twice a day; metformin 500 mg (used to treat diabetes) one tablet twice a day; vitamin D3 1000 units (used to treat vitamin D deficiency) one tablet daily; Spirvia 18 mcg (used to treat COPD) one capsule daily and clotrimazole-betamethasone (used to treat fungal infections) apply twice a day.

Review of Resident #8's physician orders revealed and order for Linzess 145 mcg one tablet daily on empty stomach.

Review of Resident #8's June 2018 medication administration record (MAR) on 06/07/18 at 12:21 pm revealed:
-An entry for clotrimazole-betamethasone apply twice daily, scheduled for administration at 8:00 am and 8:00 pm, and not documented as administered on 06/07/18 at 8:00 am (not observed as administered during the 8:00 am medication pass).
-An entry for Spiriva 18 mcg one capsule daily, scheduled for administration at 8:00 am, and not documented as administered on 06/07/18 at 8:00 am (not observed as administered during the 8:00 am medication pass).

Observation of medication administration on 06/07/18 at 8:40 am by the Administrator revealed:
-The Administrator prepared six oral medications for Resident #8.
-The Administrator administered and documented the six oral medications for Resident #8 at 8:44 am.
-Resident #8 received no additional medications.

Observation of Resident #8's medications on the facility's medication cart on 06/07/18 at 3:05 pm

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revealed:
-There was one tube of clotrimazole-betamethasone available for administration.
-There was no Spiriva available for administration.
-All of Resident #8's oral medications were available for administration.

Interview with Resident #8 on 06/08/18 at 11:59 am revealed:
-The resident did not receive any cream from the MA during the week.
-The last time she received cream from the MA was a few months ago.
-She had an area on her right shoulder that was previously treated with the cream and was now healed.
-She did use inhalers to help her "breathing".
-She did not use her inhaler yesterday because she did not "feel like it".

2. Review of Resident #2's current FL2 dated 7/25/17 revealed:
-Diagnoses included diabetes mellitus, hyperlipidemia, hypertension, myocardial infarction, and stroke.
-There was an order for ergocalciferol vitamin D2 50,000 (used to treat vitamin D deficiency) one capsule each week.
-There was an order for Ambien 5 mg (used to treat insomnia) one tablet at bedtime as needed.

Review of Resident #2' physician office visits medication lists revealed:
-The office visits were dated 09/15/17, 10/26/17, 1/25/18 and 04/25/18.
-There was a medication list with each office visit that instructed the following: "always use your most recent list".

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C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

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-The medication lists for each office visit indicated an order for vitamin D2 50,000 units by mouth once a week and Ambien 10 mg tablets take 5 mg by mouth nightly as needed for sleep.

Review of Resident #2's April 2018, May 2018 and June 2018 medication administration record (MAR) revealed:
-There was an entry for Ambien 10 mg one tablet by mouth nightly as needed, scheduled for PRN.
-There was no entry for vitamin D2.

Observation of medications on hand for Resident #2 on 06/06/18 at 4:45 pm revealed:
-Vitamin D2 50,000 units was not available for administration.
-Ambien 10 mg tablets was not available for administration.

Interview with a nurse at Resident #2's physician office on 06/11/18 at 9:26 am revealed:
-The facility staff provided a "coversheet" that the physician used to handwrite any new orders for medications, treatments, labs, or consultations.
-The office visit medication lists were to be used for medication orders because they indicated the resident's active medication orders.
-The physician also sent prescriptions electronically to Resident #2's local pharmacy.
-There was documentation in the physician notes that facility staff had contacted the physician's office on 03/28/18 to request an order for Resident #2's diabetic supplies.
-There was no documentation that the staff had contacted the physician's office about the Ambien or the vitamin D2 order.
-There was no documentation about Resident #2 not receiving the medication as ordered.
-Both vitamin D2 50,000 units weekly and Ambien 5 mg at bedtime as needed for sleep were still

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D 358	Continued From page 68 documented in the physician notes as active medication orders. Telephone interview with a pharmacy technician on 06/11/18 at 10:02 am revealed: -The pharmacy received prescriptions for Resident #2 electronically. -The pharmacy had the physician's office visit medication lists on file. -The last order for Ambien in the pharmacy system was written on 06/12/17. -Ambien was never dispensed to the facility because the facility never requested a refill. -There were certain medications that needed to have a request from the facility staff to refill and Ambien was one of those medications. -The pharmacy did enter the order for Ambien into their system. -The last order for vitamin D2 was on 05/19/17 and the order did not have any refills. -The order for vitamin D2 from the office visit medication list was not used. -She did not know why the order was not used from the office visit medication list. -Vitamin D2 was last dispensed 05/19/17. Interview with Resident #2 on 06/11/18 at 2:50 pm revealed: -He recalled the physician mentioning an order for Vitamin D. -He did not know if it was given to him daily or weekly. -He did not know how many vitamins he was prescribed. -His blood was drawn at the last physician's office visit in April 2018. -The physician discussed a medication to help him sleep and he had requested it in the past. -The last date he recalled receiving the medication for sleep was seven or eight months	D 358		

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D 358	Continued From page 69 ago. Interview with the Administrator on 06/11/18 at 4:25 pm revealed: -The facility staff reviewed and used the physician's office visit notes and orders. -The facility staff did not send the office visit notes and orders to the pharmacy. -She thought the Ambien was discontinued and that she had seen a discontinued order in Resident #2's record. -Resident #2 was taking Ambien every night and in her opinion "that was too much for him." -The hospital filled all Resident #2's medication at discharge. -Resident #2's family member ensured the facility staff had all Resident #2's medications. -The facility staff had not requested a delivery of Ambien from the pharmacy. -She did not remember an order for vitamin D2 for Resident #2. -Resident #2 had labs drawn at his last physician's office visit. -She did not know his vitamin D level results nor if this specific lab test was completed during the last physician's office visit. Attempted interview with Resident #2's family member on 06/11/18 at 9:14 am was unsuccessful. 3. Review of Resident #1's FL2 dated 04/05/18 revealed: -Diagnoses included hypertension, hyperlipidemia, hypothyroidism, diabetes, advanced dementia, altered mental status, and thyroid cancer/status post thyroid resection. -There was an order for levothyroxine (thyroid hormone replacement) 50 mcg daily.	D 358		

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Review of Resident #1's April 2018 medication administration record (MAR) revealed:
-An entry for levothyroxine 50 mcg daily at 8 am.
-There was documentation of administration of levothyroxine 50 mcg at 8:00 am from 04/01/18 to 04/30/18.

Review of Resident #1's May 2018 MAR revealed:
-An entry for levothyroxine 50 mcg daily at 8 am.
-There was no documentation of administration of levothyroxine 50 mcg at 8:00 am from 05/01/18 to 05/31/18.

Review of Resident #3's June 2018 MAR revealed:
-An entry for levothyroxine 50 mcg daily at 8:00 am.
-There was documentation of administration of levothyroxine 50 mcg at 8:00 am from 06/01/18 - 06/04/18 and from 06/08/18 - 06/10/18.
-There was no documentation that levothyroxine 50 mcg was given on 06/05/18, 06/06/18, and 06/07/18.

Review of Resident #1's record on 06/07/18 revealed no documentation that the facility staff had notified the pharmacy or the physician regarding the levothyroxine 50 mcg.

Observation of medications on hand on 06/08/18 at 3:15 pm revealed there was no levothyroxine available.

Telephone interview with a pharmacist at the facility's pharmacy on 06/11/18 at 10:15 am revealed.
-Resident #1 did not have a current order for levothyroxine 50 mcg.
-The pharmacy did not routinely use the FL-2 as

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orders for medications.
-The pharmacy used the FL2 for orders on a new admission for only 1 month or in an emergency.
-The pharmacy had not received an order to discontinue the levothyroxine.
-The pharmacy had last filled the prescription for levothyroxine in January 2018.
-The pharmacy had sent multiple faxes for renewal to the physician of record.
-The pharmacy had received a refill denial from the physician's office in February 2018 (no reason was given).
-The pharmacy had continued to send request for refills even after the denial.

Interview with a medication aide (MA) on 06/11/18 revealed:
-She did not give levothyroxine on 06/09/18 and 06/10/18 because it was not available.
-She forgot to circle that she had not given the levothyroxine.
-She had called the pharmacy to find out why it was not available.
-The pharmacy had told her that the resident did not have a current prescription and that they faxed the order to the physician several times.

Interview with the Administrator on 06/11/18 at 3:46 pm revealed:
-Only 3 months of MARs were kept in the record. The others were kept in an outside building "somewhere".
-She had contacted the pharmacy in May regarding the levothyroxine.
-She did not know when the levothyroxine was last filled by the pharmacy.
-The resident may have had some in overstock for a while or the family may have brought some levothyroxine in for her.
-She did not know why the levothyroxine had

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D 358	Continued From page 72 been documented as given any in June 2018 because it was not available. -She did not have any documentation to show that she called the prescribing physician. Attempted interviews with the physician on 06/08/18 at 10:00 am and on 06/11/18 at 8:50 am was unsuccessful. Attempted interviews with the family on 06/07/18 at 8:25 am and on 06/11/18 at 9:45 am was unsuccessful. The facility failed to assure medications were administered as ordered for 3 residents observed during the medication passes, including multiple errors with the administration of a steroid nasal spray, laxatives, and thyroid medication (#7), oral inhaler and topical antifungal/steroidal cream (#8), and 2 opthalmic drops for glaucoma (#10); and for 2 sampled residents for errors with thyroid medication (#1), and Ambien and a vitamin D2 supplement (#2). This failure placed the residents at increased risk for lethagy and constipation for Resident #7, increased breathing difficulty for Resident #8, eye damage from increased ocular pressure for Resident #1, and sleep deprevation for Resident #2, which was detrimental to the health, welfare, and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/11/18 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED JULY 26, 2018.	D 358		

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D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 363		

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reviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 2 of 2 residents (#5, and #6) during the 8:00 am medication pass on 06/07/18.

The findings are:

Observation of the Administrator outside the dining room on 06/07/18 at 8:23 am revealed:
-The Administrator was preparing morning medications for administration to residents eating breakfast.
-The Administrator prepared 2 oral medications for Resident #5 in a plastic medication cup and placed the medication cup aside on top of the medication cart; the cup was not labeled with any information and the cup was not covered or sealed.
-She prepared 3 oral medications for Resident #6 in a plastic medication cup and placed the medication cup on top of the medication cup prepared for Resident #5.
-She took the medication cups to the hallway behind the dinning room where 2 residents were seated, and placed the correct medication cup in front of Resident #5 (after calling his name) and then gave Resident #6 his medications (after calling his name).
-The residents immedicately lifted up the medication cups and took their medications.
-The Administrator watched the residents take their medications before walking away.
-The Administrator documented the medication administration on Resident #5's and Resident #6's MARs.

1. Review of Resident #5's current FL2 dated 10/16/17 revealed:

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D 363	Continued From page 75 -Diagnoses included cognitive impairment, diabetes, hypertension, and hypertension. -There was an order for amlodipine (used to treat high blood pressure) 5 mg daily. -There was an order for triamterene-hydrochlorthiazide (used to treat high blood pressure) 37.5/25 mg daily. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Refer to interview on 06/07/18 at 8:27 am with the Administrator. Refer to a second interview on 06/11/18 at 4:00 pm with the Administrator. 2. Review of Resident #6's current FL2 dated 05/27/16 revealed: -Diagnoses included mild mental retardation, and schizophrenia paranoid type. -There was an order for paroxetine hydrochloride 20 mg (used to treat depression) every morning. -There was an order for haloperidol 20 mg (used to mental disorders) three times a day. -There was an order for benzotropine mesylate 2 mg (used to muscle twitches) twice a day. Interview on 06/08/18 at 8:00 am with Resident #6 revealed: -He routinely received his morning medication at the same time Resident #5 received his medication when certain staff members were administering morning medications. -He was not certain how often he received his medications at the same time as Resident #5. -He was able to recognize his medications by the color of the tablets.	D 363		

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D 363	Continued From page 76 Refer to interview on 06/07/18 at 8:27 am with the Administrator. Refer to a second interview on 06/11/18 at 4:00 pm with the Administrator. Interview on 06/07/18 at 8:27 am with the Administrator revealed: -She prepared Resident #5 and Resident #6's medications at the same time because they sat together in the back hallway. -It saved time and energy if she took both residents their medications in one trip. -Neither resident took many medications so it was easy to keep apart. Second interview on 06/11/18 at 4:00 pm with the Administrator revealed: -She was aware each resident should have medication administered and documented before preparing and administering another resident's medications. -She had administered Residents #5's and #6's medications at one trip to save some time. -She would make sure all staff administering medications were aware that prepouring medications was not allowed unless all requirements for labeling and documentation was completed.	D 363		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.	D 406		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to follow-up on medication review recommendations for 2 of 4 sampled residents (#3, and #6) related to updating FL2s over 1 year old for Resident #3 and Resident #6.

The findings are:

1. Review of Resident #3's current FL2 dated 10/21/16 revealed diagnoses included non-Hodgkin's lymphoma, weakness of both legs, onychomycosis, schizophrenia, and Parkinson Disease (chronic).

Review of Resident #3's record revealed there was no FL2 dated after 10/21/16.

Review of Resident #3's Consultant Pharmacist's Quarterly Medication Reviews revealed:
-Resident #3 had drug (medication) reviews documented on 11/08/17, 02/27/18, and 05/22/18.
-On 02/27/18, the Pharmacist documented Resident #3's FL2 was dated 10/21/16 and was "due".
-On 05/22/18, the Pharmacist documented Resident #3's FL2 was dated 10/21/16 with no further documentation related to the FL2.

Refer to telephone interview with the Consultant Pharmacist on 06/11/18 at 3:20 pm.

Refer to interview with the Administrator on 06/11/18 at 3:50 pm.

2. Review of Resident #6's current FL2 dated 05/27/16 revealed diagnoses included mild mental retardation, and schizophrenia paranoid

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D 406	Continued From page 78 type. Review of Resident #6's record revealed there was no FL2 dated after 05/27/16. Review of Resident #6's Consultant Pharmacist's Quarterly Medication Reviews revealed: -Resident #3 had drug (medication) reviews documented on 05/24/17, 08/28/17, 02/27/18, and 05/22/18. -On 02/27/18, the Pharmacist documented Resident #3's FL2 was dated 05/27/16 and was "overdue". -On 05/22/18, the Pharmacist documented Resident #3's FL2 was dated 05/27/16 with no further documentation related to the FL2. Refer to telephone interview with the Consultant Pharmacist on 06/11/18 at 3:20 pm. Refer to interview with the Administrator on 06/11/18 at 3:50 pm. _____ Telephone interview with the Consultant Pharmacist on 06/11/18 at 3:20 pm revealed: -He was responsible to complete the pharmacy reviews every quarter at the facility. -He left written information regarding any concerns noted during the reviews for Administrator for processing. -Upon completion of the review, he discussed concerns with the Administrator. -He was aware there were residents with FL2s over 1 year old and had discussed the need for current FL2s with the Administrator. -In the event the Administrator was not on site during the pharmacy review, the Consultant Pharmacist contacted the Administrator by phone to discuss the Quarterly Drug Review recommendations.	D 406		

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D 406	Continued From page 79 Interview with the Administrator on 06/11/18 at 3:50 pm revealed: -She was responsible for completing recommendations made by the Consultant Pharmacist during Quarterly Drug Reviews. -The Consultant Pharmacist had informed her that some residents's FL2s were more than 1 year old. -She had not completed reviewing and acting on the recommendations from the Quarterly Drug Reviews because she had been staffing as a medication aide for several weeks and the pharmacy reviews had been put aside. -She planned to assign medication aide Supervisors more of the responsibilities, such as completing Quarterly Drug Review recommendations, but had not done so at the present.	D 406		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure every resident was treated in a manner that promoted dinity and respect related to residents during meal time. The findings are: Based on observations, interviews, and record	D911		

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D911	Continued From page 80 reviews, the facility failed to provide feeding assistance in a manner that promoted resident dignity and respect for a resident (#3), who needed prompting to use a fork or spoon related to eating non-finger foods with his hands and dropping food, and a resident (#1), who was assessed for needing feeding assistance. [Refer to Tag D0312, 10A NCAC 13F .0904(f)(2) Nutrition and Food Service (Type B Violation)].	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to administering medications as ordered, and management of the facility. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 8 residents (#7, #8, and #10) observed during the medication passes, including multiple errors with the administration of a steroid nasal spray, laxatives,	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034019	A. BUILDING: _____ B. WING _____	06/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

(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
D912	Continued From page 81 and thyroid medication (#7), oral inhaler and topical antifungal/steroidal cream (#8), and 2 opthalmic drops for glaucoma (#10); and for 2 of 3 residents sampled (#1 and #2) for errors with thyroid medication (#1), and a sleep medication and vitamin D2 supplement (#2). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on observations, interviews, and record review, the Administrator failed to assure the management and overall operations of the facility by failing to meet and monitor rules related to housekeeping and furnishings, physical environment, other requirements, other staff qualifications, competency validation for LHPS tasks, TB test, medical examinations, resident assessments, personal care, food and nutrition, medication orders, medication administration, and pharmaceutical care. [Refer to Tag D0176, 10A NCAC 13F .0601(a) Management of Facilities (Type B Violation)].	D912		