STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047009	A. BUILDING: _____ B. WING _____	R-C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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{D 000}	Initial Comments The Adult Care Licensure Section and the Hoke County Department of Social Services conducted a follow-up survey on 06/19/18 - 06/21/18.	{D 000}		
{D 056}	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure cleaners, disinfectants, fluid solidifiers, paint, odor eliminators, and an insecticide spray were stored in locked areas of the facility resulting in hazardous chemicals being unattended and accessible to residents. The findings are: Observation of the maintenance storage room on Townsend Hall (assisted living side of the facility) on 06/19/18 at 11:08am revealed: -There was a sign on the door labeled "maintenance storage, keep locked". -The door was unlocked. -There was a spray can of pressurized contact insecticide (caution - keep out of reach of children; hazards to humans and domestic animals) in the storage room.	{D 056}		

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{D 056}	Continued From page 1 -The insecticide spray can was approximately half full. Observation of the utility room on Townsend Hall on 06/19/18 from 11:10am - 11:11am revealed: -There was a biohazard sign on the door. -The door to the utility closet was closed. -At 11:11am, maintenance staff came out of the utility room and walked to the maintenance storage room and opened the door which was unlocked. Interview with the maintenance staff on 06/19/18 at 11:11am revealed: -He had been in the utility room for about 20 minutes cleaning a machine. -He was aware there was a can of insecticide spray in the maintenance storage room. -The maintenance storage room was not locked because he was next door in the utility room and he was going to retrieve some items and go outside to work. -He would lock the door to the maintenance storage room before going outside. -The utility room was not usually locked because it was used for soiled linen. Observation on 06/19/18 at 11:14am revealed the maintenance staff locked the door to the maintenance storage room. Observation of the utility room on Townsend Hall on 06/19/18 at 11:15am revealed: -The door was unlocked. -There were three 1.6 ounce bottles of a fluid solidifier for liquid medical wastes (eye contact may cause slight irritation and/or redness; inhaled dust may cause respiratory irritation or damage) in an unlocked cabinet.	{D 056}		

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{D 056}	Continued From page 2 Interview with the director of resident services (DRS) on 06/19/18 at 1:55pm revealed: -The maintenance storage room should be locked. -The maintenance storage items were currently being stored in a locked building outside of the facility. -The maintenance storage room should have extra towels and washcloths. -She was not aware there were any chemicals in the maintenance storage room. -The utility room was not usually locked because it was used for soiled linens. -There should not be any chemicals stored in the utility room. -She was not aware the fluid solidifier was stored in the utility room. -They used to fluid solidifier to clean up if a resident vomits. -There were at least 4 residents on the assisted living side of the facility who were confused and wandered. Interview with a housekeeper on 06/20/18 at 8:35am revealed all of the storage areas where chemicals were stored were supposed to be locked. Observations of the utility room on Townsend Hall from 06/19/18 - 06/21/18 revealed: -On 06/19/18 at 3:49pm, the utility room was unlocked and 3 bottles of fluid solidifier were in the unlocked cabinet. -On 06/20/18 at 8:37am, the utility room was locked. -On 06/21/18 at 8:37am, the utility room was unlocked and 3 bottles of fluid solidifier were in the unlocked cabinet. On 06/21/18 at 11:25am, the utility room was unlocked and 3 bottles of fluid solidifier were in	{D 056}		

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{D 056}	Continued From page 3 the unlocked cabinet. Interview with the facility's nurse consultant on 06/21/18 at 11:25am revealed the chemicals should not be stored in an unlocked room. Observation on 06/21/18 at 11:30am revealed the facility's nurse consultant removed the 3 bottles of fluid solidifier from the unlocked utility room. Observation of the janitorial/housekeeping closet on Jordan Hall (assisted living side of the facility) on 06/19/18 at 10:25am revealed: -The door to the closet was unlocked. -There was a sign on the outside of the door that read "Janitors' Closet keep locked." -There were four bottles of liquid cleaning solution to the right of the door that were on metal stands and connected to a dispenser. -There was a large container of multipurpose and glass cleaner (keep out of reach of children - causes eye irritation), neutral pH floor cleaner (causes eye irritation, harmful if inhaled), disinfectant cleaner (keep out of reach of children), and odor eliminator (keep out of reach of children- may cause an allergic skin reaction, causes serious eye irritation). Observation of the janitorial/housekeeping closet on Jordan Hall on 06/19/18 at 11:07am revealed the closet was unlocked. Observation of the janitorial/housekeeping closet on Jordan Hall on 06/19/18 at 12:30pm revealed the closet was unlocked. Interview with a second housekeeper on 06/19/18 at 12:35pm revealed: -She was not aware the janitorial/housekeeping closet on Jordan Hall was unlocked.	{D 056}		

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{D 056}	Continued From page 4 -She had locked the closet but "someone must have unlocked it". -The closet was always locked. -She was not aware of any resident ever going into the closet. Interview with the DRS on 06/19/18 at 1:00pm revealed: -The janitorial closet was supposed to be locked. -The housekeepers have been instructed to keep the doors locked on the janitorial closets. Observation of the soiled linen/biohazard room on Jordan Hall (assisted living side of the facility) on 06/19/18 at 11:12am revealed: -There was a biohazard sign on the door. -The door was unlocked. -There was a spray bottle of liquid air and fabric odor eliminator (combustible, eye irritant, harmful if swallowed) sitting on the edge of the sink. Interview with a third housekeeper on Jordan Hall on 06/19/18 at 11:15am revealed: -The door to the soiled linen/biohazard room was not kept locked. -The bottle of liquid air and fabric odor eliminator was left in the soiled linen room by the night shift after they used it. -The liquid air and fabric odor eliminator should be in the locked utility room with the other cleaning agents. -She was not sure why it was left in the soiled linen room. Observation of the soiled linen/biohazard room on Jordan Hall on 06/19/18 at 1:52pm revealed the bottle of liquid air and fabric odor eliminator had been removed and was not in the room. Observation of the janitor's central supply closet	{D 056}		

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{D 056}	Continued From page 5 on North Hall (special care unit of the facility) on 06/19/18 at 11:07am revealed: -The door to the closet was unlocked. -There was a sign on the outside of the door that read "Janitor's Central Supply keep locked." -There was a box with four 1 gallon jugs of liquid solution sitting on the floor, to the right of the door beside a royal blue cleaning machine. -The box was labeled as an odor disinfectant. -There was two 5 gallon white buckets, with large rectangular warning labels and symbols written in the color of green on each side of the large buckets. -The two large white buckets were sitting on the floor beneath a large 4 shelved black metal rack. -There was a large 4 shelved white plastic rack, upon immediate entrance to the janitor's central supply door to the right. -There were several cans of paint on each of the shelves and one nine inch paint pan with fresh unused yellow pastel color paint inside the pan with a roller brush sitting on top of two professional semi-gloss paint cans on the second shelf of the white plastic rack. Observation of the maintenance staff on 06/19/18 at 11:29am revealed he entered the closet without using a key. Interview with maintenance staff on 06/20/18 at 4:40pm revealed: -He made an error in judgment, he forgot and left the janitor's central supply closet unlocked on North Hall. -The Administrator brought it to his attention, and stressed the importance of keeping all closets doors locked at all times throughout the entire facility. Interview with the Administrator on 06/19/18 at	{D 056}		

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{D 056}	Continued From page 6 12:01pm revealed: -The housekeeping closets were supposed to be locked on all halls. -Housekeeping and maintenance staff were supposed to keep all closets locked. Observation of the janitor's central supply closet on North Hall on 06/19/18 at 1:31pm revealed the door was locked. Interview with the DRS on 06/19/18 at 1:55 p.m. revealed: -Housekeeping and maintenance staff were responsible for keeping the storage areas locked. -There was no system to check behind staff to see if the storage areas were kept locked.	{D 056}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to coordinate referral appointments for 3 of 5 residents sampled (#2, #4, #5) including a resident (#2) with a referral to an otolaryngologist for a tongue lesion; a diabetic resident (#4) with a referral to an optometrist for a	{D 273}		

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{D 273}	Continued From page 7	{D 273}		

routine diabetic eye exam; and a dialysis resident (#5) with a referral to a gastroenterologist for anemia.

The findings are:

1. Review of Resident #2's FL-2 dated 09/18/17 revealed diagnoses included Alzheimer's disease, diabetes mellitus type 2, Insomnia, hypertension, altered mental status, hyperlipidemia, and gastroesophageal reflux disease.

Review of Resident #2's emergency room after visit summary dated 06/01/18 revealed:
-Resident #2's diagnoses were periorbital cellulitis and a tongue lesion.
-Extremely important for Resident #2 to follow up the tongue lesion with Otolaryngology, specialty provider given.

Review of Resident #2's progress notes, physician's visits, and after visit summary notes revealed there was no documentation the Otolaryngology, specialty provider, was contacted or an appointment was scheduled.

Telephone interview with the Otolaryngology nurse on 06/20/18 at 2:35pm revealed:
-The Otolaryngology, specialty provider had not been contacted regarding any known upcoming, or scheduled appointment for a tongue lesion for Resident #2.
-There was no noted inquiries of calls received from the facility, or anyone, pertaining to future appointments scheduled for Resident #2's tongue lesion.

Attempted telephone interview with Resident #2's PCP on 06/20/18 at 11:30am was unsuccessful.

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{D 273}	Continued From page 8 Interview with Director of Resident Services and Transportation Aide on 06/20/18 at 4:06pm revealed: -Resident #2 was taken and seen by his PCP for follow up after his 06/01/18 emergency room visit on 06/07/18. -The Transportation Aide could not recall if a follow up Otolaryngology appointment for the tongue lesion for Resident #2 had been scheduled or not, but she would check her scheduled appointment book. Second interview with Director of Resident Services and Transportation Aide on 06/21/18 at 9:47am revealed: -Resident #2's follow up Otolaryngology appointment for the tongue lesion was not scheduled, it was a human error oversight by the Transportation Aide. -On 06/20/18 the Transportation Aide called the Otolaryngology, specialty provider and scheduled an appointment for the tongue lesion for Resident #2 for 06/29/18 at 1:00 p.m. Refer to interviews with the DRS on 06/20/18 at 10:20am and 06/21/18 at 8:50am. Refer to interview with the Administrator on 06/21/2018 at 10:41am. 2. Review of Resident #4's FL-2 dated 02/01/17 revealed diagnoses included senile dementia, type 2 diabetes, hypothyroidism, depression, incontinence, thrombocytopenia disorder, vitamin D deficiency, mixed hyperlipidemia, anxiety, asthma, gastroesophageal reflux disease and obstructive sleep apnea. Review of a visit note from Resident #4's primary care provider (PCP) dated 12/27/17 revealed the	{D 273}		

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{D 273}	Continued From page 9 PCP referred Resident #4 to an optometrist for evaluation. Review of Resident #4's record revealed there was no documentation that Resident #4 had been seen by an optometrist. Interview with the transportation aide (TA) on 06/20/18 at 10:30am revealed: -She was not aware of a referral to the optometrist for Resident #4 until it was brought to her attention on 06/20/18. -She transported Resident #4 to the doctor's appointment on the day (12/27/17) the referral was made to the optometrist. Interview with the Administrator on 06/21/18 at 10:30am revealed Resident #4 had not been established with an optometrist. Telephone interview with the medical assistant at Resident #4's PCP's office on 06/20/18 at 3:40pm revealed: -Resident #4 was referred to the optometrist for a routine appointment because he was diabetic. -The PCP had no specific concerns about Resident #4's eyes at this time. Refer to interviews with the DRS on 06/20/18 at 10:20am and 06/21/18 at 8:50am. Refer to interview with the Administrator on 06/21/18 at 10:41am. 3. Review of Resident #5's current FL-2 dated 06/13/18 revealed: -Diagnoses included anemia in chronic kidney disease, end stage renal disease, cellulitis, muscle weakness, difficulty in walking, dysphagia, essential hypertension, and pain - unspecified.	{D 273}		

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{D 273}	Continued From page 10 -The resident went to dialysis 3 times a week on Tuesdays, Thursdays, and Saturdays. Review of orders from Resident #5's dialysis center on 04/12/18 revealed the resident was to be referred to a gastroenterologist for anemia and history of esophageal ulcers. Review of Resident #5's provider visit notes and progress notes revealed no documentation the resident had been seen by a gastroenterologist. Interviews with Resident #5 on 06/20/18 at 8:25am and 5:05pm revealed: -She felt okay but she was tired especially after dialysis. -She was not sure if she had seen a gastroenterologist. Interview with the director of resident services (DRS) on 06/21/18 at 4:10pm revealed: -Resident #5 had not seen a gastroenterologist to her knowledge. -She had not noticed the referral order on the dialysis visit form dated 04/12/18. -The transportation aide (TA) usually set up the appointments. -The TA was currently not in the facility and was transporting residents. Interview with the facility's nurse consultant on 06/21/18 at 4:20pm revealed: -It was sometimes difficult to determine which information on the dialysis visit notes was for the facility staff to follow. -The TA was not currently at the facility but she was checking on the gastroenterologist referral for Resident #5. -She would contact the dialysis center regarding the gastroenterology referral.	{D 273}		

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{D 273}	Continued From page 11 Interview with the facility's nurse consultant on 06/21/18 at 4:35pm revealed the TA did not make an appointment for Resident #5 to see a gastroenterologist. Telephone interview with a nurse at Resident #5's dialysis center on 06/21/18 at 4:54pm revealed: -The facility was supposed to make the appointment for the resident to see a gastroenterologist since the facility transported the resident to appointments. -They were not aware the resident had not seen a gastroenterologist. -The referral was made because the resident's hemoglobin was low. Refer to interviews with the DRS on 06/20/18 at 10:20am and 06/21/18 at 8:50am. Refer to interview with the Administrator on 06/21/18 at 10:41am. _____ Interviews with the DRS on 06/20/18 at 10:20am and 06/21/18 at 8:50am revealed: -The transportation aide (TA) was the only employee who made routine and follow-up appointments for the residents. -When an appointment was needed for a resident the referral paperwork was put on the TA's desk. -No one checked behind the TA to make sure the appointments were made; the TA "does her own thing". Interview with the Administrator on 06/21/18 at 10:41am revealed: -The supervisor on duty should put any paperwork from provider visits or hospital visits on the TA's desk. -The TA would make appointments and document	{D 273}		

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{D 273}	Continued From page 12 in the appointment book. -There was no system to check behind the TA to make sure referral appointments were made and followed through.	{D 273}		
{D 375}	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 2 of 3 residents sampled (#3, #6) who self-administered medications had physicians' orders to self-administer including a resident (#6) with medications in her room for pain/fever, mouth sores, dry eyes, and dry nasal passages, and a resident (#3) with an antacid and an unlabeled medication for pain/fever with no label or specific instructions for use. The findings are:	{D 375}		

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{D 375}	Continued From page 13 Review of the facility's policy and procedure for self-administration of medications revealed: -Resident will be competent and physically able. -Self-administration of medications will be ordered by a physician and kept in the resident's record. -Specific instructions for administration of the medication will be printed on the label. -The physician will be notified of a resident has a change in mental or physical ability or is non-compliant with the physician's orders or facility policies. 1. Review of Resident #6's current FL-2 dated 06/05/18 revealed: -The resident's diagnoses included displaced fracture of olecranon, history of falls, muscle weakness, difficulty in walking, type 2 diabetes, current use of insulin, hypothyroidism, hyperlipidemia, acute chronic obstructive pulmonary disease, hypertension, acute chronic diastolic congestive heart failure and obstructive sleep apnea. -There were orders for Resident #6 to self-administer Cepastat Lozenges (used to treat sore is throat), Medicated Chest Rub (topical cough suppressant), Tylenol (pain reliever and fever reducer), and Melatonin (used for insomnia). Review of Resident #6's assessment and care plan dated 06/05/18 revealed: -The resident was oriented and had adequate memory. -There was no documentation regarding self-administration of medications. Observation of Resident #6's room on 06/19/18 at 11:20am revealed: -Resident #6 had several medications on her	{D 375}		

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	HAL047009	A. BUILDING: _____ B. WING _____	R-C 06/21/2018

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{D 375}	Continued From page 14	{D 375}		

night stand and in baskets by her recliner.
-Resident #6 did not have a roommate.
-There was a bottle of Magic Mouthwash. (Magic Mouthwash is used to treat mouth sores.)
-There was a bottle of Systane Gel eye drops and a bottle of Refresh Optive (Systane and Refresh Optive are lubricant eye drops used to treat dry eyes.)
-There was a bottle of Ayr Saline Nasal Spray (Ayr Saline Nasal Spray is used to treat dryness of the nose.)

Interviews with Resident #6 on 06/19/18 at 11:20am and on 06/20/18 4:20pm revealed:
-She called the local pharmacy when she needed medication and the pharmacy or her family would bring it to her.
-She put 1 drop of the Systane and Refresh in each eye when her eyes got dry.
-The facility staff was aware the medications were in the room.
- She used the nose spray sparingly; she did not use it every day.

Review of Resident #6's physician's orders revealed:
-There were no orders for Magic Mouthwash, Systane, Refresh Optive or Ayr Saline Nasal Spray.
-There were no orders for the resident to self-administer any of these medications.

Interviews with the director of resident services (DRS) on 06/20/18 at 4:10pm and 06/21/18 at 8:50am revealed:
-The DRS was not sure what medications Resident #6 had in her room.
-Resident #6 would call an outside pharmacy to order things and the pharmacy or her family would bring them to her.

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{D 375}	Continued From page 15 -Resident #6 did not have orders to self-administer the Magic Mouthwash, Systane, Refresh Optive, or Ayr Saline Nasal Spray. -She sent a fax to Resident #6's primary care provider(PCP) to request self-administration orders for some of the resident's medication. Refer to interview with the facility's nurse consultant on 06/21/18 at 9:50am. Refer to interview with the DRS on 06/21/18 at 9:58am. 2. Review of Resident #3's current FL-2 dated 06/12/18 revealed the resident's diagnoses included cutaneous abscess left limb, cellulitis left upper limb, anemia, essential hypertension, history of falling. Observation of Resident #3's room on 06/19/18 at 11:15am revealed: -Resident #3 had a clear zip lock bag that was sealed and rolled up with 16 white tablets in it sitting on the top of her desk. -There was a bottle of Tums 750mg Smoothies sitting in a basket toward the back of her desk (Tums are used to treat heartburn and acid indigestion.) -Resident #3 did not have a roommate. -Review of the imprint code on the white tablets revealed the tablets were Tylenol 325 mg tablets. (Tylenol is a pain reliever and fever reducer.) Review of Resident #3's current assessment and care plan dated 06/12/18 revealed: -The resident was oriented and had adequate memory. -The resident required limited assistance with ambulation and grooming. -The resident required extensive assistance with	{D 375}		

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{D 375}	Continued From page 16	{D 375}		

toileting, bathing, dressing and transferring.
-The resident was independent with eating.
-There was no documentation regarding self-administration of medication.

Interviews with Resident #3 on 06/19/18 at 11:20am and 2:30pm revealed:
-A friend had brought her the Tylenol and the Tums.
-Her primary care provider told her she could self-administer the Tylenol for her back and leg pain.
-She had a check off list with the date and time she took the Tylenol.
-She was taking the Tylenol every 6 hours for back and leg pain.
-She took the Tylenol out of the original bottle and put it in the zip lock bag because it was easier for her to access it.
-The facility medication aide (MA) staff knew she had the Tylenol in a zip lock bag.
-She was not aware that the Tylenol should be stored in the original container.
-She was not sure if the facility staff knew she had the Tums.
-She did not know if there was an order for the Tums.
-Her friend brought her the bottle of Tums about 2 months ago.
-She had not taken the Tums in at least a month.

Review of Resident #3's physician's orders dated 06/21/18 revealed:
-There was an order for her to self-administer the Tylenol.
-There was no physicians order for the Tums.

Interview with a MA on 06/21/18 at 10:35am revealed:
-She was aware Resident #3 had Tylenol in her

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{D 375}	Continued From page 17 room. -She thought Resident #3 had an order to self-administer the Tylenol. -She did not think Resident #3 had any other medications in her room. Interview with the facility's nurse consultant and director of resident services (DRS) on 06/21/18 at 9:53am revealed: -They knew Resident #3 was self-administering the Tylenol. -They were not aware that Resident #3 was storing her Tylenol in a zip lock bag and not in the original container. -They were not aware Resident #3 had a bottle of Tums in her room. -They do not routinely check the resident's rooms to see if they have medications that would require self-administration orders. Interview with the facility's nurse consultant on 06/21/18 at 11:45am revealed: -They were obtaining a bottle of Tylenol with an easy open lid for Resident #3. -The bottle of Tums was removed from Resident #3's room because she no longer wanted it. Refer to interview with the facility's nurse consultant on 06/21/18 at 9:50am. Refer to interview with the DRS on 06/21/18 at 9:58am. Interview with the facility's nurse consultant on 06/21/18 at 9:50am revealed: -A resident's physician made the decision of whether a resident could self-administer. -They did not have a system to routinely evaluate or check with residents who self-administered medications to assure compliance and continued	{D 375}		

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{D 375}	Continued From page 18 ability to self-administer. -If they noticed an issue and felt a resident was no longer capable of self-administering, they would notify the physician and the medication aides would start administering the medications. Interview with the DRS on 06/21/18 at 9:58 a.m. revealed: -There were no assessments or evaluations done for residents who self-administered medications. -There was no system to check the residents to determine non-compliance or continued ability to self-administer.	{D 375}		