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WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

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D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey on July 16-17, 2018 with an exit conference via telephone on July 18, 2018.	D 000		
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: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 1 of 3 staff sampled (Staff B, relief Supervisor) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40 prior to having direct contact with residents while performing duties related to resident care. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 12/18/17 as a relief Supervisor. -A criminal background check dated 12/18/17 with a notation for local county only. Interview with the Administrator on 07/17/18 at 2:10pm revealed: -She went to the county courthouse and requested a criminal background check for Staff B. -She did not realize it was for the local county	D 139		

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D 139	Continued From page 1 only. -She will request a statewide background check for Staff B. The facility failed to assure Staff B had a criminal background check in accordance with G.S. 114-19.10 and 131D-40 prior to having direct contact with residents and providing direct resident care. This failure was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/17/18 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 1, 2018.	D 139		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents were served three meals a day at regular hours with at least 10 hours between the breakfast and evening meals. The findings are:	D 297		

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D 297	Continued From page 2 Interview with the Supervisor on 07/16/18 at 8:40am revealed there were nine residents who lived in the facility. Observation on the initial facility tour on 07/16/18 at 8:45 am revealed residents were eating breakfast in the dining room. Interviews with seven residents on 07/16/18 and 07/17/18 revealed: -Four of seven residents reported getting hungry between meals. -Meals were served at 9:00am, 1:00pm, and 6:00pm. -Meals were served between 8:30-9:30am, 1:00-1:30pm, and 6:30-7:30pm. -Lunch was "usually" served between 12:30-1:00pm. -"Sometimes lunch is late 12:30-12:45." -Supper time "can be 7:30 depends on whose here." Interview with the Administrator on 07/16/18 at 10:06am revealed: -Breakfast was served at 9:00am. -Lunch was served at 1:00pm. -Supper was served at 6:00pm. Observation of the lunch meal service on 07/16/18 from 1:05pm to 1:26pm revealed: -The cook plated the food and placed it on the dining room tables. -At 1:05pm, the residents were allowed to enter the dining room to eat. -Residents received lasagna, tossed salad with dressing, a roll, fruit cocktail, water, and beverage of choice. -At 1:26pm, the residents had finished the meal.	D 297		

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D 297	Continued From page 3 Observation of the breakfast meal service on 07/17/18 from 9:16am to 9:44am revealed: -The cook plated the food and placed it on the dining room tables. -At 9:16am, the residents were allowed to enter the dining room to eat. -Residents received scrambled eggs, 2 slices of bacon, grits, toast, margarine, orange juice, milk, and coffee. -At 9:44am, the residents had finished the meal. Interview with a family member on 07/16/18 at 9:25am revealed: -She visited the facility frequently. -The residents received three meals a day. -The weekend staff served meals "earlier." -The staff in the facility during the week served meals "later." -She did not specify meal times. Interview with the Administrator on 07/17/18 at 2:10pm revealed: -"A bunch of residents complained" when breakfast was served at 7:30am. -"So we moved it to 8:00am." -When breakfast was served at 8:00am, only "half" of the residents would get up to eat breakfast. -"So then we made it later and we got everyone to the breakfast table." -"I could move it to 8:30am. I've never tried it at that time."	D 297		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to	D 298		

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residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to offer or make available three snacks a day to all residents and shown on the menu.

The findings are:

Interview with the Supervisor on 07/16/18 at 8:40am revealed there were nine residents who lived in the facility.

Interviews with seven residents on 07/16/18 and 07/17/18 revealed:
-Seven of seven residents interviewed about snacks were not offered a snack three times a day.
-Seven of seven residents stated snacks were not made available to them in the facility.
-Four of seven residents reported getting hungry between meals.
-Snacks were offered "once in awhile."
-Snacks were offered "sometimes."
-Snacks were offered "maybe once every two weeks."
-"We normally don't have snacks."
-"If someone gets hungry, they will fix them a sandwich. But, generally we don't have snacks."
-"I have asked them for a slice of bread between breakfast and lunch because I'm hungry."

Review of the facility week at a glance menu revealed:
-The menu did not list morning or afternoon

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snacks.
-The menu listed one daily snack at bedtime.

Observations on 07/16/18 at 12:25pm of the snack food available in the facility revealed:
-There were 18 packs of cookies which included regular and sugar free types.
-There were 2 plastic containers with cookies.
-There was a box of microwave popcorn.
-There were 2 boxes of Pop Tarts.
-There were several boxes of pudding and gelatin.
-There were several cans of fruit.
-There were 2 boxes of cake mix.
-There was one box of saltine crackers.

Observations on 07/16/18 from 8:45am to 1:26pm revealed no snacks were offered or made available to residents.

Observations on 07/16/18 from 2:30pm to 3:45pm revealed no snacks were offered or made available to residents.

Observations on 07/17/18 from 8:45am to 12:00pm revealed no snacks were offered or made available to residents.

Observation on 7/17/18 at 3:05pm revealed a medication aide passed out cookies to residents for afternoon snack.

Interview with a medication aide on 7/17/18 at 2:40pm revealed she served snacks to the residents three times a day.

Interview with the Administrator on 07/17/18 at 2:10pm revealed:
-The staff offered the residents snacks "in the morning and afternoon and they get snacks at

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D 298	Continued From page 6 night with their meds." -Staff took snacks to the residents' rooms and offered them to the residents. -Snacks offered to the residents included cookies, crackers, popcorn, and fruit. -Beverages were also made available to residents at snack time. -"I'm buying tons of snack supplies."	D 298		
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 observations, interviews, and record reviews, 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 3 of 3 sampled residents (Residents #1, #2, and #3). The findings are: 1. Review of Resident #3's current FL2 dated 11/11/17 revealed: -Diagnoses included schizophrenia, hypertension, type 2 diabetes, hypothyroidism, and osteoarthritis. -There was an order for aspirin EC (used to	D 349		

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prevent blood clots) 325mg 1 tablet daily.
-There was an order for glipizide (used to regulate blood sugar) 5mg daily with breakfast.
-There was an order for vitamin D3 (used to treat vitamin D deficiency) 2,000 units 2 tablets daily.
-There was an order for lisinopril (used to treat high blood pressure) 10mg 1 tablet daily.
-There was an order for levothyroxine (used to treat hypothyroidism) 50mcg 1 tablet daily.
-There was an order for propranolol (used to treat tremors) 10mg 1 tablet three times daily.
-There was an order for vitamin B12 (used to treat vitamin B12 deficiency) 1,000mcg 2 tablets daily.
-There was an order for Depakote DR (used to treat seizures) 250mg 1 tablet daily.
-There was an order for docusate sodium (used to treat constipation) 100mg 1 capsule two times daily.
-There was an order for gabapentin (used to treat neuropathy) 600mg 1 tablet twice daily.
-There was an order for metformin ER (used to regulate blood sugar) 750mg 1 tablet twice daily.
-There was an order for risperidone (used to treat schizophrenia) 2mg 1 tablet daily at bedtime.
-There was an order for Miralax powder (used to treat constipation) 17 gm. in 8 oz. of water daily.
-There was an order for haldol (used to treat schizophrenia) 2mg 1 tablet twice daily as needed for anxiety.
-There was an order for trazodone (used to treat insomnia) 50mg 1 tablet daily at bedtime as needed.
-There was an order for Dulcolax suppository (used to treat constipation) 10mg per rectum three times weekly.
-There was an order for Gold Bond Medicated Powder (used to treat skin conditions) apply under breasts daily as needed.
-There was an order for Senna-Gen NF (used to

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treat constipation) 2 tablets at bedtime as needed for constipation.

Review of Resident #3's record revealed there was no six month physician review of the resident's medications and treatments after the FL2 dated 11/11/17.

Review of Resident #3's pharmacy medication review dated 04/20/18 revealed a recommendation to obtain a copy of current physician orders for the resident record.

Observation of Resident #3's medications on hand on 07/17/18 at 11:27am revealed there was no propranolol 10mg available for administration.

Telephone interview with a pharmacist from the facility pharmacy on 07/17/18 at 4:10pm revealed:
-There was no current order for Resident #3's propranolol.
-The pharmacy had "tried to fill it 05/04/18" and sent the medication to the facility.
-The facility had sent the propranolol back to the pharmacy because "they didn't have an order for it."
-The pharmacy did not have a six month medication update for Resident #3.
-The facility was "waiting on some doctor's orders to be signed" to verify Resident #3's current medication orders.

Telephone interview with Resident #3's primary care provider's medical assistant on 07/18/18 at 10:37am revealed:
-"We have no record of an 11/11/17 FL2."
-"It's an ongoing issue with us and the facility."
-"We have not completed an FL2 for her with that date."
-They had no record of completing an FL2 for

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Resident #3 for 2017 or 2018.
-They had not seen the resident since March 2017.
-The resident had missed her scheduled appointment in September 2017.
-The resident had an urgent care visit to another provider in their practice in May of 2018.
-Resident #3 had a scheduled appointment to see her regular primary care provider on 07/23/18.

Telephone interview with the Resident Care Coordinator (RCC) on 07/18/18 at 12:28pm revealed:
-She had a "call in" to Resident #3's primary care provider's office to get a new script for the propranolol.
-Resident #3's primary care provider had signed the FL2 dated 11/11/17.
-Resident #3 had an appointment with her primary care provider for 07/23/18 to go over her medications and treatments and to get prescriptions.

Telephone interview with the Administrator on 07/18/18 at 12:52pm revealed:
-Resident #3's FL2 dated 11/11/17 came from her primary care provider.
-"It just didn't get logged into their system."
-The FL2 problem had been identified in May 2018 and the staff had "tried to get it taken care of and couldn't get an appointment."
-"We took her over there and they wouldn't see her as a walk-in."

Refer to the interview with the RCC on 07/17/18 at 2:30pm and 3:55pm.

2. Review of Resident #1's current FL2 dated 08/24/17 revealed:
-Diagnoses included chronic obstructive

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pulmonary disease, hypertension, bipolar, osteoporosis, and osteoarthritis.
-There was an order for albuterol (used to treat shortness of breath) 90mcg/inh 2 puffs four times daily as needed.
-There was an order for Eliquis (used to prevent blood clots) 5mg 1 tablet twice a day.
-There was an order for Lipitor (used to reduce cholesterol) 20mg 1 tablet daily at bedtime.
-There was an order for caltrate + D (used to treat osteoporosis) 1 tablet three times a day with meals.
-There was an order for Zyrtec (used to treat allergy symptoms) 10mg 1 tablet daily.
-There was an order for vitamin D3 (used to treat osteoporosis) 1,000 units 1 tablet daily.
-There was an order for Premarin vaginal (used to treat symptoms of menopause) 0.625mg/gm 1 applicator full vaginally every Wednesday and Sunday.
-There was an order for Voltaren topical (used to treat pain) 1% gel 1 application topically four times a day.
-There was an order for furosemide (used to reduce fluid) 20mg 1.5 tablets every day.
-There was an order for Neurontin 300mg (used to treat pain) 1 capsule every day.
-There was an order for Neurontin 300mg 2 capsules daily at bedtime.
-There was an order for vistaril pamoate (used to treat anxiety) 50mg 1 capsule two times a day as needed.
-There was an order for Lamictal (used to treat seizures) 200mg 1.5 tablets daily.
-There was an order for magnesium oxide (used to treat low magnesium levels) 250mg 1 tablet daily.
-There was an order for Nitrostat (used to treat chest pain) 0.3mg 1 tablet sublingual every 5 minutes as needed for chest pain.

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D 349	Continued From page 11 -There was an order for omeprazole (used to reduce stomach acid) 20mg 1 capsule twice a day before meals. -There was an order for Zofran (used to treat nausea) 4mg 1 tablet three times a day as needed for nausea and vomiting. -There was an order for polyethylene glycol 3350 17 gms. once daily in liquid as needed for constipation. -There was an order for quetiapine (used to treat bipolar disorder) 25mg 1 tablet daily at bedtime. -There was an order for ropinirole (used to restore levels of dopamine in the brain) 1mg 1 tablet three times daily. -There was an order for Zoloft (used to treat depression) 50mg three tablets daily. -There was an order for sotalol (used to treat high blood pressure) 1 tablet twice daily. -There was an order for aldactone (used to reduce fluid) 25mg 1 tablet daily. -There was an order for trazodone (used to treat insomnia) 100mg two tablets daily at bedtime. -There was an order for zinc oxide (used to treat skin irritations) topical 20% ointment 1 application daily. -There was an order for latanoprost ophthamic (used to treat glaucoma) 0.005% solution 1 drop in right eye at bedtime. -There was an order for hydrocodone/acetaminophen 5/325mg 1 tablet three times a day as needed for pain. Review of Resident #1's medication and treatment orders pharmacy print out dated 04/11/18 revealed: -The orders were signed by a nurse practitioner. -The orders were not dated by the nurse practitioner. -There was an order for quetiapine 25mg 1 tablet twice daily.	D 349		

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D 349	Continued From page 12 -There was an order for quetiapine 25mg 1 tablet daily as needed for anxiety. Review of Resident #1's pharmacy medication review dated 04/20/18 revealed a recommendation to obtain a copy of current physician orders for the resident record. Observation of Resident #1's medications available on hand on 07/17/18 at 10:27am revealed there was no quetiapine 25mg on hand for scheduled or as needed administration. Interview with the RCC on 07/16/18 at 11:25am revealed: -The orders signed by the nurse practitioner on the print out dated 04/11/18 were the most current orders for Resident #1. -"I'm going today to the doctor's office to get them signed." -Resident #1 would have needed a medication and treatment order update in February 2018. -"We don't have it." -"I just took over the position of RCC." -"I don't know why it was not done." Interview with the RCC on 07/17/18 at 11:20am revealed: -Resident #1 was "out" of her quetiapine. -"I have to order some today." -"She just ran out this morning cause I gave it to her last night." Interview with the Administrator on 07/17/18 at 2:10pm revealed she had no idea why there was no quetiapine on hand for Resident #1. Telephone interview with a pharmacist from the facility pharmacy on 07/17/18 at 4:10pm revealed: -The quetiapine 25mg 1 tablet twice daily was	D 349		

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from an order dated 05/04/18.
-Initially the pharmacy sent out 30 tablets of quetiapine 25mg or a 15 day supply on 05/04/18.
-Then the pharmacy dispensed 60 tablets or a one month supply of quetiapine for Resident #1 on 5/5/18, 6/12/18, and 7/17/18.

Refer to the interview with the RCC on 07/17/18 at 2:30pm and 3:55pm.

3. Review of Resident #2's current FL2 dated 12/06/17 revealed:
-Diagnoses which included hypertension, coronary artery disease, schizoaffective disorder with paranoia and major depressive disorder.
-There was an order for Effexor (used to treat depression) 150mg 1 tablet daily.
-There was an order for Cogentin (used to treat symptoms of Parkinson's disease) 0.5mg 1 tablet daily.
-There was an order for Abilify (used to treat schizophrenia and bipolar disorder) 30mg 1 tablet daily.
-There was an order for vitamin D3 (used to treat Vitamin D deficiency) 1000units 1 tablet daily.
-There was an order for metoprolol (used to treat hypertension) 25mg 1 tablet daily.
-There was an order for Synthroid (used to treat hypothyroidism) 50mcg 1 tablet daily.
-There was an order for Fenofibrate (used to treat high cholesterol) 145mg 1 tablet daily.
-There was an order for Depakote (used to treat bipolar disorder) 250mg 1 tablet in the morning.
-There was an order for Depakote 500mg 2 tablets at bedtime.
-There was an order for Klonopin (used to treat agitation) 0.5mg 1 tablet in the morning.
-There was an order for Klonopin 0.5mg 2 tablets at bedtime.
-There was an order for Klonopin 0.5mg 1 tablet

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twice daily as needed for agitation.
-There was an order for aspirin-enteric coated (used to prevent blood clots) 325mg 1 tablet daily with food.
-There was an order for multivitamin (used to treat vitamin deficiency) 1 tablet daily.
-There was an order for flaxseed oil 1000mg 1 tablet twice daily.
-There was an order for Remeron (used to treat depression) 15mg 1 tablet at bedtime.
-There was an order for tamulosin (used to treat benign prostatic hyperplasia) 0.4mg 2 tablets at bedtime.
-There was an order for trazodone (used to help with sleep) 150mg 1 tablet at bedtime.
-There was an order for Aricept (used to treat dementia symptoms) 10mg 1 tablet at bedtime.
-There was an order for Sennalax-S 2 tablets at bedtime as needed for constipation.
-There was an order for Nitrostat 0.3mg 1 tablet every 5 minutes for chest pain not to exceed 4 tablets.
-There was an order for Mucinex ER 600mg 1 tablet four times daily as needed for congestion.
-There was an order for ibuprofen 400mg 1 tablet every 8 hours as needed for back pain.
-There was an order for Tylenol 325mg 2 tablets every 6 hours as needed for pain, fever and headache.

Review of Resident #2's record revealed there was no six month physician review of the resident's medications and treatments after the FL2 dated 12/06/17.

Refer to the interview with the RCC on 07/17/18 at 2:30pm and 3:55pm.

Interview with the Resident Care Coordinator

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D 349	Continued From page 15 (RCC) on 07/17/18 at 2:30pm and 3:55pm revealed: -She had just taken over the RCC responsibilities. -The previous RCC had been responsible for getting all the medication and treatment orders reviewed and updated by a primary care provider. -The previous RCC had not kept the medication and treatment orders up-to-date. -She was currently working on updating 6 month medication orders for all residents.	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: Based on observations, interviews, and record reviews the facility failed to assure medications were administered as ordered for 2 of 3 sampled residents related to an eye drop (Resident #1) and a beta blocker (Resident #3). The findings are: 1. Review of Resident #3's current FL2 dated 11/11/17 revealed: -Diagnoses included schizophrenia, hypertension, type 2 diabetes, hypothyroidism, and	D 358		

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osteoarthritis.
-There was an order for propranolol (used to treat tremors) 10mg 1 tablet three times daily.

Review of Resident #3's record revealed there was no six month physician review of the resident's medications and treatments after the FL2 dated 11/11/17.

Observation of Resident #3's medications available in the facility's medication cart on 07/17/18 at 11:27am revealed there was no propranolol 10mg on hand for administration.

Interview with the Resident Care Coordinator on 07/17/18 at 11:30am revealed:
-She had notified the pharmacy Resident #3's propranolol was out on the morning of 07/16/18.
-The resident's propranolol script was "out of date" and the pharmacy was waiting on the physician to send a new script.
-The resident had been out of the propranolol since 7/16/18.

Review of Resident #3's May 2018 Medication Administration Record (MAR) revealed:
-An entry for propranolol 10mg 1 tablet three times a day for tremor scheduled at 9:00am, 1:00pm, and 6:00pm.
-The propranolol was documented as administered 93 occurrences out of 93 opportunities from 05/01/18 to 05/31/18.

Review of Resident #3's June 2018 MAR revealed:
-An entry for propranolol 10mg 1 tablet three times a day for tremor scheduled at 9:00am, 1:00pm, and 6:00pm.
-The propranolol was documented as administered 90 occurrences out of 90

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opportunities from 06/01/18 to 06/30/18.

Review of Resident #3's July 2018 electronic Medication Administration Record (eMAR) revealed:
-An entry for propranolol 10mg 1 tablet three times a day for tremor scheduled at 9:00am, 1:00pm, and 6:00pm.
-The propranolol was documented as administered 49 occurrences out of 50 opportunities from 07/01/18 to 07/17/18 at 1:00pm.
-On 07/17/18 at 2:36pm, the propranolol was documented as not administered due to the resident being "out of facility."

Interview with Resident #3 on 07/17/18 at 2:00pm revealed:
-She did not know if she had been receiving propranolol recently.
-"I don't know the difference between my meds."
-"I just take what they give me and hope I do alright."
-She was experiencing tremors in her hands.
-The tremors in her hands made it harder for her to use her hands, especially the use of her right hand to feed herself.

Telephone interview with a pharmacist from the facility pharmacy on 07/17/18 at 4:10pm revealed:
-There was no current order for Resident #3's propranolol.
-The pharmacy had "tried to fill it 05/04/18" and sent the medication to the facility.
-The facility had sent the propranolol back to the pharmacy, because "they didn't have an order for it."
-The pharmacy had never received a discontinue order from the physician.
-The facility was "waiting on some doctor's orders

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to be signed" to verify Resident #3's current medication orders.

Interview with the RCC on 07/17/18 at 4:20pm revealed:
-"I called and left a message with the triage nurse to get a new script. I called yesterday morning (07/16/18)."
-"She's been on it a long time for tremors."

Telephone interview with Resident #3's primary care provider's pharmacy on 07/18/18 at 10:02am revealed:
-The pharmacy had not filled anything for Resident #3 "in a long time."
-"We have everything on hold for her."
-"If she's not getting them from [the facility pharmacy name] I'm not sure where she's getting them."

Telephone interview with a representative from the facility pharmacy on 07/18/18 at 10:20am and 11:06am revealed:
-They had not filled Resident #3's propranolol "since May for the June cycle fill."
-The propranolol would have been delivered to the facility on 06/01/18.
-She could not find a record of any propranolol being returned to the pharmacy.
-"We don't have a current order."
-The pharmacy only had a "MAR attached but no signature, so no order."
-"We have been faxing the doctor, but the doctor has been refusing to fill it."

Telephone interview with Resident #3's primary care provider's medical assistant on 07/18/18 At 10:37am revealed:
-The order for the propranolol on the 11/11/17 FL2 had not been prescribed by the primary care

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provider.
-"We have no record of an 11/11/17 FL2."
-"It's an ongoing issue with us and the facility."
-"We have not completed an FL2 for her with that date."
-They had no record of completing an FL2 for Resident #3 for 2017 or 2018.
-They had not seen the resident since March 2017.
-The resident had missed her scheduled appointment in September 2017.
-The resident had an urgent care visit to another provider in their practice in May of 2018.
-Resident #3 had a scheduled appointment to see her regular primary care provider on 07/23/18.

Telephone interview with the Resident Care Coordinator (RCC) on 07/18/18 at 12:28pm revealed:
-She had a "call in" to Resident #3's primary care provider's office to get a new script for the propranolol.
-Resident #3's primary care provider had signed the FL2 dated 11/11/17.
-Resident #3 had an appointment with her primary care provider for 07/23/18 to go over her medications and treatments and to get prescriptions.

Interview with the Administrator on 07/17/18 at 2:10pm revealed:
-She would expect the staff to call the physician and get them to send a new script if the script was running out.
-When an medication was "down to the last couple of days" of the supply, "they are supposed to reorder."
-"On the electronic MAR, it now tells us when you need to call the doctor for a new script."
-They had begun using the electronic MARs in

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the facility on 07/01/18.

Telephone interview with the Administrator on 07/18/18 at 12:52pm revealed:
-"To the best of her knowledge" Resident #3's FL2 dated 11/11/17 came from her primary care provider.
-"It just didn't get logged into their system."
-The FL2 problem had been identified in May 2018 and the staff had "tried to get it taken care of and couldn't get an appointment."
-"We took her over there and they wouldn't see her as a walk-in."

2. Review of Resident #1's current FL2 dated 08/24/17 revealed:
-Diagnoses included chronic obstructive pulmonary disease, hypertension, bipolar, osteoporosis, and osteoarthritis.
-There was an order for latanoprost ophthalmic (used to treat glaucoma) 0.005% solution 1 drop in right eye at bedtime.

Review of Resident #1's physician's order dated 02/14/18 revealed latanoprost 1 drop in both eyes nightly.

Observation of Resident #1's medication available on the medication cart on 07/17/18 at 10:27am revealed:
-There was one almost full 2.5ml bottle on hand.
-The label instructions were to instill 1 drop into both eyes at bedtime.
-The date dispensed was 02/14/18.

Review of Resident #1's February 2018 Medication Administration Record (MAR) revealed:
-An entry for latanoprost 0.005% instill 1 drop in right eye only at bedtime scheduled at 9:00pm.

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-The latanoprost was documented administered 28 occurrences out of 28 opportunities from 02/01/18 to 02/28/18.

Review of Resident #1's March 2018 MAR revealed:
-An entry for latanoprost 0.005% instill 1 drop in right eye only at bedtime scheduled at 9:00pm.
-Handwritten to the right of the entry was written "Finished."
-There were no documented administrations.

Review of Resident #1's April and May 2018 (MARs) revealed there were no entries for latanoprost or documented administrations of latanoprost.

Review of Resident #1's June 2018 MAR revealed:
-An entry for latanoprost 0.005% 1 drop into both eyes at bedtime scheduled at 8:00pm.
-The latanoprost was documented administered 30 occurrences out of 30 opportunities from 06/01/18 to 06/30/18.

Review of Resident #1's July 2018 electronic Medication Administration Record (eMAR) revealed:
-An entry for latanoprost 0.005% 1 drop into both eyes at bedtime scheduled at 9:00pm.
-The latanoprost was documented administered 16 occurrences out of 16 opportunities from 07/01/18 to 07/16/18.

Interview with Resident #1 on 07/17/18 at 12:00pm revealed:
-She no longer received eye drops.
-"I figured I had run out."
-She did not remember receiving eye drops since her cataract surgery "last year."

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D 358	Continued From page 22 Telephone interview with a pharmacist from the facility pharmacy on 07/17/18 at 4:10pm revealed: -Resident #1's latanoprost drops were last filled on 02/14/18. -A 2.5ml bottle was a one month supply of the medication. -The eye drops had never been reordered. -There had been no refills on the original prescription. Telephone interview with Resident #1's physician's office assistant on 07/17/18 at 4:22pm revealed: -Resident #1's ocular pressures had been "okay" on her last visit on 02/14/18. -The ocular pressures would decrease with use of the latanoprost drops. -Increases in ocular pressures could cause vision loss. -In February the physician's intent was to use the drops and see if they helped. -His plan was then to have a period where the resident did not take the drops to see if the ocular pressure increased. -If the ocular pressures increased without the drops, the resident might need to take the drops indefinitely.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367		

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administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure Medication Administration Records (MARs) were accurate for 2 of 3 sampled residents (Resident #1 and #3) related to documenting PRN (as needed) administrations of hydrocodone-acetaminophen 5/325mg (#1), scheduled latanoprost (#1), and scheduled propranolol (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 08/24/17 revealed diagnoses included chronic obstructive pulmonary disease, hypertension, bipolar, osteoporosis, and osteoarthritis.

a. Review of Resident #1's current FL2 dated 8/24/17 revealed there was an order for latanoprost ophthalmic (used to treat glaucoma) 0.005% solution 1 drop in right eye at bedtime.

Review of Resident #1's physician's order dated

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D 367	Continued From page 24 02/14/18 revealed latanoprost 1 drop in both eyes nightly. Observation of Resident #1's medication available on the medication cart on 07/17/18 at 10:27am revealed: -There was one almost full 2.5ml bottle on hand. -The label instructions were to instill 1 drop into both eyes at bedtime. -The date dispensed was 02/14/18. Review of Resident #1's February 2018 Medication Administration Record (MAR) revealed: -An entry for latanoprost 0.005% instill 1 drop in right eye only at bedtime scheduled at 9:00pm. -The latanoprost was documented administered 28 occurrences out of 28 opportunities from 02/01/18 to 02/28/18. Review of Resident #1's March 2018 MAR revealed: -An entry for latanoprost 0.005% instill 1 drop in right eye only at bedtime scheduled at 9:00pm. -Handwritten to the right of the entry was written "Finished." -There were no documented administrations. Review of Resident #1's April and May 2018 (MARs) revealed there were no entries for latanoprost or documented administrations of latanoprost. Review of Resident #1's June 2018 MAR revealed: -An entry for latanoprost 0.005% 1 drop into both eyes at bedtime scheduled at 8:00pm. -The latanoprost was documented administered 30 occurrences out of 30 opportunities from 06/01/18 to 06/30/18.	D 367		

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D 367	Continued From page 25 Review of Resident #1's July 2018 electronic Medication Administration Record revealed: -An entry for latanoprost 0.005% 1 drop into both eyes at bedtime scheduled at 9:00pm. -The latanoprost was documented administered 16 occurrences out of 16 opportunities from 07/01/18 to 07/16/18. Interview with Resident #1 on 07/17/18 at 12:00pm revealed: -She no longer received eye drops. -"I figured I had run out." -She did not remember receiving eye drops since her cataract surgery "last year." Telephone interview with a pharmacist from the facility pharmacy on 07/17/18 at 4:10pm revealed: -Resident #1's latanoprost drops were last filled on 02/14/18. -A 2.5ml bottle was a one month supply of the medication. -The eye drops had never been reordered. -There had been no refills on the original prescription. Interview with the RCC on 07/17/18 at 4:20pm revealed: -The latanoprost drops were on the eMAR "now." -The latanoprost drops were in the medication cart. -The previous RCC did not "watch that it wasn't on the MAR." -"That has got to be a pharmacy mistake." Refer to the interview with the Administrator on 07/17/18 at 5:00pm. b. Review of Resident #1's current FL2 dated 08/24/17 revealed there was an order for	D 367		

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hydrocodone/acetaminophen 5/325mg 1 tablet three times a day as needed for pain.

Review of Resident #1's prescription dated 06/19/18 revealed hydrocodone/acetaminophen 5/325mg 1 tablet three times a day for 30 days as needed for pain.

Review of Resident #1's June 2018 MAR revealed:
-There was an entry for hydrocodone/acetaminophen 5/325mg take one tablet three times a day as needed for pain for 30 days.
-The hydrocodone/acetaminophen 5/325mg was documented as administered for 12 doses on the MAR from 06/25/18 to 06/30/18.

Review of Resident #1's July 2018 eMAR revealed:
-There was an entry for hydrocodone/acetaminophen 5/325mg take one tablet three times a day as needed for pain for 30 days.
-The hydrocodone/acetaminophen 5/325mg was documented as administered for 44 doses on the MAR from 07/01/18 to 07/16/18.

Review of Resident #1's Controlled Substance Count Sheet (CSCS) for hydrocodone/acetaminophen 5/325mg compared to Resident #1's June 2018 MAR and July 2018 eMAR revealed:
-There were 57 doses of hydrocodone/acetaminophen 5/325mg documented as administered on the CSCS from 06/25/18 to 07/17/18.
-There were 56 doses of hydrocodone/acetaminophen 5/325mg documented as administered on the MARs from

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D 367	Continued From page 27 06/25/18 to 07/17/18. -There were 13 time and date discrepancies on the MARs out of the 57 documented as administered on the CSCS. Hydrocodone/acetaminophen 5/325mg doses documented for administration on Resident #1's CSCS, but not documented as administered on Resident #1's July 2018 eMAR were as follows: -On 07/01/18 at 2:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/06/18 at 9:00am-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/08/18 at 2:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/08/18 at 9:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/10/18 at 9:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/11/18 at 2:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/12/18 at 9:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/13/18 at 9:00am-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/13/18 at 2:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/14/18 at 2:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR. -On 07/15/18 at 2:00pm-1 tablet documented as	D 367		

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administered on the CSCS, but not documented on the eMAR.
-On 07/15/18 at 9:00pm-1 tablet documented as administered on the CSCS, but not documented on the eMAR.
-On 07/17/18 at 9:00am-1 tablet documented as administered on the CSCS, but not documented on the eMAR.

Interview with Resident #1 on 07/16/18 at 9:45am revealed:
-The Resident Care Coordinator (RCC) had come into her room that morning and asked her to sign the control sheet for her pain medication for four doses.
-She had to sign the control sheet whenever she received a dose of her pain medication.
-She had problems in the past not getting her pain medication, so the Administrator had come up with the system for her to cosign each dose as it was administered to her.

Interview with Resident #1 on 07/17/18 at 3:05pm revealed:
-She had not asked for a hydrocodone/acetaminophen 5/325mg that morning.
-She did not get one "unless they put it in the cup" with her other morning medications "because I didn't ask for it."
-The resident did not remember getting a hydrocodone/acetaminophen 5/325mg the evening before on 07/16/18 at 9:00pm.

Interview with the RCC on 07/17/18 at 4:20pm revealed:
-On 07/16/18, there were 2 hydrocodone/acetaminophen 5/325mg signed out on the CSCS and 3 administrations documented on the eMAR, "I forgot to document the MAR

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cause I was stressed."
-On 07/15/18, there were 3 hydrocodone/acetaminophen 5/325mg signed out on the CSCS and 1 administration documented on the eMAR, the RCC had documented she had administered the medication however "[another medication aides name] gave meds that day."
-"She couldn't sign in to do her documentation" in the eMAR, so the other medication aide had signed in under the RCC's login.
-The resident "signed for them, so she must have gotten them."
-On 07/14/18, there were 3 hydrocodone/acetaminophen 5/325mg signed out on the CSCS and 2 documented on the eMAR.
-In the eMAR when she gave a hydrocodone/acetaminophen 5/325mg "I document I gave it in the eMAR and put the reason and record and when I go out the hydrocodone is still lit up like I still need to give it."
-She had not been entering the medication again in the eMAR because "I'm afraid the count will be off."
-"Looks like I'm giving two."
-She put Resident #1's hydrocodone/acetaminophen 5/325mg in a "separate cup" and the resident would "still say she's not getting it."

Interview with the Administrator on 07/17/18 at 2:10pm revealed:
-The resident had complained in the past she had not received her pain medication.
-She had asked the resident to sign the control sheet each time she received her medication.
-The staff were struggling to learn how to document using the new eMAR system.
-They had just started using the new eMAR system on 07/01/18.

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Refer to the interview with the Administrator on 07/17/18 at 5:00pm.

2. Review of Resident #3's current FL2 dated 11/11/17 revealed:
-Diagnoses included schizophrenia, hypertension, type 2 diabetes, hypothyroidism, and osteoarthritis.
-There was an order for propranolol (used to treat tremors) 10mg 1 tablet three times daily.

Observation of Resident #3's medications available on hand on 07/17/18 at 11:27am revealed there was no propranolol 10mg on hand for administration.

Interview with the Resident Care Coordinator on 07/17/18 at 11:30am revealed:
-She had notified the pharmacy Resident #3's propranolol was out.
-The resident's propranolol script was "out of date" and the pharmacy was waiting on the physician to send a new script.
-The resident had been out of the propranolol since 7/16/18.

Review of Resident #3's June 2018 MAR revealed:
-An entry for propranolol 10mg 1 tablet three times a day for tremor scheduled at 9:00am, 1:00pm, and 6:00pm.
-The propranolol was documented as administered 90 occurrences out of 90 opportunities from 06/01/18 to 06/30/18.

Review of Resident #3's July 2018 electronic Medication Administration Record (eMAR) revealed:
-An entry for propranolol 10mg 1 tablet three times a day for tremor scheduled at 9:00am,

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1:00pm, and 6:00pm.
-The propranolol was documented as administered 49 occurrences out of 50 opportunities from 07/01/18 to 07/17/18 at 1:00pm.
-On 07/17/18 at 2:36pm, the propranolol was documented as not administered due to the resident being "out of facility."

Interview with Resident #3 on 07/17/18 at 2:00pm revealed:
-She did not know if she had been receiving propranolol recently.
-"I don't know the difference between my meds."
-"I just take what they give me and hope I do alright."
-She was experiencing tremors in her hands.
-The tremors in her hands made it harder for her to use her hands, especially the use of her right hand to feed herself.

Telephone interview with a pharmacist from the facility pharmacy on 07/17/18 at 4:10pm revealed:
-There was no current order for Resident #3's propranolol.
-The pharmacy had "tried to fill it 05/04/18" and sent the medication to the facility.
-The facility had sent the propranolol back to the pharmacy, because "they didn't have an order for it."
-The pharmacy had never received a discontinue order from the physician.
-The facility was "waiting on some doctor's orders to be signed" to verify Resident #3's current medication orders.

Interview with the RCC on 07/17/18 at 4:20pm revealed "I called and left a message with the triage nurse to get a new script. I called yesterday morning (07/16/18)."

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D 367	Continued From page 32 Telephone interview with a representative from the facility pharmacy on 07/18/18 at 10:20am and 11:06am revealed: -They had not filled Resident #3's propranolol "since May for the June cycle fill." -The propranolol would have been delivered to the facility on 06/01/18 to provide a 30 day supply of the medication. -She could not find a record of any propranolol being returned to the pharmacy. Interview with the Administrator on 07/17/18 at 2:10pm revealed: -She would expect the staff to call the physician and get them to send a new script if the script was running out. -When an medication was "down to the last couple of days" of the supply, "they are supposed to reorder." -"On the electronic MAR, it now tells us when you need to call the doctor for a new script." -They had begun using the electronic MARs in the facility on 07/01/18. Refer to the interview with the Administrator on 07/17/18 at 5:00pm. _____ Interview with the Administrator on 07/17/18 at 5:00pm revealed: -The new eMAR system was "slow to respond" when staff clicked to choose to administer a medication. -If you clicked more than one time the eMAR would document the administration of the medication the number of times clicked. -The eMAR was new and staff were still learning how to use it.	D 367		

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D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure a readily retrievable record of controlled substances for 1 of 2 sampled residents (Resident #1) related to hydrocodone/acetaminophen 5/325. The findings are: Review of Resident #1's current FL2 dated 08/24/17 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypertension, bipolar, osteoporosis, and osteoarthritis. -There was an order for hydrocodone/acetaminophen 5/325mg 1 tablet three times a day as needed for pain. Review of Resident #1's medication and treatment orders from a pharmacy print out dated 04/11/18 revealed: -The orders were signed by a nurse practitioner. -The orders were not dated by the nurse practitioner. -There was an order for hydrocodone/acetaminophen 5/325mg 1 tablet three times a day for 30 days as needed for pain.	D 392		

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Review of Resident #1's prescription dated 06/19/18 revealed hydrocodone/acetaminophen 5/325mg 1 tablet three times a day for 30 days as needed for pain.

Interview with Resident #1 on 07/16/18 at 9:45am revealed:
-The Resident Care Coordinator (RCC) had come into her room that morning and asked her to sign the control sheet for her pain medication for four doses.
-She had to sign the control sheet whenever she received a dose of her pain medication.
-She had problems in the past not getting her pain medication, so the Administrator had come up with the system for her to cosign each dose as it was administered to her.

Observation of Resident #1's hydrocodone/acetaminophen 5/325mg available on hand on 07/17/18 at 10:27am revealed:
-There was one bubble pack with 3 tablets remaining out of 60 dispensed on 06/25/18.
-There was one bubble pack with 21 tablets remaining out of 21 dispensed on 06/25/18.

Review of the controlled substance count sheet (CSCS) for the card of 60 tablets dispensed 06/25/18 for Resident #1's hydrocodone/acetaminophen 5/325mg revealed:
-The prescription label on the CSCS matched the order with instructions to take 1 tablet three times a day as needed for pain for 30 days.
-A medication aide signed that 60 hydrocodone/acetaminophen 5/325mg tablets were received on 06/25/18.
-The first entry on the CSCS was 1 hydrocodone/acetaminophen 5/325mg tablet administered on 06/25/18 at 9:00pm.
-The last entry on the CSCS was 1

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hydrocodone/acetaminophen 5/325mg tablet administered on 07/17/18 at 9:00am.
-Resident #1 had initialed she had received the medication for 55 out of 57 doses signed out.
-The doses not initialed by Resident #1 were dated 07/16/18 at 9:00pm and 07/17/18 at 9:00am.
-The CSCS count matched the amount of medication available for administration.

Interview with Resident #1 on 07/17/18 at 3:05pm revealed:
-She had not asked for a hydrocodone/acetaminophen 5/325mg that morning.
-She did not get one "unless they put it in the cup" with her other morning medications "because I didn't ask for it."
-The resident did not remember getting a hydrocodone/acetaminophen 5/325mg the evening before on 07/16/18 at 9:00pm.

Review of Resident #1's July 2018 electronic Medication Administration Record (eMAR) revealed:
-The hydrocodone/acetaminophen 5/325mg was not documented administered on 07/17/18.
-The hydrocodone/acetaminophen 5/325mg was documented administered for 3 occurrences on 07/16/18 at 9:45am, 1:25pm, and 9:15pm.

Interview with the RCC on 07/17/18 at 4:20pm revealed:
-On 07/16/18, there were 2 hydrocodone/acetaminophen 5/325mg signed out on the CSCS and 3 administrations documented on the eMAR, "I forgot to document the MAR cause I was stressed."
-On 07/15/18, there were 3 hydrocodone/acetaminophen 5/325mg signed out

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D 392	Continued From page 36 on the CSCS and 1 administration documented on the eMAR, the RCC had documented she had administered the medication however "[another medication aides name] gave meds that day." -"She couldn't sign in to do her documentation" in the eMAR, so the other medication aide had signed in under the RCC's login. -The resident "signed for them, so she must have gotten them." -On 07/14/18, there were 3 hydrocodone/acetaminophen 5/325mg signed out on the CSCS and 2 documented on the eMAR. -In the eMAR when she gave a hydrocodone/acetaminophen 5/325mg "I document I gave it in the eMAR and put the reason and record and when I go out the hydrocodone is still lit up like I still need to give it." -She had not been entering the medication again in the eMAR because "I'm afraid the count will be off." -"Looks like I'm giving two." -She put Resident #1's hydrocodone/acetaminophen 5/325mg in a "separate cup" and the resident would "still say she's not getting it." Interview with the Administrator on 07/17/18 at 2:10pm revealed: -The resident had complained in the past she had not received her pain medication. -She had asked the resident to sign the control sheet each time she received her medication. -The staff were struggling to learn how to document using the new eMAR system. -They had just started using the new eMAR system on 07/01/18.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 37 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to staff qualifications. The findings are: Based on record reviews and interviews, the facility failed to assure 1 of 3 staff sampled (Staff B, relief Supervisor) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40 prior to having direct contact with residents while performing duties related to resident care. [Refer to Tag 0139 10A NCAC 13F.0407(a)(7) Other Staff Qualifications (Type B Violation)].	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care	D934		

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D934	Continued From page 38 home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 3 staff sampled (Staff A and C) who had been working for a least a year as Medication Aides (MA) received yearly state approved infection control training. The findings are: 1. Review of Staff A's, MA, personnel records revealed: -Staff A was hired in September 2012 as a Supervisor. -Staff A's most recent certificate for state approved infection control training was dated 06/01/17. Refer to the interview with the Administrator on 07/17/18 at 2:10pm. Refer to the telephone interview with the registered nurse who provided infection control	D934		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(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
D934	Continued From page 39 training for the facility on 07/17/18 at 2:35pm 2. Review of Staff C's, MA, personnel records revealed: -Staff C was hired in December 2015 as a MA. -Staff C's most recent certificate for state approved infection control training was dated 06/01/17. Refer to the interview with the Administrator on 07/17/18 at 2:10pm. Refer to the telephone interview with the registered nurse who provided infection control training for the facility on 07/17/18 at 2:35pm. Interview with the Administrator on 07/17/18 at 2:10pm revealed: -She had overlooked the due date for the training. -The state approved infection control training was now scheduled for Friday, July 20, 2018. -She had scheduled the training on Tuesday, July 17, 2018. Telephone interview with the registered nurse who provided infection control training for the facility on 07/17/18 at 2:35pm revealed the infection control training had been scheduled to be completed on Friday, July 20, 2018.	D934		