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FALLS RIVER COURT MEMORY CARE COMMUNITY	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 19 and July 20, 2018.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the ice machine was free from contamination related to a build-up of a wet black and pink, thick mold-like substance in the ice machine. The findings are: Observation of the ice machine in the kitchen on 07/19/2018 at 3:55pm revealed: -There was a build-up of a wet pink and black mold like substance on the lower portion of the white shield and a heavier concentration of a black and pink mold-like substance on the upper portion of the white shield that separated the ice bin from the upper vaulted section of the ice machine. -There was black substance surrounding the front panel section of the ice cube pan where the ice cubes are formed and dispensed. -Water was dripping into the stored ice from the whiteshield with the build-up. Observation of the cleaning schedule on 07/19/2018 revealed:	D 283		

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-The ice machine cleaning log was last initialed and dated on 07/05/2018.
-There were no instructions for cleaning the inside of the ice machine.

Interview with Dietary Manager on 07/19/2018 at 4:01pm revealed:
-She cleaned the ice machine the first few months when she started working at the facility.
-The ice machine was cleaned weekly.
-She never cleaned inside the ice machine.
-She would "just wipe it down, the front and the sides."
-She assigned staff who worked the weekends to clean the ice machine weekly.
-There was no weekly cleaning schedule provided, she would create one.
-The Maintenance Director would come and unscrew, upper portion of the white shield of the ice machine for cleaning, when needed.
-The Maintenance Director, "I believe came and unscrewed, upper portion and cleaned it about a month or so ago."
-She had not seen the wet black and pink, thick mold -like substance in the ice machine.

Interview with the Maintenance Director on 07/19/2018 at 4:10pm revealed:
-He and the Dietary Manager were the two people that cleaned the inside of the ice machine.
-He did not have an explanation of why there would be build-up of wet pink and black mold substance on the upper and lower portion of the ice machine white shield.
-He would turn off, unplug, check filters, unscrew upper and lower portion of the white shields of the ice machine.

Interview with Maintenance Director and Dietary Manager on 07/20/2018 at 4:49pm revealed:

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D 283	Continued From page 2 -He and the Dietary Manager would be the two responsible people to provide a cleaning schedule to include clean in the front panel and inside the ice machine. -An outside maintenance provider was called on 07/20/2018, an initial appointment was scheduled for 07/23/2018 to check filters, coils, and delime if necessary. Interview with Administrator on 07/20/2018 at 5:04pm revealed: -She was not aware of the build-up of wet pink and black mold substance on the upper and lower portions of the ice machine white shield. -She would be meeting with her Dietary Manager and Maintenance Director to review ice machine cleaning process and schedule. -She would designate the Maintenance Director to be responsible for the ice machine cleaning and she would ensure that the task would be completed.	D 283		
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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure documented actions were taken based on the medication reviews for 2 of 3 sampled residents (#1, #3) which included requesting clarification of orders, assuring that facility staff used the proper reason for	D 406		

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administration of as needed medications, and physician's response to recommendations.

The findings are:

1. Review of Resident #1's current FL-2 dated 6/05/18 revealed:
-Diagnoses included dementia and sepsis.
-There was a note to "SEE DC (discharge) summary" for medications.

Review of Resident #1's hospital discharge summary dated 6/05/18 revealed:
-A list of Resident #1's discharge medication orders which included Lorazepam (Ativan) 0.5 milligram (mg) tablet, take 0.5 mg by mouth every 6 (six) hours as needed for anxiety; pantoprazole (Protonix) 40 mg tablet, take 1 tablet (40 mg total) by mouth daily; ranitidine (Zantac) 150 mg tablet, take 150 mg by mouth 2 (two) times a day; risperidone 0.25 mg tablet, take 0.25 mg by mouth 2 (two) times a day as needed (confusion).
-No order for Micatin was found on the list of discharge medication orders.
-No order for Nystatin powder was found on the list of discharge medication orders.

a. Review of Consultant Pharmacist's Medication Regimen Review summary in chart for Resident #1 dated 6/28/18 revealed:
-There was a note that stated "PRN (as needed) Ativan x3, Risperdal x5- may want to d/c (discontinue) one since staff giving Ativan effective for both anxiety and agitation per MARs (Medication Administration Records)".
-There was a notation to monitor PRNs.
-There was a memo to clarify PRN reason.

Review of Consultant Pharmacist's Medication Regimen Review provided by facility on 7/20/18

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D 406	Continued From page 4 for Resident #1 dated 6/28/18 revealed: -There was a note which stated "Ativan is ordered for anxiety and Risperdal is ordered for agitation. Please assure staff put the proper reason for administration on the back of the MAR as there are 3 instances since March when Ativan is charted for "agitation" and not "anxiety"". -There was an area next to the note which requested "Follow- Through". -There was no documentation of follow- through. Review of Resident #1's May and June 2018 MARs revealed: -A computerized entry for Ativan (lorazepam) 0.5 milligram (mg) tablet, take 0.5 tablet (0.25 mg) by mouth every 8 hours as needed for anxiety. -There was documentation that Ativan was administered on 5/26/18. -There was documentation on the back of MAR dated 5/26/18 at 4:00 a.m. which stated that Ativan 0.5 mg was administered for c/o (complaint of) agitation with effective results at 5:00 a.m. -A hand written entry for lorazepam (Ativan) 0.5 mg, take one tablet by mouth every 6 hours as needed for anxiety. -There was documentation that Ativan 0.5 mg was administered on 6/21/18. -There was documentation on the back of MAR dated 6/21/18 at 10:25 a.m. which stated that lorazepam (Ativan) 0.5 mg was administered for anxiety with effective results at 11:30 a.m. -A computerized entry for risperidone (Risperdal) 0.25 mg tablet, take 1 tablet by mouth every 12 hours as needed for confusion/ agitation. -There was documentation that risperidone (Risperdal) 0.25 mg was administered on 5/12/18. -There was documentation on the back of MAR dated 5/12/18 at 1:30 a.m. which stated that	D 406		

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risperidone (Risperdal) 0.25 mg was administered for c/o (complaint of) agitation with effective results at 2:00 a.m.
-A hand written entry risperidone (Risperdal) 0.25 mg, take one tablet by mouth twice daily as needed, confusion.
-There was documentation that Risperdal 0.25 mg was administered on 6/14/18.
-There was documentation on the back of MAR dated 6/14/18 at 5:00 p.m. which stated that Risperdal 0.25 mg was administered for agitation with effective results not noted.
-There was documentation that Risperdal 0.25 mg was administered on 6/17/18.
-There was documentation on the back of MAR dated 6/17/18 at 2:00 p.m. which stated that Risperdal 0.25 mg was administered for agitation with effective results.

Refer to interview with the Resident Care Director (RCD) on 07/20/2018 at 12:37 p.m.

Refer to interview with the Resident Care Director (RCD), Special Care Coordinator (SCC), and Administrator on 07/20/2018 at 4:12 p.m.

Refer to interview with the Administrator on 07/20/2018 at 5:04 p.m.

b. Review of Consultant Pharmacist's Medication Regimen Review summary provided by facility on 7/20/18 for Resident #1 dated 6/28/18 revealed:
-There was a note that stated Resident #1 "was using PRN Micatin cream and PRN Nystatin powder prior to going into the hospital in June. These were not on the hospital discharge orders. Please request provide give written clarification to D/C or continue these orders."
-There was an area next to the note which requested "Follow- Through".

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D 406	Continued From page 6 -There was no documentation of follow- through. Refer to interview with the Resident Care Director (RCD) on 07/20/2018 at 12:37 p.m. Refer to interview with the Resident Care Director (RCD), Special Care Coordinator (SCC), and Administrator on 07/20/2018 at 4:12 p.m. Refer to interview with the Administrator on 07/20/2018 at 5:04 p.m. c. Review of Resident #1's Pharmacist's Note to Attending Physician/ Prescriber dated 6/28/18 provided by facility on 7/20/18 revealed: -There was a note "for the guidance of unlicensed staff administering this medication, please specify the exact dose of Voltaran gel to apply". -There was a recommendation order "Voltaren 1 % gel, apply (2 gm or 4 gm) grams topically to neck TID". -There was an area below for "Physician/Prescriber Response" with a choice of three actions to recommendation to Agree, Disagree or Other. -There was an area for Signature and Date which was not completed. Refer to interview with the Resident Care Director (RCD) on 07/20/2018 at 12:37 p.m. Refer to interview with the Resident Care Director (RCD), Special Care Coordinator (SCC), and Administrator on 07/20/2018 at 4:12 p.m. Refer to interview with the Administrator on 07/20/2018 at 5:04 p.m. d. Review of Resident #1's Pharmacist's Note to Attending Physician/ Prescriber dated 6/28/18	D 406		

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provided by facility on 7/20/18 revealed:
-There was a note that stated Resident #1 "was taking Zantac 150 mg BID".
- The hospital added Protonix 40 mg every AM on 6/5/18.
-There was a request to d/c the AM dose of Zantac "since acid suppression should be covered in the AM with the Protonic".
-There was a recommended plan to d/c Zantac and start Zantac 150 mg by mouth every bedtime.
-There was an area below for "Physician/Prescriber Response" with a choice of three actions to recommendation to Agree, Disagree or Other.
-There was an area for Signature and Date which was not completed.

Refer to interview with the Resident Care Director (RCD) on 07/20/2018 at 12:37 p.m.

Refer to interview with the Resident Care Director (RCD), Special Care Coordinator (SCC), and Administrator on 07/20/2018 at 4:12 p.m.

Refer to interview with the Administrator on 07/20/2018 at 5:04 p.m.

2. Review of Resident #3's current FL-2 dated 07/09/2018 revealed:
Diagnoses included dementia with behavioral disturbance, Alzheimer's disease, acute cystitis without hematuria, tachycardia, restlessness and agitation.

Review of the Consultant Pharmacist's Medication Regimen Review summary dated 06/01/2018 through 06/28/2018 revealed there was a "general note" where the pharmacist documented. "RE: unused PRN medications. The following medications has not been used in 60-90

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days. Please consider discontinuation due to non-use. Discontinue PRN Zofran.

Review of Resident #3's May and June 2018 medication administration records (MARs) revealed an order of Zofran 4mg take 1 tablet by mouth every 6 hours as needed (PRN) (for nausea and vomiting).

Review of Resident #3's May and June 2018 medication administration records (MARs) revealed there was no administration of Zofran 4mg take 1 tablet by mouth every 6 hours as needed (PRN) (for nausea and vomiting).

Review of the Primary Care Provider (PCP) visit notes and Note To Attending Physician/Prescriber Form dated 06/28/2018 printed out for Resident #3 revealed no physician/prescriber response, the form was blank.

Interview with the lead medication aide (LMA) on 07/20/2018 at 2:36pm for Resident #3 revealed no Zofran 4mg take 1 tablet by mouth every 6 hours as needed (for nausea and vomiting) had been given to Resident #3 at all. Resident #3 had no nausea, or vomiting symptoms that she could recall, or request for the medication.

Observation with the lead medication aide (LMA) on 07/20/2018 for medication on hand review at 2:36pm for Resident #3 had a order and medication on hand for Zofran 4mg take 1 tablet by mouth every 6 hours as needed (PRN) (for nausea and vomiting). The medication had not been given to Resident #3 at all.

Refer to interview with the Resident Care Director (RCD) on 07/20/2018 at 12:37 p.m.

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D 406	Continued From page 9 Refer to interview with the Resident Care Director (RCD), Special Care Coordinator (SCC), and Administrator on 07/20/2018 at 4:12 p.m. Refer to interview with the Administrator on 07/20/2018 at 5:04 p.m. _____ Interview with the Resident Care Director (RCD) on 07/20/2018 at 12:37pm revealed: -The RCD and SCC received emails of the Pharmacy Medication Regimen Review Summary. -The PCP had a designated file box in the medication room/nursing office where all reports, and documents are placed for the PCP to review. -The PCP and Nurse Practioner (NP) were there weekly. Interview with the Resident Care Director (RCD), Special Care Coordinator (SCC), and Administrator on 07/20/2018 at 4:12pm revealed: -There were two Pharmacist's Medication Regimen Review summaries done, by two different pharmacy providers. -We recently transferred our pharmacy services to a differnt pharmacy provider. -The SCC and RCD received emails of the Pharmacy Medication Regimen Review summary. -The SCC and RCD were responsible for reviewing Pharmacy Medication Regimen Review Summary report, make notation receive of report, printing out report for primary care practitioner (PCP), placing pharmacist medication regimen review summary report, and physician/prescriber form in the PCP designated file box for review in the medication/nursing office. -The PCP and Nurse Practioner (NP) were there	D 406		

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D 406	Continued From page 10 weekly. -The RCD typically reviewed and looked too see if any pertinent forms, or orders needed to be sent out to a provider, or any controls needed to be addressed. -The RCD, "I do.....generally, but what happened this instance, I don't know, or I don't think so." -The RCD, "There has been a lot of recent changes ....change over, some families went with an outside community pharmacy provider. This part slipped a little bit, with meds being changed over." Interview with the Administrator on 07/20/2018 at 5:04 pm revealed: -She would be added to the email list to receive and review the pharmacist medication regimen review summary reports. -She would monitor and create a pharmacy QA (quarterly reviews and follow up process) for the RCD and SCC.	D 406		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.	D 468		

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D 468	Continued From page 11 (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure staff assigned to the special care unit had completed 6 hours of orientation during the first week of employment and within six months of employment, 20 hours of training specific to the population being served for 1 of 3 special care unit staff. (Staff B) The findings are: Review of the staff record for Staff B revealed: -Staff B was hired on 12/14/17 to work in the facility, a special care unit, as a personal care aide (PCA). -There was documentation of 6 hours of special care unit training completed on 01/11/18. -There was documentation of 7 hours of special care unit orientation completed between the dates of 03/11/18 and 04/26/18. -There was a total of 13 hours documented of special care unit training from 01/11/18 to	D 468		

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D 468	Continued From page 12 04/26/18 in Staff B's record. Interview on 07/20/18 at 03:40 pm with Staff B revealed: -He had worked at the facility as a PCA "since December". -He was unable to recall the exact start date of his employment. -He was unable to recall if he had completed any specific special care unit training. Interview on 07/20/18 at 3:35 pm with the Administrator revealed: -She was not aware Staff B needed additional special care unit training. -She was aware of the requirement for completion of 6 hours of special care unit training during the first week of employment for any special care unit employee. -She was also aware of the requirement for an additional 20 hours of special care unit training to be completed within 6 months of hire for any special care unit employee. -The Resident Care Director (RCD) and the Business Office Manager (BOM) were responsible for ensuring staff qualifications were completed as required. -She was not aware if the employee records were reviewed after the hiring process was completed. -Staff qualifications and training were in many different files and it was difficult to locate needed documents. -The RCD and BOM would review all employee records for accuracy and ensure completion and accurate documentation of the required 6 and 20 hour special care unit training for each employee. Interview on 07/20/18 at 4:20 pm with the (RCD) revealed: -She was aware of the requirement for	D 468		

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	HAL092141	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT MEMORY CARE COMMUNITY	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 468	Continued From page 13 completion of 6 hours of special care unit training during the first week of employment, and for an additional 20 hours of special care unit training to be completed within 6 months of hire for any special care unit employee. -The facility was in the process of setting up a system to ensure completion of required training for all staff. -She was not aware Staff B needed an additional 13 hours of training. Attempt to interview the BOM on 07/20/18 was unsuccessful.	D 468		