NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

Janurary 03, 2019

Patrick Ogbonna, Executive Officer
The Villas at Benson VII, Inc., Licensee
The Villas at Benson VII
1801 St. Albans Drive, Suite G
Raleigh, North Carolina 27609

email address:Ogbonnapi@yahoo.com

RE: Return of Statement of Deficiencies dated October 18, 2018 - Plan of Correction not accepted (TZJO11)
Facility: The Villas at Benson VII
Licensure Number: FCL-051-065
County: Johnston

Dear Mr. Ogbonna:

Thank you for responding to the Statement of Deficiencies for the survey completed October 18, 2018 at your facility. We are returning your response for the following reasons:

__x__ **1.** The report has not been signed under Provider's Representative Signature.

_____ **2.** The date was not entered for the Provider's Representative Signature.

__x__ **3.** The completion dates for the provider's response were omitted. (Refer to Tags **C 202** and **C 341**)

_____ **4.** The completion date(s) is/are unacceptable for Findings:

_____ **5.** The provider's response does not include the methods to be used for monitoring and evaluating the corrective action to be implemented.

_____ **6.** The provider's response is not acceptable for Findings NCAC 13G .0601(d) Management and Other Staff (Refer to Tag # C 191); NCAC 13G .0702(a) Tuberculosis Test and Medical Examination (Refer to Tag # C 202); and NCAC 13G .1004(i) Medication Administration (Refer to Tag # C 341). Please revise in keeping with the directions contained in the cover letter.

Continued failure to submit an acceptable plan of correction does not prevent a follow up survey to the rule areas cited to determine compliance.

We appreciate your cooperation. If you have any questions regarding this matter do not hesitate to contact me at 910-260-0364.

Sincerely,

Deborah H. Hering, RN

Deborah Hering, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure: Statement of Deficiencies with the plan of correction

cc: Jerricke Fontenette, Supervisor/Designee, Johnston County Department of Social Services
Tamara Talbot, Team Supervisor, East 6 Region, Adult Care Licensure Section
Raleigh Facility File

RECEIVED

DEC 12 2018

PRINTED: 11/19/2018
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081057	A. BUILDING: _____ B. WING _____	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BENSON VII	606 EAST MORRIS AVENUE BUILDING 7 BENSON, NC 27504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
c 0001	Initial Comments The Adult Care Licensure Section and the Johnston County Department of Social Services (DSS) conducted an initial survey on 10/18/18.	C 000		
C 191	10A NCAC 13G .0601(d) Management and Other Staff 10A NCAC 13G .0601 Management and Other Staff (d) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure sufficient staff were on duty and awake at all times to meet the supervision needs for 2 of 2 residents (Resident #1 and #2) who were constantly disoriented and known to go out of an exit door at night to smoke without first alerting staff (#1) and a resident who was intermittently disoriented (#2). The findings are: Interview with the live-in supervisor/medication aide (SIMA) on 10/18/18 at 9:30 a.m. revealed: -The facility had a current census of *TWO* residents residing in the facility. -Live-in medication aides (MAs) worked from Monday at 7:00 a.m. through the following Monday at 7:00 a.m. -Staff were allowed to sleep at night, however, staff were required to make rounds to check on the residents at least two to three times per night. Interview with a live-in MA on 10/18/18 at 11:08 a.m. revealed: -She had worked at the facility since the facility	C 191	Reference 10A NCAC 13G.0601(d) Regarding Management and other staff, the facility has a house-keeping staff that is responsible for all house-keeping needs of the building. The facility provided further training to the live-in aides. Henceforth, the staff would make rounds every hour to adequately monitor the residents. The loud exit door buzzer is a added level of security to ensure that the residents can not exit the building without alerting the staff. The SIC should make sure that the MAs are following the new rounds schedule and the buzzer is tested for operational issues.	10-22-18

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATE FORM 6899 TZJO11 If continuation sheet 1 of 17

The Plan of Correction reviewed; not accepted. DW 01/31/19

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C 191	Continued From page 1 opened this year. -She worked 24 hours from Monday to the next Monday and had sleeping quarters in the facility. -She worked alone during this time with no other staff in the facility. -When she worked, she normally went to bed around 12:30 p.m. to 1:00 a.m. which was the same time all the residents went to sleep. -She was required to get up approximately three times per night to check on the two residents at the facility. 1. Review of Resident #1's hospital generated FL-2 dated 08/27/18 revealed: -Diagnoses included bronchitis, iron deficiency anemia, homelessness, and elevated serum creatinine, acute cystitis without hematuria, disoriented to time, dehydration and sepsis. -The resident was constantly disoriented. Interview with Resident #1 on 10/18/18 revealed he declined to be interviewed any further. Interview with a live-in medication aide on 10/18/18 at 11:09 a.m. revealed: -Resident #1 occasionally got up during the night and would go out the side door to smoke. -The facility's exit door alarms would sound when Resident #1 opened the exit door. -She always got up when Resident #1 went out the exit doors of the facility to smoke at night. The door alarms always woke her up, "I am a light sleeper". Telephone interview with the Resident #1's primary care physician on 10/18/18 at 4:09 p.m. revealed: -Resident #1 required 24 hour supervision with awake staff at all times due to the resident's "marginal intelligence status".	C 191		

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C 191	Continued From page 2 -There would be a concern that the resident would leave the facility at night and wander away due to his mental status or enter other resident rooms at night while staff were asleep which could result in harm from altercations between the residents. Refer to the interview with the supervisor in charge (SIC) on 10/1818 at 4:35 p.m. Refer to the telephone interview with the Administrator on 10/18/18 at 4:30 p.m. 2. Review of Resident #2's current FL-2 dated 08/14/18 revealed: -Diagnoses included brain injury, bipolar 1 disorder/depressed, alcohol dependence, stroke, hypertension, pancreatitis, coronary obstructive pulmonary disease and sleep apnea. -The resident was intermittently disoriented. Interview with Resident #2 on 10/18/18 at 8:24 a.m. revealed: -The resident was not sure how long he had lived at the facility. -Staff were very attentive and always at the facility. -He slept well at night. -If he needed anything at night staff were there. -He never had to wake up staff at night, but if he needed to "I guess I could". Interview with a live-in medication aide (MA) on 10/18/18 at 11:09 a.m. revealed Resident #2 never got up at night and was not exit seeking. Telephone interview with the Resident #2's primary care physician on 10/18/18 at 4:09 p.m. revealed: -Resident #2 required 24 hour supervision with	C 191		

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C 191	Continued From page 3 awake staff at all times due to the resident's "marginal intelligence status". -There would be a concern that the resident could leave the facility at night and wander away due to his mental status or enter other resident rooms at night while staff were asleep which could result in harm from altercations between residents. Refer to the interview with the supervisor in charge (SIC) on 10/1818 at4:35p.m. Refer to the telephone interview with the Administrator on 10/18/18 at 4:30 p.m. _____ Interview with the supervisor in charge (SIC) on 10/1818 at4:35 p.m. revealed: -She was aware that supervision and care of the residents was required at all times. -She had recently discussed with local county staff about the need to have awake staff to meet the supervision needs of the residents. -She had spoken with the Administrator about awake staff at night after speaking with the local county staff. Telephone interview with the Administrator on 10/18/18 at 4:30 p.m. revealed: -He had spoken with the SIC about the concern for awake staff at night to supervise the residents at the facility. -They (management) were planning a meeting next week to discuss the staff shifts.	C 191		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each	C202	Reference 10A NCAC 13G.0702 (a) The facility's policy and procedure stated that before admission, new residents will be tested for tuberculosis(TB)	

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C 202	Continued From page 4	C 202		

resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 1QA NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 2 of 2 residents sampled (Resident #1, #2) were tested upon admission for tuberculosis (TB) disease.

The findings are:

Review of the facility's "Admission's Policies" form revealed:
-Prior to admission, each resident shall be tested for the first step of tuberculosis (TB) disease in compliance with the control measures adopted by the Commission for Health Services.
-The second TB step would be completed 2 to 3 weeks after the first TB step is read.

1. Review of Resident#1's hospital generated FL-2 dated 08/27/18 revealed:
-Diagnoses included bronchitis, iron deficiency anemia, homelessness, elevated serum creatinine, acute cystitis without hematuria, disoriented to timl::l, dehydration and sepsis.
-Immunizations administered for the resident's admission revealed a PPD test (a purified protein derivative skin test used for tuberculosis (TB) testing) was placed on 07/06/18.

Review of an immunization report form from the

The facility has constituted an electronic process that generates reports weekly on the residents that need 2nd Step TB Test. The resident is not admitted into the facility without proof of 1st Step TB Test. Going forward the electronic software would remind the SIC to ensure that the 2nd Step Test is done within 7 days of admission. Without this process the admission is not considered completed.
The administrator would verify that this policy is adhered to completely.

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C 202	Continued From page 5 same local hospital for Resident #1 revealed a negative TB skin test on 07/08/18 Review of Resident #1's Resident Register revealed an admission date of 08/27/18. Review of Resident #1's immunization records revealed there were no additional TB skin tests. Interview with Resident #1 on 10/18/18 revealed: -He thought he had TB skin tests done in the past but was not sure when. -He had never had a positive TB skin test that he was aware of. Interview with the supervisor in charge (SIC) on 10/18/18 at 2:15 p.m. revealed: -She was responsible to assure all residents had at least a one TB skin test on admission and a second TB skin test within 2-3 weeks after admission. -She knew Resident #1 needed a second TB skin test. -Resident #1's second TB skin test had "Slipped her mind" -She realized earlier this week Resident #1 needed a second TB skin test. -She was taking Resident #1 to the local health department Monday, 10/23/18 for his second TB skin test. -Resident #1 should have had a test done within 2 - 3 weeks after his admission on 08/27/18. Telephone interview with Resident #1's physician on 10/18/18 at 4:09 pm. revealed - Resident #2 had no symptomatic signs of TB. - He expected the facility to comply with all rules and regulations for tuberculosis testing for Resident #1 on admission to the facility,	C 202		

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C 202	Continued From page 6 Refer to the telephone interview with the Administrator on 10/18/18 at 4:30 p.m. 2. Review of Resident #2's current FL-2 dated 08/14/18 revealed diagnoses included brain injury, bipolar 1 disorder/depressed, alcohol dependence, stroke, hypertension, pancreatitis, coronary obstructive pulmonary disease and sleep apnea. Review of Resident #2's Resident Register revealed and admission date of 08/02/18. Review of an immunization report form from the same local hospital for Resident #2 revealed a negative TB skin test on 07/20/18. Review of Resident #2's immunization records revealed there were no additional TB skin tests. Interview with Resident #2 on 10/18/18 at 3:44 p.m. revealed: -He remembered having a TB skin test done just before he was admitted to the facility and had several TB skin tests when he was a child. -He had never had a positive TB skin test. Interview with the supervisor in charge (SIC) on 10/18/18 at 2:15 p.m. revealed: -She was responsible to assure all residents had at least one TB skin test on admission and a second TB skin test within 2-3 weeks after admission. -She knew Resident #2 needed a second TB skin test. -Resident #1's second TB skin test had "slipped her mind'. -She realized earlier this week Resident #2 needed a second TB skin test. -She was taking Resident #2 to the local health	C 202		

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C 202	Continued From page 7 department Monday, 10/23/18 for his second TB skin test. -Resident #2 should have had a test done within 2-3 weeks after his admission on 08/27/18. Telephone interview with Resident #2's physician on 10/18/18 at4:09 pm. revealed - Resident #2 had no symptomatic signs of TB. - He expected the facility to comply with all rules and regulations for tuberculosis testing for Resident #2 on admission to the facility. Refer to the telephone interview with the Administrator on 10/18/18 at 4:30 p.m. Telephone interview with the Administrator on 10/18/18 at4:30 p.m. revealed: -The facility had a tuberculosis policy. -The supervisor in charge (SIC) was responsible to assure all residents had at least one tuberculosis (TB) skin test on admission and a second TB skin test if needed 2 to 3 weeks after the resident was admitted to the facility.	C202		
C341	10A NCAC 13G .1004 (i) Medication Administration 1QA NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	C341	Reference 10A NCAC 13G.1004(i) Medication Administration, the facility provided more training to the staff after the initial survey. Henceforth the Medication Technicians will pass out the medications and also observe the residents taking the medications before attending to another resident or any other situation. The SIC will incorporate as part of her evaluation, the verification that MA's noted that they witnessed the actual taking of medication by resident.	

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C 341	Continued From page 8 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure a constantly disoriented resident was actually observed taking medications resulting in the resident having double doses of the same medications hidden from staff for 1 of 2 residents sampled (Resident #1). The findings are: Review of Resident#1's hospital generated FL-2 dated 08/27/18 revealed: -Diagnoses included bronchitis, iron deficiency anemia, and elevated serum creatinine, acute cystitis without hematuria, disoriented to time, dehydration and sepsis. -The resident was constantly disoriented. -There was an order for Aspirin 325 mg (used as a blood thinner), take one daily. -There was an order for Ferrous Sulfate 325 mg (used as an iron supplement), take three times daily. -There was an order for Vitamin B-1 100 mg (used as a vitamin supplement) take one tablet daily. -There was an order for Vitamin B-12 1000 mcg (used as a vitamin supplement), take one tablet daily. -There was an order for Glipizide 5 mg (used to treat high blood sugar) take 0.5 mg tablet twice a day before meals. -There was an order for Tradjenta 5 mg (used to treat high blood sugar) take one tablet daily. -There as an order for Folic Acid 1mg (used as a vitamin supplement), take one tablet daily. -There was an order for Protonix 40 mg (used to	C 341	Trainings provided to the Med. Techs included instructions that should any Resident refuse to take medication, such individual will be encouraged to take the medication by informing the resident about the advantage of taking the medication. If all efforts to encourage the resident fails, the Med. Tech. should document the refusal and inform the SIC about the situation. The SIC will inform the Residents Doctor about the refusal.	

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C 341	Continued From page 9 treat stomach and esophagus problems), take one tablet daily. Review of Resident #1's Resident Register revealed an admission date of 08/27/18 Interview with Resident #1 on 10/18/18 at 9:25 a.m. revealed: -He had lived at the facility for a few months. -Staff gave him his medication but he did not take them because "I don't know what they are for, they (staff) just hand them to me and don't tell me what they are for and I ain't taking them." Observation of Resident #1 on 10/18/18 at 9:25 a.m. revealed the resident placed his hand into his shirt pocket and removed approximately thirteen tablets with many of the tablets identical in color, shape and markings and two one-half white tablets and placed the tablets on the end of the bed. Observation of the medications Resident #1 removed from his shirt pocket and placed on his bed and one tablet on the bedroom floor on 10/18/18 at 8:37 a.m. revealed -There were two orange colored, round shaped tablets with "44, 227" marked on one side of the tablets. -There were two red colored, round shaped tablets with no markings. -There were two white colored, round shaped tablets with no markings. -There were two pink colored, round shaped tablets with no markings. -There were two, white colored one-half tablets. -There were two mauve colored, round shaped tablets with a logo on one side and D 5 on the other side. -There were two scored yellow colored tablets	C 341		

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C 341	Continued From page 10 with "B, 01" tablets and no marking on the other side. -There was one yellow colored, oval shaped tablet with "M, pg" on one side and no markings on the other side. A second identical pill was on the bedroom floor between the bed and the dresser. Observation of the live-in medication aide (MA) on 10/18/18 at 8:37 a.m. revealed: -He entered Resident #1's room. -He looked at the medication tablets on the resident's bed. -He asked Resident #1 "where did you get these medicines?" -He gathered all of the tablets and removed the tablets from the room. Observation of Resident #1's medications on hand revealed: -There was one bottle of Aspirin 325 mg labeled to take one tablet daily. Each tablet in the bottle was orange colored, round shaped tablets with black imprinted markings of "44, 227" on each tablet. -There was one bottle of Ferrous Sulfate 325 mg labeled to take one tablet three times a day. Each tablet in the bottle was red colored, round shaped tablets with no markings. -There was one medication blister pack labeled as Vitamin B1 100 mg, take one tablet daily. The tablets in each blister pocket were white colored, round shaped tablets with no markings on the tablets. -There was one medication blister pack labeled as Vitamin B-12 1000 mcg, take one tablet daily. Each tablets in the blister pockets were pink colored, round shaped tablets, with no markings on the tablets. -There was one medication blister pack labeled	C 341		

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C 341	Continued From page 11 as Glipizide 5 mg, take ½ tablet (2.5 mg) twice daily before meals. Each tablet in the blister pack was white colored one- half tablets. -There was one medication blister pack labeled as Tradjenta 5 mg, take one tablet daily. The tablets in each blister pack was mauve colored, round shaped tablets with a logo marking on one side and D 5 on the other side of the tablets. -There was one medication blister pack labeled as Folic Acid 1 mg, take one tablet daily. The tablets in each blister pack were yellow colored, round shaped tablets with "B, 01", a scored mark and no markings on the other side of the tablets. -There was one medication blister pack labeled as Protonix 40 mg, take one tablet daily. The tablets in each blister pocket were yellow colored, oval shaped tablets with M pg on one side and no other markings on the other side of the tablets. Review of Resident #1's October 2018 medication administration record (MAR) revealed -There was a computer printed entry for Folic Acid 1 mg take one daily, and scheduled to be administered at 8:00 a.m. -There was documentation the Folic Acid 1 mg had been administered from 10/01/18 - 10/18/18 at 8:00 a.m. -There was a computer printed entry for Protonix 40 mg take one daily and scheduled to be administered at 8:00 a.m. -There was documentation the Protonix had been administered from 10/01/18 - 10/18/18 at 8:00 a.m. -There was a computer printed entry for Aspirin 325 mg take one daily and scheduled to be administered at 8:00 a.m. -There was documentation the Aspirin 325 mg had been administered from 10/01/18 - 10/18/18 at 8:00 a.m. -There was a computer printed entry for Vitamin	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051057	A. BUILDING: _____ B. WING _____	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 341	Continued From page 12 B-12 1000 mcg take one daily and scheduled to be administered at 8:00 a.m. -There was documentation the Vitamin B-12 1000 mcg had been administered from 10/01/18 - 10/18/18 at 8:00 a.m. -There was a computer printed entry for Tradjenta 5 mg take one daily and scheduled to be administered at 8:00 a.m. -There was documentation the Tradjenta 5 mg had been administered from 10/01/18 - 10/18/18 at 8:00 a.m. -There was a computer printed entry for Vitamin B1 100 mg take one daily and scheduled to be administered at 8:00 a.m. -There was documentation the Vitamin B1 100mg had been administered from 10/01/18 - 10/18/18 at 8:00 a.m. -There was a computer printed entry for Glipizide 5 mg take one-half tablet (2.5mg) daily 30 minutes before a meal scheduled to be administered at 8:00 a.m. and 5:30 p.m. -There was documentation the Glipizide 5 mg had been administered through 8:00 a.m. starting on 10/01/18 through 8:00 a.m. on 10/18/18. -There was a computer printed entry for Ferrous Sulfate 325mg take one tablet three times a day scheduled to be administered at 8:00 a.m., 2:00 p.m. and 8:00 p.m. -There was documentation the Ferrous Sulfate 325 mg had been administered from 8:00 a.m. starting on 10/01/18 through 8:00 a.m. on 10/18/18. Interview with the live-in MA on 10/18/18 at 8:41 a.m. revealed: -He gave Resident #1 his 7:00 a.m. medications in the dining room this morning in a clear medication cup and encouraged him to take his medicine while the resident was sitting at the table.	C 341		

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C 341	Continued From page 13 -Resident #1 "just kept it there" and he continued to encourage the resident to take his medicine. -Resident #1 told him "no" and that he wanted to drink his coffee. -He had to go back to the kitchen because the water was running at the kitchen sink and left the clear medication cup filled with Resident #1's morning medication on the table with Resident #1. -He could not see Resident #1 when he went into the kitchen. -He did not want to "rise anger" with Resident #1 and would leave the resident and go back into kitchen. After four attempts of encouraging the resident to take the medication, the medication cup was empty and Resident #1 told him he had taken the medication. -He estimated that it took approximately 10 minutes to get Resident #1 to take the medications. -He did not physically observe Resident #1 take his medication this morning (10/18/18). A second interview with the live-in MA on 10/18/18 at 11:05 a.m. revealed: -He knew he was expected to observe the residents take medications. -He knew someone usually was with him, but the live-in supervisor had to leave and he handed the medications to the resident and ran to cut the water off, instead of watching him swallow it. -He knew in the future to be prepared to stay until the resident swallows the medications before he left the room. Interview with the supervisor in charge (SIC) on 10/18/8 at 8:47 a.m. revealed: -The live-in MA was in training and was not passing medications to the residents independently.	C 341		

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C 341	Continued From page 14 -The live-in supervisor/medication aide (S/MA) who prepared the medication was responsible for administering all of the residents' medications and the live-in MA should have only been observing the medication pass. -The live-in S/MA prepared the medication this morning (10/18/18) but had to leave to assist another resident before the medication was given to Resident #1 and left the medications with the live-in MA who should have actually observed the resident take the medication. -The live-in MA should have "stood there" and watched Resident #1 take his morning medications and if the live-in MA walked away then he should have taken the medication with him. -MAs were to always physically observe residents swallow all medications. -Resident #1 had dementia but she was not aware of any issues with Resident #1 taking his medication before today (10/18/18), "it had never been a problem". -The facility had a medication policy that was reviewed with all staff during orientation and staff always had access to the policy which was kept in the facility's main office for staff reference. A second interview with the SIC on 10/18/18 at 4:30 p.m. revealed she was not sure why or how Resident #1 had 16 tablets of medication for more than one scheduled dosing including morning and afternoon medications. Telephone interview with the Administrator on 10/18/18 at 4:25p.m. revealed: -The live-in MA would receive additional medication administration training. -The live-in MA should have only observed the residents' medication passes. -The live-in MA should have never left Resident	C 341		

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C 341	Continued From page 15 #1 alone with any medication. -Staff were expected to physically observe Resident #1 swallow all of their medications. Telephone interview with Resident #1's physician on 10/18/18 at 4:09 p.m. revealed: -The facility had contacted him today (10/18/18) and was told several different medication tablets were found in Resident #1's room. -He was not aware of any issues prior to today (10/18/18) with the resident not taking his medication. -The resident had dementia and staff should always physically observed the resident take his medication. Review of the facility's medication policy revealed: -Residents should not be allowed to self-administer medication without a written order by the physician. -No resident should be left alone while taking medication. -Staff would ensure that medication was taken properly and in the quantities prescribed. The facility failed to assure staff physically observed a resident (Resident #1) who was constantly disoriented actually take his medications, resulting in the resident hiding 16 medications that equaled two daily scheduled doses in his shirt pocket. This failure was detrimental to the heath and safety of the resident which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/18/18 for this violation. CORRECTION DATE FOR THE TYPE B	C 341		