

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey 03/13/19-03/15/19.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of truth of the facts alleged or conclusion set forth in the statement of deficiencies or corrective action, report, the Plan of Correction prepared solely as a matter of compliance with State Laws.	
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the facility was free of hazards as related to a skin infection outbreak for 4 of 4 sampled residents (#1, #2, #3, and #4). The finding are: Review of the facility's "infection control and universal precautions" policy revealed "the infectious disease control staff will assure the local county health department is notified upon occurrence of any outbreak, illness, or disease of two or more residents or as otherwise directed by the infectious disease manual or Health Department". 1. Review of Resident #4's current FL2 dated	D 079	ED provided in-service training for staff of proper use of laundry equipment. Training documents located in ED office. Infection Control training provided for staff by LHPS nurse. Documentation located in ED office. The local Department of Health will be notified by the ED/DRC or designee of any outbreak, illness or disease of two or more residents.	4/22/19 4/25/19 3/15/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

Q6SH11

If continuation sheet 1 of 39

Just Black Administrator 4/5/19
MyP Reviewed and Acknowledged
5/2/19

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D 079	Continued From page 1 10/26/18-revealed diagnoses included dementia, hypertension, hyperlipidemia, and acid reflux. Review of subsequent physician order dated 10/29/18 revealed an order for permethrin 5% topical cream (used to treat scabies) to apply to the entire body and leave of for 12 hours then shower. Review of a subsequent order dated 12/05/18 revealed an order for Ivermectin 3mg (used to treat parasitic infestations), take four tablets with food, may repeat in two weeks if still symptomatic. Review of a subsequent order dated 02/04/19 revealed an order to administer permethrin 5% cream orders from 10/31/18 to 02/04/19, orders were on hold due to lack of specific scabies diagnosis with no confirmed skin scrapings. Refer to interview with the Memory Care Coordinator (MCC) on 03/15/19 at 10:19am. Refer to interview with a medication aide (MA) on 03/14/19 on 9:11am. Refer to interview with the Public Health Nurse on 03/14/19 at 2:45pm. Refer to interview with the Physician Assistant (PA) on 03/14/19 at 3:00pm Refer to interview with the Administrator on 03/15/19 at 1:30pm. Based on observation, interview, and record review revealed Resident #2 was not interviewable.	D 079		

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D 079	Continued From page 2 2- Review of Resident #2's current FL2 dated 01/30/19 revealed diagnoses included dementia, muscular degeneration, history of fractures. Review of subsequent physician order dated 10/29/18 revealed an order for permethrin 5% topical cream (used to treat scabies) to apply to the entire body and leave of for 12 hours then shower. Review of a subsequent order dated 02/04/19 revealed an order to administer permethrin 5% cream orders from 10/31/18 to 02/04/19, orders were on hold due to lack of specific scabies diagnosis with no confirmed skin scrapings. Refer to interview with the Memory Care Coordinator (MCC) on 03/15/19 at 10:19am. Refer to interview with a medication aide (MA) on 03/14/19 on 9:11am. Refer to interview with the Public Health Nurse on 03/14/19 at 2:45pm. Refer to interview with the Physician Assistant (PA) on 03/14/19 at 3:00pm Refer to interview with the Administrator on 03/15/19 at 1:30pm. Based on observation, interview, and record review revealed Resident #2 was not interviewable. _____ Interview with the Memory Care Coordinator (MCC) on 03/15/19 at 10:19am revealed: -She worked at the facility since November 2018 as the MCC.	D 079		

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D 079	Continued From page 3 -All of the residents were experiencing a rash when she came to work at the facility. -She was told by the Administrator that no one had confirmed scabies and that it was an issue with the laundry detergent. -She saw a rash on everyone but could not remember when she saw the rash. -She had not contacted the health department about the skin infection outbreak. -Resident #3 complained of a rash and saw a Dermatologist in February 2019. -Resident #3's family member informed her that Resident #3 did not have scabies, however was been treated with permethrin cream. -She had not spoken to the Dermatologist who saw Resident #3. -The physician assistant ordered the permethrin cream on 02/04/19 for everyone. Interview with a medication aide (MA) on 03/14/19 on 9:11am revealed: -Residents in the facility had order for creams and pills due to skin irritation. -She was told by management that the skin irritation came from the laundry detergent. -Other staff told her that they had a rash and some of the residents had a rash, and it might be scabies. -The physician order the permethrin cream for everyone in the facility. Telephone interview with the Public Health Nurse on 03/14/19 at 2:45pm revealed: -Facilities are required to report outbreaks/illness for 2 or more residents. -According to the local county communicable disease database, there had not been a report from the facility within the past 2 years. -The communicable disease unit would want to know of any outbreak to discuss infectious	D 079			

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D 079	Continued From page 4 precautions to prevent the illness from affecting the entire facility. Interview with the Physician Assistant (PA) on 03/14/19 at 3:00pm revealed: -She ordered permethrin cream for all of the residents in the facility in October 2018. -She came to the facility to examine the residents who complained of rashes, however all of them had different rashes and she could not confirm scabies. -She was later told by the Administrator that there was an issue with the laundry detergent, which was highly concentrated and felt that it may have been the cause of skin irritation. -She held the permethrin cream after being notified about the detergent. -Residents in the facility continued to have skin irritations and she ordered medication accordingly. -She ordered the permethrin cream on 02/04/19 for all of the residents because residents were complaining about skin irritation again. Interview with the Administrator on 03/15/19 at 1:30pm revealed: -Staff observed a rash on the residents and rumored that it was scabies in October 2018. -She had a Physician Assistant (PA) come to the facility to see the residents. -The PA could not confirmed scabies and said that it was contact dermatitis. -On 10/31/18, the physician ordered permethrin cream for all the residents in the building. -She observed the laundry being completed with a high concentrated detergent and told the physician who said that it could cause a skin rash. -In December 2018, there was another issue with skin irritation and the physician ordered	D 079		

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D 079	Continued From page 5 medication for some of the residents. -There had never been any confirmed cases of scabies since she was the Administrator. -She never reported the skin irritation outbreak to the health department. -She thought she addressed the skin irritation outbreak, therefore she did not contact the health department. 3. Review of Resident #3's current FL2 dated 10/12/18 revealed diagnoses included dementia, atrial fibrillation and hypertension. Review of Resident #3's Resident Register dated 09/24/18 revealed an admission date of 09/01/2018. Review of Resident #3's physician's order dated 10/29/18 revealed: -Resident #3 had an order for permethrin cream 5%, a medication used to treat scabies, apply to entire body. -Leave the cream on for 12 hours, then shower and remove. -Repeat treatment in 2 weeks. Review of Resident #3's record revealed there was no documentation the permethrin cream was applied to Resident #3. Review of Resident #3's subsequent physician's order dated 12/05/19 revealed: -Resident #3 had an order for ivermectin 3 mg, a medication used to treat parasitic infestations such as scabies, take 4 tablets by mouth with food one dose. -May repeat in 2 weeks if still symptomatic. Review of Resident #3's later physician's order dated 01/31/19 revealed: -Resident #3 had an order for permethrin 5%	D 079			

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D 079	Continued From page 6 -topical cream one topical application. -Apply the cream to skin, from head to feet, and remove by washing in 8-14 hours. -Repeat the treatment in 1 week. Interview with a second PCA on 03/13/19 at 12:15pm revealed: -Resident #3 was suspected of having scabies last month. -Resident #3's family member made an appointment with her primary care physician (PCP) to be examined. -Resident #3 returned from the appointment with a prescription for a cream to treat scabies. -Resident #3's roommate also had reddened itchy areas on her back. -Another resident was suspected of a skin irritation on her scalp. -"We have not had any instruction from our Supervisors on infectious disease prevention recently." Refer to interview with the Memory Care Coordinator (MCC) on 03/13/19 at 12:00pm. Interview with the first shift medication aide (MA) on 03/13/19 at 11:10am revealed: -She did not know of any recent scabies or skin infection incidents in the community. -Resident #3 was treated for scabies, as well as everyone else, a few months ago as a precaution. -She did not know if there was a diagnosed case of scabies that led to the treatment of the residents. -The management team told the staff the rash and itching the residents and staff were experiencing was due to a laundry detergent issue. Interview with a third PCA on 03/13/19 at	D 079		

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D 079	Continued From page 7 12:40pm revealed: -She thought Resident #3 was diagnosed with scabies last month. -She did not know of any resident presently with symptoms of a skin infection. -"We do not always know of the diseases the residents have unless the MAs let us know." -We have not had any meetings regarding infection control of infectious diseases. Interview with the second shift MA on 03/13/19 at 3:40pm revealed: -A few months ago, Resident #3 may have had scabies- she was not sure. -She was informed by other staff members that all the residents in the facility had received a cream to treat them proactively in case the skin irritation was scabies. -She had not been informed of a diagnosed case of rabies amongst the staff or residents. -She was told the cream was not effective, so a tablet was ordered for all the residents. -She did administer the ivermectin tablet to some residents. -She had heard the management team had an infection control meeting to inform the staff on how to prevent the spread of scabies. -She did not attend the meeting. -Staff that did not attend the meeting had to rely on other staff to inform them of the meeting information. Refer to interview with the PCA on 03/14/19 at 9:35am. Telephone interview with the PCP's Office Manager on 03/15/19 at 10:35am revealed: -Resident #3 was seen in the office on 01/31/19. -Resident #3 was prescribed permethrin cream for a diagnosis of scabies.	D 079			

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D 079	Continued From page 8 Telephone interview with Resident #3's family member on 03/14/19 at 9:40am revealed: -She had taken Resident #3 to the PCP on 01/31/19. -The facility had treated her family member for the skin irritation, but it was not clearing up. -The PCP prescribed a cream to treat scabies. Refer to interview with the personal care assistant (PCA) on 03/13/19 at 9:26am. Refer to interview with a medication aide (MA) on 03/14/19 on 9:11am. Refer to telephone interview with the Public Health Nurse on 03/14/19 at 2:45pm. Refer to a second interview with the MCM on 03/15/19 at 10:05am. Refer to interview with the Physician Assistant (PA) on 03/14/19 at 3:00pm. Refer to interview with the Administrator on 03/15/19 at 2:25pm. Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable. 4. Review of Resident #1's current FL2 dated 10/12/18 revealed diagnoses included Alzheimer dementia with behavioral disturbances, depression, polypharmacy and a history of trans ischemic attacks (TIAs). Review of Resident #1's Resident Register revealed an admission date of 01/13/16.	D 079		

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STREET ADDRESS, CITY, STATE, ZIP CODE

WELLINGTON HOUSE

850 MAJESTIC COURT
GASTONIA, NC 28054

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D 079	Continued From page 9 Review of Resident #4's physician's order dated 10/31/18 revealed: -Resident #1 had an order for permethrin cream 5%, a medication used to treat scabies, apply to entire body. -Leave the cream on for 12 hours, then shower and remove. -Repeat treatment in 2 weeks. Review of Resident #1's record revealed: -There was no documentation the permethrin cream was applied to Resident #1. -There was no documentation the permethrin cream treatment was repeated in 2 weeks. Review of Resident #1's subsequent physician's order dated 12/05/19 revealed: -Resident #1 had an order for ivermectin 3 mg, a medication used to treat parasitic infestations such as scabies, take 4 tablets by mouth with food one dose. -May repeat in 2 weeks if still symptomatic. Review of Resident #1's later physician's order dated 01/31/19 revealed: -Resident #1 had an order for permethrin 5% topical cream one topical application. -Apply the cream to entire body and leave on for 12 hours. -Repeat the treatment in 2 weeks. Review of Resident #1's record revealed there was no documentation the permethrin cream treatment was repeated in one week Interview with Resident #1's prescribing physician on 03/15/19 at 11:10am revealed: -She could not confirm a case of scabies with her residents. -She did not perform any skin scrapings on the	D 079		

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D 079	Continued From page 10 residents. -She prescribed the rabies treatment, "in case it was scabies." -She did not refer her residents to a dermatologist. -The Administrator told her the rash was from a reaction to the detergent in the facility. Review of Resident 1's record revealed there was no documentation the permethrin cream treatment was repeated in one week. Attempted telephone interview with the responsible party on 03/14/19 at 3:45pm was not successful. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. Refer to interview with personal care assistant (PCA) on 03/13/19 at 9:26am. Refer to observation on 03/13/19 at 9:31am in the community shower room. Refer to interview with the Memory Care Coordinator (MCM) on 03/13/19 at 12:00pm. Refer to interview with the PCA on 03/14/19 at 9:35am. Refer to interview with a medication aide (MA) on 03/14/19 on 9:11am. Refer to telephone interview with the Public Health Nurse on 03/14/19 at 2:45pm. Refer to a second interview with the MCM on 03/15/19 at 10:05am.	D 079			

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D 079	Continued From page 11 Refer to interview with the Physician Assistant (PA) on 03/14/19 at 3:00pm. Refer to interview with the Administrator on 03/15/19 at 2:25pm. Interview with personal care assistant (PCA) on 03/13/19 at 9:26am revealed: -The residents were bathed in the community shower room. -Their toiletries were labeled with their names and hung in individual pockets on the wall outside the shower. -The resident's used the same shower seat. -The PCA was responsible for disinfecting the shower area after their resident was bathed. -The commercial disinfectant, located in the shower room, was to remain on the surface for 5 minutes before removing. -The PCA providing the next resident's shower assumed this process had been completed. -No resident showers had been performed today. Observation on 03/13/19 at 9:31am in the community shower room revealed: -There were 4 bottles of body wash on the shower rail inside the shower stall. -One bottle was labeled with a resident's name. -The other 3 bottles of body wash were not labeled with a name. Interview with the Memory Care Coordinator (MCM) on 03/13/19 at 12:00pm revealed: -She was recently hired when the incident regarding suspected scabies infection amongst the residents was occurring-last November (2018). -She was not involved in the orders or treatments of the residents at that time. She was in training.	D 079			

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D 079	Continued From page 12 -There have been no recent incidents of skin infections. Interview with the PCA on 03/14/19 at 9:35am revealed: -She provided personal care to the residents, including showering, toileting and dressing. -The PCA's were also doing the resident's laundry until a month ago when a staff person was hired to do the resident's laundry. -She observed rashes that were causing the residents to itch on many of the residents. -The management team informed the staff that it was an irritation due to the laundry detergent. -In October or November of last year, the previous MCM ordered a cream to treat all the residents for scabies. -She did not think it was used. -She did not know if there was a diagnosed case of scabies at that time. -The current MCM kept the creams in her office. -The PCA's were not given any direction on how to prevent the transmission of scabies. -The PCAs were not given any direction on the protocol of washing clothes suspected of a transmitted disease. -The management team instructed the staff that the skin rash and subsequent itching was due to laundry detergent sensitivity. Interview with a medication aide (MA) on 03/14/19 on 9:11am revealed: -Residents in the facility had order for creams and pills due to skin irritation. -She was told by management that the skin irritation came from the laundry detergent. -Other staff told her that they had a rash and some of the resident had a rash, and it might be scabies. -The physician order the permethrin cream for	D 079			

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D 079	Continued From page 13 everyone in the facility; -"There was an outbreak of something, but I don't know what it was". -There had not been anyone from the health department at the facility to address the skin irritation. Telephone interview with the Public Health Nurse on 03/14/19 at 2:45pm revealed: -Facilities are required to report outbreaks/illness for 2 or more residents. -According to the local county communicable disease database, there had not been a report from the facility within the past 2 years. -The communicable disease unit would want to know of any outbreak to discuss infectious precautions to prevent the illness from affecting the entire facility. A second interview with the MCM on 03/15/19 at 10:05am revealed: -There were tubes of permethrin cream delivered from the pharmacy in the MCM office when she was hired. -She did not administer the cream to the residents because the Administrator related to her the resident's skin condition was due to an irritation caused by the laundry detergent. -In December there were more reports of skin rashes and itching amongst the residents and the staff. -The in house physician assistant (PA) ordered Ivomec, a tablet, for the residents as a prophylactic. -The PA did not diagnose the residents with scabies at this time. Interview with the Physician Assistant (PA) on 03/14/19 at 3:00pm revealed: -She ordered permethrin cream for all of the	D 079		

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NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054		
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D 079	Continued From page 14 residents in the facility in October 2018. -She came to the facility to examine the residents who complained of rashes, however all of them had different rashes and she could not confirm scabies. -She was later told by the Administrator that there was an issue with the detergent was highly concentrated and felt that it may have been the cause of skin irritation. -She held the permethrin cream after being notified about the detergent. -Residents in the facility continued to have skin irritations and she ordered medication accordingly. -She ordered the permethrin cream on 02/04/19 for all of the residents because residents were complaining about skin irritation again. Interview with the Administrator on 03/15/19 at 2:25pm revealed: -In October of 2018, several of the residents had a rash that was itchy. -The in house PA told the Administrator the rash looked like dermatitis. -The PA could not conclude it was scabies. -The PA prescribed Permethrin cream for all her residents. -Before the cream arrived from the pharmacy, she was informed by another Administrator in their sister community that the rash was probably from the inaccurate measurement of laundry detergent -The MCM did not administer the cream when it arrived from the pharmacy due to this conclusion. -In December there was continued concern regarding the rash on some residents back and arms, so the PA prescribed an oral medication for some of the residents affected. -In February, there were some residents that continued to have a rash and itching.	D 079		

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D 079	Continued From page 15 -The PA ordered permethrin cream for all her residents. -"We did not contact the Health Department because we did not have a confirmed case of scabies." -"It was the laundry detergent. We never confirmed the laundry detergent was responsible through a medical source." The facility failed to assure the facility was free of hazards as related to a skin infection outbreak. The facility's failure placed the residents at risk to possible exposure and transmission of skin infections. This failure was detrimental to the health, 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 03/06/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 29, 2019.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 16	D 273		
	This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician notification for 2 of 4 sampled residents related to an anti-psychotic medication that was stopped abruptly and not administered for 26 days (Resident #1), and not completing antibiotic medications for a urinary tract infection (Resident #1) and bronchitis (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 10/12/18 revealed diagnoses included dementia, depression, polypharmacy and chronic back pain. Review of Resident #1's physician's order dated 10/12/18 revealed a medication order for quetiapine (used as an anti-psychotic) 100mg one tablet at bedtime. Review of Resident #1's signed physician's order dated 01/09/19 revealed a medication order for quetiapine extended release (ER) 200mg one tablet by mouth at bedtime. Review of Resident #1's February 2019 eMAR from 02/13/19-02/28/19 revealed: -There was an entry for quetiapine 200mg ER, one tablet by mouth, to be administered daily at 9:00pm. -There was documentation the quetiapine medication was "On Hold". Review of Resident #1's March 2019 eMAR from 03/01/19-03/06/19 revealed: -There was an entry for quetiapine 200mg ER, one tablet by mouth, to be administered daily at 9:00pm.		MCM or designee will clarify all non-covered medication with pharmacy. 3/15/19 MCM provided training to staff on the proper processing of orders using the "Bucket System". Documentation of training maintained in ED office. 4/1/19 "Bucket System" implemented in facility to manage process of physician orders and follow up. System folders are located in copy room for staff to access. 4/1/19 ED/MCM or designee will review MARs monthly for accuracy. 4/1/19 MCM or designee will clarify all non-covered dosages with pharmacy and then contact MD with pharmacy dosage recommendations. Documenting results/recommendations using the "Bucket System" 3/15/19	

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D 273	Continued From page 17 -There was documentation the quetiapine medication was "On Hold". Review of Resident #1's record and progress notes revealed no documentation Resident #1's primary care physician had been notified quetiapine had not been administered to Resident #1 for 26 days. Telephone interview with the facility's contracted pharmacist on 03/14/19 at 11:10am revealed: -On 01/09/19 a faxed physician's signed order for Resident #1 for quetiapine 200mg ER was received by the pharmacy. -A bubble card of 30 tablets of quetiapine 200mg ER was dispensed on 01/09/19 and delivered to the facility on 01/09/19. -No further refill orders of the medication were dispensed for Resident #1, since prior authorization from the physician was needed for insurance coverage. -On 02/08/19 a representative from the pharmacy billing department left a message for the facility's Memory Care Coordinator (MCC) regarding the need for a prior authorization. -This was the second attempt to retrieve the physician's contact information for a prior authorization approval for the medication. -On 03/02/19 a "non fill" notification was sent to the facility for the refill prescription for quetiapine 200mg ER. Interview with the medication aide (MA) on 03/14/19 at 4:25pm revealed: -She contacted the pharmacy representative "the beginning of February" when the refill for quetiapine was not delivered. -She was informed the medication could not be refilled due to insurance issues. -She informed the MCC and was not given any	D 273		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WELLINGTON HOUSE

850 MAJESTIC COURT
GASTONIA, NC 28054

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D 273	Continued From page 18 further directives. -She did not inform the physician. "That is the nurse's responsibility." Interview with the second shift MA on 03/14/19 at 4:30pm revealed: -She had noticed Resident #1 was not sleeping as well in the past month. -Resident #1 would get up frequently during the night, agitated and anxious. -She thought someone was taking her possessions. -She did not report this to the MCC or the nurse practitioner (NP). Interview with the Memory Care Coordinator (MCC) on 03/15/19 at 9:20am revealed: -If a medication was not in the building, the MA contacted the pharmacy to determine the reason. -If the pharmacy could not deliver the medication, she expected the MAs to notify her. -She would contact the physician to request a "hold" on the current medication order or a new medication order for the resident. -She did not know the medication needed prior authorization. -She had not contacted Resident #1's physician to inform her the quetiapine had not been administered for 26 days. Telephone interview with the prescribing NP on 03/15/19 at 8:55am revealed: -She prescribed the quetiapine 200mg ER for Resident #1 for behaviors causing distress to her and others. -Resident #1 was diagnosed as psychotic and depressed with behaviors. -She had visited the resident on 02/12/19 and was not informed by the staff the resident was not receiving her medication.	D 273		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WELLINGTON HOUSE

**850 MAJESTIC COURT
GASTONIA, NC 28054**

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D 273	Continued From page 19 -She did not know a prior authorization was needed to refill the quetiapine. -She would have written the prior authorization and changed the medication if she had been informed. -Stopping quetiapine abruptly could cause Resident #1's psychosis and depression to worsen. She could also experience headaches and lethargy. Interview with the Administrator on 03/15/19 at 1:15pm revealed: -She relied on the MCC for the clinical aspects of the facility. -The MCC was responsible for physician orders and medications. -The MCC was responsible for contacting the physician if there was a question regarding medication orders. -The MAs should notify the MCC if medications had not been filled by the pharmacy. -She did not know Resident #1 had not received quetiapine for 26 days. -It was her expectation the MCC and clinical staff ensured residents received their prescribed medications. b. Review of Resident #1's record revealed: -Resident #1 was diagnosed with a urinary tract infection on 01/26/19. -There was a physician's order dated 01/26/19 for nitrofurantoin capsules 100mg take 1 capsule every 12 hours for 5 days. Review of the January 2019 electronic administration record (eMAR) from 01/27/19-01/30/19 revealed: -There was an entry for nitrofurantoin capsules 100mg take 1 capsule every 12 hours, to be administered at 12:00am and 12:00pm.	D 273		

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D 273	Continued From page 20 -There was documentation the medication was administered for 4 days, 01/27/19-01/30/19. Review of Resident #1's record and progress notes revealed no documentation Resident #1's primary care physician had been notified the resident had not finished nitrofurantoin as ordered. Interview with the Memory Care Coordinator (MCC) on 03/15/19 at 9:40am revealed: -The pharmacist entered the physician orders onto the eMAR system when they were faxed from the facility. -The medication for these orders often arrived the next day. -She did not know Resident #1 did not complete her nitrofurantoin. -She did not inform the physician the medication prescription was not completed by the resident. Refer to interview with the Administrator on 03/15/19 at 1:25pm. Attempted telephone interview with the primary care physician was unsuccessful. 2. Review of Resident #3's current FL2 dated 10/12/18 revealed diagnoses included dementia, atrial fibrillation and hypertension. Review of Resident #3's record revealed there was a signed order dated 01/31/19 for doxycycline 100mg take one tablet twice a day for 10 days. Telephone interview with the facility's contracted pharmacist on 03/14/19 at 11:10am revealed: -On 02/01/19 a faxed physician's signed order for Resident #1 was received by the pharmacy for	D 273			

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D 273	Continued From page 21 doxycycline 100mg, one capsule twice a day, for 10 days. -A bubble card of 30 tablets of quetiapine 200mg ER was dispensed on 02/02/19 and delivered to the facility on 02/02/19. Review of Resident #3's electronic medication administration record (eMAR) for February 2019 from 02/01/19-02/10/19 revealed: -There was an entry for doxycycline 100mg, one capsule twice a day, to be administered at 8:00am and 8:00pm, for 10 days. -There was documentation the medication was administered from 02/02/19 at 8:00pm through 02/10/19 at 8:00pm. Review of Resident #3's record and progress notes revealed no documentation Resident #3's primary care physician had been notified regarding doxycycline 100mg not administered for 5 doses. Interview with the Memory Care Coordinator (MCC) on 03/15/19 at 9:50am revealed: -She did not know Resident #3 had not completed her antibiotic prescription for doxycycline. -The MAs were responsible for cart audits and informing the MCC if there were any irregularities with the eMAR entries and medications. -She did not review the eMARs for accuracy monthly. -She did not know the medication arrived after the order was entered on the eMAR with a start date of 02/01/19 at 8:00am and a finish date of 02/10/19 at 8:00pm. -She did not inform the physician the medication prescription was not completed by the resident. Interview with the office manager of the primary	D 273			

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D 273	Continued From page 22 care physician's office revealed: -Resident #3 had been diagnosed with bronchitis. -The doxycycline was the antibiotic of choice for her infection. -The physician was not informed the resident had missed 5 doses of the antibiotic. -The physician, as related to the office manager, expected the facility to complete medications as prescribed or notify her if there was an issue. -The physician, as related to the office manager, expected the facility to observe the resident for any signs the resident was symptomatic and return to the office to be assessed. Refer to interview with the Administrator on 03/15/19 at 1:25pm. Interview with the Administrator on 03/15/19 at 1:25pm revealed: -She did not know residents' primary care physicians were not notified when their medication prescriptions had not been completed. -She expected the Memory Care Coordinator to be the contact person between the residents and the physicians. -It was her expectation the MCC would notify the prescribing physicians of any medication irregularity.	D 273			
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from	D 282	ED provided in-service training for dining room staff reviewing rule 13F .0904. Documentation maintained in ED office. continued on page 24		4/1/19

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D 282	Continued From page 23 contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to assure the dining room was clean and protected from contamination. The finding are: Observation of the dining room on 03/13/19 at 12:22pm revealed: -There were no residents in the dining room. -The lunch meal service had not begun. -There were 30 place settings of utensils and drinks on the table. -There were 14 tables with 43 chairs. -The chairs at each of the place settings were stained, with dried white residue on the spindles and back of the chairs. -Each of the chairs with place settings had stains on the back chairs and were scuffed on all four legs. -The base of the tables had splatter of white and brown substance. -The chairs or the base of the tables were not cleaned prior to residents entering the dining room at 12:30pm. Observation of the dining room on 3/14/19at 12:20pm revealed: -There were no residents in the dining room. -The lunch meal service had not begun. -There were 30 place settings of utensils and drinks on the table. -There were 14 tables with 43 chairs. -The chairs at each of the place settings were stained dried white residue on the base and back of the chairs. -Each of the chairs with place settings had stains on the chairs and were scuffed on all four legs.	D 282	Daily & weekly cleaning schedule established to maintain cleanliness of kitchen, dining and food storage areas. Documentation of cleaning maintained in ED office.	4/1/19

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D 282	Continued From page 24 -The base of the tables had splatter of white and brown substance. -The chairs of the base of the tables were not cleaned prior to residents entering the dining room at 12:30pm. Interview with a personal care aide (PCA) on 03/15/19 at 3:02pm revealed: -She worked second shift and assisted residents to the dining room for meals when she worked. -The chairs had been dirty "for a while". -She never observed the chairs being cleaned and "the chairs always appeared dirty". Interview with a housekeeper on 03/14/19 at 12:21pm revealed: -The housekeeping staff were responsible for only cleaning the floors in the dining room. -The dietary staff were responsible for cleaning the chairs and tables in the dining room. Interview with a dietary aide/cook on 03/14/18 at 12:21pm revealed: -She worked as a cook and a dietary aide. -The dietary aides were supposed to wipe down the chairs in the dining room after each meal. -There was no schedule for cleaning the dining room. -All of the cooks took turns cleaning the chairs and the tables. -The seat of the chairs were to be wiped down after each meal. -She had not been cleaning the back or the spindles of the chairs. -She did not know why she had not cleaned the back or spindles of the chair. -She had not noticed the dirt on the base of the tables. -She had not cleaned the base of the tables. -The Dietary Manager (DM) completed most of	D 282			

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D 282	Continued From page 25 the cleaning in the dining room. Interview with the DM on 03/14/19 at 12:24pm revealed: -She and the other two dietary aides/cooks were responsible for ensuring the dining room tables and chairs were cleaned. -The dining room tables/seats of the chairs were to be cleaned daily. -She cleaned the chairs and tables "mostly", but it was "whoever could get to it first". -The chairs are cleaned with a sanitizer daily. -The back and spindle of the chairs were to be cleaned once a week. -She had not noticed the dirt and splatter on the base of the table. -Cleaning the base of the table was to be completed weekly. -"I don't know why the chairs look like that, we use sanitizer". Interview with the Administrator on 03/14/19 at 12:29pm revealed: -The DM and the dietary aides/cooks were responsible for cleaning the chairs and tables in the dining room daily. -A "deep cleaning" was supposed to occur once per week which included the back and spindle of chairs and base of tables were to be cleaned. -She had not noticed the condition of the chairs and tables in the dining room.	D 282		
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	D 358		

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D 358	Continued From page 26 by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for sampled 3 of 4 residents #1, 2 and 3) related to an anti-psychotic medication that was stopped abruptly and not administered for 26 days (Resident #1), not administering the complete antibiotic medications for a urinary tract infection (Resident #1) and bronchitis (Resident #3), and not administering a prescription shampoo (Ketoconazole) for scaly patches on the scalp 3 times a week. The findings are: 1. Review of Resident #1's current FL2 dated 10/12/18 revealed diagnoses included dementia, depression, polypharmacy and chronic back pain. a. Review of Resident #1's physician's order dated 10/12/18 revealed a medication order for	D 358	MCM or designee will conduct cart audits weekly to ensure medications are available as directed by MD order. Documentation of audits are maintained on corporate drive per policy. ED/MCM or designee will review MARs monthly for accuracy.	4/1/19 4/1/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054		
(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 358	Continued From page 27 quetiapine 100mg one tablet at bedtime. Review of Resident #1's signed physician's order dated 01/09/19 revealed quetiapine extended release (ER), (an anti-psychotic medication), 200mg one tablet at bedtime. Review of Resident #1's February 2019 eMAR from 02/13/19-02/28/19 revealed: -There was an entry for quetiapine 200mg ER, one tablet by mouth, to be administered daily at 9:00pm. -There was documentation the quetiapine medication was "On Hold". Review of Resident #1's March 2019 eMAR from 03/01/19-03/06/19 revealed: -There was an entry for quetiapine 200mg ER, one tablet by mouth, to be administered daily at 9:00pm. -There was documentation the quetiapine medication was "On Hold". Observation of medication on hand on 03/14/19 at 10:44am for Resident #1 revealed there were no bubble cards of quetiapine 200mg ER tablets available for administration. Telephone interview with the facility's contracted pharmacist on 03/14/19 at 11:10am revealed: -On 01/09/19 a faxed physician's signed order for quetiapine 200mg ER was received by the pharmacy. -A bubble card of 30 tablets of quetiapine 200mg ER was dispensed to the facility on 01/09/19. -No further refill orders of the quetiapine were dispensed for Resident #1, since prior authorization from the physician was needed. -On 02/08/19 a representative from the pharmacy billing department left a message for the facility's	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054		
(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 358	Continued From page 28	D 358			
	Memory Care Coordinator (MCC). -This was the second attempt to retrieve the physician's contact information for a prior authorization approval for the medication. -On 03/02/19 a "non fill" notification was sent to the facility for the refill prescription for quetiapine 200mg ER. -"Non Fill" notifications were emailed to the facility to inform the staff the refill for the medication would not be dispensed. Interview with the medication aide (MA) on 03/14/19 at 4:25pm revealed: -She contacted the pharmacy representative "the beginning of February" when the refill for quetiapine was not delivered. -She was informed the medication could not be refilled due to insurance issues. -She informed the MCC and was not given any further directives. -Resident #1 was not administered quetiapine 200mg ER from 02/09/19 - 03/06/19. -There was a new order for quetiapine on 03/06/19. Interview with the MCC on 03/15/19 at 9:20am revealed: -If a medication was not in the building, the MA contacted the pharmacy to determine the reason. -If the pharmacy could not deliver the medication, she expected the MAs to notify her. -She would contact the physician to request a "hold" on the current medication order, or a new medication order for the resident. -Each week the MAs were given 6 residents to audit for medications to match their orders, and removal of expired medications. -She did not know Resident #1 had not received the quetiapine ER 200mg for 26 days. -She had not received a "Hold" order from the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054			
(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 358	Continued From page 29 physician. -She did not recall the MA informing her the medication would not be refilled due to insurance issues. -She did not know the medication needed prior authorization. -She did not remember the pharmacy contacting her regarding the medication. Telephone interview with the prescribing nurse practitioner (NP) on 03/15/19 at 8:55am revealed: -Stopping quetiapine abruptly could cause Resident #1's psychosis and depression to worsen. -She could also experience headaches and lethargy. Interview with the second shift MA on 03/14/19 at 4:30pm revealed: -She had noticed Resident #1 was not sleeping as well in the past month. -Resident #1 would get up frequently during the night, agitated and anxious. -Resident #1 thought someone was taking her possessions. Interview with the Administrator on 03/15/19 at 1:15pm revealed: -The MCC was responsible for physician orders and medications. -The MAs should notify the MCC if medications have not been filled by the pharmacy. -She did not know Resident #1 had not received the prescribed medication, quetiapine, for 26 days. -It was her expectation the MCC and clinical staff ensured residents received their prescribed medications. b. Review of Resident #1's record revealed:	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054			
(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 358	Continued From page 30 -Resident #1 was diagnosed with a urinary tract infection on 01/26/19. -There was a physician's order dated 01/26/19 for nitrofurantoin capsules 100mg take 1 capsule every 12 hours for 5 days. Review of the January electronic administration record (eMAR) from 01/26/19-01/30/19 revealed: -There was an entry for nitrofurantoin capsules 100mg take 1 capsule every 12 hours, to be administered at 12:00am and 12:00pm, on 1/26/19-1/30/19. -There was documentation the medication was administered for 4 days, 01/27/19-01/30/19. Telephone interview with the facility's contracted pharmacist on 03/14/19 at 11:10am revealed: -On 01/26/19 a faxed physician's signed order for nitrofurantoin capsules 100mg take 1 capsule every 12 hours for 5 days was received by the pharmacy. -A bubble card of 10 tablets of nitrofurantoin capsules 100mg was dispensed to the facility on 01/26/19. Telephone interview with the prescribing nurse practitioner (NP) on 03/15/19 at 8:55am revealed: -She was not informed Resident #1 had not completed the prescribed antibiotic treatment. -She expected the facility to complete the entire antibiotic treatment for an infection. -She expected the facility staff to observe Resident #1 for symptoms of a urinary tract infection and contact her office. Interview with the Memory Care Coordinator on 03/15/19 at 9:40am revealed: -The pharmacist entered the physician orders into the eMAR system when they were faxed from the facility.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054		
(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 358	Continued From page 31 -She verified the new physician's orders on the eMARs. -The medication for these orders often arrived the next day. -She did not know Resident #1 did not complete her prescription for nitrofurantoin. Interview with the second shift MA on 03/14/19 at 4:30pm revealed: -She administered medications as they were transcribed onto the eMAR. -She did not remember an extra nitrofurantoin capsule in the bubble pack. -Medications not completed were sent back to the pharmacy or destroyed. Review of Resident #1's record revealed no documentation nitrofurantoin was returned to the pharmacy. Refer to interview with the Administrator on 03/15/19 at 1:25pm. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. 2. Review of Resident #3's current FL2 dated 10/12/18 revealed diagnoses included dementia, atrial fibrillation and hypertension. Review of Resident #3's record revealed there was a signed order dated 01/31/19 for doxycycline 100mg take one tablet twice a day for 10 days. Observation of Resident #1's medications on hand on 03/14 /19 at 3:45pm revealed: -There was a bubble card of 5 doxycycline 100mg tablets on the medication cart.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054			
(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 358	Continued From page 32 -The pharmacy label on the bubble card read 20 tablets were dispensed to the facility on 02/01/19 to be administered twice a day for 10 days. Review of Resident #3's electronic medication administration record (eMARs) on February 2019 from 02/01/19-02/10/19 revealed: -There was an entry for doxycycline 100mg, one tablet twice a day, to be administered at 8:00am and 8:00pm, for 10 days. -There was documentation the medication was administered from 02/02/19 at 8:00pm through 02/10/19 at 8:00pm. Interview with the Memory Care Coordinator on 03/15/19 at 9:50am revealed: -She did not know Resident #3 had not completed her antibiotic prescription for doxycycline. -She had not verified the start date and ending date on the eMAR when the medication arrived. -She did not know why the medication was not removed from the medication cart during a cart audit and brought to her attention. Interview with the office manager of the primary care physician's office revealed: -Resident #3 had been diagnosed with bronchitis. -The doxycycline was the antibiotic of choice for her infection. -The physician was not informed the resident had missed 5 doses of the antibiotic. -The physician expected the facility to complete medications as prescribed or notify her if there was an issue. -The physician expected the facility to notify her if the resident became symptomatic. Based on observations, interviews, and record review, it was determined Resident #3 was not	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 860 MAJESTIC COURT GASTONIA, NC 28054			
(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 358	Continued From page 33 Interviewable. Refer to interview with the Administrator on 03/15/19 at 1:25pm. _____ Interview with the Administrator on 03/15/19 at 1:25pm revealed: -She did not know the MCC was not fully trained on the eMAR system. -She expected the MCC to review the eMARs and ensure residents were receiving their medications as prescribed. -She expected the MAs to notify the MCC if there were any irregularities in the administration of medications. -The MCC was responsible for medication orders, medication administration, liaison with the physicians and supervision of the MAs. 3. Review of Resident #4's current FL2 dated 10/26/18 revealed diagnoses included dementia and hypertension. Review of subsequent physicians order dated 10/31/18 revealed an order for ketoconazole shampoo 2% (used to treat a fungal infection) topical use on shower days. Review of the January 2019 electronic Medication Administration Record (eMAR) revealed: -An entry for ketoconazole shampoo 2% topical use 3 times weekly on shower days (once a day on Tuesday, Thursday, and Saturday). -The ketoconazole shampoo was documented as administered 3 times weekly, during 2nd shifts from 01/01/19-01/31/19. Review of the February 2019 eMAR revealed: -An entry for ketoconazole shampoo 2% topical use 3 times weekly on shower days (once a day	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054		
(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 358	Continued From page 34 on Tuesday, Thursday, and Saturday). -The ketoconazole shampoo was documented as administered 3 times weekly, during 2nd shifts from 02/01/19-02/28/19. Review of the March 2019 eMAR revealed: -An entry for ketoconazole shampoo 2% topical use 3 times weekly on shower days (once a day on Tuesday, Thursday, and Saturday). -The ketoconazole shampoo was documented as administered 3 times weekly, during 2nd shifts from 03/01/19-03/12/19. Observation of medication available for Resident #4 on 03/14/19 at 12:07pm revealed: -A 4oz. (120mL) bottle of ketoconazole shampoo 20% with a pharmacy label indicating the date filled was 10/12/18. -The ketoconazole shampoo appeared to have approximately 90% of lotion remaining in the bottle. Telephone interview with the pharmacist at the contracted pharmacy on 03/14/19 at 5:15pm revealed: -The ketoconazole shampoo 2% was filled on filled on 10/12/18. -The facility had not requested any refills for ketoconazole shampoo 2% since 10/12/18. -If the ketoconazole shampoo was used as ordered, it would only last three weeks. Interview with a second shift personal care aide (PCA) on 03/14/19 at 4:25pm revealed: -She did not know Resident #4 had an order for ketoconazole shampoo. -None of the MAs provided her with shampoo from the medication cart for Resident #4. -She used store brought shampoo to wash Resident #4's scalp.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WELLINGTON HOUSE

850 MAJESTIC COURT
GASTONIA, NC 28054

(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 358	Continued From page 35	D 358		
	Interview with another second shift PCA on 03/14/19 at 4:15pm revealed: -She only used the shampoo once two months ago. -She relied on the MA to supply her with the shampoo since it was on the medication cart. -Resident #4's scalp experienced scalp irritation daily. -"Regular" shampoo was used on Resident #4's hair. Interview with a second shift MA on 03/14/19 at 3:36pm revealed: -She knew Resident #4 had an order for ketoconazole shampoo. -Resident #4 received her showers during second shift. -She applied the ketoconazole shampoo to Resident #4 when he received his showers three times per week when she worked. -She only used a little bit of the shampoo because Resident #4 had short hair. -She did not know why the same bottle of ketoconazole shampoo was on cart since it was originally filled. Interview with the Memory Care Coordinator (MCM) on 03/15/19 at 10:19am revealed: -MAs were responsible for applying the ketoconazole shampoo for Resident #4. -She did not know if Resident #4 was receiving the ketoconazole shampoo. -MAs were expected to follow orders according to the MAR. -She had not noticed the ketoconazole shampoo had been on the cart since it was originally filled on 10/12/18. Interview with the primary care provider (PCP) on			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054		
(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)		(X6) COMPLETE DATE
D 358	Continued From page 36 3/14/19 at 8:59am revealed: -She ordered ketoconazole shampoo for Resident #4 to treat a fungal infection of the scalp. -She did not discontinue the ketoconazole for Resident #4, she wanted her to continue to receive it. -Resident #4 would be at risk for continued irritation of the scalp and hair loss. Interview with the Administrator on 03/14/19 at 1:30pm revealed she expected MAs to administer medications as ordered by the physician. Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable. The facility failed to assure medications were administered as ordered to 3 residents (#1, #2, and #3) related to an anti-psychotic medication not administered for 26 days resulting in increased anxiety and agitation in the evening (Resident #1), not administering the full dosage of antibiotics for a urinary tract infection and bronchitis (Resident #1 and #2) and not administering medicated shampoo for a fungal infection of the scalp three times weekly. This failure of not receiving medications as ordered could result in failure to treat diseases properly and increased risk of exacerbations of clinical symptoms which was detrimental to the health, 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 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED April 29,	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054		
(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 358	Continued From page 37	D 358		
D912	2019. G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure the facility was free of hazards as related to a skin infection outbreak for 4 of 4 sampled residents (#1, #2, #3, and #4). [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for sampled 3 of 4 residents #1, 2 and 3) related to a scheduled	D912	Every resident shall have the following rights: To receive care and services which are adequate, appropriate and in compliance with relevant federal state laws and rules and regulations. In-service training for staff on Resident Rights provided by LHPS nurse. Documentation of training maintained in ED office.	4/1/19 4/25/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAJESTIC COURT GASTONIA, NC 28054			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D912	Continued From page 38 anti-psychotic medication (quetiapine) that was stopped abruptly and not administered for 26 days (Resident #1), not administering the complete antibiotic medications for a urinary tract infection (Resident #1) and bronchitis (Resident #3), and not administering a prescription shampoo (Ketoconazole) for scaly patches on the scalp 3 times a week.[Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912			