McLamb's Rest Home
998 Five Points Road, Benson, NC 27504
919-207-0282 (office) 919-894-2349 (fax)

December 23, 2019

NC Department of Health and Human Services
Division of Health Service Regulations
2708 Mail Service Center
Raleigh, NC 27699-2709

Ref: Annual Survey completed November 14, 2019
HAL-051-008
Johnston County

Please find enclosed comments to the State Survey done on 11/14/19. The comments are on separate pages and correspond to the deficiency items stated on your form.

Sincerely,
Wanda Berrier
Office Administrator

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
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ADULT CARE LICENSURE SECTION
RALEIGH

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 11/13/19 with an exit via telephone on 11/14/19.	D 000	See attached form for comments to deficiencies. Thank you, Wanda Bernier	
D 127	10A NCAC 13F .0403(c) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (c) Medication aides and staff who directly supervise the administration of medications, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 1 medication aides sampled (Staff A) completed six hours of continuing education annually related to medication administration. The findings are: Review of Staff A, medication aide's (MA) personnel record revealed: -Staff A was hired on 09/28/2000. -There was documentation of two continuing education units (CEU) related to medication administration (infection control) in Staff A's personnel record for 2019. -There were no other CEUs for 2018 or 2019 related to medication administration.	D 127	(Form begins after Page 26 of this form.)	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda Bernier
TITLE: Office Admin
(X6) DATE: 12/23/19

I have reviewed and accepted this plan of correction on 01/07/20. Pamela Dailey

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D 127	Continued From page 1 Telephone interview with Staff A on 11/14/19 at 2:12pm revealed: -She had a certificate for continuing education related to medication dated 2017. -She completed whatever CEU classes were set up by the Business Office Manager. -She had continuing education training in 2018; she did not know she had to have CEUs specific to medication administration. Telephone interview with the Business Office Manager on 11/14/19 at 2:10pm revealed: -She was responsible for personnel records. -She had set-up training for the staff in September 2018; she did not think about needing medication specific training. Attempted interview with the Administrator on 11/14/19 at 2:16pm was unsuccessful.	D 127		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A 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, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff C) was tested for tuberculosis (TB) disease with	D 131		

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D 131	Continued From page 2 the two-step skin test in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Staff C, personal care aide's (PCA) personnel record revealed: -Staff C was hired on 09/11/19. -There was no documentation Staff C had a two-step tuberculosis (TB) skin test. Interview with Staff C on 11/13/19 at 6:24pm revealed: -She had not had a two-stepTB test. -She knew she needed a TB test; she was waiting on facility staff to coordinate. Telephone interview with the Business Office Manager (BOM) on 11/13/19 at 6:45pm revealed: -She was responsible for personnel records. -She knew Staff C needed a two-step TB test upon hire. -She gave Staff C an employment package that contained information that was needed, including information about obtaining a TB test. -She had not followed-up with Staff C to make sure she had completed the required items in the employment package. Telephone interview with the Administrator on 11/14/19 at 11:06am revealed: -The BOM was responsible for personnel records. -She was not aware Staff C did not have a two-step TB test completed.	D 131		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications	D 139		

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D 139	Continued From page 3 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete a criminal background check on 1 of 3 sampled staff (Staff C). The findings are: Review of Staff C, personal care aide's (PCA) personnel record revealed: -Staff C was hired on 09/11/19. -There was a release form for a criminal background check signed by Staff C on 09/21/19. -There was no documentation Staff C had a criminal background check. Interview with Staff C on 11/13/19 at 6:24pm revealed she did not know if a criminal background check had been completed. Telephone interview with the Business Office Manager (BOM) on 11/13/19 at 6:45pm revealed: -She was responsible for personnel records. -She knew Staff C needed a criminal background check. -She gave Staff C an employment package that contained information that was needed, including information about obtaining a criminal background check. -She had not followed-up with Staff C to make sure she had completed the required items in the employment package. Telephone interview with the Administrator on	D 139		

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D 139	Continued From page 4 11/14/19 at 11:06am revealed: -The BOM was responsible for personnel records. -She was not aware Staff C did not have a criminal background check. -She thought the BOM had obtained a criminal background check on Staff C.	D 139		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents were provided with a non-disposable place setting, including a knife. The findings are: Observation of the lunch meal on 11/13/19 at 1:07pm revealed: -There were ten residents in the dining room. -The meal consisted of a piece of BBQ chicken on the bone, macaroni and cheese, peas, and sugar free vanilla pudding. -Each resident received a fork and a spoon with their place setting; none of the residents received	D 287		

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D 287	Continued From page 5 a knife to cut the chicken off the bone. -Four residents used their fingers to pick up the chicken to eat with while two others held the piece of chicken with their fingers and pulled the meat off the bone with a fork. -One resident used his spoon to hold the chicken breast while he pulled the meat off the bone with his fork. Observation of the kitchen on 11/13/19 at 1:50pm revealed there were four pairing knives, one steak knife, and two butter knives in a drawer; there were no other knives in the kitchen. Interview with a resident on 11/13/19 at 1:21pm revealed: -He thought he could ask for a knife if he needed it to eat, but he had never asked for a knife to use to eat. -He used his spoon to spread his jelly on his toast in the morning; a knife would make it easier to spread jelly. Interview with a second resident on 11/13/19 at 1:34pm revealed: -She had never gotten a knife to use; she would like a knife to use to eat. -There were times like that day at lunch she could have used a knife; she pulled the chicken meat off the bone with her fingers and a fork for lunch. -The staff spread her jelly or butter on her bread for her. -She did not know if she could ask for a knife or it there were knives to use at meals. Interview with a third resident on 11/13/19 at 1:44pm revealed: -He did not get a knife to use to eat with; he used his hands and a fork to pull meat apart. -The staff just did not give knives to the residents	D 287		

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and he never asked because he "just made do" with his fork and his fingers.

Interview with a fourth resident on 11/13/19 at 7:35pm revealed:
-He had not seen knives in the dining room in a while; it had been so long he could not remember the last time he saw knives.
-He kept plastic knives in his room to take to the dining room so he could spread his own peanut butter and jelly.
-He did not ask staff for a knife from the kitchen.

Interview with the cook on 11/13/19 at 1:50pm revealed:
-She set the tables and washed the dishes; none of the residents got knives to use to eat.
-She had never been trained or told to give the residents knives; she thought it was for safety reasons.
-She thought there was a safety concern because she did not know diagnoses or what medications residents were on and they could use a knife to hurt someone or themselves.
-None of the residents ever asked for a knife; she cut the food for the residents prior to serving it.
-She did not cut the chicken for lunch that day because the residents picked it up to eat or used their forks to pull the meat off the bone.
-She did not know what the residents used to spread butter or jelly with; she thought they used their spoons.

Interview with the Resident Care Coordinator (RCC) on 11/13/19 at 4:32pm revealed:
-She did not know each resident was supposed to have a knife to use; she was concerned some of the residents should not have a knife to use to eat.
-She did not know of any residents that were

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D 287	Continued From page 7 violent; she just did not think it was a good idea to give the residents knives. Telephone interview with the Administrator on 11/14/19 at 11:08am revealed: -There was no need to give residents a knife because the kitchen staff or cook cut up the food for the residents. -The RCC decided which residents got knives and which residents did not get a knife to use. -The RCC decided who got a knife on a case by case basis based on who was responsible; responsible residents would not use a knife to hurt someone. -She thought not every resident had enough cognition to use a knife. -Staff would ask the resident what they were going to use a knife for before giving them a knife, even at meal time. -She knew each resident was supposed to get a knife and she thought there were enough knives available to give one to each resident.	D 287		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for food service guidance for 1 of 3 sampled residents, (#4) with physician orders	D 296		

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D 296	Continued From page 8 for a mechanical soft (MS) and no concentrated sweets (NCS) diet (#4). The findings are: Review of the diet list provide by the Office Manager on 11/13/19 revealed there were four diets for the eleven residents listed; regular, mechanical soft (MS), no concentrated sweets (NCS), and a low sodium (LS) diet. Review of the menu located in the kitchen in a spiral bound note book on 11/13/19 revealed: -There were four diets listed on the menu for the kitchen staff guidance; regular, 1600 calorie, 1800 calorie and NCS. -There was no diet menu listed for the MS or LS diet. Review of Resident #4's current FL-2 dated 06/21/19 revealed: -Diagnoses included seizures, anemia, gastroesophageal reflux disease, abnormal posture, hyperlipidemia, diabetes Meletus type two, and schizoaffective disorder. -There was an order for a mechanical soft (MS) and no concentrated sweets (NCS) diet. Review of the diet list on 11/13/19 revealed Resident #4 was listed as served a NCS diet. Interview with Resident #4 on 11/13/19 at 7:56pm revealed: -The kitchen cut his food up for him; mostly his meat was cut up. -He did not know why he had a MS diet; he ate his food with no problems. Observation of the lunch meal on 11/13/19 at 1:07pm revealed:	D 296		

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D 296	Continued From page 9 -BBQ chicken on the bone, macaroni and cheese, peas, bread and sugar free vanilla pudding were served to the residents. -Resident #4 was served a pimento cheese sandwich, macaroni and cheese, peas, and sugar free vanilla pudding. Interview with the cook on 11/13/19 at 1:16pm revealed: -She did not have a diet menu to follow for the mechanical soft (MS) diet; she cut up Resident #4's food before she gave it to him. -She did not know if there were any foods Resident #4 was not allowed to eat. Interview with the Resident Care Coordinator (RCC) on 11/13/19 at 9:00am revealed: -She did not know the diets that were listed on the diet menu did not include a MS diet; she thought the menu was about five years old. -She knew the cook would cut up meat for the MS diet for Resident #4; she did not know if anything else needed to be done for the MS diet. -The Administrator had spoken to a dietitian about a month ago about updating the menu; the RCC did not know there needed to be a diet menu to include the MS diet but would let the dietitian know. Interview with the Administrator on 11/14/19 at 11:08am revealed: -The diet menu was only a year and a half old. -She thought the diet menu included no concentrated sweets (NCS), LS, and calorie specific diets. -The primary care physician (PCP) usually let the facility staff know at the time of residents' appointments what they could and could not have based on their diets. -She did not know the MS diet needed to be	D 296		

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D 296	Continued From page 10 included on the diet menu. -The cook would cut up, mash up and put food in the blender to make it "real soft" so residents on a MS diet could eat.	D 296		
D 308	10A NCAC 13F .0904(e)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be brand specific, unless the facility has defined a house supplement in its communication to the physician, and shall specify quantity and frequency. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 sampled residents (#3) who used nutritional supplements had a written physician's order. The findings are: Review of Resident #3's current FL-2 dated 8/26/19 revealed: -Diagnoses included diabetes mellitus, schizophrenia, hypertension, high cholesterol, asthma, irritable bowel syndrome, and chronic constipation. -There was an order for a no concentrated sweets diet. -There was no physician's order for nutritional supplements. Review of the Resident Diet Sheet (not dated) revealed Resident #3 was not listed as receiving a nutritional supplement.	D 308		

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D 308	Continued From page 11 Review of Resident #3's Medication Administration Record (MAR) for September 2019, October 2019, and November 2019 revealed there was no entry for nutritional supplements. Observation of a refrigerator in Resident #3's room revealed 5 bottles of a glucose control nutritional supplement. Interview with Resident #3 on 11/13/19 at 8:28am revealed: -He drank one bottle of a nutritional supplement in the place of a meal when he did not like what was on the menu. -He would ask for a substitution on the menu if he did not like what was on the menu for dinner but for lunch, he would drink the nutritional supplement instead of asking for a substitution. -He did not know if there was a physician's order for him to have a supplement. -The facility staff knew he had nutritional supplements he drank in the place of a meal. -He drank a supplement, "about three times a week." -His family member purchased the nutritional supplement and brought it to the facility. Interview with the Resident Care Coordinator (RCC) on 11/13/19 at 3:53pm revealed: -She knew Resident #3 had a nutritional supplement in his personal refrigerator. -Resident #3 drank a nutritional supplement when he did not like what was on the menu. -The nutritional supplement was provided by Resident #3's family member. -She had not talked to Resident #3's primary care provider (PCP) about the nutritional supplement. -She knew an order was required for nutritional	D 308		

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supplements when nutritional supplements were needed for a nutritional need, not because the resident wanted to drink them.

Telephone interview with Resident #3's family member on 11/13/19 at 4:16pm revealed:
-She purchased the nutritional supplement for Resident #3.
-Resident #3 drank the nutritional supplement 3-4 times per week.
-She purchased the nutritional supplement because Resident #3 was diabetic, and she did not want him to miss a meal.
-She did not remember if she asked anyone if she could provide the nutritional supplement for Resident #3.
-She did not know a physician's order was required for Resident #3 to use a nutritional supplement.

Telephone interview with a medication aide (MA) on 11/13/19 at 7:00pm revealed:
-She knew Resident #3 drank a nutritional supplement in the place of a meal when he did not like what was being served for lunch.
-Resident #3 drank a nutritional supplement 2-3 times per week.
-She did not know Resident #3 needed a physician's order for a nutritional supplement.

Telephone interview with Resident #3's PCP on 11/13/19 at 5:49pm revealed:
-She was not aware Resident #3 was drinking supplements.
-She would have liked to have known Resident #3 was using supplements in the place of meals.
-She would be concerned if Resident #3 was using supplements in the place of meals every day.
-She would have been more concerned that

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D 308	Continued From page 13 Resident #3 was drinking a supplement instead of eating a meal if Resident #3 was on meal-controlled insulin (Resident #3 was not on meal-controlled insulin). Telephone interview with the Administrator on 11/14/19 at 11:06am revealed: -She did not know a physician's order was needed for a resident to use a nutritional supplement. -She knew Resident #3 drank nutritional supplements in the place of meals when he did not like what was on the menu. -Resident #3's family member purchased the nutritional supplement as needed.	D 308		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents (#2) sampled including errors with a medication used to treat high blood pressure. The findings are: Review of Resident #2's current FL-2 dated	D 358		

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D 358	Continued From page 14 05/07/19 revealed: -Diagnoses included hyperkalemia, type 2 diabetes mellitus, gastroesophageal reflux disease, spina bifida, hydrocephalus, and hypertension. -There was an order for amlodipine 5mg 1 tablet once in the morning. (Amlodipine is a medication used to treat high blood pressure.) Review of Resident #2's physician's orders dated 11/07/19 revealed there was an order for amlodipine 10mg take 1 tablet once daily. Review of Resident #2's September 2019 medication administration record (MAR) revealed: -There was an entry for amlodipine 5mg every day with a scheduled administration time of 8:00am. -Amlodipine 5mg was documented as administered daily at 8:00am from 09/01/19 to 09/30/19; amlodipine was noted as held on 09/10/19 and 09/11/19. -Blood presures were documented taken once weekly on Mondays; the ranges were 90/62 to 135/74. Review of Resident #2's October 2019 MAR revealed: -There was an entry for amlodipine 5mg every day with a scheduled administration time of 8:00am. -Amlodipine 5mg was documented as administered daily at 8:00am from 10/01/19 to 10/31/19. -Blood presusers were documented as taken once weekly on Mondays; the ranges were 83/59 to 98/67. Review of Resident #2's November 2019 MAR revealed:	D 358		

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D 358	Continued From page 15 -There was an entry for amlodipine 5mg every day with a scheduled administration time of 8:00am. -Amlodipine 5mg was documented as administered daily at 8:00am from 11/01/19 to 11/13/19. -There were no other entrees for amlodipine on the MAR. -Blood presures were documented as taken once weekly on Mondays; the ranges were 100/68 to 100/63. Observation of Resident #2's medication on hand on 11/13/19 at 12:15pm revealed: -There were two medication cards for amlodipine. -The first card contained amlodipine 5mg; 30 tablets were dispensed on 10/27/19 and 15 tablets remained in the card. -The second card contained amlodipine 10 mg; 18 tables were dispensed on 11/7/19 and 13 tablets remained in the card. Interview with Resident #2 on 11/13/19 at 7:35pm revealed: -He had high blood pressure for a long time; he knew he took medication for high blood pressure, but he did not know the name of the medication or the dosage. -He knew at his last appointment with the primary care physician (PCP) on 11/07/19 his blood pressure medication was increased because his blood pressure was too high. -He "took a cup full of pills every morning" but did not know how much medication he took because he never counted. -His blood pressure was taken every morning and he had been fine and felt "good". Telephone interview with a representative from the contracted pharmacy on 11/13/19 at 2:18pm	D 358		

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D 358	Continued From page 16 revealed: -The order for amlodipine 5mg was discontinued on 11/07/19 when the new order increased the amlodipine from 5mg to 10mg on the same date. -Thirty tables of amlodipine 5mg were last dispensed on 10/24/19; eighteen tables of amlodipine 10mg were dispensed on 11/07/19. -Amlodipine was on an auto fill status; the medication was auto matically sent to the facility everymonth. -Amlodipine was a medication used to decrease blood pressure and the dosage would be ordered based on blood pressure levels of the resident. -The maximum dosage of amlodipine was 10mg; that was why the dosage for amlodipine 5mg was discontinued. -If both dosages of amlodipine were administered Resident #2's blood pressure could have dropped too low. Telephone interview with Resident #2's PCP on 11/13/19 at 3:29pm revealed: -The order for amlodipine 5mg was discontinued when the dosage was increased to 10mg on 11/07/19. -Resident #2's was seen by the PCP on 11/07/19 and his blood pressure was 159/81; the PCP increased the dosage because his blood pressure was still "high". -The PCP had not been notified of any "drops" in Resident #2's blood pressure; there would be concern if Resident #2 had any changes in his blood pressure. Interview with the medication aide (MA) on 11/13/19 at 7:10pm revealed: -She gave Resident #2 his medication and checked his blood pressure before giving the amlodipine. -She was not aware of the amlodipine 5mg dose	D 358		

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D 358	Continued From page 17	D 358		

being discontinued; she just began giving the amlodipine 10mg when the new medication came in from the pharmacy.

Interview with the Resident Care Coordinator (RCC) on 11/13/19 at 3:55pm revealed:
-She had called the PCP's office on 11/07/19 and clarified the order was supposed to be 15mg of amlodipine, but she did not have documentation.
-She named the Registered Nurse (RN) she spoke to when she called the PCP office for clarification.
-She understood the negative outcomes Resident #2 could have had if he continued to take 15mg of amlodipine; "we could have killed him".
-She called the pharmacy on 11/07/19 after the incorrect dosage was brought to her attention; the pharmacy was going to call the PCP for clarification.

Telephone interview with the RN from the PCP's office on 11/14/19 at 2:21pm revealed:
-On 11/04/19 the facility staff had notified the PCP of a high blood pressure reading for Resident #2 and wanted advice from the PCP.
-The PCP wanted to see Resident #2 in the office; Resident #2 was seen by the PCP on 11/07/19 and the amlodipine was increased from 5mg to 10mg at the visit.
-On 11/07/19 the order for amlodipine 5mg was discontinued and the new order for amlodipine 10mg was given.
-She was not sure the RCC called the PCP for clarification of the dosage change; all calls were documented at the PCP's office and there was no documentation of the phone call for clarification.
-She did not speak to the RCC about clarification of the medication order.

Telephone interview with the Administrator on

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D 358	Continued From page 18 11/14/19 at 11:08am revealed: -The PCP sent medication orders to the pharmacy; any changes were checked once the medication was sent by the pharmacy and the "old dose" was returned to the pharmacy. -The RCC was responsible for checking the medication against the orders and calling the PCP for clarification. -She was concerned Resident #2 received the wrong dosage of his amlodipine; his blood pressure was high but she did not want it to drop too low and have him go to the hospital.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 3 residents sampled (#1) had physicians' orders to self-administer medications for an antacid medication, a pain medication, an anti-diarrheal	D 375		

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D 375	Continued From page 19	D 375		

medication, a lubricant eye drop, a diuretic, and an antihypertensive medication.

The findings are:

Review of Resident 1's current FL-2 dated 05/14/19 revealed:
-Diagnoses included congestive heart failure, chronic obstructive pulmonary disease, hypertension, edema, coronary artery disease, and anemia.
-Resident #1 was intermittently confused.
-There was a medication order for Terazosin 10mg at bedtime. (Terazosin is used to treat high blood pressure).
-There was a medication order for Furosemide 10mg daily. (Furosemide is a diuretic used to treat fluid retention).
-There was no order for Tylenol (used to treat mild pain), Antacid tablets (used to treat heartburn), Anti-diarrheal medication (used to treat diarrhea), and lubricant eye drops (used to treat dry eyes).
-There was no order for self-administration.

Review of Resident #1's record revealed:
-There was no documentation of a "Self-Administration of Medication Assessment" and no physician's order to self-administer medications.
-Resident #1 initialed a page titled "Drug Management and Review Policy"; there was documentation specific to residents who may not keep any medication in their room or on their person unless a physician had authorized that the resident may self-administer the medication.
-Resident #1 signed his admissions paperwork on 05/11/17.

Observation of Resident #1's room on 11/13/19 at

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D 375	Continued From page 20 8:45am and 11:41am revealed: -The resident had two bottles of over the counter (OTC) eye drops sitting on a table. -The resident had a bottle of OTC Tylenol, OTC antacid tablets, and a prescription bottle with the prescription marked out and the letters AD written on the top and side, in a drawer in a table by his bed. -The resident had a prescription bottle labeled Terazonsin 10mg with a dispense date of 09/27/19 in a drawer on the opposite side of his bed; the bottle contained 4 of 30 tablets. -The resident had a prescription bottle labeled Furosemide 20mg take ½ tablet daily with a dispense date of 10/11/19 in a drawer on the opposite side of his bed; the bottle appeared to contain 45 of 45 tablets. Interview with Resident #1 on 11/13/19 at 8:45am and 11:41am revealed: -He used eye drops twice a day, every day for allergies. (He could not find the bottle of eye drops he referred to as allergy eye drops). -He used artificial tears during the day as needed. (He used them when his eyes were burning). -He did not use artificial tears every day; he used artificial tears on 11/12/19. -He used Tylenol when his leg was hurting; he used it "about a month ago." -He used the anti-diarrheal medication "about 3 weeks ago" after eating something greasy. -He used the antacid tablets for heartburn and indigestion; he used the bottle of tablets "about 2 weeks ago." -He had prescription bottles of medication in his room to give staff when they told him he was getting low on his prescription. -He ordered his own prescriptions from a local pharmacy when the medication aides (MA) notified him his prescriptions needed to be	D 375		

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D 375	Continued From page 21 refilled. -He liked to keep a "few" of the Teraazosin tablets in his room so when the MA came to tell him he did not have any to be administered he could give the MA the tablets he had on hand and order another bottle. -"I am more than capable of taking my own medicine when I need it." -He did not self-administer the prescription medication he kept in his room, "just OTC medication" -No one had told him he could not keep medications in his room. -He did not know he had to have an order to self-administer medications. Interview with the Resident Care Coordinator (RCC) on 11/13/19 at 11:48am revealed: -She was responsible for obtaining self-administration orders. -She did not know Resident #1 had medications in his room. -Residents and families were told at admission that medications could not be kept in the room; residents and families were not reminded. -She expected the personal care aides (PCA) to tell her if they saw medication in a resident's room; the PCAs were in the residents' rooms daily. -She checked on the residents daily but did not go through the residents' things. Interview with a PCA on 11/13/19 at 1:43pm revealed: -She knew residents could not have medication in their rooms. -She did not know of any residents who had medications in their rooms. -Resident #1 did not want anyone touching his things in his room.	D 375		

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D 375	Continued From page 22 -She had not seen eye drops in Resident #1's room. -She had not seen any other medication in Resident #1's room. Telephone interview with Resident #1's Primary Care Provider (PCP) on 11/13/19 at 5:34pm revealed: -She did not know Resident #1 had medications in his room. -No one had called her about a self-administration order for Resident #1. -She would prefer Resident #1 not administer his own medication. -She would be concerned Resident #1 would take too much medication and not remember he had already taken it. -She would be okay with Resident #1 keeping eye drops at his bedside and administering the eyes drops as needed. Interview with Resident #1's family member on 11/13/19 at 5:56pm revealed: -She did not know Resident #1 could not have medications in his room. -She thought Resident #1 could have OTC items in his room, including eye drops. -She did not know a physician's order was needed for Resident #1 to self-administer his OTC medications. -Ninety-nine percent of the time she gave prescription medication directly to facility staff. -There were times she had left prescription medication with Resident #1 to give to the MA; she only gave the prescription medication to Resident #1 when she did not see any staff at the time she entered the facility. Telephone interview with a MA on 11/13/19 at 7:00pm revealed:	D 375		

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D 375	Continued From page 23 -She did not know Resident #1 had medications in his room. -She had not administered eye drops for Resident #1; Resident #1 did not have an order for eye drops. -Resident #1 ordered his own medications. -She told Resident #1 when his medications needed to be ordered and when the medications came in, he gave the medications bottles to her. -Resident #1 had never given her medications he kept in his room when he was out of a medication, only when medications came in from the pharmacy. Telephone interview with the Administrator on 11/14/19 at 11:06am revealed: -She knew a physician's order was needed for a resident to self-administer medications. -She did not know Resident #1 currently had medications in his room; she took medications out of Resident #1's room about three weeks ago. -She told Resident #1 when his prescriptions were picked up, the prescriptions needed to be given to the facility staff.	D 375		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening	D992		

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D992	Continued From page 24 procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure examination and screening was completed for the presence of controlled substances for 1 of 3 sampled staff (Staff B) who was hired after 10/01/13. The findings are: Review of Staff C, personal care aide's (PCA) personnel record revealed: -Staff C was hired on 09/11/19.	D992		

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D992	Continued From page 25 -There was no documentation Staff C had a drug screening. Interview with Staff C on 11/13/19 at 6:24pm revealed: -She had not had a drug screening -She knew she needed a drug screening; she was waiting on facility staff to coordinate. Telephone interview with the Business Office Manager (BOM) on 11/13/19 at 6:45pm revealed: -She was responsible for personnel records. -She knew Staff C needed a drug screening upon hire. -She gave Staff C an employment package that contained information that was needed, including information about obtaining a drug screening at a local laboratory. -She had not followed-up with Staff C to make sure she had completed the required items in the employment package. Telephone interview with the Administrator on 11/14/19 at 11:06am revealed: -The BOM was responsible for personnel records. -She was not aware Staff C did not have a drug screening completed.	D992		

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Measures put in place to correct the deficient area of practice	**Measure to prevent the problem from occurring again**	**Who will monitor the situation to ensure it will not occur again**	**How often the monitoring will take place**	**Completion dates by which the plan of correction will be completed**
D127 – Pharmacy nurse has been contacted to schedule a Med Review class for all med aides.	Office Admin will keep roster of med aides' dates of hire and certification dates and will schedule med aide classes as required.	Office Administrator	Monthly – so that timely med classes can be scheduled.	Roster completed 12/20/29. Med review classes are currently being done online and through pharmacy.
D131 – Staff C received TB test on 11/15/19	Office Administrator will make initial appointment for TB tests for new hires to ensure will not left up to new hire) to make their own appointment.	Office Administrator	Upon hire of new employees	As of 12/30/19 – two-step TB tests were completed.
D139 – Background check received 11/25/19.	Office Administrator will set up "tickler " files for all new hires in order to ensure all required documentation is completed in a timely manner.	Office Administrator	Upon hire	Completed 11/25/19

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Measures put in place to correct the deficient area of practice	Measure to prevent the problem from occurring again	Who will monitor the situation to ensure it will not occur again	How often the monitoring will take place	Completion dates by which the plan of correction will be completed
D287 – Knives along with forks and spoons are given to all residents at each meal.	Food service staff have been informed of rule requiring knives to be included with eating utensils.	SIC and RCC	Daily (each meal)	Completely 11/15/19
D296 – Specific orders were obtained from PCP for residents requiring mechanically soft diets.	Residents meals will be prepared according to their specific order (ground, cut up, soft)	Food Service Staff/RCC	Daily (each meal)	Completed 11/20/19
D308 – Obtained following order from PCP for nutritional supplement "Boost Glucose Control daily as needed for meal refusal." Resident is aware of PCP order	Staff will be more attentive to foods and drinks residents or families bring into the home and will report to RCC.	SIC/RCC	Staff will regularly monitor residents for food or drink that requires doctor orders.	11/15/19
D358 – This resident's medication (amlodipine) was clarified and corrected on 11/14/19.	Med staff and RCC will ensure written documentation is clear on any med changes or new prior to beginning meds.	RCC/MA	Upon starting, changing, or discontinuing a med – and at the beginning of each month when new MARs are printed.	This deficiency was corrected on 11/14/19 – after contacting doctor and pharmacy.

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Measures put in place to correct the deficient area of practice	**Measure to prevent the problem from occurring again**	**Who will monitor the situation to ensure it will not occur again**	**How often the monitoring will take place**	**Completion dates by which the plan of correction will be completed**
D375 – Meds were removed from resident's room on 11/14/19. Resident was reminded of policy he signed and agreed to upon admission.	Facility admission forms state that no meds are to be kept in resident's room or self-administered without doctor's orders. Upon admission, we will stress this policy to resident as well as family.	RCC/MA/SIC	Weekly and as needed	11/14/19
D992 – Negative lab results received 11/27/19	Office Administrator will set up "tickler " files for all new hires in order to ensure all required documentation is completed in a timely manner.	Office Administrator	Upon hire	Completed 11/25/19