STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on October 9-11, 2019.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 2 of 6 sampled staff (Staff A and Staff F) had a criminal background check completed prior to hire. The findings are: 1. Review of Staff A, medication aide/Administrative Assistant's (MA/AA), personnel record revealed: -Staff A was hired on 01/04/10. -There was documentation of a county criminal background check on 07/16/07. -There was no documentation of a State of North Carolina criminal background check completed on Staff A. -There was no consent for a State of North Carolina criminal background check. Interview with Staff A on 10/11/19 at 9:10 am revealed: -He was a medication aide and the Administrative Assistant. -He did not know if he had a State of North Carolina criminal background check. -The county criminal background check was all that he had in his personnel record.	D 139	It is the policy of the CRT Golden Lamb that each staff personal have a criminal background check upon hire. This will be monitored by the administrative assistants and the administrator. In the future I will designate one staff member to handle all staff charts and ensure all required employment and staff qualifications have been met prior to working. The employment checklist will be used to ensure all qualifications are met.	10/15/19

Received and approved. AJS 01/24/20

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D 139	Continued From page 1 Interview with the Administrator on 10/11/19 at 9:50 am revealed she was not aware Staff A did not have a State of North Carolina criminal background check. Interview with the facility contracted nurse on 10/11/19 at 11:15 am revealed: -She did not know the criminal background check had to be for the State of North Carolina. -She did not verify if Staff A's criminal background check was through the State of North Carolina or the county. Refer to interview with the Administrator on 10/11/19 at 9:55 am. Refer to interview with the facility contracted nurse on 10/11/19 at 11:20 am. 2. Review of Staff F, the housekeeper's, personnel record revealed: -Staff F was hired on 08/22/16. -There was no documentation of a criminal background check completed on Staff F. -There was no consent for a criminal background check. -There was a check list of Staff F's personnel requirements and documentation of a criminal background check was not checked. Interview with the Administrator on 10/11/19 at 9:50 am revealed: -Staff F was a housekeeper. -She was not aware Staff F did not have a criminal background check. Interview with the facility contracted nurse on 10/11/19 at 11:15 am revealed she created a check list for Staff F's personnel record, and if a	D 139		

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D 139	Continued From page 2 requirement was not checked, it was not in the personnel record. Attempted telephone interview with Staff F on 10/11/19 at 11:05 am was unsuccessful. Refer to interview with the Administrator on 10/11/19 at 9:55 am. Refer to interview with the facility contracted nurse on 10/11/19 at 11:20 am. Interview with the Administrator on 10/11/19 at 9:55 am revealed: -The Administrative Assistant, was responsible for assuring criminal background checks were completed on all staff. -The Administrator was responsible for auditing personnel records and she did not know the last time she audited the records. -She expected the Administrative Assistant to run criminal background checks on staff, and if the Administrative Assistance did not, she would run the criminal background checks. -The facility contracted nurse also audited staff records and she did not know when she completed the last audit. Interview with the facility contracted nurse on 10/11/19 at 11:20 am revealed: -She audited personnel records for criminal background checks about a month and a half ago. -She made a list of incomplete documentation in personnel records and provided the list to the facility. -She audited personnel records in order to help the Administrator; auditing personnel records was not in her job description. -The Administrator was responsible for assuring	D 139		

Division of Health Service Regulation

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D 139	Continued From page 3 the personnel records were completed.	D 139		
D 150	.0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 6 sampled staff (Staff A) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program.	D 150	It is the policy of the CRT Golden Lamb that staff who provide or directly supervise staff that provides personal care to residents shall complete an 80-hour personal care training. All staff providing or directly supervising staff providing care to residents will have 80-hour PCA training or CNA certification. This will be monitored by the ~~Administration~~ Administrator.	1/30/20

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D 150	Continued From page 4 The findings are: Review of Staff A's, medication aide/Administrative Assistant (MA/AA), personnel record revealed: -Staff A was hired on 01/04/10. -There was no documentation Staff A had completed an 80 hour personal care training and competency evaluation program. Observation of nurse documentation on 10/09/19 revealed: -Staff A's personnel record was audited 09/18/19. -Staff A did not have documentation of an 80 hour personal care training and competency evaluation program in his personnel record. Interviews with two residents on 10/10/19 revealed Staff A assisted residents with bathing. Interview with Staff A on 10/11/19 at 9:10 am revealed: -He was a medication aide and the Administrative Assistant. -He administered medications to residents, and he assisted with residents' personal care needs and activities of daily living "once in a blue moon, but not regularly." -He did not complete the 80 hour personal care training and competency evaluation program because he was told he did not need to take the training when he took the medication aide class. -The Administrator was responsible for supervising medication aides. Interview with the Administrator on 10/11/19 at 9:50 am revealed: -She was responsible for assuring staff completed the 80 hour personal care training and competency evaluation program.	D 150		

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D 150	Continued From page 5 -All medication aides had personal care training except Staff A because he "really [doesn't] work with residents like that" and he did not routinely provide personal care to residents. -Staff A was a supervisor and supervised personal care aides. -Personal care aides assisted residents with toileting, dressing, and bathing. -She was responsible for completing and maintaining personnel records. -She was responsible for auditing personnel records and she did not know the last time she audited the records. -The facility contracted nurse also audited staff records and she did not know when she completed the last audit. Interview with the facility contracted nurse on 10/11/19 at 11:15 am revealed: -She audited Staff A's personnel records about a month and a half ago. -She audited personnel records in order to help the Administrator; auditing personnel records was not in her job description. -She made a list of incomplete documentation in personnel records and provided the list to the facility. -The Administrator was responsible for assuring Staff A's personnel record was complete.	D 150		
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	D 358		

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D 358	Continued From page 6 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 2 of 6 residents (Resident #1 and #4) related to a medication for low vitamin D levels, smoking cessation, and hypertension during the 8:00 am medication pass on 10/10/19 and 2 of 3 sampled residents (#2 and #3) for a record review related to a beta blocker, an antipsychotic, a statin medication, and a diuretic (#2), antiseizure medications and a dementia medication (#3). The findings are: The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 8:00 am medication pass on 10/10/19. 1. Review of Resident #4's FL-2 dated 02/22/19 revealed diagnoses included dementia with a behavioral disturbance, hypertension, hyperlipidemia, and history of a stroke. a. Review of Resident #4's current FL-2 dated 02/22/19 revealed an order for lisinopril (used to treat hypertension) 10 mg daily. Review of Resident #4's signed physician orders dated 08/26/19 revealed an order for lisinopril 10 mg daily. Review of Resident #4's October 2019 medication administration record (MAR) revealed there was an entry for lisinopril 20 mg take ½	D 358	It is the policy of the CRT Golden Lamb that the home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed practitioner which are maintained in the resident's record. Training will be done by the facility's nurse. Medication aides will document medications given on the MARS. This will be monitored by the medication aides and the nurse. To reduce medication errors contracted RN will have weekly review for MA. These reviews are to serve as refreshers to keep CRT Golden Lamb policy and procedures as well as medication administration requirements errors to a minimum.	11/1/2019

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D 358	Continued From page 7 tablet daily scheduled for 8:00 am. Observation of the 8:00 am medication pass on 10/10/19 revealed: -At 8:10 am, the morning medication aide (MA) prepared 5 medications, including lisinopril, for administration to Resident #4. -Lisinopril was dispensed as 20 mg tablets and required to be broke in half. -The MA did not break the Lisinopril 20 mg in half. She put the whole tablet in Resident #4's cup and administered the medications. Attempted interview with Resident #4 on 10/10/19 at 2:00 pm was unsuccessful. Interview with the MA on 10/10/19 at 11:15 am revealed: -She administered Resident #4's 8:00 am medication on 10/10/19. -She knew Resident #4 only received ½ tablet of lisinopril. -She forgot to cut Resident #4's lisinopril in half. -She was responsible for administering medications as ordered by the physician. Attempted telephone interview with Resident #4's primary care physician (PCP) on 10/10/19 at 3:44 pm was unsuccessful. Refer to the interview with the Administrator on 10/10/19 at 11:20 am. Refer to the interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to the interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative	D 358		

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D 358	Continued From page 8 Assistant on 10/11/19 at 9:15 am. b. Review of Resident #4's current FL-2 dated 02/22/19 revealed an order for nicotine patch 14 mg/24 hour apply to skin daily. Review of Resident #4's signed physician orders dated 08/26/19 revealed an order for nicotine patch 14 mg/24 hour apply to skin daily. Review of Resident #4's October 2019 medication administration record (MAR) revealed there was an entry for nicotine patch 14 mg/24 hour apply to skin daily scheduled for 8:00 am. Observation of the 8:00 am medication pass on 10/10/19 revealed: -At 8:10 am, the morning medication aide (MA) prepared 5 medications for administration to Resident #4 then placed his unopened nicotine patch in the top drawer of her medication cart. -The MA administered Resident #4's medication while he was in the dining room, but she did not apply his nicotine patch. -She returned to the medication cart and documented administration of the medications including his nicotine patch. Attempted interview with Resident #4 on 10/10/19 at 2:00 pm was unsuccessful. Interview with the MA on 10/10/19 at 11:15 am revealed: -She administered Resident #4's 8:00 am medications on 10/10/19. -She knew Resident #4 received a nicotine patch. -She was not allowed to apply the nicotine patch while Resident #4 was in the dining room because she had to place it on his back so that he did not remove it.	D 358		

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D 358	Continued From page 9 -Resident #4 attended a day program and left right after breakfast. -She forgot to apply his daily nicotine patch before he left. -She was responsible for administering medications as ordered by the physician. Interview with the Administrator on 10/10/19 at 3:00 pm revealed she expected all medications to be administered during med pass. Attempted telephone interview with Resident #4's primary care physician (PCP) on 10/10/19 at 3:44 pm was unsuccessful. Refer to the interview with the Administrator on 10/10/19 at 11:20 am. Refer to the interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to the interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. 2. Review of Resident #1's current FL-2 dated 02/18/19 revealed diagnoses paranoid schizophrenia, hypertension, history of substance dependence, hypertriglyceridemic waist (HTW), and chronic back pain. Review of Resident #1's signed physician's order dated 06/17/19 revealed an order for vitamin D 3 (a supplement used to treat vitamin D deficiency) 2000 units daily. Review of Resident #1's October 2019 medication administration record (MAR) revealed	D 358		

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D 358	Continued From page 10 there was an entry for vitamin D3 2000 units daily scheduled for 8:00 am. Observation of the 8:00 am medication pass on 10/10/19 revealed: -At 8:03 am, the morning medication aide (MA) prepared 6 medications for administration to Resident #1. -Vitamin D3 was not prepared or offered to the resident as ordered. Interview with Resident #1 on 10/10/19 at 2:30 pm revealed: -She did not count her medications when the aide brought them to her. -She did not know how many medications she took. -She believed she received all her medications during medication pass. Interview with the MA on 10/10/19 at 11:15 am revealed: -She administered Resident #1's 8:00 am medications on 10/10/19. -She overlooked the Vitamin D3 2000 units for Resident #1. -Vitamin D3 was in a bottle and not on cards like Resident #1's other medications. -She knew Resident #1 was ordered Vitamin D3. -She was responsible for administering medications as ordered by the physician. Interview with the Administrator on 10/10/19 at 3:00 pm revealed she expected all medications to be administered during med pass. Interview with Resident #1's primary care physician on 10/10/19 at 3:44 pm revealed: -The primary care physician's office had not been notified of the missed dose of vitamin D3.	D 358		

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D 358	Continued From page 11 -There was no detriment in missing 1 dose of vitamin D. Refer to the interview with the Administrator on 10/10/19 at 11:20 am. Refer to the interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to the interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. 3. Review of Resident #3's current FL-2 dated 08/25/19 revealed diagnoses epilepsy, hypertension, aphasia, muscle weakness, dementia, and major depressive disorder. a. Review of Resident #3's FL-2 dated 08/25/19 revealed an order for divalproex (used to treat seizures) 500 mg 1 tablet twice daily. Review of Resident #3's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for divalproex 500 mg 1 tablet twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Divalproex was documented as administered 53 out of 60 opportunities from 09/01/19 to 09/30/19. -Divalproex was not documented as administered at 8:00 pm on 09/03/19, 09/10/19, 09/13/19, 09/14/19, 09/20/19, 09/22/19, and 09/27/19. -There was no documentation on the back of Resident #3's MAR for the reason divalproex was not administered for 7 opportunities. Review of Resident #3's October 2019 MAR	D 358		

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D 358	Continued From page 12 revealed: -There was an entry for divalproex 500 mg 1 tablet twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Divalproex was documented as administered 13 out of 17 opportunities from 10/01/19 to 10/09/19. -Divalproex was not documented as administered at 8:00 pm on 09/01/19, 09/02/19, 09/03/19, and 09/04/19. -There was no documentation on the back of Resident #3's MAR for the reason divalproex was not administered for 4 opportunities. Observation of Resident #3's medications on hand on 10/09/19 at 4:00 pm revealed: -Resident #3's divalproex 500 mg 1 tablet was prepackaged in a pouch with 2 other medications. -Medication pouches were on a roll and each pouch was numbered. -The medications were packaged on 10/04/19 and the next pouch on the roll was numbered 5 of 120. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's primary care physician (PCP) on 10/10/19 at 4:22 pm was unsuccessful. Refer to interview with the Administrator on 10/10/19 at 11:20 am. Refer to interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to interview with a first shift MA on 10/10/19 at 2:15 pm.	D 358		

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D 358	Continued From page 13 Refer to interview with MA/Administrative Assistant on 10/11/19 at 9:15 am. b. Review of Resident #3's FL-2 dated 08/25/19 revealed an order for levetiracetam (used to treat seizures) 750 mg 2 tablets twice daily. Review of Resident #3's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for levetiracetam 750 mg 2 tablets twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Levetiracetam was documented as administered 53 out of 60 opportunities from 09/01/19 to 09/30/19. -Levetiracetam was not documented as administered at 8:00 pm on 09/03/19, 09/10/19, 09/13/19, 09/14/19, 09/20/19, 09/22/19, and 09/27/19. -There was no documentation on the back of Resident #3's MAR for the reason levetiracetam was not administered for 7 opportunities. Review of Resident #3's October 2019 MAR revealed: -There was an entry for levetiracetam 750 mg 2 tablets twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Levetiracetam was documented as administered 15 out of 17 opportunities from 10/01/19 to 10/09/19. -Levetiracetam was not documented as administered at 8:00 pm on 09/01/19 and 09/02/19. -There was no documentation on the back of Resident #3's MAR for the reason levetiracetam was not administered for 2 opportunities. Observation of Resident #3's medications on	D 358		

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D 358	Continued From page 14 hand on 10/09/19 at 4:00 pm revealed: -Resident #3's divalproex 500 mg 1 tablet was prepackaged in a pouch with 2 other medications. -Medication pouches were on a roll and each pouch was numbered. -The medications were packaged on 10/04/19 and the next pouch on the roll was numbered 5 of 120. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's primary care physician (PCP) on 10/10/19 at 4:22 pm was unsuccessful. Refer to interview with the Administrator on 10/10/19 at 11:20 am. Refer to interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to interview with MA/Administrative Assistant on 10/11/19 at 9:15 am. c. Review of Resident #3's FL-2 dated 08/25/19 revealed an order for vimpat (used to treat seizures) 200 mg 1 tablet twice daily. Review of Resident #3's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for vimpat 200 mg 1 tablet twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Vimpat was documented as administered 53 out	D 358		

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D 358	Continued From page 15 of 60 opportunities from 09/01/19 to 09/30/19. -Vimpat was not documented as administered at 8:00 pm on 09/03/19, 09/10/19, 09/13/19, 09/14/19, 09/20/19, 09/22/19, and 09/27/19. -There was no documentation on the back of Resident #3's MAR for the reason vimpat was not administered for 7 opportunities. Review of Resident #3's October 2019 MAR revealed: -There was an entry for vimpat 200 mg 1 tablet twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Vimpat was documented as administered 15 out of 17 opportunities from 10/01/19 to 10/09/19. -Vimpat was not documented as administered at 8:00 pm on 09/01/19 and 09/02/19. -There was no documentation on the back of Resident #3's MAR for the reason vimpat was not administered for 2 opportunities. Observation of Resident #3's medications on hand on 10/09/19 at 4:00 pm revealed: -Resident #3's divalproex 500 mg 1 tablet was prepackaged in a pouch with 2 other medications. -Medication pouches were on a roll and each pouch was numbered. -The medications were packaged on 10/04/19 and the next pouch on the roll was numbered 5 of 120. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's primary care physician (PCP) on 10/10/19 at 4:22 pm was unsuccessful. Refer to interview with the Administrator on	D 358		

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D 358	Continued From page 16 10/10/19 at 11:20 am. Refer to interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to interview with MA/Administrative Assistant on 10/11/19 at 9:15 am. d. Review of Resident #3's FL-2 dated 08/25/19 revealed an order for donepezil (used to treat dementia) 10 mg 1 tablet daily. Review of Resident #3's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for donepezil 10 mg 1 tablet daily with scheduled administration times at 8:00 pm. -Donepezil was documented as administered 53 out of 60 opportunities from 09/01/19 to 09/30/19. -Donepezil was not documented as administered at 8:00 pm on 09/03/19, 09/10/19, 09/13/19, 09/14/19, 09/20/19, 09/22/19, and 09/27/19. -There was no documentation on the back of Resident #3's MAR for the reason donepezil was not administered for 7 opportunities. Review of Resident #3's October 2019 MAR revealed: -There was an entry for donepezil 10 mg 1 tablet daily with scheduled administration times at 8:00 pm. -Donepezil was documented as administered 15 out of 17 opportunities from 10/01/19 to 10/09/19. -Donepezil was not documented as administered at 8:00 pm on 09/01/19 and 09/02/19. -There was no documentation on the back of	D 358		

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D 358	Continued From page 17 Resident #3's MAR for the reason donepezil was not administered for 2 opportunities. Observation of Resident #3's medications on hand on 10/09/19 at 4:00 pm revealed: -Resident #3's divalproex 500 mg 1 tablet was prepackaged in a pouch with 2 other medications. -Medication pouches were on a roll and each pouch was numbered. -The medications were packaged on 10/04/19 and the next pouch on the roll was numbered 5 of 120. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's primary care physician (PCP) on 10/10/19 at 4:22 pm was unsuccessful. Refer to interview with the Administrator on 10/10/19 at 11:20 am. Refer to interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to interview with MA/Administrative Assistant on 10/11/19 at 9:15 am. 4. Review of Resident #2's current FL2 dated 08/21/19 revealed diagnoses included frontotemporal dementia. a. Review of Resident #2's current FL2 dated 08/21/19 revealed an order dated 08/07/19 revealed an order for carvedilol 12.5 mg (used to	D 358		

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D 358	Continued From page 18 treat high blood pressure or heart failure) twice a day with meals. Review of Resident #2's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for carvedilol 12.5 mg twice a day with meals scheduled at 8:00 am and 5:00 pm. -Carvedilol was documented as administered at 8:00 am and 5:00 pm from 08/01/19 through 08/31/19. Review of Resident #2's September 2019 MAR revealed: -There was an entry for carvedilol 12.5 mg twice a day with meals scheduled at 8:00 am and 5:00 pm. -Carvedilol was documented as administered at 8:00 am from 09/01/19 through 09/30/19. -Carvedilol was documented as administered for 24 of 30 opportunities at 5:00 pm from 09/01/19 through 09/30/19. Review of Resident #2's October 2019 MAR revealed: -There was an entry for carvedilol 12.5 mg twice a day with meals scheduled at 8:00 am and 5:00 pm. -Carvedilol was documented as administered at 8:00 am from 10/01/19 through 10/09/19. -Carvedilol was documented as administered for 5 of 8 opportunities at 5:00 pm from 10/01/19 through 10/09/19. Observation of Resident #2's medication on hand on 10/10/19 at 3:15 pm revealed: -Carvedilol 12.5 mg was available to be administered. -There were 180 tablets of carvedilol dispensed on 07/23/19.	D 358		

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D 358	Continued From page 19 -Staff had written the bottle was opened on 07/26/19. -There were 52 tablets of carvedilol remaining. -There should have been 26 tablets remaining if administered as ordered. Telephone interview with Resident #2's pharmacy on 10/11/19 at 11:04 am revealed: -The current order in the pharmacy system was for carvedilol 12.5 mg twice a day with meals. -There were 180 tablets of carvedilol 12.5 mg dispensed on 07/23/19. -The facility had to call to request refills. Interview with the Administrator on 10/10/19 at 11:15 am revealed she did not know carvedilol was not documented as administered for Resident #2 in September 2019 and October 2019. Interview with the facility contracted nurse on 10/10/19 at 1:40 pm revealed: -She knew there were holes in the resident MARs but did not know Resident #2 specifically was missing documentation for carvedilol for September 2019 and October 2019. -If the medication aide (MA) did not document carvedilol as administered she would assume the medication was not given. Interview with a first shift MA on 10/10/19 at 2:10 pm revealed: -She knew there were holes in the MAR, but she did not know carvedilol was not documented as administered on several occasions in September 2019 and October 2019. -Carvedilol was not administered if it was not documented. Interview with MA/Administrative Assistant on	D 358		

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D 358	Continued From page 20 10/11/19 at 9:10 am revealed he did not know Resident #2's carvedilol was not documented as administered in September 2019 and October 2019. Interview with Resident #2's Primary Care Provider (PCP) on 10/11/19 at 12:05 pm revealed: -Carvedilol was prescribed to manage coronary artery disease. -The PCP expected the carvedilol to be administered as ordered. -The PCP expected to be notified of any errors with carvedilol administration. -The PCP was not notified of missed doses of carvedilol in September 2019 and October 2019. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to interview with the Administrator on 10/10/19 at 11:20 am. Refer to interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. b. Review of Resident #2's current FL2 dated 08/21/19 revealed an order dated 08/07/19 revealed an order for quetiapine fumarate 25 mg (used to treat depression or behaviors with dementia), 0.5 tablet twice a day. Review of Resident #2's record revealed a	D 358		

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D 358	Continued From page 21 medication clarification dated 08/21/19 for quetiapine fumarate 25 mg at bedtime. Review of Resident #2's August 2019 Medication Administration Record (MAR) revealed: -There was a handwritten entry for quetiapine fumarate 25 mg at bedtime scheduled at 8:00 pm -Quetiapine fumarate was documented as administered for 29 of 31 opportunities at 8:00 pm from 08/01/19 through 08/31/19. Review of Resident #2's September 2019 MAR revealed: -There was a handwritten entry for quetiapine fumarate 25 mg at bedtime scheduled at 8:00 pm -Quetiapine fumarate was documented as administered for 19 of 30 opportunities at 8:00 pm from 09/01/19 through 09/30/19. Observation of Resident #2's medication on hand on 10/10/19 at 3:15 pm revealed: -Quetiapine fumarate 25 mg was available to be administered. -There were 30 tablets of quetiapine fumarate 25 mg dispensed on 09/13/19. -There were 26 tablets of quetiapine fumarate remaining. Telephone interview with Resident #2's pharmacy on 10/10/19 at 10:19 am revealed: -The current order in the pharmacy system was for quetiapine fumarate 25 mg at bedtime. -There were 30 tablets of quetiapine fumarate 25 mg dispensed on 07/15/19. -There were 30 tablets of quetiapine fumarate 25 mg dispensed on 08/14/19. -There were 30 tablets of quetiapine fumarate 25 mg dispensed on 09/13/19. -The facility had to call to request refills.	D 358		

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D 358	Continued From page 22 Interview with the Administrator on 10/10/19 at 11:15 am revealed she did not know quetiapine fumarate was not documented as administered for Resident #2 in August 2019 and September 2019. Interview with the facility contracted nurse on 10/10/19 at 1:40 pm revealed: -She knew there were holes in the resident MARs but did not know Resident #2 specifically was missing documentation for quetiapine fumarate for August 2019 and September 2019. -If the medication aide (MA) did not document quetiapine fumarate as administered she would assume the medication was not given. Interview with a first shift MA on 10/10/19 at 2:10 pm revealed: -She knew there were holes in the MAR, but she did not know quetiapine fumarate was not documented as administered on several occasions in August 2019 and September 2019. -Quetiapine fumarate was not administered if it was not documented. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed he did not know Resident #2's quetiapine fumarate was not documented as administered in August 2019 and September 2019. Interview with Resident #2's Primary Care Provider (PCP) on 10/11/19 at 12:05 pm revealed: -Quetiapine fumarate was prescribed to manage frontotemporal dementia. -The PCP expected the quetiapine fumarate to be administered as ordered. -The PCP expected to be notified of any errors with quetiapine fumarate administration.	D 358		

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D 358	Continued From page 23 -The PCP was not notified of missed doses of quetiapine fumarate in August 2019 and September 2019. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to interview with the Administrator on 10/10/19 at 11:20 am. Refer to interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. c. Review of Resident #2's current FL2 dated 08/21/19 revealed an order dated 08/07/19 revealed an order for atorvastatin 40 mg (used to treat high cholesterol) at bedtime. Review of Resident #2's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for atorvastatin 40 mg at bedtime scheduled at 8:00 pm -Atorvastatin was documented as administered for 29 of 31 opportunities at 8:00 pm from 08/01/19 through 08/31/19. Review of Resident #2's September 2019 MAR revealed: -There was an entry for atorvastatin 40 mg at bedtime scheduled at 8:00 pm -Atorvastatin was documented as administered for 24 of 30 opportunities at 8:00 pm from 09/01/19 through 09/30/19.	D 358		

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D 358	Continued From page 24 Review of Resident #2's October 2019 MAR revealed: -There was an entry for atorvastatin 40 mg at bedtime scheduled at 8:00 pm -Atorvastatin was documented as administered for 6 of 8 opportunities at 8:00 pm from 10/01/19 through 10/09/19. Observation of Resident #2's medication on hand on 10/10/19 at 3:15 pm revealed: -Atorvastatin 40 mg was available to be administered. -There were 30 tablets of atorvastatin 40 mg dispensed on 09/13/19. -There were 9 tablets of atorvastatin remaining. Telephone interview with Resident #2's pharmacy on 10/10/19 at 10:19 am revealed: -The current order in the pharmacy system was for atorvastatin 40 mg at bedtime. -There were 30 tablets of atorvastatin 40 mg dispensed on 06/17/19. -There were 30 tablets of atorvastatin 40 mg dispensed on 08/14/19. -There were 30 tablets of atorvastatin 40 mg dispensed on 09/13/19. -The facility had to call to request refills. Interview with the Administrator on 10/10/19 at 11:15 am revealed she did not know atorvastatin was not documented as administered for Resident #2 in August 2019, September 2019, and October 2019. Interview with the facility contracted nurse on 10/10/19 at 1:40 pm revealed: -She knew there were holes in the resident MARs but did not know Resident #2 specifically was missing documentation for atorvastatin for August	D 358		

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D 358	Continued From page 25 2019, September 2019, and October 2019. -If the medication aide (MA) did not document atorvastatin as administered she would assume the medication was not given. Interview with a first shift MA on 10/10/19 at 2:10 pm revealed: -She knew there were holes in the MAR, but she did not know atorvastatin was not documented as administered on several occasions in August 2019, September 2019, and October 2019. -Atorvastatin was not administered if it was not documented. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed he did not know Resident #2's atorvastatin was not documented as administered in August 2019, September 2019, and October 2019. Interview with Resident #2's Primary Care Provider (PCP) on 10/11/19 at 12:05 pm revealed: -Atorvastatin was prescribed to manage coronary artery disease. -The PCP expected the atorvastatin to be administered as ordered. -The PCP expected to be notified of any errors with atorvastatin administration. -The PCP was not notified of missed doses of atorvastatin in August 2019, September 2019, and October 2019. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to interview with the Administrator on 10/10/19 at 11:20 am.	D 358		

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D 358	Continued From page 26 Refer to interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. d. Review of subsequent physician's orders dated 09/10/19 revealed an order for Lasix (used to treat fluid retention) 20 mg on Monday, Wednesday, and Friday. Review of Resident #2's October 2019 Medication Administration Record (MAR) revealed: -There was an entry for Lasix 20 mg on Monday, Wednesday, and Friday scheduled at 8:00 am. -Lasix was documented as administered daily from 10/02/19 through 10/09/19. Observation of Resident #2's medications on hand on 10/10/19 at 3:15 pm revealed: -Lasix 20 mg was available to be administered. -There were 12 tablets of Lasix 20 mg dispensed on 09/13/19. -There was 1 tablet remaining. Interview with a representative from Resident #2's pharmacy on 10/10/19 at 10:19 am revealed: -The current order in the pharmacy system was for Lasix 20 mg on Monday, Wednesday, and Friday. -There were 12 tablets of Lasix 20 mg dispensed on 09/13/19. Interview with the Administrator on 10/10/19 at 11:15 am revealed: -She expected the medication aide (MA) to	D 358		

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D 358	Continued From page 27 administer Resident #2 Lasix as ordered. -She did not know Resident #2 was administered Lasix every day instead of Monday, Wednesday, and Friday as ordered in October 2019. Interview with the facility contracted nurse on 10/10/19 at 1:40 pm revealed: -If the MA did not document Lasix as administered she would assume the medication was not given. -She did not know Lasix was administered daily in October 2019. Interview with a first shift MA on 10/11/19 at 9:40 am revealed: -She thought Resident #2's Lasix was ordered to be administered daily. -Prior to 10/10/19 she administered Lasix daily. Interview with a representative from Resident #2's Primary Care Provider (PCP) on 10/11/19 at 12:05 pm revealed: -Resident #2 was ordered Lasix for lower extremity edema. -The PCP expected the Lasix 20 mg to be administered on Monday, Wednesday, and Friday. -The PCP would expect to be notified with any medication errors. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to interview with the Administrator on 10/10/19 at 11:20 am. Refer to interview with the facility contracted nurse on 10/10/19 at 1:45 pm.	D 358		

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D 358	Continued From page 28 Refer to interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. Interview with the Administrator on 10/10/19 at 11:20 am revealed: -If the medication aide (MA) did not document a medication as administered, she had to assume the medication was not given. -She expected the MAs to use the MAR to determine medications to be administered. -MAs were responsible for documenting on the MAR when medications were administered. -She expected the MAs to document all medications administered immediately after administration. -She completed monthly MAR audits and the facility contracted nurse completed weekly MAR audits. -She knew about the "holes" in the MAR in August 2019, September 2019, and October 2019. -She did not know if the MA/Administrative Assistant administered the medications as ordered in September 2019 and October 2019. -She was concerned that medication administration was not being documented in the MAR because when medication administration was not documented, a MA cannot state it was given. -She expected staff and the facility contracted nurse to communicate medications concerns and issues with her. -When she noticed missing documentation, she would notify the MA, and she expected the MA to go back and document when they were reminded. -She reminded MAs to correct medication	D 358		

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D 358	Continued From page 29 administration documentation on the MAR two weeks ago. -She did not follow up with MAs to assure medications were administered as ordered and documented as administered. -The facility contracted pharmacy and facility contracted nurse conducted MA training. Interview with the facility contracted nurse on 10/10/19 at 1:45 pm revealed: -She was in the facility 1-2 days every week. -She completed MAR and cart audits monthly for all residents. -During MAR audits she compared the resident record with the current month MAR. -She made notes of any errors and passed off information to the MAs. -It was the MAs responsibility to correct documentation if the medication was administered. Interview with a first shift MA on 10/10/19 at 2:15 pm revealed: -She was a MA and had worked at the facility for 3 years. -She administered medications according to the MAR. -The MAs were expected to document all medications administered immediately after administered. -If a medication was not administered the MA was expected to document their initials and circle initials to indicate the medication was not administered. -The MA should also document a reason the medication was not administered on the back of the MAR. -If a medication was not documented as administered the medication was not given. -MAR and cart audits were conducted by the	D 358		

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D 358	Continued From page 30 facility contracted nurse. -If errors were found the facility nurse would communicate errors with the MAs and they were responsible for following up. -The Administrator was responsible for the MAs. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed: -He cannot recall what nights he worked in August 2019, September 2019, and October 2019. -It was "very well possible" he worked the nights the medication was not documented in August 2019, September 2019, and October 2019. -He used the MAR to know what medications to administer. -The person who administered the medications was responsible for documenting on the MAR. -If a medication was not documented on the MAR, then it technically meant it was not administered. -The facility contracted nurse completed MAR audits "pretty often" and the Administrator completed MAR audits weekly. -The Administrator let him know when he had "holes" in his MAR documentation. -He was not aware of the "holes" in his MAR documentation in September 2019 and October 2019. -He was told there were "holes" in his documentation in the MAR in August 2019, September 2019, and October 2019 but he did not double check his documentation. -The Administrator was responsible for supervising MAs.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 31 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MAR) for 1 of 3 sampled residents (Resident #1) related to the documentation of administration of a bronchodilator, an antihypertensive, and antipsychotic, a pain medication, and an anti-diabetic medication (#1).	D 367	It is the policy of the CRT Golden Lamb that the resident's medication administration record be accurate and include the resident's name, name of medication or treatment order, strength and dosage of medication administered instructions for administering the medication or treatment, reason for the administration of medications or treatments PRN and documenting the resulting effect on the resident, date and time of administration, documentation of any omission of medications or treatments and the reason for the omission, including refusals, name or initals of the person administering the medication or treatment. Additional training will be provided by the facility's registered nurse and the facility's pharmacy. Each medication aide will document all	

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D 367	Continued From page 32 The findings are: Review of Resident #1's current FL-2 dated 02/18/19 revealed diagnoses paranoid schizophrenia, hypertension, history of substance dependence, hypertriglyceridemic waist (HTW), and chronic back pain. a. Review of Resident #1's FL-2 dated 02/18/19 revealed an order for fluticasone-salmeterol (a bronchodilator used to treat chronic obstructive pulmonary disease (COPD) 250/50 mcg twice daily. Review of Resident #1's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for fluticasone-salmeterol 250/50 mcg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Fluticasone-salmeterol was documented as administered 30 out of 36 opportunities from 08/12/19 to 08/29/19. -Fluticasone-salmeterol was documented as not administered at 8:00 pm on 08/17/19 by circled staff initials. -There was documentation on the back of Resident #1's MAR that Resident #1 refused all 8:00 pm medications on 08/17/19. -Fluticasone-salmeterol was not documented as administered at 8:00 pm on 08/12/19, 08/19/19, 08/22/19, 08/23/19, and 08/29/19. -There was no documentation on the back of Resident #1's MAR for the reason fluticasone-salmeterol was not documented as administered for 5 out of 36 opportunities from 08/12/19 to 08/29/19. Review of Resident #1's September 2019 MAR revealed: -There was an entry for fluticasone-salmeterol	D 367	medication or treatment when given. This will be monitored by the medication aides and the registered nurse 10/31/19	

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D 367	Continued From page 33 250/50 mcg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Fluticasone-salmeterol was documented as administered 43 out of 50 opportunities from 09/03/19 to 09/27/19. -Fluticasone-salmeterol was not documented as administered at 8:00 pm on 09/03/19, 09/10/19, 09/13/19, 09/14/19, 09/20/19, 09/22/19, and 09/27/19. -There was no documentation on the back of Resident #1's MAR for the reason fluticasone-salmeterol was not administered for 7 out of 50 opportunities from 09/03/19 to 09/27/19. Review of Resident #1's October 2019 MAR revealed: -There was an entry for fluticasone-salmeterol 250/50 mcg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Fluticasone-salmeterol was documented as administered 4 out of 8 opportunities from 10/01/19 to 10/04/19. -Fluticasone-salmeterol was not documented as administered at 8:00 pm on 10/01/19, 10/02/19, 10/03/19, and 10/04/19. -There was no documentation on the back of Resident #1's MAR for the reason fluticasone-salmeterol was not administered for 4 out of 8 opportunities from 10/01/19 to 10/04/19. Observation of Resident #1's medications on hand on 10/09/19 at 3:30 pm revealed: -There was one inhaler (60 doses) of fluticasone-salmeterol 250/50 mcg dispensed on 09/11/19 with 59 doses remaining and available for administration. -"Opened 10/07/19" was handwritten on the fluticasone-salmeterol box. Telephone interview with a representative from	D 367		

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D 367	Continued From page 34 the facility's contracted pharmacy on 10/09/19 at 2:45 pm revealed: -Fluticasone-salmeterol 250/50 mcg two puffs two times daily was the current order for Resident #1. -On 05/29/19, there was one inhaler (60 puffs) of fluticasone-salmeterol dispensed. -On 08/01/19, there was one inhaler (60 puffs) of fluticasone-salmeterol dispensed. -On 09/11/19, there was one inhaler (60 puffs) of fluticasone-salmeterol dispensed. -Resident #1's medications refills were on cycle-fill and would be dispensed monthly, except for inhalers. -The inhaler, fluticasone-salmeterol, would need to be called into the pharmacy and requested to be refilled as needed. -The facility requested for the pharmacy not to send inhalers with the cycle-filled medications; the representative did not know who requested the change or when the change occurred. -If the fluticasone-salmeterol inhaler dispensed on the first of the month was administered as ordered, the inhaler should have lasted one month. -Inhalers requested to be refilled by the facility would be delivered the same day. Interview with Resident #1 on 10/10/19 at 8:31 am revealed: -She received two inhalers in the morning and one inhaler at night every day. -She did not know the names of the inhalers. Observaton of Resident #1 on 10/10/19 at 8:31 am revealed she was sitting upright in a straight back chair with no signs of wheezing or shortness of breath. Interview with a second representative from the facility's contracted pharmacy on 10/10/19 at 9:35	D 367		

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D 367	Continued From page 35 am revealed: -The pharmacy stopped sending the inhalers with the monthly cycle-filled medications in June 2019 or July 2019. -The facility would need to call for inhaler refills starting in June 2019 or July 2019. -Fluticasone-salmeterol was ordered to be administered two times a day and one fluticasone-salmeterol inhaler should last one month. -In June 2019 and July 2019, the facility had extra fluticasone-salmeterol inhalers for Resident #1. -Resident # 1 had enough fluticasone-salmeterol that Resident #1 should not have had a break in fluticasone-salmeterol administration. -She did not know who requested to change inhalers from cycle-filled medication refills to call as needed for inhaler refills. -The date labeled on fluticasone-salmeterol was the date the medication was requested by the facility and filled at the pharmacy. Interview with a medication aide (MA) on 10/10/19 at 10:40 am revealed: -Each fluticasone-salmeterol inhaler was administered until it was empty, then the next fluticasone-salmeterol inhaler was opened, regardless of the day of the month. -She handwrote a start date on the fluticasone-salmeterol inhaler box when a new box was opened. -MAs needed to call and request refills for fluticasone-salmeterol from the pharmacy for Resident #1. Interview with the Administrator on 10/10/19 at 10:40 am revealed: -When Resident #1 came to the facility, she had a lot of medications on hand that the facility did not want to waste.	D 367		

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D 367	Continued From page 36 -Extra medications for Resident #1 were placed in the overstock medication cart. -The overstock medications were administered first, and then the medications from the pharmacy would be administered. -She put a start date on the fluticasone-salmeterol inhaler boxes when she opened a new box. -Resident #1's inhalers were not delivered to the facility routinely and MAs would need to call the pharmacy and request refills. -She did not know who requested the change, when the change occurred, or why the fluticasone-salmeterol inhalers needed to be called for refills instead of monthly cycle-filled refills. -She expected the MAs to use the MAR to determine medications to be administered. Second interview with the Administrator on 10/10/19 at 11:15 am revealed: -She did not know fluticasone-salmeterol was not documented as administered for Resident #1 in August 2019, September 2019, and October 2019. -She expected the MAs to administer fluticasone-salmeterol as ordered. -She expected the MAs to document in the MAR when fluticasone-salmeterol was administered. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed he did not know Resident #1's fluticasone-salmeterol was not documented as administered in August 2019, September 2019, and October 2019. Refer to the interview with the Administrator on 10/10/19 at 11:20 am. Refer to the interview with the facility contracted	D 367		

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D 367	Continued From page 37 nurse on 10/10/19 at 1:45 pm. Refer to the interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. b. Review of Resident #1's FL-2 dated 02/18/19 revealed an order for amlodipine (used to treat hypertension) 2.5 mg at bedtime. Review of Resident #1's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for amlodipine 2.5 mg at bedtime with a scheduled administration time at 8:00 pm. -Amlodipine was documented as administered 13 out of 18 opportunities from 08/12/19 to 08/29/19. -Amlodipine was documented as not administered at 8:00 pm on 08/17/19 by circled staff initials. -There was documentation on the back of Resident #1's MAR that Resident #1 refused all 8:00 pm medications on 08/17/19. -There was no documentation of administration for amlodipine on 08/12/19, 08/22/19, 08/23/19, and 08/29/19. -There was no documentation on the back of Resident #1's MAR for the reason amlodipine was not administered for 4 out of 18 opportunities from 08/12/19 to 08/29/19. Review of Resident #1's September 2019 MAR revealed: -There was an entry for amlodipine 2.5 mg at bedtime with a scheduled administration time at 8:00 pm. -Amlodipine was documented as administered 20 out of 28 opportunities from 09/03/19 to 09/30/19.	D 367		

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D 367	Continued From page 38 -There was no documentation for amlodipine on 09/03/19, 09/10/19, 09/14/19, 09/20/19, 09/22/19, 09/23/19, 09/27/19, 09/30/19. -There was no documentation on the back of Resident #1's MAR for the reason amlodipine was not administered for 8 out of 28 opportunities from 09/03/19 to 09/30/19. Review of Resident #1's October 2019 MAR revealed: -There was an entry for amlodipine 2.5 mg at bedtime with a scheduled administration time at 8:00 pm. -Amlodipine was documented as administered 0 out of 2 opportunities from 10/01/19 to 10/02/19. -There was no documentation of administration for amlodipine on 10/01/19 and 10/02/19. -There was no documentation on the back of Resident #1's MAR for the reason amlodipine was not administered for 2 out of 2 opportunities from 10/01/19 to 10/02/19. Observation of Resident #1's medications on hand on 10/09/19 at 3:30 pm revealed: -There were 30 tablets of amlodipine dated 08/23/19 with 14 tablets remaining and available for administration. -There was a handwritten start date of 09/22/19 on the amlodipine medication card. -There were 31 tablets of amlodipine dated 09/19/19 with 31 tablets remaining and available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 10/10/19 at 9:35 am revealed: -Resident #1's medication refills were cycle-filled every month. -Cycle-filled medications were dispensed prior to the first of the month and delivered to the facility a	D 367		

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(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 367	Continued From page 39 few days before the first of the month. -The date observed on the amlodipine card was the bill date and not the dispense date. -The pharmacy started billing the facility prior to dispensing because some medication bills were unpaid. -Bill dates were used on the medication labels starting in June 2019 or July 2019. -Cycle-filled medications should start on the first of each month, regardless of the bill date on the medication card. -Medications billed on 08/23/19 should not be started until 09/01/19. -Amlodipine 2.5 mg at bedtime was the current order for Resident #1. -On 07/23/19, 31 tablets of amlodipine were billed for August 2019. -On 08/23/19, 30 tablets of amlodipine were billed for September 2019. -On 09/19/19, 31 tablets of amlodipine were billed for October 2019. Interview with a medication aide (MA) on 10/10/19 at 10:40 am revealed: -She would start a new amlodipine medication card when the previous amlodipine medication card was completed, regardless of the day of the month. -Medication cards did not always start on the first of the month. -She did not want to waste medication that overflowed into the next month. -MAs handwrote the start date on the top of Resident #1's medication card when a new card was started. Interview with the Administrator on 10/10/19 at 10:40 am revealed: -When Resident #1 came to the facility, she had a lot of medications on hand that the facility did	D 367		

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D 367	Continued From page 40 not want to waste. -Medication cards did not start on the first of the month because Resident #1 had overstock medications that needed to be used first, and then a new card would be started, regardless of the day of the month. -MAs administered all medications in Resident #1's cards before the next card was started. -She was never told to start Resident #1's medications cards on the first of the month. -MAs handwrote the start date on the top of Resident #1's medication card. -She expected the MAs to use the MAR to determine medications to be administered. Second interview with the Administrator on 10/10/19 at 11:15 am revealed: -She did not know amlodipine was not documented as administered for Resident #1 in August 2019, September 2019, and October 2019. -She expected the MAs to administer amlodipine as ordered. -She expected the MAs to document in the MAR when amlodipine was administered. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed he did not know Resident #1's amlodipine was not documented as administered in August 2019, September 2019 and October 2019. Refer to the interview with the Administrator on 10/10/19 at 11:20 am. Refer to the interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to the interview with a first shift MA on 10/10/19 at 2:15 pm.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 41 Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. c. Review of Resident #1's FL-2 dated 02/18/19 revealed an order for haloperidol (used to treat mental disorders) 10 mg twice daily. Review of Resident #1's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for haloperidol 10 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Haloperidol was not documented as administered 30 out of 36 opportunities from 08/12/19 to 08/29/19. -Haloperidol was documented as not administered at 8:00 pm on 08/17/19 by circled staff initials. -There was documentation on the back of Resident #1's MAR that Resident #1 refused all 8:00 pm medications on 08/17/19. -Haloperidol was not documented as administered on 08/12/19, 08/19/19, 08/22/19, 08/23/19, and 08/29/19. -There was no documentation on the back of Resident #1's MAR for the reason haloperidol was not administered for 5 out of 36 opportunities from 08/12/19 to 08/29/19. Review of Resident #1's September 2019 MAR revealed: -There was an entry for haloperidol 10 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Haloperidol was documented as administered 43 out of 50 opportunities from 09/03/19 to 09/27/19. -Haloperidol was not documented as administered on 09/03/19, 09/10/19, 09/13/19, 09/14/19, 09/20/19, 09/22/19, and 09/27/19.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 42 -There was no documentation on the back of Resident #1's MAR for the reason haloperidol was not administered for 7 out of 50 opportunities from 09/03/19 to 09/27/19. Review of Resident #1's October 2019 MAR revealed: -There was an entry for haloperidol 10 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Haloperidol was documented as administered 5 out of 8 opportunities from 10/01/19 to 10/04/19. -Haloperidol was not documented as administered on 10/01/19, 10/02/19, and 10/04/19. -There was no documentation on the back of Resident #1's MAR for the reason haloperidol was not administered for 3 out of 8 opportunities from 10/01/19 to 10/14/19. Observation of Resident #1's medications on hand on 10/09/19 at 3:30 pm revealed: -There were 62 tablets of haloperidol dated 09/19/19 with 49 tablets remaining and available for administration. -There was a handwritten start date of 10/02/19 on the haloperidol medication card. Telephone interview with a representative from the facility's contracted pharmacy on 10/10/19 at 9:35 am revealed: -Resident #1's medication refills were cycle-filled every month. -Cycle-filled medications were dispensed prior to the first of the month and delivered to the facility a few days before the first of the month. -The date observed on the haloperidol card was the bill date and not the dispense date. -The pharmacy started billing the facility prior to dispensing because some medication bills were	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 43 unpaid. -Bill dates were used on the medication labels starting in June 2019 or July 2019. -Cycle-filled medications should start on the first of each month, regardless of the bill date on the medication card. -Medications billed on 09/19/19 should not be started until 10/01/19. -Haloperidol 10 mg twice daily was the current order for Resident #1. -On 07/23/19, 62 tablets of haloperidol were billed for August 2019. -On 08/21/19, 60 tablets of haloperidol were billed for September 2019. -On 09/19/19, 62 tablets of haloperidol were billed for October 2019. Interview with a medication aide (MA) on 10/10/19 at 10:40 am revealed: -She would start a new haloperidol medication card when the previous haloperidol medication card was completed, regardless of the day of the month. -Medication cards did not always start on the first of the month. -She did not want to waste medication that overflowed into the next month. -MAs handwrote the start date on the top of Resident #1's medication card when a new card was started. Interview with the Administrator on 10/10/19 at 10:40 am revealed: -When Resident #1 came to the facility, she had a lot of medications on hand that the facility did not want to waste. -Medication cards did not start on the first of the month because Resident #1 had overstock medications that needed to be used first, and then a new card would be started, regardless of	D 367		

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D 367	Continued From page 44 the day of the month. -She was never told to start Resident #1's medications cards on the first of the month. -MAs administered all medications in Resident #1's cards before the next card was started. -MAs handwrote the start date on the top of Resident #1's medication card. -She expected the MAs to use the MAR to determine medications to be administered. Second interview with the Administrator on 10/10/19 at 11:15 am revealed: -She did not know haloperidol was not documented as administered for Resident #1 in August 2019, September 2019, and October 2019. -She expected the MAs to administer haloperidol as ordered. -She expected the MAs to document in the MAR when haloperidol was administered. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed he did not know Resident #1's haloperidol was not documented as administered in August 2019, September 2019, and October 2019. Refer to the interview with the Administrator on 10/10/19 at 11:20 am. Refer to the interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to the interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. d. Review of Resident #1's FL-2 dated 02/18/19	D 367		

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D 367	Continued From page 45 revealed an order for topiramate (used to treat nerve pain) 50 mg twice daily. Review of Resident #1's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for topiramate 50 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Topiramate was documented as administered 44 out of 50 opportunities from 09/03/19 to 09/27/19. -Topiramate was not documented as administered on 09/03/19, 09/13/19, 09/14/19, 09/20/19, 09/22/19, and 09/27/19. -There was no documentation on the back of Resident #1's MAR for the reason the topiramate was not administered for 6 out of 50 opportunities from 09/03/19 to 09/27/19. Review of Resident #1's October 2019 MAR revealed: -There was an entry for topiramate 50 mg twice daily with scheduled administration times at 8:00 am and 8:00 pm. -Topiramate was documented as administered 5 out of 8 opportunities from 10/01/19 to 10/04/19. -Topiramate was not documented as administered on 10/01/19, 10/02/19, and 10/04/19. -There was no documentation on the back of Resident #1's MAR for the reason the topiramate was not administered for 3 out of 8 opportunities from 10/01/19 to 10/04/19. Observation of Resident #1's medications on hand on 10/09/19 at 3:30 pm revealed: -There were 62 tablets of topiramate dated 09/19/19 with 56 tablets remaining and available for administration. -There was a handwritten 10/05/19 start date on	D 367		

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D 367	Continued From page 46	D 367		

the topiramate medication card.

Telephone interview with a representative from the facility's contracted pharmacy on 10/10/19 at 9:35 am revealed:
-Resident #1's medication refills were cycle-filled every month.
-Cycle-filled medications were dispensed prior to the first of the month and delivered to the facility a few days before the first of the month.
-The date observed on the topiramate card was the bill date and not the dispense date.
-The pharmacy started billing the facility prior to dispensing because some medication bills were unpaid.
-Bill dates were used on the medication labels starting in June 2019 or July 2019.
-Cycle-filled medications should start on the first of each month, regardless of the bill date on the medication card.
-Medications billed on 09/19/19 should not be started until 10/01/19.
-Topiramate 50 mg twice daily was the current order for Resident #1.
-On 07/23/19, 62 tablets of topiramate were billed for August 2019.
-On 08/21/19, 60 tablets of topiramate were billed for September 2019.
-On 09/19/19, 62 tablets of topiramate were billed for October 2019.

Interview with a medication aide (MA) on 10/10/19 at 10:40 am revealed:
-She would start a new topiramate medication card when the previous topiramate medication card was completed, regardless of the day of the month.
-Medication cards did not always start on the first of the month.
-She did not want to waste medication that

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D 367	Continued From page 47 overflowed into the next month. -MAs handwrote the start date on the top of Resident #1's medication card when a new card was started. Interview with the Administrator on 10/10/19 at 10:40 am revealed: -When Resident #1 came to the facility, she had a lot of medications on hand that the facility did not want to waste. -Medication cards did not start on the first of the month because Resident #1 had overstock medications that needed to be used first, and then a new card would be started, regardless of the day of the month. -MAs administered all medications in Resident #1's cards before the next card was started. -She was never told to start Resident #1's medications cards on the first of the month. -MAs handwrote the start date on the top of Resident #1's medication card. -She expected the MAs to use the MAR to determine medications to be administered. Second interview with the Administrator on 10/10/19 at 11:15 am revealed: -She did not know topiramate was not documented as administered for Resident #1 in September 2019 and October 2019. -She expected the MAs to administer topiramate as ordered. -She expected the MAs to document in the MAR when topiramate was administered. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed he did not know Resident #1's topiramate was not documented as administered in September 2019 and October 2019.	D 367		

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D 367	Continued From page 48 Refer to the interview with the Administrator on 10/10/19 at 11:20 am. Refer to the interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to the interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. e. Review of Resident #1's FL-2 dated 02/18/19 revealed an order for metformin (used to treat diabetes) extended release (ER) 750 mg two tablets every evening. Review of Resident #1's September 2019 Medication Administration Record (MAR) revealed: -There was an entry for metformin ER 750 mg two tablets every evening with a scheduled administration time at 5:00 pm. -Metformin was documented as administered 10 out of 15 opportunities from 09/10/19 to 09/24/19. -Metformin was not documented as administered on 09/10/19, 09/17/19, 09/18/19, 09/22/19, and 09/24/19. -There was no documentation on the back of Resident #1's MAR for the reason metformin was not administered for 5 out of 15 opportunities from 09/10/19 to 09/24/19. Observation of Resident #1's medications on hand on 10/09/19 at 3:30 pm revealed: -There were 62 tablets of metformin dated 09/24/19 with 54 tablets remaining and available for administration. -There was a handwritten 10/05/19 start date on the metformin medication card.	D 367		

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D 367	Continued From page 49 Telephone interview with a representative from the facility's contracted pharmacy on 10/10/19 at 9:35 am revealed: -Resident #1's medication refills were cycle-filled every month. -Cycle-filled medications were dispensed prior to the first of the month and delivered to the facility a few days before the first of the month. -The date observed on the metformin card was the bill date and not the dispense date. -The pharmacy started billing the facility prior to dispensing because some medication bills were unpaid. -Bill dates were used on the medication labels starting in June 2019 or July 2019. -Cycle-filled medications should start on the first of each month, regardless of the bill date on the medication card. -Medications billed on 09/24/19 should not be started until 10/01/19. -Metformin ER 750 mg two tabs every evening was the current order for Resident #1. -On 07/23/19, 62 tablets of metformin were billed for August 2019. -On 08/21/19, 60 tablets of metformin were billed for September 2019. -On 09/24/19, 62 tablets of metformin were billed for October 2019. Interview with a medication aide (MA) on 10/10/19 at 10:40 am revealed: -She would start a new metformin medication card when the previous metformin medication card was completed, regardless of the day of the month. -Medication cards did not always start on the first of the month. -She did not want to waste medication that overflowed into the next month.	D 367		

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D 367	Continued From page 50 -MAs handwrote the start date on the top of Resident #1's medication card when a new card was started. Second interview with the Administrator on 10/10/19 at 10:40 am revealed: -When Resident #1 came to the facility, she had a lot of medications on hand that the facility did not want to waste. -Medication cards did not start on the first of the month because Resident #1 had overstock medications that needed to be used first, and then a new card would be started, regardless of the day of the month. -MAs administered all medications in Resident #1's cards before the next card was started. -She was never told to start Resident #1's medications cards on the first of the month. -MAs handwrote the start date on the top of Resident #1's medication card. -She expected the MAs to use the MAR to determine medications to be administered. Interview with the Administrator on 10/10/19 at 11:15 am revealed: -She did not know metformin was not documented as administered for Resident #1 in September 2019. -She expected the MAs to administer metformin as ordered. -She expected the MAs to document in the MAR when metformin was administered. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed he did not know Resident #1's metformin was not documented as administered in September 2019. Refer to the interview with the Administrator on 10/10/19 at 11:20 am.	D 367		

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D 367	Continued From page 51 Refer to the interview with the facility contracted nurse on 10/10/19 at 1:45 pm. Refer to the interview with a first shift MA on 10/10/19 at 2:15 pm. Refer to the interview with the MA/Administrative Assistant on 10/11/19 at 9:15 am. Interview with the Administrator on 10/10/19 at 11:20 am revealed: -If the medication aide (MA) did not document a medication as administered, she had to assume the medication was not given. -She expected the MAs to use the MAR to determine medications to be administered. -MAs were responsible for documenting on the MAR when medications were administered. -She expected the MAs to document all medications administered immediately after administration. -She completed monthly MAR audits and the facility contracted nurse completed weekly MAR audits. -She knew about the "holes" in the MAR in August 2019, September 2019, and October 2019. -She did not know if the MA/Administrative Assistant administered the medications as ordered in September 2019 and October 2019. -She was concerned that medication administration was not being documented in the MAR because when medication administration was not documented, a MA cannot state it was given. -She expected staff and the facility contracted nurse to communicate medications concerns and issues with her. -When she noticed missing documentation, she	D 367		

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D 367	Continued From page 52 would notify the MA, and she expected the MA to go back and document when they were reminded. -She reminded MAs to correct medication administration documentation on the MAR two weeks ago. -She did not follow up with MAs to assure medications were administered as ordered and documented as administered. -The facility contracted pharmacy and facility contracted nurse conducted MA training. Interview with the facility contracted nurse on 10/10/19 at 1:45 pm revealed: -She was in the facility 1-2 days every week. -She completed MAR and cart audits monthly for all residents. -During MAR audits she compared the resident record with the current month MAR. -She made notes of any errors and passed off information to the MAs. -It was the MAs responsibility to correct documentation if the medication was administered. Interview with a first shift MA on 10/10/19 at 2:15 pm revealed: -She was a MA and had worked at the facility for 3 years. -She administered medications according to the MAR. -The MAs were expected to document all medications administered immediately after administered. -If a medication was not administered the MA was expected to document their initials and circle initials to indicate the medication was not administered. -The MA should also document a reason the medication was not administered on the back of	D 367		

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D 367	Continued From page 53 the MAR. -If a medication was not documented as administered, the medication was not given. -MAR and cart audits were conducted by the facility contracted nurse. -If errors were found the facility nurse would communicate errors with the MAs and they were responsible for following up. -The Administrator was responsible for the MAs. Interview with MA/Administrative Assistant on 10/11/19 at 9:10 am revealed: -He cannot recall what nights he worked in August 2019, September 2019, and October 2019. -It was "very well possible" he worked the nights the medication was not documented in August 2019, September 2019, and October 2019. -He used the MAR to know what medications to administer. -The person who administered the medications was responsible for documenting on the MAR. -If a medication was not documented on the MAR, then it technically meant it was not administered. -The facility contracted nurse completed MAR audits "pretty often" and the Administrator completed MAR audits weekly. -The Administrator let him know when he had "holes" in his MAR documentation. -He was not aware of the "holes" in his MAR documentation in August 2019, September 2019, and October 2019. -He was told there were "holes" in his documentation in the MAR in August 2019, September 2019, and October 2019, but he did not double check his documentation. -The Administrator was responsible for supervising MAs.	D 367		

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D 438	Continued From page 54	D 438		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to report allegations of physical abuse of a resident (Resident #2) by Staff A, medication aide (MA)/Administrative Assistant, to the Health Care Personnel Registry (HCPR). The findings are: Interview with a staff revealed: -She worked at the facility as a PCA for 8 months. -She worked third shift on 09/11/19. -She was in the hallway in front of the nursing desk around 12:00 am on 09/11/19. -Resident #2 was sitting in the chairs located in front of the nursing desk. -She walked down the hallway and started into another room when she heard a noise like a chair slid across the floor. -She came back to the nursing desk where she found Resident #2 in the floor with Staff A standing behind her. -She approached Resident #2 and brought a wheelchair over to her.	D 438	It is the policy of the CRT Golden Lamb to report all alleged physical abuse to the HCPR. The supervising staff on each shift is responsible for making an incident report and assuring the administrator is given a copy. The proper authorities will be contacted of all alleged physical abuse. The resident will be sent to the ER for medical attention. The medication aides and the administrator had a meeting regarding the incidents and reporting. Staff was reminded of the location of the incident reports and the steps to follow for all incident reporting. This will be monitored by the administrator. The report was filed to the HCPR on 10/11/2019. ~~11/1/2019~~ NK	

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D 438	Continued From page 55 -She asked Resident #2 if she could help her up. -Resident #2 used expletive language and informed her that Staff A put her in the floor. -Staff A came around to the front of Resident #2 and grabbed her by the throat, with his thumb in her mouth, and threw her into the wheelchair. -The force of Staff A throwing Resident #2 into the wheelchair caused her dentures to fly out of her mouth. -Staff A told Resident #2 if she put her hands on him again, he would hit her. -She saw Resident #2 grab Staff A's leg when he was standing over her. -Resident #2 was taken to her room and stayed there for the reminder of the night. -She monitored Resident #2 frequently throughout the night. -Resident #2 was not sent to the hospital for evaluation. -The on-duty MA (Staff A) was responsible for completing an incident report. -She did not think Staff A documented the incident in the progress notes or completed an incident report. -She would have been required to give a witness statement and she was not asked to document what she witnessed the night of 09/11/19. -She did not report the incident to the Administrator because Staff A was a family member of the Administrator. -She did not feel comfortable speaking with anyone at the facility regarding the incident on 09/11/19 because most of the employees were related to each other. -She spoke with the facility contracted nurse (a few days after the incident) regarding the incident on 09/11/19. -She reported the incident to the County Department of Social Services and to a family member.	D 438		

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D 438	Continued From page 56 -She did not know if the incident on 09/11/19 was reported to the local police or to the HCPR. -She did not report the incident on 09/11/19 to the HCPR. -She did not know if the facility conducted an internal investigation regarding the incident on 09/11/19. Telephone with a representative from HCPR on 10/09/19 at 10:37 am revealed: -The incident on 0911/19 was not reported to the HCPR. -Staff A had not been reported to the HCPR. Observation of Staff A on 10/09/19 from 2:00 pm to 4:30 pm revealed Staff A was working at the facility. Review of residents' September 2019 Medication Administration Records (MARs) revealed Staff A was the MA working the night of 09/11/19. Interview with a second staff revealed: -She worked as a first shift MA. -Staff A did not report an incident from third shift on 09/11/19. -She remembered Resident #2 having bruising to her face, arms, and shoulder in September 2019. -She did not know what caused the bruising. -She had witnessed Staff A had being mean to Resident #2. -She did not report Staff A's behavior to anyone. -She did not know if Resident #2's family or Primary Care Provider (PCP) was notified of the incident on 09/11/19. -If an incident occurred, the facility policy required the MA on duty to complete an incident report. -Once the incident report was completed it was given to the Administrator. -She did not know where the incident reports	D 438		

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D 438	Continued From page 57 were kept. -She did not know if the incident on 09/11/19 was reported to HCPR. -She did not know if the facility conducted an internal investigation regarding the incident on 09/11/19. Interview with a third staff revealed: -An employee spoke with her in regarding an incident she witnessed between Resident #2 and Staff A on 09/11/19. -She did not know if the employee reported the incident to the Administrator or to HCPR. -She did not report the incident to the Administrator. -She knew she could report the incident to the HCPR, but she did not make a report. Telephone interview with Staff A, MA/Administrative Assistant, on 10/11/19 at 9:10 am revealed: -He worked as a MA on 09/11/19. -He checked on residents every 2 hours. -He came out of another residents room and found Resident #2 on the floor by the nursing desk on 09/11/19. -He did not know how Resident #2 ended up on the floor. -He asked Resident #2 if she was alright and she became combative with him. -He tried to reach down to assist Resident #2 up and she swung at him. -Resident #2 had a history of getting up without assistance and falling. -He hooked his arms under Resident #2's arms and assisted her into a wheelchair. -He remembered Resident #2 digging her nails into his arms. -Resident #2 put his thumb into her mouth and attempted to bite him.	D 438		

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D 438	Continued From page 58 -Resident #2's dentures were coming out, so he asked a PCA working with him to take the dentures out of Resident #2's mouth. -The PCA took Resident #2 back to her room. -Resident #2 was not sent to the hospital for evaluation because she was not injured. -He did not document the incident in progress notes or complete an incident report. -He did not feel he needed to complete an incident report because Resident #2 was "ok". -He would document an incident that resulted in injury. -The incident was not reported to HCPR. -He verbally reported the incident to the oncoming MA. -The facility did not complete an internal investigation. Interview with the Administrator on 10/10/19 at 11:15 am and 10/11/19 at 10:00 am revealed: -She was made aware of the 09/11/19 incident on 10/08/19 when the local county Adult Protective Services made a visit to the facility. -She conducted an internal investigation, she spoke with several MAs and PCAs (date unknown) regarding the alleged incident on 09/11/19. -She could not conduct a complete investigation because she did not have specific details of the alleged incident on 09/11/19. -She did not speak with Staff A regarding the incident on 09/11/19. -She did not speak with Resident #2 regarding the incident on 09/11/19. -Staff A was a MA/Administrative Assistant. -Staff A passed medications and worked as a MA on third shift. -Staff A supervised staff on third shift. -She did not report the incident to HCPR. -She did not contact law enforcement regarding	D 438		

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D 438	Continued From page 59 the incident. -The facility policy required the MA on duty to complete an incident report. -If there were witnesses to an incident any other employees would have to provide a statement of what occurred. -There was no incident report completed regarding the alleged incident on 09/11/19 because she did not know there was an incident on 09/11/19. -She was not aware of any verbal or physical abuse between staff and residents. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. The facility failed to investigate and report allegations of alleged physical abuse of Resident #2 by Staff A on 09/11/19 to the HCPR. The facility's 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 10/11/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, NOVEMBER 26, 2019.	D 438		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914	It is the policy of the CRT Golden Lamb that every resident be free of mental and physical abuse, neglect and exploitation.	

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D914	Continued From page 60 This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all residents were free from physical abuse and neglect related to health care personnel registry. The findings are: Based on record reviews and interviews, the facility failed to report allegations of physical abuse of a resident (Resident #2) by Staff A, medication aide (MA)/Administrative Assistant, to the Health Care Personnel Registry (HCPR). [Refer to Tag 0438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].	D914	The facility staff had meetings regarding the Resident's Rights. They were read, talk about and discussed. Each staff is given a copy to read up employment. The Ombudsman will be contacted to provide additional training on the Resident's rights. This will monitored by the administrative assistants and the registered nurse.	
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 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	D992	11/15/19 It is the policy of the CRT Golden Lamb that upon employment an applicant shall have an examination and screening for the presence of controlled substances. No staff shall begin employment without the results of the drug	

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D992	Continued From page 61 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 interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was completed for 1 of 6 sampled staff (Staff D) prior to hire. The findings are: Review of Staff D, personal care aide's, personnel record revealed: -Staff D was hired on 07/14/14. -There was no documentation Staff D had completed the examination and screen for the presence of controlled substance. -There was no consent for a drug screening and examination. -There was a check list of Staff D's personnel requirements and screening for the presence of	D992	Screenings. This will be monitored by the administrative assistants and the administrator. 10/31/19	

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D992	Continued From page 62 controlled substances was not checked. Interview with the Administrator on 10/11/19 at 9:50 am revealed: -She knew Staff D needed an examination and screening for controlled substances prior to hire. -She did not know an examination and screening for controlled substances was not completed for Staff D. -She was responsible for assuring all personnel had a an examination and screening for controlled substances prior to hire. -She was responsible for completing and maintaining personnel records. -She was responsible for auditing personnel records and she did not know the last time she audited the records. -The facility contracted nurse also audited staff records and she did not know when she completed the last audit. Interview with the facility contracted nurse on 10/11/19 at 11:15 am revealed: -She audited personnel records about a month and a half ago. -She audited personnel records in order to help the Administrator; auditing personnel records was not in her job description. -She created a check list for each personnel record, and if a requirement was not checked, it was not in the personnel record. -She made a list of incomplete documentation in personnel records and provided the list to the facility. -She contacted Staff D and let her know she was missing the controlled substance screening requirement in her personnel record (date unknown). -The Administrator was responsible for assuring Staff D's personnel record was complete.	D992		

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D992	Continued From page 63 Attempted telephone interview with Staff D on 10/11/19 at 11:05 am was unsuccessful.	D992		