Kirby, Linda H

From: Rhonda Boyd Todd <waterbrooke.adm@gmail.com>
Sent: Monday, July 20, 2020 11:51 AM
To: Kirby, Linda H
Subject: [External] Follow up survey with attachment
Attachments: FollowUp Corrections to LKirby.pdf; Attachment Policy on Medication Change Out.pdf

Linda,
Please see the following information with policy attached. Any questions please let me know
Thank you,

Rhonda Boyd Todd, CPhT
Administrator-In-Charge
Waterbrooke of Elizabeth City
252-331-2149
252-331-1271 (fax)

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070008	A. BUILDING: _____ B. WING _____	R 04/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERBROOKE OF ELIZABETH CITY	143 ROSEDALE DRIVE ELIZABETH CITY, NC 27909

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a desk review follow-up survey from April 21,2020 - April 24,2020.	{D 000}	New Policy on Med change out, not on cart.	7/20/20
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure medications were administered as ordered for 2 of 5 residents sampled (#2, #5). The findings are: Review of the facility's Medication Orders Policy revealed: -There was no documentation related to reordering of cycle fill medications. -There was no documentation related to the stocking of cycle fill medications. 1.Review of Resident #2's current FL-2 dated 10/16/19 revealed: -Diagnoses included anxiety,foot drop, hypertension, hypothyroidism, seizure disorder, and Tourette disorder. -There was an order for Amlodipine 5mg take 1 tablet every day. (Amlodipine is used to treat high	{D 358}	SEE Attachment Rhuda Byd-Todd, CRNA Administrator Cycle Fill medications are sent automatically by the pharmacy per contract. Policy was created for staff to follow if a med is not sent in change out of cycle Fill and for 1st shift to change out cycle Fill meds day prior to due date. Clinical staff to monitor. Training on cycle fill & other documentation training will be held 5/27 during 2 scheduled classes.	4/27/20 5/27/20

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/4/2020

STATE FORM 6899 3K7U12 If continuation sheet 1 of 13

Plan of Correction w/Addendum dated 7/20/20 Reviewed & Accepted
RN
Nurse Consultant
7/20/20

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{D 358}	Continued From page 1 blood pressure). -There was an order for Atorvastatin 10mg take 1 tablet at bedtime. (Atorvastatin is used to help lower cholesterol). -There was an order for Baclofen 10mg take 1/2 tablet 4 times a day. (Baclofen is used to treat muscle spasms). -There was an order for Clonidine 0.1mg take 1 tablet 2 times a day. (Clonidine is used to treat high blood pressure). -There was an order for Levoxyl 100 mcg take 1 tablet every day. (Levoxyl is used to treat hypothyroidism). -There was an order for Vascepa 1 gm capsule take 4gm every day. (Vascepa is used to lower triglycerides). -There was an order for Losartan Potassium 100mg take 1 tablet every day. (Losartan Potassium is used to treat high blood pressure). -There was an order for Protonix 40mg take 1 tablet every day. (Protonix is used to treat gastroesophageal reflux disease). -There was an order for Trazadone 100mg take 1 tablet at bedtime. (Trazadone is used to treat depression). -There was an order for Vitamin D 2000 Units take 1 tablet every day. (Vitamin D is a supplemental vitamin). Review of a physician order sheet for Resident #2 on 04/03/20 revealed: -There was an order for Levetiracetam 500mg take 1 tablet 2 times a day. (Levetiracetam is used to treat seizures). -There was an order for Singular 10mg take 1 tablet every day. (Singular is used to treat asthma and allergic rhinitis). Review of Resident #2's March 2020 electronic medication administration record (e-MAR)	{D 358}		

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{D 358}	Continued From page 2 revealed: -There was a computer printed entry for Amlodipine 5mg take 1 tablet every day at 7:00am. -Amlodipine was not documented as administered on 03/21/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Atorvastatin 10mg take 1 tablet at bedtime at 7:00pm. -Atorvastatin was not documented as administered on 03/19/20 at 7:00pm due to medication not on cart -There was a computer printed entry for Baclofen 10mg take 0.5 tablet four times a day at 7:00am, 11:00am, 3:00pm and 7:00pm. -Baclofen was not documented as administered on 03/20/20 at 7:00pm and 03/21/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Clonidine 0.1mg take 1 tablet two times a day at 7:00am and 7:00pm. -Clonidine was not documented as administered on 03/21/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Levoxyl 100 mcg take 1 tablet every day at 5:45am. -Levoxyl was not documented as administered on 03/20/20 at 5:45am and 03/21/20 at 5:45am due to medication not on cart. -There was a computer printed entry for Vascepa 1 gm capsule take 4gm every day at 7:00am. -Vascepa was not documented as administered on 03/21/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Losartan Potassium 100mg take 1 tablet every day at 7:00am. -Losartan Potassium was not documented as administered on 03/21/20 at 7:00am due to	{D 358}		

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{D 358}	Continued From page 3 medication not on cart. -There was a computer printed entry for Protonix 40mg take 1 tablet every day7:00am. -Protonix was not documented as administered on 03/21/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Trazadone 100mg take 1 tablet at bedtime at 7:00pm. -Trazadone was not documented as administered on 03/20/20 at 7:00pm due to medication not on cart. -There was a computer printed entry for Vitamin D 2000 Units take 1 tablet every day at 7:00am. -Vitamin D was not documented as administered on 03/21/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Levetiracetam 500mg take 1 tablet two times a day at 7:00am and 7:00pm. -Levetiracetam was not documented as administered on 03/21/20 at 7:00am due to medication not cart. -There was a computer printed entry for Singular 10mg take 1 tablet every day at 7:00am. Singular was not documented as administered on 03/21/20 at 7:00am due to medication not on cart. Review of Resident #2's April 2020 e-MAR revealed: -There was a computer printed entry for Amlodipine 5mg take 1 tablet every day at 7:00am. -Amlodipine was not documented as administered on 04/20/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Baclofen 10mg take 0.5 tablet four times a day at 7:00am, 11:00am, 3:00pm and 7:00pm. -Baclofen was not documented as administered	{D 358}		

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{D 358}	Continued From page 4 on 04/20/20 at 7:00pm due to medication not on cart. -There was a computer printed entry for Clonidine 0.1mg take 1 tablet two times a day at 7:00am and 7:00pm. -Clonidine was not documented as administered on 04/20/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Losartan Potassium 100mg take 1 tablet every day at 7:00am. -Losartan Potassium was not documented as administered on 04/20/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Protonix 40mg take 1 tablet every day7:00am. -Protonix was not documented as administered on 04/20/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Vitamin D 2000 Units take 1 tablet every day at 7:00am. -Vitamin D was not documented as administered on 04/20/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Levetiracetam 500mg take 1 tablet two times a day at 7:00am and 7:00pm. -Levetiracetam was not documented as administered on 04/20/20 at 7:00am due to medication not cart. Telephone interview with the Resident Care Director on 04/24/20 at 1:15pm revealed: -No one had informed her Resident #2 was missing any medications. -That would have been reported to the assistant administrator. -The days Resident #2 did not receive her medications may have been due to change out of the cycle fill medications.	{D 358}		

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{D 358}	Continued From page 5 Refer to the telephone interview with a Medication Aide (MA) on 04/24/20 at 10:40am. Refer to the telephone interview with the Billing Supervisor at the facility's contracted pharmacy on 04/24/20 at 11:38. Refer to the telephone interview with the Resident Care Director (RCD) on 04/24/20 at 1:15pm. Refer to the telephone interview with the Medication Aide Supervisor on 04/24/20 at 1:42pm revealed: Refer to the telephone interview with the Assistant Administrator on 04/24/20 at 2:41pm. 2.Review of Resident #5's current FL-2 dated 11/14/19 revealed: -Diagnoses included anemia, right facial paralysis, hypertension, insulin dependent diabetes mellitus, and a history of stroke. -There was an order for Acamprosate Calcium 333mg take 1 tablet daily. (Acamprosate Calcium is used to reduce the desire to drink alcohol). -There was an order for Amlodipine 5mg take 1 tablet 2 times a day. (Amlodipine is used to treat high blood pressure and chest pain). -There was an order for Clonidine 0.1mg take 1 tablet 2 times a day. (Clonidine is used to treat high blood pressure). -There was an order for Lisinopril 20mg take 1 tablet daily. (Lisinopril is used to treat high blood pressure and heart failure). -There was an order for Metformin ER 1000mg take 1 tablet 2 times a day. (Metformin is used to treat high blood sugars). -There was an order for Omeprazole 20mg take 1 tablet every day. (Omeprazole is used to treat	{D 358}		

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{D 358}	Continued From page 6 heart burn and gastroesophageal reflux disease). -There was an order for Potassium Chloride Micro 10 meq ER take 1 tablet 3 times a day with meals. (Potassium Chloride Micro is used to treat low levels of potassium). -There was an order for Simvastatin 20 mg take 1 tablet every evening. (Simvastatin is used to help lower cholesterol). -There was an order for Tradjenta 5mg take 1 tablet every day. (Tradjenta is used to treat high blood sugar). Review of Resident #5's March 2020 electronic medication administration record (e-MAR) revealed: -There was a computer printed entry for Acamprosate Calcium 333mg take 1 two times a day at 9:00am and 9:00p -Acamprosate Calcium was not documented as administered on 03/21/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Amlodipine 5mg take 1 tablet two times a day at 9:00am and 9:00pm. -Amlodipine was not documented as administered on 03/21/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Clonidine 0.1mg take 1 tablet two times a day at 9:00am and 9:00pm. -Clonidine was not documented as administered on 03/20/20 at 9:00pm and 03/21/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Lisinopril 20mg take 1 tablet every day at 9:00am. -Lisinopril was not documented as administered on 03/21/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Omeprazole 20mg take 1 tablet every day at	{D 358}		

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{D 358}	Continued From page 7 6:45am. -Omeprazole was not documented as administered on 03/21/20 at 6:45am due to medication not on cart. -There was a computer printed entry for Potassium Chloride Micro 10 meq ER take 1 tablet 3 times a day with meals at 7:00am, 12:00pm and 5:00pm. -Potassium Chloride Micro was not documented as administered on 03/21 /20 at 7:00am due to medication not on cart. -There was a computer printed entry for Simvastatin 20mg 1 tablet every evening at 5:00pm. -Simvastatin was not documented as administered on 03/20/20 at 5:00pm due to medication not on cart. -There was a computer printed entry for Tradjenta 5mg take 1 tablet every day at 9:00am. -Tradjenta was not documented as administered on 04/21/20 at 9:00am due to medication not on cart. Review of Resident #5's April 2020 e-MAR revealed: -There was a computer printed entry for Acamprosate Calcium 333mg take 1 tablet 2 times a day at 9:00am and 9:00pm. -Acamprosate Calcium was not documented as administered on 04/19/20 at 9:00pm and 04/20/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Amlodipine 5mg take 1 tablet two times a day at 9:00am and 9:00pm. -Amlodipine was not documented as administered on 04/20/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Clonidine 0.1mg take 1 tablet two times a day at 9:00am and 9:00pm.	{D 358}		

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{D 358}	Continued From page 8 -Clonidine was not documented as administered on 04/20/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Lisinopril 20mg take 1 tablet every day at 9:00am. -Lisinopril was not documented as administered on 04/20/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Potassium Chloride Micro 10 meq ER take 1 tablet 3 times a day with meals at 7:00am, 12:00pm and 5:00pm. -Potassium Chloride Micro was not documented as administered on 04/20/20 at 7:00am due to medication not on cart. -There was a computer printed entry for Tradjenta 5mg take 1 tablet every day at 9:00am. -Tradjenta was not documented as administered on 04/20/20 at 9:00am due to medication not on cart. -There was a computer printed entry for Metformin ER tablet 1000mg take 1 tablet two times a day. -Metformin was not documented as administered on 04/20/20 at 9:00am due to medication not on cart. Telephone interview with the Resident Care Director on 04/24/20 at 1:15pm revealed: -No one had informed her Resident #5 was missing any medications. -That would have been reported to the administrator. -The days he did not receive his medications may have been due to change out of the cycle fill medications. Refer to the telephone interview with a Medication Aide (MA) on 04/24/20 at 10:40am.	{D 358}		

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{D 358}	Continued From page 9 Refer to the telephone interview with the Billing Supervisor at the facility's contracted pharmacy on 04/24/20 at 11:38. Refer to the telephone interview with the Resident Care Director (RCD) on 04/24/20 at 1:15pm. Refer to the telephone interview with the Medication Aide Supervisor on 04/24/20 at 1:42pm. Refer to the telephone interview with the Assistant Administrator on 04/24/20 at 2:41pm. _____ Telephone interview with a Medication Aide (MA) on 04/24/20 at 10:40am revealed: -When medications needed to be reordered a medication reorder form was filled out and faxed to pharmacy then a phone call was placed to the pharmacy to verify the fax was received. -The MA and the Clinical Supervisor were responsible for reordering medications. -A resident can't go without their medication more than 3 days before the physician was notified. -The cycle fill medications were received in a 28-day supply. -Every residents' medication is "changed out" on the same day. -Some residents' medications had to be ordered when refills were needed. Telephone interview with the Billing Supervisor at the facility's contracted pharmacy on 04/24/20 at 11:38 revealed: -The facility's cycle fill medications were started on the 4th Wednesday of every month. -The facility received the cycle fill medications 3 days prior to the start date. -If medications ran out prior to the next cycle fill	{D 358}		

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{D 358}	Continued From page 10 start date, then the facility could call and request enough medication to get the resident through until the next cycle start date. -Cycle fill medications were maintenance medications and started for every resident on the same day. -The facility received a delivery of medications on 03/21/20 at 1:21am and was signed for by staff from the facility. -The facility received a delivery of medication on 04/18/20 at 12:14am and was signed for by staff from the facility. Telephone interview with the Resident Care Director (RCD) on 04/24/20 at 1:15pm revealed: -The cycle fill medications were 28-day supply of medications. -The facility received the cycle fill medications 2 days prior to the next cycle start day. -If a medication was not on the medication cart, she would go look for it. -She looked for a delivery slip if she did not find it; she would call the pharmacy about the medication. -The MAs did not report medication issues to her. -The medication issues were reported to the Assistant Administrator. -Sometimes the medication would be in the facility but not on the medication cart. -If the medication was not given it had to be documented as to why on the e-MAR. -The 20th of each month was when the cycle fill medications started. -The policy was the resident could go 3 days without medications not in the facility before the physician has to be notified. -She could not provide an answer why medications were in the facility but not on the medication cart.	{D 358}		

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{D 358}	Continued From page 11 Telephone interview with the Medication Aide Supervisor on 04/24/20 at 1:42pm revealed: -If a resident was out of medications and it was not time for the change out of cycle fill medications, the MA would call the pharmacy to get enough to last to next cycle fill start date. -New cycle fill start date occurred around the 20th of the month. -The facility had 72 hours to get the medications in if they were out. -If "critical medications" were out the pharmacy would be notified. -Some critical medications were on cycle fill. -Critical medications were those medications like Keppra and Coumadin. -Cart audits were done weekly which consisted of checking expiration dates and making sure all medications were on the cart. -Medication expiration dates were checked along with making sure all medications were on the carts. Telephone interview with the Assistant Administrator on 04/24/20 at 2:41pm revealed: -The facility's cycle fill medications were changed out on the 20th of the month. -The medications were changed out on first shift after the morning medication pass. -The change out required two MAs to complete it and took 1-2 hours. -The residents' missed medications were likely due to change out. -When the change out was done after morning medication pass, the MA would not go back and give the medications, because the medications would be late, and they would be out of compliance. -The change out of the cycle fill medications was supposed to be completed the day following the delivery.	{D 358}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERBROOKE OF ELIZABETH CITY	143 ROSEDALE DRIVE ELIZABETH CITY, NC 27909

(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

Medication Orders

New Orders

1. Fax physician orders to pharmacy **before 4pm**
2. Attach confirmation to order
3. Sign and date order
   a. For Antibiotics or Stat orders, call Southern Pharmacy to send to back-up at Walgreens
4. Place order in Pending Box
5. Check EMar system regularly for Pending Orders waiting for Approval
   a. If not in Pending Orders within 3 hours, input at Temp Order in EMar system
   b. If inputting as Temp Order, Document "Temp" on front of order and keep In Pending Box
6. Once order appears in Pending on EMar, check the order against input information for date, directions, time, and administration information
   a. If order is correct, click Approve
   b. If order is not correct, reject and send back to pharmacy
7. Once Approved, place order in finished order box
8. If pharmacy is unable to send the medication in the order being received that evening, you will be notified to pick it up from the back-up pharmacy between 6pm-9pm.
9. If the order is not received, please notify RCD or SCD, communicate to the on-coming shift that order was not received, and contact the pharmacy if possible. If you are on 3rd shift and unable to contact the pharmacy, you should communicate to the next shift so they may contact the pharmacy during regular business hours.

If medications are not received **within 72 hours**, please notify physician for instructions. If physician can't be reached, contact the administrator for instructions.

Refill Orders

1. Fax all updated and refill orders to the pharmacy **before 2pm** to ensure no lapse in medications
2. PRN orders should be checked **every Thursday** and re-ordered if less than 3 days or 10 dosage units are available to ensure no lapse if needed.
3. If a new prescription is necessary for insulin, ear/eye drops, topicals, PRN or Narcotics, please notify the physician via phone or fax and let them know if it is an emergency.
4. Please document all communications, dates, and times of calls including with whom you spoke
5. Contact the RCD, SCD, or Administrator with questions or concerns regarding refill medications

Med change out, not on cart

1. The medication aide will send a refill request to pharmacy and call to have them send a limited day supply.
2. The medication will be pulled from the change out medications, if they are in the facility.
3. Check to ensure dose is correct and the medication will be placed on cart.
4. When change out is done the medication aide will check to ensure the medication is checked with other change out medications.

**There are situations that become uncontrollable and beyond our immediate control as caregivers such as the physician not calling the medication in, the physician being out of the office, medication not covered by insurance, medication requires prior authorization, or the medication being too soon to get a new prescription such as a control narcotic, etc. Please try to identify if you know a resident takes medications regularly, if there may be a problem and speak with a nurse or physician directly for instructions.

Leave of Absence (LOA)

Resident or family is required to give a 24 hour notice to ensure staff have ample time to ensure medications will be available for the length of absence. Staff will notify pharmacy is medications are needed.

1. Document medication on LOA form
2. If it is a control medication, only send one card.
3. Family must sign out medications if resident has POA or Guardian and all instructions explained
4. In EMar, go to resident profile
   Click Option > Admin > go to bar and click LOA
4. Place LOA form on cork board
5. Upon resident's return, Med Tech counts and signs medication back in
6. For controls, ensure count documentation is included on Control Sheet. Notify RCD or SCD if control count is inaccurate for the number of doses that should have been returned.
7. File under MISC in Patient Chart

LOA Missing or No Medication Returned:

1. Document possible reason medication is missing or not returned
2. Inquire with the family if it was possibly left and the importance of it being returned to the facility by the next medication pass time
3. Contact RCD/SCD is medications can't be located or returned for further instructions
4. After hours or on the weekend, contact regular contracted pharmacy for a backup supply of medications if necessary until the following business day when problem may be rectified
5. Document all possible reasons, causes, and explanations of missing or non-returned medications

<u>*Unable to Give Medication (Hospital, Discharge, LOA)</u>

In the EMar system, if you click on a resident profile and then click Option. You will find a bar with Active, Hospital, Discharge, LOA, etc. You must ensure you choose the correct option for medications to either "pop" or "not pop" in the system.

Ex. If Resident Smith goes to the hospital, you will go to Profile > click Option > Click Hospital
Upon return from hospital go to Resident Smith Profile > Click Option > Click Active

Medication Refusals

1. Talk to the resident in a calm manner and do not make sudden movements or gestures.
2. Attempt to re-approach the resident in a few minutes to try again
3. If a second attempt does not work, ask a coworker (another Med Tech) to try to re-approach the resident.
4. If resident continues to refuse after 3 attempts over a 30 minute period of time, discard medication appropriately and properly document on MAR. Give a reason if possible.
5. Document number of attempts and who attempted giving the meds in nursing notes and communication log.

After 3 Refusals:

6. If resident continues refusing medications, for next 24 hours, contact RCD, SCD and/or Administrator. If during normal business hours, contact MD if possible for instructions.
7. Notify family or POA.
8. Document all calls and instructions in nursing notes and communication log.
9. Observe resident and if necessary check vitals and monitor behaviors. Place resident in Hot Box until instructed differently by RCD, SCD, or MD.
10. If resident continues to **refuse medications for 72 hours**, please contact physician and get instructions on steps to be taken **Document on the resident daily**

Dropped/Spit Out Medications

1. Medication dropped or spit out must be discarded
2. Document dropped or spit out medication
3. If medications are spit out, follow procedure for refusal of medications
4. If medications are controlled substances, have a witness to documentation

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

July 17, 2020

Dana Rabon Smith, Administrator, Executive Officer
The Brooks Senior Living, LLC, Licensee
Waterbrooke of Elizabeth City
143 Rosedale Drive
Elizabeth City, NC 27909

Email address:waterbrooke.admin@gmail.com

RE: Return of Statement of Deficiencies dated May 04, 2020 - Plan of Correction not accepted (3K7412)
Facility: Waterbrooke of Elizabeth City
Licensure Number: HAL-070-008
County: Pasquotank

Dear Ms. Smith:

Thank you for responding to the Statement of Deficiencies for the survey completed April 24, 2020 at your facility. We are returning your response for the following reasons:

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

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

_____ **3.** The completion dates for the provider's response were omitted.

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

__X__ **5.** The provider's response does not include the methods to be used for monitoring and evaluating the corrective action to be implemented. **(Please include policy which was created for staff to follow).**

_____ **6.** The provider's response is not acceptable for Findings #____. Please revise in keeping with the directions contained in the cover letter.

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

We appreciate your cooperation. If you have any questions regarding this matter do not hesitate to contact me at 910-305-4819.

Sincerely,

Linda Kirby RN

Linda Kirby, RN, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure: Statement of Deficiencies with the plan of correction

cc:

Carolyn T. Perry, Supervisor/Designee, Pasquotank County Department of Social Services
Suzy Morgan, Team Supervisor, East 5 Region, Adult Care Licensure Section
Raleigh Facility File