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	HAL051048	A. BUILDING: _____ B. WING _____	R 05/28/2015

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GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Johnston County Department of Social Services conducted a follow-up survey and complaint investigations on 05/20/15-05/22/15 and 05/26/15-05/28/15. The complaint investigation were initiated by the Johnston County Department of Social Services on 04/23/15 and 05/04/15. ***On 06/26/15, this new Event ID # CF1711 dated 05/28/15 was created for the follow-up Event ID # R6WE12 dated 05/28/15 in order to link the complaints in ACTS. The contents of the report findings were not changed.***	D 000		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 176		

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Based on observations, interviews and record reviews, the administrator failed to assure the total operation of the facility to meet and maintain rules related to Personal Care and Supervision, Health Care, Nutrition and Food Service, Medication Administration, Health Care Personnel Registry, Special Care Unit Staffing, and Resident Rights. The findings are:

Interview with the Administrator on 05/28/15 at 1:17 p.m. revealed:
- She had worked at the facility since the middle of January 2015.
- She was usually at the facility Monday - Friday from around 8:30 a.m. - 6:30 p.m.
- She usually worked one manager on duty weekend every 2 months.
- They facility employed a full time Licensed Practical Nurse until around the middle of February 2015.
- There were no systems in place when she started working at the facility.
- Schedules and other paperwork was missing.
- They had a lot of work to do and there had been a lot of staff turnover.
- They started with hiring staff and meeting staff qualification requirements.
- She hired 16 new staff in the first 4 weeks so a lot of time was spent hiring and training staff.
- They are working on new systems currently for example they started new order tracking forms for labs and medication orders.
- A new Registered Nurse was hired and just started on 05/18/15 to help put new systems in place for compliance.

1. Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed

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needs, care plan, and current symptoms for 1 of 6 residents (#2) sampled with multiple falls, including falls with head injuries requiring visits to the emergency room. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).]

2. Based on observation, record review and interview, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 5 of 6 residents (#1, #2, #3,#5, #6) sampled as related to: obtaining urinalysis for two residents (#1, #2) with urinary tract infections resulting in a fall with head injury for one resident and hospital visits for both residents; coordinating with the pharmacy and physician to obtain Potassium supplement for a resident (#3) whose potassium levels became critically low causing nausea and vomiting and significant weakness leading to resident being unable to feed herself; notifying the physician of a significant weight change for a resident (#2) with swelling and hospitalization for congestive heart failure; obtaining a glucometer and notifying the physician of a resident (#6) whose blood sugar and sliding scale insulin was not being done resulting in high blood sugar reading and hospitalization; and coordinating to get a diabetic resident's fingernails (#5) trimmed resulting in long, jagged nails on both hands. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).]

3. Based on record review and interviews, the facility failed to assure documentation and implementation of physician's order for 7 of 8 residents (#1, #2, #3, #5, #6, #9, #10) sampled including orders for blood sugars (#2, #6), blood pressures (#3, #5, #9), pulses (#5) , weights (#1, #2, #3, #5), ted hose (#2), hot/cold packs (#10),

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D 176	Continued From page 3 and nail care (#5). [Refer to Tag D276 10A NCAC 13F .0902(c)(3)(4) Health Care (Type A1 Violation).] 4. Based on observation and interview, the facility failed to assure the Special Care Unit dining area was clean, orderly, and protected from contamination. [Refer to Tag D282 10A NCAC 13F .0904(a)(1) Nutrition and Food Service.] 5. Based on observations, interviews, and record reviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to third shift staff waking residents up as early as 5:00 a.m. to get up and get dressed for the day. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights.] 6. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 7 residents (#12) observed during the medication passes, including errors with medications for blood thinning, acid reflux, and constipation, and 8 of 9 (#1, #2, #3, #4, #5, #6, #8, #12) sampled for review related to errors with medications for diabetes, high blood pressure, low potassium levels, infection, inflammation, swelling, constipation, breathing problems, allergies, cough and congestion. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).] 7. Based on interview and record reviews, the facility failed to assure medication administration records (MARs) were accurate and complete for 2 of 9 residents (#2, #5) sampled for review including medications for diabetes, hepatic encephalopathy, and skin rashes and infections.	D 176		

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D 176	Continued From page 4 [Refer to Tag D367 10A NCAC 13F .1004(j) Medication Administration.] 8. Based on observation, interview and record review, the facility failed to report an allegation of abuse against health care personnel for 1 of 1 staff (F) within 24 hours of facility becoming aware of allegations of Staff F shoving Resident #11 down, along with any investigation by facility within 5 working days. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation).] 9. Based on observation, record review, and interview, the facility failed to assure that the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 15 of 42 shifts from 04/17/15 to 04/23/15 and 05/13/15 to 05/19/15. [Refer to Tag D465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation).] _____ Review of the facility's plan of protection dated 05/28/15 revealed: - Administrator will ensure the facility is following systems put in place to adhere to rules and regulations to include staffing, medication administration, and overall health care. - When administrator is unavailable, a designated person-in-charge will be available to oversee these systems. - Weekly audits will be done by Administrator (Executive Director), Resident Services Director, or designee for the next four weeks to ensure all staff knows and is familiar with all systems that pertains to their work environment. - Audits will be done every two weeks thereafter to follow-up on these systems to ensure	D 176		

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D 176	Continued From page 5 compliance. - Then, monthly audits will be done to ensure systems are working properly and being followed. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 27, 2015.	D 176		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 1 of 6 residents (#2) sampled with multiple falls, including falls with head injuries requiring visits to the emergency room. The findings are: Review of Resident #2's FL-2 dated 4/23/15 revealed: -Diagnoses included liver cirrhosis, diabetes mellitus, hypertension, depression and high cholesterol. - Resident was ambulatory with assistance. -Resident #2 required assistance with bathing and dressing.	D 270		

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D 270	Continued From page 6 Review of Resident #2's assessment and personal service care plan dated 01/15/15 revealed: -Resident required 1 person assist with toileting, transfer and ambulation. -Resident can pivot and stand to wheelchair. -Resident uses wheelchair for mobility. Observation of Resident # 2 on 05/22/15 at 10:00 a.m. revealed: -Resident was in her room alone watching tv. -Resident had incontinence supplies in the corner of the room and bedside commode up against the far wall. Interview with Resident # 2 on 05/22/15 at 10:00 a.m. revealed: -Resident used a standard wheelchair as her primary source of ambulation. -Resident had just returned yesterday from a 2 week stay in the hospital due to congestive heart failure. -Resident received no assistance when using bathroom, transferring or taking a bath. Review of facility incident reports for Resident #2 revealed: -Resident had 15 falls from 1/25/15-4/25/15. -1/25/15: Resident slid out of chair and fell to floor; no apparent injury. -2/01/15: (10:30pm) Resident fell in her bathroom; resident hit head and was bleeding; resident sent to emergency room (ER). -2/22/15: (3:15am) Resident found crawling in the hall on the floor; Resident's wheelchair was at the entrance of her room; no apparent injury. -2/22/15: (4:30am) Resident found on floor outside of her room; Resident's wheelchair was at the bedside; no apparent injury. -2/22/15: (10:45pm) Resident found on her	D 270		

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D 270	Continued From page 7 stomach on floor; no other information noted. -2/23/15: (2:05am) Resident found on floor; no apparent injury. -2/24/15: (3:00am) Resident found on floor; Resident stated she slipped out of her wheelchair; no apparent injury. -2/25/15: (7:40am) Resident found on floor; no other information noted. -3/01/15: (2:30pm) Resident slid off toilet; no apparent injury. -3/03/15: (12:00pm) Resident slid to the floor when aide trying to transfer from couch to wheelchair; no apparent injury. -3/11/15: (8:15am) unwitnessed fall; Resident rolled out of bed; no apparent injury. -4/01/15: (3:15pm) unwitnessed fall; Resident stated she fell transferring from bed to wheelchair and complained of hitting her head; sent to ER. -4/18/18: (2:00pm) Resident confused and slid out of wheelchair; sent to ER. -4/23/15: (10:30pm) unwitnessed fall; Resident stated she was trying to get up; no apparent injury. -4/24/15: (7:00pm) Resident slipped out of wheelchair; no apparent injuries. -4/25/15: (11:45am) Resident found on room floor; Resident stated she was trying to get in her chair; no apparent injuries. -4/25/15: (9:05pm) Resident found on room floor; no apparent injuries. Review of the facility's policy on falls revealed residents who needed limited assistance with transfers and ambulation would be monitored every hour or as frequently as needed to ensure their safety. Interview with a personal care aide (PCA) on 05/27/15 at 11:00 a.m. revealed Resident # 2 was being monitored every 2 hours and no additional	D 270		

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D 270	Continued From page 8 supervision was implemented. Interview with Administrator on 5/27/15 at 2:00 p.m. revealed: -Facility does have a fall policy. -Policy states to assist residents per their needs and increase frequency of resident room checks to 1 per hour. -Administrator was unable to confirm Resident #2's room checks had been increased. Interview with a medication aide on 5/27/15 at 2:15 p.m. revealed: -Staff moved resident to a room closer to the nurse's station (around the first week of April 2015). -Staff put sign up in residents room to remind her to use pull cord for assistance. Interview with a family member on 5/28/15 at 11:30 a.m. revealed: - The family member was concerned about the resident continuing to fall with staff. - The family member was concerned regarding the resident calling her on the phone requesting help because the resident had pulled her cord for assistance and no one would come. Family went to check on resident after fall. Review of resident #2's current FL-2 dated 5/20/15 revealed: -FL-2 was from hospitalization of 5/18/15. -Physical therapy was ordered for evaluation and treatment 2 to 3 times a week. Interview with the physician's assistant (PA) on 05/28/15 at 12:00 noon revealed: - She was aware of Resident #2's falls. - She thought at least one fall had been caused by a urinary tract infection.	D 270		

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D 270	Continued From page 9 - She reported sometimes the falls may be related to attention seeking behavior. - The resident would try to get up on her own sometimes. - Some falls were related to the resident's weakness. - Resident #2 was discharged from their medical group's service on 04/23/15 by the family. _____ Review of the facility's plan of protection dated 05/27/15 revealed: - Facility will identify high risk residents with potential of needed additional supervision. - Facility will assess identified high risk residents and care plan their needs and supervision (interventions) needed. - Facility will review staffing to identify if residents' needs can be met. - If identified that staffing is not sufficient, additional staff will be hired to provide sufficient supervision and care. - Resident Services Director / Executive Director will in-service staff on fall prevention and fall management. - In-service will include residents identified as high fall risk and any applicable interventions currently being used. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 27, 2015.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observation, record review and interview, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 5 of 6 residents (#1, #2, #3,#5, #6) sampled as related to: obtaining urinalysis for two residents (#1, #2) with urinary tract infections resulting in a fall with head injury for one resident and hospital visits for both residents; coordinating with the pharmacy and physician to obtain Potassium supplement for a resident (#3) whose potassium levels became critically low causing nausea and vomiting and significant weakness leading to resident being unable to feed herself; notifying the physician of a significant weight change for a resident (#2) with swelling and hospitalization for congestive heart failure; obtaining a glucometer and notifying the physician of a resident (#6) whose blood sugar and sliding scale insulin was not being done resulting in high blood sugar reading and hospitalization; and coordinating to get a diabetic resident's fingernails (#5) trimmed resulting in long, jagged nails on both hands. The findings are:

1. Review of Resident #1's current FL-2 dated 10/20/14 revealed diagnoses included acute respiratory infection, shortness of breath, delirium, edema, hypertension, and arthritis.

Review of Resident #1's record revealed:
- Order dated 02/19/15 to recollect urinalysis with urine culture on 02/23/15.

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D 273	Continued From page 11 - There was no documentation to indicate the urinalysis was collected. Review of nurses' note dated 03/21/15 revealed resident was very confused, yelling out wants to go home. Review of a fax to the physician dated 03/23/15 revealed: - Facility was requesting order for urinalysis because resident was very confused and getting up without walker and wheelchair numerous times. - Staff documented "possible UTI" (urinary tract infection) and noted the resident had a catheter. Review of Resident #1's record revealed: - Physician's order dated 03/23/15 to collect urine specimen for urinalysis. - Handwritten note on order sheet read, "collected 03/24/15". - Handwritten note on order sheet did not indicate who collected the specimen. Review of nursing notes for Resident #1 revealed on 03/23/15 (11:30 a.m.) - received order for urinalysis. Collected in fridge. Review of the March 2015 medication administration record (MAR) revealed staff documented they collected urine from Resident #1 on 03/23/15. Review of Resident #1's record revealed no documentation the urine collected on 03/23/15 was sent to the lab and tested. Review of incident report dated 03/30/15 at 9:10 a.m. revealed Resident #1 had an unwitnessed fall with no apparent injuries.	D 273		

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D 273	Continued From page 12 Review of nursing notes for Resident #1 revealed: - 04/02/15 (2nd shift) - Resident very agitated the whole shift. - 04/03/15 - Resident very agitated and confused. Resident pulled catheter apart from bag. Review of an incident report form for Resident #1 revealed: - Resident #1 had a fall on 04/12/15 at 11:00 a.m. - Staff member found resident in sitting area in front of building and observed notable injuries and bleeding (scrapes and lacerations) on face and finger. - Resident left wheelchair inside building and had walked outside and fell during ambulation. Review of an emergency room form dated 04/12/15 revealed Resident #1 was diagnosed with a closed head injury but did not suffer a concussion. Interview with the Marketing Director on 05/26/15 at 10:15 a.m. revealed: - She saw an empty wheelchair in the front lobby on 04/12/15 and went outside to see who it belonged to. - She saw Resident #1 sitting on the side walk and he said he fell. - The resident's forehead and pinky were bleeding and he was confused. - He usually gets confused when he has a urinary tract infection. Interview with a medication aide on 05/26/15 at 11:05 a.m. revealed: - She was working when Resident #1 fell in April	D 273		

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2015.
- The resident was disoriented and talking about someone had stolen his car.
- The resident was usually disoriented if he had a urinary tract infection.
- Staff changes his catheter bag.
- Staff can collect urine from the catheter bag for specimens.

Review of a physician's assistant visit form dated 04/14/15 revealed the visit was for a follow-up to a fall and to order urinalysis.

Review of nurses' note dated 04/15/15 revealed a home health nurse obtained a urine specimen for urinalysis.

Review of a physician's assistant visit form dated 04/16/15 revealed an antibiotic was ordered to treat the resident for a urinary tract infection.

Review of nurses' note dated 04/17/15 revealed Resident #1 has been agitated and tried to leave the facility twice

Review of lab form for Resident #1 dated 04/18/15 revealed urine culture showed "multiple bacterial morphotypes present".

Review of a physician's order dated 05/14/15 revealed order to collect urinalysis for Resident #1 to rule out urinary tract infection.

Review of shift reports revealed:
- 05/15/15 (3rd shift) - please recollect urinalysis, not enough urine in cup.
- 05/15/15 (1st shift) - please recollect urinalysis, not enough urine in cup.

Interview with a medication aide on 05/27/15 at

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9:00 a.m. revealed:
- Orders for urinalysis are written on the MARs.
- She noticed on 05/21/15 that the urinalysis for Resident #1 had not been done.
- She collected it herself on 05/21/15 and contacted the physician's office.
- The medication aides will let the personal care aides know about the orders and the PCAs usually collect the urine.
- The PCAs will give the urine specimens to the medications aides to put in the refrigerator.
- The medication aides call the physician's office who contact the lab.
- The lab usually picked up specimens the same day or the next day if it is collected after 2:00 - 3:00 p.m.

Review of lab report dated 05/25/15 for Resident #1 revealed:
- Urine for urinalysis and urine culture was collected on 05/22/15 (more than 1 week after it was ordered).
- The urine culture was positive for bacterial growth.

Review of Resident #1's physician's order dated 05/26/15 revealed an order for Augmentin 875mg 1 tablet twice a day for 7 days for urinary tract infection.

Interview with Resident #1 on 05/26/15 at 10:22 a.m. revealed:
- He has not had any problems with his catheter bag.
- Staff changes it for him.
- He could not recall if he had any urinary tract infections.
- He did not know if his urine had been collected for urinalysis.
- He denied any current symptoms of urinary

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D 273	Continued From page 15 tract infection. Interview with the Wellness Coordinator (WC) on 05/26/15 at 11:50 a.m. revealed: - Staff are supposed to use the lab order tracking sheet and put it in the new order tracking book. - WC tries to check the tracking book daily but at least every 48 hours. - They use a dry erase board in the SCU to track urinalysis for all residents. - It should also be written on the 24 hour report. - A medication aide or personal care aide will collect urine samples, label them and put them in the refrigerator. - Staff will then call the lab or the physician's group. - The lab usually picks up the sample the same day. - If the sample is not picked up, staff will call the lab. - The sample can be kept in their refrigerator for 48 hours. - WC checks the lab order checklist, the refrigerator, and the 24 hour report. - The lab usually faxes the results to the facility within 24 hours and if not staff should call the lab. - Lab results are faxed to the physician and then filed in the record. - She did not know what happened with the collected urine specimens that were not tested in March 2015 or why there was a delay in collecting the specimen ordered on 05/14/15. Interview with the Administrator on 05/27/15 at 10:05 a.m. revealed if a resident with a catheter has an order for a urinalysis, staff should contact home health. Interview with the Wellness Coordinator (WC) on	D 273		

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05/27/15 at 10:05 a.m. revealed:
- The personal care aides have been collecting urinalysis for residents with catheters since they no longer have a nurse at the facility.
- They have not contacted home health to collect any urine samples for any residents.
- She was unsure if the urinalysis orders had been done for Resident #1.
- She stated they would contact the lab and get all records of urinalysis for 2015 faxed to the facility.

Review of lab reports faxed to the facility revealed:
- Urinalysis and urine culture collected on 01/17/15 with report date of 01/22/15.
- Urinalysis and urine culture collected on 02/03/15 with report date of 02/07/15.
- Urine culture collected on 04/15/15 with report date of 04/18/15.
- Urinalysis and urine culture collected on 05/22/15 with report date of 05/25/15.
- No lab results for urinalysis ordered on 02/23/15 and 03/23/15.

Interview with a home health nurse on 05/28/15 at 10:55 a.m. revealed she had not been contacted by the facility to obtain any urine specimens for Resident #1.

2. Review of Resident #5's current FL-2 dated 11/13/14 revealed diagnoses included diabetes mellitus type 2, hypothyroidism, osteoarthritis with chronic pain, depression, vertigo, morbid obesity, cutaneous candidiasis, hypertension, chronic venous stasis, peripheral neuropathy, and hypoalbuminemia.

Review of Resident #5's resident register dated 11/18/13 revealed the resident required

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D 273	Continued From page 17 assistance with nail care. Review of Resident #5's assessment and care plan dated 12/11/14 revealed the resident required one person assistance for bathing, dressing, grooming, and toileting. Observation interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed: - Resident's fingernails on her left hand were all ½ to ¾ inches long and jagged. - Resident's thumb nail and 4th and 5th fingernails on her right hand were ½ to ¾ inches long and jagged. - The 1st and 2nd fingernails on the right had were broken off and jagged. - All fingernails were yellow and had thick brown substance underneath the nails. - Resident used one fingernail to dig brown substance out from under another nail. - The brown flakes were falling on the resident's bed sheets. Observation and interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed: - The resident's fingernails had been that way "a long time". - Her fingernails were too long and needed trimming. - She did not like her nails to be that long. - Her fingernails looked "terrible". - She thought the podiatrist was supposed to trim her fingernails today but they had not been yet. Review of a physician's visit form dated 01/15/15 revealed the resident fingernails were trimmed during the visit. Interview with a medication aide on 05/27/15 at	D 273		

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D 273	Continued From page 18 1:05 p.m. revealed: - Facility policy was staff were not allowed to trim the resident's fingernails since she was diabetic. - She thought the doctor was supposed to trim the resident's fingernails. - She did not know the last time the resident's fingernails had been trimmed. - Facility staff do not usually trim the resident's fingernails because she was diabetic. - The resident had complained about her fingernails being too long. - The podiatrist was asked to trim the resident's fingernails during routine visit to the facility yesterday. - As far as she knew, the resident's fingernails were trimmed by the podiatrist yesterday on 05/26/15. Review of Resident #5's record revealed: - Podiatry visit on 03/24/15 noting debridement of resident's toenails. - No documentation on the 03/24/15 of any care provided to resident's fingernails. - No documentation the resident's fingernails had been trimmed by anyone. Interview with Resident #5 on 05/28/15 at 10:42 a.m. revealed: - Her fingernails still had not been trimmed. - She thought they were going to trim them yesterday. - She did not know why her fingernails were not trimmed. Observation of Resident #5 on 05/28/15 at 10:42 a.m. revealed fingernails on both hands were still long, jagged, and yellow with brown substance underneath the nails.	D 273		

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D 273	Continued From page 19 Interview with the Administrator on 05/28/15 at 11:40 a.m. revealed: - Podiatry was supposed to trim Resident #5's fingernails yesterday because the nails were "so bad". - Podiatry did not trim the resident's fingernails yesterday. - When staff realized podiatry did not trim Resident #5's fingernails yesterday, they called podiatry. - Podiatry is supposed to come back to the facility today to trim the resident's fingernails. 3. Review of Resident #6's FL-2 (with fax stamp dated 04/06/15) revealed: - Diagnoses included diabetes mellitus type II, subarachnoid hemorrhage, dementia, hypertension, and depression. - An order for fingerstick blood sugar (FSBS) to be checked before meals and at bedtime. - An order for Humalog sliding scale (no scale indicated). (Humalog insulin is rapid-acting insulin used to lower blood sugar.) Review of a prescription dated 04/03/15 revealed an order for Humalog insulin per sliding scale: 150- 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units, 301 - 350 = 8 units, and 351 - 400 = 10 units. Review of Resident #6's closed record revealed he was admitted to the facility from another state on 04/06/15. Review of the April 2015 medication administration record (MAR) revealed: - Page 2 of 2 of the April 2015 MAR was missing. (Staff was unable to locate.) - There was a printed order for FSBS checks before meals and at bedtime scheduled for 7:30 a.m., 11:30 a.m., 4:30 p.m. and 8:00 p.m.	D 273		

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- There was no entry for Humalog sliding scale insulin on the MAR.
- There were no FSBSs documented from admission on 04/06/15 through 04/12/15.
- Only 5 documented FSBS: 120 on 04/13/15 at 7:30 a.m.; 118 on 04/13/15 at 11:30 a.m.; 124 on 04/13/15 at 4:30 p.m.; "HI" on 04/13/15 at 8:00 p.m.; and 536 on 04/14/15 at 7:30 a.m.
- ["HI" blood sugar reading on most glucometers indicates blood sugar is greater than 600 according to most manufacturers.]

Review of pharmacy dispensing records and delivery sheets revealed no Humalog was dispensed to Resident #6.

Interview with the pharmacist on 05/28/15 at 10:44 a.m. revealed:
- Humalog insulin was never dispensed for Resident #6 but the order was on file in the computer.
- They usually send all medications unless the facility requests them not to send something.
- She was unsure why the Humalog was not sent to the facility with the initial medications for Resident #6.
- There was no documentation in the pharmacy's notes regarding the Humalog.
- There was no documentation that the facility contacted the pharmacy to obtain the Humalog.

Confidential staff interview revealed:
- Resident #6's spouse, who was also a resident at the facility, reported to the staff person that no one ever checked Resident #6's blood sugar.
- The staff person checked the April 2015 MAR and did not see any initials documented beside the entry for blood sugar checks.
- The staff person reported to medication aide on duty about Resident #6's blood sugars not

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being checked.
- A medication aide told staff person she did not know anything about the resident's blood sugar.
- Resident #6 did not have a glucometer.

Interview with a medication aide on 05/27/15 at 4:00 p.m. revealed:
- The resident's blood sugar was not checked because he did not have a glucometer when he was admitted.
- She did not know why he did not have a glucometer.
- She did not contact the pharmacy, family, or physician about the resident not having a glucometer.
- He did not have a glucometer until 04/13/15 when the facility got one from a local retail pharmacy.
- She checked the resident's blood sugar when it registered "HI" on the machine.
- She was not sure what "HI" meant.
- She did not recheck the blood sugar that night and she did not notify the physician of the "HI" reading.

Interview with the Wellness Coordinator (WC) on 05/27/15 at 4:00 p.m. revealed:
- Resident #6 was admitted without a glucometer or any medications.
- They thought the family was bringing in a glucometer.
- The facility purchased a glucometer because the family would not bring a glucometer.
- She could not recall the date it was purchased but they started using it when it was purchased.
- Staff should have contacted the pharmacy to obtain the sliding scale insulin.
- One of the physician's assistants (PA) from the facility's primary medical group saw the resident on 04/14/15 and said the resident was cold,

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clammy, and pale.
- The PA had the resident sent to the emergency room.

Interview with Resident #6's responsible party on 05/28/15 at 10:40 a.m. revealed:
- Resident #6 was admitted to the facility on 04/06/15 from another state.
- The resident did not bring any medications with him from the other state.
- He was not aware the resident's blood sugar was not being checked.
- Facility staff never asked the family for a glucometer.

Interview with a physician's assistant (PA) on 05/28/15 at 12:00 noon revealed:
- She saw Resident #6 for his initial visit with the medical group on 04/09/15.
- The resident did not have a glucometer at that time.
- It was her understanding from staff that the family was going to provide a glucometer.
- The resident was a new admission to the facility and they were in the process of getting everything in order for him.
- The facility usually requested an order for a glucometer if the family did not bring in one.
- The facility did not request an order for a glucometer.
- The facility had not notified her after that day on 04/09/15 that the resident continued not to have a glucometer.
- She was unaware after 04/09/15 that the resident was not receiving blood sugar checks or sliding scale insulin.
- She was not notified of a blood sugar reading of "HI".
- Her coworker, another PA, went to the facility on 04/14/15 for a routine visit.

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D 273	Continued From page 23 - Her coworker found Resident #6 in his room in bed covered in a blanket with urine on the floor. - The resident was alert but not oriented and said he was cold. - Her coworker had the facility call emergency services and resident was taken to the hospital. Interview with the coworker PA on 05/28/15 at 1:00 p.m. revealed: - She never received a request for a glucometer for Resident #6. - She was not notified of the resident's "HI" blood sugar reading on 04/13/15. - She had not been notified of any issues with Resident #6's blood sugars prior to 04/14/15. - Her first visit with Resident #6 was on 04/14/15, the day he went to the hospital. - Staff informed her that Resident #6's blood sugar was 536 that morning on 04/14/15. - When she entered Resident # 6's room on 04/14/15, the floor was covered with urine. - The resident was laying on his side in the bed saying he was very cold. - The resident complained he could not see very well out of his right eye and it had been that way for a few days. - The resident's blood pressure was low (unsure of exact reading). - Resident #6 was very pale and clammy. - She requested resident be sent out to the hospital immediately. Review of a hospital discharge summary for Resident #6 revealed: - Resident #6 was admitted to the hospital on 04/14/15 with one of chief complaints being hyperglycemia (high blood sugar). - The resident was noted to have uncontrolled diabetes with a Hemoglobin A1C greater than 12. [Hemoglobin A1C is a blood test used to	D 273		

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determine how well blood sugar has been controlled over the last 2 to 3 months. It is recommended for diabetics Hemoglobin A1C to be less than 7.]

4. Review of Resident #3's FL-2 dated 03/12/15 revealed:
-Diagnoses included congestive heart failure exacerbation and dementia.
-A note to see hospital discharge summary for medications.

Review of Resident #3's discharge summary dated 03/13/15 revealed:
- An order to take Potassium Chloride (KCL) 20mEq tablet : 20mEq by mouth every morning.
-(Potassium is a supplement used to treat low potassium levels. Potassium is important for muscles to work effectively including the heart. It also has a role in regulating blood pressure. Symptoms of low potassium may include fatigue, weakness, nausea and vomiting, cramping, and heart palpitations. Potassium tablets are extended-released and should not be crushed or chewed because too much can be released at one time or it can irritate the mouth, throat, and stomach.)

Review of a physician's order for Resident #3's dated 03/31/15 revealed an order to discontinue Potassium Chloride tablets, and start Potassium Chloride 40mEq/15ml liquid take 15ml by mouth every day.

Review of a physician assistant (PA) visit summary dated 04/16/15 for Resident #3 revealed an order to discontinue Potassium Chloride liquid and start Potassium Chloride 40mEq tab- take 2 half (pills precut in half) tabs twice a day (please either crush and put in ensure

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D 273	Continued From page 25 or cut in half for patient to swallow). Review of a physician assistant (PA) visit summary dated 04/23/15 for Resident #3 revealed: - The PA noted the resident had not received ANY potassium supplements in the last week as previously prescribed. - Potassium was to be given as previously prescribed. - Please assist the resident with ALL feeding for meals due to extreme fatigue. Review of pharmacy dispensing records revealed a 15 day supply of Potassium Chloride tablets were not dispensed until 04/23/15. Review of a physician's communication form dated 04/28/15 for Resident #3 revealed: - The PA noted the resident had low potassium. - The PA noted okay to crush Potassium pills and put in pudding or ensure if the resident could not swallow in halves. Review of lab work for Resident #3 revealed Resident #3's Potassium level was 3.3 (low) on 04/29/15 with normal range of 3.5 - 5.3. Interview with the pharmacy on 05/26/15 at 9:20 a.m. revealed: -An order to discontinue Potassium liquid and start Potassium Chloride 40mEq tab- 2 half (pills precut in half) tabs twice a day, with a note to either crush and put in ensure or cut in half for the patient to swallow was received by the pharmacy on 04/16/15. -Facility refaxed order that was written on 04/16/15 and requested that it be sent although the pharmacy had not received clarification on directions regarding crushing the Potassium.	D 273		

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Pharmacy dispensed Potassium Chloride 20mEq tabs with the directions " take 2 tabs (=40mEq) twice daily (cut in half for patient to swallow or dissolve in water- cannot crush).
-An order was received on 04/28/15 at 3:35 p.m. to crush Potassium pills if the resident cannot swallow the halves (put in pudding or ensure).
-The pharmacy dispensed Potassium Chloride 10mEq capsules with the directions to take 4 caps (=40 mEq) twice a day (open capsule and sprinkle on pudding, applesauce or liquid) after the pharmacy tech tried to call the facility several times to remind them the tabs were not made to be crushed.
-On 05/07/15, a clarification was received by the pharmacy at 8:25 p.m. that the resident was currently taking Potassium Chloride 10mEq caps (4 cap by mouth twice a day).
-The pharmacy was waiting for the facility to clarify the order related to crushing the Postassium tablets since they should not be crushed.

Review of documentation kept by the pharmacy related to Resident #3's Potassium (KCL) revealed:
4/16 -- Pharmacist noted the order needed to be clarified and sent the following info back to the tech to call on because KCL tablets should not be crushed. The home could break the tabs in half to make it easier to swallow or they could dissolve the tab in 4 ounces water, let stand about 2 minutes, stir, and drink immediately.
4/16 -- Pharmacy tech called Facility and spoke to business office staff. She tried to transfer to another employee, but was unable to reach her and so took a message for her to call us back.
4/16 -- Pharmacy tech called Facility twice more and faxed a clarification request sheet.
4/20 - Pharmacy tech was told by Wellness

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Coordinator (WC) at facility that they were in the process of getting order clarified.
4/21 - Pharmacy tech was told by WC that the MD would be coming in on that day to clarify order.
4/22 - Pharmacy tech was told by business office staff that Med Tech was unavailable.
4/23 - Pharmacy tech was told that WC would call her back.

Interview with Wellness Coordinator on 05/26/15 at 10:15 a.m. revealed:
-She thought the pharmacy was contacting the physician about clarifying the Potassium order.
-She was unsure if the physician was notified about the patient missing doses of potassium. If the PA was contacted it should be documented on a physician's order sheet along with a fax sheet, indicating it had been faxed to the PA.

Interview with Administrator on 05/22/15 at 11:00 a.m. revealed:
-Administrator knew there had been some issues with Resident #3's Potassium.
-She was unaware what exactly had been the problem with her getting it.
-She was unaware how many doses the resident missed.
-She stated if the physician had been notified it would have been documented in the nurse's notes or on a physician order sheet.

5. Review of Resident # 2's current FL2 dated 04/23/15 revealed diagnoses of liver cirrhosis, diabetes mellitus, portal vein thrombosis, hypertension, depression and high cholesterol.

A. Review of Resident #2's progress notes reavealed:
-Resident had begun showing signs of confusion

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D 273	Continued From page 28 on 4/13/15. -Resident #2 began showing signs of nausea and vomiting on 4/15/15. Review of a physician's order dated 04/16/15 for Resident #2 revealed an order for urinalysis to rule out urinary tract infection. Review of Resident #2's nurses' notes and labwork in the record revealed no documentation to indicate the urinalysis was done. Review of progress note revealed the resident fell on 4/18/15 and was very confused and disoriented. Review of Resident #2's hospital discharge summary dated 4/23/15 revealed: -Resident was admitted to hospital on 4/19/15-4/23/15 due to untreated urinary tract infection. Interview with Administrator 5/27/15 at 3:45 p.m. revealed she would contact the lab for records to see if the urinalysis ordered on 04/16/15. No further documentation was provided for the urinalysis ordered on 04/16/15. Interview with the physician's assistant (PA) on 05/21/15 at 4:24 p.m. revealed: - The PA saw Resident #2 on 04/16/15 for fatigues, falls, and weakness. - Urinalysis was ordered to rule out urinary tract infection but it was not done. - The resident was sent to the hospital a couple of days later per family request because of change in mental status. - Resident was determined to have a urinary tract infection.	D 273		

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D 273	Continued From page 29 B. Review of a physician's order for Resident # 2 dated 1/22/15 revealed an order to start weekly weight checks. Review of facilities weight log and Medication Administration Record (MAR) revealed: -There was weight gain from 2/23/15-3/23/15 of 46 pounds; 258 pound to 303 pounds. -There was weight gain from 3/23/15-4/27/15 of 19 pounds; 303 pounds to 322 pounds. -There was weight loss of 17 pounds from 4/27/15-5/4/15; 322 pounds to 305 pounds. Review of Resident #2's record revealed no documentation of contact with the physician regarding the weight gain or loss. Interview with the Administrator on 05/22/15 at 10:30 a.m. revealed she had no explanation for the physician not being contacted regarding the weight gain and loss. Review of resident 2's discharge summary dated 04/19/15 revealed the resident complained of legs being swollen and getting more swollen daily, felt that fluid was building up in her legs. Observation of Resident #2 on 05/22/15 at 10:00 a.m. revealed her legs appeared to be swollen. Review of the facility's plan of protection dated 05/22/15 revealed: - Resident Services Director (RSD) / Executive Director (ED) / Designee will conduct audit of all current residents' charts to ensure all physician orders and referrals are being followed as directed. - Any orders or referrals found to be not in process, will be processed immediately.	D 273		

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D 273	Continued From page 30 - Area Director will train RSD / ED / Designee on new order/lab tracking system to ensure all orders/referrals/labs are implemented properly. - New order/referral/lab tracking system will be used on all new orders/referrals/labs to ensure all are processed correctly. - Any changes in a resident's condition will be reported and documented to the physician using the physician communication form. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 27, 2015.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record review and interviews, the facility failed to assure documentation and implementation of physician's order for 7 of 8 residents (#1, #2, #3, #5, #6, #9, #10) sampled including orders for blood sugars (#2, #6), blood pressures (#3, #5, #9), pulses (#5) , weights (#1, #2, #3, #5), ted hose (#2), hot/cold packs (#10), and nail care (#5). The findings are:	D 276		

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D 276	Continued From page 31 1. Review of Resident #6's FL-2 (with fax stamp dated 04/06/15) revealed: - Diagnoses included diabetes mellitus type II, subarachnoid hemorrhage, dementia, hypertension, and depression. - Order for fingerstick blood sugar (FSBS) to be checked before meals and at bedtime. Review of Resident #6's closed record revealed he was admitted to the facility from another state on 04/06/15. Review of the April 2015 medication administration record (MAR) revealed: - Printed order for FSBS checks before meals and at bedtime scheduled for 7:30 a.m., 11:30 a.m., 4:30 p.m. and 8:00 p.m. - No FSBS documented from admission on 04/06/15 through 04/12/15. - Only 5 documented FSBS: 120 on 04/13/15 at 7:30 a.m.; 118 on 04/13/15 at 11:30 a.m.; 124 on 04/13/15 at 4:30 p.m.; " HI " on 04/13/15 at 8:00 p.m.; and 536 on 04/14/15 at 7:30 a.m. - ["HI" blood sugar reading on most glucometers indicates blood sugar is greater than 600 according to most manufacturers.] Confidential staff interview revealed: - Resident #6's spouse, who was also a resident at the facility, reported to the staff person that no one ever checked Resident #6's blood sugar. - Staff person checked the April 2015 MAR and did not see any initials documented beside the entry for blood sugar checks. - Staff person reported to medication aide on duty about Resident #6's blood sugars not being checked. - Medication aide told staff person she did not know anything about the resident's blood sugar.	D 276		

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D 276	Continued From page 32 - Resident #6 did not have a glucometer. Interview with a second medication aide on 05/27/15 at 4:00 p.m. revealed: - The resident's blood sugar was not checked because he did not have a glucometer when he was admitted. - She did not know why he did not have a glucometer. - She did not contact the pharmacy, family, or physician about the resident not having a glucometer. - He did not gave a glucometer until 04/13/15 when the facility got one from a local retail pharmacy. Interview with the Wellness Coordinator (WC) on 05/27/15 at 4:00 p.m. revealed: - Resident #6 was admitted without a glucometer or any medications. - They thought the family was bringing in a glucometer. - The facility purchased a glucometer because the family would not bring a glucometer. - She could not recall they date it was purchased but they started using it when it was purchased. - One of the physician's assistants (PA) from the facility's primary medical group saw the resident on 04/14/15 and said the resident was cold, clammy, and pale. - The PA had the resident sent to the emergency room. Interview with Resident #6's responsible party on 05/28/15 at 10:40 a.m. revealed: - Resident #6 was admitted to the facility on 04/06/15 from another state. - The resident did not bring any medications with him from the other state. - He was not aware the resident's blood sugar	D 276		

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was not being checked.
- Facility staff never asked the family for a glucometer.

Interview with a physician's assistant (PA) on 05/28/15 at 12:00 noon revealed:
- She saw Resident #6 for his initial visit with the medical group on 04/09/15.
- The resident did not have a glucometer at that time.
- It was her understanding from staff that the family was going to provide a glucometer.
- The resident was a new admission to the facility and they were in the process of getting everything in order for him.
- The facility usually requested an order for a glucometer if the family did not bring in one.
- The facility did not request an order for a glucometer.
- She was unaware after 04/09/15 that the resident was not receiving blood sugar checks.

Interview with the coworker PA on 05/28/15 at 1:00 p.m. revealed:
- She never received a request for a glucometer for Resident #6.
- She was not notified of the resident's "HI" blood sugar reading on 04/13/15.
- She had not been notified of any issues with Resident #6's blood sugars prior to 04/14/15.
- Her first visit with Resident #6 was on 04/14/15, the day he went to the hospital.
- Staff informed her that Resident #6's blood sugar was 536 that morning on 04/14/15.
- When she entered Resident # 6's room on 04/14/15, the floor was covered with urine.
- The resident was laying on his side in the bed saying he was very cold.
- The resident complained he could not see very well out of his right eye and it had been that way

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for a few days.
- The resident's blood pressure was low (unsure of exact reading).
- Resident #6 was very pale and clammy.
- She requested resident be sent out to the hospital immediately.

Review of a hospital discharge summary for Resident #6 revealed:
- Resident #6 was admitted to the hospital on 04/14/15 with one of chief complaints being hyperglycemia (high blood sugar).
- The resident was noted to have uncontrolled diabetes with a Hemoglobin A1C greater than 12. [Hemoglobin A1C is a blood test used to determine how well blood sugar has been controlled over the last 2 to 3 months. It is recommended for diabetics Hemoglobin A1C to be less than 7.]

2. Review of Resident #5's current FL-2 dated 11/13/14 revealed diagnoses included diabetes mellitus type 2, hypothyroidism, osteoarthritis with chronic pain, depression, vertigo, morbid obesity, cutaneous candidiasis, hypertension, chronic venous stasis, peripheral neuropathy, and hypoalbuminemia.

A. Review of Resident #5's record revealed:
- An order dated 12/11/14 to please file resident's fingernails x 10.
- Subsequent order dated 03/26/15 to please file resident's fingernails x 10 down to even with tip o finger.

Review of Resident #5's resident register dated 11/18/13 revealed the resident required assistance with nail care.

Review of Resident #5's assessment and care

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plan dated 12/11/14 revealed the resident required one person assistance for bathing, dressing, grooming, and toileting.

Review of a physician's visit form dated 01/15/15 revealed the resident fingernails were trimmed during the visit.

Review of the March 2015 medication administration record (MAR) revealed:
- Computer printed entry to please file resident's fingernail x 10 down to even with tip of finger.
- No time was scheduled on the MAR.
- No documentation on the MAR indicating the resident's fingernails had been filed.

Review of the April 2015 MAR revealed:
- Entry to file resident's fingernails was included but no time was scheduled.
- No documentation on the MAR indicating the resident's fingernails had been filed.

Review of the May 2015 MAR revealed:
- Entry to file resident's fingernails was included but no time was scheduled.
- No documentation on the MAR indicating the resident's fingernails had been filed.

Interview with a medication aide on 05/27/15 at 1:05 p.m. revealed:
- She thought one of the aides had filed Resident #5's fingernails in the past but she could not recall when or who may have done it.
- She had not filed the resident's fingernails.
- She did not know the last time the resident's fingernails had been filed.

Observation of Resident #5 on 05/27/15 at 3:15 p.m. revealed:
- Resident's fingernails on her left hand were all

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D 276	Continued From page 36 ½ to ¾ inches long and jagged. - Resident's thumb nail and 4th and 5th fingernails on her right hand were ½ to ¾ inches long and jagged. - The 1st and 2nd fingernails on the right had were broken off and jagged. - All fingernails were yellow and had thick brown substance underneath the nails. - Resident used one fingernail to dig brown substance out from under another nail. - The brown flakes were falling on the resident's bed sheets. Interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed: - The resident's fingernails had been that way "a long time". - The resident felt her fingernails were too long and needed trimming. - She did not like her nails to be that long. - She felt her fingernails looked "terrible". - No one files her nails. Review of Resident #5's record revealed: - Podiatry visit on 03/24/15 noting debridement of resident's toenails. - No documentation on 03/24/15 of any care provided to resident's fingernails by podiatry. - No documentation the resident's fingernails had been filed. Observation of Resident #5 on 05/28/15 at 10:42 a.m. revealed fingernails on both hand were still long, jagged, and yellow with brown substance underneath the nails. Interview with Resident #5 on 05/28/15 at 10:42 a.m. revealed: - Her fingernails still had not been trimmed or filed.	D 276		

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D 276	Continued From page 37 - She thought they were going to trim them yesterday. - She did not know why her fingernails had not been trimmed or filed. Interview with the Administrator on 05/28/15 at 11:40 a.m. revealed: - Facility staff do not trim nails for diabetic residents. - She was unaware of the order to file the resident's fingernails and was unsure why it was not being done. - Podiatry was supposed to trim Resident #5's fingernails yesterday because the nails were "so bad". - It did not get done. - When staff realized podiatry did not trim Resident #5's fingernails yesterday, they called podiatry. - Podiatry is supposed to come back to the facility today to trim the resident's fingernails. B. Review of Resident #5's FL-2 dated 11/13/14 revealed orders to check pulse and blood pressure weekly. Review of the March 2015 medication administration record (MAR) revealed: - There was an entry to check pulse weekly at 6:30 a.m. on Tuesdays. - There was no pulse documented for 2 of 5 occasions on 03/09/15 and 03/30/15. - Pulse ranged from 60 - 75 for other 3 weeks in March 2015.. - There was no entry to check blood pressures weekly. - There was no documentation of any blood pressures. Review of the April 2015 MAR revealed:	D 276		

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D 276	Continued From page 38 - There was an entry to check pulse weekly at 6:30 a.m. on Tuesdays. - There was no pulse documented on 2 of 4 weeks on 04/07/15 and 04/21/15. - The pulse was 76 on 04/14/15 and 65 on 04/28/15. - There was no entry to check blood pressures weekly. - There was no documentation of any blood pressures. Review of the May 2015 MAR revealed: - There was an entry to check pulse weekly at 6:30 a.m. Tuesdays. - There was no pulse documented on 05/19/15. - The pulse was 71 on 05/15/15 and 54 on 05/12/15. - There was no entry to check blood pressures weekly. - There was no documentation of any blood pressures. Interview with a medication aide on 05/27/15 at 1:05 p.m. revealed: - Staff should be checking and documenting the pulse weekly. - She was unsure why the pulse had not been checked weekly. - She was not aware the blood pressure was supposed to be checked because it was not listed on the MAR. - She had not checked Resident #5's blood pressure. Interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed: - Staff check her pulse but she was not sure how often. - She did not recall if staff had checked her blood pressure.	D 276		

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D 276	Continued From page 39 C. Review of Resident #5's FL-2 dated 11/13/14 revealed an order to monitor weights daily. Review of the March 2015 medication administration record (MAR) revealed: - There was an entry to check weights daily at 8:00 a.m. - There was no weights documented on 03/20/15, 03/22/15, and 03/29/15. - Weights documented ranged from 215 - 228 pounds. Review of the April 2015 MAR revealed: - There was an entry to check weights daily at 8:00 a.m. - There was no weights documented on 12 of 30 days. - There was no weights on 04/04/15, 04/05/15, 04/13/15, 04/18/15, 04/19/15, 04/21/15, and 04/24/15 - 04/26/15, and 04/28/15 -04/30/15. - Weights documented ranged from 224 - 238 pounds. Review of the May 2015 MAR revealed: - There was an entry to check weights daily at 8:00 a.m. - There was no weights documented 05/17/15. - Weights documented ranged from 222- 248 pounds. Interview with a medication aide on 05/27/15 at 1:05 p.m. revealed: - Staff should be checking and documenting the weight daily. - She was unsure why the weight had not been checked daily. Interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed staff weigh her but she was not	D 276		

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D 276	Continued From page 40 sure how often. 3. Review of Resident #1's current FL-2 dated 10/20/14 revealed diagnoses included acute respiratory infection, shortness of breath, delirium, edema, hypertension, and arthritis. Review of Resident #1's record revealed a physician's order dated 10/30/14 to check weights daily. Review of the March 2015 medication administration record (MAR) and weight log revealed: - An entry to check weight daily was included on the MAR and scheduled at 8:00 a.m. - There was no weights documented on 03/01/15, 03/03/15 and 03/22/15. - Weights ranged from 221 - 234 in March 2015. Review of the April 2015 MAR and weight log revealed: - There was no weights documented on 19 of 30 days in April 2015. - There was no weights on 04/04/15 - 04/06/15, 04/13/15, 04/15/15, and 04/17/15 - 04/30/15. - Weights ranged from 231 - 237 in April 2015. Review of the May 2015 MAR and wieght log revealed: - There was no weights documented on 05/10/15 and 05/17/15. - Weights ranged from 231 - 240 in May 2015. Review of Resident #1's record revealed: - Physician's order dated 10/30/14 for Lasix 20mg 1 tablet daily as needed for weight gain of 3 pounds in 24 hours or 5 pounds in 72 hours. (Lasix is a diuretic used to treat swelling from fluid retention.)	D 276		

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D 276	Continued From page 41 - Facility staff could not determine if the prn (as needed) Lasix would have been required without the resident's weight being checked. Interview with a medication aide on 05/22/15 at 2:00 p.m. revealed: - The personal care aides weigh the residents and report weights to the medication aides and they document them on the MAR. - She had no explanation for the missing weights for Resident #1 and she had not administered any prn Lasix to the resident. Interview with Resident #1 on 05/26/15 at 10:22 a.m. revealed: - He denied any problems with swelling. - His lower legs did not appear swollen. - He thought he had been weighed one time. Interview with the Wellness Coordinator (WC) on 05/26/15 at 11:50 a.m. revealed: - Staff had been trained to read the MARs and follow the orders. - She was unaware Resident #1's weight had not been checked as ordered. - She had not been able to check MARs in a while due to time constraints. 4. Review of Resident # 2's current FL2 dated 04/23/15 revealed diagnoses of liver cirrhosis, diabetes mellitus, portal vein thrombosis, hypertension, depression and high cholesterol. A. Review of a physician's order for Resident # 2 dated 01/22/15 revealed an order to check finger stick blood sugars (FSBS) 2 times a day. Review of resident # 2's April 2015 and May 2015 Medication Administration Records (MARs) revealed:	D 276		

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-Finger stick blood sugars were to be checked at 8am and 8pm.
-FSBS were not documented at 8:00 a.m. on 4/24, 4/25, and 4/26.
-FSBS were not documented at 8:00 p.m. on 4/5, 4/13, 4/18, 4/24, 4/25, 4/26, 4/28, 4/29, 4/30, 5/5, 5/6, 5/12, 5/13, and 5/14.
-FSBS ranged from 93-258 for April 2015 and 53 - 167 for May 2015.
-Resident was in the hospital on 4/19/15-4/23/15.

Interview with Medication Aide on 5/26/15 at 3:00 p.m. revealed no information was given as to why finger stick blood sugar was not done.

B. Review of a physician's order dated 01/22/15 for Resident # 2 revealed an order to start weekly weight checks.

Review of facility's weight log and Medication Administration Record (MAR) revealed:
- There were no weights documented for the week of 3/9/15, 4/13/15 or 5/14/15
-There was weight gain from 2/23/15-3/23/15 of 46 pounds; 258 pound to 303 pounds
-There was weight gain from 3/23/15-4/27/15 of 19 pounds; 303 pounds to 322 pounds
-There was weight loss of 17 pounds from 4/27/15-5/4/15; 322 pounds to 305 pounds
-There was no contact with doctor to address weight gain or loss.

Interview with the Administrator on 05/22/15 at 10:30 a.m. revealed she had no explanation for the resident's weights not being done or the physician not being contacted regarding the weight gain and loss.

Review of resident 2's discharge summary dated 04/19/15 revealed the resident complained of

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legs being swollen and getting more swollen daily, felt that fluid was building up in her legs.

Interview with the physician's assistant (PA) on 05/28/15 at 12:00 noon revealed:
- The resident routinely has 2+ to 3+ pitting edema in both lower legs which causes her shortness of breath to worsen.
- She wrote an order on 04/16/15 to increase the resident's Lasix because of swelling and shortness of breath.
- Resident #2 was discharged from their medical group's service on 04/23/15 by the family.

Observation of Resident #2 on 05/22/15 at 10:00 a.m. revealed her legs appeared to be swollen.

C. Review of physician's orders for Resident #2 revealed:
- An order dated 3/10/15 to wear ted hose daily.
- An order dated 3/12/15 to re-measure for ted hose.

Review of Resident #2's March 2015 medication administration record (MAR) revealed:
-Handwritten order dated 3/10/15 for ted hose; apply in the morning and remove at bedtime.
-Ted hose to be put on at 8am and removed at 8pm.
-There were no staff initials on 3/18/15 at 8pm; 3/20/15 at 8pm, and 3/22/15 at 8pm.
-There were 20 days initialed and circled by staff due to resident not wearing.
-Staff documented on the back of the MAR:
3/11/15 at 8pm; not worn
3/13/15 at 8am and 8pm; not worn
3/15/15 at 8am, not worn, resident refused
3/15/15 at 8pm; not worn

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D 276	Continued From page 44 3/16/15 at 8pm; not worn 3/17/15 at 8am and 8pm; not worn 3/19/15 at 8pm; not worn 3/20/15 at 8pm; ted hose not properly fitting; resident refused 3/21/15 at 8pm; not applied 3/23/15 at 8am; not applied 3/24/15 at 8pm; not worn 3/25/15 at 8am and 8pm; not worn 3/27/15 no time noted; not worn 3/28/15 at 8am and 8pm; not worn 3/29/15 at 8am and 8pm; not worn 3/31/15 at 8am and 8pm; not worn Review of the April 2015 MAR revealed: - Staff circled initials on 13 of 30 days and noted the ted hose were not worn, do not fit, reordered for proper fit, and still waiting for them. - Doucmentation for the other 17 days were blank with no reasons for the omissions. Review of the May 2015 MAR revealed no entry for ted hose. Observation of Resident #2 on 05/22/15 at 10:00 a.m. revealed: -Resident was not wearing ted hose - Her legs appeared to be swollen. Interview with Resident #2 on 05/22/15 at 10:00 a.m. revealed her ted hose should be worn but the ones offered do not fit and the staff and resident have "given up on trying to get them on". Review of Resident #2's progress notes and nurses' notes in the record revealed no documentation staff had remeasured for the ted hose or the physician was notifed the resident was not wearing the ted hose.	D 276		

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D 276	Continued From page 45 Interview with the Wellness Coordinator on 05/26/15 at 3:15 p.m. revealed staff remeasured for the ted hose (could not recall when) but they still did not fit. Interview with the physician's assistant (PA) on 05/28/15 at 12:00 noon revealed: - At one point the resident wore the TED hose but they got uncomfortable and she refused to wear them. - Staff was told to encourage the resident to wear the TED hose. - She gave the facility an order to remeasure the resident's legs to get a better size. - She was not aware the resident was not wearing the TED hose. - The resident routinely has 2+ to 3+ pitting edema in both lower legs which causes her shortness of breath to worsen. - She wrote an order on 04/16/15 to increase the resident's Lasix because of swelling and shortness of breath. - Resident #2 was discharged from their medical group's service on 04/23/15 by the family. 5. Review of Resident #3's FL-2 dated 03/12/15 revealed diagnoses included congestive heart failure exacerbation and dementia. Review of a physician's order for Resident #3 dated 02/26/15 revealed an order for daily weights and blood pressures three times a week. Review of the March 2015 medication administration records (MARs) revealed: -Handwritten entry for daily weights. -Weights only documented on March 16th as 109 pounds and 17th as 109 pounds. -Computer generated entry to check weight once	D 276		

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daily.
-Weights were entered for the 16th and 21st-30th, ranging from 109-111 pounds.
-Weights were not documented for the 13th -15th and 18th-20th.
-Computer generated entry to check BP three times a week.
- Blood pressures were only entered twice in the month, they were 113/69 on the 21st and 98/50 on the 28th.
-There were 6 missed opportunities to check blood pressure.

Review of April 2015 MARs revealed:
-Computer generated entry to check weight once daily.
-The weight was left blank in 20 of the 30 opportunities with no reason for the omissions.
-The ranges of the weights taken were 104-109 pounds.
-Computer generated entry to check BP three times a week.
-Blood pressures were documented 7 of 13 opportunities with 6 missed opportunities.
-The ranges of these blood pressures were: 135/81 to 88/62.

Review of the May 2015 MARs revealed.
-Computer generated entry to check weight once daily and write on the MAR.
-There were weights for all days except the 18th and 22nd.
-Weights were documented on the 21st as 101, 23rd, 24th, and 25th all as 101 pounds.
-Computer generated entry to check BP three times a week.
-There was 1 missed opportunity on the 8th.

-Blood pressures were entered in 9 times with ranges as 100/58 to 123/72.

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D 276	Continued From page 47 Interview with the Wellness Coordinator on 05/26/15 at 10:15 a.m. revealed: -She did not know the weights and blood pressures were not being taken as ordered. -She thought the resident refused to have her weight and blood pressure taken sometime but that should be documented. Interview with the medication aide on 05/28/15 at 12:45 p.m. revealed: -They take the resident's blood pressure and record them. -She did not know why there were blanks with the blood pressures. -She noted at times the resident would refuse to have her weight taken. -She stated that should be recorded as a refusal on the MAR. 6. Review of Resident #10's FL-2 dated 12/12/14 revealed: - Diagnoses included Dementia, Diet Controlled Diabetes Mellitus, Lower Back Surgery, Alzheimer's Dementia, Parkinson's disease and Bipolar. - The resident is alert and oriented to person constantly, place constantly and time intermittently. Review of Resident #10's records revealed a physician's order dated 2/11/15 for cold pack to low back for 20 minutes at 2:00 P.M., 4:00 P.M., 6:00 P.M. and 8:00 P.M., also heat pack to low back at 9:00 A.M. and 11:00 A.M. for 20 minutes. Interview with Resident #10 on 5/20/15 at 9:50 A.M. revealed: - He denied ever having had hot and cold packs.	D 276		

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D 276	Continued From page 48 - He stated that they mentioned something about it yesterday "but I have never had it." Interview with Medication Aide on 5/22/15 at 10:20 A.M. revealed: - There are no heat packs or cold packs on medication cart for Resident #10. - Resident #10's family supplies the hot packs and the cold packs. Interview with Resident #10's family on 5/22/15 at 11:05 A.M. revealed: - Family denies purchasing any heat packs or cold packs for the resident's use. - The family member had never seen any heating pack or cold pack been used on resident's lower back or anywhere on his body. Interview with Pharmacist on 5/22/15 at 11:20 A.M. revealed: - The Pharmacist placed the treatment orders for cold pack to lower back and heat pack to lower back on the Medication Administration Record in February 2015. - They did not dispense any heat packs or cold packs to facility for Resident #10. - Pharmacy was not sure if they should send the heat packs and cold packs. - They had no paperwork stating that facility wanted them to send the cold packs and heat packs. A subsequent interview with the Medication Aide on 5/22/15 at 11:50 A.M. revealed: - When she arrived in February 2015 to work at the facility, there were some heat packs in a red box on the medication cart. - Since those heat packs finished, the staff had been using a heated towel to resident ' s lower back and bags filled with ice wrapped in a towel	D 276		

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D 276	Continued From page 49 for cold packs to lower back. Interview with a Nurse's Assistant (NA)/ Medication Aide (MA) on 5/22/15 at 12:15 P.M. revealed: - She saw the orders on the MAR for ice pack to lower back and heat pack to lower pack and asked if we had any, I was told no. - To her knowledge there was nothing else that was used. Interview with another NA/ MA on 5/26/15 at 9:55 A.M. revealed: - We use wet towels warmed in the steamer and covered with another towel as heat pack to resident ' s lower back. - For the ice packs we use ice in a bag wrapped with a towel to resident ' s lower back. - She had not seen any cold packs or heat packs for Resident #10. Review of Resident #10's March 2015 MAR revealed: - Treatment for the cold packs to lower back for Resident #10 was not documented as administered ten times in the month of March 2015. - Treatment for the heat packs to lower back for Resident #10 was not documented as administered twenty six times in the month of March 2015. Review of Resident #10's April 2015 MAR revealed: - Treatment for the cold packs to lower back for Resident #10 was not documented as administered sixty-three times in the month of April 2015. - Treatment for the heat packs to lower back for Resident #10 was not documented as	D 276		

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D 276	Continued From page 50 administered twenty-seven times in the month of April 2015. Interview with Wellness Coordinator on 5/26/15 at 2:43 P.M. revealed: - She was not sure why and if the MA did or did not do heat packs and ice packs to Resident #10 lower back. - When we receive treatment orders such as the cold packs to lower back and heat packs to lower back, we first see if the pharmacy will send us the cold and heat packs. - If we do not get the cold and heat packs from the pharmacy then we ask the family if they will get it out of pocket. - If we are not able to get cold or heat packs from pharmacy or family, we use heated towels and plastic bag with ice cubes wrapped in a towel for ice pack. - Blank areas in the MAR will need to be follow-up by myself, the Resident Services Director or the Administrator. Interview with the physician's assistant (PA) on 05/21/15 at 4:24 p.m. revealed: - Resident #10 was ordered hot/cold packs because he has severe chronic low back pain. - PA discovered during a visit on 04/23/15 that it had not been done or documented for the entire month of April 2015. - Staff did not give any reason of why these were not done. 7. Review of Resident #9's current FL-2 dated 12/23/14 revealed diagnoses of dementia with behavioral disturbances, hypertension, history of gastrointestinal bleed, right shoulder arthralgia, gastroesophageal reflux disease, chronic kidney disease, anemia, and atrial fbrillation.	D 276		

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D 276	Continued From page 51 Review of a physician's order for Resident #9 dated 12/24/14 revealed an order for blood pressure (BP) to be checked weekly. Review of March 2015 medication administration record (MAR) revealed: - An entry for resident's BP to be checked once a week at 8:00 a.m. - Resident's BP was not documented for 2 of 5 weeks, the week of 03/02/15 and 03/30/15. - Resident #9's BP documented for 3 out of 5 weeks ranged from 121/83 - 122/70. Review of April 2015 (MAR) revealed: - Resident's BP was not documented for 2 of 5 weeks, the week of 04/20/15 and 04/27/15. - Resident #9's BP was done on 3 out of 5 weeks and ranged from 116/73-132/68. Review of May 2015 MAR revealed BPs were taken as ordered by physician and ranged from 118/74-127/69. Interview with a medication aide on 05/22/15 at 1:20 p.m. revealed: - She was unsure if Resident #9's BPs were checked on the weeks they BPs were not documented. - Staff are supposed to document the blood pressure readings and initial on the MARs if the BPs are taken. Interview with the Wellness Coordinator (WC) on 05/26/15 at 1:45 p.m revealed: - She was unaware that BPs were not being taken as ordered by physician. - There were usually 2 staff (WC and a Supervisor/medication aide) that check behind the medication aides to assure the MARs are documented.	D 276		

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D 276	Continued From page 52 - She was supposed to check the MARs daily, but she did not have time. Interview with the Administrator on 05/22/15 at 1:10 p.m. revealed the BPS were not being checked as ordered. _____ Review of the facility's plan of protection dated 05/27/15 revealed: - Executive Director (ED) / Resident Services Director (RSD) will in-service medication aides currently working in the facility at time of plan of protection. - ED / RSD will in-service nursing staff not present by close of business on 05/28/15. - Facility will conduct weekly monitoring for 4 weeks of compliance on all incidental health care tasks. - Monthly monitoring will be done thereafter, to ensure all incidental health care tasks are being completed and documented. - Any devices or medical equipment necessary for immediate incidental health care tasks will be obtained for use within 24 hours. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 27, 2015.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.	D 282		

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D 282	Continued From page 53 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the Special Care Unit dining area was clean, orderly, and protected from contamination. The findings are: Interview with the Dietary Manager at 4:30pm on 5/22/15 revealed: - The kitchen staff work until 6:30pm to 7pm in the evenings. - Evening snacks and beverages are prepared and delivered to the SCU before the facility kitchen is closed. - The kitchen is locked overnight. - A key to the kitchen was left in the Special Care Unit nurse's workspace for the Supervisor-in-Charge to unlock the kitchen to remove uneaten evening snacks and soiled plates, cups and utensils from the SCU to the kitchen. - The dietary staff cleaned the dishes, cups, and eating utensils the next morning. - The dietary staff will dispose of foods and beverages left over from the previous evening snack. - He stated he was not aware foods, beverages, and soiled plates and cups were left in the SCU dining area all night long. - He was not aware that some SCU residents wandered around the Unit during the night. - He stated the Dietary Aide assigned to the breakfast shift must have cleaned the dining area and removed leftover snacks and beverages. - He will leave another key to the kitchen with the evening shift nursing Supervisor-in-Charge so nursing staff can remove soiled equipment used for dining and to place uneaten foods and beverages in the kitchen.	D 282		

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D 282	Continued From page 54 Observation on 05/26/15 at 6:15am in the SCU dining room revealed the following items in the counter seating area and in the kitchen sink area: - A 2-liter plastic pitcher containing approximately 1.5 liters ice tea that was at room temperature. - An open, 20-ounce bottle of cola containing approximately 4 ounces of cola, at room temperature. - Four empty, dirty 6-ounce plastic tumblers. - Two opened cups of yoghurt, at room temperature. - Two soiled spoons. - One Styrofoam plate, covered with a plastic plate cover, containing approximately 1/3rd cup wilted green salad with French dressing, 1 baked chicken thigh, 1 slice Italian bread, and ½ cup rice with mixed vegetables. Continued observation on 05/26/13 at 6:15am in the SCU dining room revealed a rolling cart parked in front of the ice dispenser in the SCU dining room held: - A large, uncovered stainless steel bowl containing approximately 1 gallon cracker snack mix. - A 4-ounce package of strawberry yoghurt, unopened and at room temperature. - A 2-liter plastic pitcher containing approximately 1 liter fruit punch that was at room temperature. - The cart was littered with cracker crumbs and beverage spills. Continued observation of the SCU dining area on 5/26/15 at 6:15am revealed: - Ten residents were dressed and congregating in the joint living room/dining room area. - One resident was seated at a dining room table. - Two residents were wandering in the dining room area. - One resident attempted to take cracker snack	D 282		

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D 282	Continued From page 55 mix from the stainless steel bowl with his bare hands, and was led back to the living room area by a Personal Care Assistant (PCA). - One resident pointed to the fruit punch, the PCA told the resident to wait for breakfast. Interview with the Dietary Supervisor at 6:45am on 5/26/15 revealed: - He had given an extra key to the kitchen to the evening Supervisor-in-Charge on Friday night. - He did not realize leftover foods and beverages were left out overnight in the dining area. - He did not realize the used cups, utensils, and plates were left out overnight in the dining area. - He would conduct staff training on food safety and again request nursing staff to unlock the kitchen and place all food, food containers, and soiled eating utensils, plates, and tumblers in the kitchen for dietary staff to clean up the next morning. Interview with the Medication Aide/Supervisor in Charge at 7am on 5/26/15 revealed: - She had been given a key to kitchen to use in the evening. - She stated she did not unlock the kitchen last night to store food and to place soiled eating and drinking equipment in the kitchen. - She stated the dietary staff take care of storing food and cleaning cups and utensils. - She thought she got a key to kitchen to fulfill resident requests for a food or beverage. - She did not know whose plate of food was left out all night, perhaps it was an employee's meal. Interview with the Administrator at 1:00pm on 5/26/15 revealed: - The Dietary Manager had told her of the leftover foods and beverages sitting out all night in the SCU.	D 282		

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D 282	Continued From page 56 - Nursing staff knew they were given a key to the kitchen to remove dirty dishes and leftover foods and beverages from the dining room. - Staff will receive training in keeping foods and beverages safe from contamination, and to keep the dining area clean and free of food and drink when there is no staff in the dining area to supervise resident consumption.	D 282		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to third shift staff waking residents up as early as 5:00 a.m. to get up and get dressed for the day. The findings are: Confidential staff interview revealed: - Third shift staff get up at least 14 residents in the special care unit (SCU) in the mornings. - The Special Care Unit Coordinator and the Administrator told third shift staff they had to get residents up. - They did not specify a time but staff would start getting residents up by at least 5:30 a.m. to have time to get them all up before first shift staff came. - Residents would complain and say it was way too early to get up. - Some of the SCU residents would fight staff	D 338		

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D 338	Continued From page 57 when they tried to get them up. Confidential interview with a second staff person revealed: - They start getting residents up a little after 5:00 a.m. on third shift. - Some residents get mad if they don't want to get up that early. - If a resident says no to getting up, she will come back in a few minutes and have them to at least get dressed and then they can lay back down in their beds. - First shift staff will get mad at third shift if the residents are not up when first shift starts. - Management is aware they are getting residents up because there is an assignment sheet. - A couple of residents have been taken off the list at the family's request. - The Administrator said she was going to try to cut down the list. - A couple of weeks ago, it went from 16 residents to 10 residents in the SCU. - There are about 4 to 5 residents to get up on the assisted living side. Confidential interview with a third staff person revealed: - They had a list of 16 residents they had to get up in the mornings on third shift. - There were usually 3 staff on the floor in the SCU but 5 assignments. - They usually start getting residents up between 5:15 a.m. and 5:30 a.m. and it usually took until 6:45 a.m. to get them up and dressed. - If they wake up a resident early and they don't want to get up they will leave them for first shift. - They will still wake up the residents the next morning even if they did not want to get up the previous morning to see if they want to get up.	D 338		

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D 338	Continued From page 58 - If they don't want to get up, they will let them sleep. - One resident in the SCU had complained about not wanting to get up early, so staff lets her sleep. Confidential interview with a fourth staff person revealed: - Third shift gets residents up in the mornings. - If they don't start getting residents up about 5:00 a.m. or 5:15 a.m., staff will be there after their shift ends at 7:00 a.m. - If a resident says they don't want to get up that is their right but first shift will complain about it. - At least one resident had complained about getting up early and having to sit to wait for breakfast. Interviews with residents and their family members during the initial facility tour on 05/20/15 from 10:00 a.m. to 12:30 p.m. revealed: - One resident of the Assisted Living Unit stated she refused to get up early, she did her own personal care and preferred to sleep until 10am. - Three residents of the Assisted Living Unit stated they always got up by 5:30am for their job before they moved to the facility, they did not mind getting up early at all. - Family members of 5 residents of the Special Care Unit (SCU) stated their loved one always awoke by 5 - 5:30am, that was their usual work schedule all their life. They did not mind having their loved one get up so early to shower and dress for the day, and their loved one never complained about getting up early to them. - One family member stated her loved one wanted to eat breakfast early when he got up early. She stated her loved one was confused why he had to sit and wait 2 hours for breakfast after he was showered and dressed.	D 338		

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D 338	Continued From page 59 Review of the SCU assignment sheets for showers, linen changes, laundry for 34 named residents of the SCU revealed 13 residents were to be up, washed, dressed and have their rooms cleaned by third shift staff. Interview with the SCU Medication Aide at 6:30 a.m. on 05/26/15 revealed: - Ten residents are gotten up "around 5:45 or 6am" to shower and dress before breakfast. - Three nursing staff work in the SCU on the overnight shift, but there are 4 assignment sheets. The fourth assignment sheet is shared by the 3 nursing staff. - Thirteen residents were scheduled to be showered by the end of the third shift (7am). - Two residents refused to get up early today, "We let them sleep later, it's their right if they don't want to get up early." - One resident who usually showered early was out of the facility today, he had been out of the facility since 5/22/15. - Some residents and their families have requested to never get up before 6:30 or 7am, because of ill health or it was not their usual habit to get up early. - Heavy care residents were not awakened early due to more time and staff needed to complete personal care, and only 3 staff on third shift. Observation of the SCU at 6:15 a.m. on 05/26/15 revealed: - Ten residents were up, dressed, and present in the communal living room/ dining room area. - Residents sat quietly in chairs in the living room and dining room, the television was playing. - Residents were not offered any beverage or food while waiting for breakfast. - Medications were administered to residents	D 338		

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D 338	Continued From page 60	D 338		

during this time period.
- One resident was seated at a table, asking for breakfast.
- Two residents wandered in and out of the dining room, looking at evening snacks and beverage left in the dining room from the previous day.

Observation of the SCU at 7:30 a.m. on 05/26/15 revealed:
- Twenty-three residents were waiting for breakfast in the communal living/dining area.
- Three residents were sleeping while seated in the communal living area.

Interview with NA from first shift on 5/22/15 at 12:15 P.M. revealed:
- When first shift comes in "around maybe 1/3 of the residents in the Secure Care Unit (SCU) would be up".
- She had not had or heard any one complain of getting up too early.

Interview with a resident on the SCU on 5/27/15 at 9:24 A.M. revealed:
- Resident does not like getting up early in the morning.
- She did not let staff know that she does not like getting up early in the mornings.
- She states "I don't argue with them".

Interview with another resident on the SCU on 5/27/15 at 9:53 A.M. revealed:
- I get up early, "around 5 o'clock I think".
- She does not particularly like getting up early.
- She had not told any staff she does not like getting up early.

Interview with Wellness Coordinator on 5/27/15 at 10:59 A.M. revealed:
- Residents are gotten up on last round at 6:00

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D 338	Continued From page 61 A.M. - She was not aware that residents were gotten up as early as 5:00 A.M. - Staff is not supposed to start getting up residents before 6:00 A.M. - One of the resident's family requested that she not be gotten up on third shift and was moved to first shift. - We asked residents what time they would like to get up and get their showers. - We use the information that we receive from the residents to make up our wake up and shower schedule. Review of the staff Assignment sheets revealed: - Fourteen residents are on assignment scheduled to be gotten up, washed and dressed on third shift. - Notation below reads that "all showers must be completed". - All assignment sheets with showers completed highlighted in yellow must be turned in at 6:30 A.M. Interview with a resident's family member on 5/27/15 at 11:30 A.M. revealed: - Resident have never complained about getting up too early. - Family member feels that resident would not be able to tell her what time she was getting up. Interview with another resident's family member on 5/27/15 at 11:32 A.M. revealed: - Resident does not really talk so she would not know if resident did not like been gotten up early. - Resident had never mentioned getting up too early to her. - "I don't know if she doesn't remember."	D 338		

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D 338	Continued From page 62 Interview with SCU Activity Director on 5/27/15 at 11:10 A.M. revealed: - Residents are gotten up between 6:00 A.M. and 8:00 A.M. - Five o'clock is a little too early. - We do have some residents that like to get up as early as five o'clock. - There are some residents that family says that they like to get up early. - Last round typically start at 6:00 A.M. Interview with Administrator on 5/27/15 at 1:30 P.M. revealed: - Staff starts to get residents up anywhere from 5:45 A.M. to 6:00 A.M. depending on how many residents third has to get up. - The last time she looked at assignment sheets there were only four residents per assignment sheet. - There are five assignment sheets. - Last time she spoke with the third shift Supervisor in Charge, she informed me that they start getting residents up as early as 5:30 A.M. to 5:45 A.M. - When making the get up schedule we take into consideration what residents personal preference is and what family member informs us of resident's history. - If resident does not want to get up that early we do not force them. Interview with Regional Nurse on 5/27/15 at 1:50 P.M. revealed that they may need to look into putting in place having a split shift to assist with late sleepers.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 63 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: TYPE A1 VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 7 residents (#12) observed during the medication passes, including errors with medications for blood thinning, acid reflux, and constipation, and 8 of 9 (#1, #2, #3, #4, #5, #6, #8, #12) sampled for review related to errors with medications for diabetes, high blood pressure, low potassium levels, infection, inflammation, swelling, constipation, breathing problems, allergies, cough and congestion. The findings are: 1. Review of Resident #6's FL-2 (with fax stamp date of 04/06/15) revealed: - Diagnoses included diabetes mellitus type II, subarachnoid hemorrhage, dementia, hypertension, and depression. - Order for fingerstick blood sugar (FSBS) to be checked before meals and at bedtime. - Order for Humalog sliding scale (no scale indicated). (Humalog insulin is rapid-acting insulin used to lower blood sugar.) - Order for Lantus insulin, 5 units at bedtime. (Lantus is long-acting insulin used to lower blood sugar.)	D 358		

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D 358	Continued From page 64 Review of a prescription dated 04/03/15 revealed an order for Humalog insulin per sliding scale: 150- 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units, 301 - 350 = 8 units, and 351 - 400 = 10 units. Review of Resident #6's closed record revealed he was admitted to the facility from another state on 04/06/15. Review of the April 2015 medication administration record (MAR) revealed: - Page 2 of 2 of the April 2015 MAR was missing. (Staff was unable to locate) - Printed entry for FSBS checks before meals and at bedtime scheduled for 7:30 a.m., 11:30 a.m., 4:30 p.m. and 8:00 p.m. - No entry for Humalog sliding scale insulin on the MAR. - No FSBS documented from admission on 04/06/15 through 04/12/15. - Only 5 documented FSBS: 120 on 04/13/15 at 7:30 a.m.; 118 on 04/13/15 at 11:30 a.m.; 124 on 04/13/15 at 4:30 p.m.; "HI" on 04/13/15 at 8:00 p.m.; and 536 on 04/14/15 at 7:30 a.m. - ["HI" blood sugar reading on most glucometers indicates blood sugar is greater than 600 according to most manufacturers.] - Printed entry for Lantus 5 units at bedtime scheduled for 9:00 p.m. - No Lantus was documented as administered on 4 of 8 nights: 04/06/15, and 04/10/15 - 04/12/15. - Lantus was documented as refused on 3 nights: 04/07/15 - 04/09/15. - Lantus was documented as administered on one occasion only: 04/13/15. Review of pharmacy dispensing records and	D 358		

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D 358	Continued From page 65 delivery sheets for April 2015 revealed: - No Humalog was dispensed to Resident #6. - One vial of Lantus insulin was dispensed on 04/06/15 and delivered to the facility on 04/06/15 at 10:00 p.m. - One Lantus insulin pen was dispensed on 04/07/15 and delivered to the facility on 04/07/15 at 9:59 p.m. Interview with the pharmacist on 05/28/15 at 10:44 a.m. revealed: - They dispensed 1 vial of Lantus on 04/06/15. - They dispensed 1 Lantus insulin pen on 04/07/15. - She stated the facility must have requested the pen after the vial was dispensed on 04/06/15. - Humalog insulin was never dispensed for Resident #6 but the order was on file in the computer. - They usually send all medications unless the facility requests them not to send something. - She was unsure why the Humalog was not sent to the facility with the initial medications for Resident #6. - There was no documentation in the pharmacy's notes regarding the Humalog. - There was no documentation that the facility contacted the pharmacy to obtain the Humalog. - She was unable to print a duplicate copy of the resident's MAR that was sent to the facility upon admission since the resident was inactive in their computer system. Confidential staff interview revealed: - Resident #6's spouse, who was also a resident at the facility, reported to the staff person that no one ever checked Resident #6's blood sugar. - Staff person checked the April 2015 MAR and did not see any initials documented beside the entry for blood sugar checks.	D 358		

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D 358	Continued From page 66 - Staff person reported to medication aide on duty about Resident #6's blood sugars not being checked. - Medication aide told staff person she did not know anything about the resident's blood sugar. - Resident #6 did not have a glucometer. Interview with medication aide on 05/28/15 at 2:00 p.m. revealed she did not remember the resident having a sliding scale insulin. Interview with a second medication aide on 05/27/15 at 4:00 p.m. revealed: - The resident's blood sugar was not checked because he did not have a glucometer when he was admitted. - She did not contact the pharmacy, family, or physician about the resident not having a glucometer. - He did not have a glucometer until 04/13/15 when the facility got one from a local retail pharmacy. - She could not recall which brand glucometer was purchased and used for the resident. - She checked the resident's blood sugar when it registered "HI" on the machine. - She was not sure what "HI" meant. - She did not recheck the blood sugar that night and she did not notify the physician of the "HI" reading. - She did not recall Resident #6 being on sliding scale insulin. - She never administered any sliding scale insulin. - She was not sure about the resident's Lantus insulin. Interview with the Wellness Coordinator (WC) on 05/27/15 at 4:00 p.m. revealed: - Resident #6 was admitted without a	D 358		

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glucometer or any medications.
- They thought the family was bringing in a glucometer.
- The facility purchased a glucometer because the family would not bring a glucometer.
- She could not recall the date it was purchased but they started using it when it was purchased.
- She could not recall the brand of glucometer that was purchased.
- One of the physician's assistants (PA) from the facility's primary medical group saw the resident on 04/14/15 and said the resident was cold, clammy, and pale.
- The PA had the resident sent to the emergency room.
- They went by the orders on the FL-2 and the printed prescriptions brought in by the family upon admission.
- She was unsure why the Humalog sliding scale was not sent by the pharmacy or administered because it was included in the orders.
- Staff should have contacted the pharmacy to obtain the sliding scale insulin.

Interview with Resident #6's responsible party on 05/28/15 at 10:40 a.m. revealed:
- Resident #6 was admitted to the facility on 04/06/15.
- The resident did not bring any medications with him upon admission.
- The resident had suffered a fall prior to admission and had a 1mm brain bleed upon admission to the current facility.
- He was not aware the resident's blood sugar was not being checked.
- Facility staff never asked the family for a glucometer.
- The resident was sent out on 04/14/15 due to being "out of sorts".
- The resident was checked out at the local

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hospital near the facility and then transferred to a larger hospital.
- The resident did not return to the facility because he was transferred to a skilled nursing facility.

Interview with a physician's assistant (PA) on 05/28/15 at 12:00 noon revealed:
- She saw Resident #6 for his initial visit with the medical group on 04/09/15.
- The resident did not have a glucometer at that time.
- It was her understanding from staff that the family was going to provide a glucometer.
- The resident was a new admission to the facility and they were in the process of getting everything in order for him.
- The facility usually requested an order for a glucometer if the family did not bring in one.
- The facility did not request an order for a glucometer.
- The facility had not notified her after that day on 04/09/15 that the resident continued not to have a glucometer.
- She was unaware after 04/09/15 that the resident was not receiving blood sugar checks or sliding scale insulin.
- She was not notified of a blood sugar reading of "HI".
- Her coworker, another PA, went to the facility on 04/14/15 for a routine visit.
- Her coworker found Resident #6 in his room in bed covered in a blanket with urine on the floor.
- The resident was alert but not oriented and said he was cold.
- Her coworker had the facility call emergency services and resident was taken to the hospital.

Interview with the second PA on 05/28/15 at 1:00 p.m. revealed:

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D 358	Continued From page 69 - She never received a request for a glucometer for Resident #6. - She was not notified of the resident's "HI" blood sugar reading on 04/13/15. - She had not been notified of any issues with Resident #6's blood sugars prior to 04/14/15. - Her first visit with Resident #6 was on 04/14/15, the day he went to the hospital. - Staff informed her that morning when she arrived to the facility for routine visits taht Resident #6's blood sugar was 536 that morning. - When she entered Resident # 6's room on 04/14/15, the floor was covered with urine. - The resident was laying on his side in the bed saying he was very cold. - The resident complained he could not see very well out of his right eye and it had been that way for a few days. - The resident's blood pressure was low (unsure of exact reading). - Resident #6 was very pale and clammy. - She requested resident be sent out to the hospital immediately. Review of a hospital discharge summary for Resident #6 revealed: - Resident #6 was admitted to the hospital on 04/14/15 with one of chief complaints being hyperglycemia (high blood sugar). - The resident was noted to have uncontrolled diabetes with a Hemoglobin A1C greater than 12. [Hemoglobin A1C is a blood test used to determine how well blood sugar has been controlled over the last 2 to 3 months. It is recommended for diabetics Hemoglobin A1C to be less than 7.] 2. Review of Resident #1's current FL-2 dated 10/20/14 revealed diagnoses included acute respiratory infection, shortness of breath,	D 358		

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D 358	Continued From page 70 delirium, edema, hypertension, and arthritis. A. Review of Resident #1's record revealed an order dated 01/15/15 for Bactrim SS (single strength) take 1 tablet at bedtime for urinary tract infection (UTI) prophylaxis. [Bactrim is an antibiotic used to treat and prevent infections.] Review of the March 2015 medication administration record (MAR) revealed: - Entry for Bactrim 1 tablet at bedtime for UTI prophylaxis and it was scheduled to be administered at 8:00 p.m. - Bactrim was not documented as administered on 03/02/15 - 03/04/15. - Documentation on the back of the MAR indicated Bactrim was not available and the pharmacy was contacted on 03/03/15. Review of pharmacy dispensing records revealed: - 30 Bactrim tablets (30 day supply) were dispensed on 01/15/15. - 30 Bactrim tablets (30 day supply) were dispensed on 03/04/15. - 23 Bactrim tablets (23 day supply) were dispensed on 04/16/15. - 20 Cipro 500mg tablets (10 day supply) were dispensed on 04/17/15. Review of the April 2015 MAR revealed: - Bactrim was scheduled to be administered at 8:00 p.m. - Bactrim was documented as refused on 04/02/15. - Staff initials were circled on 04/04/15, 4/05/15, 04/07/15, 04/09/15, 04/10/15, and 04/14/15. - Documentation was blank on 04/06/15, 04/08/15, and 04/15/15 - 04/17/15. - Bactrim was documented as administered on	D 358		

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D 358	Continued From page 71 04/11/15 - 04/13/15. - Staff documented Bactrim was unavailable on 04/05/15. - There was no other documentation of reason the Bactrim was not administered. Review of shift notes for Resident #1 revealed: - 04/03/15 (1st shift): resident more agitated and confused. - 04/03/15 (2nd shift): please call pharmacy, Resident #1 out of Bactrim. - 04/04/15 (3rd shift): please call pharmacy for Resident #1's Bactrim. Review of an incident report form for Resident #1 revealed: - Resident #1 had a fall on 04/12/15 at 11:00 a.m. - Staff member found resident in sitting area in front of building and observed notable injuries and bleeding (scrapes and lacerations) on face and finger. - Resident stated he just fell. - Resident was sent to the emergency room. Review of a fax to the physician dated 04/12/15 revealed: - Resident #1 had a fall at approximately 11:00 a.m. and was sent to the emergency room and treated and released. - The resident sustained injuries to his left face and forehead and left pinky finger. - The resident was treated at the emergency room for closed head injury. Review of an emergency room form dated 04/12/15 revealed: - Resident #1 was diagnosed with a closed head injury. - The resident did not suffer a concussion.	D 358		

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D 358	Continued From page 72 Interview the Marketing Director on 05/26/15 at 10:15 a.m. revealed: - She saw Resident #1 sitting on the side walk on 04/12/15 and he said he fell. - He usually gets confused when he has a urinary tract infection. - The resident was sent to the emergency room because he hit his head. Interview with a medication aide on 05/26/15 at 11:05 a.m. revealed: - She was working when Resident #1 fell in April 2015. - The resident was disoriented and talking about someone had stolen his car. - The resident was usually disoriented if he had a urinary tract infection and he had not walked out of the building like that before to her knowledge. Review of a physician's assistant visit dated 04/14/15 revealed: - The visit was for a follow-up to a fall and to order urinalysis. - The resident had abrasion to left eye and skin tear to left pinky. Review of a lab form revealed urinalysis for Resident #1 was collected on 04/15/15. Review of a physician's assistant visit dated 04/16/15 revealed: - Order to start Cipro 500mg 1 tablet twice a day for 10 days. - PA wrote to "PLEASE" have Bactrim to be delivered from pharmacy. Hold during administration of Cipro for 10 days then restart Bactrim. Review of lab form for Resident #1 dated	D 358		

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D 358	Continued From page 73 04/18/15 revealed urine culture showed "multiple bacterial morphotypes present". Review of the April 2015 MAR revealed: - Bactrim was documented as administered on 04/18/15. - Bactrim was documented as held on 04/19/15 - 04/28/15. - Documentation was blank on 04/29/15 and 04/30/15. - Handwritten entry for Cipro 500mg 1 tablet twice a day for 10 days. - The order was transcribed on 04/16/15. - The first dose was not documented as administered until 04/19/15 at 8:00 p.m. - One dose on 04/24/15 at 8:00 p.m. was blank with no reason for the omission. Review of the May 2015 MAR revealed: - Bactrim was documented as ordered daily except one omission on 05/18/15. - No reason for the omission was documented. Review of pharmacy dispensing records revealed 31 Bactrim tablets (31 day supply) were dispensed on 05/09/15. Interview with Resident #1 on 05/26/15 at 10:22 a.m. revealed: - He could not recall if he had any urinary tract infections. - He was unsure what kind of medications he took. - He denied any current symptoms of urinary tract infection. Interview with the Administrator on 05/22/15 at 1:20 p.m. revealed: - She had worked at the facility for about 4 months.	D 358		

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D 358	Continued From page 74 - When she started there was no system to check the medications. - They have since implemented a "hot box", an order tracking form. - Medication aide on duty is responsible for implementing orders. - The Wellness Coordinator was monitoring new orders and found some errors. - They changed system to have Wellness Coordinator transcribe new orders about 2 and ½ weeks ago. - Medication aides were in-serviced on transcribing order and implementing orders if the Wellness Coordinator was not here. - The facility has also been without a nurse since February 2015. - The facility's nurse was responsible for overseeing the medications and making sure they were administered as ordered. Interview with the Wellness Coordinator (WC) on 05/26/15 at 11:50 a.m. revealed: - Medication aides transcribe orders and fax orders to the pharmacy. - A second check was supposed to be done by another medication aide or management to check accuracy of the MAR. - Staff are supposed to use medication order tracking sheet and put it in the new order tracking book. - WC tried to check the tracking book daily or at least every 48 hours. - She faxed a signed physician's order sheet with the Bactrim to the pharmacy on 04/16/15 when it was brought to her attention. - The pharmacy said no one had called to let them know it was out. - She did not document her contact with the pharmacy. - The Bactrim was sent the same day she faxed	D 358		

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the physician's order sheet on 04/16/15.
- Staff should call the pharmacy if a medication is unavailable and let the WC aware.
- WC was unaware Resident #1's Bactrim was unavailable until 04/16/15.
- WC was supposed to check the MARs for accuracy daily but she was not doing the checks that often due to time restraints.
- WC stated it had "been a while" since she had checked the MARs.

Interviews with the pharmacist on 05/26/15 at 11:21 a.m. and 05/27/15 at 3:40 p.m. revealed:
- A 30 day supply of Bactrim was dispensed on 03/04/15.
- There were no refills left on this prescription.
- The pharmacy sent a no refill list to the facility about 2 to 3 weeks before the next batch fill was due.
- The facility was supposed to use that list to obtain any needed refills for routine cycle fill medications.
- A medication aide contacted the pharmacy on 04/11/15 and asked about the Bactrim and stated the resident had been out of the medication for 4 days.
- Pharmacist told the medication aide they would need a prescription for further refills.
- Pharmacist called in 3 tablets to the back-up pharmacy on 04/11/15 to give the facility time to get a refill order.
- Pharmacy did not receive a refill order from the facility for the Bactrim until 04/16/15 at 5:43 p.m.
- Pharmacy dispensed 23 Bactrim tablets on 04/16/15, enough to last until the next batch fill on 05/09/15.
- The Bactrim tablets were delivered to the facility after 8:00 p.m. on 04/17/15 due to receiving the order late on 04/16/15.
- They received the order for Cipro on 4/16/15 at

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D 358	Continued From page 76 5:43 p.m. and it was filled and delivered on 04/17/15. - It was sent in the regular delivery on 04/17/15 which would have been delivered after 8:00 p.m. - Medications are sent out with the regular delivery unless the facility requested to have them sent by back-up pharmacy. - Medications are sent out with the regular delivery unless the facility requested to have them sent by back-up pharmacy. Interview with the physician's assistant (PA) on 05/21/15 at 4:24 p.m. revealed: - Resident #1 had an order to receive a prophylactic antibiotic to prevent urinary tract infections. - He did not receive the antibiotic for several days because staff failed to get refills - The resident developed a urinary tract infection and wandered outside under the porch awning and had a fall. - The resident was sent to the emergency room and had significant ocular bruising to the head. - The resident is usually alert and oriented to self. - The resident had 2 or 3 wandering episodes that were directly correlated with urinary tract infections. - She recently evaluated the resident to determine if he needed to be in the SCU but she decided not to because his wandering was directly related to urinary tract infections. B. Review of Resident #1's record revealed a physician's order dated 10/30/14 for Lasix 20mg 1 tablet daily as needed for with gain of 3 pounds in 24 hours or 5 pounds in 72 hours. [Lasix is a diuretic used to treat edema (swelling)] Review of the March 2015 medication	D 358		

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D 358	Continued From page 77 administration record (MAR) revealed: - Entry for Lasix 20mg 1 tablet daily as needed for weight gain of 3 pounds in 24 hours or 5 pounds in 72 hours was included on the MAR. - There was no documentation that any prn (as needed) Lasix had been administered on 6 of 6 occasions that it would have been required. - Weight of 227 pounds (lbs.)on 03/20/15 and 232 lbs. on 03/23/15, a 5 pound gain, but no prn Lasix was documented as administered. - Weight of 227 lbs. on 03/05/15 and 232 lbs. on 03/06/15, a 5 pound gain, but no prn Lasix was documented as administered. - Weight of 221 lbs. on 03/07/15 and 225 lbs. on 03/08/15, a 4 pound gain, but no prn Lasix was documented as administered. - Weight of 225 lbs. on 03/14/15 and 231 lbs. on 03/15/15, a 6 pound gain, but no prn Lasix was documented as administered. - Weight of 227 lbs. on 03/20/15 and 233 lbs. on 03/21/15, a 6 pound gain, but no prn Lasix was documented as administered. - Weight of 230 lbs. on 03/26/15 and 233 lbs. on 03/27/15, a 3 pound gain, but no prn Lasix was documented as administered. - No weights documented on 03/01/15, 03/03/15 and 03/22/15. - Without weights, facility was unable to determine if prn Lasix would have been required on those 3 days. Review of the April 2015 MAR revealed: - There was no documentation that any prn (as needed) Lasix had been administered on 2 of 2 occasions that it would have been required. - Weight of 233 lbs. on 04/09/15 and 236 lbs. on 04/10/15, a 3 pound gain, but no prn Lasix was documented as administered. - Weight of 231 lbs. on 04/14/15 and 237 lbs. on 004/16/15, a 6 pound gain, but no prn Lasix was	D 358		

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GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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
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documented as administered.
- No weights documented on 19 of 30 days in April 2015.
- Without weights, facility was unable to determine if prn Lasix would have been required on those 19 days.

Review of the May 2015 MAR revealed:
- There was no documentation that any prn (as needed) Lasix had been administered on 3 of 3 occasions that it would have been required.
- Weight of 231 lbs. on 05/06/15 and 238 lbs. on 05/07/15, a 7 pound gain, but no prn Lasix was documented as administered.
- Weight of 233 lbs. on 05/11/15 and 239 lbs. on 05/12/15, a 6 pound gain, but no prn Lasix was documented as administered.
- Weight of 233 lbs. on 05/15/15 and 237 lbs. on 05/16/15, a 4 pound gain, but no prn Lasix was documented as administered.
- No weights documented on 05/10/15 and 05/17/15.
- Without weights, facility was unable to determine if prn Lasix would have been required on those 2 days.

Interview with a medication aide on 05/22/15 at 2:00 p.m. revealed:
- She was unaware of the order for prn Lasix.
- She administered the resident's scheduled dose of Lasix 20mg every morning but she had not noticed the order for prn Lasix.
- The personal care aides weigh the residents and report weights to the medication aides and they document them on the MAR.
- She had no explanation for the missing weights for Resident #1.

Interview with a personal care aide (PCA) on 05/27/15 at 9:05 a.m. revealed:

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- The medication aides let the PCAs know who needed to be weighed each day.
- The PCAs weighed the residents and usually wrote it on a loose piece of paper and gave it to the medication aides to document in the MARs.
- She reported if a resident was weighed, it should be documented on the MARs.
- She had no explanation for the missing weights for Resident #1.

Interview with Resident #1 on 05/26/15 at 10:22 a.m. revealed:
- He was unsure what kind of medications he took.
- He denied any current problems with swelling or shortness of breath.
- His lower legs did not appear swollen.
- He thought he had been weighed one time.

Interview with the Wellness Coordinator (WC) on 05/26/15 at 11:50 a.m. revealed:
- Staff had been trained to read the MARs and administer medications as ordered.
- She was unaware of the missing weights for Resident #1.
- She was unaware staff was not following the prn Lasix order.
- She had not been able to check MARs in a while due to time constraints.

Interview with the physician's assistant on 05/28/15 at 12:00 noon revealed:
- She was unaware staff was not weighing the resident or giving the prn Lasix as ordered.
- The resident has not had a lot of swelling upon physical exam or shortness of breath.

C. Review of Resident #1's record revealed a physician's order for Ketoconazole 2% shampoo, use 2 days per week, massage with deep

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D 358	Continued From page 80 pressure on scalp and in and around both ears. (Ketoconazole shampoo is an antifungal used to treat scaling, itching and flaking of the scalp.) Review of the May 2015 medication administration record (MAR) revealed: - Handwritten entry dated 05/14/15 for Ketoconazole 2%, use shampoo 2 days per week. - No days or times were scheduled for the medicated shampoo to be administered. - No documentation that any Ketoconazole shampoo had been administered. Observation of medications on hand on 05/22/15 revealed one full 4 ounce bottle of Ketoconazole 2% shampoo. Interview with the medication aide on 05/22/15 at 3:55 p.m. revealed: - She had not noticed the order on the MAR because there was no scheduled time documented on the MAR. - She had not used the Ketoconazole shampoo on the resident. Interview and observation of Resident #1 on 05/26/15 at 10:22 a.m. revealed: - His scalp itches sometimes. - He had not been administered any medicated shampoo to his knowledge. - There was dry, flaky skin around his hairline and on the top of his ears. Interview with the pharmacist on 05/26/15 at 11:21 a.m. revealed: - The order for Ketoconazole shampoo was received on 05/15/15 at 1:33 p.m. - It was dispensed and sent out in the delivery that same day on 05/15/15.	D 358		

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D 358	Continued From page 81 Interview with the Wellness Coordinator (WC) on 05/26/15 at 11:50 a.m. revealed: - Staff had been trained to read the MARs and administer medications as ordered. - She was unaware of the Ketoconazole had not been administered to the resident. - She had not been able to check MARs in a while due to time constraints. 3. Review of Resident #5's current FL-2 dated 11/13/14 revealed diagnoses included diabetes mellitus type 2, hypothyroidism, osteoarthritis with chronic pain, depression, vertigo, morbid obesity, cutaneous candidiasis, hypertension, chronic venous stasis, peripheral neuropathy, and hypoalbuminemia. A. Review of Resident #5's record revealed a physician's order dated 01/01/15 for fingerstick blood sugars (FSBS) before meals and at bedtime with Humalog insulin according to the sliding scale: 70 - 130 = no insulin; 131 - 180 = 2 units; 181 - 240 = 4 units; 241 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; >400 = 12 units and call physician. [Humalog is a rapid-acting insulin that lowers blood sugar.) Review of the March 2015 medication administration record (MAR) revealed: - Humalog sliding scale order was handwritten on the MAR and scheduled to be administered at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. - Humalog was not documented as administered on 19 occasions when the FSBS would have required administration. - On 19 occasions, the FSBS ranged from 140 - 243 and would have required 2 to 4 units of insulin. - For example, FSBS was 219 on 03/21/15 at	D 358		

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D 358	Continued From page 82 7:30 a.m., 194 at 11:30 a.m. on 03/12/15, 224 at 4:30 p.m. on 03/02/15, and 218 at 8:00 p.m. on 03/30/15 but MAR was blank and no insulin was documented as administered. - The wrong amount of insulin was administered on 2 occasions. - FSBS 175 at 7:30 a.m. on 03/22/15 and 4 units were documented but 2 were required. - FSBS 129 at 4:30 p.m. on 03/15/15 and 2 units were documented but none was required. - FSBS was not documented on 10 occasions with no reasons for the omissions. - Staff could not determine if Humalog would have been required on those 10 occasions. - For example, no FSBS on 03/29/15 at 7:30 a.m., 03/21/15 at 11:30 a.m., 03/01/15 at 4:30 p.m., and 03/10/15 at 8:00 p.m. - FSBS ranged from 104 - 447 from 03/01/15 - 03/31/15. Review of the April 2015 MAR revealed: - Humalog sliding scale order was handwritten on the MAR and scheduled to be administered at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. - Humalog was not documented as administered on 61 occasions when the FSBS would have required administration. - On 61 occasions, the FSBS ranged from 136 - 388 and would have required 2 to 10 units of insulin. - For example, FSBS was 374 on 03/06/15 at 7:30 a.m., 363 at 11:30 a.m. on 03/09/15, 361 at 4:30 p.m. on 03/07/15, and 388 at 8:00 p.m. on 03/18/15 but MAR was blank and no insulin was documented as administered. - The wrong amount of insulin was administered on 1 occasion. - FSBS 390 at 4:30 p.m. on 03/27/15 and 8 units were documented but 10 were required. - FSBS was not documented on 8 occasions	D 358		

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with no reasons for the omissions.
- It could not be determined if Humalog would have been required on those 8 occasions.
- For example, no FSBS on 03/1815 at 11:30 a.m., 03/08/15 at 4:30 p.m., 03/29/15 at 8:00 p.m., and 03/30/15 at 8:00 p.m.
- FSBS ranged from 99 - 415 from 04/01/15 - 04/30/15.

Review of the May 2015 MAR revealed:
- Entry dated 05/14/15 for Humalog sliding scale with first dose documented as administered on 05/14/15.
- FSBS were included on the MAR and scheduled at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m.
- Humalog was not documented as administered on 79 occasions when the FSBS would have required administration.
- 44 of the 79 occasions were from 05/01/15 - 05/13/15 when the order was not transcribed on the MAR.
- On 79 occasions, the FSBS ranged from 132 - 290 and would have required 2 to 6 units of insulin.
- For example, FSBS was 271 on 05/23/15 at 7:30 a.m., 289 at 11:30 a.m. on 05/13/15, 290 at 4:30 p.m. on 03/22/15, and 288 at 8:00 p.m. on 05/24/15 but no insulin was documented as administered.
- The wrong amount of insulin was administered on 1 occasion.
- FSBS 345 at 11:30 a.m. on 05/14/15 and 10 units were documented but 8 were required.
- FSBS was not documented on 05/06/15 with no reason for the omissions.
- It could not be determined if Humalog would have been required on that occasion.
- FSBS ranged from 108 - 375 from 05/01/15 - 05/27/15.

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D 358	Continued From page 84 Interview with a medication aide on 05/27/15 at 10:40 a.m. revealed: - When the sliding scale order was changed on 01/01/15, the new order never printed on the MARs. - The old order continued to print on the MARs so staff would have to mark through it and handwrite the new order. - She was unsure if the pharmacy had a copy of the Humalog order dated 01/01/15 but "they should". - The old order was marked through on the May 2015 MAR but staff failed to transcribe the more current Humalog order. - She noticed the error on 05/14/15 and transcribed the Humalog sliding scale on the MAR and that was when staff began to administer it for the month of May 2015. - She did not notify the physician that the resident did not receive sliding scale insulin from 05/01/15 - 05/13/15. - When sliding scale insulin is administered, staff documents it on the MAR, usually on the back of the MAR. - If it was not documented, the sliding scale was not administered. Interview with a second medication aide on 05/27/15 at 10:42 a.m. revealed: - If sliding scale insulin was administered, it would be documented on the back of the MARs. - She had no explanation for Resident #5's sliding scale insulin not be administered as ordered. Review of pharmacy dispensing records for 01/01/15 - 05/22/15 revealed: - One 10ml vial of Humalog was dispensed on 02/12/1.	D 358		

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D 358	Continued From page 85 - One 10ml vial of Humalog was dispensed on 03/10/15. - One 10ml vial of Humalog was dispensed on 04/22/15. Review of medications on hand on 05/27/15 revealed: - One 10ml vial of Humalog dispensed on 04/22/15. - Staff had documented an open date of 04/23/15 on the vial. Interview with the Administrator on 05/27/15 at 10:25 a.m. revealed: - She was unaware of the errors with Resident #5's sliding scale insulin. - She was unaware of a system to monitor administration and documentation of sliding scale insulin. - She stated they would start a system to monitor the insulin. Interview with the Wellness Coordinator on 05/27/15 at 10:30 a.m. revealed: - She was unaware staff was not administering Resident #5's Humalog as ordered. - Staff had not notified her that they sliding scale insulin order had been left off the MAR for the first 2 weeks of May 2015. - She was unaware of a system to monitor sliding scale insulin. Interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed: - Staff checks her blood sugar at least 3 times a day. - She gets insulin about 3times a day sometimes depending on her blood sugar. - She gets Lantus insulin at bedtime.	D 358		

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D 358	Continued From page 86 Interview with the pharmacist on 05/27/15 at 3:40 p.m. revealed: - They never received the order change for Humalog on 01/01/15. - If received, the MARs would have been updated to reflect the change and staff would not have to rewrite the sliding scale order each month. B. Review of Resident #5's record revealed: - Physician's order dated 05/14/15 for Flonase Nasal Spray 50mg, use 2 sprays intranasal once daily. (Flonase is used to treat allergy symptoms.) - No confirmation was attached to indicate the order was faxed to the pharmacy. Review of the May 2015 medication administration record (MAR) revealed: - Handwritten entry dated 05/14/15 for Flonase 50mg, 2 sprays into each nostril every day. - Flonase was scheduled to be administered at 8:00 a.m. - There was no documentation to indicate any Flonase had been administered to the resident. - No reasons for the omissions were documented. Review of medications on hand on 05/27/15 revealed there was no Flonase available for Resident #5. Interview with the medication aide on 05/27/15 at 1:05 p.m. revealed: - She had never known Resident #5 to have any nasal spray. - She had not administered any nasal spray to Resident #5. - She had not noticed the order written on the MAR for the Flonase.	D 358		

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D 358	Continued From page 87 - Medication staff on duty when an order is received are supposed to fax the order to the pharmacy, staple the confirmation to it and fill out an order tracking form. - She did not see confirmation or tracking form for the Flonase. - She would contact the pharmacy and send the order to get the Flonase. Interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed: - She had not received any nasal spray. - She denied any current allergy symptoms. Interview with the pharmacist on 05/27/15 at 3:40 p.m. revealed: - No Flonase had been dispensed for Resident #5. - They did not receive the order dated 05/14/15 for Flonase until today on 05/27/15. C. Review of Resident #5's record revealed: - Order dated 05/12/15 for Mucinex DM 1 tablet twice daily for 5 days then as needed for cough. (Mucinex DM is for cough and congestion.) - Order dated 05/12/15 for Albuterol inhaler, 2 puffs 3 times a day for 5 days, then as needed for shortness of breath. (Albuterol is used to treat breathing problems by increasing air flow to the lungs.) Review of the May 2015 medication administration record (MAR) revealed: - Handwritten entry for Mucinex DM take 1 tablet twice a day for 5 days. - Staff documented 6 doses of Mucinex DM were administered at 8:00 a.m. and 8:00 p.m. from 05/13/15 - 05/15/15. - Mucinex DM was administered 3 days instead of 5 days.	D 358		

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D 358	Continued From page 88 - Handwritten entry for Albuterol 2 puffs 3 times a day for 5 days. - Albuterol was scheduled to be administered at twice a day at 8:00 a.m. and 8:00 p.m. instead of 3 times a day as ordered. - Staff documented Albuterol was administered from 05/13/15 - 8:00 a.m. on 05/16/15 instead of 5 days as ordered. Review of medications on hand on 05/27/15 revealed: - 10 Mucinex DM tablets were dispensed on 05/12/15 but only 4 tablets had been used. - One Albuterol inhaler was dispensed on 05/12/15 with instructions to give 2 puffs 3 times a day. Interview with the medication aide on 05/27/15 at 1:05 p.m. revealed: - Medication aides on duty were responsible for implementing and transcribing new orders on the MAR. - She was unsure why the Mucinex DM and Albuterol were not administered 5 days as ordered. - She stated the Albuterol times were incorrect and should have noted 3 times to give the medication. - Staff had been trained to compare the MARs with the medication labels when administering medications. Interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed: - She had taken some medication for congestion for a few days but she was unsure how long she took the medication. - She felt like her congestion was better. - She used an inhaler also but could not recall how many times a day.	D 358		

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D 358	Continued From page 89 - She stated the inhaler helped her breathing. - She still had shortness of breath when she moves around. 4. Review of Resident # 2's current FL2 dated 4/23/15 revealed: -Diagnoses of Liver Cirrhosis, Diabetes Mellitus, Hypertension, Depression and High Cholesterol -Note to refer to hospital discharge summary for medications. Review of Resident #2's hospital discharge summary dated 4/23/15 revealed a medication order for Lasix 20 mg 2 tabs twice a day. (Lasix is a diuretic.) Review of Resident #2's April 2015 Medication Administration Report (MAR) revealed: -An entry on the MAR for Lasix 20 mg 1 tab by mouth twice a day scheduled for administration at 8:00am and 8:00pm -Lasix 20 mg. twice daily was documented as administered from 4/23/15 to 4/30/15, instead of Lasix 40 mg. twice daily. Review of Resident #2's May 2015 medication administration record (MAR) revealed: -Computerized entry on the MAR for Lasix 20 mg. once daily at 2 pm. - Lasix 20 mg. once daily at 2 pm was documented as administered from 5/1/15 to 5/12/15 . Interview with the medication aide on 5/27/15 at 2:35pm revealed staff were following the order dated 4/17/15 for Lasix 20 mg. 1 tab daily at 2pm. Review of a physician's order dated 5/12/15 for Resident #2 revealed an order for Lasix 20mg to be administered one time a day.	D 358		

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D 358	Continued From page 90 Review of Resident #2's May 2015 medication administration record (MAR) revealed Lasix 20 mg. once daily at 2 pm was documented as administered from 5/13/15 to 5/15/15 . Review of a hospital discharge summary dated 5/20/15 revealed: -Resident # 2 was sent to the hospital on 5/15/15 due to headache and requested to go to the hospital. - Medication orders included Lasix 20 mg. 2 tablets twice daily. Review of Resident #2's May 2015 medication administration record (MAR) on 5/24/15 revealed: - Handwritten entry dated 5/20/15 for Lasix 20 mg. 2 tablets twice daily with administration times of 8 am and 2 pm. - Lasix 40 mg. was only documented as administered twice daily on 05/21/15 at 8 am and 2 pm, from 05/21/15 through 5/24/15. Interview with medication aide on 5/27/15 at 2:35pm revealed she was unsure why the Lasix was not given on 5/22/15, 5/23/15 and 5/24/15. Review of a facility incident report dated 5/25/15 revealed: - Resident # 2 pulled call bell and told staff she needed to go to the emergency room due to she could not breathe. -Resident # 2 was sent to hospital at 5:35 am on 5/25/15. Interview with a medication aide on 5/26/15 revealed Resident # 2 was sent to the hospital due to shortness of breath and was still at the hospital.	D 358		

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D 358	Continued From page 91 Review of Resident #2 ' s pharmacy dispensing record from March 2015- May 2015 revealed: -31 tablets of Lasix were dispensed on 3/9/15. -30 tablets of Lasix were dispensed on 4/9/15. -15 tablets of Lasix were dispensed on 5/21/15. Review of medications on hand on 5/27/15 at 2:30pm revealed there were only 3 doses of the Lasix 20 mg. missing from the Lasix package dispensed on 5/21/15. Interview with Administrator on 5/27/15 at 3:15pm revealed: -She was unaware that medications were not being given or MARs were not being documented. 5. Review of Resident #3's current FL-2 dated 03/12/15 revealed: -Diagnoses of congestive heart failure exacerbation and dementia. -Note to see discharge summary for medications. Review of Resident #3's hospital discharge summary dated 03/13/15 revealed: -Order for Potassium Chloride (KCL) 20mEq tablet: take 20mEq by mouth every morning. -(Potassium is a supplement used to treat low potassium levels. Potassium is important for muscles to work effectively including the heart. It also has a role in regulating blood pressure. Symptoms of low potassium may include fatigue, weakness, nausea and vomiting, cramping, and heart palpitations.) Review of Resident #3's record revealed an order dated 03/31/15 to discontinue Potassium Chloride tablets, and start Potassium Chloride 40mEq/15ml liquid take 15ml by mouth every day.	D 358		

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D 358	Continued From page 92 Review of lab work for Resident #3 revealed Resident #3's Potassium level was 2.7 (low) on 03/31/15 with normal range of 3.5 - 5.3. Review of pharmacy dispensing records revealed an 8 day supply (120mls) of Potassium Chloride liquid was dispensed on 03/31/15. Review of the April 2015 medication administration records (MARs) revealed: -Handwritten entry for Potassium Chloride 40mEq- take 1 tab by mouth daily with staff initials circled on 04/01/15 and 04/02/15 and noted not given - on order. Interview with a medication aide on 05/26/15 at 1:00 p.m. revealed: -Resident #3 did not like the taste of the liquid Potassium. -She would refuse to take the liquid Potassium many times. -Staff did not mix the liquid potassium with anything to give it to resident. -She did not report the resident's dislike of the Potassium to the physician. Review of Resident #3's record revealed: -A visit summary signed by the physician's assistant (PA) on 04/02/15 that noted: due to the Potassium not being administered on 04/01/15 and 04/02/15 in the morning, please administer Potassium Chloride 40mEq liquid 15ml at 2:30 p.m. and at bedtime on 04/02/15 and 04/03/15, then resume Potassium Chloride 40mEq liquid at 15ml daily on 04/04/15. Review of the April 2015 MARs revealed: -No transcription of Potassium Chloride to be administered at 2:30 p.m. and at bedtime on 04/02/15 and 04/03/15.	D 358		

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-A handwritten entry for Potassium Chloride 40mEq liquid take 15mls daily scheduled at 8:00 a.m.
-Potassium Chloride was documented by staff to be administered from 04/02/15 - 04/07/15 and was then marked through and noted to be rewritten.

Review of lab work for Resident #3 revealed Resident #3's Potassium level was 2.4 (low) on 04/07/15 with normal range of 3.5 - 5.3.

Review of Resident #3's record revealed an order with fax stamp date of 04/07/15 noted to discontinue the previous Potassium orders and start Potassium Chloride 40mEq liquid, give 15ml by mouth twice a day.

Review of pharmacy dispensing records revealed:
-1 and ½ day supply (45mls) of Potassium Chloride liquid was dispensed on 04/08/15.
-30 day supply (946mls) of Potassium Chloride liquid was dispensed on 04/09/15.

Review of the April 2015 MARs revealed:
-Handwritten entry for Potassium Chloride 40mEq liquid, take 15ml by mouth twice a day scheduled at 8:00 a.m. and 8:00 p.m.
-There was no documentation the Potassium Chloride was administered from 04/08/15 - 04/13/15 and no reason for the omissions.
-Potassium was documented as administered at 8:00 p.m. from 04/09/15 - 04/12/15.
-Staff initials were circled at 8:00 p.m. on 04/13/15 and 8:00 a.m. and 8:00 p.m. on 04/14/15 with no reason for the omissions.
-Staff documented the resident refused on 04/15/15 due to taste.
-Potassium Chloride was documented as

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D 358	Continued From page 94 administered once at 8:00 a.m. on 04/16/15 then the order was noted to be discontinued. Review of nurses notes located in the resident's record revealed on 04/09/15 the resident was vomiting and feeling weak. Review of Resident #3's record revealed: -Physician assistant (PA) visit summary on 04/16/15 with order to discontinue Potassium Chloride liquid and start Potassium Chloride 40mEq tab- take 2 half (pills precut in half) tabs twice a day (please either crush and put in ensure or cut in half for patient to swallow). -Fax confirmation sheet indicating the order dated 04/16/15 was faxed to the pharmacy on 04/23/15 at 11:41 a.m. -PA visit summary dated 04/23/15 noted the resident had not received ANY potassium supplements in the last week as previously prescribed. Potassium was to be given as previously prescribed. Please assist the resident with ALL feeding for meals due to extreme fatigue. Review of pharmacy dispensing records revealed a 15 day supply of Potassium Chloride tablets were not dispensed until 04/23/15. Review of the April 2015 MARs revealed: -Handwritten entry for Potassium Chloride 40mEq tab, take 2 half (pill precut in half) tabs twice a day scheduled at 8:00 a.m. and 8:00 p.m. -Staff circled initials at 8:00 a.m. and 8:00 p.m. on 04/17/15 noting resident refused ("med is liquid"). -Documentation for 04/18/15 - 04/21/15 was blank with no reason for the omissions. -Initials were circled on 04/22/15 and 04/23/15 and documented as not given due to being unavailable.	D 358		

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D 358	Continued From page 95 -Staff documented Potassium was administered twice daily on 04/24/15, 04/25/15, and 04/27/15 and once on 04/28/15 and 04/29/15. -Documentation for Potassium Chloride was blank on 04/26/15 (8:00 a.m. and p.m.) and 04/28/15 (8:00 a.m.). Review of nurses' notes revealed a note on 04/24/15 to please assist Resident #3 with all feedings due to extreme fatigue, per physicians order. Review of Resident #3's record revealed: -Physician's communication form dated 04/28/15 noting the resident had low potassium. -PA noted okay to crush Potassium pills and put in pudding or ensure if the resident could not swallow in halves. Review of lab work for Resident #3 revealed Resident #3's Potassium level was 3.3 (low) on 04/29/15 with normal range of 3.5 - 5.3. Review of pharmacy dispensing records revealed an 11 day supply of Potassium Chloride 10mEq capsules was dispensed on 04/28/15. Review of the April 2015 MARs revealed: -Handwritten entry for Potassium Chloride 10mEq capsules, take 4 capsules (40mEq) by mouth twice a day (Open capsule and sprinkle on pudding or applesauce or liquid) -Staff documented administration of the Potassium capsules twice a day on 04/29/15 and 04/30/15. Review of the discharge summary from a hospital visit on 05/03/15. -Resident was sent to the emergency room for chronic nausea and vomiting.	D 358		

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D 358	Continued From page 96 -Resident notes when she takes a deep breath she has pain in her chest. -The physician explains to the family the patient has had a myocardial infarction, according to the labs. -Due to patient's hospice status, she was not admitted to the hospital, per family request. Review of Resident #3's record revealed: -PA visit on 05/07/15 noted to please continue to DOCUMENT administration of potassium chloride as there was no documentation of administration at start of visit but later documented. Clarification; resident is currently taking Potassium Chloride 10mEq take 4 caps by mouth twice a day. Review of lab work for Resident #3 revealed Resident #3's Potassium level was 4.2 (within normal range) on 05/08/15 with normal range of 3.5 - 5.3. Review of the May 2015 MARs revealed: -Handwritten entry for Potassium Chloride 10mEq capsules, take 4 capsules (40mEq) by mouth twice a day (Open capsule and sprinkle on pudding, applesauce or liquid) -Documentation for Potassium Chloride was blank for 8:00 p.m. on 05/01/15, 05/03/15, 05/05/15, 05/06/15 and 8:00 a.m. on 05/22/15 with no reasons for the omissions. -Staff documented resident refused at 8:00 a.m. on 05/21/15 and 05/23/15. Interview with the Wellness Coordinator on 05/26/15 at 10:45 a.m. revealed: -She did not know why the order written on 04/02/15 for Potassium to be administered at 2:30 p.m. and bedtime on 04/02/15 and 04/03/15 was never added to the MARs.	D 358		

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D 358	Continued From page 97 -She noted if it was not on the MARs then it was not done. -She did not know if the physician was notified that it was never done. Interview with a medication aide on 05/22/15 at 11:30 a.m. revealed: -She had no recollection of the order for Potassium 15 ml being administered at 2:30 and bedtime on 04/02/15 and 04/03/15. -She stated the Wellness Coordinator would be the one to write it on the MAR. Interview with the pharmacy on 05/26/15 at 9:20 a.m. revealed she would fax the pharmacy's documentation related to Resident #3's Potassium Chloride orders. Review of documentation kept by the pharmacy related to Resident #3's Potassium (KCL) revealed: 4/16 -- Pharmacist noted the order needed to be clarified and sent the following info back to the tech to call on because KCL tablets should not be crushed. The home could break the tabs in half to make it easier to swallow or they could dissolve the tab in 4 ounces water, let stand about 2 minutes, stir, and drink immediately. 4/16 -- Pharmacy tech called Facility and spoke to business office staff. She tried to transfer to another employee, but was unable to reach her and so took a message for her to call us back. 4/16 -- Pharmacy tech called Facility twice more and faxed a clarification request sheet. 4/20 - Pharmacy tech was told by Wellness Coordinator (WC) at facility that they were in the process of getting order clarified. 4/21 - Pharmacy tech was told by WC that the MD would be coming in on that day to clarify order.	D 358		

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D 358	Continued From page 98 4/22 - Pharmacy tech was told by business office staff that Med Tech was unavailable. 4/23 - Pharmacy tech was told that WC would call her back. Interview with Wellness Coordinator on 05/26/15 at 10:15 a.m. revealed: -She thought the pharmacy was contacting the physician about clarifying the Potassium order. -She was aware of the Potassium issues with Resident #3, but did not know she went without any Potassium for several days. -She noted if the MAR was left blank, then she assumed the medication was not given. -She was unsure if the physician was notified about the patient missing doses of potassium. If she were contacted it should be documented on a physician's order sheet along with a fax sheet, indicating it had been faxed to the physician. -She was unaware of the order to give potassium 15 ml at 2:30 and bedtime on 4/2 and 4/3, since the potassium was not given on 4/1 and 4/2 at 8am. -She reported, if it had been done it would have been on the MAR. Interview with Administrator on 05/22/15 at 11:00 a.m. revealed: -Administrator knew there had been some issues with Resident #3's Potassium. -She was unaware what exactly had been the problem with her getting it. -She was unaware that she had missed doses of Potassium Chloride. -She stated if the physician had been notified it would have been documented in the nurse's notes or on a physician order sheet. Interview with the physician's assistant (PA) on 05/21/15 at 4:24 p.m. revealed:	D 358		

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D 358	Continued From page 99 - The resident had been ordered liquid Potassium Chloride because of problems swallowing. - Resident #3 had an order to discontinue liquid Potassium Chloride because the resident did not like it. - The resident had refused the Potassium liquid. - Potassium order was changed to 1/2 tablets because she could swallow it better than the whole tablets. - Facility discontinued the Potassium liquid but failed to get the Potassium tablets for one week from the pharmacy. - The PA reviewed the MARs and discovered the Potassium tablets had not been obtained from the pharmacy. - The new order had not been sent to the pharmacy. - The resident had a critically low Potassium level of 2.7 that decreased to 2.4 (critically low). - The resident became very lethargic and could not feed herself which the PA directly correlated with her low Potassium levels. - During a visit around the first week of May 2015, the PA noticed Potassium was not listed on the 05/2015 MAR. - The PA told staff and staff went back and documented the Potassium on the MAR. - The resident's Potassium level was rechecked and it was back within the normal range. - The PA discussed the issues with Resident #3's Potassium with the Administrator. 6. Review of Resident #4's current FL-2 dated 9/4/14 revealed the following: - Diagnoses included paroxysmal atrial fibrillation, chronic obstructive pulmonary disease (COPD), hyperlipidemia, hypertension, allergic rhinitis, pulmonary hypertension, vitamin D insufficiency, and depression.	D 358		

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D 358	Continued From page 100 Review of a physician visit summary report dated 04/16/15 for Resident #4 revealed the resident was seen by a physician's assistant for exacerbation of COPD on 04/16/15. A. Review of a physician visit summary report dated 04/16/15 for Resident #4 revealed the following orders: - Monitor resident's temperatures every 4 hours for 5 days due to existing temperature of 101.3 degrees F. - Tylenol 325 mg, 1 tablet by mouth every 4 hours as needed for fever. (Tylenol is used to reduce temperature and relieve pain.) - Albuterol 90 mcg/2 ml solution via nebulizer - inhale 2 ml by mouth every 4 hours for 5 days then every 4 hours as needed if wheezing. (Albuterol is a bronchodilator used to treat COPD.) - Prednisone taper for 6 day. (Prednisone is used to relieve inflammation in the lungs): - Guaifenesin-codeine syrup - give 5 ml by mouth every 4 hours for 5 days then as needed every 4 hours if cough. (Guaifenesin-codeine is prescribed to control cough and thin bronchial secretions) Review of documentation from the physician assistant in the resident's record revealed: - Resident #4 was seen on 4/21/15 at the facility for cough and COPD exacerbation. - Orders included: - Robitussin with codeine 5ml by mouth three times daily for three days. - Start Prednisone taper as ordered by the physician assistant [on 4/16/15] Review of the Resident # 4's April 2015 MAR documentation for Prednisone taper revealed:	D 358		

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D 358	Continued From page 101 - The first dose of Prednisone was not administered until 4/23/15. - The Prednisone taper was administered from 4/23/15 to 4/28/15. Review of the pharmacy dispensing records revealed the pharmacy received the prescription for Prednisone at 5:40pm on 4/17/15. Review of the Resident # 4's April 2015 MAR for Robitussin-codeine cough syrup revealed: - Staff documented administration of 5 ml of the cough syrup 3 times daily for 3 days from April 19 -22, 2015. - Staff documented administration of 5 ml of the cough syrup at 8am and 2pm on 4/23/15. - Staff documented administration of 5 ml of the cough syrup at 8am, 12noon, 4pm, and 8pm on 4/23/15, per documentation on another block of the April 2015 MAR. - Staff documented administration of no cough syrup to Resident #4 on 4/24/15. - The back of the April 2015 MAR documented Resident did need the cough syrup, it was not given at 4pm on 4/25/15. Review of Resident # 4's Controlled Drug Record for 120 ml Guaifenesin-Codeine Syrup for Resident #4 revealed it was filled by the pharmacy on 4/21/15. 120 ml. The Controlled Drug Record showed: Staff documented administration of 5 ml of the cough syrup four times daily on 4/24/15. B. Review of a prescription for Resident # 4 faxed on 4/17/15 at 11:54am revealed: -Order for Azithromycin 250 mg, 2 tablets by mouth for 1 day and then 1 tablet by mouth for 4 days. (Azithromycin is an antibiotic for infection.)	D 358		

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D 358	Continued From page 102 Review of a nurse's note dated 4/19/15 at 1pm revealed: - Resident #4 complained of cough and fever. - Robitussin was given. - Temperature was 100.1 degrees F. - Temperature came down to 99.6 at 2:24pm. A nurse's note dates 4/20/15 revealed the resident had no fever or complaints of pain, temperature 98.3 degrees F. Review of Resident # 4's April 2015 MAR for Azithromycin administration revealed: - The first dose of Azithromycin administered was on 4/21/15 - Documentation revealed the medication was also administered on 4/22/15, 4/23/15 and 4/24/15. - The back of the MAR sheet showed documentation the Azithromycin was not given, not available on 4/19 and 20, 2015. A nurse's note dated 4/22/15 at 9pm documented: - The resident was found laying on floor. - Resident stated he went to get up, felt weak and fell. - Temperature 97.9 degrees F, blood pressure 106/70, pulse 103, respirations 21. Review of a visit summary dated 4/23/15 by the physician assistant revealed: - Please ensure ALL medications for previous orders have been processed that have not been done: a. Stop Albuterol 90 mcg/2 ml b. Start Albuterol 2.5 mg/3 ml solution - instill 3 ml via nebulizer every 4 hours for 5 days then as needed for shortness of breath/wheezing. c. Stop previous order for Robitussin with	D 358		

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codeine - 5ml by mouth for 5 days (NOT DONE and is duplicate therapy with current orders).

d. Please check patient's temperature every 4 hours for 5 days.

e. Administer Tylenol 325 mg tablet, 1 tablet by mouth every 4 hours as needed for a temperature > 100.5 degrees F (NOTE: temperature clarified with this order)

- Physician Assistant to see Resident #4 on Tuesday [April 28, 2015].

Interview with the physician's assistant (PA) on 05/21/15 at 4:24 p.m. revealed:

- Resident #4 was diagnosed with a chronic obstructive pulmonary disease (COPD) exacerbation.
- Order for a treatment regimen was sent to the facility on 04/17/15.
- Another prescribing practitioner from their practice followed up on the resident on the following Tuesday, 04/21/15, and identified the treatment regimen had not been done.
- The PA came back on Thursday, 04/23/15, and the resident did not receive first dose of antibiotic until 04/21/15 and the other medications were not started until that morning on 04/23/15.
- The resident had declined significantly.

Interview with the physician's assistant (PA) on 05/26/15 at 5:45pm revealed:

- Resident #4 had orders for medications to ease his breathing, prevent further inflammation, and clear up his fevers.
- He did not receive the antibiotic for several days.
- The resident developed an infection and fell due to weakness caused by COPD.
- The resident was usually alert and oriented to self.
- Resident #4 was very conscientious about

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D 358	Continued From page 104 following her orders and recommendations Interview with the pharmacist on 5/27/15 at 1:15pm revealed: - They received the order for Azithromycin on 4/17/15. - They called the prescribing provider on 4/17/15 to get the order clarified, as there was a possible interaction of Azithromycin with Resident # 4's other medication. - The prescribing provider provided clarification on the order on 4/20/15. - The pharmacist estimated the facility would have received the medication on either 4/21/15 or 4/22/15. Further interview with the pharmacist on 5/27/15 at 1:15 revealed: - New prescription order deadline is 5pm for the pharmacy. - The pharmacy filled the Prednisone prescription on 4/18/15. - The pharmacist estimated the facility would have received the medication very late on 4/18/15, as the delivery truck does not leave the pharmacy until after 8:30pm. Review of the resident record revealed there was no documentation of the physician being contacted by the facility from 04/18/15 through 04/23/15 regarding the delay in implementing the Azithromycin order. Interview with the Administrator on 5/27/15 at 3:30pm revealed: - They know they should compare the labels and the MARs when preparing medications. - Medication aides have been trained to read the MARs to assure medications are administered as ordered.	D 358		

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D 358	Continued From page 105 - They recently identified some issues with medication orders being implemented. - They have started using a new order tracking form and have trained staff on how to use the form. - Medication aide on duty is responsible for implementing orders. - The Wellness Coordinator was monitoring new orders and found some errors. - They changed system to have Wellness Coordinator transcribe new orders about 2 and ½ weeks ago. - Medication aides were in-serviced on transcribing order and implementing orders if the Wellness Coordinator was not here. - The facility has also been without a nurse since February 2015. - Getting new medications filled after the pharmacy's time cut-off and after hours is not a problem for the facility. Interview with the Medication Aide (MA) on 5/28/15 at 11:30am revealed: - It was difficult to keep up with medications when they are handwritten on the MAR. - Some providers make frequent changes in dosage, it is hard to keep up with them unless you look over the entire MAR for a resident. - She is busy passing medications, frequent changes in orders need to be flagged to alert the MA. - She was not aware of a system to check the MARs since they have not had a nurse at the facility in 2 to 3 months. Interview with Resident #4 at 10:30am on 5/28/15 revealed: - As far as he knew he got the medicines ordered by his provider every day. - He stated the Medication Aides on the day shift	D 358		

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were top notch, but he frequently got his medications late on second shift and on the overnight shift, if he requested something for pain or to help him breathe.
- He was not aware if a medication was ever not available or on delayed delivery from the pharmacy.
- He knew some of his medications were "as needed" for relief of pain or to ease breathing, the Medication Aides told him if taking a medicine was optional. "The Medication Aides and my provider are able to answer my questions about medication."

7. Review of Resident #8's FL-2 dated 03/13/15 revealed:
- Resident was admitted to the facility on 03/16/15.
- Diagnoses included coronary artery disease, hyperlipidemia, and pain in limb.
- Order to check blood pressures (BP) daily.
- Order for Losartan 100mg daily. (Losartan is for high blood pressure.)

Review of Resident #8's record revealed:
- Subsequent physician's order dated 03/26/15 to check BP every morning and hold Losartan if systolic blood pressure (SBP) <150.

Review of Resident #8's March 2015 medication administration record (MAR) revealed:
- Entry to document BP daily at 8am.
- There were no BPs documented from admission on 3/16/15 to 3/31/15.
- Losartan medication administered daily at 8:00 a.m.
- It could not determine if Losartan should have been administered without BP readings.

Review of Resident #8's April 2015 MAR

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revealed:
- Losartan was documented as administered on 4 occasions when it should have been held for SBP <150.
- Losartan was administered on 04/04/15: 126/60, 04/05/15: 128/55, 04/06/15: 141/85, and 04/07/15: 122/77.
- There were no blood pressure readings documented on MAR for 04/08/15 or 04/09/15 but Losartan was documented as administered.

Review of Resident #8's record revealed:
- Subsequent physician's order dated 04/09/15 to check BP twice daily for one week and hold Losartan unless SBP >155.

Review of Resident #8's April 2015 MAR revealed:
- Entry for order dated 04/09/15 to check BP twice daily for one week (4/10/15 to 4/16/15) and hold Losartan unless SBP>155.
- Resident #8's blood pressure readings revealed:
  4/10/15 8am 114/77, 8pm 130/70;
  4/11/15 8am 108/59, 8pm 126/78,
  4/12/15 8am 114/67, 8pm 118/67,
  4/13/15 8am 101/72, 8pm 137/69;
  4/14/15 8am 136/78, 8pm 140/70;
  4/15/15 8am 109/56, 8pm 126/68;
  4/16/15 8am 120/78, 8pm 120/70.
- Resident #8 was administered Losartan twice daily from 4/10/15 to 4/16/15 when it should have been held.

Review of Resident #8's record revealed subsequent physician's order dated 04/16/15 to discontinue Losartan and check blood pressure every morning.

Interview with the physician's assistant (PA) on

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D 358	Continued From page 108 05/21/15 at 4:24 p.m. revealed: - Resident #8 had order to check blood pressure (BP) every morning and hold Losartan (BP medication) if systolic BP was less than 150. - Documentation on the MAR was "spotty". - Staff administered Losartan when the SBP was below the parameters and it should have been held. - Resident had ongoing dizziness. - The resident had a history of low BP episodes. - The PA was unaware of any current low BP episodes. Interview with Resident #8 on 05/21/15 at 11:10 a.m. revealed: - Staff checked his blood pressure almost every day. - He denied any current symptoms of high or low blood pressures. - He took medication for his blood pressure but did not know the name of it. Interview with Wellness Coordinator (WC) on 05/26/15 at 1:45 p.m. revealed: - She was unaware the BPs were not being checked and documented on the MARs. - There were usually 2 staff (WC and Supervisor/medication aide) that check behind the medication aides to assure the MARs were documented. - She was supposed to check the MARs daily but she did not have time. Interview with a medication aide on 05/22/15 at 1:20 p.m. revealed: - The medication aides were supposed to initial and circle on the MAR if a medication is not given and document the reason on the back of the MAR. - She had no explanation for the Losartan	D 358		

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D 358	Continued From page 109 being administered when it should have been held or for the missing BPs. Interview with the Administrator on 05/22/15 at 12:50 p.m. revealed: - She was unaware the MARs were not documented accurately. - She was unaware that BPs were not being checked as ordered for Resident #8. 8. Review of Resident #12's current FL-2 dated 05/01/15 revealed: - Diagnoses included diabetes mellitus type II, hypertension, congestive heart failure, anemia, failure to thrive, malaise, fatigue, hypothyroidism, and pneumonia. - Order for Vitamin D3 50,000 units once a week. (Vitamin D3 is a supplement used to treat Vitamin D deficiency). Review of the May 2015 medication administration records (MARs) revealed: - Order was transcribed as Vitamin D3 50,000 units once a week on Fridays. - Staff documented administration of Vitamin D3 50, 000 units daily from 05/05/15 - 05/12/15 and on 05/16/15, 05/19/15, and 05/20/15. Interview with the medication aide on 05/21/15 at 10:25 a.m. revealed: - She did not recall administering any Vitamin D3 50,000 units to Resident #12. - She did not recall there ever being any Vitamin D3 50,000 units on hand for Resident #12. - The MARs should have been marked off for once weekly administration. - She could not locate any Vitamin D3 50,000 units on hand for Resident #12. - She would contact the pharmacy.	D 358		

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D 358	Continued From page 110 Interview with the medication aide on 05/21/15 at 11:22 a.m. revealed: - Pharmacy staff told her they filled the Vitamin D3 on 05/04/15. - They are going to send more tonight since she could not find it at the facility. - The resident should get a dose tomorrow. Interview with the pharmacist on 05/26/15 at 11:21 a.m. revealed: - They dispensed 4 Vitamin D3 50,000 unit tablets on 05/04/15. - They dispensed 3 Vitamin D3 50,000 unit tablets on 05/21/15. Interview with Resident #12 on 05/21/15 at 2:25 p.m. revealed he was uncertain if he received any Vitamin D. 9. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00 a.m. / 9:00 a.m. and the 11:00 a.m. / 12:00 noon medication passes on 05/21/15 and the 11:30 a.m. medication pass on 05/22/15. Review of Resident #12's current FL-2 dated 05/01/15 revealed diagnoses included diabetes mellitus type II, hypertension, and congestive heart failure. A. Review of Resident #12's current FL-2 dated 05/01/15 revealed an order for Plavix 75mg once daily. (Plavix is a blood thinner.) Review of the May 2015 medication administration record (MAR) revealed Plavix was scheduled to be administered daily at 8:00 a.m. Observation of the 8:00 a.m. medication pass on	D 358		

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D 358	Continued From page 111 05/21/15 revealed: - Medication aide punched Resident #12's oral medications scheduled for 8:00 a.m. in a paper soufflé cup. - She picked up the bubble card for Plavix 75mg and stated the resident would get one Plavix and pointed to the entry for Plavix on the MAR. - She then put the bubble card down on the cart without punching one of the Plavix tablets into the cup. - The medication aide continued to punch other medications into the cup. - Surveyor asked medication aide if she stated the resident would be receiving Plavix. - The medication aide stated, "Yes", while holding up the Plavix bubble card and pointing to the label on the card. - She did not punch a Plavix tablet in the cup. - After medication aide finished preparing the medications and began to go to administer the medications, surveyor intervened. - The medication aide was asked if the Plavix tablet was in the medication cup. - After checking the cup, the medication aide realized she forgot to punch the Plavix tablet into the cup. - She then added a Plavix 75mg tablet and administered it to the resident with the other 8:00 a.m. medications at 9:08 a.m. Interview with the medication aide on 05/21/15 at 9:10 a.m. revealed: - She usually gave the Plavix when she administered the other 8:00 a.m. medications. - She stated she forgot to punch the Plavix in the cup because she was nervous. Interview with the Administrator on 05/21/15 at 12:32 p.m. revealed: - Medication aides have been trained to read the	D 358		

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MARs.
- They should compare the labels and the MARs when preparing medications.

B. Review of Resident #12's current FL-2 dated 05/01/15 revealed an order for Prilosec 20mg once daily 30 to 60 minutes before a meal. (Prilosec is for acid reflux.)

Review of the May 2015 medication administration record (MAR) revealed:
- Prilosec entry noted it was to be given 30 to 60 minutes before a meal.
- Prilosec was scheduled to be administered at 7:30 a.m.

Observation of the 8:00 a.m. medication pass on 05/21/15 revealed the medication aide administered Prilosec 20mg to Resident #12 at 9:08 a.m. at the same time her medications scheduled for 8:00 a.m. were administered.

Interview with the medication aide on 05/21/15 at 10:34 a.m. revealed:
- Breakfast was served at 8:00 a.m.
- She was aware the Prilosec should be given before breakfast instead of after breakfast.
- She usually tried to give Resident #12 his morning medications before breakfast but sometimes he would eat before she got to him.
- The resident had already eaten breakfast that morning on 05/21/15 when she administered his medications.
- She always gave the Prilosec scheduled for 7:30 a.m. when she administered the medications scheduled for 8:00 a.m.
- She would start administering the Prilosec earlier before she started administering the 8:00 a.m. medications.

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D 358	Continued From page 113 Interview with the Administrator on 05/21/15 at 12:32 p.m. revealed: - Medications ordered before a meal should be administered before the meal. - Medications aides have been trained to read the MARs to assure medications are administered as ordered. Interview with Resident #12 on 05/21/15 at 2:25 p.m. revealed: - He received his morning medications this morning after he had eaten breakfast. - He received his morning medications after breakfast most of the time. - He denied any current symptoms of acid reflux or indigestion. C. Review of Resident #12's record revealed a physician's order dated 05/07/15 to start Colace 100mg twice daily. (Colace is a stool softener.) Review of the current computer printed May 2015 medication administration record (MAR) (for 05/13/15 - 05/21/15) revealed Colace was not included on MAR. Observation of the 8:00 a.m. medication pass on 05/21/15 revealed: - Medication aide punched Resident #12's oral medications scheduled for 8:00 a.m. in a paper soufflé cup. - She picked up the bubble card with Colace 100mg labeled for Resident #12 with instructions to administer twice daily. - The Colace was dispensed on 05/09/15 and 11 doses had been punched from the card. - Medication aide stated she would not give the Colace since it was not listed on the MAR. - She would check to see if there was an order for Colace.	D 358		

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D 358	Continued From page 114 Review of a handwritten May 2015 MAR (for time period of 05/04/15 - 05/12/15) in the resident's record revealed: - The order for Colace was handwritten on the MAR and staff started documentation of the administration of Colace on 05/09/15 at 8:00 a.m. - Eight doses were documented as administered from 05/09/15 - 05/12/15. Interview with the medication aide on 05/21/15 at 10:24 a.m. revealed: - She did not see an order for the Colace in Resident #12's record. - She was going to send the Colace back to the pharmacy. - Surveyor intervened and showed the medication aide an order dated 05/07/15 to start Colace 100mg twice daily on a physician's visit form. - After looking at the handwritten MAR in the record, the medication aide stated the order did not get transcribed onto the newly printed MAR. - The resident was admitted on 05/04/15 so they used a handwritten MAR when he first came until they could get a computer printed one from the pharmacy on 05/13/15. - She was not aware of a system to check the MARs since they have not had a nurse at the facility in 2 to 3 months. Interview with the Administrator on 05/21/15 at 12:32 p.m. revealed: - They recently identified some issues with medication orders being implemented. - They have started using a new order tracking form and have trained staff on how to use the form. - Medication aides should be reading and reviewing the MARs.	D 358		

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D 358	Continued From page 115 Interview with Resident #12 on 05/21/15 at 2:25 p.m. revealed: - He thought he was getting a pill for constipation. - He denied any current symptoms of constipation. _____ Review of the facility's plan of protection dated 05/22/15 revealed: - Executive Director (ED) / Resident Services Director (RSD) Designee will conduct immediate audit of all current resident charts to ensure all physician orders are being followed as directed. - Audits will include review of medication administration records (MARs) and medications on hand. - Any orders found to be not in process will be processed immediately. - Area Director will train RSD / ED / Designee on new order tracking system to ensure all orders are transcribed and implemented properly. - In-service for new order tracking system was held on 0/22/15 for medication staff. - New order tracking system will be used on all new orders to ensure all orders are processed correctly. - Any identified medication errors will be reported to the physician for any further follow-up and documented on medication error report. - Random medication pass observations will be done at least bimonthly by RSD or Designee. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 27, 2015.	D 358		

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D 367	Continued From page 116	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 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 interview and record reviews, the facility failed to assure medication administration records (MARs) were accurate and complete for 2 of 9 residents (#2, #5) sampled for review including medications for diabetes, hepatic encephalopathy, and skin rashes and infections. The findings are: 1. Review of Resident #5's current FL-2 dated 11/13/14 revealed diagnoses included diabetes mellitus type 2, hypothyroidism, osteoarthritis with chronic pain, depression, vertigo, morbid obesity, cutaneous candidiasis, hypertension, chronic	D 367		

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D 367	Continued From page 117 venous stasis, peripheral neuropathy, and hypoalbuminemia. A. Review of Resident #5's record revealed: - Order on the current FL-2 dated 11/13/14 for Nystatin cream apply thin layer to left and right lateral abdominal skin folds twice a day until rash resolved. - Order dated 02/03/15 for Nystatin cream apply thin layer to groin skin folds 4 times a day. Review of the April 2015 medication administration records (MARs) revealed: - Nystatin cream to left and right lateral abdominal skin folds twice a day was scheduled to be administered once on 1st shift from 7:00 a.m. - 3:00 p.m. and once on 2nd shift from 3:00 p.m. - 11:00 p.m. - Documentation for Nystatin to abdominal skin folds was blank on 19 of 60 occasions with no reasons for the omissions noted. - Nystatin cream to groin skin folds 4 times a day was scheduled to be administered at 8:00 a.m., 12:00 noon, 4:00 p.m. and 8:00 p.m. - Documentation for Nystatin to groin skin folds was blank on 64 of 120 occasions with no reasons for the omissions noted. Review of the May 2015 MARs revealed: - Documentation for Nystatin to abdominal skin folds was blank on 3 occasions with no reasons for the omissions noted. - Documentation for Nystatin to groin skin folds was blank on 36 of 86 occasions with no reasons for the omissions noted. Interview with the medication aide on 05/27/15 at 1:05 p.m. revealed: - They usually apply the Nystatin to Resident #5. - Some days the resident ' s skin was a little pink	D 367		

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D 367	Continued From page 118	D 367		

in her skin folds but it did not usually get red.
- She did not know why the documentation was blank on the MARs because they usually applied the cream.
- Staff should document when they administer the medication.

Review of medications on hand revealed a tube of Nystatin cream that was dispensed on 05/08/15.

Interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed:
- Her skin gets irritated "once in a while".
- Staff usually put cream on it but she was unsure how often.

Refer to interview with the Administrator on 05/22/15 at 1:20 p.m. and the Wellness Coordinator on 05/26/15 at 11:50 a.m.

B. Review of Resident #5's record revealed order dated 02/12/15 for Lantus insulin 17 units in the morning and 24 units at bedtime (hold if blood sugar <100). (Lantus is a long-acting insulin used to lower blood sugar.)

Review of the April 2015 medication administration records (MARs) revealed:
- Lantus was scheduled to be administered at 8:00 a.m. and 9:00 p.m.
- Lantus was not documented as administered at 8:00 a.m. on 04/16/15 and 04/24/15 - 04/26/15.
- Lantus was not documented as administered at 9:00 p.m. on 04/24/15, 04/27/15, 04/29/15, and 04/30/15.
- No reasons for the omissions were documented.

Review of the May 2015 MARs revealed:

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D 367	Continued From page 119 - Lantus was not documented as administered at 9:00 p.m. on 05/05/15, 05/06/15, and 05/16/15. - No reasons for the omissions were documented. Interview with the medication aide on 05/27/15 at 1:05 p.m. revealed: - Lantus was usually administered to the resident. - The resident did not refuse her medications. - She did not know why the documentation was blank on the MARs. - Staff should document when they administer the medication. Review of medications on hand revealed one vial of Lantus insulin dispensed on 05/08/15. Interview with Resident #5 on 05/27/15 at 3:15 p.m. revealed: - She usually got insulin about 3 times a day. - She knew she got Lantus insulin at bedtime. - Staff hold the insulin if her blood sugar was low. Refer to interviews with the Administrator on 05/22/15 at 1:20 p.m. and the Wellness Coordinator on 05/26/15 at 11:50 a.m. 2. Review of Resident # 2's current FL2 dated 04/23/15 revealed diagnoses of liver cirrhosis, diabetes mellitus, portal vein thrombosis, hypertension, depression and high cholesterol. A. Review of Resident #2's hospital discharge summary on 4/23/15 revealed: -Resident was admitted to the hospital on 4/19/15 and diagnosed with hepatic encephalopathy. -Medication order for Xifaxan 550 mg 1 tab twice a day. (Xifaxan is used to decrease the risk of	D 367		

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D 367	Continued From page 120 recurrences of hepatic encephalopathy.) Review of Resident #2's April 2015 medication administration record (MAR) revealed: -Xifaxan 550 mg one tablet twice a day. -Medication was to be given at 8am and 8pm. -Xifaxan was not documented as administered on 4/30/15 at 8pm. Review of Resident #2's May 2015 MAR revealed: -Handwritten entry dated 4/23/15 for Xifaxan 550mg one tablet twice a day. -The medication was to be given at 8am and 8pm. -There was no documentation the medication was given at 8am from 5/2/15 to 5/6/15. -There was no documentation the medication was given at 8pm from 5/1/15 to 5/8/15. -There was no reason for the missed doses documented. Review of Resident #2's pharmacy dispensing record for April 2015 revealed: -31 Xifaxan 550mg tablets were dispensed on 4/23/15. -60 Xifaxan 550mg tablets were dispensed on 5/9/15. Interview with medication aide on 5/27/15 at 2:45 p.m. revealed she was unsure if medication was given on 4/30/15. Interview with the Administrator 5/27/15 at 3:45 p.m. revealed: -She had no excuse for medication not being given or signed off. - The facility has been in touch with the consultant to come in and help get charts organized. No date was given.	D 367		

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D 367	Continued From page 121 Refer to interviews with the Administrator on 05/22/15 at 1:20 p.m. and the Wellness Coordinator on 05/26/15 at 11:50 a.m. B. Review of Resident # 2's current FL2 dated 4/23/15 revealed a note to refer to hospital discharge summary for medications. Review of Resident #2's hospital discharge summary dated 04/23/15 revealed an order for Lantus insulin 12 units at night. (Lantus is long-acting insulin that lowers blood sugar.) Review of Resident #2's April 2015 medication administration record revealed: - There was no documentation of Lantus given on 4/24/15, 4/25/15, 4/26/15, 4/28/15, 4/29/15, and 4/30/15. - Finger stick blood sugar (FSBS) ranges for April 2015 were 93-304. Review of Resident #2's pharmacy dispensing record for April 2015 revealed Lantus 10ml was dispensed on 4/23/15 for 30 days. Review of Resident #2' s May 2015 MAR revealed: -Handwritten entry dated 4/23/15 for Lantus every night at 8pm. -There was no documentation of medication given on 5/1/15 to 5/8/15 . -Finger stick blood sugars (FSBS) were to be check and documented at 8am and 8pm. -FSBS ranged for May 2015 were 63-140. Review of Resident #2's pharmacy dispensing record for May 2015 revealed: -Record was from 5/1/15 to 5/21/15. -Lantus was not dispensed during this time.	D 367		

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D 367	Continued From page 122 Interview with medication aide on 5/27/15 at 2:40pm revealed she was unaware why Lantus was not documented as administered on the MAR. Refer to interviews with the Administrator on 05/22/15 at 1:20 p.m. and the Wellness Coordinator on 05/26/15 at 11:50 a.m. _____ Interview with the Administrator on 05/22/15 at 1:20 p.m. revealed: - She had worked at the facility for about 4 months. - When she started there was no system to check the medications. - They have since implemented a "hot box", an order tracking form. - Wellness Coordinator should be checking the MARs. - The facility has also been without a nurse since February 2015. Interview with the Wellness Coordinator (WC) on 05/26/15 at 11:50 a.m. revealed: - Medication aides transcribe orders and fax orders to the pharmacy. - A second check was supposed to be done by another medication aide or management to check accuracy of the MAR. - WC was supposed to check the MARs for accuracy daily but she was not doing the checks that often due to time restraints. - WC stated it had "been a while" since she had checked the MARs.	D 367		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

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D 438	Continued From page 123 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 A2 Violation Based on observation, interview and record review, the facility failed to report an allegation of abuse against health care personnel for 1 of 1 staff (F) within 24 hours of facility becoming aware of allegations of Staff F shoving Resident #11 down, along with any investigation by facility within 5 working days. The findings are: Review of Resident #11's FL-2 dated 2/27/15 revealed: - Diagnoses included Diabetic Renal Disease, Malaise and fatigue, Benign Hypertensive Renal Disease, Dementia. - Resident #11 is constantly disoriented, ambulatory, incontinent of bladder and requiring total care. Review of Resident #11's care plan dated 5/21/15 revealed: - Resident #11 is a resident of the facility's Secure Care Unit (SCU). - The resident needs 1 person assistance with all activities of daily living (ADL). - She needs to be coached and directed prior to performing actions. - She likes to be spoken to in soft tone and kneel to eye level. - She does not like to be towered over. - Use positive physical approach.	D 438		

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D 438	Continued From page 124 - Resident #11 is a former kindergarten teacher. Interview with Resident #11's sitter on 5/20/15 at 11:00 A.M. revealed: - There was a situation concerning Resident #11 and a staff member. - There was an accusation of abuse during the second shift by a second shift staff member. - The Administrator and corporate are aware of the accusation of abuse. - Resident #11 was scared when she reported to the sitter that she was shoved on and jerked down by staff member and that staff member was very mean. - The Medication Aide (MA) went to Resident #11's room and spoke with the resident, then stated that something happened to resident. - Resident #11's family member was called and came to the facility concerning the alleged incident of abuse. - Resident #11's family member sent an email to the Administrator informing her of the alleged abuse. Review of email addressed to Administrator from Resident#11's family member sent May 13, 2015 at 7:45 A.M. revealed: - "Yesterday, most likely between 5:30- 6:15, [Resident #11] says that she was mistreated by one of the staff." - Resident #11 "described the incident as she was shoved and spoken to in a mean manner". - Resident #11's sitter "immediately noticed a difference in [Resident #11's] demeanor when she arrived around 6:30 P.M. yesterday and questioned [the resident] about what happened". - Resident #11's sitter also called in the Medication Aide (MA) "to see if there was consistency to her story and there was".	D 438		

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D 438	Continued From page 125 - Resident #11's family member spoke with MA "last night and she confirmed that she believes something did happen". - Both the sitter and MA reported that Resident #11's "behavior changed when the individual was in the room later that evening". - Resident #11 "became quiet and suspicious". - "We would like for this incident to be investigated". Review of Resident #11's nurse's notes written by MA dated 5/12/15 at 10 P.M. revealed: - The resident's sitter approached the MA concerned that Resident #11 told her that one of our staff members did something to her today. - MA went to Resident #11's room and asked her what happened and she proceeded to tell MA that someone "shoved her and was mean to her". - This was the same statement that Resident #11 had made to her sitter and she seem very upset that someone was mean to her. - Sitter reported Resident #11's statement to her family. - Resident #11's family came to facility and MA told them exactly what resident told her. Attempt to interview Resident #11 on 5/20/15 at 4:25 P.M. revealed: - There was no staff member that she was fearful to be around. - No one has ever been rough with her or mean to her. - She was upset because one of the teachers was upset with her. Interview with Administrator on 5/20/15 at 3:07 P.M. revealed: - Resident #11 was afraid of something or someone. - Administrator was unable to pinpoint if she	D 438		

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D 438	Continued From page 126 was afraid of someone here, present or pass. - Administrator reported not seeing any bruising or skin tear. - The Administrator received an email from family saying something had happened. - The Administrator spoke with sitter, Resident #11 and employees (MA and Certified Nursing Assistant) that were on duty on the night of 5/12/15. - Facility's policy concerning suspected abuse is to fill out a 24 hour report to Department of Health and Human Services (DHHS) and County Monitor; start an investigation and then do a 5 day report back to DHHS and County Monitor. - Administrator did not notify Cooperate Office because there was no consistency or clear direction. - Administrator did not send in a 24 hour or 5 day report to DHHS, County Monitor or Health Care Personal Registry (HCPR). - Accused staff was moved to another assignment/ hallway on the SCU. - Accused staff was not reassigned to old assignment/ hallway once Administrator's investigation was complete. - Administrator did not suspend accused staff pending investigation because she did not take incident as an allegation of abuse. - Attempt to interview resident but Resident #11 was uncomfortable talking with Administrator, therefore she had sitter speak with resident while she stood by the resident's room door. - Administrator understood that Resident #11 was fearful but when asked what happened, resident could not say something specifically happened. - Administrator states that at no point or time was it explained to her about the jerking and shoving of resident by accused staff, which would "warrant an official investigation" .	D 438		

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D 438	Continued From page 127 - An official investigation would include interviews with Resident #11, family member, sitter and everyone on staff that night. Review of facility's Resident Abuse Policy revealed that if a staff member is accused or suspected of abuse, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation. Review HCPR 24-Hour Initial Report dated 5/20/15 revealed: - Incident occurred 0n 5/13/15 between 5:30 P.M. to 6:15 P.M. - Description of allegation states that "Resident spoken to in mean manner". - Resident resides in an Assisted Living Facility's SCU. - This report was faxed to HCPR on 5/20/15 at 5:48 P.M. Review of the revised HCPR 24-Hour Initial Report dated 5/20/15 revealed that the physical aspect, "and shoved" of allegation was added and refaxed on 5/26/15 at 9:33 A.M. Interview with Administrator on 5/21/15 at 9:45 A.M. revealed that the HCPR 5-Working Day Report was faxed on 5/20/15 at the same time of 5:48 P.M. as the HCPR 24-Hour Initial Report which gives allegation details as "reported that resident was spoken to in mean manner". Interview with Administrator on 5/27/15 at 9:00 A.M. revealed that the revised HCPR 5-Working Day Report was faxed on 5/27/15 at the same time of 9:33 A.M. as the revised HCPR 24-Hour Initial Report, which included the physical aspect of the shove in the allegation detail.	D 438		

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D 438	Continued From page 128 Interview with accused Certified Nursing Assistant (CNA) on 5/20/15 at 4:30 P.M. revealed: - CNA did not notice a change in Resident #11 behavior on the night of the incident or after. - CNA is sometimes assigned to care for Resident #11. - CNA was last assigned to care for Resident #11 on Tuesday, 5/19/15. - Resident was "real talkative like she normally is". - No one spoke to CNA about incident with Resident #11. - "This is the first or second time I have had this assignment since last week that I can remember." Review of facility's assignment schedule for Tuesday, 5/19/15 revealed accused CNA was assigned to care for Resident #11 on second shift in the SCU. Interview with MA on 5/21/15 at 3:42 P.M. revealed: - Resident #11's sitter came to MA concerning resident "not acting herself" and told her that someone had shoved her and had been mean to her. - The incident happened between 5:00 P.M. and 6:30 P.M. - When I spoke with Resident #11, she told me the same thing that someone shoved her and was been mean to her. - Resident #11 would not speak when accused CNA came into the room. - Per sitter, later that night when accused CNA came in the room Resident #11 "tensed up". - After accused CNA left resident's room, sitter asked resident if that was who shoved her, she said, yes.	D 438		

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D 438	Continued From page 129 - "She never changed her story and it was the same each time". - MA charted in Resident #11's chart but did not call Administrator to report incident. - MA knows what the policy is at her old job but is "not sure what the policy is here". - "My gut told me to call Administrator and I did not". - MA did leave a copy of the Nurse's Notes in Administrator's box. - Administrator called MA the next morning and told MA that she should have called her when incident occurred. - The sitter called Resident #11's family and when the family arrived I informed him of what occurred, which was basically everything that Resident #11 told me. - Administrator has not spoken to me since about the incident. - There was no in-service after incident. - MA was told by sitter that as long as accused CNA did not come in Resident #11's room she was ok. - There was no change in assignment for accused CNA. Interview with second MA on 5/21/15 at 4:25 P.M. revealed: - That if there is an allegation or accusation of abuse you are to report it. - No one have ever gone over the facility's Resident Abuse Policy with us. - The Administrator told us any accusation of abuse to come to her about it. Interview with Resident #11's family member on 5/22/15 at 12:00 P.M. revealed: - Incident between Resident #11 and facility staff happened early last week. - The sitter called to inform us that when she	D 438		

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D 438	Continued From page 130	D 438		

arrived at the facility Resident #11 did not look very happy.
- Resident #11 told sitter that someone pushed her and was mean to her.
- Per sitter, Resident #11 was able to point out the person.
- For a short while Resident #11 did not want to be in the presence of that staff person.
- He has not seen any staff member push or shove or being mean with residents.
- He really could not say what happened, just that something did happen.
- He sent an email the next morning to the Administrator with his concerns.
- He was contacted by the Administrator, he thought via a phone conversation.
- He was told that an investigation was started and it would take a little while because everyone had to be interviewed.

Interview with Administrator on 5/22/15 at 12:35 P.M. revealed:
- When Administrator spoke with the MA the next morning, what she kept hearing was that someone was speaking harshly to Resident #11.
- Her first conversation with MA gave her the impression that it pertained mainly concerning a verbal incident.
- Some of the staff are versed on what to do in cases of abuse or neglect.
- The area of what to do in cases of abuse or neglect is an area that needs to be looked at for further in-service.
- Administrator only questioned the accused CNA in passing.
- Administrator viewed incident as no different from any other complaint made by sitter.
- Administrator states that if it had been any other resident it would have been handled different but with the sitter's history of complaints

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D 438	Continued From page 131 and blowing things out of proportion. Interview with Wellness Coordinator on 5/26/15 at 2:43 P.M. revealed: - Sitter did speak with me concerning Resident #11 stating that she was afraid of someone but did not go into details. - All abuse are reported to Administrator whether alleged or suspected. Interview with Administrator on 5/26/15 at 2:10 P.M. revealed: - Administrator states that sitter came back to her and said she was talking to the family and they do not think anything happened. - Sitter and family feel that Resident #11 is just being fearful, possible because of the environment. - The discussion with the sitter was what swayed her away from following the facility's written policy. - Administrator did not start and do an official investigation after speaking with the sitter and resident. - Resident #11's family asked for accused staff to be pulled off assignment, which Administrator stated she did. - Administrator then followed up with Positive Physical Approach training the next day. - Administrator states that at the time had the family and sitter come back to her and say this is abuse, she would have moved the staff from the SCU. - The Administrator spoke with MA, accused CNA, sitter and twice with resident, then did in-service with everyone on the nursing team, which includes CNAs, MAs and managers that come to our "stand-up meetings" both on the Assisted Living and SCU. - Administrator knows what the company's	D 438		

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D 438	Continued From page 132 protocol and state requirements are concerning abuse. _____ Review of the facility's plan of protection dated 05/22/15 revealed: - Executive Director (ED) sent in 24 hour and 5 day reports to the Health Care Personnel Registry (HCPR) for Resident #11 on 05/20/15. - ED will revise the reports to include allegation of physical abuse and resend to the HCPR. - Any future allegations will be immediately reported to the HCPR. - Facility will audit all health care workers with new updated HCPR checks to ensure no allegations of abuse. - Area Director of Nursing educated Resident Services Director (RSD), ED, and Special Care Unit Coordinator on company policy on abuse. - Facility will start educating health care workers on company abuse policy. - RSD / ED will review all HCPR background checks prior to offer of employment. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 27, 2015.	D 438		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to	D 465		

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D 465	Continued From page 133 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record review, and interview, the facility failed to assure that the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 15 of 42 shifts from 04/17/15 to 04/23/15 and 05/13/15 to 05/19/15. The findings are: Review of the Special Care Unit (SCU) daily census for 04/17/15 revealed: - The total residents on the SCU are 40 with 4 in the hospital making the actual residents on SCU 36 residents for this date. - The staffing requirements for the SCU with an actual census of 36 was 4 staff plus 4.0 additional staff hours (total of 36 hours) for 2nd shift. Review of staff assignment schedule created by the Administrator for April 17, 2015 revealed four staff were scheduled to work in the SCU on second shift. Review of the time card detailed report for April 17, 2015 revealed: - Staffing for the SCU was less than the state requirement of 36 hours for second shift. - On second shift the SCU had four staff clocked in for SCU assignments equal to 28.21 hours, plus 3.42 hours carried over from first shift to total 31.63 hours. - The facility staffing was short by 4.37 hours for second shift.	D 465		

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D 465	Continued From page 134 Review of the Special Care Unit (SCU) daily census for April 18, 2015 revealed: - The total residents on the SCU was 36 residents for this date. - The staffing requirements for the SCU with an actual census of 36 was 4 staff plus 4 additional staff hours (total of 36 hours) for 1st shift. - The staffing requirements for the SCU with an actual census of 36 was 3 staff plus 4.8 additional staff hours (total of 28.8 hours) were needed to fulfill staffing requirements for 3rd shift. Review of staff assignment schedule created by the Administrator for April 18, 2015 revealed the following: - Four staff were scheduled to work in the SCU on first shift. - Only three of the four staff worked - Two staff were scheduled to work in the SCU for third shift with one staff moved to the Assisted Living (AL) because there was no one scheduled to staff the AL. Review of the time card detailed report for April 18, 2015 revealed: - Staffing for the SCU was less than the state requirement of 36 hours for first shift and 28.8 hours for third shift. - On first shift the SCU had three staff clocked in for SCU assignments equal to 22.5 hours, plus 0.5 hours carried over from third shift to total 23.0 hours. - On third shift the SCU had two staff clocked in for SCU assignments with one staff moved to AL unit assignment leaving 8.0 hours plus 0.5 hours carried over from second shift to total 8.5 hours. - The facility staffing was short by 13.0 hours	D 465		

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D 465	Continued From page 135 for first shift and short by 20.3 hours for third shift. Interview with Nurse's Assistant (NA) dated 5/28/15 at 3:15 P.M. revealed: - Sometime in April there were only two staff for both the AL unit and the SCU. - Medication Aide (MA) made a call but I do not know to whom. - The two of us worked together, one worked the AL unit while the other worked the SCU. - We checked on each other throughout the shift. - That night I had to get up around four residents. - There was another night where there were only two staff for both units, but they got someone to come into work. Review of the Special Care Unit (SCU) daily census for May 13, 2015 revealed: - The total residents on the SCU was 34. - The staffing requirements for the SCU with an actual census of 34 was 3 staff plus 3.2 additional staff hours (total of 27.2 hours) were needed to fulfill staffing requirements for 3rd shift. Review of staff assignment schedule created by the Administrator for May 13, 2015 revealed three staff were scheduled to work the SCU on third shift. Review of the time card detailed report for May 13, 2015 revealed: - Staffing for the SCU was less than the state requirement of 27.2 hours for third shift. - On third shift, the SCU had three staff clocked in for SCU assignments for a total of 22.2 hours. - The facility staffing was short by 5.0 hours on third shift.	D 465		

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D 465	Continued From page 136 Review of the Special Care Unit (SCU) daily census for May 16, 2015 revealed the following: - The total residents on the SCU was 35. - The staffing requirements for the SCU with an actual census of 35 was 3 staff plus 4.0 additional staff hours (total of 28.0 hours) were needed to fulfill staffing requirements for 3rd shift. Review of staff assignment schedule created by the Administrator for May 16, 2015 revealed three staff were scheduled to work the SCU on third shift. Review of the time card detailed report for May 16, 2015 revealed: - Staffing for the SCU was less than the state requirement of 28.0 hours for third shift. - On third shift, the SCU had three staff clocked in for SCU assignments for a total of 22.2 hours. - The facility staffing was short by 5.8 hours for third shift. Review of the Special Care Unit (SCU) daily census for May 18, 2015 revealed: - The total residents on the SCU was 34. - The staffing requirements for the SCU with an actual census of 34 was 4 staff plus 2.0 additional staff hours (total of 34 hours) for 2nd shift. - The staffing requirements for the SCU with an actual census of 34 was 3 staff plus 3.2 additional staff hours (total of 27.2 hours) were needed to fulfill staffing requirements for 3rd shift. Review of staff assignment schedule created by the Administrator for May 18, 2015 revealed the following: - Five staff were scheduled to work in the SCU	D 465		

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on second shift.
- Four staff were scheduled to work in the SCU for third shift.
- Only three of the four staff worked on the third shift.

Review of the time card detailed report for May 18, 2015 revealed:
- Staffing for the SCU was less than the state requirement of 34 hours for second shift and 27.2 hours for third shift.
- On second shift the SCU had four staff clocked in for SCU assignments to total 31 hours.
- On third shift the SCU had three staff clocked in for SCU assignments to total 24 hours.
- The facility staffing was short by 3.0 hours for second shift and short by 3.2 hours for third shift.

Review of the Special Care Unit (SCU) daily census for May 19, 2015 revealed the following:
- The total residents on the SCU was 34.
- The staffing requirements for the SCU with an actual census of 34 was 3 staff plus 3.2 additional staff hours (total of 27.2 hours) were needed to fulfill staffing requirements for 3rd shift.

Review of staff assignment schedule created by the Administrator for May 19, 2015 revealed three staff were scheduled to work the SCU.

Review of the time card detailed report for May 19, 2015 revealed:
- Staffing for the SCU was less than the state requirement of 27.2 hours for third shift.
- On third shift the SCU had three staff clocked in for SCU assignments for a total of 24.0 hours.
- The facility staffing was short by 3.2 hours for third shift.

Review of the Special Care Unit (SCU) daily

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census for April 19, 2015 revealed:
- The total census on the SCU was 36.
- The staffing requirements for the SCU with a census of 36 residents was 4 staff plus an additional 4 staff hours (total of 36 hours) for 1st and 2nd shift.
- The staffing requirements for the SCU with a census of 36 residents was 3 staff plus 4.8 additional staff hours (total of 28.8 hours) for 3rd shift.

Review of staff assignment schedule created by the Administrator for April 19, 2015 revealed:
-Four staff were scheduled to work on the SCU on the first shift.
-Five staff were scheduled to work on the second shift.

Review of the time card detailed report for April 19, 2015 revealed:
- On first shift, staff worked a total of 29 hours instead of the 36 hours required.
- On second shift, staff worked a total of 30.8 hours instead of the 36 hours required.
-The facility staffing was short by 7 hours for first shift and short by 5.2 hours for second shift.

Review of the Special Care Unit (SCU) daily census for April 20, 2015 revealed:
- The total census on the SCU was 36.
- The staffing requirements for the SCU with a census of 36 residents was 4 staff plus an additional 4 staff hours (total of 36 hours) for 1st and 2nd shift.
- The staffing requirements for the SCU with a census of 36 residents was 3 staff plus 4.8 additional staff hours (total of 28.8 hours) for 3rd shift.

Review of staff assignment schedule created by

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the Administrator for April 20, 2015 revealed:
-Five staff were scheduled to work on the SCU on the first shift.
-Four staff were scheduled to work on the SCU on the third shift.

Review of the time card detailed report for April 20, 2015 revealed:
- On first shift, staff worked a total of 18.3 hours instead of the 36 hours required.
- On third shift, staff worked a total of 24.5 hours instead of the 28.8 hours required.
-The facility staffing was short by 17.7 hours for first shift and short by 4.3 hours for third shift.

Review of the Special Care Unit (SCU) daily census for May 14, 2015 revealed:
- The total census on the SCU was 34.
- The staffing requirements for the SCU with a census of 34 residents was 4 staff plus an additional 2 staff hours (total of 34 hours) for 1st and 2nd shift.
- The staffing requirements for the SCU with a census of 34 residents was 3 staff plus 3.2 additional staff hours (total of 27.2 hours) for 3rd shift.

Review of staff assignment schedule created by the Administrator for May 14, 2015 revealed three staff were scheduled to work in the SCU on third shift.
Review of the time card detailed report for May 14, 2015 revealed:
- On third shift, staff worked a total of 23 hours instead of the 27.2 hours required.
-The facility staffing was short by 3.8 hours for third shift.

Review of the Special Care Unit (SCU) daily census for May 15, 2015 revealed:

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D 465	Continued From page 140 - The total census on the SCU was 35. - The staffing requirements for the SCU with a census of 35 residents was 4 staff plus an additional 3 staff hours (total of 35 hours) for 1st and 2nd shift. - The staffing requirements for the SCU with a census of 35 residents was 3 staff plus 4 additional staff hours (total of 28 hours) for 3rd shift. Review of staff assignment schedule created by the Administrator for May 15, 2015 revealed three staff were scheduled to work in the SCU on third shift. Review of the time card detailed report for May 15, 2015 revealed: - On third shift, staff worked a total of 22.5 hours instead of the 28 hours required. -The facility staffing was short by 5.5 hours for third shift. Review of the Special Care Unit (SCU) daily census for May 17, 2015 revealed: - The total census on the SCU was 35. - The staffing requirements for the SCU with a census of 35 residents was 4 staff plus an additional 3 staff hours (total of 35 hours) for 1st and 2nd shift. - The staffing requirements for the SCU with a census of 35 residents was 3 staff plus 4 additional staff hours (total of 28 hours) for 3rd shift. Review of staff assignment schedule created by the Administrator for May 17, 2015 revealed five staff were scheduled to work in the SCU on first shift. Review of the time card detailed report for May 17, 2015 revealed:	D 465		

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D 465	Continued From page 141 - On first shift, staff worked a total of 30.5 hours instead of the 35 hours required. -The facility staffing was short by 4.5 hours for first shift. Confidential interview with a staff person revealed: - There was usually two aides and one medication aide working in the special care unit (SCU) on third shift. - One weekend in April 2015, there was only 1 staff scheduled for the whole building on third shift. - Staff person thought two other people were called in to help that night on third shift for the whole building. - There had been a lot of staff turnover because of the pay and a heavy work load. - Some staff left because they thought the residents needed to be in a nursing home because they were heavy care. - The Wellness Coordinator and the Administrator would put staff on the schedule that they knew no longer worked at the facility. - So then, the shifts would be short staffed. Confidential interview with a second staff person revealed: - The facility has lost a lot of staff since last month. - Staff had worked double shifts to help with staff shortage. - Sometimes there are only two staff working in the SCU on third shift and 2 staff in the assisted living side of the facility. - There was two nights in April 2015 when there was only two staff working the whole facility on third shift. - The facility has had problems with being short staffed for over a year.	D 465		

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	HAL051048	A. BUILDING: _____ B. WING _____	R 05/28/2015

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D 465	Continued From page 142 - They do incontinent rounds every 2 hours in the SCU and routine rounds to check on residents every hour. - They had a list of 16 residents they had to get up in the mornings on third shift. - There were usually 3 staff on the floor in the SCU but 5 assignments. - They usually start getting residents up between 5:15 a.m. and 5:30 a.m. and it usually took until 6:45 a.m. to get them up and dressed. Confidential interview with a third staff person revealed: - Staff had been asked to work double shifts. - The facility was sometimes short staffed because there had been high turnover. - They have worked with two staff in the SCU and two staff in the AL on third shift at times. - Staff stated, "It's a lot", but they pull together and get it done with a lot of "rushing". Confidential interview with a fourth staff person revealed: - They usually have one personal care aide on the assisted living side and one medication aide who goes back and forth to the SCU. - Third shift has to get residents up in the mornings. - If they don't start getting residents up about 5:00 a.m. or 5:15 a.m., staff will be there after their shift ends at 7:00 a.m. Interview with 2 Medication Aide/Nursing Aide (MA/NAs) on 5/26/15 at 6:50am revealed: - The schedule for first and second shifts typically included 1 MA and 2-3 NAs, sometimes as many as 4 NAs. - The schedule for third shift in the SCU typically included 1 MA and 1-2 PCAs. - She informed the Wellness Coordinator when	D 465		

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D 465	Continued From page 143 staff called ahead stating they were unable to work. "She tries to fill in gaps in staffing." Interview with a MA/NA, on 5/27/15 at 5:30pm revealed: - The scheduled staff for third shift in the facility includes 2 PCAs and a Medication Aide. Two staff work in the SCU, including a PCA and the Medication Aide/Supervisor. - The scheduled staff for first and second shift in the SCU includes 3 PCAs/NAs and one Medication Aide. - NAs sometimes don't show up to work their assigned shift. Interview with the Special Care Unit Coordinator at 9:45am on 5/28/15 revealed: - She spent her time as Activity Director for the SCU and working one-on-one with SCU residents. - She did not direct the schedule or work of the NAs or Medication Aides. - She works weekdays, 8am to 5pm. Interview with the Wellness Director and 11am on 5/28/15 revealed: - She kept abreast of staffing needs in the facility. - She had asked nursing staff to contact her if workers "call out" for any reason. - She fills in some gaps by working alongside the NAs and MAs. - A Resident Care Coordinator has just been hired for the facility, "we have been without a nurse for several months". Interview with Administrator on 5/28/15 at 5:45 P.M. revealed: - Administrator does a monthly schedule and Wellness Coordinator (WC) manages it.	D 465		

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D 465	Continued From page 144 - If there is a call-out both WC and Resident Services Director (RSD) are responsible for filling that call-out. - Administrator goes by the state regulations when staffing the units. - Although WC floats and assist where needed, this is not considered when staffing units. Interview with Wellness Coordinator (WC) on 5/28/15 at 6:15 P.M. revealed: - Administrator does schedule and WC manages it. - WC does daily assignment sheets. - Handle all call outs and find replacements or see if they switched with another coworker. - If short on weekend, staff would call WC. - If unable to find coverage, WC would come in and work shift either as a CNA or MA. - That includes WC working all shifts when needed. - There have never been a time when she has been unable to cover shifts. _____ Review of the facility's plan of protection dated 05/28/15 revealed: - Facility will staff per state regulations or based upon resident care needs. - Facility will staff to state regulations and use back up on-call system to ensure proper staffing for the special care unit. - Staffing will be monitored by the Executive Director / Resident Services Director, Wellness Coordinator or Designee to ensure compliance daily. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 12, 2015.	D 465		

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D911	Continued From page 145	D911		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure residents were treated with respect, consideration, and dignity as related to staff waking up residents as early as 5:00 a.m. so residents would be up and dressed prior to start of first shift. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to third shift staff waking residents up as early as 5:00 a.m. to get up and get dressed for the day. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights.]	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and	D912		

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D912	Continued From page 146 services which are adequate, appropriate, and in compliance with rules and regulations as related to personal care and supervision, health care personnel registry, and special care unit staffing. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 1 of 6 residents (#2) sampled with multiple falls, including falls with head injuries requiring visits to the emergency room. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 2. Based on observation, interview and record review, the facility failed to report an allegation of abuse against health care personnel for 1 of 1 staff (F) within 24 hours of facility becoming aware of allegations of Staff F shoving Resident #11 down, along with any investigation by facility within 5 working days. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation).] 3. Based on observation, record review, and interview, the facility failed to assure that the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 15 of 42 shifts from 04/17/15 to 04/23/15 and 05/13/15 to 05/19/15. [Refer to Tag D465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D914		

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D914	Continued From page 147 Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure residents were free of neglect as related to management of facilities, health care and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the administrator failed to assure the total operation of the facility to meet and maintain rules related to Personal Care and Supervision, Health Care, Nutrition and Food Service, Medication Administration, Health Care Personnel Registry, Special Care Unit Staffing, and Resident Rights. [Refer to Tag D176 10A NCAC 13F .0601(a) Management of Facilities (Type A1 Violation).] 2. Based on observation, record review and interview, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 5 of 6 residents (#1, #2, #3,#5, #6) sampled as related to: obtaining urinalysis for two residents (#1, #2) with urinary tract infections resulting in a fall with head injury for one resident and hospital visits for both residents; coordinating with the pharmacy and physician to obtain Potassium supplement for a resident (#3) whose potassium levels became critically low causing nausea and vomiting and significant weakness leading to resident being unable to feed herself; notifying the physician of a significant weight change for a resident (#2) with swelling and hospitalization for congestive heart failure; obtaining a glucometer and notifying the	D914		

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D914	Continued From page 148 physician of a resident (#6) whose blood sugar and sliding scale insulin was not being done resulting in high blood sugar reading and hospitalization; and coordinating to get a diabetic resident's fingernails (#5) trimmed resulting in long, jagged nails on both hands. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).] 3. Based on record review and interviews, the facility failed to assure documentation and implementation of physician's order for 7 of 8 residents (#1, #2, #3, #5, #6, #9, #10) sampled including orders for blood sugars (#2, #6), blood pressures (#3, #5, #9), pulses (#5) , weights (#1, #2, #3, #5), ted hose (#2), hot/cold packs (#10), and nail care (#5). Refer to Tag D276 10A NCAC 13F .0902(c)(3)(4) Health Care (Type A1 Violation).] 4. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 7 residents (#12) observed during the medication passes, including errors with medications for blood thinning, acid reflux, and constipation, and 8 of 9 (#1, #2, #3, #4, #5, #6, #8, #12) sampled for review related to errors with medications for diabetes, high blood pressure, low potassium levels, infection, inflammation, swelling, constipation, breathing problems, allergies, cough and congestion. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).]	D914		