STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060111	A. BUILDING: _____ B. WING _____	06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE ASSISTED LIVING	2140 MILTON ROAD CHARLOTTE, NC 28205

(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 Mecklenburg County Department of Social Services conducted an annual survey on June 1-2, 2016.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled staff (Staff A and Staff B) had no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hiring. The findings are: A. Review of Staff A's personnel records revealed: -A hire date of 11/10/15 as a Medication Aide. -Documentation of a completed HCPR check was dated 11/12/15 with no substantiated findings. Interviews on 6/01/16 at 10:00 am and 6/02/16 at 3:00 pm with Staff A revealed: -She had previously worked at the facility, left "before the summer of 2015" and returned the "end of 2015". -The office staff performed background checks, but she was not sure what checks were performed.	D 137		

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D 137	Continued From page 1 Interview on 6/02/16 at 10:15 am with the Business Office Manager (BOM) revealed: -She was responsible for maintaining the information in the staff folders. -She had worked at the facility as the BOM for 1 year. -"The HCPR check was run after the background check came back clear, but before a position was offered." -The HCPR check was "probably overlooked because Staff A had previously worked here". -The BOM was not aware that the HCPR check had to be completed again since Staff A had previously worked at the facility. -Staff A had left the facility for approximately 5 months before returning to work. Interview on 6/02/16 at 11:20 am with the Executive Director revealed that "since Staff A was a rehire it was thought initially that the HCPR would not need to be re-checked, then we decided to check it anyway". Refer to interview on 6/02/16 at 11:25 am with the Administrator. B. Review of Staff B's personnel records revealed: -A hire date of 5/8/14 as a Personal Care Aide (PCA). -Documentation of a completed HCPR check was dated 7/22/15 with no substantiated findings. -Documentation that an audit of the Staff B's record was completed 10/02/15. Interviews on 6/01/16 at 3:30 pm and 6/02/16 at 10:15 am with the Business Office Manager (BOM) revealed: -She was "not sure why a HCPR check was done	D 137		

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D 137	Continued From page 2 in July 2015 when Staff B was hired in May 2014. The files could have been audited and at that time, the HCPR may have been missing from the file and completed at that time." -She was responsible for maintaining the information in the staff folders. -She had worked at the facility as the BOM for 1 year. -"The HCPR check was run after the background check came back clear, but before a position was offered." Interview on 6/02/16 at 10:50 am with Staff B revealed: -She had worked as a PCA at another facility before being hired in May 2014. -The facility performed background checks but she was not aware what checks were performed. Further interview on 6/02/16 at 10:55 am with the BOM revealed: -She "cannot speak to why Staff B's HCPR check was done after the hire as I did not work here then". -An audit of staff files was completed in 10/2015 and Staff B had a HCPR check dated 7/22/15. -"I checked the facility's scanned back-up files and did not find an earlier dated HCPR check" for Staff B. Refer to interview on 6/02/16 at 11:25 am with the Administrator. Interview on 6/02/16 at 11:25 am with the Administrator revealed the HCPR check was important related to resident interaction and was to be performed before a staff member was hired.	D 137		

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D 344	Continued From page 3	D 344		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify conflicting orders for 1 of 5 sampled residents (Resident #2) regarding blood pressure monitoring and new medication ordered (Amlodipine). The findings are: Review of Resident #2's current FL2 dated 12/11/15 revealed: -Diagnoses included Alzheimer's disease, dementia with behavior disturbance anxiety, elevated blood pressure (BP) without hypertension and Diabetes. -Medications listed did not include medications to treat high blood pressure. -A physician's order to check the BP weekly. -There were no ordered BP parameters for notifying the physician. Review of Resident #2's record revealed:	D 344		

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-A pre-printed physician's order page listing "current orders as of 5/23/16" signed and dated 5/23/16 by the physician to check BP weekly.
-Conflicting physician's orders from clinic notes dated 5/10/16 and 5/23/16, but both printed and sent to the facility on 5/23/16.

Review of Resident #2's clinic note dated 5/10/16 revealed:
-Resident #2 had a well visit with his physician on 5/09/16.
-Resident #2's BP was 165/90.
-The physician's plan of care included a new medication order for Amlodipine 2.5 mg daily (a medication to treat high BP).
-The physician's plan of care included an order to "check BP 3 times weekly and record on medication administration record (MAR)".
-No ordered BP parameters for notifying the physician.
-The clinic notes were "finalized and signed" at 5/10/16 by the physician.
-The clinic notes were printed by the Nurse Practitioner (NP) on 5/23/16 at 9:35 am (documented at the top of the page).
-A fax date stamp at the top of the page dated 5/23/16 at 10:20 am.

Review of Resident #2's clinic note dated 5/23/16 revealed:
-Resident #2 had a well visit with his physician on 5/23/16.
-Resident #2's BP was 145/85.
-Amlodipine 2.5 mg daily was not listed on the active list of medications.
-BP frequency was not specified.
-The plan of care entry was "no changes".
-The clinic notes were "finalized and signed" at 5/23/16 by the physician.
-The clinic notes were printed by a named office

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D 344	Continued From page 5	D 344		

staff on 5/23/16 at 2:30 pm (documented at the top of the page).
-A fax date stamp at the top of the page dated 5/23/16 at 14:58 pm (2:58 pm).

Review of Resident #2's April 2016 electronic MAR (eMAR) revealed the BP was obtained weekly as ordered and ranged from 100/70 to 159/79.

Review of Resident #2's May 2016 eMAR revealed:
-An entry to check BP weekly. There were no BP parameters listed to notify the physician.
-BP results were documented weekly from 5/01/16 to 5/31/16 and ranged from 107/85 to 165/90.
-There was no entry for an order to change BP checks to 3 times weekly.
-No BP results were documented 3 times weekly from 5/10/16 to 5/31/16.
-There was no entry for Amlodipine 2.5 mg daily.

Review of Resident #2's June 2016 eMAR on 6/02/16 revealed:
-An entry to check BP weekly. There were no BP parameters listed to notify the physician.
-No BP results were documented as the weekly check was not due to be checked until 6/06/16.
-There was no entry for BP checks 3 times weekly.
-No BP results were documented 3 times weekly.
-There was no entry for Amlodipine 2.5 mg daily.

Review of Resident #2's record on 6/02/16 revealed a telephone physician's order dated 6/01/16 to "continue orders as signed on PO (physician's orders page) 5/23/16, no action needed".

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D 344	Continued From page 6 Review of medications on hand and available to be administered to Resident #2 on 6/01/16 at 3:50 pm revealed no Amlodipine 2.5 mg available. Interview on 6/01/16 at 3:00 pm with Resident #2's family member revealed: -She was also the Power of Attorney for Resident #2. -She was pleased with the care the facility provided. -The facility kept her well informed with the orders, treatments and needs for Resident #2. -She expected physician's orders to be followed. -She was not aware of how often BP checks were performed, and did not think that Resident #2 was on any BP medications. Interview on 6/01/16 at 3:45 pm with a MA revealed: -Either the pharmacy or the Resident Care Coordinator (RCC) entered new orders into the electronic eMAR system. A Supervisor MA would enter orders during the recent weeks without an RCC. -BP checks were obtained every Monday on Resident #2 as the order on the eMAR was for weekly checks. -There was no entry for Amlodipine on the eMAR, so she had not administered it. -When the facility received physician clinic visits reports, if they contained orders, they were faxed to the pharmacy. Interview on 6/01/16 at 4:00 pm with the Administrator revealed: -Resident #2's clinic note with physician orders dated 5/10/16 was not printed or received by the physician's NP until 5/23/16 and then was faxed to the facility on 5/23/16.	D 344		

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-Resident #2's clinic note dated 5/23/16 was faxed to the facility on 5/23/16 and had no changes to the plan of care.
-The Subsequent Physician Order page was also signed, dated, and faxed to the facility on 5/23/16 that did not include Amlodipine or changing the BP checks to 3 times weekly.
-The facility staff should have clarified the orders with the physician since the orders received on 5/23/16 were different.

A second interview on 6/02/16 at 8:30 am with the Administrator revealed:
-He had contacted the physician and clarified the orders.
-The physician did not want the Amlodipine started, and wanted to keep the BP checks weekly.
-The facility should have clarified orders sooner.

Interview on 6/02/16 with Resident #2's physician revealed:
-When he visited the facility and saw the residents, he entered orders into the computer and expected his NP to print the orders out to initiate them.
-He was not sure why the orders for Amlodipine and change in BP checks were not started after his 5/09/16 visit.
-He did not write prescriptions for Amlodipine. The facility used the orders he entered into the computer as were on his clinic notes.
-He was not aware the 5/09/16 visit orders were not printed out until 5/23/16 by his NP and were not sent to the facility until 5/23/16.
-He expected new orders to start within 24 hours to allow the facility time to process and obtain new medications.
-He expected the facility to contact him if necessary to clarify orders. No one had contacted

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D 344	Continued From page 8 him regarding the Amlodipine and BP check orders until the Administrator contacted him 6/01/16. -He would evaluate Resident #2 next week before starting the Amlodipine and increasing the BP checks. He gave that order to the facility yesterday (6/01/16). Interview on 6/02/16 at 12:15 pm with Resident #2's physician's NP revealed: -The physician entered orders into the computer when he visited the facility and resident. "He can complete ("finalize") the notes and orders at anytime, and from anywhere, even home". -Finalized physician's clinic notes should have been sent to the facility within 24 hours for orders to be followed. -He was not sure why the 5/10/16 finalized notes and orders were not submitted to the facility before 5/23/16. -He thought that maybe since the physician had not re-ordered the medication and BP checks when he visited the resident on 5/23/16, then the resident had not needed the treatment after all. -He thought the physician wrote out orders and gave them to the facility to process and start that day. -It was the facility's responsibility to clarify orders as necessary, and to fax orders to the pharmacy. -The physician would visit Resident #2 on Monday, 6/06/16 to evaluate.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 2 of 5 (#1 and #5) sampled residents regarding Humalog insulin and an antibiotic.

The findings are:

A. Review of Resident #1's current FL2 dated 12/08/15 revealed:
-Diagnoses included Alzheimer's Disease, dementia, schizophrenic disorder, vitamin D deficiency, hyperlipidemia, alcohol abuse and diabetes mellitus.
-A physician's order for Humalog insulin - inject 5 units after meals and hold if resident eats less than 50% of meals or if blood sugar is less that 100 (Humalog is a fast acting insulin used to lower blood sugar).

Review of Resident #1's record revealed:
-A physician's order dated 4/27/16 to discontinue the fixed dose of Humalog.
-A physician's order for Finger Stick Blood Sugar (FSBS) less than 40 call Emergency Medical Service (EMS), for a FSBS of 40-60 give 1 cup of juice and notify the doctor, for a FSBS of 60-80 give 1/2 cup of juice, for FSBS over 400 give 10 units of Humalog and for a FSBS over 451 or more call the doctor.

Review of Resident #1's electronic Medication

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D 358	Continued From page 10 Administration Records (eMAR) for April, May and June 2016 revealed: -An entry for Humalog Insulin - inject 5 units after meals (hold if patient eats less than 50% of meal or fingerstick blood sugar is less than 100). -Documented as administered at 7:30 am, 12:30 pm and 5:30 pm from 4/01/16 to 4/30/16 and at 7:30 am and 12:30 pm on 6/01/16. -There was no entry for Finger Stick Blood Sugar (FSBS) less than 40 call Emergency Medical Service (EMS), for a FSBS of 40-60 give 1 cup of juice and notify the doctor, for a FSBS of 60-80 give 1/2 cup of juice, for FSBS over 400 give 10 units of Humalog and for a FSBS over 451 or more call the doctor. -In April the blood sugars ranged from 64-329. -In May the blood sugar ranges from 60-430. Interview with a Medication Aide (MA) on 6/02/16 at 3:50 pm revealed: -She faxed all new orders to the pharmacy and called the pharmacy to verify the order was received. -She checked the printed label on the medication and compared it to the eMAR. -She did not compare the entry on the eMAR against the written or printed physician orders in the Resident Records. -She did not know if the supervisors or other MAs did or were expected to compare the eMAR with the written or printed physician orders. Interview with a second MA on 6/02/16 at 10:44 am revealed: -The facility had problems in the past with the pharmacy not entering orders that they had faxed. -If she received a physician order she would fax it to the pharmacy and call the pharmacy to verify the order was received.	D 358		

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D 358	Continued From page 11 -She would most often check the eMAR with the new physicians order to verify accuracy. -Sometimes it took the pharmacy longer to enter the new orders on the eMAR and she might not be in the facility when the order got entered. -She always told the oncoming shift of any new orders and would call the facility after she left to verify that they had been processed. -She would check the new entries the next day to verify accuracy of the eMAR. -She did not know if other MAs compared new orders with the eMAR to verify accuracy. Interview with the Administrator on 6/02/16 at 11:34 am revealed: -The MAs were expected to call the pharmacy after faxing all new orders to verify the pharmacy received them. -The Memory Care Manager (MCM) was expected to check all physician orders and verify the eMARs were accurate. -As of 4/25/16 they no longer had a MCM. -A group of the managers and the more seasoned MAs were working together to make sure physician orders were processed and accurate. -The other orders that were included on Resident #1's physician order dated 4/27/16 were processed appropriately by the pharmacy and he did not know why they overlooked the Humalog insulin order change. -He was not aware of the Humalog order change. -The MCM was also expected to ensure all eMARs were accurate from month to month to ensure all new orders were processed and accurate but this did not occur because they had not replaced the MCM at that time. Interview with a Nurse from Resident #1's physician office 6/02/16 at 11:30 am:	D 358		

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D 358	Continued From page 12 -No one from the facility had called to clarify or verify the physician's order to change the Humalog until 6/01/16. -There was a Physician note that the facility had informed him on 6/01/16 the Humalog order from 4/27/16 had not been initiated. -The Physician reviewed the blood sugars and there was no clinical repercussions for the missing order. Interview with a Representative from the contracted pharmacy on 6/02/16 at 10:08 am revealed: -There was no communication from the facility requesting the new Humalog order be entered. -The pharmacy did receive the new Humalog order dated 4/27/16 and he did not know why the Humalog order was not processed. -The pharmacy would expect a phone call from the facility to notify the pharmacy of any orders that were not processed or processed inaccurately. Based on observation, record review and attempted interview, it was determined Resident #1 was not interviewable.	D 358		