STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051024	A. BUILDING: _____ B. WING _____	R 06/25/2015

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BROOKDALE SMITHFIELD	830 BERKSHIRE ROAD SMITHFIELD, NC 27577

(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 conducted an annual and follow-up survey on June 23 - 25, 2015.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 5 sampled residents (Resident #4) was tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #4's FL-2 dated 05/21/14 revealed: -Diagnoses which included altered mental status and dementia. -Review of the Resident Register revealed the resident was admitted to the facility on 5/23/14. Review of Resident #4's admission records (from a local hospital discharge records dated 5/23/14) revealed a Tuberculosis Test was completed on	D 234		

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D 234	Continued From page 1 5/18/14 (negative results). Record review revealed no other TB skin test for Resident #4. Interview with the facility's Administrator on 6/24/15 at 11:45am revealed: - All residents were admitted with at least 1 negative TB skin test or negative chest x-ray. - The 2nd step TB skin test was done at the resident's primary physician's office in about 2-3 weeks from admission. - If Resident #4 did not have a second step, either the physician did not send the results to the facility or the 2nd TB test was not done. - The facility will transport Resident #4 to the physician's office as soon as possible to complete the 2nd step. - The Administrator stated she was not aware Resident #4's 2nd step TB skin test was not done.	D 234		
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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure physician notification of systolic blood pressure readings less than 100 according to physician parameters for 1 of 3 sampled residents (Resident #3).	D 273		

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D 273	Continued From page 2 The findings are: Review of Resident #3's current FL-2 dated 04/06/2015 revealed: -Diagnoses included Atrial Fibrillation, Hypertension, Pulmonary Hypertension, Gastro-esophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Degenerative Joint Disease, Status Post Pelvic and Femur Fracture, Anemia, and Difficulty Walking. -A physician order for blood pressure checks on Monday, Wednesday, and Friday and notify physician if systolic blood is less than 100. Review of vital sign recordings for 5/2015 Resident #3 revealed: -On 5/11/2015 9am, systolic blood pressure reading documented as 88. -On 5/13/2015 9am, systolic blood pressure reading documented as 92. -On 5/15/2015 9am, systolic blood pressure reading documented as 93. -On 5/18/2015 9am, systolic blood pressure reading documented as 91. -On 5/20/2015 9am, systolic blood pressure reading documented as 89. Review of vital sign recordings for 6/2015 Resident #3 revealed: -On 6/3/2015 8am, systolic blood pressure reading documented as 92. -On 6/5/2015 8:30am, systolic blood pressure reading documented as 87. -On 6/8/2015 8:30am, systolic blood pressure reading documented as 98. -On 6/10/2015 9am, systolic blood pressure reading documented as 90. -On 6/12/2015 9am, systolic blood pressure reading documented as 93. -On 6/15/2015 9am, systolic blood pressure	D 273		

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reading documented as 89.
-On 6/17/2015 9am, systolic blood pressure reading documented as 91.
-On 6/19/2015 9am, systolic blood pressure reading documented as 91.
-On 6/22/2015 9am, systolic blood pressure reading documented as 90.
-On 6/24/2015 9am, systolic blood pressure reading documented as 87.

Record review revealed no documentation that Resident #3's physician had been contacted regarding the resident's systolic blood readings less than 100.

Interview with a Medication Aide (MA) on 6/25/2015 at 11:30am revealed:
-The MA did not usually work first shift at the facility.
-The MA usually worked in the Special Care Unit at the facility.
-The MA had never checked Resident #3's blood pressure.

Interview with a MA on 6/25/2015 at 12:45pm revealed:
-Medication Aides were responsible to obtain resident vital signs.
-The facility faxes the physician the vital sign recording.
-The MA had never contacted the physician about Resident #3.
-If the physician had been called concerning the resident, documentation would be in the resident's record or on the 24 hour report sheet.
-The May 2015 24 hour report sheets had been filed and the MA was not sure where the May 2015 24 hour report sheets were.

Review of the 24 hour report sheets for 06/1/205

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through 06/25/2015 revealed no documentation of physician contact regarding systolic blood pressure readings for Resident #3.

Interview with a facility Licensed Practical Nurse (LPN) on 06/25/2015 at 3:10pm revealed:
-The LPN knew at one time of blood pressure parameters for Resident #3.
-Staff sometimes would call the physician and because Resident #3 was on Hospice, the staff might be referred back to hospice by the physician.
-Usually the nurse or the medication aide would call the physician.
-The LPN was not aware of any low blood pressure readings obtained for Resident #3.

Interview with the Health and Wellness Director (RN/HWD) on 06/25/2015 at 3:20pm revealed:
-The RN/HWD was not aware of systolic blood pressure parameters for Resident #3 until today (6/25/2015).
-The RN/HWD had been stopped by medication aides and the MA would say Resident #3's blood pressure was low and the RN/HWD would call the Physician Assistant (PA).
-The RN/HWD could not think of any specific times when the PA had been notified about Resident #3's blood pressure.
-The RN/HWD did not know Resident #3's blood pressure was low on 06/24/2015.
-The RN/HWD was not in the facility on 6/22/2015 (Monday), so was not aware of the low blood pressure reading obtained for Resident #3 on 6/22/2015.

Telephone interview with the PA on 6/25/2015 at 3:25pm revealed:
-There were no notes documenting notification from the facility of low systolic blood pressures for

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Resident #3.
-Resident #3 was seen at the facility about every 2 - 3 months unless something was going on with the resident that staff had informed the PA about.
-Resident #3 was last seen at the facility on 6/18/2015 for a follow up visit following a hospitalization.
-If the PA had known about the low systolic blood pressures, the PA probably would not have changed any orders other than adjusting Resident #3's blood pressure medications.

Observation of Resident #3 on 6/25/2015 at 3:35pm revealed:
-Resident #3 was sitting in the facility parlor.
-Resident #3's blood pressure was checked by the LPN in the left arm and systolic blood pressure was 102.
-The LPN asked Resident #3 about dizziness and headache and Resident #3 denied having both.
-Resident #3 stated "sometimes" when asked if staff checked her blood pressure, and "think so" when asked if her blood pressure was checked three times a week.

The MA working on 6/24/2015 from 7am to 3pm could not be reached by telephone for interview.

Telephone interview with the hospice agency director on 6/25/2015 at 4:00pm revealed she did not have any information regarding notification from the facility on low systolic blood pressures for Resident #3 but would check with the nurse following Resident #3 and return a call.

Interview with the facility LPN on 6/25/2015 at 4:30pm revealed the hospice agency had returned a call to the facility and the hospice nurse following Resident #3 had not received any calls from the facility about blood pressures.

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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: Based on observations, record reviews, and interviews, the facility failed to implement treatments for oxygen administration in accordance with the orders of prescribing medical provider for 1 of 5 sampled residents (Resident #2). The findings are: Review of Resident #2 's current FL-2 dated 05/01/2015 revealed: -Diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and dementia. -Resident is constantly disoriented. -Order for oxygen at 4 liters per minute (LPM) continuous. Review of Resident Registry revealed Resident #2 was admitted to facility on 4/28/2015. Observation of Resident #2 at 12:29 P.M. on 06/23/2015 revealed: -Resident #2 was sitting in a wheelchair at the dining table in the Special Care Unit -Resident #2 was noted to have intact nasal	D 276		

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cannula which was attached to secured portable oxygen canister.
-The dial on the portable oxygen canister was set to deliver oxygen to Resident at 2 LPM.

Interview and observation of Resident #2 at 5:46 P.M. on 06/23/2015 revealed:
-Resident was lying in bed with nasal cannula intact and attached to floor oxygen unit.
-The oxygen unit was set to deliver oxygen at 2 LPM.
-Resident #2 said "I' m supposed to get 4. You look to see if I'm not supposed to get 4."

Interview with Resident Care Aide (RA) at 5:50 P.M. on 06/23/2015 revealed:
-RAs do not adjust oxygen delivery rate but do turn oxygen on and off at portable oxygen canisters and floor oxygen units when switching between devices while assisting residents with ambulation and other needs.
-The RA said "I think it's 2 liters or something ...as long as it is at the 2 liter line it' s ok. "

Interview with Resident Care Coordinator (RCC) 5:57 P.M. on 06/23/2015 revealed:
-Treatment orders for oxygen are on the FL-2.
-It is facility procedure to document oxygen orders on each resident's Medication Administration Record (MAR).
-Resident #2's oxygen order should be transcribed to her MAR.
-The facility RCC and Health and Wellness Director (HWD) are responsible for ensuring oxygen orders are transcribed on resident's MARs.
-The RCC, HWD, and MAs are responsible for administering medications and treatments per provider orders.
-The RCC stated Resident #2 "Is very alert. "

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D 276	Continued From page 8 Observation of the RCC at 6:07 P.M. on 6/23/2015 revealed: -The RCC reviewed Resident #2's June 2015 MAR and stated the oxygen order was not transcribed to the MAR. -The RCC walked into Resident #2's room and checked the oxygen unit. - The oxygen unit was set to deliver oxygen at 2 LPM. -The RCC asked Resident #2 how much oxygen she should be receiving. Resident #2 replied "4." Interview with a Resident Care Aide/Medication Aide (RA/MA) at 6:10 P.M. on 6/23/2015 revealed: -Oxygen orders are found on the FL-2 form. -It is facility procedure for oxygen orders to be transcribed on each resident's MAR. -Resident #2 received oxygen at 2 LPM. -Resident #2 had oxygen ordered but the order was not transcribed to the June 2015 MAR. -The MA/RA checked Resident #2's oxygen administration once every shift. -The MA/RA had no knowledge of how or when other staff check Resident #2' s oxygen. -MAs are responsible for administering medications and treatments to facility residents per provider order. Interview with RCC at 9:43 A.M. on 6/24/2015 revealed: -The facility contacted Resident #2's medical provider to clarify the oxygen order on 6/24/2015. -Resident #2 would receive oxygen per the FL-2 form order of 4 LPM until the order was clarified. Interview and observation with another RA/MA at 11:30 A.M. on 6/24/2015 revealed: -When Resident #2 was admitted to the facility,	D 276		

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her family member told staff she was to be administered oxygen at 2 LPM.
-Resident #2's oxygen is checked at random intermittent intervals.
-MAs, the Registered Nurse (RN), and the Licensed Practical Nurse (LPN) are responsible for checking to ensure oxygen is administered to each resident per medical provider order.
-Oxygen orders are on the FL-2 form.
-Oxygen orders are on each resident's MAR.
-The staff member receiving or clarifying a provider order is responsible for documenting the order on to the residents MAR.
-Upon review of Resident #2's FL-2 form, RA/MA noticed oxygen was ordered at 4 LPM. RA/MA stated "We should get clarification on that."

Interview with RCC at 9:17 A.M. on 6/25/2015 revealed:
-Resident #2's oxygen order was clarified by medical provider and transcribed to June MAR on 6/24/2015.
-The provider clarified the oxygen at 3 LPM continuous for Resident #2.

Interview with the Health and Wellness Director at 9:26 A.M. on 6/25/2015 revealed:
-It is facility procedure to contact the prescribing medical provider to clarify discrepancies with orders for medications or treatments.
-The HWD said the oxygen order should have been clarified when the family told staff that Resident #2 received oxygen at 2 LPM because the FL-2 showed oxygen at 4 LPM.

Interview with Executive Director (ED) on 6/25/2015 at 3:45 P.M. revealed:
-Resident MARS should contain the most up to date orders.
-The RCC and HWD are responsible for ensuring

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D 276	Continued From page 10 medication and treatment orders are on each resident's MAR and administered per order of medical provider. -Utilization of the Order Tracking Tool, MAR checks, having a Registered Nurse (RN) in the facility, and having Regional RN oversight are utilized by the facility to ensure procedures are followed. .	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs	D 280		

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D 280	Continued From page 11 (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status for 2 of 3 residents sampled (Resident #2 and Resident 3). The findings are: 1. Review of Resident #2's current FL-2 dated 5/01/15 revealed: -Diagnoses included dementia and Chronic Obstructive Pulmonary Disease (COPD). -Order for oxygen at 4 liters per minute (LPM) continuous. Review of the Resident Registry for Resident #2 revealed resident was admitted to facility on 4/28/2015. Observation of Resident #2 on 6/23/2015 at 12:29 revealed: -Resident was sitting in a wheelchair at the dining table eating lunch. -Resident had intact nasal cannula attached to portable oxygen canister. -The canister was set to deliver oxygen at 2 LPM. -Resident's respirations were unlabored. Observation of Resident #2 on 6/23/2015 at 5:46 P.M. revealed: -Resident was lying in bed with nasal cannula intact and attached to floor oxygen unit. -The unit was set to administer oxygen at at 2 LPM. -Resident was alert without signs and symptoms of increased work of breathing.	D 280		

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D 280	Continued From page 12 Observation of Resident #2 on 6/24/2015 at 9:25 A.M. revealed: -Resident was lying in bed with nasal cannula intact and attached to floor oxygen unit. -The unit was set to administer oxygen at 2 LPM. -Resident was alert but confused; requiring reorientation. -There was no evidence of respiratory distress or increased work of breathing. Review of Resident #2's record revealed no Licensed Health Professional Support (LHPS) Checklist LHPS found in the record. Interview with Health and Wellness Director (HWD) at 9:24 A.M. on 6/25/2015 revealed: -Resident #2 had a physician order for oxygen on admission, therefore an LHPS review should have been done. -The facility HWD is responsible for completing the LHPS review. -The LHPS review for Resident #2 had not been done. -The LHPS review was to be completed for Resident #2 on 6/25/2015 Review of Resident #2's record on 6/25/215 revealed the LHPS review for Resident #2 signed by HWD and dated 6/25/2015. 2. Review of Resident #3's most recent FL-2 dated 04/06/2015 revealed: -Diagnoses included Atrial Fibrillation, Hypertension, Chronic Obstructive Pulmonary Disease, Degenerative Joint Disease, Status Post Pelvic and Femur Fracture, Anemia, and Difficulty Walking. -An admission date of 12/03/2012. Observation of Resident #3 in her room on	D 280		

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D 280	Continued From page 13 6/23/2015 at 11:30am revealed: -Resident #3 was sitting in a high back wheelchair next to the hospital bed. -A concave mattress was on the bed. -There was a lift chair sitting against the wall close to the window. -An electric wheelchair and a walker were in Resident #3's room. Interview with Resident #3's Power of Attorney (POA) on 06/23/2015 at 11:40am revealed: -Resident #3 had been instructed by staff not to try to get up from anywhere by herself. -Resident #3 had a history of falls at a previous facility. -Resident #3 had fallen at this facility. -The POA depended on staff to provide care for Resident #3. -The POA had no concerns with the care provided by staff to Resident #3. Interview with a Medication Aide on 06/25/2015 at 11:30am revealed Resident #3 was a two person transfer. Review of Licensed Health Professional Support (LHPS) evaluations for Resident #3 revealed: -LHPS evaluations dated 10/09/2013 and 3/26/2015. -LHPS tasks listed on the 10/09/2013 and 3/26/2015 LHPS evaluations included transferring semi ambulatory or non-ambulatory residents and ambulation using assistive devices that require physical assistance. -No quarterly LHPS evaluations for 1/2014, 4/2014, 7/2014, 10/2014, and 1/2015. -No evaluation of transfer status and ambulation with assistive device from 10/9/2013 to 3/26/2015.	D 280		

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D 280	Continued From page 14 Interview with the Executive Director (ED) on 06/24/2015 at 2:30pm revealed: -The RN/HWD was responsible to complete LHPS evaluations. -The ED thought LHPS evaluations were done yearly but would check with the RN/HWD on the frequency of completing LHPS evaluations. Interview with the Health and Wellness Director (RN/HWD) on 6/24/2015 at 3:55pm revealed: -The RN/HWD was responsible to complete LHPS evaluations. -LHPS evaluations are done within 15 - 30 days of admission, then quarterly or with changes. -The completed LHPS evaluations were filed in the resident's record by the third shift medication aide. Interview with the RN/HWD on 6/25/2015 at 11:00am revealed: -The RN/HWD had not located any additional LHPS evaluations for Resident #3. -The RN/HWD thought the missing LHPS evaluations may have been misfiled. No additional LHPS evaluations were made available for review for Resident #3.	D 280		
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;	D 344		

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D 344	Continued From page 15 (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 provider orders for 1 of 5 sampled residents for Aricept (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 6/02/2015 revealed: -Diagnosis included dementia with behavioral disturbances. -Resident #1 is intermittently confused. -No medication order for Aricept. Review of Resident #1's record on revealed: -According to Resident Registry, Resident #1 was admitted to facility 6/03/2015 -A prescription signed by a medical provider dated 6/02/2015 for donepezil (Aricept), take 3 tablets by mouth every evening (Aricept is a medication prescribed for the treatment of dementia). Review of Resident #1's June 2015 Medication Administration Records (MARs) revealed: -Entries were hand written on the MAR. -There was no entry for Aricept on MAR. Interview and observation with Resident #1 on 6/23/2015 at 11:38 A.M. revealed: -Resident was sitting is his room listening to	D 344		

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D 344	Continued From page 16	D 344		

music.
-Resident was alert and oriented.
-Resident said he had been living in the facility only a few weeks and was satisfied with the care. he was receiving,

Observation on the medication cart on 6/24/2015 at 10:00 A.M. revealed:
-60 tablets of 10 mg. Aricept on hand for Resident #1 with a pharmacy dispense date of 6/06/2015.
-There was no medication punched out of the Aricept bubble card.
-The Aricept was stored in the medication cart in a compartment separate from Resident #1's other medications.

Interview with a Medication Aide (MA) on 6/24/2015 at 11:30 A.M. revealed:
-The facility communicates medical provider orders to the facility pharmacy by copying and faxing the orders to the facility pharmacy. Fax confirmation is obtained and retained in each resident's record.
-When a medication cannot be obtained from the facility pharmacy, a local pharmacy is used to ensure the medication is acquired in a timely manner.
-It is facility procedure to check the resident's record and FL-2 form for a signed medical provider order if a medication is received from the facility pharmacy that is not on a resident's MAR.
-It is facility procedure to contact the prescribing medical provider to clarify orders as needed.
- When a staff member obtains a new order, or clarification of an order, it is the responsibility of that staff member to document the order to the resident's MAR using a hand-written entry.
-Resident #1's Aricept was stored in the medication cart separate from the resident's other

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D 344	Continued From page 17 medications because it was not on the Resident's current MAR. Record review on 6/25/2015 revealed: -Copy of signed prescription from Resident #1's medical provider for Aricept 5 mg. three tablets daily dated 6/25/2015. Interview with the Health and Wellness Director (HWD) on 6/25/2015 at 9:26 A. M revealed: -There are instances in which prescriptions written by a medical provider are not written on the FL-2 form. -It is facility procedure to clarify FL-2 orders that do not match or conflict with other orders -Medications are received from the facility pharmacy in totes. -Upon receipt, medications are supposed to be checked by staff for accuracy. -It is the responsibility of the MA to ensure the label on the medication matches the order. -The 3rd shift MA does the majority of checking medications received from the pharmacy. -When asked about Resident #1's Aricept, the HWD stated "Staff should have caught it when the medication came in." Interview with the Executive Director on 6/24/2015 revealed: -Upon receipt of an FL-2 form less than 24 hours old without evidence for need of clarification of provider orders, it is facility procedure to fax a copy of the orders to the facility pharmacy and transcribe the orders to the facility order tracking form and the resident MAR. -Upon receipt of an FL-2 form greater than 24 hours old, it is facility procedure to clarify the orders with the provider before proceeding with above process.	D 344		

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D 344	Continued From page 18 Interview with ED on 6/25/2015 at 3:45 P.M. revealed: -Upon notification that Resident #1 had a medical provider order for Aricept that was not clarified or administered from 6/03/2015 through 6/24/2015, the ED acknowledged that facility expectation was not met.	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 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 that medications are administered in accordance with orders by licensed prescribing practitioner for 1 of 5 sampled residents (Namenda for Resident #1) The findings are: Review of Resident #1's current FL-2 dated 6/02/2015 revealed: -Diagnosis included dementia with behavioral disturbances. -Resident #1 is intermittently confused -Medication order for Namenda 10 mg. daily. (Namenda is used to treat the symptoms of Alzheimer's disease). According to the Resident Registry, Resident #1	D 358		

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D 358	Continued From page 19 was admitted to facility on 6/03/2015. Record review on 6/23/2015 revealed: -A copy of prescription dated 6/02/2015 written and signed by medical provider for Namenda XR 28 mg. oral capsule, sprinkle, ER 24 hour daily. -Refill Request Form dated 6/09/2015 signed by medical provider for Namenda 10 mg. mouth daily with 5 refills. Review of Resident #1's June 2015 Medication Administration Records (MARs) revealed: -Hand written entry for Namenda transcribed onto MAR as: "Namenda 28 mg, one tab by mouth daily." Observation on the medication cart on 6/24/2015 at 10:00 A.M. revealed: -Namenda 28 mg. was on the medication cart for Resident #1. Interview of a Medication Aide/Resident Care Aide (MA/RA) on 6/24/2015 between 11:17 and 11:29 A.M. revealed: -MA's and nurses are responsible for ensuring medications and treatments are administered per medical provider orders. -The MA/RA noticed that Namenda 28 mg. daily was received from the pharmacy for Resident #1 but the MAR showed Namenda 10 mg. daily. -The MA/RA reports checking the record of Resident #1 and noticing two different Namenda orders. -Resident #1's medical provider was contacted to request clarification of Namenda order. -The MA/RA communicated to staff on the next shift that the medical provider was notified to clarify whether Resident #1 should receive Namenda 10 mg. or Namenda 28 mg. daily. This communication was also written on the 24 Hour Shift Report.	D 358		

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D 358	Continued From page 20 -MA/RA was off work for the next several days and did not check the outcome of the provider clarification.. -The MA/RA reviewed the facility 24 Hour Shift Report and noticed that clarification of the Namenda order had been documented on the 24 Hour Shift Report on 6/18/2015 and 6/19/2015. -The MA/RA reviewed Resident #1' s record. -The MA/RA found a Refill Request form for Namenda 10 mg. by mouth daily completed by another MA/RA dated 6/09/2015. -The medical provider had made a hand written order entry at the bottom of the Refill Request dated 6/09/2015 for "Namenda 10 mg. by mouth daily with 5 refills." Interview with another MA/RA on 6/25/2015 at 11:40 A.M. revealed: -MAs are responsible for administering medication per medical provider orders. -The MA/RA noticed Resident #1 had Namenda 28 mg. on the medication cart but the entry on the June 2015 MAR was transcribed as Namenda 10 mg. daily. -The MA/RA faxed a Refill Request form to Resident #1's medical provider for Namenda 10 mg. daily because the medication in stock for Resident #1 did not match the documentation on the MAR. -It is facility procedure to document pertinent information such as physician orders on the facility 24 Hour Shift Report for communication between all three shifts. -The MA/RA reviewed Resident #1's record and the facility 24 Hour Shift Report. -MA/RA noticed that Resident #1's medical provider had made a hand written entry in the record for Namenda 10 mg. by mouth daily with 5 refills. -The order was written on the bottom of the Refill	D 358		

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D 358	Continued From page 21 Request form that was previously faxed 6/09/2015. -The MA/RA stated the medical provider wrote the Namenda order "when she came for one of her visits." -The MA/RA noticed that communication regarding Resident #1's Namenda order was first documented on the 24 Hour Shift Report on 6/15/2015. -The MA/RA said she must have forgotten to document the information on the 24 Hour Shift Report on 6/09/2015. Interview with the Health and Wellness Director (HWD) on 6/25/2015 at 9:26 A.M. revealed: -It is the responsibility of the MAs to administer medication and treatments per provider orders. -HWD said failure to initiate the hand written provider order for Namenda 10 mg. by mouth daily for Resident #1 was a medication error. Interview with the Executive Director on 6/24/2015 at 9:20 A.M. revealed: -Upon receipt of an FL-2 form less than 24 hours old without need of clarification by provider, it is facility procedure to fax a copy of the orders to the facility pharmacy and transcribe the orders to the facility order tracking form and the resident MAR. -Upon receipt of an FL-2 form greater than 24 hours old, it is facility procedure to clarify the orders with the prescribing provider prior to initiation of the orders -The HWD and Resident Care Coordinator (RCC) are responsible for ensuring physician orders are transcribed per provider orders and in a timely manner.	D 358		

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D 464	Continued From page 22	D 464		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a resident assessment and care plan within 30 days of admission for 1 of 2 special care unit residents sampled (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 05/01/2015 revealed: -Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), dementia, and abdominal cellulitis.	D 464		

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D 464	Continued From page 23 -Resident is constantly disoriented. -An order for oxygen at 4 liters per minute (LPM) continuous. Record review on 6/23/1015 revealed: -According to Resident Registry, Resident #2 was admitted to facility on 4/28/2015. -The 72 Hour Resident Registry dated 4/28/2015 was found in Resident #2's record. -No subsequent assessment and care plan was found in Resident #2's record. Interview with the Health and Wellness Director (HWD) on 6/25/2015 at 9:26 A.M. revealed: -Facility has 30 days from resident's admission date to complete care plan. -Resident #2's care plan was not completed within 30 (thirty) days. -"I am just behind. I did not get it done." -The HWD was working to complete Resident #2's assessment and care plan. Observation and record review on 6/25/2015 revealed HWD presented a signed care plan for Resident #2 dated 6/25/2015.	D 464		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all	D935		

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D935	Continued From page 24 of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to assure 1 of 1 staff (Staff A) Medication Aide, hired after October 2013, who administered medications, had passed the written medication administration examination within 60 days of completing the medication clinical skills	D935		

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D935	Continued From page 25 validation. The findings are: Review of Staff A, Medication Aide personnel file revealed: -Hire date of 10/17/2014. -Medication clinical skills validation completed 03/12/2015. -No documentation of successful completion of medication administration examination. Interview with Staff A on 06/25/2015 at 1:30pm revealed: -Staff A had been administering medications since March 2015. -Staff A had not taken the state medication aide test. Review of May 2015 Medication Administration Records (MARs) revealed Staff A initialed the MARs for administration of medications on 5/15/2015, 5/16/2015, 5/22/2015, 5/25/2015, and 5/31/2015. Review of June 2015 Medication Administration Records (MARs) revealed Staff A initialed the MARs for administration of medications on 6/4/2015, 6/9/2015, 6/14/2015, 6/15/2015, 6/16/2015, 6/18/2015, 6/19/2015, and 6/22/2015. Interviews with the Health and Wellness Director (RN/HWD) on 06/25/2015 between 4:50pm and 6:00pm revealed: -Staff A was a RA (Resident Assistant) and "potentially" a MA. -The RN/HWD would have to look at the schedule to determine when Staff A was scheduled to work as a MA. -The RN/HWD had determined Staff A worked as	D935		

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D935	Continued From page 26 a MA on 06/22/2015. -The request for Staff A to take the medication aide test had been mailed. -Staff A is scheduled to take the medication aide test on 07/22/2015.	D935		