North Carolina Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section
2708 Mail Service Center • Raleigh, North Carolina 27699-2708
http://www.ncdhhs.gov/dhsr/

Drexdal Pratt, Director

Beverly Eaves Perdue, Governor
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Phone: 919-855-3765
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CERTIFIED MAIL and HAND DELIVERED
 # 7008 3230 0000 3164 5592

January 9, 2012

Richard Cresenzo, President/Administrator
Wake Forest Care Center, Inc., Licensee
Wake Forest Care Center
PO Box 642
Blowing Rock, NC 28605

Re: Statement of Deficiencies: Follow-up Survey and Complaint Investigation completed December 15, 2011
WHP411/NC 00077184; NC 00077200; NC 00077167; NC 00077287)
Type A1 Violation
Type B Violations
Facility: Wake Forest Care Center, Inc.
Licensure Number: HAL-092-020
County: Wake

Dear Mr. Cresenzo:

A survey was completed December 15, 2011 at Wake Forest Care Center, Inc. by the staff with the Adult Care Licensure Section. As a result of the survey, it is determined that the facility is operating in violation of required rules. Findings were shared with facility management during the exit conference on December 15, 2011. The Statement of Deficiencies summarizing the findings is enclosed.

Based on the survey findings, 4 of the 4 complaint allegations were substantiated resulting in deficiencies 10A NCAC 13 F .0901 (b) Personal Care and Supervision.

Type A1 Violation

- Type A1 rule violation is cited for **10A NCAC 13F .0901 (b) Personal Care and Supervision** and **G.S. § 131D-21 Resident Rights.**
- Type A1 Violation must be **corrected** within 30 days from the exit date of the survey which is **January 14, 2012**.

This letter will serve as official notification of the Type A1 Violation. It is the intent of the Adult Care Licensure Section to prepare and forward a penalty proposal for the Type A1 Violation. If you have additional information concerning the violation for this agency to review prior to preparation of the penalty, please send the information to my attention at the above address on or before **5 days from receipt of this letter**.

As set forth in G. S. 131D-34 where the facility has a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of **no less than $1,000 or more than $20,000 for Adult Care facilities of 7 or more beds** for each Type A1 Violation identified.

As set forth in G.S. § 131D-34 where a facility has failed to correct a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of up to $1,000 for each day that the violation continues beyond the time specified for correction.

Type B Violation(s)

- Type B rule violations are cited for **10A NCAC 13F .0305 (h)(4); 10A NCAC 13F .0403 (a) Qualifications of Medication Staff; 10A NCAC 13F .0505 Training on the Care of Diabetic Residents; 10A NCAC 13F .0909 and G.S. 131D -21(1) Resident's Rights; 10A NCAC 13 F .1004 (a) Medication Administration;** and **G.S. § 131D-21 Resident Rights.**
- Type B Violation must be corrected within 45 days from the exit date of the survey, which is **January 29, 2012.**

As set forth in G.S. § 131D-34 where a facility has failed to correct a Type B Violation, the Department shall assess the facility a civil penalty in the amount of up to $400.00 for each day that the violation continues beyond the time specified for correction.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by January 31, 2012. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by January 31, 2012. You must submit 5 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiencies. Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: Frances Messer, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

The findings identified during the complaint investigation completed January 5, 2012, will be mailed at a later date. The findings, including violations, were discussed during the exit conference with facility staff on January 5, 2012. The Suspension of Admissions notification dated December 29, 2011 remains in effect.

If you have questions regarding the violations identified in the Statement of Deficiencies dated 12/15/2011, please contact me at 919-855-3765.

Sincerely,

Eva Oakley, BSN, RN, Licensure Consultant
Adult Care Licensure Section

Enclosures

cc. Catherine Goldman, Supervisor/Designee Wake Human Services
Cassandra Gibson, Team Supervisor, Raleigh Region, Adult Care Licensure Section
Raleigh Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job. The survey has been designed to address key expectations of our surveyors and our division regarding the survey process.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Drexdal Pratt, Director at 919-855-3750 or email at drexdal.pratt@dhhs.nc.gov.

Customer Service Survey web site: **http://prod.ncsurveymax.com/TakeSurvey.aspx?SurveyID=l8K05l5**

(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092020	A. BUILDING ______ B. WING ______	R-C 12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKE FOREST CARE CENTER, INC.	**306 SOUTH ALLEN STREET WAKE FOREST, NC 27587**

(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 a follow-up survey and complaint investigation on 12/09/2011- 12/15/2011. The complaint investigation was initiated by the Wake County Human Services on 12/08/2011.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to equip the front door with a sounding system that was activated when the front door was opened to assure resident safety for 1 of 1 resident who wandered away from the facility and was struck by a vehicle and later died from injuries. (Resident #6) The findings are: Review of Resident #6's current FL-2 dated 11/2/11 revealed diagnoses of diabetes mellitus, hypertension and stomach lesions. Further review	D 067		

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D 067	Continued From page 1 revealed the patient information section did not have any information marked for disorientation. The same FL-2 listed the following medication Donepezil 10 mg by mouth at bedtime. (Donepezil is used to treat dementia) According to the Resident Register, Resident #6 was admitted to the facility on 10/22/2011. Review of the history and physical dated 11/2/2011 revealed Resident #6 was disoriented x 3 with a past medical history of dementia. Observation on 12/9/11 at 9:15 am revealed the exit door on the 400 hall wing sounded when activated. Continued observation revealed the exit door located by the sun room sounded when activated. Observation of the front door there was no sounding device when the front door opened. Interview with Staff A(medication aide) on 12/9/11 at 11:30 am revealed the front door does not have an alarm. The television room and the kitchen door had a chiming sounding device that sounds at the nurse's station. Interview with the Resident Care Coordinator (RCC) on 12/9/11 at 2:05 pm revealed the front door entrance does not have an alarm. The television room side door has a chiming device that remits a sound at the nurse's station. Confidential resident interview on 12/12/11 at 12:30 pm revealed the front door did not have a alarm and there is no alarm on the television room exit door "you have to be tagged for the alarm to sound". Interview with Staff B (medication aide) on	D 067		

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NAME OF PROVIDER OR SUPPLIER: **WAKE FOREST CARE CENTER, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE: **306 SOUTH ALLEN STREET WAKE FOREST, NC 27587**		

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D 067	Continued From page 2	D 067		

12/12/11 at 12:45 pm revealed Resident #6 did not exit the back door because Staff B was outside the kitchen door entrance smoking during the time of Resident #6's wandered away. Further interview revealed the facility used to have wander guards for the residents who wandered but that has been years ago "early 2000".

Interview with the Director on 12/12/11 at 1:15 pm revealed Resident #6 exited the facility through the front door and was hit by a vehicle and later died. No alarms were reported to the Director as being activated. When asked, the Director stated there was no system in place to monitor the front door entrance when the door was unlocked. The front door did not have an alarm. No one saw the resident exit the facility.

Interview with the Director on 12/14/11 at 8:30 am revealed all residents can go in and out the front door all day. Staff were supposed to remind residents to sign in and out. The Director stated the front door was typically locked around 10:00 pm and opened around 7:00 am. Staff were responsible to check door alarms each shift and report any problems to the Director.

Observation on 12/14/11 at 3:15 pm of the location where Resident #6 was struck by a vehicle was approximately 3/4th of a mile away from the facility to a busy intersection. The speed limit at the intersection was 35 mile per hour when the light was remitted as green.

According to the police report dated 12/6/11 the vehicle struck the resident as Resident #6 continued through the intersection. Documentation in the report noted that a facility employee stated the resident had dementia.

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D 067	Continued From page 3 Review of the plan of protection dated 12/15/2011 revealed the front door would be monitored by staff. Assigned staff would be stationed at the sign in and out table. Staff would be directed to monitor high risk resident who are documented on the list. This system will be in affect until the wander guard system is in place. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2012.	D 067		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and staff who directly supervise the administration of medications shall have documentation of successfully completing the clinical skills validation portion of the competency evaluation according to Paragraphs (d) and (e) of Rule 10A NCAC 13F .0503 prior to the administration or supervision of the administration of medications. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure 2 of 5 medication aides (Staff P, Q) had successfully completed the clinical skills checklist prior to administration of medications. The findings are:	D 125		

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D 125	Continued From page 4 1. Review of Staff P's (medication aide) personnel files revealed Staff P was hired on 9/15/11 as a 7:00 p.m.- 7:00 a.m. medication aide. Further review revealed no documentation that Staff P had successfully completed the clinical skills checklist. Telephone interview with Staff P (medication aide) on 12/15/11 at 4:30 p.m. revealed her clinical skills had not been checked off. Staff P stated when the class was scheduled approximately two weeks after employment she was unable to attend and was told she would have to attend the next scheduled class. Staff P revealed she was assigned to administer medications when scheduled to work. Record review revealed Staff P administered medications including insulin to Resident #7 on 11/10/11 and 12/2/11. Interview with the Director on 12/15/11 at 11:50 am revealed Staff P had not had the required check offs prior to medication administration. Interview with the Licensed Health Professional Support (LHPS) on 12/15/11 at 3:50 pm revealed Staff P had not been clinically validated. Refer to interviews with LHPS nurse and Director. 2. Review of Staff Q's (medication aide) personnel files revealed Staff Q was hired on 10/5/11 as 7:00 p.m.- 7:00 a.m. medication aide. Further review revealed no documentation that Staff Q had successfully completed the clinical skills checklist. Telephone interview with Staff Q on 12/15/11 at	D 125		

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D 125	Continued From page 5 4:10 p.m. revealed she was given fingerstick training by the LHPS nurse. Staff Q revealed she had not been checked off for any other skills. Record review revealed Staff Q administered medications including insulin to Resident #7 on 11/12/11,11/13/11,11/16/11,11/21/11,11/29/11,12/5/11,12/7/11,12/10/11 and 12/11/11. Interview with the Director on 12/15/11 at 11:50 am revealed Staff Q had not had the required check offs prior to medication administration. Interview with the Licensed Health Professional Support (LHPS) on 12/15/11 at 3:50 pm revealed Staff Q had not been clinically validated. Refer to interviews with LHPS nurse and Director. ______________________________ Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 12/15/11 at 3:50 pm revealed a clinical checklist class was done at the facility on 9/20/11 and 10/21/11 which included LHPS skills task competency validation, medication aide competency validation and diabetic training. The LHPS nurse stated she is at the facility at least once a month and the Director would inform her of any staff who needs to be checked off/clinically validated. Continued interview revealed if the facility needs additional validation check offs due to staff turnover or new hires then the Director would call the LHPS nurse to schedule another class. Interview with the Director on 12/15/11 at 11:50 am revealed the LHPS nurse comes to the facility and completes the clinical skills validation. If needed the nurse would come as requested by the director. The Director stated that the classes	D 125		

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D 125	Continued From page 6 are mandatory for staff to attend or they have to go somewhere else where the LHPS is offering a class. Continued interview revealed the Director was not aware that the medication aides needed to be checked off prior to medication administration if the medication aide had passed the medication examination. Interview with the Director on 12/15/11 at 5:00 p.m. revealed she was aware medication staff needed to be checked off by the registered nurse (RN) but she thought that could be done after staff trained on the medication carts with another medication aide for 2 to 3 days. The Director did not indicate a system to assure medication aides completed the medication clinical skills checklist prior to administering medications. Review of the Plan of Protection dated 12/15/11 revealed the Director will review staff personnel files for training, clinical skills check off/validation needed and will immediately scheduled a training class for Staff. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2012.	D 125		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.	D 164		

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D 164	Continued From page 7	D 164		

(2) Training shall include at least the following:
(a) basic facts about diabetes and care involved in the management of diabetes;
(b) insulin action;
(c) insulin storage;
(d) mixing, measuring and injection techniques for insulin administration;
(e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;
(f) blood glucose monitoring; universal precautions;
(g) universal precautions;
(h) appropriate administration times; and
(i) sliding scale insulin administration.

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

Based on interview and record review, the facility failed to assure 2 of 5 medication aides (Staff P, Q) received training on the care of diabetic residents. The findings are:

1. Review of Staff P's (medication aide) personnel files revealed Staff P was hired on 9/15/11 as a 7:00 pm- 7:00 am medication aide. Further review revealed no documentation that Staff P had training for the care of Diabetic residents at the facility.

Telephone interview with Staff P on 12/15/11 at 4:30 pm revealed she had not received training on the care of Diabetic residents from this facility, however; Staff P revealed she had training at a previous facility. Staff P stated that when the class was scheduled approximately two weeks after employment she was unable to attend and was told that she would have to attend the next

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D 164	Continued From page 8	D 164		

scheduled class. Staff P revealed she was assigned to administer medications when scheduled to work.

Review of Resident #7's December 2011 medication administration record (MAR) revealed Staff P had administered insulin.

Review of the November 2011 MAR revealed Staff P had administered insulin without an order.

Interview with the Director on 12/15/11 at 11:50 am revealed Staff P had not had the required diabetic training prior to medication administration.

Telephone interview with the LHPS nurse on 12/15/11 at 3:50 pm revealed Staff P had not been checked off.

Refer to interviews with the LHPS nurse and Director.

2. Review of Staff Q (medication aide) personnel files revealed Staff Q was hired on 10/5/11 as 7:00 pm- 7:00 am medication aide. Further review revealed no documentation Staff P had training for the care of Diabetic residents.

Telephone interview with Staff Q on 12/15/11 at 4:10 pm revealed she received fingerstick training from the LHPS nurse. Staff Q revealed she had not had any further training on the care of Diabetic residents.

Review of Resident #7's December 2011 medication administration record (MAR) revealed Staff Q had administered insulin without an order on two different occasions.

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D 164	Continued From page 9	D 164		

Interview with the Director on 12/15/11 at 11:50 am revealed The Director revealed Staff Q had not had the required diabetic training prior to medication administration.

Telephone interview with the LHPS nurse on 12/15/11 at 3:50 pm revealed Staff Q had not been checked off.

Refer to interviews with the LHPS nurse and Director

____

Telephone interview with the LHPS nurse on 12/15/11 at 3:50 pm revealed a class for clinical checklist was done at the facility on 9/20/11 and 10/21/11 which included LHPS skills task competency, medication aide competency and diabetic training. The LHPS nurse stated she was at the facility at least once a month and the Director would inform her of any staff that needs to be checked off/validation/training. Continued interview revealed if the facility needs additional check off and training due to staff turnover or new hires then the Director would call the LHPS nurse to schedule another class.

Interview with the Director on 12/15/11 at 11:50 am revealed the LHPS nurse comes to the facility and completes the clinical skills. If needed the nurse would come as requested by the director. The Director stated that the classes are mandatory for staff to attend or staff have to go where the LHPS was offering a class. Continued interview revealed the Director was not aware that the medication aides needed to be checked off/validated prior to medication administration if the medication aide had passed the medication examination.

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D 164	Continued From page 10 Review of the Plan of Protection dated 12/15/11 revealed the Director will review staff personnel files for training, clinical skills check off needed and will immediately scheduled at training class for Staff. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2012.	D 164		
D 182	10A NCAC 13F .0602 (b) Management Of Facilities With A Capacity Or 10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents (b) When the administrator is not on duty in the facility, there shall be a person designated as administrator-in-charge on duty in the facility who has the responsibility for the overall operation of the facility and meets the qualifications for administrator-in-charge required in Rule .0602 of this Section. The personal care aide supervisor, as required in Rule .0605 of this Subchapter, may serve simultaneously as the administrator-in-charge. This Rule is not met as evidenced by: Based on observation and interview, the Director (administrator-in-charge) failed to assure that all required duties were carried out in the facility related to the rule areas of physical environment, qualifications of medication staff, training on care of diabetic residents, personal care and supervision, nutrition and food service, medication administration, use of physical restraints and alternatives, and declaration of residents' rights. The findings are:	D 182		

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Interview with the Director on 12/12/11 at 10:25 a.m. revealed she began working as the Director in January 2011 and had not received any continuing education since employed as Director. The Director revealed she was responsible for the overall operations of the facility in the absence of the Administrator.

1. Based on observation, interview, and record review, the facility failed to equip the front door with a sounding system that was activated when the front door was opened to assure resident safety for 1 of 1 resident who wandered away from the facility and was struck by a vehicle and later died from injuries. (Resident #6) [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]

2. Based on interview and record review, the facility failed to assure 2 of 5 medication aides (Staff P, Q) had successfully completed the clinical skills checklist prior to administration of medications. [Refer to Tag D125 10A NCAC 13F .0403(a) Qualifications of Medication Staff (Type B Violation)]

3. Based on interview and record review, the facility failed to assure 2 of 5 medication aides (Staff P, Q) received training on the care of diabetic residents. [Refer to Tag D164 10A NCAC 13F .0505 Training On Care Of Diabetic Residents (Type B Violation)]

4. Based on observation, interview, and record review, the facility failed to assure supervision for 5 of 12 residents, one resident who wandered away from the facility and was struck by a vehicle and later died from injuries, three residents smoking in the facility and one resident with multiple falls (Resident #1, #6, #7, #14, #16).

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D 182	Continued From page 12 [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)] 5. Based on interviews and record review, the facility failed to assure resident were treated with respect and dignity. [Refer to Tag D911 G.S. 131D-21 (1) Declaration of Residents' Rights (Type B Violation)] 6. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 5 of 8 residents (#11, #12, #13, #14, #15) observed during the medication pass and 4 of 8 residents (#3, #4, #7, #9) sampled for record review. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)] 7. Based on observation, interview, and record review, the facility failed to assure graduated measuring devices were used by 1 of 3 staff (Staff G) reviewed in order for insulin to be accurately and safely administered to 2 of 6 (#7, #14) residents reviewed. [Refer to Tag D370 10A NCAC 13F .1004(m) Medication Administration] 8. Based on observation, interview, and record review, the facility failed to assess, care plan and consider restraint alternatives for 2 of 3 residents who had physical restraints[Refer to Tag D482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives] 9. Based on observation, interviews, and record review, the facility failed to clarify a thickened liquids order for 1 of 1 resident with orders for thickened liquids (Resident #1). [Refer to Tag D307 10A NCAC 13F .0904(e)(4) Nutrition &	D 182		

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D 182	Continued From page 13 Food Service]	D 182		
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 A1 VIOLATION Based on observation, interview, and record review, the facility failed to assure supervision for 5 of 12 residents, one resident who wandered away from the facility and was struck by a vehicle and later died from injuries, three residents smoking in the facility and one resident with multiple falls (Resident #1, #6, #7, #14, #16). The findings are: 1. Review Resident #6's current FL-2 dated 11/2/11 revealed diagnoses of diabetes mellitus, hypertension and stomach lesions. Further review revealed the patient information section did not have any information marked for disorientation. The same FL-2 listed the following medication Donepezil 10 mg at bedtime. (Donepezil is used to treat dementia) According to the Resident Register Resident #6 was admitted to the facility on 10/22/2011. Review of the FL-2 dated 10/22/2011 revealed diagnoses of diabetes mellitus, hypertension and stomach lesions. Further review revealed the patient information section did not have any	D 270		

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information marked for disorientation. The same FL-2 listed the following medication Donepezil 10 mg 1 tablet by mouth daily at bedtime.

Review of the history and physical dated 11/2/2011 revealed Resident #6 was disoriented x 3 with a past medical history of dementia.

Review of the Resident Activity interest sheet completed by the power of attorney at admission on 10/20/2011 revealed Resident #6's physical limitations as "dementia, blindness in the right eye, pace maker, diabetic and needed a cane for walking" .

Review of the nurse's notes dated 10/31/11 (no time documented) written by the home health provider revealed Resident #6 had dementia, social withdrawn and was a new admit from home.

Review of the nurse's notes dated 11/8/11, 11/9/11, 11/17/11 and 11/28/11 (no time documented) written by the assigned home health agency speech therapist revealed Resident # 6 had been seen for cognitive/memory orientation and continued as a elopement risk with frequent attempts to exit the building. "Patient is unable to maintain their safety".

Review of the facility shift communication log dated 11/9/11 revealed "keep eye on Resident #6".

Review of the facility shift communication log dated 11/14/11 revealed "keep eye on Resident #6 "the resident has tried to leave the facility twice today".

Review of the nurse's notes dated 11/17/11 (no

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time documented) revealed staff needed to keep an eye on the resident.

Review of the facility shift communication log dated 11/22/11 revealed "keep eye on resident is trying to leave the building".

Review of the nurse's notes dated 11/25/11 (no time documented) revealed Resident #6 had "walked up to the church on his way somewhere". Staff escorted the resident back to the facility.

Review of the facility shift communication log dated 11/26/11 revealed keep eyes on Resident #6 the resident is going outside with other residents.

Review of the nurse's notes dated 11/28/11 (no time documented) revealed Resident #6 "decided to walk up the road again" staff escorted the resident back to the facility and staff was aware of resident leaving the facility. "The assigned home health agency was informed about the resident leaving and was "going to get an order for the resident".

Review of the facility communication log dated 11/28/11 revealed Resident #6 "left the building keep a eye on the resident".

Review of the nurse's notes dated 12/1/11 at 1:15 pm revealed Resident #6 walked off away from the facility down the street. Resident was escorted back to the facility by staff. The Resident Care Coordinator (RCC) was notified.

Review of the nurse's notes dated 12/6/11 at 10:20 am revealed Resident #6 had "exited the facility through the kitchen door".

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Review of the nurse's notes dated 12/6/11 at 2:15 pm revealed another resident saw Resident #6 walking away from the facility heading down the driveway entrance into the facility. Resident #6 was brought back into the facility and taken to an activity program.

Confidential interview with another resident revealed Resident #6 walked slow and tried to leave the facility. Resident #6 would go outside like everyone else. Staff always had to go after Resident #6.

Confidential resident interview revealed Resident #6 was seen leaving the facility and another resident yelled for Resident #6 to come back. This resident went into the facility to get staff while Resident #6 was leaving the facility. This resident could not recall the date.

Another confidential resident interview indicated Resident #6 would wander off.

Another confidential resident interview indicated Resident #6 wandered and had a tendency to walk away from the facility and staff had to catch the resident.

Review of the facility shift communication log dated 12/6/11 revealed Resident #6 had wandered off after dinner.

Interview with Staff D (personal care aide) on 12/9/11 at 10:14 am stated she never worked with Resident #6 but staff had been told to keep a eye on every resident. Every resident should be checked on at least every two hours.

Interview with Staff B (medication aide) on 12/9/11 at 10:20 am stated Resident # 6 would

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exit the facility through the back kitchen door and walk toward the front of the building. Staff B revealed the resident was escorted back into the building. Further interview revealed another resident had informed staff Resident #6 had left the facility and was in the parking lot. Staff B stated she went and got the resident and escorted the resident into the dining room to participate in activities. Staff B stated the personal care aides had been instructed to keep an eye on Resident #6 " know the residents where about at all times". Staff B stated if the personal care aides (PCA) are helping other residents, normally other staff would be asked to watch their assigned residents. Staff B stated Resident #6 walked fast at times and referred to when she saw Resident #6 exiting the building through the back kitchen door and headed toward the front of the building parking lot area the resident would began to walk very fast. Staff B could not recall the date this had happened but "it was not that long ago" Staff B stated on 12/6/11 Staff B approached the two scheduled medication aides around 5:45 pm. Staff B stated Staff C asked if they had seen Resident #6. Staff B stated Resident #6's family member did not want Resident #6 to leave the facility unattended.

Interview with Staff U (housekeeper) on 12/9/11 at 11:00 am revealed Resident #6 would go outside unattended by staff and staff would need to go get the resident.

Interview on 12/9/11 at 11:30 am revealed Staff A (medication aide) stated "Resident #6 had left the facility and walked approximately 500 feet in the yard of the church located next to the facility on 11/25/11". Staff A stated another resident informed Staff A that Resident #6 had left the facility. Staff A stated Resident # 6 walked away

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from the facility on 11/28/11. Staff A stated "you have to keep and eye on him" when the resident first came to the facility he did not leave. Then the resident began to go out of the building. Staff A stated Resident #6 would get confused and try to go to the staff bathroom instead of the resident's bathroom located on the hallway across from the kitchen and required redirection.

Staff A stated on 12/6/11 she saw Resident #6 walking down the hall around 4:30 pm - 4:40 pm, approximately five minutes later Staff C (personal care aide) asked Staff A if she had seen the resident. Staff C stated she could not find Resident #6. Staff A stated she immediately instructed staff to begin a search. Staff A stated when she went to search the surrounding areas by vehicle she heard sirens. Staff A stated she saw an accident at the intersection approximately 3/4th of mile from the facility. Staff A stated she gave a bystander a description of Resident #6 to see if the resident was involved. Staff A returned to the facility and called 911 to report a missing person. During the call, the police stated Resident #6 was involved in the accident. Later that evening the local hospital notified the facility the resident had died. According to Staff A , Resident #6 had a quick fast shuffling walk and it would have taken the resident 2-3 minutes to reach the tree in the church yard. The location of the tree was approximately 500 feet from the facility front door entrance. Staff A stated residents with dementia are redirected back to time, place and date and monitored more frequently than every two hours checks. Resident #6 was monitored least every hour. Staff A stated staff tried to keep Resident #6 busy. Staff A stated one staff should have been assigned to watch Resident #6 to keep a closer watch. Staff A stated staff would take the resident outside on the

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D 270	Continued From page 19 front porch while staff was smoking. Further interview revealed Power of Attorney (POA) did not want Resident #6 to go outside alone. When Resident #6 was first admitted there was a note posted at the nursing station medication room that instructed staff not to allow resident to leave the facility alone. Staff A stated the note had been removed since the accident. Interview with the psychiatric nurse practitioner on 12/9/11 at 11:45am revealed based on her assessment dated 11/18/2011 Resident #6 had dementia and the facility was expected to maintain safety for the resident. The facility should monitor and report any behavioral changes. Interview with Staff C (personal care aide) on 12/9/11 at 1:15 pm revealed staff was in the dining room around 4:45 pm on 12/6/11 serving dinner. Staff C had assisted another resident to the bathroom. After assisting the resident to the bathroom the same resident requested to go to bed. Staff C revealed she responded to the resident stating, "I have to go check for Resident #6". Staff C was assigned Resident #6 on 12/6/11. Staff C went back into the dining room and asked where was Resident #6. Staff C stated she then asked the two medication aides on duty where was Resident #6. Staff C stated at that time they began searching for Resident #6 and could not find the resident in the building. Staff A then left the building and searched the surrounding neighborhood by vehicle. During that time two other staff went outside to search the immediate premises for Resident #6. While staff were searching the area near the facility, one of the neighbors stated they had seen a man in the road. Staff C stated all staff knew to watch Resident #6 because he would try and go	D 270		

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outside.

Interview with the Resident Care Coordinator (RCC) at 2:05 pm on 12/9/11 revealed the medication aides were responsible for telling the RCC the needs or issues with the residents. The facility staff can write notes in the 24 hour communication log and the resident record. The communication log was for the staff to communicate information regarding residents. The RCC revealed the communication is read daily at shift change by the medication aides. Further interview revealed the RCC was supposed to read the residents record after residents were seen by providers. The RCC would retrieve information about residents verbally from the local providers of home health or by reading the documentation in the resident's record. Continued interview with the RCC revealed "Resident #6 would walk a couple of hundred feet away from the main driveway entrance daily". The RCC continued to state Resident #6 would walk outside with other residents. The RCC stated "Residents would come in the facility yelling residents are running away". The RCC stated she makes sure any recommendations made by the providers were followed up. The RCC stated she was not aware Resident #6 had been leaving the facility premises.

Interview with Staff A (medication aide) on 12/9/11 at 2:50 pm revealed on 12/1/11 Resident #6 had walked down the entrance driveway. Staff A stated the RCC instructed staff to keep eye on the resident and keep the resident busy. Staff A revealed staff were supposed to document any unusual behavior presented by residents. Staff A revealed the RCC was supposed to read notes written by providers and the RCC told staff what

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D 270	Continued From page 21 recommendations had been written and what plans should be put in place for the residents. When asked about the note written on 11/28/11, Staff A stated she did not speak back with the therapist regarding the conversation and the written note that had been documented in the nurse's notes on 11/28/11 which indicated the therapist was contacting the physician for an order. When asked, Staff A was not sure of what kind of order the therapist was obtaining. Staff A indicated there was no increase of supervision put in place for the resident. Interview with the Licensed Health Profession Support (LHPS) Registered Nurse on 12/13/11 at 3:40 pm revealed a recommendation was made on 11/15/11 which indicated staff to follow up with the speech therapist regarding cognitive and orientation issues. The LHPS nurse stated her request was for staff to obtain information regarding memory deficits issues Resident #6 was experiencing. Interview with the Director on 12/12/11 at 1:00 pm revealed Resident #6 would go outside to the front porch because he enjoyed walking and had to be constantly redirected. The Director revealed the Power of Attorney (POA) had requested Resident #6 not go outside alone and a note had been posted at the nurses station medication room. Further interview revealed Resident #6 would go outside with another resident and pick up pine cones in the yard by the dumpster. The Director further revealed there were no assigned time frames for Resident #6 to be monitored except for every two hours. The Director stated "I did not feel the resident was endangered by going out in the yard". "Resident #6 knew what he was doing he was just going for	D 270		

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a walk". When asked, the Director stated "I assumed Resident #6 should have been checked more often".

Interview with the RCC and the Director on 12/12/11 at 1:15 pm revealed neither were aware of the documentation by the speech therapist dated 11/28/11. The RCC revealed the home health agency staff normally reports to medication aides or the RCC information regarding residents. Continued interview revealed the RCC "constantly reviewed the resident notes for information that needed to be followed up. The Director and the RCC revealed the medical providers were not notified of Resident #6 leaving the building because it was not a problem for Resident #6 to go outside in the parking lot alone.

Interview with the home health agency speech therapist (SLP) on 12/12/11 at 4:00 pm revealed on 11/28/11 staff had reported Resident #6 had been leaving the facility alone and unsupervised stating he was going home. The POA wanted the resident to participate in activities in the facility, therefore, the resident was open for services to address cognitive issues. On 11/17/11 the SLP found the resident wandering in the hallway and was only oriented to person. According to the cognitive test administered by the SLP, the SLP revealed the resident had moderate cognitive impairment. Continued interview revealed the resident began receiving services on 10/31/11. The SLP stated staff reported Resident #6 would stand by the front door watching staff to see if the resident could go out the door. Staff pointed to the taped note at the nurse's station indicating the POA did not want the resident to go outside alone. The SLP stated staff were on alert to make sure Resident #6 did not walk out the door and believed Resident #6 was clever in watching the

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D 270	Continued From page 23 staff whereabouts. Interview with the Director on 12/12/11 at 10:20 am revealed the 24 hour shift to shift report was documented in the communication log notebook, which was kept at the nurse's station medication room desk. The medication aide/ supervisor were responsible for documenting information on resident's each shift. The RCC was responsible for reading the shift reports daily and responding accordingly. Interview with Staff H (medication aide) on 12/12/11 at 10:40 am revealed the 24 hour report should be documented in the communication log. Documentation should be regarding issues and concerns with resident's behaviors or physical status. Staff H stated the RCC and the Director read the communication log shift reports. Interview with the Power of Attorney (POA) on 12/13/11 at 9:00 am revealed Resident #6 was confused and should not be outside by himself. This information had been shared with the Director, and the Director had informed the POA that a note had been posted for the staff. The POA stated the Director indicated the resident would be watched at all times. The POA revealed admission paperwork had noted Resident #6 had dementia, blind in the right eye and walked with a cane. The POA stated that during the admission process she had declined a mobile transmitter for the resident because the resident would lose the device or would not know how to use the device. The POA was not sure how the transmitter would be used by the resident. Interview with the home health agency physical therapist (PT) on 12/13/11 at 11:45 am revealed Resident #6 was confused and the staff had	D 270		

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reported the resident had dementia. The PT stated initially the resident was weak and had an unbalanced shuffling walk. After working with the resident, Resident #6's walking had improved using the 3-4 prong cane intermittently.

Interview with the medical provider on 12/15/11 at 9:15 am revealed Resident #6 had a history and physical on 11/2/11 and was assessed to be oriented to self and not to time or place. The medical provider revealed Resident #6 should have been supervised because he had dementia and was disoriented and had been prescribed Donepezil 10 mg for Alzheimer dementia. The medical provider revealed the protocol for the facility was when history and physicals were completed a copy is placed in the record and was supposed to remain in the record even if the record had been thinned. Further interview revealed it was the expectation the facility would review the history and physical and create a care plan that met the resident's needs especially when a resident had a diagnosis of dementia. The facility should increase surveillance of residents with dementia.

Review of the facility policy titled "identification and supervision of wandering resident's policy" stated the following:

1. Residents with the potential for elopement, the facility shall ensure the safety of any resident identified as having the potential for elopement from the facility, including procedures to consistently monitor the location of each such resident.
2. Pre- admissions screening review of the information from family members and responsible persons regarding any history or the risk of wandering.

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3. After admission safeguards/assessment documentation of an identified "at risk" resident list will be made available to all staff.
4. Inform staff upon admission of potential risk residents to wander.

Observation on 12/15/11 at 7:30 am revealed staff position at a desk with the sign in and out logs, monitoring the front door entrance.

2. Review of the facility's "Smokiing Policy" effective 9/1/10 noted that smoking was prohibited anywhere inside the facility. The policy documented the following:

If a resident is found smoking in the facility, staff would immediately confiscate all smoking materials from the resident. The resident would be required to ask staff for their cigarettes and lighter and the staff would escort the resident outside. If a resident were caught smoking inside the facility again after the cigarettes and lighter had been confiscated, the resident would be given an immediate discharge notice. The Director would issue the discharge notice to the resident and to the responsible party or next of kin. The facility would also contact the county department of human services and the omsbudsman. The form provided designated places for the date, resident, and Administrator signatures.

A. Record review for Resident #14 revealed diagnoses on the current FL-2 dated 10/17/11 included: schizoaffective disorder, bipolar type, depression with psychosis, diabetes mellitus.

Record review of Resident #14's current assessment and care plan revealed the resident was independent in all activities of daily living. No

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documentation was made about the resident smoking.

Record review of a Staff Communication Log entry documented Resident #14 smoked in his room on 11/5/11. A second log entry for Resident #14 documented the resident smoked in his room on 11/8/11.

Record review of Resident #14's Business Folder revealed the resident had signed the facility smoking policy.

Interview on 12/13/11 at 9:25 am with Resident #14 revealed the resident smoked outside in the courtyard and stated it was the only place residents could smoke. The resident then revealed smoking a couple of times in his room when first admitted, but was told by staff "smoking was not allowed inside." The resident was unaware of any other residents who smoked in their rooms.

Interview on 12/13/11 at 10:45 am with Staff A (Medication Aide) revealed on 11/5/11 staff saw Resident #14 had a cigarette in his mouth and the resident's room smelled of cigarette smoke. When staff questioned the resident if he had been smoking in the room, the reply was "no". On 11/8/11 staff again asked the resident if the resident had been smoking inside and Resident #14 replied "yes, it was too cold to go outside."

Further interview with Staff A revealed facility residents were deterred from smoking by reminding them to go outside if they want to smoke.

Interview on 12/13/11 at 12:15 pm with Staff V (Housekeeping), revealed residents were to

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smoke only outside at the courtyard or out back. Staff V stated having observed only one resident who smoked in their room and it was Resident #14. The middle of last week staff observed a cigarette butt and several clumps of cigarette ashes on the floor of the resident's bathroom. Staff V revealed having talked with the resident and stating smoking inside was not allowed and to go outside to smoke. No further action was taken.

Interview on 12/13/11 at 3:20 pm with Staff W (Housekeeping), revealed staff had smelled cigarette smoke in Resident #14's bathroom yesterday (12/12/11). Today, about 11 am staff walked into Resident#14 ' s bathroom and again smelled smoke. The resident was lying on the bed. Staff asked the resident if the resident had been smoking and received no reply. Staff W stated telling the resident to stop smoking in the room. Staff revealed asking Staff V (Housekeeping), who was responsible for cleaning the resident's room, to notify the Director. Staff W also revealed having smelled cigarette smoke in Resident #14's room twice before.

Interview on 12/14/11 at 5:50 pm with the facility Director revealed the Director was unaware of Resident #14 smoking in the resident ' s room until yesterday when two housekeeping staff reported it. The Director had not talked with the resident, but would take his privileges away and contact his responsible person.

Observation of Resident #14's room on 12/15/11 at 9:25 am revealed the resident sitting on the bed and the room smelled strongly of cigarette smoke. The resident declined to be interviewed.

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D 270	Continued From page 28 Refer to interview with Staff V (housekeeping) on 12/13/11. Refer to interviews with Staff W (housekeeping) on 12/13/11 and 12/15/11. Refer to interviews with Staff A, Staff G and Staff F (medication aides) on 12/13/11. Refer to interviews with the facility Director on 12/14/11. Refer to observations on 12/13/11 and 12/15/11. B. Record review for Resident #7 revealed diagnoses on the current FL-2 dated 11/7/11 included: left lower lobe pneumonia, chronic obstructive pulmonary disease, diabetes mellitus, and history of smoking. Record review of Resident #7's assessment and care plan revealed the resident was independent, but needed assistance with bathing. No documentation was made about the resident smoking. Record review of MD Progress Notes for Resident #7 dated 11/21/11 revealed the resident having current, every day tobacco use with a plan for smoking and tobacco use cessation counseling. Record review of Nurse's Notes entry documented Resident #7 smoking (while talking) on phone inside the facility on 12/9/11. Record review of a Staff Communication Log entry documented Resident #7 smoked in the activity room on 12/9/11. A second log entry documented Resident #7 smoked in the	D 270		

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D 270	Continued From page 29 Activity/TV room on 12/10/11. Record review of Resident #7's Business Folder revealed Resident #7 did not sign the facility smoking policy. Observation on 12/13/11 at 9:50 am revealed Resident #7 in the courtyard smoking. Interview on 12/13/11 at 9:55 am with Resident #7 revealed the resident smoked only in the courtyard and was not allowed to smoke inside the building. The resident stated it would be "stupid to smoke inside as it would be obvious to do so." Interview on 12/13/11 at 10:45 am with Staff A (Medication Aide), revealed Resident #7, on the first or second day in December, was smoking just inside the activity room door. The resident continued to smoke when approached by staff. Staff revealed not taking away Resident #7's cigarettes or lighter, but talked to the resident about not smoking inside the building. The resident left to continue smoking outside. Further interview with Staff A revealed not having seen a facility smoking policy and was not aware of any residents being given discharge notices for smoking in the facility. Interview on 12/13/11 at 10:05 am with Staff G (Medication Aide) revealed Resident #7 smoked in the Activity/TV room two days ago (12/11/11). Staff revealed talking with the resident saying smoking was not allowed in the facility. No other action was taken. Confidential resident interview revealed residents can keep their own cigarettes and supplies if they	D 270		

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don't break the rules and they have been deemed safe to keep them. The resident reported Resident #7 sat inside at the door with the door cracked and blew the smoke outside. The resident stated he did it as soon as it got dark and cold outside and he did it all during the night. The resident stated Resident #7 usually did this at the door in the television room or at the door that leads outside to the courtyard on long hall. The resident reported seeing Resident #7 smoking inside at the door just within the last few days smoking inside at the courtyard door. The resident stated Staff G caught the resident and asked him to put it out and the resident put the cigarette out. The resident stated Resident #7's cigarettes and supplies had not been taken away but even if they took it away, he would still hide it.

Interview on 12/14/11 at 5:50 pm with the facility Director revealed the Director having a " conversation " with Resident #7 regarding smoking in the Activity/TV room on 12/9/11 and on 12/10/11 to remind the resident of the facility smoking policy.

Refer to interview with Staff V (housekeeping) on 12/13/11.

Refer to interviews with Staff W (housekeeping) on 12/13/11 and 12/15/11.

Refer to interviews with Staff A, Staff G and Staff F (medication aides) on 12/13/11.

Refer to interviews with the facility Director on 12/14/11.

Refer to observations on 12/13/11 and 12/15/11.

C. Record review for Resident #16 revealed

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diagnoses on the current FL-2 included: angina, coronary artery disease, atrial fibulation, coronary obstructive pulmonary disease, bipolar disorder.

Record review of Resident #16 ' s assessment and care plan revealed resident was independent, needed assistance with bathing, and was ambulatory using a wheelchair. No documentation was made about the resident smoking.

Observation on 12/13/11 at 9:15am revealed Resident #16 lying in bed and having a pack of cigarettes lying on the dresser beside the bed.

Interview on 12/13/11 at 9:15 am with Resident #16 revealed the resident went outside to the courtyard to smoke and usually went out every 3-4 hours. The resident stated no where else was allowed for smoking, but in the cold weather would like an inside room to smoke in.

Record review of a Staff Communication Log entry documented Resident #16 was caught smoking in the facility dining room on 11/29/11. Log entry was made by Staff L (Medication Aide).

Interview on 12/14/11 at 12 noon with Staff L (Medication Aide) was attempted by phone as staff was not at the facility. A message and phone number was given to return call to surveyor. No response was received from Staff L.

Record review of Resident #16's Business Folder revealed the resident signed the facility smoking policy.

Interview on 12/14/11 at 5:50 pm revealed the facility Director, when questioned about Resident #16 smoking in the dining room, stated being

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D 270	Continued From page 32 unaware the resident smoked in the facility. Refer to interview with Staff V (housekeeping) on 12/13/11. Refer to interviews with Staff W (housekeeping) on 12/13/11 and 12/15/11. Refer to interviews with Staff A, Staff G and Staff F (medication aides) on 12/13/11. Refer to interviews with the facility Director on 12/14/11. Refer to observations on 12/13/11 and 12/15/11. ____ Interview with Staff V on 12/13/11 at 12:15pm revealed staff was not aware of any measures in place to deter residents from smoking in the facility. Staff V also stated having read the facility smoking policy. Interview on 12/13/11 at 3:20 pm with Staff W (Housekeeping) revealed staff tried to correct residents from smoking inside the facility in the past, but there was not much staff could do except report incidents to management. The Director would tell the residents they could not smoke in the facility, but Staff W did not know the details of how smoking inside would be handled. Staff W also revealed " no smoking " signs were posted inside the building, but staff was not aware of a facility smoking policy. Also, Staff W was not aware of anything being done to deter residents from smoking inside the facility or of the consequences for residents who continue to smoke in the building.	D 270		

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D 270	Continued From page 33 Interview on 12/13/11 at 5:10 pm with Staff A (Medication Aide) revealed general resident checks were done every 2 hours. Residents who smoked in their rooms were checked on every hour. Staff A also revealed other than herself checking every hour, Staff A was not aware of any facility monitoring system in place to check on residents who smoke. Interview on 12/13/11 at 5:15 pm with Staff G (Medication Aide) revealed general checks for all residents were done every two hours. If Staff G knew of a resident smoking in their room, staff would do checks every 15 minutes. Staff G stated " there is no current facility monitoring system for residents who smoke inside the building." Interview on 12/13/11 at 5:30 pm with Staff F (Medication Aide) revealed resident checks were every 2 hours except if there were wanderers. Staff would check on residents if there was a cigarette smoke odor present. Staff F also revealed there was no facility monitoring system for residents smoking in their rooms. Observation of the facility building on 12/13/11 at 5:45pm revealed "no smoking" signs were posted at the front inside door, in the Activity/TV room, entrance to the dining room, entrance to the west wing, dining room entrance on the west wing, and on the Cardroom/phone room door. Interview on 12/14/11 at 5:50 pm with the facility Director revealed according to facility policy there was to be no smoking in the facility. There was a designated place for residents to smoke which was the courtyard. New residents are given a smoking policy to sign upon admission and the document is kept in the resident ' s Business Folder. Residents who did not follow the policy for	D 270		

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the first time, the Director would have a discussion with the resident reminding them of the policy and that the resident had signed the smoking policy on admission. The second time a resident was known to be smoking inside the facility, the resident's cigarettes and lighter were taken. The medication aides keep them in the med cart. The resident would receive one cigarette and lighter the next time they wanted to smoke and then could keep the lighter.

Further interview with the Director revealed staff who have observed residents smoking inside the facility were to stop the resident and let the Resident Care Coordinator (RCC) or the Director know immediately and to document the observation in the Nurse ' s Notes. The Director stated " all staff is responsible for assuring the policy is followed and ultimately the Director is responsible " . The Director further revealed not having to give a discharge notice to a resident for smoking in the facility, and not having to contact the next of kin or ombudsman regarding resident smoking. The Director also revealed there was no specific training for staff on resident smoking, but staff was given basic verbal instructions by the RCC during initial training.

Continued interview with the Director revealed the RCC reads the Nurse's Notes and 24 hour communication log. The Director had not read the notes or the log entries saying the RCC usually gives the Director any vital information. The Director further stated not having information on residents smoking in the building and not having a system in place for reading the Communication Log and Nurse's Notes. The Director revealed "general 2 hour checks are done for residents. No special monitoring system is in place for residents who smoke and a system is needed to follow the

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facility policy and to deter residents from smoking in the facility."

Observation on 12/15/11 at 9:05 am revealed the 400 hall Shower Room floor had a cigarette butt lying between the tub and the sink.

Observation on 12/15/11 at 9:30 am revealed the 300 hall Men's restroom had 3 smeared cigarette ashes piles in front of the toilet.

Observation on 12/15/11 at 9:35 am revealed the west wing Cardroom/telephone room having a "no smoking" sign on the entrance door and also having small round dark burn spots in the carpet.

Interview on 12/15/11 at 9:40 am with Staff W (housekeeping) who was vacuuming the hall carpet revealed 7 spots looked like cigarette burn marks. Staff also stated 2 of the spots near the door were new since yesterday.

Observation on 12/15/11 at 9:50am revealed the west wing Dayroom having a "no smoking" sign beside the doorway and having 36 small round dark burn spots in the carpet which appeared to have been recently made.

Interview on 12/15/11 at 9:50 am with Staff W revealed the spots in the Dayroom carpet were also cigarette burn marks. Staff W revealed not seeing residents during the daytime in this room, stating residents were, according to other staff reports, known to come in this section and room during the night.

Observation on 12/15/11 at 10:00 am revealed 4 small round dark burn spots in the carpet just inside the Activity/TV room door which opened to the outside and appeared to have been recently

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made; circumference of the carpet fiber around these burned spots were still raised.

Observation on 12/15/11 at 10:05 am revealed the Sunroom flooring carpet also had 11 small round dark burn spots which appeared to have been recently made. A "no smoking" sign was posted on the wall in the room.

3. Record review of the current FL-2 for Resident #1 dated 11/9/11 revealed diagnoses to include Alzheimer's Dementia, Hypertension, Muscular Degeneration, Left Pneumothorax, Left Orbital Fractures, Multiple Rib Fractures, Maxillary Wall Fractures, Compression Fracture, Osteoarthritis and Right Hip Fracture secondary to fall.

Review of hospital discharge summary (6/22/11) revealed Resident #1 was seen in the local hospital emergency department (ED) with a diagnosis of a fall and contusion of scalp.

Record review revealed on 7/16/11 Resident #1 was seen at the ED and diagnosed with a Closed Head Injury (CHI) and hematoma due to a fall.

Hospital discharge summary (10/29/11) revealed Resident #1 was seen in the ED with a diagnosis of Contusion of Right Knee due to "falling out of bed."

Resident #1 was seen in the ED (12/7/11) and diagnosed with "laceration of scalp without mention of complication due to CHI from fall."

Record review revealed a Licensed Health Professional Support (LHPS) recommendation (7/19/11) for a body alarm, "since the resident [Resident #1] has increase in agitation and multiple falls and Ativan is not working."

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Interview with the LHPS nurse on 12/13/11 at 2:52pm revealed Resident #1 had increased agitation and multiple falls. The nurse stated the "body alarm" was recommended to alert staff to catch the resident before she falls. It was the expectation of the nurse that the facility would have implemented the "body alarm" at the time of the recommendation. In the event, the facility does not agree with the recommendation, they should come up with a plan to prevent the resident from further falls. A copy of the recommendation had been sent to both the Director and RCC.

Interview with Resident # 1's family member on 12/9/11 at 1:25pm and 12/13/11 at 12:45pm revealed the resident had four falls occurring this year at the facility. The family member frequently visited and had been very involved with the resident's care. Family stated the resident's bed had been observed with one rail up and the other side of the bed against the wall. When the family asked about the bed, staff reported the one rail was put up to prevent Resident #1 from falling out of bed. Staff administered medication to the resident so the resident would be "calm and not try to get out of the bed." Family further stated the medication did not prevent the resident from falling as recently as 12/7/11. The family had not been informed a body alarm had been recommended in July, 2011. Family revealed a body alarm had not been applied for the resident and that the "body alarm would have been a great idea and could prevent potential falls" since Resident #1 would get out of bed without assistance.

Interview with the RCC on 12/13/11 at 4:00pm revealed Hospice recommended the "body

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alarm," therefore Hospice was responsible for obtaining the body alarm, not the facility.

Interview with the Director on 12/13/11 at 2:52pm revealed she was unaware of the "body alarm" recommendation (7/19/11) for Resident #1 until recently. The director was unclear as to who should have ordered the "body alarm" for Resident #1 but the RCC was responsible for following up recommendations, making sure they are done. The director stated Resident #1's bed had one side rail up to prevent the resident from getting out of bed. "Staff need to keep a close eye" on Resident #1 since the resident has had multiple falls and if the resident is agitated, Ativan should be administered to keep the resident calm.

Observation with Staff C (Nursing Assistant- usually assigned to Resident #1) on 12/12/11 at 10:30 am, revealed Staff C turned Resident #1 from side to side to apply a clean incontinent product and pad for the resident. Resident #1 was observed to have multiple bruises on left scalp, left eye, left facial, and left upper thigh. Staff C completed applying the incontinent product and pad, then raised one side rail up before leaving the room.

Interview with Staff C on 12/12/11 at 10:50 pm, revealed the bruises observed on Resident #1 were from injuries related to falls. Staff C stated the side rail was up (when Resident #1 was in bed) to prevent the resident from getting out of bed and falling. Also if Resident #1 became agitated, the Medication Aides would administer something so the resident could calm down and not get out of bed. She stated that on her shift she would make hourly rounds making sure Resident #1 was not falling out of bed. However,

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it was hard because she has a whole hall with residents who are "heavy care" (dependent on her for ADLs). It was hard to keep a close eye on all residents since there was only one of her. She stated that she was not aware of any body alarm and the resident did not have a body alarm.

Staff revealed standard facility policy was for 2 hour checks to be performed on each resident. There was no evidence of any additional or specific plan of surpervision for Resident #1.

Based on record review and observation of Resident #1 on 12/9/11, the resident was determined not be interviewable.

____
____

Review of the plan of protection dated 12/15/11 revealed the facility would ensure the safety of all residents. Residents at risk will be reassessed by the Director. The front door will be monitored to reduce the risk of elopement and when a resident is identified as an elopement risk a wander guard will be issued to the resident. Staff will be stationed at the desk by the front door until the wander guard system is activated and in place. Each smoking resident will be checked on each hour. All residents will be reassessed for falls by the Director. Residents found to be a fall risk will be check on every 30 minutes. Residents who are found to be a great risk for fall will not be admitted to the facility. Staff will be in-serviced on resident "change in needs or decline" by Home Health.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 14, 2012.

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D 307	Continued From page 40	D 307		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to clarify a thickened liquids order for 1 of 1 resident with orders for thickened liquids (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 11/9/11 revealed the resident's diagnoses included Alzheimer's Dementia, Hypertension, Muscular Degeneration, Left Pneumothorax, Left Orbital Fractures, Multiple rib Fractures, Maxilary Wall fractures, Compression Fracture, Osteoarthritis, and Right Hip fracture secondary to fall. Review of the dietary orders dated 7/6/11 revealed a physician's order for a mechanical soft diet (mechanical soft diet is a regular diet modified in texture only by chopping or grinding with added moisture where necessary) with chopped meats (chopped meats are cut up into bite size pieces). Record review revealed on 11/28/11 the speech	D 307		

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therapist performed an evaluation on Resident #1. The speech therapist notified the resident's physician of the resident's dysphagia and an order was obtained to begin using Thick-It in the resident liquids to prevent aspiration (Dysphagia is the medical term for the symptom of difficulty in swallowing).

Review of dietary orders dated 11/28/11 revealed a physician's order, "please add Thick-It to her diet to prevent aspiration; has difficulty swallowing." (Thick-It food thickener is a tasteless powder that helps thicken up foods to make them easier to swallow. The liquid consistencies are thickened to nectar-like, honey/puree-like, or spoon-thick consistency sometimes called pudding-thick. Proper consistency is necessary to provide the safest possible diet for each resident). There was no clarification of the order for Resident #1 in regards to the liquid consistency.

Observation of the noon meal on 12/12/11 at 12:05 pm revealed Staff C (Nursing Assistant) fed Resident #1. White powder was observed in a paper bowl. Staff C poured some of the white powder in a 12 oz white glass, and the remainder of the white powder in another 12 oz red glass. Staff C stirred the powder in the 12 oz white glass and the 12 oz red glass for approximately 30 to 60 seconds. Staff C offered the 12 oz liquid in the white glass to Resident #1 through a straw. The resident consumed it without difficulty.

Interview with Staff C on 12/12/11 at 12:30 pm, revealed Staff T (one of the kitchen staff) measured the Thick-It and placed it in the paper bowl and gave it to her. Staff C stated she mixed the Thick-It (the white powder in the paper bowl) in Resident #1's liquids before she fed Resident

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#1. Staff C could not explain what was the liquid consistency that she prepared for Resident #1.

Observation and interview on 12/12/11 at 4:45 pm, revealed Staff T preparing thickened liquids for Resident #1. Staff T obtained 2 scoops of Thick-It and poured it into a 12 oz glass of water. Staff T obtained another 2 scoops of Thick-It and poured it into a 12 oz glass of tea. She stirred both liquids with a straw for approximately 30 to 60 seconds and stated the liquids were ready. Staff T could not explain the consistency of the liquids she had prepared for the resident..

Interview with Staff H (Medication Aide), who was assigned to Resident #1 on 12/12/11 at 5:15 pm, stated she does not prepare thickened liquids for Resident #1, therefore she does not know the consistency Resident #1 should receive. Staff H stated Staff C, who fed Resident #1, was responsible for preparing and knowing the liquid consistency for the resident.

Interview with the Director and the Resident Care Coordinator (RCC) on 12/28/11 at 6:20 pm, revealed the dietary orders for Resident #1, was because of difficulty in swallowing (11/28/11).

The RCC further stated that even though the 11/28/11 diet order did not include consistency, she interpreted the order to reflect "nectar-like" consistency. The RCC did not feel the need to obtain physician clarification for consistency

Phone interview with the physician's nurse for Resident #1 on 12/13/11 at 11:26 am, revealed an order written on 11/28/11 based on the recommendation of the speech therapist. The physician's nurse was not aware the liquid consistency was not included in the orders.

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D 307	Continued From page 43 Phone interview with the speech therapist on 12/13/11 at 4:54 pm (who performed the evaluation on Resident #1 on 11/28/11), stated after her assessment on Resident #1, she contacted the resident physician's nurse via phone, and recommended add Thick-It in the resident fluids to prevent aspiration since resident had dysphagia. The speech therapist stated she also informed the RCC regarding her recommendation. According to the speech therapist, it's the facility's responsibility to follow through with the thickened liquids orders and obtain the clarification if the order does not indicate consistency. In regards to preparation of thickened liquids, the speech therapist stated liquid consistency would not be beneficial if not prepared correctly. Based on record review and observation of Resident #1 on 12/9/11, the resident was determined not be interviewable.	D 307		
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 observation, interview and record review the faility failed to assure residents were treated in accordance to their Declaration of resident's rights. The findings are: Based on interviews and record review the facility failed to assure residents were treated with respect and dignity.[Refer to Tag 911, G.S.	D 338		

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D 338	Continued From page 44 131D-21(1)]	D 338		
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: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 5 of 8 residents (#11, #12, #13, #14, #15) observed during the medication pass and 4 of 8 residents (#3, #4, #7, #9) sampled for record review. The findings are: 1. The medication error rate was 19% as evidenced by the observation of 7 errors out of 36 opportunities during the 11:00 a.m./12:00 noon medication pass on 12/12/11 and the 8:00 a.m. medication pass on 12/13/11. A. Record review revealed Resident #11's diagnoses on the current FL-2 dated 06/15/11 included uncontrolled diabetes mellitus, chronic pancreatitis, chronic diarrhea, schizophrenia, hypertension, total abdominal hysterectomy, and eczema. Record review revealed Resident #11 had a	D 358		

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D 358	Continued From page 45 physician's order dated 08/17/11 for Novolin R insulin to be administered based on fingerstick blood sugars (FSBS) before meals and at bedtime according to the following sliding scale: 70 - 150 = 0 units; 151 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; and >450 or < 50 call physician. (Novolin R is short-acting insulin used to lower blood sugar.) During the 11:00 a.m./12:00 noon medication pass observed on 12/12/11, Resident #11's FSBS was 502 at 11:36 a.m. Staff H (medication aide) stated she would administer 12 units of insulin to the resident because the physician had told them if the FSBS was >500 to give 12 units and then fax the physician's office. Staff H stated the Resident Care Coordinator (RCC) would have the order. Based on observation, Staff H administered 12 units of Novolin R insulin at 11:38 a.m. but she did not contact the physician's office. Continued observation of the 11:00 a.m./12:00 noon medication pass on 12/12/11 revealed Staff H continued to administer medications to other residents and stated she was finished at 12:17 p.m. Staff H left the medication cart and began other tasks. Surveyor reminded Staff H she had not contacted Resident #11's physician's office regarding the FSBS of 502. She revealed she would contact them at that time. Review of a fax received by the facility and dated 12/12/11 at 12:31 p.m. revealed an order to administer 10 units of insulin for FSBS of 502 and recheck in 1 hour. Interview with Staff H on 12/12/11 at 1:26 p.m. revealed she had called the physician's office and	D 358		

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D 358	Continued From page 46 notified them of the FSBS of 502 but she did not notify them she had already administered 12 units of insulin. Staff H stated she had just rechecked the resident's FSBS and it was 283. Interview with the Resident Care Coordinator (RCC) on 12/12/11 at 1:32 p.m. revealed she did not have an order for staff to administer 12 units of insulin to Resident #11 for FSBS > 500. The RCC stated staff were supposed to contact the physician's office to find out how much insulin to administer if the FSBS goes beyond the parameters. The RCC stated staff were not supposed to administer insulin without an order. Interview with the Director on 12/12/11 at 1:32 p.m. revealed staff should not give insulin without an order. She revealed staff was supposed to contact Resident #11's physician's office for FSBS >450 to find out how much insulin to administer to the resident. She stated the physician's office would usually fax an order immediately once they are notified of FSBS beyond the parameters on the sliding scale. The Director stated a medication error report would be completed. Review of the December 2011 medication administration record (MAR) revealed Resident #11's FSBS was 512 on 12/05/11 at 11:45 a.m. and 542 on 12/07/11 at 4:45 p.m. and both times the medication aide documented 12 units of Novolin R insulin were administered to the resident. Record review revealed there were no orders for the resident to receive 12 units of insulin on these two occasions. Interview with the Director on 12/12/11 at 3:20	D 358		

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p.m. revealed she was unaware staff was administering insulin without orders. She stated the RCC was responsible for reviewing the monthly MARs but no errors had been reported to her. The Director stated she did not have a system in place to check behind the RCC.

Interview with the RCC on 12/12/11 at 3:20 p.m. revealed she checks the orders on the MARs against the previous month's MARs. The RCC revealed she had not noticed staff had administered insulin without orders.

Review of the December 2011 MAR revealed the resident's FSBS ranged from 55 - 542 from 12/01/11 - 12/13/11.

Interview with Resident #11 on 12/13/11 at 12:20 p.m. revealed her FSBS usually runs high but sometimes she had to go to the hospital when it gets too low. The resident stated on 12/12/11 at lunchtime when her FSBS was >500, she had drank some hot chocolate and had eaten some cookies. The resident stated she usually got 12 units of insulin when her FSBS was >500. The resident revealed she did not usually have symptoms and could not usually tell if her FSBS was high or low.

Telephone interview with the Nurse Practitioner (NP) on 12/14/11 at 2:20 p.m. revealed Resident #11 was in and out of the hospital with hypoglycemia. The NP stated he expected to be notified of FSBS >450 so he could order the amount of insulin to be administered. The NP confirmed he had been made aware of the medication error on 12/12/11 when staff administered 12 units of insulin without an order prior to contacting his office.

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D 358	Continued From page 48 B. Record review revealed Resident #14's diagnoses on the current FL-2 dated 10/19/11 included diabetes mellitus, schizoaffective disorder bipolar type, depressed with psychosis, asthma, hypertension, back pain, and obesity. Record review revealed Resident #14 had an order on the current FL-2 dated 10/19/11 for Novolog Mix 70/30 insulin inject 45 units subcutaneously twice daily. (Novolog Mix 70/30 is combination insulin used to lower blood sugar.) During the 8:00 a.m. medication pass observed on 12/13/11 at 8:48 a.m., Staff G (medication aide) did not administer any Novolog Mix 70/30 to Resident #14 when he received his other morning insulin (Levemir). Review of the December 2011 medication administration record (MAR) revealed the order for Novolog Mix 70/30 was included on the MAR and it was scheduled to be administered at 8:00 a.m. and 8:00 p.m. There were no initials documented on the MAR to indicate any Novolog Mix 70/30 had been administered from 12/01/11 - 12/12/11 at either time. The blocks on the MAR beside 8:00 a.m. and 8:00 p.m. had been crossed out in ink with no explanation for the marks and no initials to indicate who marked the blocks out. Interview with Staff G (medication aide) on 12/13/11 at 10:35 a.m. revealed he did not administer the Novolog Mix 70/30 because the resident did not have any on hand in the facility. Staff G stated he thought it was discontinued according to the Resident Care Coordinator (RCC). Record review revealed no order to discontinue the Novolog Mix 70/30 insulin.	D 358		

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Review of the November 2011 MARS revealed Novolog Mix 70/30 was documented as administered twice daily at 7:45 a.m. and 8:00 p.m. from 11/01/11 - 11/30/11 and the resident's blood sugar ranged from 87 - "HI" (>600) during that time.

[Interview with the Director on 12/13/11 at 4:30 p.m. revealed when the blood glucose machines used by the facility registered "HI", the blood sugar was >600.]

Interview with the Director and RCC on 12/13/11 at 11:20 a.m. revealed they were not aware the Novolog Mix 70/30 was not being administered as ordered. They revealed to their knowledge it had not been discontinued. The RCC stated if a medication is discontinued she will mark it as discontinued on the MAR and date it and initial it. The RCC revealed she reviews the MARs monthly but she had not noticed the Novolog Mix 70/30 had been crossed out and she did not know who crossed it out. During the interview, the RCC contacted the pharmacy and was told they had an order for Novolog Mix 70/30 inject 45 units twice daily on file. The pharmacy did not have an order to discontinue the insulin. The Director stated they would complete a medication error report and notify the physician's office.

Review of the December 2011 MAR revealed the resident's blood sugar ranged from 92 - 292 in December 2011.

Interview with Resident #14 on 12/14/11 at 9:25 a.m. revealed his blood sugar gets "a little high" when he overeats but it was better than it had been in the past. The resident stated he previously received Novolog Mix 70/30 insulin, 45

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units twice a day. He revealed he stopped receiving the Novolog Mix about a month ago and he was not sure why it stopped. Resident #14 stated he felt like he needed the Novolog Mix insulin and he thought he was supposed to see the physician that day on 12/14/11.

Interview with the Nurse Practitioner (NP) on 12/14/11 at 2:20 p.m. revealed prior to receiving the medication error report, he was not aware Resident #14 was not receiving the Novolog Mix 70/30 as ordered. The NP stated when he received notification the resident had missed the doses of Novolog Mix 70/30; he decided to change the order to Novolog sliding scale since the resident was on Levemir. He stated they would monitor the resident and determine if the Novolog Mix 70/30 will need to be restarted.

C. Record review revealed Resident #13's diagnoses on the current FL-2 dated 04/27/11 included atrial fibrillation, peripheral vascular disease status post stent to right lower extremity plus renal arteries, chronic renal insufficiency, anemia, hypothyroidism, hyperlipidemia, deep vein thrombosis, gastroesophageal reflux disease, biceps tendonitis, Vitamin B12 deficiency, anxiety disorder, and left femur fracture status post open reduction internal fixation.

Record review revealed Resident #13 had a physician's order dated 08/31/11 for Diltiazem 30mg take ½ tablet 4 times a day, check pulse before giving medication and hold medication if pulse is less than 50.

During the 12:00 noon medication pass observed on 12/12/11 at 12:11 p.m., Diltiazem 30mg ½ tablet was administered to the resident. Staff H

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(medication aide) did not check the resident's pulse prior to administering the Diltiazem as ordered.

Review of the December 2011 medication administration record (MAR) revealed the order for Diltiazem was printed as ordered with Diltiazem 30mg take ½ tablet 4 times a day, check pulse before giving medication and hold medication if pulse is less than 50. The medication was scheduled and documented as administered at 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. from 12/01/11 - 12/12/11 with no pulses documented for the month of December 2011.

Further review of the August 2011 - November 2011 MARs revealed staff documented the administration of Diltiazem without any pulses documented on the MARs from 08/01/11 - 11/30/11. Review of the July 2011 MAR revealed the pulse was checked in July 2011 and ranged from 50 - 114.

Interview with Staff H (medication aide) on 12/12/11 at 1:22 p.m. revealed she had worked at the facility since September 2011 and she did not know the resident's pulse was supposed to be checked prior to administering the Diltiazem. Staff H stated she had not noticed the directions on the MAR stated to check the pulse before giving the medication.

Interview with the Director on 12/12/11 at 1:36 p.m. revealed she was unaware staff was not checking Resident #13's pulse before giving the Diltiazem as ordered. She stated staff had been trained to read the MARs and should have been checking the pulse before giving the medication. The Director stated the Resident Care

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Coordinator (RCC) was responsible for checking the MARs each month. She stated it must have been overlooked. The Director stated there was no system to check behind the RCC to assure the MARs were reviewed. The Director stated a medication error report would be completed and sent to the physician's office.

Upon request of surveyor, Staff H checked Resident #13's pulse and stated it was 68 at 1:50 p.m.

Interview with Resident #13 on 12/13/11 at 4:12 p.m. revealed staff had checked her pulse in the past but stopped for a while and just started back checking it yesterday on 12/12/11. The resident stated she felt "fine" but she occasionally had "pounding" of her heart but she has an irregular heartbeat and it was a chronic problem.

Review of the faxed response to the medication error report from the physician's office on 12/12/11 revealed an order for the facility to check heart rate prior to administration of Diltiazem and hold if less than 60.

Interview with the Nurse Practitioner (NP) on 12/14/11 at 2:20 p.m. revealed he expected staff to check the resident's pulse as ordered before giving the medication and if it was below the parameter, they should notify him.

D. Record review revealed Resident #12's diagnoses on the current FL-2 dated 11/09/11 included gastroesophageal reflux disease, upper respiratory infection, right hip arthroplasty, Parkinson's disease, paranoid schizophrenia, hypertension, history of myocardial infarction, hypercholesterolemia, and constipation.

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D 358	Continued From page 53 i. Record review revealed Resident #12 had an order on the current FL-2 dated 11/09/11 for Tussin 100mg/5ml take 10ml by mouth every 4 hours as needed for cough. (Tussin is an expectorant used to treat cold symptoms such as congestion and cough.) During the medication pass observed on 12/12/11 at 11:56 a.m., Resident #12 asked Staff H (medication aide) for something for her cold/cough. Staff H noted the order for Tussin printed on the MAR and stated she would give the resident some Tussin for her cold symptoms. Staff H was unable to locate the Tussin in the medication cart and she stated the facility did not carry house stock medication so there was no Tussin available to give the resident. She stated she would order the Tussin from the primary pharmacy but it would not be delivered to the facility until during the night around 2:00 a.m. Interview with the Director on 12/12/11 at 1:36 p.m. revealed the medication aides on duty were responsible for checking the medication supply daily and ordering any medications needed that were not on the cycle fill such as prn (as needed) medications. The Director confirmed the order was usually delivered from the primary pharmacy during the night so staff should have ordered the Tussin from the back up pharmacy. The Director stated they would order it from back up and it should be available soon for the resident. Interview with Resident #12 on 12/12/11 at 1:40 p.m. revealed she had taken some Tylenol (pain reliever/fever reducer) earlier and it had help her symptoms some but she had some congestion and a cough and would like to have something to help those symptoms.	D 358		

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Interview with the Director on 12/12/11 at 3:22 p.m. revealed the back up pharmacy had been contacted and staff was going to pick up the Tussin.

Review of the December 2011 medication administration record (MAR) on the next day, 12/13/11, revealed no Tussin had been documented as being administered to the resident on 12/12/11 or 12/13/11. The medication aide on duty on 12/13/11 at 5:30 p.m. was unable to locate any Tussin in the medication cart for the resident.

Further interview with the Director on 12/13/11 at 5:40 p.m. revealed she thought the Tussin had been picked up from the back up pharmacy on the previous day, 12/12/11. She had no explanation for the Tussin continuing to be unavailable for the resident on 12/13/11.

Interview with Staff A (medication aide) on 12/13/11 at 5:58 p.m. revealed she had just picked up the Tussin from the back up pharmacy. The label on the Tussin revealed a dispense date of 12/12/11.

ii. Record review revealed Resident #12 had an order on the current FL-2 dated 11/09/11 for Omeprazole 20mg 1 tablet daily. (Omeprazole reduces stomach acid.)

Review of the December 2011 medication administration record (MAR) revealed Omeprazole 20mg was scheduled to be administered at 8:00 p.m.

During the 8:00 a.m. medication pass observed on 12/13/11, Staff A (medication aide) administered Omeprazole 20mg to Resident #12

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at 9:22 a.m. instead of 8:00 p.m. as scheduled.

Review of the December 2011 MAR revealed the resident had received Omeprazole 20mg at 8:00 p.m. on the previous night on 12/12/11 and was not due to receive the medication again until 8:00 p.m. on 12/13/11.

Interview with Staff A (medication aide) on 12/13/11 at 9:35 a.m. revealed she did not notice the Omeprazole was scheduled to be administered at 8:00 p.m. Staff A stated she usually sees that particular medication scheduled for 8:00 a.m. and she had not noticed it was scheduled for 8:00 p.m. for this resident.

Interview with the Director on 12/13/11 at 12:20 p.m. revealed staff had been trained to read the MARs and they should administer medications when they are scheduled. The Director stated a medication error report would be completed and sent to the physician's office.

Review of a faxed response from the physician's office on 12/13/11 revealed an order to hold the evening dose of Omeprazole since it had been administered in error that morning.

Interview with Resident #12 on 12/15/11 at 9:55 a.m. revealed she did not know if she received any medication to reduce stomach acid. The resident stated she did not feel well but she denied any current symptoms of heartburn.

E. Record review revealed Resident #15's diagnoses on the current FL-2 dated 10/04/11 included psychosis secondary to traumatic brain injury (03/05/11), cognitive disorder not otherwise specified, cerebrovascular accident (11/2011 and 04/2011), hypertension, hyperlipidemia, diabetes

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D 358	Continued From page 56 mellitus type II, left brachial plexus injury (03/08/11), and chronic renal insufficiency. Record review revealed the resident was admitted to the facility on 11/25/11. Record review revealed Resident #15 had orders on the current FL-2 dated 10/04/11 for Miralax mix and drink 17 grams in 8 ounces of water once daily and Multivitamin 1 tablet once daily. (Miralax is for constipation. Multivitamin is a vitamin supplement.) During the 8:00 a.m. medication pass observed on 12/13/11, Resident #15 was not administered Miralax or Multivitamin at 8:58 a.m. when he received his other morning medications. Review of the November 2011 and December 2011 medication administration records (MARs) revealed Miralax and Multivitamin were not included on the December 2011 MARs. Record review revealed there were no orders to discontinue these two medications. Interview with Staff G (medication aide) on 12/13/11 at 10:40 a.m. revealed he was not aware of the orders for Miralax and Multivitamin. Staff G stated he administered medications according to the MARs and since these medications were not listed, he had not administered them. Staff G searched the medication cart and stated there was no Multivitamin on hand for this resident. Staff G found a bottle of Miralax in the bottom drawer of the medication cart that was dispensed on 11/17/11 and had not been opened. He had not noticed the Miralax was in the cart. Staff G stated Resident #15 had not reported any problems with constipation to him.	D 358		

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Interview with the Resident Care Coordinator (RCC) on 12/13/11 at 11:20 a.m. revealed she was responsible for transcribing medication orders and she usually went straight down the FL-2 for new residents and listed them on the MAR. The RCC stated she must have overlooked the orders for Miralax and Multivitamin when she transcribed the orders when Resident #15 was admitted. She indicated they would notify the physician's office regarding the Miralax and Multivitamin.

Interview with the Director on 12/13/11 at 12:20 p.m. revealed the medication aides should compare the medications in the cart to the MARs and clarify any discrepancies. She revealed the RCC was responsible for transcribing the orders and she did not know why the Miralax and Multivitamin were not included on the MARs.

Interview with Resident #15 on 12/13/11 at 4:15 p.m. revealed he did not receive a Multivitamin and he had not received any Miralax since being admitted to the facility. He stated he received Miralax prior to coming to the facility. He did not know why he no longer received the Miralax. The resident denied any current problems with constipation.

Interview with the Nurse Practitioner (NP) on 12/14/11 at 2:20 p.m. revealed Resident #15 was a new resident and he had not evaluated him yet. He stated the resident was scheduled to be seen on the following Wednesday (12/21/11).

2. Record review revealed Resident #3's diagnoses on the current FL-2 dated 11/29/11 included edema, venous insufficiency with ulcer, hypertension, chronic obstructive pulmonary

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D 358	Continued From page 58 disease, insomnia, obstructive sleep apnea, history of cerebrovascular accident, gout, and Vitamin B12 deficiency. Review of a previous FL-2 dated 09/19/11 also included a diagnosis of diabetes mellitus. Record review revealed Resident #3's current FL-2 dated 11/29/11 included the following medications orders: Allopurinol 100mg daily (used for gout); Apidra injection per sliding scale (rapid-acting insulin that lowers blood sugar); Aspirin 81mg daily (reduce risk of heart problems); Bupropion 100mg twice daily (antidepressant); Citalopram 20mg daily (antidepressant); Docusate 100mg at bedtime (stool softener); Enalapril 10mg twice daily (blood pressure/heart); Hydralazine 50mg every 8 hours (heart/blood pressure); Isosorbide Mononitrate 30mg ER daily (heart/blood pressure); Klor Con 10mEq daily (potassium supplement); Metoprolol 100mg twice daily (heart/blood pressure); Niaspan 1000mg ER twice daily (lowers cholesterol); Simvastatin 40mg daily (lowers cholesterol); Spironolactone 25mg daily (diuretic); Multivitamin 1 tablet daily (vitamin supplement); and accuchecks 4 times a day. Record review and review of the December 2011 medication administration record (MAR) revealed Resident #3 was readmitted to the facility from a rehabilitation center on 12/02/11 in the evening. Review of the December 2011 MAR revealed Resident #3 did not receive any medications from 8:00 p.m. on 12/02/11 through 8:00 p.m. on 12/05/11. Documentation on the MAR revealed the medications were not administered due to "unavailable, awaiting arrival from pharmacy". According to documentation, the resident began receiving the medications at 8:00 a.m. on 12/06/11.	D 358		

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Review of the December 2011 MAR also revealed Apidra injection per sliding scale was handwritten on the MAR but there was no documentation any Apidra had been administered and no reasons for the omissions. There was no scale transcribed onto the MAR but staff documented the resident's fingerstick blood sugar (FSBS) 4 times daily from 8:00 p.m. on 12/02/11 through 7:30 a.m. on 12/15/11. The resident's FSBS ranged from 79 - "HI" (>600) during this time. No insulin was documented as administered.

Record review revealed no documentation the physician had been contacted to clarify the sliding scale to be used with Apidra. Record review revealed the resident had been on a Regular insulin sliding scale prior to going to the rehabilitation center in October 2011.

Interview with Staff G (medication aide) on 12/15/11 at 11:40 a.m. revealed he did not administer any sliding scale insulin to Resident #3 because he did not know what scale to use. Staff G stated Resident #3 had no insulin in the facility.

Interview with the Resident Care Coordinator (RCC) on 12/15/11 at 1:20 p.m. revealed she thought the FL-2 with the orders were faxed when the resident returned to the facility but she could not recall. She thought she had contacted the pharmacy on 12/04/11 about the medications but she was not sure and she had no documentation of contacts with the pharmacy. The RCC did not recall contacting the back up pharmacy regarding the medications. The RCC stated she faxed a note to the medical office on 12/04/11 to clarify the Apidra insulin but she had not heard back and she had put a copy of the faxed note in the Nurse

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Practitioner's (NP) box at the facility so he could review it when he comes to the facility. She stated the NP usually comes to the facility on Wednesdays and he did not clarify the orders when he came on 12/07/11 because he wanted to see a copy of the hospital records. The RCC stated she had contacted the hospital to get the resident's records but she had not been able to get them yet. The RCC stated the NP did not come this week on 12/14/11 so she just left the fax in his box. She had not contacted the NP since his visit on 12/07/11 regarding the resident's sliding scale insulin and his blood sugars.

Review of a note to the physician's office dated 12/04/11 revealed the RCC documented resident returned from hospital with order for Apidra sliding scale but no sliding scale given, please clarify. There was no fax confirmation with the form to note when it was faxed or if it was received.

Interview with the Director on 12/15/11 at 1:20 p.m. revealed she was unaware the administration of the resident's medications had been delayed until 12/06/11 when he was readmitted on 12/02/11. The Director stated the RCC or the medication aides on duty at the time orders are received are responsible for ordering the medications and implementing the orders. The Director reported that medications usually come in the facility the same night they are ordered and if they do not come in, staff should notify the RCC who would then order it from the back up pharmacy. The Director was unaware Resident #3's Apidra was not being administered and there had been no clarification of which sliding scale to use. She revealed the RCC or the medication aides on duty are responsible for

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clarifying orders.

Telephone interviews with a pharmacy representative on 12/15/11 at 3:50 p.m. and 4:15 p.m. revealed the pharmacy received the resident's current FL-2 via fax on Monday, 12/05/11. The pharmacy representative stated she thought they received it on Monday because she thought the resident returned to the facility late and it was a weekend and the primary pharmacy is closed on the weekends. She reported if the facility needed the medications when the resident returned, they would have needed to use the back up pharmacy and not wait until the primary pharmacy reopened on Monday. In regards to the Apidra, the pharmacy representative revealed she thought there was a problem with the resident's insurance covering the Apidra and they were waiting to get a clarification from the facility or the physician. She stated to her knowledge, there had been no communication back from the facility regarding the Apidra order since she spoke with the RCC around 12/05/11. She revealed no Apidra had been dispensed to the resident and no other insulin had been dispensed to the resident since he was readmitted to the facility. According to pharmacy records, Resident #3's medications were dispensed on 12/05/11 after the pharmacy received the FL-2 from the facility. She indicated the medications would have been delivered to the facility late that night on 12/05/11.

Attempts to contact the Nurse Practitioner (NP) regarding Resident #3 on 12/15/11 were unsuccessful.

Telephone interview with the Triage Nurse at the physician's office on 12/15/11 at 4:30 p.m. revealed there was no record of the physician's

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office receiving a fax on 12/04/11 to clarify Apidra. She reported there was no record of any correspondence in regards to clarifying Apidra. The Triage Nurse noted there was a phone contact documented on 12/05/11 by the RCC related to another medication but no documentation regarding Apidra or any other insulin.

Record review revealed a note by the home health nurse indicated the resident was sent to the hospital on 12/12/11 due to issues with the swelling in legs and leg ulcers/wounds. On 12/15/11, the resident was still in the hospital and unavailable for interview.

3. Record review revealed Resident #4's diagnoses on the current FL-2 dated 10/26/11 included diabetes mellitus, cellulitis, lymphedema, obesity, obstructive sleep apnea, chronic pain syndrome, hypertension, schizoaffective disorder, and anoxic brain injury.

A. Review of hospital records dated 10/21/11 revealed Resident #4 had previously been diagnosed with right lower extremity deep vein thrombosis (blood clot) in August 2011 and was started on Coumadin therapy at that time.

Record review revealed Resident #4 had a physician's telephone order dated 11/23/11 to increase Coumadin from 5mg to 6mg daily based on an INR of 1.29 (below therapeutic range) on 11/22/11. The INR was to be rechecked in 1 week (due 11/29/11). (Coumadin is a blood thinner. INR is a lab value used to monitor Coumadin therapy. The INR is generally recommended to be 2.0 - 3.0 for most clinical situations or as specified by the physician.)

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D 358	Continued From page 63 Review of the November 2011 medication administration record (MAR) revealed the order to increase Coumadin to 6mg daily was not transcribed onto the MAR. Staff continued to document the administration of Coumadin 5mg daily from 11/23/11 - 11/28/11. Record review revealed the resident's INR was rechecked on 11/29/11 and was 1.15 (below therapeutic range). There was a physician's order dated 11/29/11 for Coumadin 7mg on Mondays, Wednesdays, and Fridays and Coumadin 6mg on Sundays, Tuesdays, Thursdays, and Saturdays. Interview with the Resident Care Coordinator (RCC) on 12/14/11 at 6:15 p.m. revealed she was unaware the order dated 11/23/11 had not been implemented. She stated she would look into it and see if there was another order not filed in the record. Interview with the RCC on 12/15/11 at 12:40 p.m. revealed she was responsible for transcribing and implementing orders when she was working and the medication aide on duty was responsible when the RCC was not working. The RCC stated she could not locate any other orders and it appeared the order was overlooked and not transcribed onto the MAR and implemented. The RCC indicated she checked the MARs monthly against the previous month's MARs and physician's orders. She revealed she must have overlooked the order for 11/23/11. Interview with the Director on 12/12/11 at 1:36 p.m. revealed the RCC was responsible for transcribing and implementing orders and for checking the MARs each month. She stated the order to increase Coumadin on 11/23/11 must	D 358		

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have been overlooked. The Director stated there was no system to check behind the RCC to assure the MARs were reviewed.

Interview with Resident #4 on 12/13/11 at 3:00 p.m. revealed the resident was currently receiving an alternating dose of Coumadin but she did not know the dosage. The resident stated she gets her INR checked every week and sometimes the dosage changes. She stated she was taking the Coumadin because she had a blood clot in her leg a few months ago. She denied any current signs or symptoms of bleeding/bruising or blood clots.

B. Record review revealed Resident #4 had a physician's order dated 11/03/11 for Humalog insulin to be administered based on fingerstick blood sugars (FSBS) before meals and at bedtime according to the following sliding scale: 70 - 150 = 0 units; 151 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; and >450 or < 50 call physician. (Humalog is rapid-acting insulin used to lower blood sugar.)

Review of the November 2011 medication administration record (MAR) revealed on 2 of 2 occasions the resident's FSBS was >450 and staff documented administering insulin without a physician's order. Staff documented administration of 10 units of Humalog on 11/13/11 at 7:45 a.m. for a FSBS of 462 and 12 units of Humalog on 11/13/11 at 4:45 p.m. for a FSBS of 550. Review of the November 2011 MAR revealed the resident's FSBS ranged from 75 - 550 from 11/01/11 - 11/30/11.

Record review revealed no documentation the physician was notified of the blood sugars >450

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and no documentation of any physician's orders for staff to administer the 10 units and 12 units as documented on 11/13/11.

Interviews with Staff H (medication aide) on 12/12/11 at 11:36 a.m. and 1:26 p.m. revealed she usually administered 12 units of insulin if it was >450 because she thought there was an order to do that. She stated the RCC would have the order.

Interview with the Resident Care Coordinator (RCC) on 12/12/11 at 1:32 p.m. revealed she did not have an order for staff to administer 12 units of insulin if it was beyond the resident's parameter ordered by the physician. The RCC stated staff were supposed to contact the physician's office to find out how much insulin to administer if the FSBS goes beyond the parameters. The RCC stated staff were not supposed to administer insulin without an order.

Interview with the Director on 12/12/11 at 1:32 p.m. revealed staff should not give insulin without an order. She revealed staff was supposed to contact the physician's office for FSBS >450 to find out how much insulin to administer to the resident. She stated the physician's office would usually fax an order immediately once they are notified of FSBS beyond the parameters on the sliding scale.

Review of the December 2011 MAR revealed Resident #4's FSBS ranged from 112 - 382 from 12/01/11 - 12/14/11 and had not been >450 during that time.

Interview with the Director on 12/12/11 at 3:20 p.m. revealed she was unaware staff was administering insulin without orders. She stated

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the RCC was responsible for reviewing the monthly MARs but no errors had been reported to her. The Director stated she did not have a system in place to check behind the RCC.

Interview with the RCC on 12/12/11 at 3:20 p.m. revealed she checks the orders on the MARs against the previous month's MARs. The RCC revealed she had not noticed staff had administered insulin without orders.

Interview with Resident #4 on 12/13/11 at 3:00 p.m. revealed her FSBS was more often high than it was low. The resident stated her FSBS was checked 4 times a day and she usually needed insulin everyday. The resident stated she did not usually have symptoms and she could not tell if her FSBS was high or low.

Telephone interview with the Nurse Practitioner (NP) on 12/14/11 at 2:20 p.m. revealed he expected to be notified of FSBS >450 for residents with a sliding scale so he could order the amount of insulin to be administered.

4. Record review for Resident #7 current FL-2 dated 11/7/11 revealed diagnoses of pneumonia, Diabetes Mellitus, chronic obstructive pulmonary disease, chronic pain, gastrointestinal reflux disease, and hypertension. The same FL-2 had physician orders for sliding scale insulin Lispro. (Lispro in a is a fast acting insulin)

Review of the sliding scale orders dated 11/7/11 revealed the following scale:
130-149=1u, 150-169=2u, 170-189=3u, 190-209=4u, 210-229=5u, 230-249=6u, 250-269= 7u, 270-289= 8u, 290-309= 9u, 310-329=10u, 330-349=11 u

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Review of Resident #7's December 2011 medication administration record (MAR) revealed 11 out of 11 opportunities the resident's blood sugar readings where above 349 and insulin had been administered the following times.

On 12/3/11 at 4:30 pm blood sugar was "HI", 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading.

On 12/3/11 at 8:00 pm blood sugar was 480, 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading.

On 12/5/11 at 7:30 am blood sugar was 598, 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading.

On 12/7/11 at 8:00 pm blood sugar was 526, 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading.

On 12/10/11 at 4:30 pm blood sugar was 523, 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading.

On 12/12/11 at 8:00 pm blood sugar was 545, 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading.

Review of the November 2011 MAR revealed 6 out of 6 opportunities the resident blood sugar readings where above 349 and insulin had been administered the following times.

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D 358	Continued From page 68 On 11/12/11 at 7:30 am blood sugar was 358, 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading. On 11/21/11 at 11:30 am blood sugar was 592, 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading. On 11/24/11 at 8:00 pm blood sugar was 445, 11 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading. On 11/25/11 at 4:30 pm blood sugar was 389, 15 units of insulin was documented as administered. There was no sliding scale order for the blood sugar reading. Interview with the Resident Care Coordinator (RCC) and Director on 12/14/11 at 11:45 a.m. revealed when there were no parameters for blood sugar readings the medication aides were supposed to call the medical provider. The RCC revealed Resident #7 had been to the local hospital and returned to the facility on 11/7/11 with new sliding scale orders. Continued interview revealed the physician was not called for clarification of the sliding scale orders. The Director revealed the RCC was responsible for reviewing the physician orders when residents return to the facility and was not sure what happen. The RCC revealed it was an oversight because the resident had previous parameters and it was assumed the order was the same. The Director revealed the facility had no blood sugar policy and each resident had their on parameters for staff to follow.	D 358		

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D 358	Continued From page 69 Interview with Staff H (medication aide) on 12/15/11 at 8:00 am revealed when blood sugars are above the sliding scale order and there are no additional information to follow the medication aide were supposed to call the medical provider for instructions and document in the nurses notes. Telephone interview with Staff P (medication aide) on 12/15/11 at 4:30 pm revealed on 12/7/11 the medical provider was called for Resident #7's blood sugar of 526. Staff P revealed the triage nurse at the medical provider office instructed Staff P to give 11 units of insulin recheck the residents blood sugar in one hour if the blood sugar had not gone down to call back. Staff P revealed no one had instructed her to document any information received from the medical provider. When asked Staff P stated another medication aide had told her to document any high blood sugars and contact the physician. Staff P had not received any training on the care of diabetic resident by the facility prior to medication administration. 5. Record review for Resident #9 revealed diagnoses on the current FL-2 dated 8/22/11 included: diabetes mellitus, schizophrenia, bipolar disorder, and chest pain. Review of Resident #9's FL-2 revealed physician orders for Humalog 100 units/ml injectable to use as sliding scale insulin (SSI) and having the following parameters: 150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, then 351-400 = 8 units. Record review of Resident #9's Medication Record (MAR) revealed the transcription of	D 358		

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D 358	Continued From page 70 physician orders for Humalog injectable 100 units/ml for use as sliding scale insulin (SSI) and having the following parameters: 150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, then 351-400 = 8 units. Record review of Resident #9's MAR dated 11/9/11 revealed a 4 pm finger stick blood sugar (FSBS) reading of 482. Humalog insulin 10 units were documented as administered at 4 pm to the resident. Record review Resident #9's MAR dated 11/10/11 revealed an 8 pm FSBS reading of 431. Humalog insulin 10 units were documented as administered at 8 pm to the resident. Record review of Resident #9's MAR dated 11/11/11 revealed a 7am FSBS reading of 428. Humalog insulin 10 units were documented as administered at 7am to the resident. Record review of the physician's order dated 8/24/11 did not include instructions for using 10 units of insulin for Resident #9. An additional 2 units of Humalog insulin beyond the physician's order was administered to Resident #9 on each of the above dates. Further record review revealed no clarification for or change in physician orders for Resident #9 for SSI amounts. No documentation was found in the record for physician notification of the FSBS levels and request for instructions for insulin administration. Interview on 12/14/11 at 12:40 pm with Staff A (Medication Aide) revealed Resident #9's November 2011 MAR was documented 3 times the blood sugars were over 400 and 10 units of	D 358		

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insulin were administered each time. The SSI parameters for FSBS greater than 400 were not documented. There was no order for an amount of insulin to give and the physician should have been called to find out how much insulin to give.

Interview on 12/14/11 at 12:50 pm with the Director revealed Resident #9 was given 10 units of insulin for FSBS over 400. There was not a physician's order for administering insulin for blood sugars over 400 or for administering 10 units of insulin. The physician should have been called before insulin was administered to find out how much to give. Staff needed to call and clarify the order.

Further interview with the Director revealed there was no facility SSI policy; physician orders were individualized for each resident.

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Review of the plan of protection dated 12/15/11 revealed the facility would review all diabetic residents' current orders and MARs to assure orders are being properly carried out and clarified. All medication aides will be immediately in-serviced on medication administration. All residents' records and MARs will be audited to ensure orders are being properly carried out. Daily audits for the diabetic MARs will be done to ensure all sliding scale insulin and accuchecks are being carried out properly. The RCC will do medication pass observations at random. There will be a two step sign off of MAR check for the monthly change over. Each admission, return from the hospital, and medication update will be completed by the RCC and checked by the Director.

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D 358	Continued From page 72 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED January 29, 2012.	D 358		
D 370	10A NCAC 13F .1004 (m) Medication Administration 10A NCAC 13F .1004 Medication Administration (m) Medication administration supplies, such as graduated measuring devices, shall be available and used by facility staff in order for medications to be accurately and safely administered. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure graduated measuring devices were used by 1 of 3 staff (Staff G) reviewed in order for insulin to be accurately and safely administered to 2 of 6 (#7, #14) residents reviewed. The findings are: Interview with Staff H (medication aide) and Staff G (medication aide) on 12/15/11 at 10:15 a.m. revealed they reported the facility only had one type of insulin syringe. They stated all carts have the same syringe. Staff H opened the drawer on short hall medication cart and showed surveyor a stack of 1cc insulin syringes that were marked in one scale with 10 unit increments from 10 to 100. The markings on the syringe represented 2 unit increments and therefore only accurately measured even numbered units of insulin. When asked how the medication aides would measure 15 units (odd number) of insulin, both Staff H and Staff G indicated they would pull the plunger halfway between 10 and 20 to estimate the dose.	D 370		

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D 370	Continued From page 73 Further interview with Staff G on 12/15/11 at 10:20 a.m. revealed he had administered an odd number of units (7 units) of insulin to Resident #7 that morning on 12/15/11 using those syringes and had to estimate the dose. During the interview with Staff H and Staff G on 12/15/11 at 10:25 a.m., the Resident Care Coordinator (RCC) came in the medication room and stated she orders two types of insulin syringes and both kinds should be in the cart. The RCC stated she was working as a medication aide when the facility was previously using the wrong syringes so she made sure there were some on hand. Staff H then checked the short hall medication cart again and found a small amount (approximately 5 to 10) of 1cc syringes marked with a double scale (one for even numbers and one for odd numbers) underneath the stack of 1cc syringes with the even scale only. The RCC stated staff was supposed to use these syringes for any odd units and she was not aware staff had been estimating the doses. Staff H then changed her previous statement about estimating the odd doses and indicated she was aware the syringes were there and that is what she used for insulin dosages with odd numbered units. Further interview and observation of long hall medication cart assigned to Staff G on 12/15/11 at 10:40 a.m. revealed there were no double scaled insulin syringes in his cart. Staff G stated he usually used the syringes in the cart with the even scale and he could recall two residents (Resident #7 and Resident #14) with odd insulin dosages he had estimated using the even scaled syringe. Staff G then paused and reported he thought he sometimes had the double scaled syringes in the cart but if they were not in the cart he would just estimate with the even scaled	D 370		

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syringes.

Interview with the Director on 12/15/11 at 1:42 p.m. revealed she was unaware staff was not using the appropriate syringes to accurately measure the insulin doses. She revealed the RCC was responsible for ordering the appropriate syringes to assure they measured the insulin doses accurately. She was unable to indicate a system to monitor staff to assure the correct syringes were being used by staff to accurately measure the insulin.

Record review and review of the December 2011 diabetic medication administration records (MARs) revealed Resident #7 and Resident #14 had received insulin dosages requiring odd numbered units.

1. Record review revealed Resident #7's diagnoses on the current FL-2 dated 11/07/11 included diabetes mellitus, chronic obstructive pulmonary disease, hyperlipidemia, chronic pain, hypertension, gastroesophageal reflux disease, left lower lobe pneumonia, and history of smoker.

Record review revealed Resident #7 had an order on the current FL-2 dated 11/07/11 for Humalog insulin to be administered based on fingerstick blood sugars (FSBS) before meals and at bedtime according to the following sliding scale: 130 - 149 = 1 unit; 150 - 169 = 2 units; 170 - 189 = 3 units; 190 - 209 = 4 units; 210 - 229 = 5 units; 230 - 249 = 6 units; 250 - 269 = 7 units; 270 - 289 = 8 units; 290 - 309 = 9 units; 310 - 329 = 10 units; and 330 - 349 = 11 units. (Humalog is rapid-acting insulin used to lower blood sugar.)

Review of the December 2011 medication administration record (MAR) revealed the

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D 370	Continued From page 75 resident's FSBS was checked 4 times daily and at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. Review of documentation revealed staff documented administering odd units of insulin on 28 occasions from 12/01/11 - 12/15/11. The resident's FSBS ranged from 48 - "HI" (>600) in December 2011. Interview with Resident #7 on 12/15/11 at 2:05 p.m. revealed he receives Lantus insulin in the morning and Humalog sliding scale insulin based on FSBS before meals. The resident stated his FSBS varies depending on the day and it sometimes runs high. He revealed it also was 47 on the previous day (12/14/11). The resident stated he did not get symptoms when his FSBS was high and when it was low on the previous day, he felt "bummed out". 2. Record review revealed Resident #14's diagnoses on the current FL-2 dated 10/19/11 included diabetes mellitus, schizoaffective disorder bipolar type, depressed with psychosis, asthma, hypertension, back pain, and obesity. Record review revealed Resident #14 had an order on the current FL-2 dated 10/19/11 for Levemir insulin 20 units in the morning and 25 units at bedtime. (Levemir is long-acting insulin used to lower blood sugar.) Review of the December 2011 medication administration record (MAR) revealed the resident received 25 units (odd number) of Levemir insulin at 8:00 p.m. daily from 12/01/11 - 12/14/11. The resident's FSBS ranged from 92 - 292 in December 2011. Interview with Resident #14 on 12/14/11 at 9:25 p.m. revealed his blood sugar gets "a little high"	D 370		

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D 370	Continued From page 76 when he overeats but it was better that it had been in the past.	D 370		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives	D 482		

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are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to assess, care plan and consider restraint alternatives for 2 of 3 residents who had physical restraints (Resident #1 and #10). The findings are:

1. Record review of Resident #1's current FL-2 dated 11/9/11 revealed the resident's diagnoses included Alzheimer's Dementia, Hypertension, Muscular Degeneration, Left Pneumothorax, Left Orbital Fractures, Multiple rib Fractures, Maxilary Wall fractures, Compression Fracture, Osteoarthritis, and Right Hip fracture secondary to fall.

Record review for Resident #1 revealed no restraint order/care plan or restraint alternatives.

Interview with Staff I (Nursing Assistant) on 12/15/11 at 9:15 am, who provided care for Resident #1, revealed Resident #1's bed was positioned one side of the bed against the wall and the other side, the side rail was up when the resident was in bed. According to Staff I the side rail was up when Resident #1 was in bed to prevent the resident from falling out of bed. Staff

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I was not aware of any facility policy regarding the side rail as a restraint nor the use of alternatives for Resident #1.

Interview with Staff C on 12/15/11 revealed Resident #1 had a fall that occurred during her shift around lunch time. The side rail was up but Resident #1 slid down the bed, got up, took small steps, and fell right next to the bed.

Interview with Staff H (Medication Aide) on 12/15/11 at 9:31 am, who provided care for Resident #1, revealed the side rail was used to protect Resident #1 so "she won't get out of bed on her own." Staff H also stated that Resident #1 did not have any physician order for restraint.

Interview with Resident #1's family on 12/9/11 at 1:25 pm and 12/13/11 at 12:45 pm revealed the resident had 4 falls at the facility this year. The family stated they frequently visited and had been very involved with the resident's care. The family observed the resident's bed with one rail up on one side and the other side of the bed against the wall. Staff stated this was to prevent the resident from falling. Staff administered medication to calm the resident however this did not prevent the resident from falling recently on 12/7/11. The family was unaware of any restraint alternatives for Resident #1.

Based on record review and observation of Resident #1 on 12/9/11, the resident was determined not be interviewable.

2. Record review of Resident #10's current FL-2 dated 8/10/11 revealed the resident's diagnoses included Major Depression, Diabetes Mellitus, Parkinson, Hypertension, Anxiety, Edema, Constipation, Urinary Frequency. Record review

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for Resident #10 revealed no restraint order/care plan or restraint alternatives.

Interview with Staff J (Nursing Assistant) on 12/15/11 at 9:15 am who provided care for Resident #10, revealed Resident #10's bed was positioned with one side of the bed against the wall and the other side, with the rail was up when Resident #10 was in bed. Staff J stated side rails were up so Resident #10 woould not roll over and fall out of bed. Resident #10 can't get out of bed by himself, the side rail prevented him from getting out of bed or rolling out of bed. According to Staff J, about one month ago the resident fell while trying to climb into bed when the rail was up; resident returning to room after meal via wheelchair. The side rail was up and blocked the resident from transferring from wheelchair to bed. Consequently, the resident fell right next to the side rail of the bed. Staff J stated she was not aware of any restraint policy or restraint alternatives considered for Resident #10.

Observation with Staff F (Medication Aide) on 12/15/11 at 9:00 am who provided care for Resident #10, observed Staff F transferred Resident #10 from wheelchair to bed after breakfast. She raised the side rail up before leaving Resident #10's room.

Interview with Staff F on 12/15/11 at 9:35 am, she stated she raised the side rail to keep the resident secure in bed. Since Resident #10 had 1 fall in October or November of this year. The side rail hinders the resident from getting out of bed and hurt himself. She was not aware that Resident #10 was in restraint, therefore no physician order, restraint policy, restraint assessment or restraint alternatives were done on Resident #10.

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D 482	Continued From page 80 Phone interview with Resident #10's family, who is very involved and visited Resident #10 regularly, on 12/15/11 at 3:50 pm, the family observed the side rail was up so the resident would not fall out of bed. The family noticed the side rail was up during visits. The family was unaware of any restraint alternatives for Resident #10. Based on record review and observation of Resident #10 on 12/14/11, the resident was determined not be interviewable. Interview with the Director on 12/14/11 at 5:15 pm, revealed there was no restraint policy at the facility. She further stated, using the half side rail and only one side of the bed was not consider a restraint. Therefore, Resident #1 and Resident #10 did not have physician order for restraint, restraint assessment/care plan, and restraint alternatives were not necessary.	D 482		
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: TYPE B VIOLATION Based on interviews and record review the facility failed to assure resident are treated with respect and dignity. The findings are: Confidential resident interview revealed the resident does not like the type of residents that	D911		

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are now living in the facility. The resident stated some residents are dangerous, have come from prison (one who killed her husband). The resident stated this female resident (referring to Resident #9) went after another resident (boyfriend) in the dining room with a pair of scissors about a month ago. The resident stated staff intervened and no one was physically harmed but this type of behavior makes the resident nervous. The resident stated the boyfriend would not press charges against Resident #9. The resident stated the resident had not been threatened but felt unsafe because of other residents' behaviors. The resident stated the concerns were reported to the Director and the resident was told the female resident was not going to hurt them and the Director commented that people come from different backgrounds.

Record review of Nurse's Notes dated 12/1/11 for Resident #9 revealed the following documentation: "had been verbally abusive to everyone the resident came into contact with today and had been cursing all day".

Record review of Nurse's Notes dated 12/5/11 for Resident #9 revealed the following documentation: "medication aide was going to check Resident #9's blood pressure and accidently dropped the blood pressure kit. (The resident) got real mad and got into fussing and cussing."

Interview on 12/12/11 at 11:45 am with Resident #2 revealed the resident was scared that Resident #9 would try to kill Resident #2. Resident #9 tried to stab other residents using knitting needles, scissors, butter knives, and forks. Resident #9 tried to stab a male resident with scissors and just missed him before staff

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could stop the resident. Anyone in Resident #9's path would be cursed and yelled at and could be threatened and attacked. Resident #2 said Resident #9 stated "better watch your back because I will kill you". Resident #9 "took a swing" at another resident last week in the smoking courtyard because the other resident was coughing. Resident #2 also revealed Resident #9 sleeps all day and roams around at night stealing items belonging to other residents. Resident #2 stated Resident #9 had taken ink pens and sodas out of Resident #2's refrigerator. Resident #2 had obtained a lock for the refrigerator, bedside table, and dresser drawer. Further interview revealed Resident #2 had talked with several staff expressing concerns about Resident #9's behaviors. Resident #2 stated staff was afraid of Resident #9.

Confidential resident interview revealed Resident #9 always tells residents that she is going to hurt them, Resident #9 is loud and disruptive. You have to keep your mouth shut not to get in confrontations with other residents around here.

Confidential resident interview revealed Resident #9 always tells residents that she is going to hurt them, Resident #9 is loud and disruptive. You have to keep your mouth shut not to get in confrontations with other residents around here.

Confidential resident interview revealed Resident #9 curse all the time the choice word is "F...". The resident revealed staff does not say anything to the resident. It's a lack of courtesy to other residents, you just don't say anything, you just have to ignore it. Every one keeps to themselves the best they can and that is usually in their rooms".

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Confidential resident interview revealed, "I have learned just not to say anything to anyone around here. The resident stated they were afraid of Resident #9 the resident threatens to hurt me all the time. Staff tell me to stay away from Resident #9 but the resident scares me "she has a history of hurting people" Another resident had been threaten to have her neck broken by Resident #9.

Interview with Staff A on 12/9/11 at 11:30 am reveals Resident #9 yells and threatens other residents stating "F... you up" Residents have very strong tendencies to argue with each other and it occurs mostly in the dining room.

Interview on 12/12/11 at 4:15 pm with Resident #9 revealed the resident was uncomfortable at the facility stating "anytime something happens, I am to blame". The resident "wants to be safe; does not feel the best being here".

Further interview revealed Resident #9 "argues with other residents, stating "verbally only, no physical interactions". The resident then revealed "if other residents try to spit on me I try to knock their lights out". Resident #9 further revealed last week one resident "punched me on the arm and I threw ice water on them".

In a confidential resident interview the following was revealed: "Resident #9 has a volatile, unpredictable temper and is a danger to everyone here. The resident tried to stab another resident with a pair of scissors about 1-2 weeks ago. Staff did not do anything and did not take the scissors away."

Additional record review and interviews revealed the following:

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D911	Continued From page 84 Review of the facility communication log dated 11/19/11 at 5:30 pm revealed Resident #17 had a physical altercation with Resident #21 after a verbal argument. Review of the nurse's notes dated 11/20/11 revealed Resident #9, #18, #19 had a verbal argument in the lobby Resident #20 called Resident #9 a female dog. Resident #18 called the police because he was afraid of Resident #19. Review of the communication log dated 12/4/11 revealed Resident #20 pushed Resident #6 in the dining room. Review of nurses notes dated 12/11/11 revealed Resident #19 started an argument with Resident #22 in the television room and Resident #19 started to push Resident #22 and to threaten to beat the resident up if he called 911. Police were called and spoke to both residents and was told to stay in their rooms. Telephone interview with a family member 12/15/11 at 9:00 am revealed when they were at the facility one resident stated to another resident "I will knock the hell out of you if you hit me again "The family member stated they became afraid. The family member stated the cursing was horrible. Confidential resident interview revealed Resident #18 attacked the kitchen staff. The resident stated Resident #18 is very hateful- I try to stay away from Resident #18. Confidential resident interview revealed you have to stay in your room just to stay out of trouble. You hear a lot of bickering and arguing amongst	D911		

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D911	Continued From page 85 the residents all the time. Confidential resident interview revealed during meals in the dining room, several residents will curse continuously at each other and at staff during the meals. The resident stated staff usually does nothing about it unless the state is in the building or the church groups. The resident stated, "it makes me feel like I don't want to eat in the dining room". The resident revealed the resident continues to eat in the dining room because there is an additional charge if the resident eats in their room. Confidential resident interview revealed residents are cursed out in the dining room by residents. The same resident would stated one resident threaten them stating, "Let me get up and hit you, you black fool". The resident stated if the resident had hit them they would be going to jail afterwards. Interview with Resident #8 on 12/9/11 at 10:15 am revealed another resident had been threatened because the other resident owed him money for cigarettes. Interview with Staff U (housekeeper) on 12/9/11 at 11:00 am revealed residents are always arguing with each other and staff just doesn't deal with some of the residents unless they have to. Interview with the Director on 12/14/11 at 8:30 am revealed residents have arguments all the time. Staff was supposed to separate residents when incidents occur. If it is something serious like "fighting" staff should call the Director for instructions on what to do about the situation. The Director revealed one of the residents	D911		

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D911	Continued From page 86 reported that another resident follows the resident around in the facility. The Director stated the residents were told they may see a resident several times a day because the facility is not but so big. The Director revealed the resident was asked if every thing was ok and the resident responded ok. The Director revealed nothing else had been done. The Director revealed they were not aware of the 11/29/11 physical altercations but did know a verbal altercation had pursued. The Director responded staff were suppose to separate residents keep them away for each other. Interview with the Director on 12/14/11 at 8:44 am revealed staff knows how to handle situations with residents. Interview with the Director on 12/15/11 at 1:36 p.m. revealed no residents had complained of feeling unsafe in the facility to her. The Director reported, "They all complain about each other and we deal with it on an individual basis". CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2012.	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 observations, interviews and record	D912		

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D912	Continued From page 87 review, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical environment, qualifications of medication staff, training on care of diabetic residents, personal care and supervision, medication administration, and declaration of residents' rights. The findings are: 1. Based on observation, interview, and record review, the facility failed to equip the front door with a sounding system that was activated when the front door was opened to assure resident safety for 1 of 1 resident who wandered away from the facility and was struck by a vehicle and later died from injuries. (Resident #6). [Refer to Tag D067, 10A NCAC 13F .0305 (h)(4) Physical Environment (Type B Violation)] 2. Based on interview and record review, the facility failed to assure 2 of 5 medication aides (Staff P, Q) had successfully completed the clinical skills checklist prior to administration of medications. [Refer to Tag D125, 10A NCAC 13F .0403(a) Qualifications of Medication Staff (Type B Violation)] 3. Based on interview and record review, the facility failed to assure 2 of 5 medication aides (Staff P, Q) received training on the care of diabetic residents. [Refer to Tag D164, 10A NCAC 13F .0505 Training On Care Of Diabetic Residents (Type B Violation)] 4. Based on interviews and record review the facility failed to assure residents are treated with respect and dignity. [Refer to Tag D911,G.S. 131D-21 (1) Declaration of Residents' Rights (Type B Violation)]	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092020	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED R-C 12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKE FOREST CARE CENTER, INC.	**306 SOUTH ALLEN STREET WAKE FOREST, NC 27587**

(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
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide services necessary to maintain the physical and mental health of residents. The findings are: 1. Based on observation, interview, and record review, the facility failed to assure supervision for 5 of 12 residents, one resident who wandered away from the facility and was struck by a vehicle and later died from injuries, three residents smoking in the facility and one resident with multiple falls (Resident #1, #6, #7, #14, #16). [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)] 2. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 5 of 8 residents (#11, #12, #13, #14, #15) observed during the medication pass and 4 of 8 residents (#3, #4, #7, #9) sampled for record review. [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]	D914		