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| F 160 SS=B | 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH<br><br>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation and interviews, the facility failed to forward the full balance of an expired resident's funds to the Clerk of Court for one (1) of five (5) expired resident fund accounts reviewed. (Resident #90).<br><br>The findings include:<br><br>Resident #90 expired on 10/1/15. On 10/2/15 a Social Security check for $815.00 was deposited into Resident #90's personal funds account. On 10/2/15 the facility debited $785.00 from Resident #90's account for the resident's cost of care. On 10/5/15 the facility closed Resident #90's account with a balance of $60.00 and on 10/7/15 the facility forwarded the balance of the resident's account to the Clerk of Court for the resident's estate.<br><br>During an interview on 2/11/16 at 1:10 PM, the facility Business Office Manager revealed Resident #90 expired on 10/1/15 and he owed the facility for his cost of care. She revealed the data system automatically allocated the money to the resident's cost of care. The Business Office Manager explained that the resident's check was directly deposited into his account and the money | F 160 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 160 | Continued From page 1<br>was automatically transferred from the resident's account to the resident's liability. The Business Office Manager stated the facility had to wait for the Corporate Office to send a refund check back to the facility before anything could be done. As of 2/11/16, the facility had not received the check from the Corporate Office in order to send the balance of the resident's account to the Clerk of Court.<br><br>During an interview on 02/11/2016 at 3:49 PM, the Administrator of the facility revealed he could not control policy. He explained that Resident #90's money was transferred to the Clerk of Court on 10/2/15 and the facility was waiting for the refund check from the Corporate Office. He stated the facility did what they were supposed to do on their end. | F 160 | | |
| F 161 SS=C | 483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS<br><br>The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and documentation, the facility failed to provide a surety bond that designated the obligee as the residents in aggregate of the named facility instead of the Department of Human Resources, Division of Facility Services of the State of North Carolina.<br><br>The findings include: | F 161 | | |

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| F 161 | Continued From page 2 | F 161 | | |

Review of the facility surety bond effective date 8/1/15, read in part, the " Owner/Representative of named facility as Principal and named insurance company as Surety, hereby bind ourselves unto the Department of Human Resources, Division of Facility Services of the State of North Carolina in the penal sum of Eighty Thousand and $ no/100 Dollars ($80,000), the payment of which we bind ourselves, our heirs, executors, administrators and assigns for the benefit and use of the resident's funds of said facility who deposit, or have deposited or managed for them, resident ' s funds as provided for in 42 CFR 483.10 (c) (7) and Medicare and Medicaid Requirement of Participation for Nursing Facilities, TAG #F171. "

The Department of Human Resources, Division of Facility Services of the State of North Carolina, does not have any provisions for distributing funds to individuals in long term care facilities. In addition TAG #171 as mentioned in the document does not address the surety bond.

During an interview on 2/11/16 at 9:35 AM the Business Office Manager stated she had the old surety bond, but the company went with another insurance company when the surety bond was renewed.

During another interview on 2/11/16 at 12:58 PM, the Business Office Manager stated she would have to contact someone from the corporate office and they would send a copy of the surety bond. Review of the surety bond from last year revealed the same language in the surety bond.

On 2/11/16 at 3:49 PM, the Administrator was informed that the Department of Human

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| F 161 | Continued From page 3<br>Resources, Division of Facility Services of the State of North Carolina, does not have any provision for distributing funds to individuals in long term care facilities in the case of loss. | F 161 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to invite (1) of (3) (Resident #31) resident's family members to the Care Plan Meeting and the facility also failed to share the results of the Care Plan with (1) of (3) (Resident #31) resident's family members reviewed regarding family participation in Care Planning. | F 280 | | |

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The findings include:

Resident #31 was originally admitted to the facility on 7/7/14 with diagnoses including Cognitive Deficits due to Cerebrovascular Attack, and Altered Mental Status.

According to the most recent Annual Minimum Data Set (MDS) dated 1/27/16, Resident #31's Brief Interview for Mental Status (BIMS) revealed she had memory deficits. Resident #31 required minimal to extensive assistance in most areas of activities of daily living.

Review of an undated Care Plan Meeting invitation letter noted that Resident #31's Care Plan Meeting was held on 12/24/15. Although Resident #31's family member's name was noted on the invitation letter, the family member did not receive the letter because there was no address noted on the letter. Review of the Annual Minimum Data Set dated 1/27/16 revealed an Annual Care Plan Meeting should have been conducted.

During an interview on 2/9/16 at 8:31 PM, Resident #31's family member revealed she was not involved in decisions regarding Resident #31's care plan and she was not invited to attend Resident #31's Care Plan Meetings.

During an interview on 2/11/16 at 10:22 AM, the Minimum Data Set (MDS) Nurse revealed Resident #31's family member had been invited to attend Resident #31's Care Plan Meeting, but the family member had not attended the meetings. She revealed none of Resident #31's family members attended Care Plan Meetings.

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She shared that she was responsible for sending letters to family members inviting family members to attend Care Plan Meetings. The MDS Nurse relayed that they also assigned staff to call family members to determine if they had any concerns after Care Plan Meetings. She stated that Resident #31's family member had not been assigned to her in order to explain the results of the Care Plan Meeting. The MDS Nurse presented a Care Plan form which assigned staff would document their contact with family members regarding Care Plan Meeting results.

During another interview on 2/11/16 at 1:40 PM the MDS Nurse explained Resident #31's Care Plan invitation letter was put in her room because the facility did not have an address for the responsible party and no one was assigned to review the Care Plan with the family member. The MDS Nurse revealed Resident #31 was her own responsible person and she received notice of Care Plan Meetings.

During an interview on 2/11/16 at 2:08 PM, the facility Social Worker revealed one of Resident #31's family members was her Power Of Attorney (POA) and had been Resident #31's POA since the resident had been in the facility. She revealed the family member's address should have been in the computer since she was not able to locate the address in the record. The facility Social Worker revealed the facility did not have a copy of Resident #31's Power of Attorney (POA) document. She stated she had asked Resident #31's family member several times to supply the facility with the POA documentation, however, the family member had not done so.

On 2/11/16 at 3:49 PM, the Administrator was

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| F 280 | Continued From page 6<br>informed that Resident #31's family member was not invited to attend the resident's Care Plan Meeting nor was the family member informed regarding the results of the Care Plan Meeting. | F 280 | | |
| F 329 SS=E | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview and consulting pharmacist interview, the facility failed to monitor residents receiving an antipsychotic | F 329 | | |

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medication by failing to perform an AIMS (abnormal involuntary movement scale) for tardive dyskinesia (TD) for two (2) of four (4) residents reviewed for antipsychotic drug use (Resident #71, and 70).

The findings included:

1. Resident # 71 was admitted to the facility 7/16/14 and re-admitted on 11/25/14 with diagnoses including dementia with hallucinations.

A review of the Physician's orders dated 2/16/15 revealed Resident #71 was ordered "Risperdal .5 milligrams (mg) 1 by mouth (po) twice a day (bid) for hallucinations."

A review of the AIMS dated 3/18/15 revealed Resident 71 under section D (Global Judgments) had incapacitation due to abnormal movements. Record review revealed there were no other AIMS assessments since 3/18/15.

A review of the Care Area Assessment (CAA) dated 4/3/15 revealed Resident 71 triggered for antipsychotic medications related to dementia with hallucinations and she continued to have altered perceptions.

A review of the Pharmacy Progress Notes for 9/23/15 through 1/26/16 reflected three notes in reference to the AIMS. One note documented AIMS 3/15. The other two notes documented AIMS with no date. There were no notes documenting that the facility had been notified concerning the AIMS assessment was due.

The most recent annual Minimum Data Set (MDS) Assessment dated 1/21/16 revealed

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Resident #71 was on antipsychotic medications for hallucinations.

A review of the most recently updated care plan dated 1/21/16 revealed the resident was at risk for adverse effects of psychotropic medications related to daily use of antipsychotic medication and hallucinations. The goal was that the resident would be free from adverse effects of psychotropic medications. A review of intervention # 3 dated 5/12/15 revealed any negative outcomes associated with the use of the drug be reported to the physician.

A review of Medication Administration Record (MAR) for dates from 2/1/16 - 2/29/16 revealed Resident 71 was receiving Risperdal .5 mg 1 po bid for hallucinations.

On 2/11/16 at 1:35 PM the consulting pharmacist stated the AIMS should be done every 6 months.

On 2/11/16 at 1:40 PM the regional facility consultant stated that she would expect every resident receiving an antipsychotic medication to have an AIMS evaluation every 6 months. The regional facility consultant stated she had reviewed the medical record and Resident 71 had not had an AIMS evaluation since March 2015.

On 2/11/16 at 1:50 PM the Director of Nursing (DON) stated her expectations would be for any resident on an antipsychotic medication to have the AIMS evaluations every 6 months. She stated Resident 71 had not had an AIMS evaluation since March 2015.

On 2/11/16 at 2:05 PM the Administrator stated his expectations would be that any resident

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receiving an antipsychotic to have an AIMS evaluation every 6 months.

2. Resident #70 was originally admitted to the facility on 9/8/14 with diagnoses including Mood Disorder with Psychosis and Dementia.

A review of a Physician ' s order dated 2/11/16 read in part. " D/C (discontinue) Risperdal 0.5mgs. twice daily for mood disorder with psychosis, start Risperdal syrup 1mg./ml., give 1 mg. by mouth twice daily. "

A review of the Abnormal Involuntary Movement Scale (AIMS) dated 3/18/15 revealed Resident #70 under section D (Global Judgements) had no severity of abnormal movements, the resident had no incapacitation due to abnormal movements and there were no resident ' s awareness of abnormal movements. Review of the record revealed there were no other AIMS evaluations since 3/18/15.

Review of a pharmacist consultant note dated 5/19/15 revealed on 4/29/15 Resident #70 was receiving Seroquel 12.5 mgs. three times daily. A pharmacist consultant note dated 6/19/15, noted Resident #70 ' s Seroquel was increased on 5/20/15 to 25 mgs. three times daily.

Review of a pharmacist note dated 7/24/15 revealed on 7/1/15 Resident #70's Seroquel was changed to 12.5mgs. at noon and 12.5mgs. at bedtime. The pharmacist consultant recommended an AIMS.

Review of a pharmacist consultant note dated

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9/24/15 recommended an AIMS.

Review of a pharmacist consultant note dated 10/28/15 recommended an AIMS.

Review of a pharmacist consultant note dated 11/23/15, revealed on 11/20/15 Resident #70 ' s Seroquel dosage was changed to 25mgs. three times daily. The pharmacist recommended an AIMS.

Review of a pharmacist consultant note dated 1/26/16, revealed on 1/14/16, Seroquel was discontinued and Risperdal started twice daily.

Review of the most recent Quarterly Minimum Data Set (MDS) dated 1/7/16 revealed Resident #70 received antipsychotic medication for a psychotic disorder.

A review of the most recent updated Care Plan revealed Resident #70 was at risk for adverse effects of psychotropic medication related to the use of antipsychotic medication. The goal was the resident would be free from adverse effects of psychotropic medications and the resident would receive the least dosage of the prescribed psychotropic drug to ensure maximum functional ability both mentally and physically. A review of intervention #2 dated 2/23/15 revealed report to physician any negative outcomes associated with use of drug and intervention #7 dated 2/23/15 revealed discus/aims per protocol.

A review of the most recent Medication Administration Record (MAR) dated 2/1/16 through 2/29/16 revealed Resident #70 was receiving Risperidone 1mg/ml solution for a mood disorder and psychosis.

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| F 329 | Continued From page 11<br><br>During an interview on 2/11/16 at 1:35 PM the consulting pharmacist stated the AIMS evaluation should be done every six months.<br><br>During an interview on 2/11/16 at 1:40 PM the regional facility nurse consultant stated that she would expect every resident receiving an antipsychotic medication to have an AIMS evaluation every 6 months. The regional facility consultant revealed she had reviewed the medical record and Resident #70 had not had an AIMS evaluation since March 2015.<br><br>During an interview on 2/11/16 at 1:50 PM the Director of Nursing (DON) stated her expectation would be for any resident on an antipsychotic medication to have the AIMS evaluation every 6 months. She revealed Resident #70 had not had an AIMS evaluation since March 2015.<br><br>During an interview on 2/11/16 at 2:05 PM the Administrator stated his expectation would be that any resident receiving an antipsychotic medication to have an AIMS evaluation every 6 months. | F 329 | | |
| F 428 SS=E | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. | F 428 | | |

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This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and consulting pharmacist interview, the facility failed to perform AIMS (abnormal involuntary movement scale) for tardive dyskinesia (TD) for 2 (two) of 4 (four) sampled residents receiving antipsychotic medications (Resident #71 and Resident #70) by failing to notify the attending physician and the Director of Nursing (DON) that the facility staff had failed to perform an AIMS (abnormal involuntary movement scale) for tardive dyskinesia (TD) for (1) of 4 (four) sampled residents receiving antipsychotic medications (Resident #71) and by failing to act on the consulting pharmacist recommendations that the facility staff perform an AIMS (abnormal involuntary movement scale) for dyskinesia tardive (TD) for (1) of 4 (four) sampled residents receiving antipsychotic medications. (Resident #70).
The findings included:

1. Resident 71 was admitted to the facility 7/16/14 and re-admitted on 11/25/14 with diagnoses including dementia with hallucinations.

A review of the Physician ' s orders dated 2/16/15 revealed Resident #71 was ordered " Risperdal .5 milligrams (mg) 1 by mouth (po) twice a day (bid) for hallucinations.

A review of the AIMS dated 3/18/15 revealed Resident #71 under section D (Global Judgments) had incapacitation due to abnormal movements. There were no other AIMS located

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in the medical record.

A review of the Care Area Assessment (CAA) dated 4/3/15 revealed Resident #71 triggered for antipsychotic medications related to dementia with hallucinations and she continued to have altered perceptions.

A review of the Pharmacy Progress Notes for 9/23/15 through 1/26/16 reflected three notes in reference to the AIMS evaluation. One note documented AIMS 3/15. The other two notes documented AIMS with no date. There were no notes documenting that the facility had been notified concerning the AIMS assessment was due.

The most recent annual Minimum Data Set (MDS) Assessment dated 1/21/16 revealed Resident #71 was receiving an antipsychotic medication for hallucinations.

A review of the most recently updated care plan dated 1/21/16 revealed the resident was at risk for adverse effects of psychotropic medications related to daily use of antipsychotic and antidepressant medications and hallucinations. The goal was that the resident would be free from adverse effects of psychotropic medications. A review of intervention # 3 dated 5/12/15 revealed any negative outcomes associated with the use of the drug be reported to the physician.

A review of Medication Administration Record (MAR) for dates from 2/1/16 - 2/29/16 revealed Resident 71 was receiving Risperdal .5 mg 1 po bid for hallucinations.

On 2/11/16 at 1:35 PM the consulting pharmacist

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stated that the facility had been late with the AIMS evaluations and she had notified the facility. She stated the facility should have a copy if she had notified them. The Pharmacist further stated the AIMS should be done every 6 months.

During an interview with the facility consultant on 2/11/16 at 1:40 PM she stated that she would expect every resident receiving an antipsychotic medication to have an AIMS evaluation every 6 months. The facility consultant stated she had reviewed the medical record and Resident 71 did not have any AIMS evaluations since 3/15.

On 2/11/16 at 1:50 PM the Director of Nursing (DON) stated her expectations would be for any resident on an antipsychotic medication to have the AIMS evaluations every 6 months. She stated the pharmacist before leaving the facility would usually come up to her and let her know if there were any issues that needed to be resolved and would also send a Pharmacy Consultant note to follow up. She stated she would review the notes but did not remember ever receiving any notification. A follow up interview revealed there were no Pharmacy Consultant notes concerning Resident 71 ' s AIMS evaluation being due.

On 2/11/16 at 2:05 PM the Administrator stated his expectations would be that any resident receiving an antipsychotic have an AIMS evaluation every 6 months. He further stated the pharmacist should let the facility know if a resident was missing the AIMS evaluation.

2. Resident #70 was originally admitted to the facility on 9/8/14 with diagnoses including Mood Disorder with Psychosis and Dementia.

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A review of a Physician's order dated 2/11/16 read in part. "D/C (discontinue) Risperdal 0.5mgs. twice daily for mood disorder with psychosis, start Risperdal syrup 1mg./ml., give 1 mg. by mouth twice daily."

A review of the Abnormal Involuntary Movement Scale (AIMS) dated 3/18/15 revealed Resident #70 under section D (Global Judgements) had no severity of abnormal movements, the resident had no incapacitation due to abnormal movements and the resident had no awareness of abnormal movements. Review of the record revealed there were no other AIMS evaluations since 3/18/15.

Review of a pharmacist consultant note dated 5/19/15 revealed on 4/29/15 Resident #70 was receiving Seroquel 12.5 mgs. three times daily. A pharmacist consultant note dated 6/19/15, noted Resident #70 ' s Seroquel was increased on 5/20/15 to 25 mgs. three times daily.

Review of a pharmacist note dated 7/24/15 revealed on 7/1/15 Resident #70's Seroquel was changed to 12.5mgs. at noon and 12.5mgs. at bedtime. The pharmacist consultant recommended an AIMS.

Review of a pharmacist consultant note dated 9/24/15 recommended an AIMS.

Review of a pharmacist consultant note dated 10/28/15 recommended an AIMS.

Review of a pharmacist consultant note dated 11/23/15, revealed on 11/20/15 Resident #70 ' s Seroquel dosage was changed to 25mgs. three

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times daily. The pharmacist recommended an AIMS.

Review of a pharmacist consultant note dated 1/26/16, revealed on 1/14/16, Seroquel was discontinued and Risperdal started twice daily.

Review of the most recent Quarterly Minimum Data Set (MDS) dated 1/7/16 revealed Resident #70 received antipsychotic medication for a psychotic disorder.

A review of the most recent updated Care Plan revealed Resident #70 was at risk for adverse effects of psychotropic medication related to the use of antipsychotic medication. The goal was the resident would be free from adverse effects of psychotropic medications and the resident would receive the least dosage of the prescribed psychotropic drug to ensure maximum functional ability both mentally and physically. A review of intervention #2 dated 2/23/15 revealed report to physician any negative outcomes associated with use of drug and intervention #7 dated 2/23/15 revealed discus/aims per protocol.

A review of the most recent Medication Administration Record (MAR) dated 2/1/16 through 2/29/16 revealed Resident #70 was receiving Risperidone 1mg/ml solution for a mood disorder and psychosis.

During an interview on 2/11/16 at 1:35 PM the consulting pharmacist stated that the facility had been late with the AIMS evaluations and she had notified the facility. She stated the facility should have a copy if she had notified them. The Pharmacist further stated the AIMS should be done every 6 months.

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During an interview with the facility nurse consultant on 2/11/16 at 1:40 PM, she stated that she would expect every resident receiving an antipsychotic medication to have an AIMS evaluation every 6 months. The facility consultant stated she had reviewed the medical record and Resident #70 did not have any AIMS evaluations since March 2015.

During an interview on 2/22/16 at 1:50 PM the Director of Nursing (DON) stated her expectations would be for any resident on an antipsychotic medication to have an AIMS evaluation every 6 months. She stated the pharmacist before leaving the facility would usually come up to her and let her know if there were any issues that needed to be resolved and would also send a Pharmacist Consultant note to follow-up. She stated she would review the notes but did not remember ever receiving any notification. A follow-up interview revealed there were no Pharmacy Consultant notes concerning Resident #70 ' s AIMS evaluation being due.

During an interview on 2/11/16 at 2:05 PM the Administrator stated his expectations would be that every resident receiving an antipsychotic medication have an AIMS evaluation every 6 months. He further stated the pharmacist should let the facility know if a resident was missing the AIMS evaluation.