

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 on June 15, 16 and 17, 2021.	{D 000}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service  10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.  This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered by the resident's physician for 2 of 2 sampled residents (#2 and #4) who had an order for nectar thickened liquids (#2) and an order for a mechanical soft, ground meats diet (#4).  The findings are:  1. Review of Resident #2's current FL-2 dated 02/15/21 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia and pre-diabetes. -The diet ordered was mechanical soft.  Review of Resident #2's record revealed: -A physician's order dated 01/18/21 for nectar thickened liquids due to Resident #2 having swallowing difficulties. -A physician's order dated 06/16/21 for a pureed	{D 310}		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 310}	<p>Continued From page 1</p> <p>diet.</p> <p>Review of the therapeutic diet listing for spring/summer 2021 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was to be served a pureed diet.</li> <li>-Nectar thickened liquids were not documented on the list.</li> </ul> <p>Observation of the lunch meal service on 06/16/21 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2's lunch tray was delivered to her room at 12:22 pm and placed on the over-bed table in front of the resident seated in a wheelchair.</li> <li>-The tea on the tray was not of nectar consistency, it was too thin.</li> <li>-There was a 1-inch granular sediment in the bottom of the glass and regular consistency tea on top.</li> <li>-A personal care aide (PCA) came in to assist Resident #2 with eating her meal and stopped to stir the tea in the glass.</li> <li>-The PCA commented that Resident #2's tea did not look like nectar thickened consistency, but she held the glass up to Resident #2's mouth to drink the tea and the resident pushed the glass away.</li> <li>-The PCA took the glass of tea back to the kitchen.</li> </ul> <p>Interview with the dietary cook on 06/16/21 at 12:35pm and at 1:15pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was the only resident who had an order for thickened liquids, and he prepared the nectar thickened tea for the resident today.</li> <li>-He was not sure why the tea did not thicken correctly.</li> <li>-He used a 2-cup measuring container to measure the 8 ounces of tea to put in the glass and added the packet of nectar thickening</li> </ul>	{D 310}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 310}	<p>Continued From page 2</p> <p>powder to the glass.</p> <p>-He should have added another packet of thickener to the tea, but as per the instructions on the packet, one packet was to be used for 8 ounces of liquid.</p> <p>-He stirred the mixture and set the glass on the food cart, with the lunch plate, to be delivered to Resident #2.</p> <p>-He had not been trained by a dietitian to make thickened liquids but followed the instructions on the package of the product purchased by the facility.</p> <p>-He was very busy trying to get the meals plated and may have put 9 ounces or so instead of 8 ounces of liquid into Resident #2's glass.</p> <p>-The proportion of product to liquid would not have made the tea a nectar consistency.</p> <p>-Resident #2 was served a thin consistency drink for lunch instead of the physician ordered nectar thickened liquids.</p> <p>Review of the manufacturer's instructions for making a nectar thick liquid revealed:</p> <p>-Use one packet of product with 8 ounces of liquid and stir to dissolve the product.</p> <p>-Empty one packet for every 8 ounces of liquid to make a larger amount of nectar consistency liquids.</p> <p>Based on observations, record reviews and interviews, it was determined Resident #2 was not interviewable.</p> <p>Attempted interview with Resident #2's responsible person on 06/17/21 at 9:40am was unsuccessful.</p> <p>Telephone interview with Resident #2's primary care provider (PCP) on 06/17/21 at 9:44am revealed:</p>	{D 310}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET OXFORD, NC 27565</b>		
(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 310}	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>-Resident #2 had trouble swallowing and a swallowing study was ordered.</li> <li>-The study showed Resident #2 needed to have nectar thickened liquids to drink to prevent aspiration of the fluids causing pneumonia.</li> <li>-The order for nectar thickened liquids must be followed to keep Resident #2 from choking.</li> </ul> <p>Interview with the Facility Manager on 06/17/21 at 10:15am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had an order for nectar thickened liquids because she had swallowing difficulties and could choke if drinking regular liquids.</li> <li>-There were 4 dietary staff, 2 on (duty) and 2 off (duty) at the time.</li> <li>-All dietary staff could make thickened liquids.</li> <li>-All dietary staff had ServSafe certificates.</li> <li>-She assumed learning how to make thickened liquids was part of the ServSafe program.</li> <li>-Staff needed more training on how to prepare thickened liquids correctly.</li> </ul> <p>Interview with the Executive Director (ED) on 06/17/21 at 11:00am revealed:</p> <ul style="list-style-type: none"> <li>-The person in charge of the kitchen made the nectar thickened liquids.</li> <li>-The person in charge was to read the thickener packets and follow the instructions on how to prepare the thickened liquids.</li> <li>-Dietary staff had ServSafe training and were aware of Resident #2's swallowing difficulty.</li> <li>-The dietary staff needed more training on how to prepare the ordered nectar thickened liquids.</li> </ul> <p>According to the ServSafe website, the content of their program includes 5 sections: Basic Food Safety, Personal Hygiene, Cross-contamination and Allergens, Time and Temperature, and Cleaning and Sanitation.</p>	{D 310}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET OXFORD, NC 27565</b>		
(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 310}	<p>Continued From page 4</p> <p>2. Review of Resident #4's current FL-2 dated 01/20/21 revealed diagnoses included type II diabetes, essential hypertension, congestive heart failure, coronary artery disease, suspected liver cirrhosis, and seizure disorder.</p> <p>Review of Resident #4's diet order dated 03/31/21 revealed an order for mechanical soft, ground meats.</p> <p>Observation of the kitchen on 06/15/21 at 9:12am revealed Resident #4's name was listed on the communication board as receiving a mechanical soft diet.</p> <p>Observation of lunch meal service on 06/16/21 at 12:28pm revealed: -Resident #4 was served a whole chicken leg. -At 12:29pm the medication aide (MA) donned gloves and removed the chicken from the bone.</p> <p>Interview with the MA on 06/16/21 at 12:29pm revealed: -Resident #4 was on a chopped diet. -Every "once in a while" Resident #4's meal would not be chopped, but it was not a common thing. -Sometimes the dietary staff were swamped and would forget to chop Resident #4's meat. -When she saw Resident #4 served meats with a bone, like a pork chop, she always removed the meat from the bone. -She did not want Resident #4 to get choked.</p> <p>Interview with the cook on 06/16/21 at 1:05pm revealed: -Resident #4 was on a mechanical soft diet with chopped meats. -There was just so much going on in the kitchen, he "forgot" to pull the meat off the bone for Resident #4.</p>	{D 310}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 310}	Continued From page 5  -He knew he was supposed to serve Resident #4 chopped meats.  Interview with Resident #4 on 06/16/21 at 1:10pm revealed: -Her meats were sometimes cut up, but not every time. -She could not eat her meat if it was not cut up because she did not have teeth.  Interview with the Facility Manager on 06/16/21 at 4:44pm revealed: -A mechanical soft diet should have the meat chopped so it was easier for the resident to chew and swallow. -The cook had told him Resident #4's chicken was not chopped before it was served. -The meal should have been checked before served and the mistake would not have happened. -Resident #4's meal should have been served as ordered. -Resident #4's meat not being chopped was a choking hazard.  Telephone interview with Resident #4's primary care provider (PCP) on 06/21/21 at 11:23am revealed: -Resident #4 had been on a pureed diet but was not eating, so she changed the order to chopped to make sure the resident received the appropriate nutrition. -It was important for Resident #4's meats to be chopped because the resident was at risk for aspiration.	{D 310}		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 6</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#5) related to medications used to decrease blood glucose levels and eye drops.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL-2 dated 01/20/21 revealed diagnoses included type II diabetes, essential hypertension, congestive heart failure, coronary artery disease, suspected liver cirrhosis, and seizure disorder.</p> <p>a. Review of Resident #4's physician's orders dated 03/15/21 revealed an order for tobramycin-dexamethasone ophthalmic (used to treat eye inflammation and when there is a risk of bacterial infection in or around the eye) apply one drop into right eye four times daily.</p> <p>Review of Resident #4's Ophthalmologist's visit summary dated 04/13/21 revealed: -Resident #4 was seen for a diabetic eye exam. -Resident #4 had proliferative diabetic retinopathy.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>-Resident #4 had dry eye syndrome.</li> <li>-Resident #4 had a fast-developing band keratopathy (diminution of visual acuity and pain in the eyes due to disruption of the corneal epithelium).</li> <li>-The importance of blood glucose control was discussed.</li> <li>-The plan was to continue tobramycin-dexamethasone ophthalmic eye drops.</li> </ul> <p>Review of Resident #4's May 2021 electronic Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for tobramycin-dexamethasone ophthalmic eye drops place one drop into the right eye four times a day with a scheduled administration time of 8:00am, 12:00pm, 4:00pm, and 8:00pm.</li> <li>-There was documentation tobramycin-dexamethasone ophthalmic eye drops were administered four times daily from 05/01/21-05/31/21.</li> </ul> <p>Review of Resident #4's June 2021 eMAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for tobramycin-dexamethasone ophthalmic eye drops place one drop into the right eye four times a day with a scheduled administration time of 8:00am, 12:00pm, 4:00pm, and 8:00pm.</li> <li>-There was documentation tobramycin-dexamethasone ophthalmic eye drops were administered four times daily from 06/01/21-06/15/21 at 8:00am.</li> </ul> <p>Observation of Resident #4's medications on hand on 06/15/21 at 11:25am revealed tobramycin-dexamethasone ophthalmic eye drops were not available to be administered.</p>	D 358		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 8</p> <p>Interview with the medication aide (MA) on 06/15/21 at 11:25am and 11:33am revealed: -Resident #4 had a bottle of over the counter moisturizing eye drops. -Resident #4 did not have any other eye drops.</p> <p>Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/17/21 at 9:08am revealed: -Resident #4's tobramycin-dexamethasone ophthalmic eye drops were dispensed on 03/11/21 and based on the dosage, the bottle of eye drops would have lasted 25 days. -There were no requests to refill the tobramycin-dexamethasone ophthalmic eye drops after the 03/11/21 refill until 06/16/21. -Resident #4's tobramycin-dexamethasone ophthalmic eye drops were dispensed on 06/16/21. -The only dispensing of tobramycin-dexamethasone ophthalmic eye drops from this pharmacy was on 03/11/21 and 06/17/21 for a 25 day supply each dispensing.</p> <p>Telephone interview with Resident #4's Ophthalmologist on 06/17/21 at 9:49am revealed: -Tobramycin-dexamethasone ophthalmic eye drops were ordered for Resident #4 as a mild steroid and the eye drops also was used as a preventive for infection. -The primary use of the tobramycin-dexamethasone ophthalmic eye drops was to slow down the progression of keratopathy. -Resident #4 had a history of conjunctivitis in April 2021 and if the tobramycin-dexamethasone ophthalmic eye drops were not used, Resident #4 would have an increase in irritation and therefore touching her eye more, increasing the risk of</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 9</p> <p>infection.</p> <p>-He was not aware Resident #4's tobramycin-dexamethasone ophthalmic eye drops had not been refilled until 06/16/21.</p> <p>-Tobramycin-dexamethasone ophthalmic eye drops were not provided as a sample from their office and could only be obtained from a pharmacy.</p> <p>-He expected Resident #4's tobramycin-dexamethasone ophthalmic eye drops to be used as ordered because she was at risk for blindness without it.</p> <p>Interview with a MA on 06/17/21 at 10:35am revealed:</p> <p>-She had opened Resident #4's Tobramycin-Dexamethasone Ophthalmic eye drops today, 06/17/21.</p> <p>-She did not recall when she last administered Resident #4's Tobramycin-Dexamethasone Ophthalmic eye drops before today.</p> <p>Observation of Resident #4's medications on hand on 06/17/21 at 11:46am revealed Tobramycin-Dexamethasone Ophthalmic eye drops were dispensed on 06/16/21 and initialed as opened on 06/17/21.</p> <p>Interview with Resident #4 on 06/17/21 at 10:45am revealed:</p> <p>-She was supposed to get eye drops several times a day but was not sure of how many times.</p> <p>-Two different eye drops had been administered today, 06/07/21.</p> <p>-She had not been administered two different eye drops every day.</p> <p>-She did not recall the last time she had been administered two different eye drops before today.</p> <p>-Her eye had been hurting and sometimes she</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 10</p> <p>would see two of everything, but her eye felt better today.</p> <p>Telephone interview with Resident #4's family member on 06/17/21 at 3:15pm revealed:</p> <ul style="list-style-type: none"> <li>-He had purchased Resident #4's Tobramycin-Dexamethasone Ophthalmic eye drops at a local pharmacy.</li> <li>-He had bought the Tobramycin-Dexamethasone Ophthalmic eye drops because Resident #4 had told him she did not have any of the drops. (He did not recall the date, but it had been over 6-months).</li> <li>-He relied on the facility to take care of obtaining Resident #4's medications as needed.</li> </ul> <p>Telephone interview with a pharmacy technician at the named local pharmacy on 06/17/21 at 4:02pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4's Tobramycin-Dexamethasone Ophthalmic eye drops had been filled on 06/01/20, 08/26/20, and 10/24/20.</li> <li>-Each dispensing was for one bottle of the Tobramycin-Dexamethasone Ophthalmic eye drops and would be for a one-month supply.</li> <li>-There were no other dispensing dates for this medication.</li> </ul> <p>Interview with the Facility Manager on 06/17/21 at 12:32pm revealed:</p> <ul style="list-style-type: none"> <li>-The medication cart audits were completed by the Resident Care Coordinator (RCC).</li> <li>-He had noted on 06/14/21 (time unknown but it was in the pm) Resident #4's eye drops had expired.</li> <li>-He did not recall the open date on the eye drops but thought they had "just expired."</li> <li>-He removed the eye drops from the medication cart.</li> <li>-The RCC had completed a medication cart audit</li> </ul>	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 11</p> <p>over the weekend of 06/12/21 and had missed the eye drops expiration because the RCC did not realize the eye drops expired 28 days after they had been opened.</p> <p>-He was not aware Resident #4's tobramycin-dexamethasone ophthalmic eye drops had not been refilled since 03/11/21.</p> <p>Telephone interview with the RCC on 06/17/21 at 2:40pm revealed:</p> <p>-She had missed the expiration on the eye drops when she completed the cart audit.</p> <p>-She did not recall when the eye drops had been dispensed or opened.</p> <p>b. Review of Resident #4's physician's order dated 03/15/21 revealed an order to check Resident #4's finger stick blood sugar (FSBS) three times a day and administer Lispro (a fast acting medication to lower blood glucose) 100 unit pen to be used with the following sliding scale; 200-240=8u, 241-300=10u, 301-400=12u, 301-350=10u, &gt;351=call the primary care provider (PCP).</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for 05/15/21 - 05/31/21 revealed:</p> <p>-There was an entry for Lispro 100 unit/ml give administer at meals based on the sliding scale with an administration time of 7:00am, 12:00pm, and 4:00pm.</p> <p>-There were 9 FSBS documented between 05/17/21-05/31/21 that were not in Resident #4's glucometers memory.</p> <p>-An example included there was documentation Resident #4's FSBS was 189 on 05/17/21.</p> <p>-An example included there was documentation Resident #4's FSBS was 167 on 05/18/21.</p> <p>-An example included there was documentation</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 12</p> <p>Resident #4's FSBS was 184 on 05/19/21.</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for 06/01/21 - 06/15/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Lispro 100 unit/ml give administer at meals based on the sliding scale with an administration time of 7:00am, 12:00pm, and 4:00pm.</li> <li>-There were 7 FSBS documented between 06/01/21-06/10/21 that were not in Resident #4's glucometers memory.</li> <li>-An example included there was documentation Resident #4's FSBS was 294 on 06/01/21 and 10 units of Lispro were administered.</li> <li>-An example included there was documentation Resident #4's FSBS was 212 on 06/09/21 and 8 units of Lispro were administered.</li> <li>-An example included there was documentation Resident #4's FSBS was 284 on 06/10/21 and 10 units of Lispro were administered.</li> <li>-These readings were not in Resident #4's glucometers memory.</li> </ul> <p>Review of the memory for Resident #4's Brand A glucometer revealed:</p> <ul style="list-style-type: none"> <li>-The date displayed was 9/15 and the time was 11:43am.</li> <li>-The actual date was 06/15/21 and the time was 11:05am.</li> <li>-The difference in displayed and actual was determined to be three months and 38 minutes.</li> <li>-A FSBS of 189 was not recorded in the memory on 05/17/21.</li> <li>-A FSBS of 167 was not recorded in the memory on 05/18/21.</li> <li>-A FSBS of 184 was not recorded in the memory on 05/19/21.</li> <li>-A FSBS of 294 was not recorded in the memory on 06/01/21.</li> </ul>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 13</p> <p>-A FSBS of 212 was not recorded in the memory on 06/09/21.</p> <p>-A FSBS of 284 was not recorded in the memory on 06/10/21.</p> <p>-There were multiple FSBS recorded in the memory between 05/17/21-06/10/21 that were not documented on Resident #4's eMAR that ranged from 29-527.</p> <p>Without Resident #4's FSBS being obtained as ordered, the staff were unable to determine if Lispro was to be administered resulting in a medication error.</p> <p>Interview with the medication aide (MA) on 06/16/21 at 5:31pm revealed:</p> <p>-She had documented the 9 FSBS readings in May 2021 and 7 FSBS in June 2021 in Resident #4's MAR that were not in Resident #4's glucometer .</p> <p>-When she checked Resident #4's FSBS she always records the glucometer reading directly into the eMAR.</p> <p>-She always used Resident #4's glucometer so she did not know why the FSBS readings were not in the glucometers history.</p> <p>-She had not had any problems with Resident #4's glucometer.</p> <p>-She had "no idea" why the glucometer memory and the documented FSBS on the eMAR did not match.</p> <p>-She administered Resident #4's Lispro based on the results of the resident's FSBS.</p> <p>-When she checked Resident #4's FSBS, the eMAR directed her on how much insulin to administer based on the FSBS reading that was entered.</p> <p>Observation of Resident #4's medications on hand on 06/15/21 at 10:48am revealed Lispro</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 14</p> <p>insulin was available to be administered.</p> <p>Interview with Resident #4 on 06/17/21 at 10:45am revealed:</p> <ul style="list-style-type: none"> <li>-Her FSBS was checked twice a day, usually at breakfast and lunch.</li> <li>-Sometimes her FSBS was checked more than twice a day, but "not that often."</li> <li>-She "sometimes" got her FSBS checked before dinner, but not every night.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 06/16/21 at 3:20pm revealed:</p> <ul style="list-style-type: none"> <li>-She checked the glucometers every week to make sure the readings in the glucometer's history matched the FSBS documented in the eMAR.</li> <li>-There had been some discrepancies but not many.</li> <li>-She could only locate the documentation of her most recent audit dated, 06/01/21.</li> <li>-She recalled seeing the FSBS documented on 05/31/21 that was in Resident #4's eMAR but not in the glucometer's history.</li> <li>-She did not know why she did not make a note about it, she usually wrote discrepancies in the note section of her audit log.</li> <li>-If the documented FSBS were not in Resident #4's glucometer history, the MA may have "just put something in" or maybe the MA keyed the number in too fast.</li> <li>-She did not know why there were extra readings in Resident #4's glucometer history unless it was for a recheck that was not documented.</li> </ul> <p>Interview with the Facility Manager on 06/16/21 at 4:44pm revealed:</p> <ul style="list-style-type: none"> <li>-He reviewed the results of the RCC's glucometer audits weekly.</li> <li>-He did not know why Resident #4's glucometer</li> </ul>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET OXFORD, NC 27565</b>		
(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 358	<p>Continued From page 15</p> <p>would not have the FSBS recorded on the eMAR. -He did not think the MA's were sharing glucometers. -He did not think the MA's were "just putting numbers in out of the blue." -He thought maybe the glucometer had been reset or there was a malfunction.</p> <p>Telephone interview with Resident #4's primary care provider (PCP) on 06/21/21 at 11:23am revealed: -She expected Resident #4's FSBS to be checked as ordered and insulin administered based on the sliding scale. -There was no way for her to manage Resident #4's diabetes if she did not know the results of the FSBS. -It was important to know what Resident #4's FSBS readings were during the day, because she may need to adjust or even hold the nighttime insulin. -She was most concerned about Resident #4 having low blood sugar because the brain cannot function without sugar and Resident #4 would be at risk of seizures. -If Resident #4's FSBS was not checked, the MAs would not know whether to administer insulin or not.</p> <p>The facility failed to ensure a resident's FSBS were checked as ordered and without checking the FSBS it was not known whether to administer insulin based on the sliding scale ordered putting the resident at risk of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar), as well as the PCP, could not manage the resident's diabetes without accurate FSBS readings; and the resident who had a history of multiple eye problems was not administered her eye drops as ordered based on the dispensing records of the</p>	D 358		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 358	Continued From page 16  medication. Without her eye drop medication, the resident was at risk of losing her vision (#4). The facility's failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation.  The facility provided a plan of protection in accordance with G.S. 131D-34 on June 16, 2021 for this violation.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 17, 2021.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration  10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 367	<p>Continued From page 17</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the electronic Medication Administration Record (eMAR) for 1 of 1 sampled residents (Resident #4).</p> <p>The findings are:</p> <p>Review of Resident #4's current FL-2 dated 01/20/21 revealed diagnoses included type II diabetes, essential hypertension, congestive heart failure, coronary artery disease, suspected liver cirrhosis, and seizure disorder.</p> <p>Review of Resident #4's physician's orders dated 03/15/21 revealed an order for Tobramycin-Dexamethasone Ophthalmic (used to treat eye inflammation and when there is a risk of bacterial infection in or around the eye) apply one drop into the right eye four times daily.</p> <p>Review of Resident #4's May 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Tobramycin-Dexamethasone Ophthalmic eye drops place one drop into the right eye four times a day with a scheduled administration time of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation Tobramycin-Dexamethasone Ophthalmic eye drops were administered four times daily from 05/01/21-05/31/21.</p> <p>Review of Resident #4's June 2021 eMAR revealed: -There was an entry for</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 367	<p>Continued From page 18</p> <p>Tobramycin-Dexamethasone Ophthalmic eye drops place one drop into the right eye four times a day with a scheduled administration time of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation Tobramycin-Dexamethasone Ophthalmic eye drops were administered four times daily from 06/01/21-06/15/21 at 8:00am.</p> <p>Observation of Resident #4's medications on hand on 06/15/21 at 11:25am revealed Tobramycin-Dexamethasone Ophthalmic eye drops were not available to be administered.</p> <p>Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/17/21 at 9:08am revealed Resident #4's Tobramycin-Dexamethasone eye drops were first dispensed on 03/11/21 and based on the dosage, the bottle of eye drops would have lasted 25 days.</p> <p>Telephone interview with a pharmacy technician at the named local pharmacy on 06/17/21 at 4:02pm revealed: -Resident #4's Tobramycin-Dexamethasone Ophthalmic eye drops had been filled on 06/01/20, 08/26/20, and 10/24/20. -Each dispensing was for one bottle of the Tobramycin-Dexamethasone Ophthalmic eye drops and would be for a one-month supply.</p> <p>Based on observation, record reviews, and interviews, Resident #4's Tobramycin-Dexamethasone Ophthalmic eye drops were documented as administered 45 days between 05/01/21-06/15/21, when the bottle filled on 03/11/21 would have only lasted 25 days if administered as ordered.</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 367	Continued From page 19  Interview with a medication aide (MA) on 06/17/21 at 11:46am revealed: -She had documented administering Resident #4's Tobramycin-Dexamethasone Ophthalmic eye drops when she did not recall the eye drops being available on the medication cart. -She pulled Resident #4's medications from the medication cart drawer, verified the correct medication and dosage, administered the medications, and then pushed the "record all" button. -This would have recorded all the medications, including that Tobramycin-Dexamethasone Ophthalmic eye drops because they were listed to be administered. -She was just not paying attention and had missed the Tobramycin-Dexamethasone Ophthalmic eye drops.  Interview with the Facility Manager on 06/17/21 at 12:32pm revealed: -He had noted on 06/14/21 (time unknown but it was in the pm) Resident #4's eye drops had expired, and he removed the eye drops from the medication cart. -He noted on 06/15/21 on Resident #4's eMAR, the Tobramycin-Dexamethasone Ophthalmic eye drops were being documented after he removed the eye drops from the medication cart. -The MAs should not document administering medication if the medication was not administered. -The issue of documenting medications that were not available to be administered would be addressed with the MAs.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 375	<p>Continued From page 20</p> <p>10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 5 residents sampled (#1) had a physician's order to self-administer a cream pain reliever for knee pain.</p> <p>The findings are:</p> <p>Observation on 06/15/21 of Resident #1's room at 8:35am revealed: -A manufacturer's box labeled Pennsaid (diclofenec sodium topical solution) 2%, Rx (prescription) only, was found on Resident #1's bedside table. -Resident #1 was not present in the room. -There was no medication aide (MA) in the room or in the hallway outside Resident #1's room.</p> <p>Review of Resident #1's current FL-2 dated 05/12/21 revealed: -Diagnoses included cerebrovascular accident (stroke - CVA), left-sided weakness and</p>	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 375	<p>Continued From page 21</p> <p>numbness, hypertension and arthritis. -Resident #1 was ambulatory. -There was no order for self-administration for Pennsaid 2%.</p> <p>Review of Resident #1's record revealed: There was a physician's order dated 03/10/21 for Pennsaid 2%, apply 1 packet on knee twice daily" (Resident #1) has sample" by the personal care provider (PCP). -There was a PCP's stop date order for Resident #1 for Pennsaid 2% for 04/22/21. -There was no documentation of a "Self-Administration of Medication Assessment" and no physician's order to self-administer medications. -There was no documentation for Resident #4 to keep medications in his room or on his person.</p> <p>Review of the Charting Notes (shift notes) for Resident #1 revealed: -There were no charting notes available for March 2021, April 2021 or June 2021. - There were notes for 01/07/21 and 05/10/21 for the administration of a pain medication for headache. -There was no documentation of Resident #1 applying the Pennsaid 2% cream to his right knee. -There was no documentation of Resident #1 having physician's samples of Pennsaid.</p> <p>Interview on 06/15/21 with Resident #1 at 11:25am revealed: -He had arthritis in his right knee and was referred by his orthopedic physician, to an orthopedic surgeon (OS), for treatment in February 2021 or March 2021. -The OS gave him a sample box of the medication Pennsaid 2%, containing 6 packets,</p>	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 375	<p>Continued From page 22</p> <p>and instructed him on how to apply the cream to his right knee.</p> <p>-A facility transport staff accompanied him to see the OS and brought the Pennsaid 2% sample box back to the facility.</p> <p>-The sample box of Pennsaid 2% was kept on the medication cart for a while and the medication aide (MA) gave it to him to apply.</p> <p>-Resident #1 received additional Pennsaid 2% samples from the OS when he went back for check-up visits.</p> <p>-At the other appointments the OS gave the Pennsaid 2% samples to him and he kept them on his bedside table.</p> <p>-He did not know if there was a self-administration order in his records to have the Pennsaid 2% medication kept in his room or for him to apply it.</p> <p>-No staff asked him about having the medication in his room.</p> <p>-No staff told him he could not keep medication in his room.</p> <p>-He applied the Pennsaid 2% cream to his right knee when he was in pain.</p> <p>Interview on 06/16/21 with a transport staff at 12:00pm revealed:</p> <p>-She took Resident #1 to the OS appointments once or twice when he first became a patient of the OS.</p> <p>-The OS gave Resident #1 a cream medication to use for pain in his right knee.</p> <p>-She brought the box of Pennsaid 2% back to the facility and gave it to the Administrator.</p> <p>Interview on 06/16/21 with a medication aide (MA) at 2:45pm revealed:</p> <p>-She saw the Pennsaid 2% in Resident #1's room over a month ago.</p> <p>-Resident #1 told her his op was giving him</p>	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 375	<p>Continued From page 23</p> <p>samples of the medication, for pain in his knee, when he went to appointments.</p> <p>-She did not know if a self-administration order had been requested for Resident #1.</p> <p>-She did not remember seeing the Pennsaid 2% on the medication cart.</p> <p>-A self-administration order from a physician was required for a resident to have the medication in their room and to self-administer the medication.</p> <p>-The RCC was responsible for calling the OS or the PCP and requesting a self-administration order for Resident #4.</p> <p>Interview on 06/17/21 with a second (MA) at 10:30am revealed:</p> <p>-Resident #1 had an order for Pennsaid 2% on 03/10/21 and it was discontinued on 04/22/21 as Resident #1 wanted to leave the facility for a while.</p> <p>-Resident #1 returned to the facility and must have brought the Pennsaid 2% samples with him.</p> <p>-She saw the Pennsaid 2% medication box in the Resident Care Coordinator's (RCC) office on Tuesday (06/15/21).</p> <p>-There was no self-administration order requested for Resident #1 for Pennsaid 2%.</p> <p>-The RCC would be responsible for requesting a self-administration order for a resident.</p> <p>Interview on 06/17/21 with the facility pharmacy representative at 9:26am revealed:</p> <p>-An order was received on 03/10/21 for Pennsaid 2% for Resident #1 by his PCP.</p> <p>-The medication was to be placed in Resident #1's MAR to show the resident was given the Pennsaid 2% sample packs by the OS.</p> <p>-He was not aware of a self-administration order, sent by the facility, to be placed on the MAR for Resident #1.</p>	D 375		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 375	<p>Continued From page 24</p> <p>Interview on 06/16/21 with the OS's nurse revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's first visit was on 02/23/21.</li> <li>-He was given a sample of Pennsaid 2%, 4-40 milligram (mg.) cream packets for pain in his right knee.</li> <li>-Resident #1 was seen again for follow-ups on 03/16/21, 04/13/21, 5/11/21 and 06/08/21.</li> <li>-Resident #1 was given samples of Pennsaid 2% cream by the OS at the visits.</li> <li>-The OS did not write a self-administration order for Resident #1.</li> <li>-it was not the practice of the OS to write self-administration orders when giving patients sample sized medications as he instructs the patients on how to apply the medication.</li> <li>-If the facility needed to obtain a self-administration order for Resident #1, they should have asked for one.</li> </ul> <p>Interview on 06/16/21 with the RCC at 4:00pm revealed;</p> <ul style="list-style-type: none"> <li>-The protocol for checking in medications when residents come back from a PCP visit was to put the physician's sample in the RCC's office and call for an order and the medication would stay in the medication cart.</li> <li>-She did not recall when the Pennsaid 2% medication box was first brought into the facility; she did not see the box.</li> <li>-She did not know to call to get an order for Resident #1 to self-administer the medication.</li> <li>-No one had observed the Pennsaid 2% box in Resident #1's room.</li> </ul> <p>Interview on 06/17/21 with the Executive Director (ED) at 11:10am revealed:</p> <ul style="list-style-type: none"> <li>-He was not aware Resident #1 had the Pennsaid 2% medication in his room and was self-administering.</li> </ul>	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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 375	Continued From page 25  -The MA staff should have given any information from the physician to the RCC or the Director to process. -Thr RCC and the ED try to avoid residents having a self-administration order and have the MA's administer the medications. -He had no idea why the Pennsaid 2% cream was in Resident #1's room and there was no self-administration order in Resident #1's record or on the MAR. -The RCC was the go-to person for processing medications and orders. -The ED was responsible for ensuring medications and orders were processed appropriately.	D 375		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights  G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.  This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and infection prevention.  The findings are:  Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled	{D912}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D912}	Continued From page 26  residents (#5) related to medications used to decrease blood glucose levels and eye drops. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].  The failure of the facility to implement infection control procedures consistent with the Centers for Disease Control and Prevention (CDC) guidelines resulted in staff sharing glucometers for 4 of 4 sampled diabetic residents, placing residents at risk for bloodborne pathogen diseases. This failure was detrimental to the health, safety, and welfare of the residents, and constitutes an Unabated Type B violation. [Refer to Tag D932, G.S. 131D-4.4A(b)(1) Adult Care Home Infection Prevention Requirements (Type Unabated B Violation)].	{D912}		
{D932}	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements  G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements  (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	Continued From page 27  c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 28</p> <p>This Rule is not met as evidenced by: <b>FOLLOW-UP TO TYPE B VIOLATION</b></p> <p>Based on these findings, the previous Type B Violation was not abated.</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 4 of 4 sampled diabetic residents (#5, #6, #7, and #8) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents.</p> <p>The findings are:</p> <p>Review of the Center for Disease Control and Prevention (CDC) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents.</p> <p>Review of the facility's diabetic testing policy and procedure revealed:</p> <ul style="list-style-type: none"> <li>-Sharing of glucometers is a violation of policy and was strictly prohibited.</li> <li>-Each individual resident would have their own glucometer and it would be labeled with the resident's name.</li> <li>-Individual glucometers are kept inside the</li> </ul>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 29</p> <p>zippered glucometer bag and should be labeled with the resident's names. The glucometer should be stored inside a zip-locked bag also labeled with the resident's name.</p> <p>-Prior to checking the resident's blood sugar, ensure the name on the glucometer, zippered bag, and zip lock bag match the resident who is having their sugar checked.</p> <p>-Notify the Resident Care Coordinator (RCC) whenever you have a glucometer, glucometer bag, or a zip lock bag that does not have a label with the resident's name.</p> <p>-If a resident does not have a glucometer, notify the RCC or Administrator immediately if a new admission does not have a glucometer, a new order for blood sugar monitoring is given or a resident's glucometer breaks. Do not use another resident's glucometer in any of these cases was underlined.</p> <p>Observation of the facility's medication treatment cart on 06/15/21 at 12:35pm revealed:</p> <p>-There were multiple blue zippered cases labeled with resident's names (Brand A).</p> <p>-There were two hard black cases labeled with residents' names (Brand B).</p> <p>Review of the manufacturer's manual for Brand A and Brand B glucometers revealed the glucometers were single-use and should not be used between multiple residents.</p> <p>1. Review of Resident #5's current FL-2 dated 09/01/20 revealed:</p> <p>-Diagnoses included insulin-dependent diabetes, diabetic neuropathy, essential hypertension, cognitive impairment, cerebrovascular disease, and delirium.</p> <p>-There was an order to check fingerstick blood sugar (FSBS) three times a day.</p>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 30</p> <p>Review of Resident #5's Brand A glucometer on 06/15/21 at 12:45pm revealed:</p> <ul style="list-style-type: none"> <li>-The glucometer was in a blue zippered bag labeled with Resident #5's name.</li> <li>-The glucometer was labeled with Resident #5's name.</li> <li>-The date on the glucometer was 03/24/21 (the actual date was 06/15/21) and the time was 3:03pm (actual time was 12:45pm).</li> <li>-On 03/14/21, there were eight readings in the glucometer's history, 176 at 9:54am, 249 at 1:41pm, 21 at 2:47pm, 48 at 2:48pm, 53 at 2:49pm, 98 at 5:02pm, 124 at 7:17pm, and 287 at 8:22pm.</li> <li>-The actual date and time for the recordings on 03/14/21 were 06/05/21.</li> </ul> <p>Review of Resident #5's June 2021 electronic medication administration record (eMAR) FSBS readings for 06/05/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was a reading of 176 at 7:36am.</li> <li>-There was a reading of 98 at 2:46pm.</li> <li>-There was a reading of 167 at 4:41pm; this reading was not in Resident #5's glucometer's history.</li> <li>-There was a reading of 287 at 8:30pm.</li> <li>-There was no documentation for the readings of 249, 21, 48, 53, and 124.</li> </ul> <p>Review of Resident #5's glucometer readings for 03/16/21 (actual date 06/07/21) revealed a reading of 137 at 9:37am (actual time 7:19am); this reading was not documented on Resident #5's eMAR.</p> <p>Review of Resident #5's June 2021 eMAR and glucometer revealed:</p> <ul style="list-style-type: none"> <li>-On 06/06/21, there were four FSBS documented on the eMAR and only one of the four were in the</li> </ul>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 31</p> <p>glucometer's history.</p> <p>-On 06/07/21, there were four FSBS documented on the eMAR and only three of the four were in the glucometer's history.</p> <p>-On 06/09/21, there were four FSBS documented on the eMAR and only two of the four were in the glucometer's history.</p> <p>-On 06/10/21, there were four FSBS documented on the eMAR and only two of the four were in the glucometer's history.</p> <p>-On 06/11/21, there were four FSBS documented on the eMAR and only two of the four were in the glucometer's history.</p> <p>-On 06/14/21, there were four FSBS documented on the eMAR and only three of the four were in the glucometer's history.</p> <p>Interview with Resident #5 on 06/16/21 at 2:51pm revealed:</p> <p>-He had his FSBS checked three times a day, sometimes four, but usually three.</p> <p>-His glucometer was in a bag with his name on the bag.</p> <p>Refer to the interview with the medication aide (MA) on 06/16/21 at 2:25pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 06/16/21 at 3:20pm.</p> <p>Refer to the interview with the Facility Manager on 06/16/21 at 4:44pm.</p> <p>Refer to the telephone interview with the facility's Primary Care Provider (PCP) on 06/17/21 at 9:34am.</p> <p>2. Review of Resident #6's current FL-2 dated 09/01/20 revealed:</p> <p>-Diagnoses included diabetes mellitus and</p>	{D932}		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 32</p> <p>hypertension.</p> <p>-There was an order to check fingerstick blood sugar (FSBS) three times a day.</p> <p>Review of Resident #6's Brand A glucometer on 06/15/21 at 4:16pm revealed:</p> <p>-The glucometer was in a blue zippered bag labeled with Resident #6's name.</p> <p>-The glucometer was labeled with Resident #6's name.</p> <p>-The date on the glucometer was 03/24/21.</p> <p>-On 03/20/21 (the actual date was 06/11/21), there were two readings in the glucometer's history, 197 and 193.</p> <p>Review of Resident #6's electronic medication administration record (eMAR) FSBS readings for 06/11/21 revealed the FSBS readings of 197 and 193 were not recorded; both readings were recorded on another residents eMAR for the same date.</p> <p>Review of Resident #6's eMAR FSBS readings for 06/11/21 revealed:</p> <p>-There was a reading of 193 at 7:50am.</p> <p>-There was a reading of 197 at 11:39am.</p> <p>-There was a reading of 175 at 6:55pm; this reading was not in Resident #6's glucometer's history.</p> <p>-There was a reading of 174 at 8:12pm; this reading was not in Resident #6's glucometer's history.</p> <p>Review of Resident #6's June 2021 eMAR and glucometer revealed:</p> <p>-On 06/04/21, there were three FSBS documented on the eMAR and only one of the three were in the glucometer's history.</p> <p>-There was a reading of 169 in the glucometers history but not documented on the eMAR.</p>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 33</p> <p>-On 06/05/21, there were three FSBS documented on the eMAR and only two of the three were in the glucometer's history.</p> <p>-There was a reading of 154 in the glucometers history but not documented on the eMAR.</p> <p>-On 06/06/21, there were four FSBS documented on the eMAR and only three of the four were in the glucometer's history.</p> <p>-There was a reading of 174 in the glucometers history but not documented on the eMAR.</p> <p>Review of Resident #6's eMAR FSBS for 03/16/21 (actual date 06/07/21) revealed a FSBS reading of 137 at 7:19am; this reading was not in Resident #6's glucometer history but the same date and time was in Resident #5's glucometer history and was not documented on Resident #5's eMAR.</p> <p>Interview with Resident #6 on 06/16/21 at 2:54pm revealed his FSBS was checked three times a day; he did not notice what glucometer was used when his FSBS was checked.</p> <p>Refer to the interview with the medication aide (MA) on 06/16/21 at 2:25pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 06/16/21 at 3:20pm.</p> <p>Refer to the interview with the Facility Manager on 06/16/21 at 4:44pm.</p> <p>Refer to the telephone interview with the facility's Primary Care Provider (PCP) on 06/17/21 at 9:34am.</p> <p>3. Review of Resident #7's current FL-2 dated 12/14/20 revealed: -Diagnoses included diabetes mellitus type II,</p>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 34</p> <p>bipolar and schizoaffective disorder. -There was an order to check fingerstick blood sugar (FSBS) three times a day.</p> <p>Review of Resident #7's Brand A glucometer on 06/15/21 at 4:16pm revealed: -The glucometer was in a blue zippered bag labeled with Resident #7's name. -The glucometer was labeled with Resident #7's name. -The date on the glucometer was 04/21/21. -On 04/16/21 (the actual date was 06/10/21), there were 8 readings in the glucometer's history, 216, 214, 285, 225, 315, 364, 302, and 439.</p> <p>Review of Resident #7's electronic administration record (eMAR) FSBS readings for 06/10/21 revealed: -There was a reading of 216 at 7:24am. -There was a reading of 214 at 7:58am. -There was a reading of 239 at 8:32am; this reading was not in Resident #7's glucometer's history. -There was a reading of 285 at 11:11am. -There was a reading of 315 at 11:45am. -There was a reading of 364 at 4:31pm. -There was a reading of 300 at 4:32pm; this reading was not in Resident #7's glucometer's history. -There was a reading of 266 at 8:00pm; this reading was not in Resident #7's glucometer's history.</p> <p>Review of Resident #7's eMAR FSBS for 04/11/21 (actual date 06/05/21) revealed a FSBS reading of 249; this reading was not in Resident #7's glucometer history but the same date and time was in Resident #5's glucometer history and was not documented on Resident #5's eMAR.</p>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 35</p> <p>Interview with Resident #7 on 06/16/21 at 2:48pm revealed: -Her FSBS was checked 6-8 times a day. -Her FSBS usually ran in the 200-300's. -She did not know what glucometer was used to check her FSBS.</p> <p>Refer to the interview with the medication aide (MA) on 06/16/21 at 2:25pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 06/16/21 at 3:20pm.</p> <p>Refer to the interview with the Facility Manager on 06/16/21 at 4:44pm.</p> <p>Refer to the telephone interview with the facility's Primary Care Provider (PCP) on 06/17/21 at 9:34am.</p> <p>4. Review of Resident #8's current FL-2 dated 01/18/21 revealed diagnoses included diabetes mellitus type II, chronic obstructive pulmonary disease, and bipolar depression.</p> <p>Review of Resident #8's physician's order dated 04/04/21 revealed an order to check fingerstick blood sugar (FSBS) three times a day at 8:00am, 2:00pm and 8:00pm.</p> <p>Review of Resident #8's Brand A glucometer on 06/15/21 at 4:08pm revealed: -The glucometer was in a blue zippered bag labeled with Resident #8's name. -The glucometer was labeled with Resident #8's name. -The date on the glucometer was 03/24/21. -On 03/18/21 (actual date was 06/09/21), there was 1 reading in the glucometer's history 333.</p>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 36</p> <p>Review of Resident #8's electronic medication administration record (eMAR) FSBS readings for 06/09/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was a reading of 220 at 7:38am; this reading was not in Resident #8's glucometer's history.</li> <li>-There was a reading of 333 at 11:35am.</li> <li>-There was a reading of 234 at 8:39pm; this reading was not in Resident #8's glucometer's history.</li> </ul> <p>Review of Resident #8's eMAR FSBS for 03/18/24 (actual date 06/09/21) revealed a FSBS reading of 220; this reading was not in Resident #8's glucometer history but the same date and time was in Resident #5's glucometer history and was not documented on Resident #5's eMAR.</p> <p>Interview with Resident #8 on 06/16/21 at 2:58pm revealed:</p> <ul style="list-style-type: none"> <li>-His FSBS was checked 3 times a day.</li> <li>-His name was on his glucometer and the MA always used his glucometer to check his FSBS.</li> </ul> <p>Refer to the interview with the medication aide (MA) on 06/16/21 at 2:25pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 06/16/21 at 3:20pm.</p> <p>Refer to the interview with the Facility Manager on 06/16/21 at 4:44pm.</p> <p>Refer to the telephone interview with the facility's Primary Care Provider (PCP) on 06/17/21 at 9:34am.</p> <p>Interview with the medication aide (MA) on 06/16/21 at 2:25pm revealed:</p> <ul style="list-style-type: none"> <li>-The Resident Care Coordinator (RCC) audited</li> </ul>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 37</p> <p>the glucometers weekly to make sure the glucometer matched the name on the glucometer bag.</p> <p>-When she checked the resident's FSBS, she did not always make sure the name on the glucometer and the bag matched, but when she did, they always matched.</p> <p>-She confirmed she had initialed the FSBS readings for the dates when the documented readings were not in the corresponding glucometer for three residents.</p> <p>-She did not know how one resident's FSBS readings were recorded in another resident's glucometer.</p> <p>-She had not shared glucometers with residents.</p> <p>-Sometimes the RCC would help her obtain FSBS and she would record what the RCC told her she had obtained on that resident.</p> <p>Interview with the RCC on 06/16/21 at 3:20pm revealed:</p> <p>-She audited the glucometers every week to make sure the glucometer and the bag matched the residents name.</p> <p>-She helped the MA with FSBS if the MA was "running behind."</p> <p>-She had not shared glucometers to check the resident's FSBS.</p> <p>Interview with the Facility Manager on 06/16/21 at 4:44pm revealed:</p> <p>-All diabetic residents with orders for FSBS had their own glucometer.</p> <p>-Glucometers were not shared between residents.</p> <p>-He did not know why one resident's FSBS readings would not be in that resident's glucometer but recorded in the history of another resident's glucometer.</p> <p>-The MA's knew glucometers were not to be</p>	{D932}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL039017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>TONY REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>904 RALEIGH STREET</b> <b>OXFORD, NC 27565</b>		
(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
{D932}	<p>Continued From page 38</p> <p>shared.</p> <p>Telephone interview with the facility's Primary Care Provider (PCP) on 06/17/21 at 9:34am revealed:</p> <ul style="list-style-type: none"> <li>-She was the PCP for the facility.</li> <li>-Residents glucometers should not be shared.</li> <li>-Sharing glucometers put the residents at risk for cross contamination.</li> <li>-If the residents FSBS were not checked and recorded appropriately, she would not know if she was addressing the correct FSBS.</li> </ul> <p>The failure of the facility to implement infection control procedures consistent with the Centers for Disease Control and Prevention (CDC) guidelines resulted in staff sharing glucometers for 4 of 4 sampled diabetic residents, placing residents at risk for bloodborne pathogen diseases. This failure was detrimental to the health, safety, and welfare of the residents, and constitutes an Unabated Type B violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/07/21.</p> <p>CORRECTION DATE FOR THE UNABATED TYPE B VIOLATION SHALL NOT EXCEED JUNE 29, 2021.</p>	{D932}		