## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/24/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  THE CARDINAL AT NORTH HILLS  SUMMANY STATEMENT OF DEPOCINCES PRETIX  SERVICE MEMORITHMENT OF DEPOCINCES  ALLEGE ALLEGE AND OF CORRESPONDED TO THE FAMILY OF TAKE  AN UNABNORMAL AT NORTH HILLS STREET  RALEICH, NO. 27699  TRALEICH, NO. 2769	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
THE CARDINAL AT NORTH HILLS    SUMMARY STATEMENT OF DEPICIENCIES (LEACH DEPICIENCY MUST SEP PRECEDED BY FULL TAGE)   TAGE	345572			B. WING			05/	22/2019
CARDINAL AT NORTH HILLS   CARDINAL AT NORTH HILLS   CHARLEGH, NC 27609   PROVIDERS PLAN OF CORRECTION ON PREFIX TAG   PROVIDERS PLAN OF CORRECTION ON PROPERTY TAG   PROVIDERS PLAN OF CORRECTION ON PROPERTY TAG   PROVIDERS PLAN OF CORRECTION ON PROPERTY TAG   PROVIDERS PLAN OF CORRECTION OF CROSS REFERENCED TO THE APPROPRIANTE   DISCRECIANCY	NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG    REGULATORY OR LSc IDENTIFYING INFORMATION    PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION    PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION    PREFIX TAG   RECORDS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE THE APPROPRIATE   DATE OF THE APPROPRIA	THE CAR	DINAL AT NORTH HILLS						
An unannounced Recertification survey was conducted on 5/20/2019 through 5/22/2019. The facility was found in compliance with the requirement CFR 433.73, Emergency Preparedness. Event ID # HDYR11  F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to administer a medication according to manufacturer guidelines for 1 of 4 resident (Resident #259) observed for medication administration.  Findings Included:  Resident #259 was admitted to the facility on 05/16/19 with diagnoses including chronic obstructive pulmonary disease (COPD). An admission Minimum Data Set (MDS) assessment was pending on 05/22/19.  Review of resident #259's medical record revealed an order for Symbicort 160/4.5 micrograms 2 puffs by mouth twice daily for COPD.  Review of manufacturer guidelines for use of the inhaler read in part, "After using the inhaler, rinse	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
conducted on \$/20/2019 through \$/22/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # HDYR11  F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:  Based on observations, record review, and staff interviews the facility failed to administer a medication according to manufacturer guidelines for 1 of 4 resident (Resident #259) observed for medication administration.  Findings Included:  Resident #259 was admitted to the facility on 05/16/19 with diagnoses including chronic obstructive pulmonary disease (COPD). An admission Minimum Data Set (MDS) assessment was pending on 05/22/19.  Review of resident #259's medical record revealed an order for Symbicort 160/4.5 micrograms 2 puffs by mouth twice daily for COPD.  Review of manufacturer guidelines for use of the inhaler read in part, "After using the inhaler, rinse	E 000	Initial Comments		E	000			
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:  Based on observations, record review, and staff interviews the facility failed to administer a medication according to manufacturer guidelines for 1 of 4 resident (Resident #259) observed for medication administration.  Findings Included:  Resident #259 was admitted to the facility on 05/16/19 with diagnoses including chronic obstructive pulmonary disease (COPD). An admission Minimum Data Set (MDS) assessment was pending on 05/22/19.  Review of resident #259's medical record revealed an order for Symbicort 160/4.5 micrograms 2 puffs by mouth twice daily for COPD.  Review of manufacturer guidelines for use of the inhaler read in part, "After using the inhaler, rinse		conducted on 5/20/20 facility was found in c requirement CFR 483 Preparedness. Event Services Provided Me	19 through 5/22/2019. The ompliance with the .73, Emergency ID # HDYR11 eet Professional Standards	F 6	658			6/10/19
revealed an order for Symbicort 160/4.5 micrograms 2 puffs by mouth twice daily for COPD.  Review of manufacturer guidelines for use of the inhaler read in part, "After using the inhaler, rinse  the appropriate administration instructions are reflected in the MAR by 06/05/2019.  What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice		The services provided as outlined by the cormust- (i) Meet professional strains REQUIREMENT by: Based on observation interviews the facility medication according for 1 of 4 resident (Remedication administration) administration administration for the facility medication administration administration administration administration administration for the facility medication administration administration administration administration administration for the facility medication administration administra	d or arranged by the facility, inprehensive care plan, standards of quality. It is not met as evidenced ins, record review, and staff failed to administer a to manufacturer guidelines esident #259) observed for ation.  Idmitted to the facility on sees including chronic of disease (COPD). An obtata Set (MDS) assessment 2/19.			accomplished for those residents found have been affected by the deficient practice: Nurse #1 was immediately provided verbal education on the importance of following all instructions the Medication Administration Record by RN Director of Staff Development.  How the facility will identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taker Pharmacy will review all current resident.	on by n: nts	
inhaler read in part, "After using the inhaler, rinse make to ensure that the deficient practice		revealed an order for micrograms 2 puffs by	Symbicort 160/4.5			the appropriate administration instructionare reflected in the MAR by 06/05/2019.  What measures will be put into place of	ons ).	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		inhaler read in part, "/ your mouth with wate	After using the inhaler, rinse r and spit out. Do not			make to ensure that the deficient practi does not recur: Inservice initiated on	ce	

06/03/2019

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 080413

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345572	B. WING		05/22/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/22/2010		
THE CARDINAL AT NORTH HILLS				311 GARDEN AT NORTH HILLS STREET			
				RALEIGH, NC 27609			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION		
F 658	Continued From page	e 1	F 65	8			
F 658	swallow water."  On 05/21/19 at 07:52 medication administra conducted. Nurse #1 Symbicort 160/4.5 mi resident #259. Nurse resident #259 rinse h administration of the In an interview on 5/2 indicated he was not resident #259 rinsed use of the inhaler. He some inhalers require but he did not think S  On 05/21/19 at 09:34 DON revealed she waresidents to rinse their of Symbicort inhaler. was to prevent reside sores or a fungal inferuse of a steroid inhaler with water after use of the nurse administeric	AM observation of ation for resident #259 was was observed to administer crograms 2 puffs orally to #1 made no attempt to have is mouth with water after medication.  21/19 at 09:29 AM Nurse #1 aware he needed to ensure his mouth with water after further indicated he knew ed mouth rinsing after use ymbicort was one of them.  AM an interview with the as aware of the need for it mouth with water after use She further indicated this ents from suffering mouth ction in their mouth from the er. She went on to say the residents rinsed their mouth of Symbicort was visible to ng the medication or the administration screen at the	F 65	05/21/2019 providing education to al licensed nursing staff on the administ medications through metered dose in (MDI). All current licensed nursing staff will complete a competency assess proctored by the Director of Nursing or Designee on the administration of medication through a metered dose inhaler by June 5, 2019; for new hire competency will be completed within days of employment.  How the facility plans to monitor its performance to make sure that solut are sustained. The facility must dever plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective evaluated for its effectiveness. Direct Nursing will initiate a monitoring schewith audit of medication administration observation that will be completed by Director of Nursing and or designee. monitoring schedule is as follows: 3) week for one month, 1X week for one month, 2X month for one month; the maintain monthly monitoring schedule going forward. QAPI PIP will be initiated for medication observation to ensure professional standards of quality are sustained.  Date of Correction. Corrective action be completed 06/10/2019  This Plan of Correction is submitted	stering nhaler raff nent and es, a 30  ions elop a nust action etor of edule on y The K e n le ated ested es		
				in compliance with certain state and federal regulations. Its submission do not indicate that the facility agrees w			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345572	B. WING _			05/	22/2019
NAME OF PROVIDER OR SUPPLIER  THE CARDINAL AT NORTH HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 658	Continued From page	e 2	F6				