PRINTED: 07/08/2019 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|----------------|-------------------------------|----------------------------|
| | | 345449 | B. WING | | | C 02/08/2019 | |
| NAME OF PE | ROVIDER OR SUPPLIER | 0.01.0 | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | | 02/ | 08/2019 |
| NAME OF T | COVIDEIX OIX 301 1 EIEIX | | | | 15 WHITE ROAD | | |
| UNIVERSA | AL HEALTH CARE/KING | | | | | | |
| | | | | r | KING, NC 27021 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFII TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD E | | | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | E | 000 | | | |
| F 000 | investigation survey v 2/8/19. The facility wa | | F | 000 | | | |
| 1 000 | An unannounced Rec | certification and complaint vas conducted on 2/4/19 to | | ,,,, | | | |
| | Immediate Jeopardy | was identified at: | | | | | |
| | (J) CFR 483.25 at tag F6 | 80 at a scope and severity | | | | | |
| | (J) CFR 483.45 at tag F7 (J) | 60 at a scope and severity | | | | | |
| | The tags F684 and F7 Quality of Care. | 760 constituted Substandard | | | | | |
| | | began on 01/25/19 and was . An extended survey was | | | | | |
| | member changes and administrative review is deleted and F760 is | | | | | | |
| F 580 SS=J | Notify of Changes (In CFR(s): 483.10(g)(14 | jury/Decline/Room, etc.))(i)-(iv)(15) | F t | 580 | | | 2/8/19 |
| | · · | cation of Changes. ediately inform the resident; ent's physician; and notify, | | | | | |
| A DOD ATODY I | DIDECTORIS OR DROVIDERIS | SLIPPLIER REPRESENTATIVE'S SIGNATURE | | | TITI F | | (X6) DATE |

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.

Electronically Signed

03/04/2019

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|---------------------|--|----------|----------------------------|
| | | 345449 | B. WING | | | C 02/08/2019 |
| | NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | <u> </u> | 02/00/2019 |
| (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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 580 | representative(s) whe (A) An accident involves an injury and he physician intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-the clinical complications (C) A need to alter treatment due to advict commence a new for (D) A decision to transeident from the facility when making not (14)(i) of this section, all pertinent informatic is available and proving physician. (iii) The facility must a resident and the resi | ther authority, the resident en there is- ving the resident which has the potential for requiring an; age in the resident's physical, bial status (that is, a an, mental, or psychosocial reatening conditions or an); attent significantly (that is, a an existing form of erse consequences, or to an of treatment); or after or discharge the lity as specified in a specified in §483.15(c)(2) and ded upon request to the also promptly notify the dent representative, if any, an or roommate assignment 10(e)(6); or ent rights under Federal or ans as specified in paragraph in the record and periodically mailing and email) and | F 58 | | | |

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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------------|--|---|
| | | 345449 | B. WING | | C 02/08/2019 |
| | NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | 1 02:00:20.0 |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| F 580 | its physical configural locations that compris part, and must specification room changes between under §483.15(c)(9). This REQUIREMENT by: Based on staff interved physician interview the resident's physician of administering insulin physician to be given (Resident #192) resident administering the insulation of the readministering the insulation of the readministering the insulation on admission of administering the insulation on admission pepartment. She receintubation on admission on 1/25/19 failure, altered mental body temperature), a glucose). The facility physician of an unatter (Resident #65) sampinutrition. Immediate jeopardy to facility staff failed to each of the comprise part of the compression o | e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations is not met as evidenced iews, record review, and the facility failed to notify the of a meal refusal prior to that was ordered by the with meals for 1 of 4 dents reviewed for insuling allure of the facility to notify esident's refusal to eat and culin without a meal as the resident becoming that to the Emergency quired a central line and | F 58 | | ent by ed e and e good prove those ted by 23/2019 s. sing 3/2019 most |
| | insulin dependent, ha meal prior to adminis units of Novolog 70/3 acting and long acting | etes Mellitus (DM) and was and not eaten her breakfast tering to the resident 58 0, a combination of short g insulin, which was ordered s. The immediate jeopardy | | section I (active diagnosis) indicate resident #192 had a diagnosis of ty diabetes mellitus with diabetic neur Review of physician orders reveals resident #192 had an order for Nov Mix 70-30 to be given subcutaneou | pe 2 opathy. olog |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | LE CONSTRUCTION | · , | (X3) DATE SURVEY COMPLETED | |
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| | 345449 B. WING | | | | C 02/08/2019 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL | | 2/00/2019 | |
| | | | | 115 WHITE ROAD | - | | |
| UNIVERSA | AL HEALTH CARE/KING | | | KING, NC 27021 | | | |
| (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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 580 | Continued From pag | e 3 | F 58 | 0 | | | |
| | and implemented an allegation of Immedia facility will remain ou scope and severity o with the potential for immediate Jeopardy). Findings included: 1. Resident #192 wa 1/23/19 with the diag Mellitus Type 2, hypothyroid gland), hyperpressure), enterocoli that effects the small to clostridium difficile colon that is caused clostridium difficile. Review of the physic revealed orders place Stick Blood Sugar (Fat bedtime. There wall administer 58 units sinjection into the fat leading to the single the same and the same a | ate Jeopardy removal. The tof compliance at a lower of level "D" (no actual harm minimal than harm that is not a for example #2. Is admitted to the facility on noses that included Diabetes othyroidism (underactive tension (HTN - high blood tis (inflammation in the gut intestine and colon) related (C-diff), an infection in the by the bacteria called ian orders for Resident #192 and on 1/23/19 for Finger SBS) checks before meals & as also an order to ubcutaneously (SQ - ayer between the skin and | | twice daily with meals. On 1/25/2019 resident #192 Novolog 70-30 at 10:24am. In nurse aide #1 who was carin #192, on 1/25/2019 morning indicated resident #192 refus breakfast in the morning of 1. Interview with nurse assistant conducted by the facility St. Nursing indicates resident #1 snacks during the night of 1/2 the morning of 1/25/2019. On 1/25/2018, at 12:15pm le hours after resident #192 reconstructed with the morning of 1/25/2019. On 1/25/2018, at 12:15pm le hours after resident #192 reconstructed; she went to restroom and observed resident unresponsive. She immediate vital signs as well as blood giglucose result was noted to be normal limits 70-110). Licens contacted emergency medicate who then transferred resident hospital. On 2/8/2019; the facility Med had an extensive discussion | nterview with g for resident shift, sed her //25/2019. It #2 Director of 192 ate 24/2019 to ss than two seived the nsed nurse ident #192 #192 been ely obtained lucose. Blood be 189 (adult ed nurse #1 al services t #192 to the ical Director with the | | |
| | According to the mar a mixture of a man-m help control mealtime long-acting insulin the help control blood su manufacturer guidelin type 2 diabetes shou 15 minutes before or | with meals of Novolog 70/30. In facturer, Novolog 70/30 is made fast-acting insulin to expikes in blood sugar and least works up to 24 hours to gar between meals. The least stated that people with least the injection within later starting their meal. | | State surveyors on site to ex medical rationale for the report hypoglycemic episode for residual documented by both EMS ar room Physician on 1/25/2019 Medical Director explained the #192 hypoglycemic episode related to resident #192 cl condition that was not diagnoresident #192 was admitted to n 1/23/2019, two days before | orted sident #192 and emergency b. Facility hat resident is medically hronic thyroid bed before to the facility | | |
| | administration record | I (MAR) revealed Resident M scheduled FSBS check on | | episode of hypoglycemia. The medical director added: on 1. | e facility | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345449 | B. WING | | | 2/08/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | ·E | | |
| UNIVERSA | AL HEALTH CARE/KING | | | 115 WHITE ROAD | | | |
| 0111121107 | | | | KING, NC 27021 | | | |
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| F 580 | Continued From page | e 4 | F 58 | 0 | | | |
| F 580 | 1/25/19 at 6:37 AM an milligrams/deciliter (m 58 units of insulin sch documented as admin AM by Nurse #2. According to the mean Resident #192 did no or lunch on 1/25/19. During an interview w 2/6/19 at 4:46 PM aboundation and meal in that the resident was that morning, and that When asked if she not resident's refusal to e Nurse#2 was made at During an interview w 1:17 PM she stated the AM she went into Residential and the she was the resident refused at gave her the full dose when she knew the resident refused as when she she resident refused as when she resident refused refused refused refused refused refused refused refused r | and the result was 109 ang/dl). The Novolog 70/30 and duled for 9:00 AM was anistered on 1/25/19 at 10:24 If percentage sheet, at eat anything for breakfast With Nurse Aide (NA) #6 on out Resident #192's atake on 1/25/19, she stated on the bedpan several times at she had refused breakfast. Diffied the nurse of the atat breakfast, she stated aware. With Nurse #2 on 2/7/19 at anat at approximately 10:00 asident #192's room to ans and she was at baseline all status. Nurse #2 stated are at her breakfast and had asomething at that time, but any food. When asked if she are of Novolog 70/30 insulin assident had not eaten | F 58 | ordered thyroid stimulating horogeneous (TSH) laboratory test following from facility licensed staff that #192 was lethargic. The facility the laboratory test on 1/24/19 and received the result on 1/2 TSH result from 1/24/2019 incresident #192 had a condition Hypothyroidism. The facility Noirector expressed to the station site that resident #192 station and undiagnosed thyroid connot due to the administration that was given less than two she was observed been unrefacility Medical Director orde 100mcg, medication used to hypothyroidism but medication started as resident #192 was to the hospital on the same dordered (1/25/2019). Resident longer in the facility, no further warranted at this time. On 2/08/19; State agency sur indicated that the root cause alleged noncompliance is the licensed nurse #1 to administ 70-30 at 10:24am while resident. | g the report t resident ty obtained as ordered 25/2019. dicated a called Medical te surveyors fluctuation on er untreated dition and of the insulin hours before sponsive. red Synthroid treat in was not transferred ay it was at #192 is no er actions veyors of this action by ter Novolog | | |
| | she had gone into Re approximately 12:00 and found her unresp couldn't wake Reside blood sugar with a re stated she applied ox notified the DON, and the resident to the ho | that she did. She stated esident #192's room at PM to check her blood sugar ponsive. Nurse #2 stated she ent #192 up and checked her sult of 189 mg/dl. She eygen, checked vital signs, at EMS was called to transfer spital. She stated that she is pupils and they were fixed | | refused her breakfast meal w notifying physician before tha Address how corrective action accomplished for those reside the potential to be affected by deficient practice. Audits of 100% of residents orders were completed by the Nursing, Assistant director of and/or Unit Manager on 2/7/2 | t action. In will be ents having If the same medication EDirector of Nursing | | |

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| | | 345449 | B. WING | | , | C 2/08/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | 0.00.00 | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 2/00/2019 | |
| | 10 115211 011 001 1 21211 | | | 115 WHITE ROAD | - | | |
| UNIVERSA | AL HEALTH CARE/KING | | | KING, NC 27021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 580 | Continued From page and dilated. A progress note dated by Nurse #2 stated shroom at 12:15 PM and unresponsive. The recoxygen saturation leve (BP) was 98/68 mmH minute (bpm), and FS Review of the Januar Resident #192 had be on 1/25/19 at 1:07 PM During an interview we (DON) on 2/6/19 at 55 in Resident #192's roher being unresponsive resident's blood sugathere was no indication the insulin being admilevel. Review of Resident #1/25/19 revealed the facility to be unresponsive. | d 1/25/19 at 6:43 PM written the entered Resident #192's do found Resident #192 esident's SpO2 (blood el) was 98%, blood pressure g, Pulse 54 beats per BBS was 189. by 2019 MAR revealed that the er 11:30 AM FSBS checked of 189 mg/dl. cith the Director of Nursing 02 PM she stated she was soon after she was notified of we. She stated the rewas 189 mg/dl and that on to be concerned about inistered or blood sugar | F 58 | 2/8/19 to identify any other resany insulin order that need to be with meals. The audit conclude were eight other residents ider orders for insulin medication to with meals. Audit of Insulin additional records for the last 7 days indicated other eight identified residents their insulin as ordered with meals and to all current residential documentation within the days completed by the Director Nursing, Assistant Director of Staff development Coordinator Nurse Manager to determine a identified need for notification of that was completed in a timely The audit revealed no other missing/delayed notification of both physician and/or respons This audit was completed on 2 Findings of this audit are docu clinical records audit tool locat facility compliance binder. | sident with be given ed there natified with be given ministration cated all received eals. The last 7 for of Nursing, and/or any of changes manner. The changes to ible party. 12/08/19. The mented on the ministration cated all received eals. | | |
| | that the resident was AM, her vital signs we glucose was 129 mg/level documented by mg/dL. At 1:09 PM Dhypertonic solution of chemically identical to administered. At 1:13 glucose was 273 mg/glucose was 110 mg/ | resident was found and it was reported to EMS last seen normal at 11:00 ere all normal, and her blood dL. The first blood glucose EMS at 1:05 PM was 23 extrose 50% (D50 - a dextrose, simple sugar o glucose) 25 grams was B PM the resident's blood dL. At 1:30 PM her blood dL. At 1:30 PM her blood dL. Resident #192 was | | On 2/8/2019, 100% audit was by the Director of Nursing, Ass Director of Nursing, Staff deve Coordinator and/or Nurse Man incidents reports completed wing 7 days to ensure notifications in a timely manner. The audit is other missing/delayed notifications to both physician and responsible party. This audit wormpleted on 2/08/19. Finding audit are documented on incide audit tool located in the facility | sistant lopment lager of all ithin the last were done revealed no tion of lor as s of this lent reports | | |

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|--------------------------|--|---|---------------------------------------|---|--|----------------------------|--|
| | | 345449 | B. WING | | | C 02/08/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 02/ | 100/2013 | |
| | | | | 115 WHITE ROAD | | | |
| UNIVERSA | AL HEALTH CARE/KING | | | KING, NC 27021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | · · · · · · · · · · · · · · · · · · · | | | (X5) COMPLETION DATE | |
| F 580 | Review of the ED Rey documented the reside at the facility by EMS glucose of 23 mg/dL. admission on 1/25/19 26 mg/dL. The reside catheter placed into a medications or draw I 2:52 PM for acute reserceived D50 for hypot (IVF) for hypotension. Care Unit (ICU). Her dadmission on 1/25/19 failure, altered mental hypoglycemia. Review of hospital read M revealed a Critical Physician Assistant (Physician #1 that state Resident #192 involvidiabetes mellitus (IDE insulin dose and not experience of the properties of the properties of the properties are educated receiving insulin indivimedication administrativithold insulin if meas the further stated, if the properties of the properties of the properties of the properties are educated receiving insulin indivimedication administrativithold insulin if meas the further stated, if the properties of the propertie | tal ED staff at 1:45 PM. port from 1/25/19 lent was found unresponsive and EMS obtained a blood Triage Lab results from ED at 2:48 PM were Glucose ent required a central line (a large vein to give ab work) and intubation at piratory failure, she oglycemia, intravenous fluids and admission to Intensive final diagnoses for hospital were acute respiratory status, hypothermia, and cords from 1/27/19 at 9:22 I Care Progress Note by PA) #1 and Hospital ed problems addressed for ng her insulin dependent DM) were "likely related to eating." In 2/7/19 at 3:35 PM the Staff factor stated NAs are the nurse when a resident tation and as needed. to look at each resident | F 58 | <u> </u> | not ard, ot th an nen a notify red ne ses om s well ard the es or of cal hours ts, and 4 tion of ely ake | | |
| | provider for further or administered. | | | promptly and appropriate actions will implemented by the DON, ADON, S and/or Registered Nurse supervisor. | DC | | |

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| CENTER | S FOR WEDICARE & | WEDICAID SERVICES | | | | OIVID INC | <u>J. 0930-0391</u> | |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | | | | | | С | |
| | | 345449 | B. WING _ | | | 02 | /08/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| LININGERO | AL LIEALTH CAREWING | | | 11 | 15 WHITE ROAD | | | |
| UNIVERSA | AL HEALTH CARE/KING | | | K | ING, NC 27021 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PRÉFIX TAG | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI: TAG | X | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | COMPLETION DATE | |
| | | | | | | | | |
| F 580 | Continued From page | e 7 | F s | 580 | | | | |
| | During an interview w | vith the facility Pharmacist on | | | process will be incorporated in a daily | | | |
| | | e stated she would have | | | clinical meeting any negative findings v | | | |
| | | o hold all short acting insulin | | | be documented on the daily clinical rep | | | |
| | | umed. She stated if the | | | form and maintained in the daily clinica | al | | |
| | | ar was 109 at 6:27 AM, and | | | meeting binder. | _ | | |
| | | e glucagon administered, the | | | Effective 2/08/2019, week end Registe | red | | |
| | blood sugar going up | _ | | | Nurse supervisor and/or designated | | | |
| | 1 | PM seemed inconsistent. | | | licensed nurse will review clinical | | | |
| | _ | 70/30 is used to regulate and | | | documentation created for the last 24 | | | |
| | lower blood sugar levels for residents with diabetes, it has an onset of action within 10-20 minutes for the short acting and the medication | | | | hours for all residents, 24 hour report sheets, incident reports for the last 24 | | | |
| | | | | | hours and Physician orders written in t | ho. | | |
| | peaks within 1-4 hour | _ | | | last 24 hours to ensure any needed | iic | | |
| | pound within 1 1 11oui | io or adminionation. | | | notification of changes to the physiciar | ١. | | |
| | During an interview w | vith the Medical Director on | | | and/or responsible party was done in a | | | |
| | _ | e stated she was not aware | | | timely manner. This systemic process | | | |
| | of the particular incide | ent with Resident #192's low | | | take place every Saturday & Sunday. A | | | |
| | blood sugar and trans | sfer to the ED and her | | | identified issues will be addressed | | | |
| | associate was most li | ikely contacted for transfer | | | promptly and appropriate actions will b | e | | |
| | orders. When asked | if she expected the nurse to | | | implemented by the DON, ADON, SDO | | | |
| | | ent did not eat, she stated | | | and/or Registered Nurse supervisor. T | he | | |
| | | nursing home don't eat all | | | result of this systemic process will be | | | |
| | | ed if she expected the nurse | | | documented on the weekend supervise | | | |
| | to check another bloc | • | | | report form maintained in the Daily Sta | ind | | |
| | | after a 4-hour time period | | | up meeting binder. Findings from this | 41 | | |
| | | sumed, she stated yes but | | | systemic changes will be discussed in | | | |
| | | nurse for administering the She stated most likely the | | | daily □stand up meeting Monday throu Friday effective 2/8/2019. Week end | ign | | |
| | | ceiving this ordered insulin | | | supervisor #1  will be educated on | thic | | |
| | | d of time and for whatever | | | requirement before their next schedule | | | |
| | - | ular day she had an adverse | | | day to work by the facility Director of | | | |
| | | n, but she had probably had | | | Nursing. | | | |
| | | red at that dose without food | | | · · · · · · · · · · · · · · · · · · · | | | |
| | in the past without the | | | | | | | |
| | | | | | The Facility Director of Nursing (DON) | | | |
| | | 1, the administrator was | | | Assistant Director of Nursing and/or st | | | |
| | | ediate jeopardy. The facility | | | development coordinator will complete | | | |
| | | llegation of Immediate | | | 100% education for all licensed nurses | | | |
| | Jeopardy removal on | 2/8/19. The allegation of | | | include full time, part time and as need | ied | | |

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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | С | |
| | | 345449 | B. WING _ | | | 02 | /08/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LININGERO | NI LIEALTH CADE/IZIN | • | | 1 | 15 WHITE ROAD | | |
| UNIVERSA | AL HEALTH CARE/KIN | G | | KING, NC 27021 | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | , | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | X | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | COMPLETION DATE |
| F 580 | Continued From pa | ge 8 | F t | 580 | | | |
| | Immediate Jeopard | y removal indicated: | | | staff. The emphasis of this education on the importance of notifying Physicia | | |
| | Cradible Allegation | of Immediate Jeopardy | | | and the responsible party in a timely | 111 | |
| | removal: | or infinediate beopardy | | | manner for any incident/accidents, | | |
| | Date: 2/08/2019 | | | | resident⊡s change of condition, chang | ie of | |
| | | ccomplished for those | | | treatment/intervention an injury of | 0. | |
| | | nave been affected by the | | | unknown source and/or Medication en | or if | |
| | deficient practice. | • | | | any. The education also emphasized t | | |
| | Resident #192 was admitted on 1/23/2019 for | | | | responsibility of the licensed nurse on | | |
| | short term rehabilitation services. Resident #192 | | | | Duty to notify physician when a reside | nt | |
| | received skilled nursing and rehabilitation | | | | with ordered insulin refuse their meal/f | | |
| | services from 1/23/2019 up to 1/25/2019. Review | | | | and document physician decision in ea | | |
| | • | most recent minimum data set, with resident s medical records before the | | | | | |
| | | nce date 1/25/2018 section I | | | insulin is administered. Licensed nurse | | |
| | | ndicated resident #192 had a | | | were also educated to document any r | | |
| | | diabetes mellitus with diabetic of physician orders reveals | | | physician recommendation on the 24 h report sheets effective 2/8/19. This | ioui | |
| | | an order for Novolog Mix 70-30 | | | education will be completed by 2/8/20 | 10 | |
| | | neously twice daily with | | | Any Licensed Nurse not educated by | 10. | |
| | meals. | ee acity times aciny time. | | | 2/8/2019 will not be allowed to work ur | ntil | |
| | On 1/25/2019 reside | ent #192 received Novolog | | | educated. This education will also be | | |
| | | nterview with nurse aide #1 | | | added on new hires orientation proces | s | |
| | who was caring for | resident #192, on 1/25/2019 | | | for all new licensed nurses and will als | 0 | |
| | morning shift, indica | ated resident #192 refused her | | | be provided annually effective 2/8/20 |)19. | |
| | | rning of 1/25/2019. Interview | | | The facility plans to monitor its | | |
| | | t #2 conducted by the facilitys | | | performance to make sure that solution | าร | |
| | _ | indicates resident #192 ate | | | are sustained. | | |
| | | ight of 1/24/2019 to the | | | Effective 2/8/2019, Assistant Director of | of . | |
| | morning of 1/25/201 | | | | Nursing, and/or Staff Development | :41- | |
| | | 2:15pm less than two hours | | | Coordinator, will monitor compliance w | | |
| | | received the Novolog 70-30, urse #1 indicated; she went to | | | notification of changes to Physician ar responsible party to include notification | | |
| | · | and observed resident #192 | | | physician for any resident with insulin | 1 10 | |
| | | She immediately obtained | | | order who refuse their meal. This | | |
| | | s blood glucose. Blood | | | monitoring process will be accomplish | ed | |
| | | noted to be 189 (adult normal | | | by reviewing the daily clinical meeting | | |
| | | nsed nurse #1 contacted | | | reports to ensure completion and prop | er | |
| | emergency medical | | | | follow through. Any issues identified | | |
| | | #192 to the hospital. | | | during this monitoring process will be | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|--|------------------------------------|--|---|--|----------------------------|--|
| | | | A. BOILDI | NG _ | | , ا | С | |
| | | 345449 | B. WING | B. WING | | l | 02/08/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| UNIVERS | AL HEALTH CARE/KING | | 115 WHITE ROAD | | | | | |
| UNIVERSA | AL HEALTH CARE/KING | • | | K | ING, NC 27021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | I | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | | (X5) COMPLETION DATE | |
| F 580 | that the root cause of is the action by licens. Novolog 70-30 at 10: refused her breakfas physician before that Address how correct accomplished for the potential to be affect practice. Audits of 100% of reswere completed by the Assistant director of on 2/7/2019, and 2/8 resident with any insigiven with meals. The eight other residents insulin medication to Insulin administration indicated all other eigreceived their insulin 100% audit of all curdocumentation within by the Director of Nu Nursing, Staff develor Nurse Manager to defor notification of chara timely manner. The missing/delayed notir physician and/or responsed to the completed on 2/08/15 | ency surveyors indicated If this alleged noncompliance sed nurse #1 to administer 24am while resident #192 It meal without notifying action. Ive action will be see residents having the ed by the same deficient Sident - medication orders he Director of Nursing, Nursing and/or Unit Manager /19 to identify any other ulin order that need to be e audit concluded there were identified with orders for be given with meals. Audit of a records for the last 7 days oth identified residents as ordered with meals. rent residents clinical a the last 7 days completed rsing, Assistant Director of pement Coordinator and/or extermine any identified need anges that was completed in e audit revealed no other fication of changes to both consible party. This audit was 9. Findings of this audit are cal records audit toollocated | F | 580 | addressed promptly. Findings from this monitoring process will be documented a daily clinical report form and filed in clinical meeting binder after proper follow-ups are completed. This monitor process will take place daily for 2 week weekly x 2 more weeks, then monthly months or until the pattern of compliance is maintained. Director of Nursing will review the completion of daily clinical report, and proper follow through and ensure notification of changes is rendered as appropriate. Director of nursing documfindings from this monitoring process declinical checklist form and filed in clinical meeting binder after proper follow-ups completed. This monitoring process will take place daily Monday through Friday for 2 weeks, weekly x 2 more weeks, the monthly x 3 months or until the pattern compliance is maintained. Facility Quality Assurance & Performar Improvement Committee was notified of this plan of action on 2/8/2019. Effective 2/08/19, Facility Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification | ing s, c 3 ce ent aily al are l / nen of fe dd/or he for | | |
| | Director of Nursing, A Staff development Co Manager of all incide | audit was completed by the Assistant Director of Nursing, coordinator and/or Nurse ents reports completed within sure notifications were done | | | of this plan monthly for three months, of until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. | | | |

| CENTER | 3 FOR WEDICARE & | WIEDICAID SERVICES | | | | OIVID INC | 7. 0930-0391 |
|--------------------------|---|---|--|-----|--|-------------------------------|--------------------|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | | | | | (| C |
| | | 345449 | B. WING _ | | | 02/ | 08/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 11 | I5 WHITE ROAD | | |
| UNIVERSA | AL HEALTH CARE/KING | | | K | ING, NC 27021 | | |
| (V4) ID | SLIMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | × | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 580 | Continued From page | <u>-</u> 10 | F | 580 | | | |
| . 000 | _ | | | 000 | | | |
| | | he audit revealed no other ication of changes to both | | | The title of the person responsible for | | |
| | | onsible party. This audit was | | | implementing the acceptable plan of | | |
| | | 9. Findings of this audit are | | | correction | | |
| | | ent reports audit toollocated | | | Effective 2/8/2019 the facility | | |
| | in the facility complian | | | | Administrator and the Director of Nursi | na | |
| | Measures will be put | | | | will be ultimately responsible for the | 19 | |
| | | vill be made to ensure that | | | implementation of this plan of correctio | n | |
| | the deficient practice | | | | to ensure the facility attains and mainta | | |
| | • | d moving forward, the facility | | | substantial compliance. | | |
| | | vill not administer insulin for | | | • | | |
| | any resident with an o | order to be given with | | | Compliance Date 2/8/2019 | | |
| | meals/food when a re | esident refused his/her | | | | | |
| | meal/food. Facility Lic | censed nurse on Duty will | | | Tag 580 Part 2 | | |
| | notify physician when | a resident with ordered | | | Root Cause Analysis | | |
| | insulin refuse their me | eal/food and document | | | Based on the root cause analysis by th | е | |
| | physician decision in | each residents medical | | | facility□s administrative staff, it was | | |
| | records before the ins | | | | determined the facility failed to provide | | |
| | Licensed nurses will a | - | | | notification to the physician for resident | | |
| | | n Physician in a 24 hour | | | 65 concerning a significant weight loss | - | |
| | report form as well ef | | | | | | |
| | Effective 2/8/2019 an | _ | | | Immediate Action | | |
| | - | which includes Director of | | | Resident # 65 was discharged from the | | |
| | - | ector of Nursing, and/or | | | facility on 2-16-19. No further action is | | |
| | Nurse supervisors ini | | | | warranted at this time. | | |
| | _ | umentation create for the esidents, 24 hour report | | | Identification of Others | | |
| | | ts for the last 24 hours and | | | On 2-8-19, a 100% audit was complete | d | |
| | | en in the last 24 hours to | | | by the Director of Nursing and Assistar | | |
| | _ | otification of changes to the | | | Director of Nursing and Assistant Director of Nursing of all incident report | | |
| | _ | consible party was done in a | | | completed within the last 7 days to ens | | |
| | | systemic process will take | | | notifications were done in a timely | | |
| | place daily (Monday t | * | | | manner. The audit revealed no missing | 1/ | |
| | , | be addressed promptly and | | | delayed notifications of changes to both | | |
| | | rill be implemented by the | | | physicians and/ or responsible party. | | |
| | | nd/or Registered Nurse | | | audit was completed on 2-8-19. Finding | | |
| | | ess will be incorporated in a | | | of this audit are documented and can be | - | |
| | | any negative findings will be | | | found in the facility compliance binder. | | |
| | | aily clinical report formand | | | , <u>,</u> | | |

| NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/KING STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | C 02/08/2019 (X5) COMPLETION |
|---|---------------------------------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD | 02/08/2019 (X5) |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD | (X5) |
| UNIVERSAL HEALTH CARE/KING | |
| UNIVERSAL HEALTH CARE/KING | |
| | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | DATE |
| F 580 Continued From page 11 F 580 | |
| maintained in the daily clinical meeting binder. Systemic Changes | |
| Effective 2/08/2019, week end Registered Nurse Effective 2-8-19, the Director of Nursing/ | |
| supervisor and/or designated licensed nurse will Assistant Director of Nursing or | |
| review clinical documentation created for the last Designated Licensed Nurse will review | |
| 24 hours for all residents, 24 hour report sheets, clinical documentation created for the last | |
| incident reports for the last 24 hours and 24 hours for all residents, 24 hour report | |
| Physician orders written in the last 24 hours to sheets, incident reports for the last 24 | |
| ensure any needed notification of changes to the hours and physician orders written in the | |
| physician, and/or responsible party was done in a last 24 hours to ensure any needed | |
| timely manner. This systemic process will take notification of changes to the physician | |
| place every Saturday & Sunday. Any identified and/ or responsible part was done in a | |
| issues will be addressed promptly and timely manner. This systemic process | |
| appropriate actions will be implemented by the will take place Monday through Friday. | |
| DON, ADON, SDC and/or Registered Nurse Any identified issues will be addressed | |
| supervisor. The result of this systemic process promptly and appropriate actions will be | |
| will be documented on the weekend supervisor implemented by the DON and ADON. | |
| report form maintained in the Daily Stand up This process will be incorporated in a daily | |
| meeting binder. Findings from this systemic clinical meeting and negative findings will | |
| changes will be discussed in the daily stand up be documented on the daily clinical report | |
| meetingMonday through Friday effective form and maintained in the daily clinical | |
| 2/8/2019. Week end supervisor #1  will be meeting binder. The weekend nurse | |
| educated on this requirement before their next supervisor or designated licensed nurse | |
| scheduled day to work by the facility Director of will review clinical documentation for the | |
| Nursing. last 24 hours for all residents, 24 hour | |
| report sheets, incident reports for the last | |
| The Facility Director of Nursing (DON), Assistant 24 hours and physician orders written in | |
| Director of Nursing and/or staff development the last 24 hours to ensure any needed | |
| coordinator will complete 100% education for all notification of changes to the physician | |
| licensed nurses to include full time, part time and and/ or responsible party was done in a | |
| as needed staff. The emphasis of this education timely manner. This systemic process will | |
| was on the importance of notifying Physician and take place every Saturday and Sunday. | |
| the responsible party in a timely manner for any Any identified issues will be addressed | |
| incident/accidents, residents change of condition, promptly and appropriate actions will be | |
| change of treatment/intervention an injury of implemented by the DON or ADON. The unknown source and/or Medication error if any. | |
| unknown source and/or Medication error if any. The education also emphasized the responsibility result of this process will be documented on the weekend supervisor report form. | |
| of the licensed nurse on Duty to notify physician of the licensed nurse on Duty to notify physician Findings of this process will be reviewed | |
| when a resident with ordered insulin refuse their by the DON or ADON and will be | |
| meal/food and document physician decision in discussed in the daily stand up meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | · , | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|--|-------------------------------|--|
| | | 345449 | B. WING | | 0. | C 2/08/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 02 | 2/00/2013 | |
| | | | | 115 WHITE ROAD | | | |
| UNIVERSA | AL HEALTH CARE/KING | | | KING, NC 27021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 580 | Continued From page each residents medic is administered. Licer educated to documer recommendation on the effective 2/8/19. This by 2/8/2019. Any Lice 2/8/2019 will not be a educated. This educanew hires orientation nurses and will also be effective 2/8/2019. The facility plans to make sure that solution Effective 2/8/2019, As and/or Staff Developmentor compliance who Physician and/or renotification to physicial insulin order who refund in the daily cliensure completion and issues identified during will be addressed promonitoring process where completion and issues identified during will be addressed promonitoring process where completion and issues identified during will be addressed promonitoring process where completion and issues identified during will be addressed promonitoring process where completion are issues identified during will be addressed promonitoring process where the completion are issues identified during will be addressed promonitoring process where the completion are issues identified during will be addressed promonitoring process where the completion are issues identified during will be addressed promonitoring process where the completion are issues identified during will be addressed promonitoring process where the completion are issues identified during will be addressed promonitoring process where the completion are incompleted in the completion and the completion are incompleted in the completion and the completion are incompleted in the completion and the completion and the completion are incompleted in the completion and the completion and the completion are incompleted in the completion and the completion are incomplet | al records before the insuling and nurses were also at any new physician the 24 hour report sheets education will be completed ensed Nurse not educated by allowed to work untilation will also be added on process for all new licensed be provided annually anonitor its performance to consider a sustained. Sesistant Director of Nursing, ment Coordinator, will with notification of changes esponsible party to include an for any resident with ase their meal. This will be accomplished by nical meeting reports to and proper follow through. Any any this monitoring process mptly. Findings from this will be documented on a daily and filed in clinical meeting llow-ups are completed. | F 58 | DEFICIENCY) | or ADON ification of esponsible daily e rough. essed oring the daily ne clinical w ups are ess will ekly x 2 nonths or | | |
| | weeks, weekly x 2 momenths or until the paramaintained. Director of Nursing we daily clinical report, a ensure notification of appropriate. Director findings from this more checklist form and file after proper follow-up | ess will take place daily for 2 pre weeks, then monthly x 3 attern of compliance is will review the completion of and proper follow through and changes is rendered as of nursing document nitoring process daily clinical and in clinical meeting binder is are completed. This will take place daily Monday | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | (| С | |
| | | 345449 | B. WING | | | 02/ | 08/2019 | |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KIN | G | | 115 V | EET ADDRESS, CITY, STATE, ZIP CODE WHITE ROAD 3, NC 27021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 580 | weeks, then monthly pattern of compliance of action on 2/8/2010 Director of Nursing Nursing will report of process to the facility Performance Improved additional monitoring monthly for three of compliance is maintican modify this plantin substantial compoundation of the persimplementing the actificative 2/8/2019 to the Director of Nursing responsible for the correction to ensure maintains substanting Date of immediate just of immediate just of the correction to ensure maintains substanting the correction to ensure maintains substanting the correction of the correction to ensure maintains substanting the correction of the correction o | weeks, weekly x 2 more y x 3 months or until the ce is maintained. grance & Performance nittee was notified of this plan 9. Effective 2/08/19, Facility and/or Assistant Director of indings of this monitoring ty Quality Assurance and evement Committee for any g or modification of this plan nonths, or until the pattern of tained. The QAPI committee in to ensure the facility remains tiance. In responsible for exceptable plan of correction the facility Administrator and ing will be ultimately implementation of this plan of the facility attains and all compliance. The property of the provided in the facility attains and all compliance. The provided in-services the facility staff on the provided in the provided | F | 580 | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345449 | B. WING _ | | | C 02/08/2019 | | |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | | | 02/00/2019 | | |
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| F 580 | revealed that they we orders were changed order verbiage for all or other types of diab records audit tool, Inc 24-hour report, and the were reviewed for conductive process. During an interview we perform the performance of the performance o | tre completed and that to reflect the new insulin resident's receiving insulin etic medications. Clinical cident reports audit tool, ne clinical meeting binder impletion. With NA #3 on 2/8/19 at 7:41 was educated on the facility olicy and stated that she cerns or suspicions to the red education that stated if a few would offer alternates sal to the nurse and stake percentage in her #4 on 2/8/19 at 7:41 PM on was provided on the glect Policy. She stated that cions would be reported to ator. She stated she also sat stated if a resident fer alternatives to ensure ing, always document their | F 5 | 80 | | | | |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN | | PLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345449 | B. WING _ | | | C 02/08/2019 | | |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | | 02/00/2010 | | |
| (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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 580 | 7:55 PM she stated to ensure a snack or for giving insulin. If the provider and follow administration, then of 24-hour report. Educand Neglect Policy structured and Neglect Policy structured and Anglect Policy structured and Neglect Policy structured and Structured and Structured and Follow and follow and follow orders given She would then document and follow orders given she would be sufficient and follow orders given she would be sufficient and follow orders given she would be she would be sufficient and follow orders given she was and follow | with Nurse #1 on 2/8/19 at hat she was educated to od was consumed before resident refused to eat, notify ow orders given for insulin document changes on the cation on the facility Abuse rated that any and all should be reported to the trator. with Nurse #3 on 2/8/19 at hat she was educated to od was consumed before resident refused to eat oposed to notify the provider, en for insulin administration. Imment changes on the enon-coming nurses. admitted to the facility on so of, in part, right femuracture and vascular dmitted from hospital. She or. #65's physician orders and order was written for she was admitted on a lt diet. Review of the cord revealed on 1/6/19, | F 5 | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | , , | (X3) DATE SURVEY COMPLETED | | |
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| | | 345449 | B. WING _ | | | C 02/08/2019 | | |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | · | 02/00/2010 | | |
| (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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 580 | by the dietician reveal was 157 pounds. The recommend adding a day with medication president was at risk for use of therapeutic die above average body plan. A care plan for nutriti Resident #65 was at related to use of the dementia and weight A handwritten addition was added with no dincluded resident will through next review of handwritten goal of not through next review of handwritten goal of not handwritten | n note dated 1/10/19 written aled Resident #65's weight e registered dietician a protein supplement twice a pass. The note specified the or weight changes related to et, dementia, and weight weight. Will proceed to care on dated 1/10/19 revealed risk for weight changes apeutic diet, diagnosis of above average body weight, on of significant weight loss atte entry. The care plan goal eat at least 75% of all meals with an additional o significant weight changes andwritten. Interventions arrent listing of likes and itamins as ordered, obtain as needed, encourage dining detary recommendation add ein supplement max twice a pass for nutritional support. Assion/5 day Minimum Data and 1/11/19 revealed Resident paired cognition. She was addependent with meals after allowing disorder, was on a ghed 157 pounds and was 66 | F 5 | 80 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345449 | B. WING _ | | | 02/0 |) 08/2019 | |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED T | | | | (X5) COMPLETION DATE | | | |
| F 580 | her. Resident #65 habeans. A follow-up obapproximately 1:00 Passistant assisting Refets had consumed a her meal. On 2/7/19 at 1:13 PM revealed Resident #65 but did need assistant had good days and befriend would visit frequesident to eat. She sersident to eat in the into visit, but someting Review of Resident #60 n 1/12/19 a weekly were documented which were resident's previous were obtained on 1/6/19. Lab results of a Liver 1/7/19 revealed an all protein of 4.8. Normate 6.0-8.7, respectively. Review of Resident #7 revealed there were rephysician orders writt significant weight loss Additionally, review or record revealed the Frecommendation for the daily protein supplements. | om with lunch tray in front of d only consumed bites of her observation on 2/7/19 at M revealed the activity esident #65 to eat. Resident pproximately 75 percent of d, an interview with NA #2 5 was able to feed herself, ce at times. She stated she ad days. The family or family uently and assist the tated she encouraged the dining room if no one came mes she refused to go. 65's weight record revealed weight of 146.8 pounds was as a 10.2 pounds or 6.5 eight loss since the eight of 157 pounds Function Panel collected on bumin of 2.5 and a total I lab values are 3.5-5.2 and 65's medical record no nutritional interventions or en to address the resident's firm 1/5/19 to 1/12/19. If the resident's medical RD's 1/10/19 the resident to receive a ent was not implemented. | F | 580 | | | | |
| | On 2/7/19 at 9:32 AM | , an interview with the | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345449 | B. WING_ | | | C 02/08/2019 | | |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | |
| F 580 | dietary manager (DM of the weight that was on 1/12/19 which refle loss from 1/6/19. She with the weekly weight the report weekly and weight, she requester resident. If there was notify the dietician by recommendation for the resident's weight loss interventions were im Resident #65's weight 1/6/19 to 1/12/19. On 2/6/19 at 11:20 Al Nursing (ADON) was weights were done on 2019, the facility initial admission. Nursing a residents' weights and on the hall to enter in if there was a 3 poundobtained. If the weight physician was notified interventions could be Review of Resident # on 1/19/19 a weekly with E/F halls on 1/19/19 resided. She stated in the resident weights a or the supervisor to e system. | ected a significant weight stated she tried to keep up onts. She stated she pulled if there was a concerning donursing to reweigh the still a concern, she would phone and get a she physician to stop the still a confirmed no plemented to address at loss experienced from M the Assistant Director of interviewed. She stated in admission. In January atted weekly weights x 4 after essistants were to obtain the digive the result to the nurse to the computer. She stated do variance, a reweight was at was still concerning, the dias well as dietary so that the put into place. | F | 580 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---|---|------------------------------|-------------------------------|--|
| | | 345449 | B. WING _ | | | C 02/08/2019 | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | | | 02/00/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 580 | 157 pounds. Review of Resident # on 1/26/19 a docume which equates into a weight loss since 1/6/ A review of meal pero 1/26/19 for Resident # between 50-75% of h On 2/7/19 at 9:14 AM interviewed. She state #65 and that she was on weekly weights. Si report when she roun Manager would notify changes related to we she would ask the fact she didn't get the info #65 's weight loss ide no weekly weight was on 1/19/19. The RD of were implemented to weight loss which begwhen a house shake On 2/7/19 at 9:32 AM revealed on 1/29/19 sidilician and saw Resigney with the reside several things listed the Resident #65 to eat did DM updated the reside confirmed no intervent address Resident #65 | 65's weight record revealed need weekly weight of 139.8 17.2 pound or 10.96 percent 19. entages from 1/6/19 to #65 revealed she consumed er meals. In the dietician was ed she didn't recall Resident n't sure if the resident was ne stated she would get the ded monthly and the Dietary her of any significant eekly weights. She stated ility's risk committee why rmation regarding Resident ntified on 1/12/19 and why sobtained for Resident #65 confirmed no approaches address the resident's gan on 1/12/19 until 1/30/19 supplement was ordered. In an interview with the DM he rounded with the sident #65. She stated she nt's family member who had | F 5 | 580 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | PLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|--|--|----------------------------|--|--|
| | | 345449 | B. WING _ | | | C 02/08/2019 | | |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | | 02/00/2013 | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPLICATION OF THE PROPERTY OF THE PROVIDER O | OULD BE | (X5) COMPLETION DATE | | |
| F 689 SS=D | stated she didn't have front of her but wasn'experienced weight leexpected to be notified. Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensight shaded as free of accident has \$483.25(d)(1). The reas free of accident has \$483.25(d)(2). Each resupervision and assist accidents. This REQUIREMENT by: Based on record revision facility failed to provide two people as care pof the bed to the floor his right forearm and residents (Resident #Findings include: Resident #62 was ad 9/12/06 with diagnost and neurogenic bladed. A review of Resident Minimum Data Set resident #62 was ad 9/12/06 with diagnost and set resident #62 was ad 9/12/06 with diagnost and neurogenic bladed. | I, an interview was esident's physician. She esident's physician. She esident #65's chart in the aware she had bess. She stated she ed of a weight loss. eards/Supervision/Devices (2) I. are that - sident environment remains exards as is possible; and esident receives adequate estance devices to prevent I is not met as evidenced eliew and staff interviews, the elie incontinence care from lanned. Resident #62 slid out and received abrasions to right side of head. One of 5 esident was reviewed for falls. I is not met as evidenced eliew and staff interviews, the elie incontinence care from lanned. Resident #62 slid out and received abrasions to right side of head. One of 5 esident was reviewed for falls. I is not met as evidenced eliew and received abrasions to right side of head. One of 5 esident was that included quadriplegia der. I is not met as evidenced was the facility on esithat included quadriplegia der. | F 5 | | est #62 rsing assist assistant and de | 2/27/19 | | |
| | his right forearm and residents (Resident # Findings include: Resident #62 was ad 9/12/06 with diagnos and neurogenic blade A review of Resident Minimum Data Set recognitively impaired. under functions as to 2-person assistance | right side of head. One of 5 162) were reviewed for falls. mitted to the facility on es that included quadriplegia der. #62's 10/16/18 quarterly vealed the resident was Resident #62 was coded | | determined that staff did not provadequate supervision and assistate prevent accidents. Immediate: On 2/8/2019 care guide for reside was updated for the Certified Nur Assistants to indicate two person with incontinent care. On 2/26/2019 Certified Nursing A #5 was re-educated on reviewing following the resident □s care guident □s c | ent #62 rsing assist assistant and de ce | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--------------------------|--|--------------|--|---|-----|-------------------------------|--|
| | | | A. BUILDI | NG _ | | , | C | |
| | | 345449 | B. WING | | | 1 | 08/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| LININ/EDO | AL LIEALTH CAREWAND | | | 11 | 15 WHITE ROAD | | | |
| UNIVERSA | AL HEALTH CARE/KING | | | K | ING, NC 27021 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE | |
| F 689 | Continued From page | e 21 | F | 689 | | | | |
| | | | ' | 003 | Identification of Others: | | | |
| | diagnoses included r | n of brain, and aphasia. | | | All residents are at risk for the deficient | | | |
| | | #62's care plan dated | | | practice therefore effective 2/25/2019 a | | | |
| | | d 10/16/18 revealed the | | | 100% audit was conducted by the MDS | | | |
| | | anned for staff assistance for | | | Nurses to identify residents in need of the | | | |
| | | Living related to his limited | | | person assist while providing incontine | | | |
| | | ns on Resident #62's care | | | care. | | | |
| | | resident to have 2-person | | | 49 residents were identified for requiring | a 2 | | |
| | | ng and incontinence care. | | | assist with incontinent care. For each | 9- | | |
| | | 9 | | | resident identified, care guides were | | | |
| | A review of the facility | y's incident report dated | | | updated as of 2/25/19 to indicate two | | | |
| | | NA (Nursing Assistant) was | | | person assist with incontinence care. | | | |
| | | in bed for perineal care and | | | Systemic Changes: | | | |
| | the resident slid out of | of the bed and rubbed his | | | Effective 2/27/19, 100% of nursing staf | f | | |
| | shoulder and forearm | on the wall. It was reported | | | was re-educated by the Director of | | | |
| | Resident #62 receive | ed an abrasion to the right | | | Nursing and Assistant Director of Nursi | ng | | |
| | top of his head and ri | ight forearm. The resident | | | on following the residents□ care guide | | | |
| | | ut back in bed with 2-person | | | regarding the number of persons need | ed | | |
| | | #62's responsible party and | | | to provide assist with incontinent care. | | | |
| | | otified. A review of Resident | | | Care guides were updated for residents | | | |
| | | revealed a physician's order | | | identified as needing two person assist | | | |
| | dated 1/1/19 that ord | | | | with incontinent care. The nurses are t | | | |
| | | ent's right shoulder and right | | | include on the 24 hour report if there is | а | | |
| | side of head due to fa | all. | | | change in a resident s need for | | | |
| | D:- #00 | | | | assistance with incontinence care. | | | |
| | _ | of the right mandible with | | | Monitoring: | | | |
| | | o fracture or dislocation | | | The Director of Nursing/ Assistant | | | |
| | by the physician on 1 | Its were viewed and signed | | | Director of Nursing will monitor the 24 hour report daily during clinical meeting | . 5 | | |
| | by the physician on i | 74/19. | | | days per week (Monday □Friday) for a | | | |
| | A telephone interview | was conducted with NA #5 | | | residents with a change in assistance v | | | |
| | - | n 2/8/19 at 3:50pm. She | | | incontinence care. Monitoring will conti | | | |
| | | s providing incontinence care | | | on Saturday and Sunday by the charge | | | |
| | | /1/19 early in the morning. | | | nurse. This monitoring will be conducted | | | |
| | | d the resident turned on his | | | daily x2 weeks, then weekly x2, and the | | | |
| | | shing his buttocks and rectal | | | monthly x3 months. Findings will be | | | |
| | | her gloves were wet and the | | | reported to the monthly QAPI committee | e l | | |
| | · | ead and started sliding. She | | | for recommendations or modifications | | | |
| | | catch him but because he | | | until a pattern of compliance is achieve | d. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|--|----------------------------|-------------------------------|----------------------------|
| | | 345449 | B. WING | | | l | C 08/2019 |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP COD 115 WHITE ROAD KING, NC 27021 |)E | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE E APPROPRIA | | (X5) COMPLETION DATE |
| F 689 F 692 SS=D | the bed. She reported approximately 3 feet. was supposed to have Resident #62 but bed she thought she could only could move his hoften provided care to assistance prior to the An interview was con (Director of Nursing) reported it was her exassistants follow the assistants follow the formation (Includes naso-gastric both percutaneous error (Includes naso-gastric both percutaneous endoscenteral fluids). Based comprehensive assessensure that a residen \$483.25(g)(1) Mainta of nutritional status, sidesirable body weigh balance, unless the redemonstrates that this preferences indicate assistants. | gloves were wet, he slid off if the bed was elevated She reported she knew she e someone help her with ause he was "tiny and little," if manage. She reported he head. NA #5 reported she is Resident #62 without e fall. ducted with the DON on 2/8/19 at 5:50pm. She expectation that the nursing care plans of the residents. er expectation that the ind the unit manager make estants follow the care plans. Eatus Maintenance (-(3)) nutrition and hydration. It is and gastrostomy tubes, indoscopic gastrostomy and it on a resident's esment, the facility must the facility must the facility must the side of the resident's clinical condition is is not possible or resident otherwise; | | 692 | | | 3/4/19 |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--|--|-------------------------------|--|
| | | 345449 | B. WING | | C 02/08/2019 | |
| NAME OF PE | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 02/06/2019 | |
| | 10 7.52.1 0.1 00. 1 2.2.1 | | | 115 WHITE ROAD | | |
| UNIVERSA | AL HEALTH CARE/KING | | | KING, NC 27021 | | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION | |
| F 692 | Continued From page | e 23 | F 692 | 2 | | |
| | there is a nutritional provider orders a the | red a therapeutic diet when problem and the health care rapeutic diet. is not met as evidenced | | | | |
| | Based on observatio | ns, record review and staff | | F692 | | |
| | | ews, the facility failed to | | Root Cause Analysis | | |
| | | nt measures to address an | | Based on the root cause analysis by | | |
| | | ss for 1 of 4 (Resident #65) | | facility Administrative staff and the f | - | |
| | sampled residents re- | viewed for nutrition. | | Executive Director, the facility did no | | |
| | Findings included: | | | follow policy and procedure by failin put interventions in place for a resid having been identified with significa | ent | |
| | Resident #65 was ad | mitted to the facility on | | weight loss. | | |
| | 1/5/19 with diagnoses | s of, in part, right femur | | Immediate Action | | |
| | fracture, right wrist fra | acture and vascular | | On 2/16/2019 resident #65 was | | |
| | dementia. She was a | dmitted from hospital. She | | discharged from the facility | | |
| | was not in facility prior | | | Identification of Others | | |
| | Review of Resident # | 65's physician orders | | All residents are at risk for the defic | | |
| | | nd order was written for | | practice therefore on February 27, 2 | | |
| | | she was admitted on a | | 100% audit was completed by the D | | |
| | regular, no added sal | | | manager and the Registered Dietitia | I | |
| | | cord revealed on 1/6/19, | | residents on monthly and weekly we | | |
| | Resident #65 weighe | d 157 pounds. | | to identify any residents with signific | | |
| | December of the control of the contr | ad a Nutritional Corporing | | weight loss. If any resident was iden | | |
| | | ed a Nutritional Screening | | with significant weight loss the phys | | |
| | | ed 1/10/19 which indicated | | was notified, and an intervention wa | is put | |
| | | air appetite, consuming ls. Weight stable over last 6 | | in place. Systemic Changes | | |
| | | ember's report, usual body | | Effective March 1, 2019 The Dietary | , | |
| | - | 158 pounds, and ideal body | | Manager will review weekly and mo | | |
| | weight 130 pounds. | 100 pourids, and ideal body | | weights to identify any residents wit | | |
| | Troigitt 100 pourids. | | | significant weight loss. The dietary | " | |
| | A nutritional care plan | n note dated 1/10/19 written | | manager will place those residents | | |
| | | lled Resident #65's weight | | identified on the weekly standards of | of care | |
| | was 157 pounds. The | | | list to be reviewed by the IDT during | | |
| | | protein supplement twice a | | weekly standards of care meeting to | | |
| | | pass. The note specified the | | discuss interventions to put in place | | |
| | | or weight changes related to | | residents will be placed on the Dieti | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION IG | l\ / | E SURVEY PLETED |
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| | | 345449 | B. WING | | | C /08/2040 |
| NAME OF D | ROVIDER OR SUPPLIER | 0.01.0 | | STREET ADDRESS, CITY, STATE, ZIP COI | • | /08/2019 |
| NAME OF FI | ROVIDER OR SUFFLIER | | | | DE | |
| UNIVERSA | AL HEALTH CARE/KIN | G | | 115 WHITE ROAD | | |
| | | | | KING, NC 27021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 692 | Continued From pa | ge 24 | F6 | 92 | | |
| | use of therapeutic of above average bod plan. | liet, dementia, and weight y weight. Will proceed to care | | list to review during her next management will notified the Nurse Practitioner to inform of and approve interventions su | Physician/ of weight loss uggested. | |
| | Resident #65 was a | ition dated 1/10/19 revealed at risk for weight changes | | Effective February 27, 2019 Manager was in-serviced by | the Executive | |
| | | erapeutic diet, diagnosis of | | Director to report any resider | | |
| | | nt above average body weight. | | with significant loss to the Di | | |
| | | ion of significant weight loss | | Executive Director, and Nurs | | |
| | | date entry. The care plan goal ill eat at least 75% of all meals | | management weekly/monthly interventions are put in place | | |
| | through next review | | | future weight loss or to maint | • | |
| | _ | no significant weight changes | | Each resident identified must | - | |
| | _ | handwritten. Interventions | | on the weekly standards of c | • | |
| | _ | current listing of likes and | | list and the Dietitian list for re | _ | |
| | | vitamins as ordered, obtain | | Effective March 1, 2019 100 | | |
| | | as needed, encourage dining | | staff was in-serviced to repor | | |
| | | dietary recommendation add | | residents□ intake or the abili | | |
| | | otein supplement max twice a | | or any weight changes to nui | • | |
| | 1 | n pass for nutritional support. | | administration as soon as ide | - | |
| | - | | | Licensed staff to place on 24 | hour report | |
| | A review of an Adm | ission/5 day Minimum Data | | sheet. Nursing administratio | n will review | |
| | Set assessment da | ted 1/11/19 revealed Resident | | 24 hour report sheet daily du | ring clinical | |
| | #65 had severely in | npaired cognition. She was | | rounds. This education was p | provided by | |
| | assessed as being | independent with meals after | | the Director of Nursing/ Assis | | |
| | | wallowing disorder, was on a | | of Nursing, any staff not educ | cated will not | |
| | therapeutic diet, we | ighed 157 pounds and was 66 | | be allowed to work until educ | cated. This | |
| | inches tall. | | | education will also be added | to the new | |
| | | | | hire process. | | |
| | | 2/7/19 at 12:47 PM of | | Monitoring | | |
| | | lled she was sitting at a table | | Effective March 1, 2019 the I | | |
| | | oom with lunch tray in front of | | Nursing/ Assistant Director o | - | |
| | | nad only consumed bites of her | | Unit Manager will review the | | |
| | | observation on 2/7/19 at | | report to identify any resident | • | |
| | | PM revealed the activity | | intake, decrease in the ability | | |
| | | Resident #65 to eat. Resident approximately 75 percent of | | and weight changes during d meeting 5 days per week (M | | |
| | her meal. | approximately 73 percent of | | Friday). This Monitoring will | • | |
| | noi incai. | | | by the Charge nurses on Sat | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | , , | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|---|----------------------------|
| | | 345449 | B. WING _ | | | C 02/08/2019 |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CO 115 WHITE ROAD KING, NC 27021 | DE | 02/00/2013 |
| (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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 692 | revealed Resident #6 but did need assistant had good days and be friend would visit frequesident to eat. She seresident to eat in the in to visit, but someting Review of Resident #6 on 1/12/19 a weekly with documented which we percent significant we resident's previous we obtained on 1/6/19. Lab results of a Liver 1/7/19 revealed an all protein of 4.8. Norma 6.0-8.7, respectively. Review of Resident #7 revealed there were re physician orders writt significant weight lose Additionally, review of record revealed the Ferecommendation for the daily protein supplement On 2/7/19 at 9:32 AM dietary manager (DM of the weight that was on 1/12/19 which reflet loss from 1/6/19. She with the weekly weight the report weekly and weight, she requested | , an interview with NA #2 5 was able to feed herself, ce at times. She stated she ad days. The family or family uently and assist the tated she encouraged the dining room if no one came nes she refused to go. 65's weight record revealed weight of 146.8 pounds was as a 10.2 pounds or 6.5 eight loss since the eight of 157 pounds Function Panel collected on bumin of 2.5 and a total I lab values are 3.5-5.2 and 65's medical record no nutritional interventions or en to address the resident's from 1/5/19 to 1/12/19. If the resident's medical | F 6 | Sundays. The Dietary manager will mot/monthly weights to identify a significant weight loss and weight intervention is put in place. The monitoring will be conducted weeks, then weekly x2 week monthly x3. Findings will be monthly to the QAPI commit recommendations or modificing pattern of compliance is achieved. | residents with erify an This I daily x2 as, then reported tee for eations until a | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | ` ' | DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------------------|---|-------------|----------------------------|--|
| | | 345449 | B. WING _ | | | C 02/08/2019 | |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP COD 115 WHITE ROAD KING, NC 27021 | E ' | 1 02/00/2013 | |
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| F 692 | resident's weight loss interventions were im Resident #65's weight 1/6/19 to 1/12/19. On 2/6/19 at 11:20 A Nursing (ADON) was weights were done of 2019, the facility initial admission. Nursing a residents' weights an on the hall to enter in if there was a 3 poun obtained. If the weight physician was notified interventions could be Review of Resident # on 1/19/19 a weekly on 2/6/19 at 12:40 Printerviewed. Nurse # the E/F halls on 1/19/19 resided. She stated the resident weights or the supervisor to experience. The 14 day MDS dat 157 pounds. Review of Resident # Review of Review | the physician to stop the streephysician to stop the computer of the streephysician to the streephysician to the streephysician to the computer. She stated diversion to the computer. She stated diversion to the computer. She stated diversion to streephysician to the streephysician to streephysician to the streephysician to st | F 6 | , , , , , , , , , , , , , , , , , , , | | | |
| | which equates into a weight loss since 1/6 | | | | | | |
| | A review of meal per | centages from 1/6/19 to | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|-------------------------------|----------------------------|
| | | 345449 | B. WING _ | | | C 02/08/2019 |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | | 02/00/2013 |
| (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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 692 | between 50-75% of h On 2/7/19 at 9:14 AM interviewed. She state #65 and that she was on weekly weights. S report when she roun Manager would notify changes related to we she would ask the face she didn't get the info #65 's weight loss ide no weekly weight was on 1/19/19. The RD of were implemented to weight loss which beg when a house shake On 2/7/19 at 9:32 AM revealed on 1/29/19 se dietician and saw Res spoke with the reside several things listed to Resident #65 to eat of DM updated the reside several things listed to Resident #65 to eat of DM updated the reside several things listed to Resident #65 to eat of DM updated the reside several things listed to Confirmed no interver address Resident #65 on 1/12/19 until 1/30/ ordered. On 2/7/19 at 3:48 PM conducted with the re stated she didn't have front of her but wasn't experienced weight to | #65 revealed she consumed er meals. I, the dietician was ed she didn't recall Resident in't sure if the resident was he stated she would get the ded monthly and the Dietary her of any significant eekly weights. She stated stility's risk committee why immation regarding Resident intified on 1/12/19 and why sobtained for Resident #65 confirmed no approaches address the resident's gan on 1/12/19 until 1/30/19 supplement was ordered. I, an interview with the DM she rounded with the sident #65. She stated she int's family member who had hat she did not want flue to her bowel trouble. The lent's tray card. The DM also intions were implemented to 5's weight loss which began 19 when a house shake was esident's physician. She are Resident #65's chart in the taware she had loss. She stated she | F6 | 92 | | |
| F 760 | expected to be notified Residents are Free o | d of a weight loss. f Significant Med Errors | F 7 | 60 | | 2/8/19 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|---|--|
| | | 345449 | B. WING | | C 02/08/2019 | |
| | ROVIDER OR SUPPLIER | 3 | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | 02/00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION | |
| F 760 SS=D | Continued From pag CFR(s): 483.45(f)(2) The facility must ens | | F 760 | | | |
| | §483.45(f)(2) Resided medication errors. This REQUIREMENT by: Based on record revelemergency medical sinterviews, and emer Physician interview, significant medication physician orders to a for 1 of 4 (Resident Freviewed for insuling administering 58 unit which was ordered to did not make sure Rebreakfast meal. As a became unresponsive hospital. She required intubation. Resident hospital admission or respiratory failure, all hypothermia (low both hypoglycemia (low both hypoglyce | ants are free of any significant T is not met as evidenced view, staff interviews, service (EMS) personnel regency department (ED) the facility failed to prevent a n error by not following administer insulin with meals #192) sampled residents administration. Prior to ts of Novolog 70/30 Insulin, to be given with meals, staff the esident #192 had eaten her the result, Resident #192 the and was admitted to the the da central line and #192's final diagnoses for in 1/25/19 were acute tered mental status, dy temperature), and | | F760 Root Cause Analysis Based on the root cause analysis by the facility's administrative staff, it was determined that the staff administered Novolog 70/30 insulin to resident #192 with the order reading to give with me Resident #192 did not eat her breakfarmeal. Immediate Action: Resident #192 was sent to the emerg room for evaluation and treatment. Resident #192 was admitted to the hospital and did not re-admit to this facility. Identification of Others: 100% of resident's medication orders were completed by the DON/ ADON of 2/7/19 and 2/8/19 to identify any other resident with any insulin order that ne to be given with meals. The audit concluded there were eight other residents identified with orders for insite to be administered with meals. Attending hysician for these eight identified residents was contacted and approve of these orders to be given with any for to include a meal or snack between meals. Those orders were clarified to given with food as of 2/8/19. | als. als. ency on reded ulin ling d all bod | |

PRINTED: 07/08/2019 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOR MEDICARE & MEDICAID S | | MEDICAID SERVICES | | | OMB | DMB NO. 0938-0391 | | | |
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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | IPLE CONSTRUCTION | , , | ATE SURVEY OMPLETED | | | |
| | | 345449 | B. WING _ | | | C 02/08/2019 | | | |
| NAME OF PI | ROVIDER OR SUPPLIER | I | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CO | | 02/00/2010 | | | |
| | | | | 115 WHITE ROAD | | | | | |
| UNIVERSA | AL HEALTH CARE/KING | | | KING, NC 27021 | | | | | |
| 0(0)15 | CLIMMADV CT | ATEMENT OF DEFICIENCIES | | | CORRECTION | (V5) | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | | | |
| F 760 | Continued From page | ÷ 29 | F 7 | 760 | | | | | |
| | · - | an orders for Resident #192 | ' ' | | | | | | |
| | | ed on 1/23/19 for Finger | | Systemic Changes: | | | | | |
| | · | SBS) checks before meals & | | Effective 2/8/19 and moving | forward the | | | | |
| | at bedtime. There wa | | | facility licensed nurse will no | | | | | |
| | administer 58 units su | | | insulin for any resident with | | | | | |
| | | ayer between the skin and | | given with food when a resid | | | | | |
| | | ith meals of Novolog 70/30. | | his/ her food. Facility license | | | | | |
| | According to the man | ufacturer, Novolog 70/30 is | | notify the physician when a | resident with | | | | |
| | | ade fast-acting insulin to | | ordered insulin to give with t | | | | | |
| | • | spikes in blood sugar and | | food and document the phys | | | | | |
| | | at works up to 24 hours to | | decision in the resident's me | | | | | |
| | | gar between meals. The | | before the insulin is adminis | | | | | |
| | _ | nes stated that people with | | Effective 2/8/19 and moving | | | | | |
| | | d have the injection within after starting their meal. | | DON/ ADON or nurse super review any new insulin orde | | | | | |
| | 13 minutes before of | arter starting their mear. | | 24 hours to ensure that each | | | | | |
| | Resident #192's Janu | ary 2019 medication | | an order for insulin has an ir | | | | | |
| | | (MAR) revealed Resident | | whether it needs to be giver | | | | | |
| | | M scheduled FSBS check on | | not, and validate that license | | | | | |
| | 1/25/19 at 6:37 AM a | nd the result was 109 | | administer those orders as s | specified by | | | | |
| | milligrams/deciliter (m | ng/dl). The Novolog 70/30 | | the physician. | | | | | |
| | | eduled for 9:00 AM was | | The facility DON/ ADON and | | | | | |
| | | nistered on 1/25/19 at 10:24 | | complete 100% education for | | | | | |
| | AM by Nurse #2. | | | nurses to include full time, p | | | | | |
| | A | l | | as needed staff. The emph | | | | | |
| | According to the mea | i percentage sneet, t eat anything for breakfast | | education will be on the imp | | | | | |
| | or lunch on 1/25/19. | t eat anything for breaklast | | administering medication as the physician and in a timely | • | | | | |
| | or fuller on 1/25/19. | | | any medication specifically i | | | | | |
| | During an interview w | rith Nurse Aide (NA) #6 on | | education also emphasized | | | | | |
| | 2/6/19 at 4:46 PM abo | | | responsibility of the licensed | | | | | |
| | | take on 1/25/19, she stated | | notify the physician when a | | | | | |
| | | on the bedpan several times | | ordered insulin to be given v | | | | | |
| | | t she had refused breakfast. | | refuses their food. The edu | | | | | |
| | | tified the nurse of the | | emphasizes the need to do | cument the | | | | |
| | | at breakfast, she stated | | physician's decision in the n | | | | | |
| | Nurse#2 was made a | ware. | | The education was complete | • | | | | |
| | | | | This education will be added | d to the new | | | | |

During an interview with Nurse #2 on 2/7/19 at

hire orientation process for all new

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER (X2) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE | LETED |
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| 345449 B. WING 02/0 | |
| 345449 B. WING 02/0 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | |
| UNIVERSAL HEALTH CARE/KING 115 WHITE ROAD | |
| KING, NC 27021 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 760 Continued From page 30 1:17 PM she stated that at approximately 10:00 AM she went into Resident #192's room to administer medications and she was at baseline with no altered mental status. Nurse #2 stated she knew she did not eat her breakfast and had tried to get her to eat something at that time, but the resident retixed any food. When asked if she gave her the full dose of Novolog 70/30 insulin when she knew the resident had not eaten breakfast, she stated that she did. She stated she had gone into Resident #192's room at approximately 12:00 PM to check her blood sugar and found her unresponsive. Nurse #2 stated she couldn't wake Resident #192's pand checked her blood sugar with a result of 189 mg/dl. She stated she applied oxygen, checked vital signs, notified the DON, and EMS was called to transfer the resident to the hospital. She stated that she checked the resident's pupils and they were fixed and dilated. A progress note dated 1/25/19 at 6:43 PM written by Nurse #2 stated she entered Resident #192's room at 12:15 PM and found Resident #192's room at 12:15 PM and Fou | |

| . , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | DNSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 345449 | B. WING _ | | | 1 | C (08/2019 |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | 115 | EET ADDRESS, CITY, STATE, ZIP CODE WHITE ROAD G, NC 27021 | , , , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 760 | | e 31 inistered or blood sugar | F | 760 | | | |
| | 1/25/19 revealed the facility to be unrespondocumented that the unresponsive by staff that the resident was AM, her vital signs we glucose was 129 mg/level documented by mg/dL. At 1:09 PM Dhypertonic solution of chemically identical to administered. At 1:13 glucose was 273 mg/glucose was 110 mg/glucose was 110 mg/received by the hospinate of the facility by EMS glucose of 23 mg/dL. admission on 1/25/19 26 mg/dL. The resident catheter placed into a medications or draw left 2:52 PM for acute respondent of the composition o | and it was reported to EMS last seen normal at 11:00 ere all normal, and her blood dL. The first blood glucose EMS at 1:05 PM was 23 extrose 50% (D50 - a dextrose, simple sugar or glucose) 25 grams was 3 PM the resident's blood dL. At 1:30 PM her blood dL. At 1:30 PM her blood dL. Resident #192 was tal ED staff at 1:45 PM. Poort from 1/25/19 dent was found unresponsive and EMS obtained a blood Triage Lab results from ED at 2:48 PM were Glucose ent required a central line (a large vein to give ab work) and intubation at | | | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE | | | COMPLETED | | |
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| | | 345449 | B. WING | | | C 02/08/2019 |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | · | 02/06/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 760 | Resident #192 involved insulin dose and not diabetes mellitus (ID insulin dose and not diabetes mellitus (ID insulin dose and not diabetes mellitus (ID insulin dose and not dose not eat on orier dose not eat on orier nurses are educated receiving insulin indimedication administry withhold insulin if medication administer of administered. During an interview with a medication administered. During an interview with a medication administered if a medication interview with a medication and interview with a medication administry with a medication administry with a medication administry with a medication administry with a medication and interview w | PA) #1 and Hospital ted problems addressed for ring her insulin dependent DM) were "likely related to eating." on 2/7/19 at 3:35 PM the Staff mator stated NAs are go the nurse when a resident retation and as needed. It to look at each resident ridually during each ation and were educated to als were not consumed. It the resident does not eat a lithat the nurse call the reders before insulin is with the facility Pharmacist on the stated she would have to hold all short acting insuling the arrows 109 at 6:27 AM, and the glucagon administered, the stated in the service of the stated inconsistent. To/30 is used to regulate and rels for residents with the set of action within 10-20 acting and the medication | F 76 | 60 | | |
| | blood sugar and tran | ent with Resident #192's low sfer to the ED and her ikely contacted for transfer if she expected the nurse to | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | 7 50.25 | _ | | (| |
| | | 345449 | B. WING _ | | | 02/ | 08/2019 |
| | ROVIDER OR SUPPLIER AL HEALTH CARE/KING | | | 11 | TREET ADDRESS, CITY, STATE, ZIP CODE 15 WHITE ROAD LING, NC 27021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 760 | most residents in the the time. When asker to check another blood administering insuling and no food was consisted did not fault the minsulin without food. The sident had been recommended for a long period reason on that particular reaction to the insuling the insuling administer in the past without the Label/Store Drugs and CFR(s): 483.45(g)(h)(s) \$483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the examplicable. §483.45(h) Storage of \$483.45(h)(1) In accordance professional principles appropriate accessory instructions, and the examplicable. §483.45(h)(1) In accordance professional principles appropriate accessory instructions, and the examplicable. | ent did not eat, she stated nursing home don't eat all dif she expected the nurse of sugar prior to eafter a 4-hour time period sumed, she stated yes but turse for administering the She stated most likely the ceiving this ordered insuling the stated and for whatever allar day she had an adverse to the best that dose without food the same effect. In discologicals (1)(2) If Drugs and Biologicals to the sum of the facility must be the with currently accepted to the sy and cautionary expiration date when the state and sumpartments under proper and permit only authorized | | 760 | | | 3/4/19 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION IG | | ATE SURVEY OMPLETED | | | |
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| NAME OF P | ROVIDER OR SUPPLIER | 0.01.0 | | STREET ADDRESS, CITY, STATE, ZIP | | 02/08/2019 | | | |
| NAME OF T | NOVIDEN ON 3011 LIEN | | | | CODE | | | | |
| UNIVERSA | AL HEALTH CARE/KIN | G | | 115 WHITE ROAD | | | | | |
| | | | | KING, NC 27021 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | | | |
| F 761 | Continued From pa | ge 34 | F 7 | 761 | | | | | |
| | abuse, except wher | n the facility uses single unit | | | | | | | |
| | | bution systems in which the | | | | | | | |
| | | inimal and a missing dose can | | | | | | | |
| | be readily detected. | _ | | | | | | | |
| | | NT is not met as evidenced | | | | | | | |
| | by: | | | | | | | | |
| | Based on observat | tions and staff interviews, the | | Ftag 761 | | | | | |
| | | e one opened vial of tuberculin | | Root Cause Analysis | | | | | |
| | | storage room. The facility | | Based on root cause ana | • | | | | |
| | | ain correct refrigerator | | facility administrative staff | | | | | |
| | | 1 medication refrigerator in | | determined the facility fail | | | | | |
| | the medication stor | age room. | | facility□s policy for medic | ation storage | | | | |
| | Findings include: | | | and labeling. | | | | | |
| | | was made on 2/8/19 at 9:50 | | Immediate: | undated anamad | | | | |
| | | of the medication storage | | On February 8, 2019 the vile of tuberculin was rem | • | | | | |
| | an opened vial of tu | was observed that there was | | refrigerator and discarded | | | | | |
| | | onducted with Nurse #13 on | | refrigerator temperature v | | | | | |
| | | She reported all medication | | maintain a temperature b | | | | | |
| | | be dated and labeled. She | | degrees according to faci | | | | | |
| | | responsibility of whoever | | Identification of others: | , p, | | | | |
| | opened the vial to o | · · | | All residents are at risk fo | r deficient | | | | |
| | - | onducted with the DON | | practice. On February 18, | , 2019 a 100% | | | | |
| | (Director of Nursing | ı) on 2/8/19 at 5:55pm. She | | audit of the medication re | frigerator , | | | | |
| | reported it was her | expectation that all opened | | medication storage room, | , and each | | | | |
| | medications in the r | medication storage refrigerator | | medication cart was cond | lucted by | | | | |
| | should be labeled a | and dated. | | pharmacy any medication | ns not dated | | | | |
| | | medication refrigerator | | when opened were remov | | ed | | | |
| | | February 2019 revealed the | | discarded. The refrigerate | | | | | |
| | | ratures were logged daily at | | verified to maintain a tem | • | | | | |
| | | erature readings were 2/8/19: | | between 36 to 46 degrees | s according to | | | | |
| | | renheit), 2/7/19: 32 degrees F, | | policy. | | | | | |
| | 2/6/19: 32 degrees | F, 2/5/19: 28 degrees F. | | Systemic Changes: | 1000/ of licensed | | | | |
| | A rovious of the man | oufacturing recommendations | | Effective March 1, 2019 1 | | | | | |
| | | nufacturing recommendations | | nurses and medication ai | | | | | |
| | | dal, Tuberculin, and insulin edications should be stored | | re-educated by the Direct Assistant Director of Nurs | | | | | |
| | | s and 46 degrees Fahrenheit. | | Staff Development Coord | - | | | | |
| | | s made on 2/8/19 at 9:50 am | | facility □s policy on medic | | | | | |
| | , oboo. valion was | ,aab on <u>-</u> , o, 10 at 0.00 am | 1 | idonity to policy of illicult | andir otorage | 1 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | N (X3) DATE SUR COMPLETE | |
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| | | | | _ | | (| |
| | | 345449 | B. WING _ | | | 02/ | 08/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 11 | 15 WHITE ROAD | | |
| UNIVERSA | AL HEALTH CARE/KING | | | K | ING, NC 27021 | | |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 761 | refrigerator. The meditemperature was noted observed that 3 Trulio 0.75mg(milligrams)/0 diabetes mellitus meditype material on them observed to contain 2 vials, 2 boxes of Rispivials of Tuberculin. It Trulicity, Risperdal, Tpackaging information be stored between 38 Fahrenheit. An interview was conwith Nurse #13. She responsible for check temperatures every crefrigerator temperature temperature that the below. An interview was conwith the conversal of the should be below 41 of the temperature was but if the medication concern. She reported found frozen, it would immediately. An interview was conwordered to concern. She reported found frozen, it would immediately. An interview was conwordered to concern. She reported found frozen, it would immediately. An interview was conwordered to consultant on 2/8/19 all medication refrige and 41 degrees. She as insulin, Trulicity, a stored at 32 degrees | e medication storage room lication refrigerator ed to be 30 degrees. It was city .5ml(milliliters) (type 2 dication) pens had a frosty n. The refrigerator was 25 insulin pens, 5 insulin perdal filled syringes, and 4 was observed on the ruberculin and insulin n that the medication should degrees and 46 degrees ducted on 2/8/19 at 9:50 am reported she was king the refrigerator lay. She reported the lure should be below 41 and there was no set refrigerator should not fall aducted with the ADON in Nursing) on 2/8/19 at 10:45 in refrigerator temperature legrees. She reported that occasionally below freezing was not frozen there was no diff any medication was if be disposed of ducted with the Pharmacy at 12:38pm. She reported rators should be between 34 reported medications such and Risperdal should not be | F 7 | 761 | and labeling. Nursing staff was educate to document any findings of undated opened medications and out of range refrigerator temperatures on the 24 hor report, discard undated opened medications, reset refrigerator temperature to maintain a range of 36 46 degrees and to document in the maintenance book. Monitoring: The Director of nursing and/or Assistar Director of nursing will review the 24 hor report and verify refrigerator temperatuduring clinical meeting 5 days per weel (Monday Friday). Findings will be documented on the clinical report form Monitoring will continue on Saturday as Sunday by the charge nurse. This monitoring will be conducted daily x two weeks, then weekly x2, and monthly formonths. The Director or nursing, Assist Director of nursing and/or designated licensed nurse will audit medication can medication room and medication room refrigerator for expired/ undated items weekly x 4 weeks and then monthly thereafter. The monthly audits will be a ongoing monitoring process. Findings were ported to the monthly QAPI committee meeting for recommendatio or modifications until a pattern of compliance is maintained. | to tto tto tto res ra ant rts/ | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED C 02/08/2019 | |
|--|--|---|--|---|--|--|--|
| | | 345449 | | | | | |
| NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/KING | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 761 | reported it was her ex medication refrigerate above 41 degrees or reported she was not | ducted with the DON on 2/8/19 at 5:55pm. She | F 7 | 761 | | | |