STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		HAL001002	B. WING		03	8/02/2017
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
BURLING	TON CARE CENTER		RCH BRIDGE ROA GTON, NC 27217	D		
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 000	Initial Comments		D 000			
	The Adult Care Licen annual and follow-up	sure Section conducted an survey on 3/02/17.				
D 345	10A NCAC 13F .100	2(b) Medication Orders	D 345			
	10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility					
	interviews, the facility orders and oxygen/re were maintained in th	as evidenced by: ns, record reviews and y failed to assure medication espiratory therapy treatments ne resident's records for 2 of (#3 and #1.) The findings				
	Resident #3 revealed Hypertension, Diabet Gastro-esophageal r	rent FL-2 dated 12/02/16 for d diagnoses of Anxiety, tes Mellitus II, eflux Disorder, Hypothyroid, ase, Bipolar and Mood				
	Xarelto 20mg with dii vein thrombosis.); Se constipation; America day for muscle pain; as a mineral supplem every 12 hours for pa times per day used for	a the current FL-2 included nner. (Used to treat deep enna as needed for aine Cream three times per MagOx 400mg daily (Used nent.); Lidocaine 5% patch ain; Lyrica 150 mg three or muscular pain; Metoprolol ed to control high blood				
	Review of the March	2007 medication				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		BERTH TO/TTOIT TOIT TOIT DETC.				
		HAL001002	B. WING		03	R 3/02/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
BURLING	TON CARE CENTER		IRCH BRIDGE ROA GTON, NC 27217	D		
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D 345	Continued From page 1		D 345			
	administration records (MAR) for Resident # 3 revealed none of these medications were listed for administration.					
	Review of Resident #3's medications on hand revealed there were no medications available for administration of these medications.					
		#3's record revealed there lese medication to be				
	Administration Recommedications were list follows: - Metformin 500mg 2 minutes before meal	#3's March 2017 Medication rd revealed these ted for administration as 2 tablets twice daily 30 s. (Used to control blood				
	500mg was administ meals.	entation that Metformin ered twice daily before rery 6 hours as needed for				
	pain. - The Tramadol had administered.	not been documented as ree times per day as needed				
	with no reason for us to treat and prevent	se listed. (Sucralfate is used ulcers.) umentation Sucralfate had				
	Review of medication Metformin 500mg, Tr Sucralfate 1 gm. wer administration.	ns on hand revealed ramadol 50mg and				
	were no orders in the	esident #3 revealed there e resident's record for the Metformin, Sucralfate and				

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If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		BERTH TO ATTOT TO MELLA.	A. BUILDING:			
		HAL001002	B. WING		03	R 3/02/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
BURLING	TON CARE CENTER		IRCH BRIDGE ROA	D		
	-	BURLIN	GTON, NC 27217			
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D 345	Continued From pag	e 2	D 345			
	Tramadol.					
	 twice daily and knew available for the resider She thought orders medications. The resident had a cream use but he dider She or the nurse we obtained for the med She did not know we discontinuation order not in the records. She and the nurse ensure orders were the sensure orders were the	aled: red the Metformin 500mg the Tramadol 50mg was dent's pain. s were in the record for these a self administration for some d not use it any more. yould ensure orders were ication administered. why some of the rs for these medication were were to check records to				
	she did not know wh - Some orders were visit.	y they were not in the record. from an emergency room				
	and ensure they were	or the mission missing orders e in the records.				
	No missing medication the end of the survey	on orders were provided by /.				
	revealed diagnoses of Pulmonary Disease, Type II Diabetes Mel	rent FL-2 for Resident #1 of Chronic Obstructive Obstructive Sleep Apnea, litus, Systolic Heart Failure, n, and Schizophrenia.				
	Observation on 3/02/ Resident #1 in his ro - Oxygen concentral alth Service Regulation					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
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	-	BURLIN	GTON, NC 27217			
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D 345	Continued From pag	e 3	D 345			
	nasal cannula and tubing were attached. - A very large oxygen tank poorly stablized was standing between the two closets in the room.					
	Interview on 3/02/17 at 9:20 a.m. with Resident #1 revealed: - He used his oxygen at night and managed to adjust it to the level that worked for him by himself.					
	needed. - The oxygen tanks oxygen concentrator	rgen level to 2 liters or more if in the room were in case the did not work. ea and used a nebulizer as				
	supervisor revealed: - Resident #1 requir were to adjust the lev	ed oxygen at night and staff				
	treatment either by s by the resident. - There was not an o	esident #1 revealed: rent orders for the oxygen taff or by self administration order for continuous positive AP) treatment orders for				
	Professional Support 1/02/17 revealed Res	ecent Licensed Health t (LHPS) review dated sident #1 had LHPS tasks of ebulizer, Oxygen and Finger hecks.				
	p.m. revealed:	cility nurse on 3/02/17 at 3:40 orders may be missing since				

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		HAL001002	B. WING		03	02/2017
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URLING	TON CARE CENTER		IRCH BRIDGE ROAI GTON, NC 27217	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 345	Continued From page 4		D 345			
	 She would look for CPAP and Oxygen. She would discuss self adjusting the oxy 	rom their sister facility. the treatment orders for a with the resident about not ygen concentrator. orders were provided by the				

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