STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal002004	A. BUILDING: _____ B. WING _____	R 10/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDER ASSISTED LIVING	3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a follow-up survey and complaint investigation on October 9-11, 2017. Alexander County Department of Social Services initiated the complaint investigation on September 23, 2017.	D 000		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to protect all food being stored, prepared, and served by the facility from contamination. The findings are: Observation on 10/9/17 at 9:55am of the kitchen revealed: -No staff members were in the kitchen. -There was a 5 pound pack of ground beef wrapped in clear plastic paper partially submerged in a bowl of water in the prep sink. -Water was dripping slowly out of the faucet onto the ground beef. -There was no overflow of water from the bowl. Observation on 10/9/17 at 10:00am of a refrigerator in the kitchen revealed: -There was a 5 pound plastic container labeled	D 282		

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D 282	Continued From page 1 chicken salad with "use by 11/29/17" stamped on the lid. One serving had been removed from the container. There was no date the container was opened. -There was plastic pack labeled smoked sliced turkey breast in a clear plastic bag. There were three hand written dates on the bag, 9/12, 9/17, and 9/27. There was no hand written year. -There was a 5 pound plastic container labeled deli salad with "use by date of 10/1/17" stamped on the lid. A hand written date of 10/8 with no year was on the lid. -There was a 5 pound plastic container labeled potato salad with "use by date of 4/8/17" stamped on the lid. A hand written date of 9/20 with no year was on the lid. There was an orange substance with pudding like consistency inside the container. -There was a second 5 pound plastic container labeled potato salad. Two hand written dates of 9/20 and 9/25 with no year were on the lid. There was no visible use by date stamped on the lid. -There was a third 5 pound plastic container labeled potato salad. One hand written date of 9/29 with no year was on the lid. There was no visible use by date stamped on the lid. Observation on 10/9/17 at 10:05am of the freezer in the kitchen revealed: -There was a large clear open plastic bag with frozen biscuits -There was no date opened on the bag. -One third of the biscuits were exposed. Review on 10/10/17 of the Food Establishment Inspection Report dated 8/23/17 revealed a corrective action to have a person-in-charge who had completed an American National Standards Institute (ANSI) approved food safety managers course.	D 282		

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D 282	Continued From page 2 Interview on 10/9/17 at 10:15am with the Cook revealed: -The kitchen staff washed the plastic container lids of prepared salad and reused them. -The kitchen staff "generally" would keep the salads for 4 days before throwing them out. -The Cook had "meant to" throw out the salads and the frozen biscuits. -Frozen meat was put in a bowl of water to thaw it out. -Tap water from the faucet was left dripping on the meat. -The Cook did not know what the temperature of the water should be. -He was not sure who told him to thaw meat this way. -The Cook had been employed at the facility for two years. -The Cook had "no training from the people here". -The Cook had no food service training before his employment here. Interview on 10/10/17 at 9:40 with the Administrator revealed: -The Cook had been hired on 9/14/15. -The Cook had no prior food service training. -The Administrator trained the kitchen staff. -The Administrator had oversight of the kitchen. -The Administrator was in the facility five days per week. -The Administrator monitored "what's going on in the kitchen". -No one had food service training by anyone outside of the facility. -The Administrator expected items in the refrigerator to be thrown away in 3 to 4 days after opened. -The Administrator did not know the correct procedure to thaw out frozen meat.	D 282		

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D 282	Continued From page 3 Telephone interview with the local county Health and Sanitation staff on 10/11/17 at 9:30am revealed: -Only seafood should be thawed under running water. -Other foods should be thawed in the refrigerator and kept at 41 degrees F while thawing. Review of the personnel record for the Cook, Staff E, who worked on 10/9/17 revealed: -He was hired on 9/14/15. -There was no documentation he had completed the Food Service Orientation Training.	D 282		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure at least a three-day supply of perishable food and a five-day supply of non-perishable food was in the facility based on the menus for regular, no concentrated sweets, and vegetarian therapeutic diets. The findings are: Observation of the food supply at 9:30am on 10/9/17 compared to the facility's menu for Week	D 285		

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D 285	Continued From page 4 3 revealed the facility did not have the following perishable and non-perishable items for residents on a no concentrated sweets diet, regular diet, and a resident on a vegetarian diet: A. No Concentrated Sweets Menu: -Breakfast on 10/9/17: seasonal fruit -Lunch on 10/9/17: egg roll -Dinner on 10/9/17: sugar free fruited gelatin -Dinner on 10/10/17: field peas and snaps/crowder -Lunch on 10/11/17: sugar free ice cream -Dinner on 10/11/17: greens, seasonal fruit -Lunch on 10/12/17: sugar free cake -Dinner on 10/12/17: mushrooms, breaded vege sticks, seasonal fruit B. Vegetarian Menu: -Breakfast on 10/9/17: veggie sausage gravy, seasonal fruit -Lunch on 10/9/17: stir fry with tofu, egg roll -Dinner on 10/9/17: black bean burger -Breakfast on 10/10/17: veggie sausage -Dinner on 10/10/17: veggie sausage sloppy joe, field peas and snaps/crowder -Breakfast on 10/11/17: veggie sausage patty -Lunch on 10/11/17: veggie burger -Dinner on 10/11/17: tofu pot pie, seasonal fruit, greens -Breakfast on 10/12/17: veggie sausage -Lunch on 10/12/17: tofu alfredo -Dinner on 10/12/17: veggie patty, mushrooms, breaded vege sticks, seasonal fruit -Breakfast on 10/13/17: veggie sausage -Lunch on 10/13/17: veggie burger, lemon pudding C. Regular Menu: -Breakfast on 10/9/17: seasonal fruit -Lunch on 10/9/17: egg roll	D 285		

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D 285	Continued From page 5 -Dinner on 10/10/17: field peas and snaps/crowder -Dinner on 10/11/17: greens, seasonal fruit -Dinner on 10/12/17: mushrooms, breaded vege sticks, seasonal fruit -Lunch on 10/13/17: lemon pudding Interview on 10/9/17 at 10:15am with the Cook revealed: -The Cook had been employed at the facility for two years. -The Cook had "no training from the people here". -The Cook had no food service training before his employment at the facility. Interview on 10/10/17 at 9:00am with a second Cook revealed: -The Administrator ordered the food for the kitchen. -She was not aware of the three day and five day rule. -Most of the time she just gave the vegetarian side items. Interview on 10/10/17 at 9:40am with the Administrator revealed: -The Administrator, the Cook, and the Resident Care Coordinator would "go over" what food items needed to be ordered. -The Administrator "just missed" ordering tofu and vege burgers for the vegetarian diet menu. -He would order the missing items.	D 285		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional	D 310		

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D 310	Continued From page 6	D 310		

supplements and thickened liquids, shall be served as ordered by the resident's physician.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

Non-compliance continues with increased severity resulting in serious physical harm.

This is a TYPE A2 VIOLATION.

Based on observations, interviews, and record reviews, the facility failed to ensure all therapeutic diets for 6 of 6 sampled residents (Resident #3, #5, #9, #10, #11, and #12) were served as ordered related to puree, honey thick liquids, no concentrated sweets, vegetarian, lactose free, and chopped meat diet orders.

The findings are:

A. Review of Resident #5's current FL2 dated 8/9/17 revealed:
-Diagnoses that included mental retardation, chronic obstructive pulmonary disease, diabetes mellitus, obesity, psoriasis, gout, and osteoarthritis.
-There was a physician order for pureed diet and honey thick liquids.
-There was an order for oxygen at 2L per minute as needed.

Review of the therapeutic diet list for residents dated 7/28/17 posted in the kitchen revealed Resident #5 was to be served a pureed diet with honey thick liquids.

Review of the facility's weekly therapeutic diet

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D 310	Continued From page 7 menu book on 10/9/17 revealed all pureed food should be a creamy mashed consistency. Review of a thickening powder instant food and beverage thickener chart on 10/9/17 posted in the kitchen revealed to thicken 8 ounces of tea or coffee to honey consistency add 8-10 teaspoons of the thickener. Review of the facility menu book on 10/9/17 for the puree diet revealed the lunch menu was to be one serving of pureed stir fry with cabbage, 1/2 cup pureed fried rice, 2/3 cup pureed egg roll, 3/8 cup pureed mandarin oranges, and 1/3 cup pureed roll. Observation on 10/9/17 at 12:10pm of the lunch meal revealed: -Resident #5 was served one serving of pureed rice, one serving of applesauce, one serving of pureed chicken, and one serving of ground cabbage with dime sized visible pieces of cabbage, one 16 oz cup of tea with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency. Surveyor entered the kitchen on 10/9/17 at 12:13pm to inform staff of Resident #5's ground cabbage was not a pureed consistency and the liquids did not appear honey consistency. Observation on 10/9/17 from 12:15pm to 12:30pm of the lunch meal of Resident #5 revealed: -Resident #5 was seated in front of meal, coughing forcefully, short of breath, and face was purple in color. -There were two staff members standing next to Resident #5. -Resident #5 was removed from the dining room	D 310		

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D 310	Continued From page 8 at 12:30pm. Interview on 10/9/17 at 12:30pm with the cook revealed: -He knew Resident #5 was on a pureed diet with honey thick liquids. -He thought the cabbage was blended enough. -He "made it" like he always did. -He thought Resident #5 had put corn bread in her cabbage. -He used the chart on the wall for the thickening instructions. -He had put 5 teaspoons in the coffee cup and 9 teaspoons in the tea cup. -He thought the coffee cup was about 4 ounces and the tea cup was about 8 ounces. -He used the measuring device from the thickening powder to thicken the liquids. -He thought Resident #5 had added milk to her coffee. -He had no food service training. -He had "no training from the people here". Interview on 10/9/17 at 1:30pm with the Resident Care Coordinator (RCC) revealed: -Resident #5 was placed on 2L of oxygen and her oxygen saturation was 90%. -The doctor had been notified of Resident #5's coughing. -Resident #5 had been taken by EMS to the emergency room at 1:15pm. Attempted telephone interview on 10/9/17 at 4:15pm and 10/10/17 at 8:37am with Resident #5's guardian was unsuccessful. Interview on 10/10/17 at 8:45am with a facility Medication Aide revealed: -She always gave Resident #5 her medications crushed with regular (not thickened) water.	D 310		

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D 310	Continued From page 9 -She was aware Resident #5 was on honey thick liquids. -Resident #5 never choked. Interview on 10/10/17 at 10:30am with a second Medication Aide revealed: -She gave Resident #5 her medications whole or broken in half with regular (not thickened) water. -She was "under the impression" an order was needed from the doctor to give medications with thickened water. -Resident #5 had not choked. Telephone interview on 10/10/17 at 3:05pm with the facility's Physician Assistant revealed: -Resident #5 had dysphagia (difficulty swallowing food or liquids) and was at risk for aspiration. -Resident #5 receiving the wrong diet and wrong liquids would put the resident at risk for aspiration. Interview on 10/10/17 at 9:00am with the RCC revealed Resident #5 had been admitted into the hospital. Review of the hospital emergency room documentation for Resident #5 on 10/11/17 revealed: -"EMS reports that the patient's oxygen saturation was 83% on room air when he initially arrived to the facility (on 10/9/17)". -"The patient's (Resident #5) shortness of breath and cough became abruptly worse today (at the facility) when she choked on a piece of food". -Chest x-ray revealed right middle lobe infiltrate. Interview with a second Cook on 10/10/17 at 9:00am revealed: -The Cook had worked at the facility since April 2017.	D 310		

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D 310	Continued From page 10	D 310		

-The Cook was trained by two other Cooks.
-She looked in the menu book for what to serve the residents and in the back of the book for the servings.
-There was a list on the board in the kitchen for the special diet orders.
-The blender was used to puree the food into pudding like consistency.
-There was a measuring diagram on the board with instructions on how to mix the drinks for honey consistency.

Refer to the interview on 10/10/17 at 9:40am with the Administrator.

Pureed foods should be ready to swallow, moist, and without any lumps or visible pieces. The facility's failure to serve a pureed diet increased the risk of aspiration and choking which can result in food or liquid going into the windpipe which leads to the lungs and causing aspiration pneumonia. The facility's failure to serve thickened liquids also increased the risk of aspiration pneumonia.

B. Review of Resident #3's current FL2 dated 2/9/17 revealed:
-Diagnoses included schizophrenia paranoid type, gastro esophageal reflux disease, back pain, mild renal insufficiency, urinary tract infection, and insulin dependent diabetes.
-There was an order for no concentrated sweets diet.

Review of the therapeutic diet list for residents dated 7/18/17 posted in the kitchen revealed Resident #3 was to be served a no concentrated sweets (NCS) diet.

Review of the facility weekly therapeutic diet

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D 310	Continued From page 11 menu book on 10/9/17 revealed: -An entry that NCS and calorie controlled diets - all beverages except milk should be sugar free. -The NCS diet menu for lunch on 10/9/17 should be 2/3 cup stir fry with cabbage, 1/2 cup fried rice, 1 1/2 ounce egg roll, 1/2 cup mandarin oranges, and 1 roll. -The NCS diet menu for dinner on 10/10/17 should be 2 ounces barbecue pork, 1/2 cup field peas, 1/2 cup sweet and sour coleslaw, 1/2 cup peach bread pudding and 1 roll. Observation on 10/9/17 at 12:10pm of the lunch meal revealed: -Resident #3 had been served one serving of chicken, one serving of rice, one serving of cabbage, one serving of cornbread, and one serving of mandarin oranges. -Resident #3 ate 100% of her lunch. Observation on 10/10/17 at 5:00pm of the dinner meal revealed: -Resident #3 had been served one serving of barbecue, one serving of peas, one serving of fruit cocktail, and a roll. -Resident #3 ate 100% of her dinner. Observation on 10/9/17 and 10/10/17 of the food pantry revealed the only canned fruit available was packed in light syrup. Interview on 10/9/17 at 1:00pm with the Cook revealed: -The Cook did not know that an NCS diet could not have light syrup. -The Cook did not have any food service training outside of the facility. Interview on 10/10/17 at 9:00am with a second Cook revealed:	D 310		

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D 310	Continued From page 12 -The Cook had worked at the facility since April 2017. -The Cook was trained by two other Cooks. -She looked in the menu book for what to serve the residents and in the back of the book for the servings. -There was a list on the board in the kitchen for the special diet orders. -The Administrator was responsible for ordering food. Refer to the interview with the Administrator on 10/10/17 at 9:40am. The facility's failure to serve a No Concentrated Sweets diet increased the risk of higher blood glucose levels. C. Review of Resident #9's current FL2 dated 10/5/17 revealed: -Diagnoses included mental retardation, hyperlipidemia, vitamin D deficiency, and diabetes. -There was a diet order for no concentrated sweets (NCS) and chopped meats. Review of the therapeutic diet list for residents dated 7/18/17 posted in the kitchen revealed Resident #9 was to be served a NCS/chopped meat diet. Review of the facility weekly therapeutic diet menu book on 10/9/17 revealed: -There was an entry for NCS and calorie controlled diets - all beverages except milk should be sugar free. -The NCS diet menu for lunch on 10/9/17 should be 2/3 cup stir fry with cabbage, 1/2 cup fried rice, 1 1/2 ounce egg roll, 1/2 cup mandarin oranges, and 1 roll.	D 310		

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D 310	Continued From page 13 -The NCS diet menu for dinner on 10/10/17 should be 2 ounces barbecue pork, 1/2 cup field peas, 1/2 cup sweet and sour coleslaw, 1/2 cup peach bread pudding, and 1 roll. Observation on 10/9/17 at 12:10pm of the lunch meal revealed: -Resident #9 was served one serving of whole chicken strips, one serving of cabbage, one serving of rice, one serving of mandarin oranges, and one serving of corn bread. -Resident #9 ate 100% of his meal with no difficulty. Observation on 10/10/17 at 5:00pm of the dinner meal revealed: -Resident #9 was served one serving of chopped pork barbecue, one serving of peas, one serving of peas, one roll, and one serving of fruit cocktail. -Resident #9 ate 100% of his meal. Observation on 10/9/17 and 10/10/17 of the food pantry revealed the only canned fruit available was packed in light syrup. Interview with the Medication Aide on 10/10/17 at 10:50am revealed that Resident #9's blood glucose level of 10/9/17 at 4:00pm was 219 and he received 4 units of Novolog sliding scale insulin. Interview on 10/10/17 at 4:20pm with Resident #9 revealed: -He had no issues eating the meat on his plate. -His meat was usually chopped up. Interview with the Cook on 10/9/17 at 1:00pm revealed: -The Cook was not aware that Resident #9 had a chopped meat diet order.	D 310		

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D 310	Continued From page 14 -The Cook did not know that an NCS diet could not have light syrup. -The Cook did not have any food service training outside of the facility. Interview with a second Cook on 10/10/17 at 9:00am revealed: -The Cook had worked at the facility since April 2017. -The Cook was trained by two other Cooks. -She looked in the menu book for what to serve the residents and in the back of the book for the servings. -There was a list on the board in the kitchen for the special diet orders. -The Administrator was responsible for ordering food. Refer to the interview with the Administrator on 10/10/17 at 9:40am. The facility's failure to serve a chopped meat diet increased the risk of choking and aspiration which can result in food going into the windpipe which leads to the lungs and causing aspiration pneumonia. The facility's failure to serve a No Concentrated Sweets diet increased the risk of higher blood glucose levels. D. Review of Resident #10's current FL2 dated 12/30/16 revealed: -Diagnoses included moderate mental retardation, major depression, speech/language disorder, seizure disorder, B12 deficiency, history of deep vein thrombosis and pulmonary embolism. -There was an order for lactose free diet. Review of the therapeutic diet list for residents dated 7/18/17 posted in the kitchen revealed	D 310		

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D 310	Continued From page 15 Resident #10 was to be served a lactose free diet. Review of the facility weekly therapeutic diet menu book on 10/9/17 revealed there were no lactose free menus. Review on 10/9/17 at 10:00am of the refrigerator and food storage pantry revealed there were no lactose free dairy items. Observation on 10/10/17 at 12:05pm of the lunch meal revealed Resident #10 was served one serving of chicken salad, one serving of cottage cheese, one serving of cole slaw, one serving of pasta salad, and 4 crackers. Surveyor went to kitchen on 10/10/17 at 12:06pm to inform cook of inappropriate meal served to Resident #10. Observation on 10/10/17 at 12:10pm of Resident #10 revealed: -Resident #10 had eaten 75% of her cottage cheese. -Dietary aide removed the meal plate from the table and removed the remainder of the cottage cheese. Interview on 10/10/17 at 9:00am and 12:30pm with the Cook revealed: -She "forgot" Resident #10 was on a lactose free diet. -"I guess I got too busy, it won't happen again." -The Cook had worked at the facility since April 2017. -The Cook was trained by two other Cooks. -She looked in the menu book for what to serve the residents and in the back of the book for the servings.	D 310		

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D 310	Continued From page 16 -There was a list on the board in the kitchen for the special diet orders. -The Administrator was responsible for ordering food. Interview on 10/10/17 at 12:15pm with the Administrator revealed he was unaware that Resident #10 was on a lactose free diet. Interview on 10/11/17 at 3:30pm with the Medication Aide revealed there had been no reports of Resident #10 having any stomach discomfort or diarrhea. Interview on 10/11/17 at 3:31pm with Resident #10 revealed she had no stomach discomfort. Attempted telephone interview on 10/11/17 at 10:30am with Resident #10's guardian was unsuccessful. Interview on 10/10/17 at 3:05pm with the facility's Physician Assistant revealed the only detriment to Resident #10 not receiving a lactose free diet was "an upset stomach". Interview with the Cook on 10/9/17 at 1:00pm revealed the Cook did not have any food service training outside of the facility. Refer to the interview with the Administrator on 10/10/17 at 9:40am. The facility's failure to provide a lactose free diet increased the risk of food not properly digesting and passing into the intestine which can lead to gas, cramps, a bloated feeling, and diarrhea. E. Review of Resident #11's current FL2 dated 12/30/16 revealed:	D 310		

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D 310	Continued From page 17 -Diagnoses included gastro esophageal reflux disease, anxiety disorder, paranoid schizophrenia, history of scoliosis. -There was an order for a vegetarian diet. Review of the therapeutic diet list for residents dated 7/28/17 posted in the kitchen revealed Resident #11 was to be served a vegetarian diet. Review of the facility weekly menu diet book on 10/9/17 for the vegetarian diet revealed: -The vegetarian diet menu for lunch on 10/9/17 should be 1 cup stir fry with tofu, 1/2 cup of fried rice, 1 1/2 ounce egg roll, 1/2 cup mandarin oranges and 1 roll. -The vegetarian diet menu for dinner on 10/10/17 should be 3 ounces of veggie sausage sloppy joe, 1/2 cup field peas, 1/2 cup coleslaw, 1/2 cup peach bread pudding, and 1 roll. Observation on 10/9/17 at 12:10pm of the lunch meal revealed: -Resident #11 was served one serving of rice, one serving of cornbread, one serving of cabbage, and one serving of mandarin oranges. -There was no stir fry with tofu. -There was no protein served. -Resident #11 ate 100% of the meal. Observation on 10/10/17 at 5:00pm of the dinner meal revealed: -Resident #11 was served one serving of cole slaw, one serving of peas, one serving of fruit cocktail, and pizza sticks with the resident had ordered from a nearby restaurant. -There was no veggie sausage sloppy joe. -Resident #11 ate 100% of the meal. Observation on 10/9/17 and 10/10/17 of the food pantry revealed there was not any tofu or veggie	D 310		

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D 310	Continued From page 18 sausage in the facility. Interview with Resident #11 on 10/11/17 at 2:00pm revealed: -She was only served the side items. -Sometimes she ordered food delivered from outside restaurants. Interview with the Cook on 10/9/17 at 1:00pm revealed: -The Cook did not know that he needed to give a resident on vegetarian diet protein. -"(Resident #11) has to say she wants the alternate to get protein on her tray. Like a peanut butter or cheese sandwich". -The Cook did not have any food service training outside of the facility. Interview with a second Cook on 10/10/17 at 9:00am revealed: -The Cook had worked at the facility since April 2017. -The Cook was trained by two other Cooks. -She looked at the menu book for what to serve the residents and in the back of the book for the servings. -There was a list on the board in the kitchen for the special diet orders. -The Administrator was responsible for ordering food. -Most of the time the Cook would give the vegetarian only the side items without substituting a protein. Refer to the interview with the Administrator on 10/10/17 at 9:40am. The failure to provide a balanced vegetarian diet increases the risk of a diet low in protein which can raise the risk of muscle loss, falling, slow	D 310		

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D 310	Continued From page 19 bone healing, bone weakness, fractures and even osteoporosis. F. Review of Resident #12's current FL2 dated 7/11/17 revealed: -Diagnoses included Alzheimer's dementia, edema, depression, anxiety, and hypertension. -There was an order for a pureed diet. Review of the dietary menu for residents dated 7/18/17 posted in the kitchen revealed Resident #11 was to be served a pureed diet. Review of the facility menu book on 10/10/17 for the puree diet revealed the lunch menu was to be 1/3 cup pureed Cook's choice entree, 1/2 cup pureed rice or noodles, 3/8 cup pureed Cook's choice vegetable, 3/8 cup pureed fruit, and 1/3 cup pureed roll. Observation on 10/10/17 at 12:05pm of the lunch meal revealed Resident #12 was served one serving of pureed cottage cheese, one serving of of pureed chicken salad, one serving of chocolate pudding, and one serving of chopped pasta salad with visible nickel sized spiral noodles. Surveyor notified dietary aide on 10/10/17 at 12:06pm of inappropriately pureed food. Observation on 10/10/17 at 12:10pm of lunch revealed Resident #12's plate was removed and replaced with appropriately pureed food items. Interview with the Cook on 10/10/17 at 9:00am and 12:30pm revealed: -The Cook knew Resident #12 was on a pureed diet. -The Cook "thought the pasta salad looked pureed enough".	D 310		

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D 310	Continued From page 20	D 310		

-She was trained by two other Cooks.
-She looked in the menu book for what to serve the residents and in the back of the book for the servings.
-There was a list on the board in the kitchen for the special diet orders.
-The blender was used to puree the food into pudding like consistency.

Review of the residents' weights for six months revealed Resident #12 had a 20lb weight loss.

Interview with the facility's Physician Assistant on 10/11/17 at 11:00am revealed:
-The Physician Assistant (PA) was aware that Resident #12 had weight loss.
-Resident #12 was "overweight".
-The weight loss was intended.
-The PA was aware Resident #12 was not on any dietary supplements.
-The PA was "not concerned".

Attempted telephone interview on 10/11/17 at 10:08am with Resident #12's guardian was unsuccessful.

Based on observations, interviews, and record reviews it was determined that Resident #12 was not interviewable.

Interview on 10/9/17 at 1:00pm with the Cook revealed he did not have food service training outside the facility.

Refer to the interview on 10/10/17 at 9:40am with the Administrator.

Pureed foods should be ready to swallow, moist, and without any lumps or visible pieces. The facility's failure to serve a pureed diet increased

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D 310	Continued From page 21 the risk of aspiration and choking which can result in food or liquid going into the windpipe which leads to the lungs and causing aspiration pneumonia. _____ Interview on 10/10/17 at 9:40am with the Administrator revealed: -The Cooks had no food service training prior to their employment at the facility. -The Administrator trained the kitchen staff. -The Administrator would go over the residents' diets with the Cooks. -The Administrator had oversight of the kitchen and monitored the activity. -The Administrator was in the facility five days per week. -The last meal the Administrator had observed was on October 5, 2017. -The Administrator, the lead Cook, and the RCC would "go over" what food items needed to be ordered. - None of the staff had completed the Food Service Orientation training. _____ The facility failed to ensure physician ordered therapeutic diets were served resulting in therapeutic diets and thickened liquids not being served to 6 of 6 sampled residents (Resident #3, #5, #9, #10, #11, and #12) related to puree and honey thick liquids, no concentrated sweets, vegetarian, lactose free, and chopped meat diet orders including Resident #5 was not served a pureed and honey thickened liquids diet, aspirated, and was subsequently hospitalized. The facility's failure to serve the diets as ordered was detrimental to the residents and resulted in physical harm to Resident #5 which constitutes an A2 Violation.	D 310		

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D 310	Continued From page 22 The facility provided a Plan of Protection on 10/9/17 that included: -The Administrator will immediately discuss with all cooks the proper way to serve pureed food. -The pureed food will be served the consistency of pudding and the drinks the consistency of honey. -All diets will be served as ordered. -The Administrator or the Medication Aide will monitor all diet orders for compliance. -All cooks will meet with the Administrator and Resident Care Coordinator to review the diet list to ensure each resident is receiving the proper diet. -The facility dietician will conduct an inservice to the kitchen staff regarding therapeutic diets and menus. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2017	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 23 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 sampled residents during the medication pass related to errors in medication administration of oral inhalers, Ventolin HFA and Atrovent, to Resident #8, and hydrocortisone cream topically to Resident #4; lisinopril and potassium chloride to Resident #4 after the medications had been discontinued. The findings are: The medication pass error rate was 13% as evidenced by 5 medication errors out of 37 opportunities during medication passes observed on 10/9/17 at 11:48am and on 10/10/17 at 7:19am. A. Review of Resident #8's current FL2 dated 4/18/17 revealed: -Diagnoses included mood disorder, and chronic obstructive pulmonary disease (COPD). -There was an order for Ventolin 90mcg metered dose inhaler 1puff by mouth one time a day. (Ventolin is a fast acting bronchial dilator used to treat COPD). -There was an order for Atrovent inhaler one puff by mouth daily. (Atrovent is a long acting bronchial dilator used to treat COPD). 1. Review of Resident #8's record revealed	D 358		

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D 358	Continued From page 24 subsequent physician's orders dated 9/8/17 prescribing Ventolin 90mcg metered dose inhaler 1 puff one time a day. Observation of a medication pass on 10/10/17 at 7:19am revealed: -The Resident Care Coordinator (RCC) prepared and administered 6 solid dose oral medications to Resident #8. -Resident #8 was not administered Ventolin. Interview on 10/10/17 at 7:20am with the RCC revealed she had administered all medications schedule on the electronic Medication Administration Record (eMAR) for 8:00am. Review of Resident #8's October 2017 eMAR on 10/10/17 at 10:40am revealed: An entry for Ventolin 90 mcg inhaler one puff one time daily scheduled at 8:00am. -Ventolin 90 mcg inhaler was documented as administered on 10/10/17 at 8:00am. Observation of medications on hand for administration on 10/10/17 revealed Resident #8 had a partial Ventolin 90 mcg inhaler on the medication cart available for administration. Interview on 10/10/17 at 8:12am with the RCC revealed: -She routinely consulted the resident's eMAR displayed on the medication cart screen for medications to be administered during the medication pass. -She prepared and administered Resident #8's tablets but overlooked administering the resident's scheduled Ventolin. -Resident #8 sometimes asked for his inhaler (Ventolin) later in the morning but he had not asked for the inhaler this morning.	D 358		

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D 358	Continued From page 25 -She used the option to "document all" for the documentation of medication administration at 8:00am. -The eMAR system had the capacity to incorporate a barcode scanning system but she did not use the barcode scanning routinely. Interview on 10/10/17 at 2:20 pm with Resident #8 revealed: -He had COPD and breathing was difficult some days. -He was unable to recall if he received his Ventolin 90 mcg inhaler this morning. -He received the inhaler some days, but not every day. -He was not experiencing any shortness of breath today. Interview on 10/10/17 at 4:30pm with the Administrator revealed: -Medication aides were responsible to administer medications according to orders on the eMAR. -He was not made aware, until later in the morning, that Resident #8 did not receive his Ventolin inhaler by the RCC. 2. Review of Resident #8's record revealed subsequent physician's orders dated 9/8/17 prescribing Atrovent inhaler 1puff one time daily. Observation of a medication pass on 10/10/17 at 7:19am revealed: -The Resident Care Coordinator (RCC) prepared and administered 6 solid dose oral medications to Resident #8. -Resident #8 was not administered Atrovent. Interview on 10/10/17 at 7:20am with the RCC revealed she had administered all medications schedule on the electronic Medication	D 358		

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D 358	Continued From page 26 Administration Record (eMAR) for 8:00am. Review of Resident #8's October 2017 eMAR on 10/10/17 at 10:40am revealed: -An entry for Atrovent inhaler one puff one time daily scheduled at 8:00am. -Atrovent inhaler was documented as administered on 10/10/17 at 8:00am. Observation of medication on hand for administration on 10/10/17 revealed Resident #8 had a partial Atrovent inhaler on the medication cart available for administration. Interview on 10/10/17 at 8:12am with the RCC revealed: -She routinely consulted the resident's eMAR displayed on the medication cart screen for medications to be administered during the medication pass. -She prepared and administered Resident #8's tablets but overlooked administering the resident's scheduled inhalers. -Resident #8 sometimes asked for his Atrovent inhaler later in the morning but he had not asked for the inhaler this morning. -She used the option to "document all" for the documentation of medication administration at 8:00am. -The eMAR system had the capacity to incorporate a barcode scanning system but she did not use the barcode scanning routinely. Interview on 10/10/17 at 2:20pm with Resident #8 revealed: -He had COPD and breathing was difficult some days. -He was unable to recall if he received his Atrovent inhaler this morning. -He received the inhaler some days, but not every	D 358		

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day.
-He was not experiencing any shortness of breath today.

Interview on 10/10/17 at 4:30pm with the Administrator revealed:
-Medication aides were responsible to administer medications according to orders on the eMAR.
-He was not made aware, until later in the morning, that Resident #8 did not receive his Atrovent inhaler by the RCC.

B. Review of Resident #4's current FL2 dated 7/2/17 revealed diagnoses included hepatitis C, coronary artery disease, and hypertension.

1. Review of Resident #4's FL2 dated 6/19/17 revealed a physician's order for Lisinopril 10 mg twice a day. (Lisinopril is used alone or in combination with other medications to lower blood pressure.

Review of Resident #4's current FL2 dated 7/2/17 revealed Lisinopril 10 mg was not ordered.

Review of Resident #4's record revealed a hospital discharge summary dated 7/3/17 with documentation stating "discontinue lisinopril because of recent renal failure and control blood pressure without this medication".

Observation of a medication pass on 10/10/17 at 7:35am revealed:
-The Resident Care Coordinator (RCC) prepared and administered 6 oral medications.
-Lisinopril 10 mg (one tablet) was administered to Resident #4 at 7:35am.

Interview on 10/10/17 at 7:45am with the RCC revealed she had administered all medications

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schedule on the electronic Medication Administration Record (eMAR) for 8:00am including any scheduled topical medications.

Review of Resident #4's October 2017 eMAR on 10/10/17 at 10:50am revealed:
-An entry for Lisinopril 10 mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm.
-Lisinopril 10 mg was documented as administered twice daily from 10/1/17 to 10/09/17, and 10/10/17 at 8:00am.

Observation of medication on hand for administration on 10/10/17 revealed Resident #4 had a bubble pack of lisinopril 10 mg dispensed on 10/9/17 with 27 of 28 tablets remaining.

Interview on 10/10/17 at 8:12am with the RCC revealed:
-She routinely consulted the resident's eMAR displayed on the medication cart screen for medications to be administered during the medication pass.
-Medications appeared on the eMAR one hour before the scheduled time of administration and displayed for one hour after the scheduled time of administration.

Telephone interview on 10/10/17 at 10:53am with a representative for the contract pharmacy revealed:
-The facility was responsible to fax all hospital discharge summaries, FL2s, medication and treatment orders, and physician encounter summaries to the contract pharmacy.
-The contract pharmacy entered the orders into the eMAR system.
-The facility approved the orders which allowed the orders to appear on the eMAR for medication

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aides to administer the orders.
-The contract pharmacy had documentation for receiving Resident #4's FL2 dated 6/19/17.
-The contract pharmacy had no documentation for receiving Resident #4's current FL2 dated 7/2/17 or the hospital discharge dated 7/3/17.
-Lisinopril 10 mg was not discontinued on the eMAR.

Interview on 10/10/17 at 11:00am with Resident #4 revealed:
-He had a hospital visit at the end of June 2017 to early July 2017.
-His medications were changed but he was not aware of the changes made to his medications.
-He did not recall the hospital informing him he might have any kidney (renal) problems.
-He thought his blood pressure was pretty normal now.
-He did not know if lisinopril was discontinued.

Interview on 10/10/17 at 4:00pm with the RCC revealed:
-She had been in her current position for 4 weeks.
-The RCC and/or the Administrator was responsible to fax all medication orders, discharge summaries, and FL2s to the contract pharmacy for review and eMAR information.
-The contract pharmacy entered orders on the eMAR.
-The Administrator released the new medication orders to show up on the eMAR system for the medication aides.
-She did not have a system in place to audit the residents' records for medication orders compared to current medications listed on the eMARs.
-She had not reviewed Resident #4's FL2 when he was readmitted from the hospital because the

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readmission was before she assumed the RCC position.
-She was not aware Resident #4's lisinopril 10 mg was not listed on the 7/2/17 FL2.

Interview on 10/10/17 at 4:30pm and 11/11/17 at 4:00 pm with the Administrator revealed:
-Medication aides were responsible to administer medications according to orders on the eMAR.
-The RCC and the Administrator were responsible for reviewing orders, faxing orders and discharge summaries to the pharmacy for adjusting residents' medications according to current orders.
-The contract pharmacy entered orders on the eMAR.
-The Administrator reviewed eMAR entries and approved the entries, then the medication order would appear on the eMAR for medication aides to administer the medications.
-The facility did not currently have a system in place to verify all orders, including discharge summaries, were faxed to the pharmacy.
-Going forward the facility would stamp, date and sign all orders documenting the order had been faxed to the pharmacy.
-He was not aware Resident #4's lisinopril 10 mg was not listed on the 7/2/17 FL2.

Telephone interview on 10/11/17 at 8:52am with Resident #4's Nurse Practitioner (NP) revealed:
-The NP was aware Resident #4 had a hospitalization at the end of June 2017.
-The NP would want Resident #4's lisinopril 10 mg discontinued if the hospital discharge summary and FL2 had documented the medication should be discontinued.
-She stated there was no harm for Resident #4 taking lisinopril 10 mg up until this day (10/11/17) but the facility should discontinue lisinopril 10 mg

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D 358	Continued From page 31 at this time. 2. Review of Resident #4's current FL2 dated 7/2/17 revealed a physician's order for potassium chloride 10 milliequivalent (meq) one tablet daily. (Potassium chloride is a potassium supplement used to increase low potassium levels in the blood. Potassium is an electrolyte that conducts electricity in the body and is crucial for heart function.) Observation of a medication pass on 10/10/17 at 7:35am revealed: -The Resident Care Coordinator (RCC) prepared and administered 6 oral medications. -One potassium chloride 10 meq tablet was administered to Resident #4 at 7:35am. Review of Resident #4's hospital discharge dated 7/3/17 revealed documentation to "continue potassium chloride daily (this medication may possibly need to be discontinued since Lasix (a fluid pill used for swelling and lowering blood pressure but cause potassium levels to fall) is now being changed to as needed". Review of Resident #4's record revealed a subsequent physician's order dated 7/27/17 to discontinue potassium chloride 10 meq. Observation of medication on hand for administration on 10/10/17 revealed Resident #4 had a bubble pack of potassium chloride 10meq dispensed on 10/9/17 with 13 of 14 tablets remaining. Review of Resident #4's October 2017 eMAR on 10/10/17 at 10:50am revealed: -An entry for Potassium chloride 10 meq once daily scheduled for administration at 8:00am	D 358		

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daily.
-Potassium chloride 10 meq was documented as administered on 10/10/17 at 8:00am.

Interview on 10/10/17 at 8:12am with the RCC revealed:
-She routinely consulted the resident's eMAR displayed on the medication cart screen for medications to be administered during the medication pass.
-Medications appeared on the eMAR one hour before the scheduled time of administration and displayed for one hour after the scheduled time of administration.

Telephone interview on 10/10/17 at 10:53am with a representative for the contract pharmacy revealed:
-The facility was responsible to fax all hospital discharge summaries, FL2s, medication and treatment orders, and physician encounter summaries to the contract pharmacy.
-The contract pharmacy entered the orders into the eMAR system.
-The facility approved the orders which allowed the orders to appear on the eMAR for medication aides to administer the orders.
-The contract pharmacy had documentation for receiving Resident #4's FL2 dated 6/19/17.
-The contract pharmacy had no documentation for receiving Resident #4's current FL2 dated 7/2/17, the hospital discharge dated 7/3/17, or the physician's order dated 7/27/17 to discontinue potassium chloride 10 meq.

Interview on 10/10/17 at 11:00am with Resident #4 revealed:
-He had a hospital visit at the end of June 2017 to early July 2017.
-His medications were changed but he was not

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aware of the changes made to his medications.
-He thought his blood pressure was pretty normal now.
-He did not know if potassium chloride 10 meq was discontinued.

Interview on 10/10/17 at 4:00pm with the RCC revealed:
-She had been in her current position for 4 weeks.
-The RCC and/or the Administrator were responsible to fax all medication orders, discharge summaries, and FL2s to the contract pharmacy for review and eMAR information.
-The contract pharmacy entered orders on the eMAR.
-The Administrator released the new medication orders to show up on the eMAR system for the medication aides.
-She did not have a system in place to audit the residents' records for medication orders compared to current medications listed on the eMARs.
-She was not aware Resident #4's potassium chloride 10 meq was discontinued on 7/27/17.

Interview on 10/10/17 at 4:30pm and 10/11/17 at 4:00 pm with the Administrator revealed:
-Medication aides were responsible for administering medications according to orders on the eMAR.
-The RCC and the Administrator were responsible for reviewing orders, faxing orders and discharge summaries to the pharmacy for adjusting residents' medications according to current orders.
-The contract pharmacy entered orders on the eMAR.
-The Administrator reviewed eMAR entries and approved the entries, then the medication order

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would appear on the eMAR for medication aides to administer the medications.
-The facility did not currently have a system in place to verify all orders, including discharge summaries, were faxed to the pharmacy.
-Going forward the facility would stamp, date and sign all orders documenting the order had been faxed to the pharmacy.

Telephone interview on 10/11/17 at 8:52am with Resident #4's Nurse Practitioner (NP) revealed:
-The NP was aware Resident #4 had a hospitalization at the end of June 2017.
-The NP would want Resident #4's potassium chloride 10 meq discontinued since the resident was not taking a fluid reduction medication (Lasix) daily, as ordered on 7/27/17.
-She stated there was no harm for Resident #4 taking potassium chloride 10 meq up until this day (10/11/17) but the facility should discontinue potassium chloride 10 meq at this time.

Review of Resident #4's hospital discharge summary dated 7/3/17 revealed laboratory results documenting a potassium level of 3.8 on 06/29/17. (The reference range for the laboratory results was 3.5 to 5.1). No subsequent laboratory value for Resident #4's potassium were available for review.

3. Review of Resident #4's record revealed:
-A current FL2 dated 7/2/17 with an order for hydrocortisone 0.5% cream (a topical steroidal cream used to treat rashes) apply four times a day.

Observation of a medication pass on 10/10/17 at 7:35am revealed:
-The Resident Care Coordinator (RCC) prepared and administered 6 oral medications, one liquid

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D 358	Continued From page 35 oral medication, and one inhaler. -Hydrocortisone cream was not applied to Resident #4. Interview on 10/10/17 at 7:45am with the RCC revealed she had administered all medications schedule on the electronic Medication Administration Record (eMAR) for 8:00am including any scheduled topical medications. Observation of medication on hand for administration on 10/10/17 at 11:30am revealed Resident #4 did not have hydrocortisone 0.5% cream available for administration on the medication cart or in back-up stock. Review of Resident #4's October 2017 eMAR on 10/10/17 at 10:50am revealed: -An entry for Hydrocortisone cream 0.5% cream with instructions as follows: For insect bites, itching or minor rashes: Apply twice a day as needed. Hydrocortisone 0.5% cream was scheduled for prn (as needed) administration. -There was no entry for hydrocortisone 0.5% cream apply 4 times a day listed on the October 2017 eMAR. -Hydrocortisone 0.5% cream was not documented as administered from 10/1/17 to 10/10/17. Interview on 10/10/17 at 8:12am with the RCC revealed: -She routinely consulted the resident's eMAR displayed on the medication cart screen for medications to be administered during the medication pass. -Medications appeared on the eMAR one hour before the scheduled time of administration and displayed for one hour after the scheduled time of administration.	D 358		

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D 358	Continued From page 36 -If a medication is not listed on the eMAR, medication aides would not know to administer the medication. Telephone interview on 10/10/17 at 10:53am with a representative for the contract pharmacy revealed: -The facility was responsible to fax all hospital discharge summaries, FL2s, medication and treatment orders, and physician encounter summaries to the contract pharmacy. -The contract pharmacy entered the orders into the eMAR system. -The facility approved the orders which allowed the orders to appear on the eMAR for medication aides to administer the orders. -The contract pharmacy had documentation for receiving Resident #4's FL2 dated 6/19/17. -The pharmacy could not explain why Resident #4's hydrocortisone 0.5% cream was not listed on the eMAR to apply 4 times a day as ordered on 6/19/17 and 7/2/17 FL2s. Interview on 10/10/17 at 11:00am with Resident #4 revealed: -He was aware he had a cream to apply to rashes at one time. -He had not been administered the cream in a long time. -He had a few dry spots he would use the cream on if it was offered to him. Interview on 10/10/17 at 4:00pm with the RCC revealed: -She had been in her current position for 4 weeks. -The RCC and/or the Administrator was responsible to fax all medication orders, discharge summaries, and FL2s to the contract pharmacy for review and eMAR information.	D 358		

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D 358	Continued From page 37 -The contract pharmacy entered orders on the eMAR. -The Administrator released the new medication orders to show up on the eMAR system for the medication aides. -She did not have a system in place to audit the residents' records for medication orders compared to current medications listed on the eMARs. -She was not aware Resident #4's had an order for hydrocortisone 0.5% cream apply 4 times a day. Interview on 10/10/17 at 4:30pm and 11/11/17 at 4:00 pm with the Administrator revealed: -Medication aides were responsible to administer medications according to orders on the eMAR. -The RCC and the Administrator were responsible for reviewing orders, faxing orders and discharge summaries to the pharmacy for adjusting residents' medications according to current orders. -The contract pharmacy entered orders on the eMAR. -The Administrator reviewed eMAR entries and approved the entries, then the medication order would appear on the eMAR for medication aides to administer the medications. -The facility did not currently have a system in place to verify all orders, including discharge summaries, were faxed to the pharmacy. -Going forward the facility would stamp, date and sign all orders documenting the order had been faxed to the pharmacy. _____ The facility failed to ensure medications were administered as ordered to 2 of 4 residents during the medication pass on 10/10/17. Readmission orders dated 07/02/2017 from a	D 358		

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D 358	Continued From page 38 hospitalization for Resident # 4, with a diagnoses of hypertension and documentation of recent acute renal failure, were not implemented. Medications administered incorrectly included Lisinopril, potassium chloride, and hydrocortisone cream. The medication errors placed Resident # 4 at risk of renal failure again and electrolyte imbalance that could affect the resident's heart and other organs associated with elevated potassium. In addition, Resident #8, with a diagnosis of chronic obstructive pulmonary disease (COPD), failed to receive Ventolin and Atrovent inhalers ordered exposing him to risk of exacerbation of COPD symptoms like shortness of breath and lack of energy. The facility's failure to ensure a safe and effective system for the administration of medications was detrimental to the health and safety of the residents and this constitutes a Type B Violation. _____ The Plan of Protection provided by the facility on 10/11/17 revealed: -The Administrator and the Resident Care Coordinator will compare the incoming orders new orders to the electronic Medication Administration Record to assure all orders are current and update in a timely manner. -These orders will be reviewed by the Administrator and the Resident Care Coordinator on a daily basis. -The Administrator and the Resident Care Coordinator will continue to check orders and hold the copy of the order until they appear on the electronic Medication Administration Record. -The order will be initialed by staff to verify the order has been faxed to the pharmacy for review. -The Administrator will check to assure orders are properly handled. CORRECTION DATE FOR THE TYPE B	D 358		

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D 358	Continued From page 39 VIOLATION SHALL NOT EXCEED November 25, 2017.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 (#2 and #8) sampled residents related to documenting PRN (as needed) administration for Percocet (Oxycodone-Acetaminophen is generic for Percocet).	D 367		

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D 367	Continued From page 40 The findings are: A. Review of Resident #2's current FL2 dated 8/9/17 revealed: -Diagnoses included altered mental status,congestive heart failure, hypertension and atrial fibrillation. -Medications ordered included oxycodone 10mg-acetaminophen 325mg (a narcotic pain reliever used to treat severe pain) take 2 tablets every 6 hours as needed. Review of Resident #2's record revealed a physician's order dated 09/05/17 for oxycodone 10mg-acetamenophen 325mg (Percocet 10-325 is brand name) take 2 tablets every 6 hours as needed. Review of Resident #2's September 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for oxycodone 10mg-acetaminophen 325mg take 2 tablets every 6 hours as needed. -Documentation of doses of oxycodone 10mg-acetaminophen 325mg administered included date and time administered, reason given, MA that administered the medication, and the effectiveness of the medication. -Oxycodone 10mg-acetaminophen 325mg was documented as administered for 77 doses on the eMAR from 9/7/17 to 9/30/17. Review of Resident #2's CSCS (controlled drug count sheet) for oxycodone 10mg-acetaminophen 325mg from 9/7/17 to 9/30/17 compared to Resident #2's September 2017 eMAR revealed: -There were 79 doses of medication documented on the CSCS as administered from 9/7/17 to 9/30/17. -There were 77 doses of oxycodone	D 367		

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10mg-acetaminophen 325mg documented as administered on the September eMAR.
-There were 2 doses of oxycodone 10mg-acetaminophen 325mg not documented for administration, including date, time, reason given, MA administering medication, and the effectiveness on Resident #2's September 2017 eMAR from 09/07/17 to 09/30/17.

Oxycodone 10mg-acetaminophen 325mg was documented on Resident #2's CSCS for administration but not documented as administered on the September 2017 eMAR were as follows:
-On 9/7/17 at 11:30pm - 2 tablets documented on CSCS, but not documented on the eMAR.
-On 9/8/17 at 12:00am - 2 tablets documented on CSCS, but not documented on the eMAR.

Review of Resident #2's October 2017 eMAR revealed:
-An entry for oxycodone 10mg-acetaminophen 325mg take 2 tablets every 6 hours as needed.
-Documentation of doses of oxycodone 10mg-acetaminophen 325mg administered included date and time administered, reason given, MA that administered the medication, and the effectiveness of the medication.
-Oxycodone 10mg-acetaminophen 325mg was documented for 26 doses on the eMAR.

Review of Resident #2's CSCS for oxycodone 10mg-acetaminophen 325mg from 10/1/17 to 10/9/17 compared to Resident #2's October 2017 eMAR revealed there were 26 doses of medication documented on the CSCS as administered matching 26 doses of medication documented correctly on the October eMAR.

Refer to interview on 11/11/17 at 4:00pm with the

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D 367	Continued From page 42 Resident Care Coordinator (RCC). Refer to interview on 11/11/17 at 4:15pm with the Administrator. B. Review of Resident #8's current FL2 dated 4/18/17 revealed diagnoses included mood disorder, traumatic brain injury, history of muscle weakness, and back and neck pain. Review of Resident #8's record revealed physician's orders dated 8/9/17, and 9/8/17, and for oxycodone 5mg-acetaminophen 325mg (a narcotic pain reliever used to treat severe pain) one tablet every 6 hours as needed for pain. Review of Resident #8's record revealed physician's orders dated 10/5/17, and for oxycodone 7.5mg-acetaminophen 325mg (a narcotic pain reliever used to treat severe pain) one tablet every 6 hours as needed for pain. Review of Resident #8's September 2017 eMAR revealed: -An entry for oxycodone 5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed. -Documentation of doses of oxycodone 5mg-acetaminophen 325mg administered included date and time administered, reason given, MA that administered the medication, and the effectiveness of the medication. -Oxycodone 5mg-acetaminophen 325mg was documented as administered for 72 doses from 9/7/17 to 9/30/17. Review of Resident #8's CSCS (controlled drug count sheet) for oxycodone 10mg-acetaminophen 325mg from 9/7/17 to 9/30/17 compared to Resident #8's September 2017 eMAR revealed: -There were 76 doses of medication documented	D 367		

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D 367	Continued From page 43 on the CSCS as administered from 9/7/17 to 9/30/17. -There were 72 doses of oxycodone 5mg-acetaminophen 325mg documented as administered on the eMAR -There were 4 doses of oxycodone 10mg-acetaminophen 325mg not documented as administered on Resident #8's September 2017 eMAR. Oxycodone 5mg-acetaminophen 325mg was documented for administration on Resident #8's CSCS but not documented as administered on the September 2017 eMAR as follows: -On 9/7/17 at 8:00pm - 1 tablet documented on CSCS, but not documented on the eMAR. -On 9/10/17 at 1:00pm - 1 tablet documented on CSCS, but not documented on the eMAR. -On 9/12/17 at 5:30pm - 1 tablet documented on CSCS, but not documented on the eMAR. -On 9/25/17 at 8:00pm - 1 tablet documented on CSCS, but not documented on the eMAR. Review of Resident #8's October 2017 eMAR on revealed: -An entry for oxycodone 5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed. -Documentation of doses of oxycodone 5mg-acetaminophen 325mg administered included date and time administered, reason given, MA that administered the medication, and the effectiveness of the medication from 10/1/17 to 10/5/17 at 1:12pm. -Oxycodone 5mg-acetaminophen 325mg was documented as administered for 15 doses on the eMAR from 10/1/17 to 10/5/17 at 1:12pm. -Oxycodone 5mg-acetaminophen 325mg was documented as discontinued on 10/5/17. -An entry for oxycodone 7.5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed	D 367		

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beginning on 10/5/17.
-Oxycodone 7.5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed was documented as administered 15 times fron 10/5/17 to 10/10/17.

Review of Resident #8's CSCS for oxycodone 5mg-acetaminophen 325mg and oxycodone 7.5mg-acetaminophen 325mg from 10/1/17 to 10/10/17 compared to Resident #8's October 2017 eMAR revealed:
-There were 29 doses of medication documented as administered on the CSCS from 10/1/17 to 10/10/17.
-There were 15 doses of oxycodone 5mg-acetaminophen 325mg documented as administered on the eMAR matching 15 doses documented as administered on the CSCS.
-There were 14 doses of oxycodone 7.5mg-acetaminophen 325mg documented as administered on Resident #8's CSCS and 12 doses documented as administered on Resident #8's October 2017 eMAR.

Oxycodone 5mg-acetaminophen 325mg and oxycodone 7.5mg-acetaminophen 325mg documented as administered on Resident #8's October 2017 eMAR from 10/1/17 to 10/10/17 compared to doses documented as administered on Resident #8's CSCS revealed the following:
-On 10/7/17 at 11:30pm - 1 oxycodone 7.5mg-acetaminophen 325mg tablet documented as administered on the CSCS, but not documented on the eMAR.
-On 10/9/17 at 8:30pm - 1 oxycodone 7.5mg-acetaminophen 325mg tablet documented as administered on the CSCS, but not documented on the eMAR.

Based on observation and record review,

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D 367	Continued From page 45 Resident #8 had 4 doses of oxycodone 5mg-acetaminophen 325 mg administered but not documented on the September eMAR and 2 doses of oxycodone 7.5mg-acetaminophen 325 mg administered but not documented on the October 2017 eMAR. Refer to interview on 11/11/17 at 4:00pm with the Resident Care Coordinator (RCC). Refer to interview on 11/11/17 at 4:15pm with the Administrator. _____ Interview on 11/11/17 at 4:00pm with the Resident Care Coordinator (RCC) revealed: -She had been in her current position for 4 weeks. -She administered medications to the residents. -She was responsible for managing residents' medication orders, including managing documentation and tracking medication administration. -She was not aware medications aides were not documenting for date and time administered, reason given, medication aide (MA) administering the medication, and the effectiveness of the medication for all prn medications, especially controlled substances. -She currently had a system in place for monitoring and accounting for controlled medications received compared to controlled medications administered using the CSCS sheets and pharmacy invoices. -She did not have a system in place for routinely auditing residents' CSCS records compared to the residents' eMAR for "PRN" medications to insure accuracy of the eMAR. Interview on 11/11/17 at 4:15pm with the	D 367		

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D 367	Continued From page 46 Administrator revealed: -The RCC was responsible to manage medication aides and assure medications were administered as ordered. -The RCC was responsible to ensure medication aides were documenting administration of medications on the residents' eMARs. -He was not aware medication aides were documenting administration of "PRN" controlled medications on the CSCS but not documenting for date and time administered, reason given, medication aide (MA) administering the medication, and the effectiveness of the medication for all prn medications, especially controlled substances, on the eMARS.	D 367		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that a known drug diversion was reported to the local law enforcement as required by state law. The findings are:	D 399		

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D 399	Continued From page 47 Interview with the Administrator on 10/11/17 at 2:00pm revealed: -The Resident Care Coordinator (RCC) brought to his attention, date not known, that staff had tampered with Resident #2's Percocet and Resident #8's Percocet, which were in bubble packs in the medication cart. -Resident #2's medication card had 2 tablets of Percocet in each bubble. -Three bubbles had been opened on Resident #2's Percocet and 1 of the 2 Percocet in each bubble had been replaced with a Tylenol tablet, and the back of the bubble taped over. -Resident #8 had a medication card of Percocet with 1 tablet in each bubble. -Resident #8's Percocet bubble pack had 2 bubbles which had been opened and the Percocet was replaced with a Tylenol tablet and the back of the bubble taped over. -The medication aide, Staff G, was working on the medication cart on the shift prior to the RCC finding the tampered medication. -Staff G came to the facility on the day following the discovery of the tampered medications and was requested to be drug tested. -Staff G's urinalysis tested positive for the presence of narcotics. -Staff G was suspended for a week, had not returned to the facility, and was no longer an employee. -An investigation was completed and reported to the Health Care Personnel Registry. -He did not think he needed to report the diversion to law enforcement since it was only "five pills." -He called the pharmacy to obtain replacements for the missing medications. Review of Resident #2's record revealed: -A current FL2 dated 8/9/17 with diagnoses	D 399		

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including altered mental status, congestive heart failure, and atrial fibrillation.
-A physician's order dated 9/5/17 for oxycodone 10 mg-acetaminophen 325 mg (a narcotic pain reliever used to treat severe pain) 2 tablets every 6 hours as needed.

Based on record review and observation of Resident #2 on 10/11/17, it was determined the resident was not interviewable.

Review of Resident #8's record revealed:
-A current FL2 dated 4/18/17 with diagnoses including mood disorder, traumatic brain injury, and back and neck pain.
-A physician's order dated 9/8/17 for Percocet 5-acetaminophen 325 mg (a narcotic pain reliever used to treat severe pain) one tablet every 6 hours prn (as needed) for pain. Hold for sedation.

Interview on 10/10/17 at 2:20 pm with Resident #8 revealed:
-He depended on staff to administer his medications as ordered.
-He could not recall a time when his medications were not administered as ordered.
-He did not know all the medications that he received.

Interview with the RCC on 10/11/17 at 4:25 pm revealed:
-She did not notice the medications had been tampered with during shift change when she and another medication aide, Staff G, reconciled the control drug count on the medication cart.
-When she started administering medication on first shift, she noticed that some of Resident #8's and Resident #2's Percocet in bubble packs had been opened and was enclosed with tape.
-She reported the discovery of the tampered

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D 399	Continued From page 49 medications to the Administrator. Interview with the Hospice Nurse for Resident #2 on 10/11/17 at 3:05pm revealed: -She routinely examined the medications on hand for Resident #2 during visits. -On a facility visit, date not known, she observed Resident #2's Percocet bubble pack had a Percocet and Tylenol tablet in the 5th from the last bubble and had been taped to close in the back. -The 4th from the last bubble had no Percocet. -The 2nd and 3rd from the last bubble had not been tampered with. -The last bubble had a Percocet and Tylenol tablet and had been taped to close in the back. -She observed the markings on the Percocet and Tylenol to identify the tablets. Review of the Health Care Personnel Registry 24-Hour Initial Report dated 9/20/17 and the 5 Working Day Report dated 9/26/17 revealed: -There was an allegation of staff diverting residents' narcotics. -A medication aide, Staff G, was the accused individual. -The question, "Is there a reasonable suspicion of a crime?" was checked yes. -The question, "Incident reported to law enforcement?" was checked no. -The resident information listed Resident #2 and Resident #8. -Staff G failed a drug screen on 9/18/17. -The allegation was substantiated and the accused individual "quit." Review of Resident #8's Percocet controlled drug sheet for 30 Percocet 5/325 mg, 1 tablet every 6 hours as needed for pain revealed: -The dispense date was 9/8/17.	D 399		

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D 399	Continued From page 50 -The Percocet tablets were administered from 9/16/17 to 9/25/17 for 28 tablets, and 2 tablets were destroyed on 9/23/17. Review of Resident #2's Percocet controlled drug sheet for 48 Percocet 10/325 mg, 2 tablets every 6 hours as needed for pain, for a total of 24 doses revealed: -The dispense date was 9/5/17. -The Percocet tablets were administered from 9/16/17 to 9/22/17 for a total of 24 doses with a 0 balance. An attempted telephone interview with Staff G on 10/11/17 at 3:37pm was unsuccessful.	D 399		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to nutrition and food service, infection prevention requirements, medication administration and implementation. The findings are:	D912		

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D912	Continued From page 51 A. Based on observations, interviews, and record reviews, the facility failed to ensure all therapeutic diets for 6 of 6 sampled residents (Resident #3, #5, #9, #10, #11, and #12) were served as ordered related to puree, honey thick liquids, no concentrated sweets, vegetarian, lactose free, and chopped meat diet orders. [Refer to Tag 310 10A NCAC .0904(e)(4) Nutrition and Food Service (Type A2 Violation).] B. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters between residents for 4 of 4 sampled residents, (#3, #4, #6 and #7). [Refer to Tag 932 G.S. 131D-4.4(A)(b) ACH Infection Prevention Requirements (Unabated Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 sampled residents during the medication pass related to errors in medication administration of oral inhalers, Ventolin HFA and Atrovent, to Resident #8, and hydrocortisone cream topically to Resident #4; lisinopril and potassium chloride to Resident #4 after the medications had been discontinued. [Refer to Tag 358 10A NCAC .1004(a) Medication Administration (Type B Violation).] D. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care	D912		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 52 homes as related to medication administration, nutrition and food service, and infection control, and controlled substances. [Refer to Tag 980 G.S 131-25 Implementation (Unabated Type A2 Violation).]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident,	D932		

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D932	Continued From page 53 equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters between residents for 4 of 4 sampled residents, (#3, #4, #6 and #7). The findings are: Observation on 10/09/17 at 11:45am of a finger stick blood sugar (FSBS) check revealed: -The Resident Care Coordinator (RCC) opened a black glucometer case, labeled with a resident's name, containing a Brand A glucometer labeled with the same resident's name, and obtained a FSBS check for the resident named on the glucometer. -The RCC used disposable gloves, an alcohol swab, a new test strip, and a single use	D932		

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D932	Continued From page 54 disposable lancing device to perform the FSBS. -The RCC disposed of the test strip, lancing device, and alcohol wipe in the biohazard waste container affixed to the medication cart. Observation of the medication cart on 10/9/17 at 11:45am revealed: -There were 4 black glucometer cases located on the medication cart. -The black glucometer cases were labeled with residents' names and contained a Brand A glucometer labeled with a matching resident's name. -No other glucometers were observed on the medication cart. Telephone interview on 10/9/17 at 4:20pm with the manufacturer of the Brand A glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended. Based on the Center for Disease Control (CDC) guidelines for infection control, the recommendations are that blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list the disinfection information, the glucometer should not be shared between residents. Interview on 10/09/17 at 11:48am with the RCC revealed 4 residents were administered FSBS and one resident receiving FSBS had a diagnoses of a blood borne pathogen. Interview with the RCC on 10/9/17 at 11:50am revealed:	D932		

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D932	Continued From page 55 -She had worked at the facility previously, left for a while, and had been working at the facility for about 4 months this time. -She worked as a Medication Aide (MA) since coming back to the facility and had been training as the RCC for 4 to 5 weeks due to the departure of the former RCC. -The facility policy was for each resident to have a glucometer assigned to the resident, and used only on the assigned resident. A. Review of Resident #3's current FL2 dated 2/9/17 revealed: -Diagnoses included schizophrenia paranoid type, gastroesophageal reflux disease, back pain, mild renal insufficiency, urinary tract infection, and insulin dependent diabetes. -A physician's order for Novolog insulin (a rapid acting insulin used to lower blood sugar levels) as sliding scale insulin (SSI) subcutaneously three times a day. -A physician's order for Levemir (a long acting insulin used to lower blood sugar) insulin subcutaneously 2 times daily, at 8:00am and 8:00pm. Review Resident #3 subsequent physician's orders dated 9/8/17 revealed an order for Novolog 100 U/ml Flexpen (a type of insulin administration device) insulin use per sliding scale as needed. Sliding scale less than 70 = give orange juice with 2 packs of sugar; 150-199= 2 units; 200-249= 4 units; 250-299= 6 units; 300-349= 8 units; 350-399= 10 units; greater than 400 give 12 units. Schedule daily at 6:00am, 11:00am, 4:00pm, and 9:00pm daily. Review of Resident #3's glucometer revealed FSBS values recorded in the glucometer's history compared to values documented on Resident	D932		

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D932	Continued From page 56 #3's October 2017 and September 2017 electronic Medication Administration Record (eMAR) from 9/15/17 to 10/9/17 were inconsistent as follows: -Time and date were not set correctly. The time and date displayed on the glucometer was 5/21 at 12:02pm on 10/09/17 at 11:06am. -A FSBS reading on 5/21 at 8:39am of 140 matched the October 2017 eMAR on 10/9 at 6:00am. -No FSBS reading on 5/21 corresponded to 331 FSBS result documented on the October eMAR on 10/08 at 9:00pm. -A FSBS reading on 5/20 at 5:33am of 285 matched the October 2017 eMAR on 10/6 at 4:00pm with an additional FSBS recorded in the glucometer history on 5/20 at 5:00 am of 266 that was not documented on the October eMAR on 10/6. -A FSBS reading on 5/15 at 11:27 am of 196 that did not match the October 2017 eMAR on 10/1 at 9:00pm as 283. -A FSBS reading on 5/6 at 6:01 pm of 285 matched the September 2017 eMAR on 9/23 at 6:00am with an additional FSBS reading recorded in the glucometer history on 5/6 at 5:55pm of 202 that was not documented on the September eMAR on 9/23. -A FSBS reading of 289 documented on the September 2017 eMAR for 9/22 at 9:00pm, but no FSBS reading recorded in the glucometer's history. -A FSBS reading of 267 documented on the September 2017 eMAR for 9/16 at 6:00am, but no FSBS reading recorded in the glucometer's history. -A FSBS reading of 312 documented on the September 2017 eMAR for 9/15 at 11:00am, but no FSBS reading recorded in the glucometer's history.	D932		

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D932	Continued From page 57 Review of Resident #3's October eMAR from 10/1/17 to 10/9/17 (at 9:00am) revealed: -Novolog 100 U/ml Flexpen insulin use per sliding scale as needed. Sliding scale less than 70 = give orange juice with 2 packs of sugar; 150-199= 2 units; 200-249= 4 units; 250-299= 6 units; 300-349= 8 units; 350-399= 10 units; greater than 400 give 12 units was transcribed on the eMAR. -An entry for FSBS at 6:00 am, 11:00am, 4:00pm, and 9:00pm daily. -FSBS values were documented for 33 of 33 opportunities. Review of Resident #3's September eMAR from 9/15/17 to 9/30/17 revealed: -An entry for Novolog 100 U/ml Flexpen insulin use per sliding scale as needed. Sliding scale less than 70 = give orange juice with 2 packs of sugar; 150-199= 2 units; 200-249= 4 units; 250-299= 6 units; 300-349= 8 units; 350-399= 10 units; greater than 400 give 12 units was transcribed on the eMAR. -An entry for FSBS were at 6:00am, 11:00am, 4:00pm, and 9:00pm daily. -FSBS values were documented for 64 of 64 opportunities. Based on review of Resident #3's glucometer's history compared to the eMARS for September and October 2017, Resident #3 had one missing, one extra and one incorrectly documented FSBS in October 2017, and one extra and 3 missing FSBS values in September 2017. Refer to interview on 10/10/17 at 8:50am with a night shift Medication Aide (MA). Refer to interview on 10/10/17 at 9:00am with a first shift MA.	D932		

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D932	Continued From page 58 Refer to interview on 10/9/17 at 4:40pm with the Resident Care Coordinator (RCC). Refer to interview on 10/9/17 at 4:40pm and 10/10/17 at 9:30 am with the Administrator. B. Review of Resident #4's current FL2 dated 7/2/17 revealed: -Diagnoses included hepatitis C, coronary artery disease, hypertension, history of traumatic brain injury, mixed dementia, insulin dependent diabetes, and chronic pain. -An order for Novolog (a rapid acting insulin used to lower blood sugar) sliding scale insulin (SSI) three times daily. Review Resident #4's subsequent physician's order dated 9/8/17 revealed an order for Novolog SSI as follows: less than 200 no insulin; 200-250= 1 unit; 251-300= 2 units; 201-350= 3 units; 351-400= 4 units; 401-450= 5 units; 451-500= 6 units; greater than 500 inject 8 units, recheck blood sugar in 1 hour, if not below 400 call MD. Schedule daily at 6:00 am, 11:00 am, and 4:00 pm. Review of Resident #4's glucometer revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #3's October 2017 and September 2017 electronic Medication Administration Record (eMAR) from 9/23/17 to 10/9/17 were inconsistent as follows: -Time and date were not set correctly. The time and date displayed on the glucometer was 9/3 at 8:04pm on 10/09/17 at 2:38pm. -A FSBS reading on 9/3 at 10:39am of 161 that matched the October 2017 eMAR on 10/9 at 6:00am.	D932		

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D932	Continued From page 59 -No FSBS reading on 9/1 corresponded to 266 documented on the October 2017 eMAR on 10/6 at 4:00pm. (A FSBS value of 266 was recorded in Resident #3 glucometer's history as an extra reading on 10/6 at 4:00pm). -No FSBS reading on 8/18 corresponded to 202 documented on the September 2017 eMAR on 9/23 at 6:00am. (A FSBS value of 202 was recorded in Resident #3 glucometer's history as an extra reading on 9/23 at 6:00am). Review of Resident #4's October eMAR from 10/1/17 to 10/9/17 (at 9:00am) revealed: -There was an entry for Novolog SSI as follows: less than 200 no insulin; 200-250= 1 unit; 251-300= 2 units; 201-350= 3 units; 351-400= 4 units; 401-450= 5 units; 451-500= 6 units; greater than 500 inject 8 units, recheck blood sugar in 1 hour, if not below 400 call MD -There was an entry for FSBS at 6:00 am, 11:00 am, and 4:00 pm daily. -FSBS values were documented for 26 of 26 opportunities. Review of Resident #4's September 2017 eMAR from 9/23/17 to 9/30/17 revealed: -There was an entry for Novolog SSI as follows: less than 200 no insulin; 200-250= 1 unit; 251-300= 2 units; 201-350= 3 units; 351-400= 4 units; 401-450= 5 units; 451-500= 6 units; greater than 500 inject 8 units, recheck blood sugar in 1 hour, if not below 400 call MD -There was an entry for FSBS at 6:00 am, 11:00 am, and 4:00 pm daily. -FSBS values were documented for 24 of 24 opportunities. Based on review of Resident #4's glucometer's history compared to the eMARS for September	D932		

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D932	Continued From page 60 and October 2017, Resident #4 had two FSBS values missing in the resident's glucometer's history with FSBS values of the same amount and at the same time found extra in Resident #3's glucometer's history. Refer to interview on 10/10/17 at 8:50am with a night shift Medication Aide (MA). Refer to interview on 10/10/17 at 9:00am with a first shift MA. Refer to interview on 10/9/17 at 4:40pm with the Resident Care Coordinator (RCC). Refer to interview on 10/9/17 at 4:40pm and 10/10/17 at 9:30 am with the Administrator. C. Review of Resident #7's current FL2 dated 7/24/17 revealed: -Diagnoses included insomnia, mild mental retardation, and diabetes mellitus.. -There was an order for Lantus (a long acting insulin used to lower blood sugar) insulin 10 units subcutaneously 2 times daily. -There was an order to check finger stick blood sugar (FSBS) at 6:00am daily. Review Resident #7's subsequent physician's orders revealed an order dated 9/8/17 to check FSBS at 6:00am daily Review of Resident #7's glucometer revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #7's October 2017 and September 2017 electronic Medication Administration Record (eMAR) from 9/11/17 to 10/9/17 were inconsistent as follows: -Time and date were set correctly on the	D932		

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D932	Continued From page 61 glucometer. -A FSBS reading on 10/9 at 5:23am for 102 that matched the October 2017 eMAR on 10/9 at 6:00am. -A FSBS reading on 9/26 at 5:29am of 83 that matched the October 2017 eMAR on 9/26 at 6:00am with an additional FSBS recorded in the glucometer history on 9/26 at 9:13pm of 124 that was not documented on the October eMAR on 9/26. -A FSBS reading of 89 documented on the September 2017 eMAR on 9/20 at 6:00am, but no FSBS reading recorded in the glucometer's history. -A FSBS reading on 9/17 at 5:17am of 68 matched the October 2017 eMAR on 9/17 at 6:00am with an additional FSBS recorded in the glucometer history on 9/17 at 5:15am of 112 that was not documented on the October eMAR on 9/17. -A FSBS reading on 9/16 at 5:25am of 267 that did not match the October 2017 eMAR on 9/16 at 6:00am documented for 91. Review of Resident #7's October eMAR from 10/1/17 to 10/9/17 revealed: -An entry to check blood sugar daily at 6:00 am, use onsite blood glucose protochol. -An entry for FSBS scheduled at 6:00am daily. -FSBS values were documented for 9 of 9 opportunities. Review of Resident #7's September eMAR from 9/11/17 to 9/30/17 revealed: -An entry to check blood sugar daily at 6:00 am, use onsite blood glucose protocol was transcribed on the eMAR. -An entry for FSBS scheduled at 6:00am daily. -FSBS values were documented for 20 of 20 opportunities.	D932		

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D932	Continued From page 62 Based on review of Resident #7's glucometer's history compared to the eMARS for September and October 2017, Resident #7 had two FSBS values documented on the September 2017 eMAR but not recorded in the resident's glucometer history, and three extra FSBS values recorded in the glucometer's history but not documented on the resident's September 2017 eMAR. Refer to interview on 10/10/17 at 8:50am with a night shift Medication Aide (MA). Refer to interview on 10/10/17 at 9:00am with a first shift MA. Refer to interview on 10/9/17 at 4:40pm with the Resident Care Coordinator (RCC). Refer to interview on 10/9/17 at 4:40pm and 10/10/17 at 9:30 am with the Administrator. D. Review of Resident #6's current FL2 dated 7/24/17 revealed: -Diagnoses included anxiety, mild intellectual disabilities, and diabetic. -There was an order for Byetta (a non-insulin injection used to lower blood sugar) 5 micrograms 1 hour before breakfast and one hour before supper. -There was an order to check finger stick blood sugar (FSBS) at 6:00am. Review Resident #6 subsequent physician's order revealed there was an order dated 9/8/17 to check FSBS at 6:00am daily. Review of Resident #6's glucometer revealed FSBS values recorded in the glucometer's history	D932		

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D932	Continued From page 63 compared to values documented on Resident #6's October 2017 and September 2017 electronic Medication Administration Record (eMAR) from 9/15/17 to 10/9/17 were inconsistent as follows: -Time and date were not set correctly. The time and date displayed on the glucometer was 5/20 at 9:55am on 10/09/17 at 3:20pm. -A FSBS reading on 5/19 at 11:59pm for 102 matched the October 2017 eMAR on 10/9 at 6:00am with an additional FSBS recorded in the glucometer history on 5/19 at 3:23pm of 331 that was not documented on the October eMAR on 10/9. (FSBS 331 corresponded to a FSBS value documented on Resident #3's eMAR for 10/8 at 9:00pm but not recorded in Resident #3's glucometer history.) -A FSBS reading of 91 documented on the October 2017 eMAR for 10/2 at 6:00am, but no FSBS reading recorded in the glucometer's history. -A FSBS reading of 82 documented on the October 2017 eMAR for 10/1 at 6:00am, but no FSBS reading recorded in the glucometer's history. -A FSBS value of 112 was documented on the September 2017 eMAR for 9/17 at 6:00am, but no FSBS reading recorded in the glucometer's history. (An additional FSBS reading on 9/17 at 5:15am of 112 was recorded in Resident #7's glucometer's history corresponded to the missing value.) Review of Resident #6's October eMAR from 10/1/17 to 10/9/17 revealed: -An entry to check blood sugar daily at 6:00am. -An entry for FSBS scheduled at 6:00am daily. -FSBS values were documented for 9 of 9 opportunities.	D932		

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D932	Continued From page 64 Review of Resident #6's September eMAR from 9/15/17 to 9/30/17 revealed: -An entry to check blood sugar daily at 6:00am. -An entry for FSBS scheduled at 6:00am daily. -FSBS values were documented for 16 of 16 opportunities. Based on review of Resident #6's glucometer's history compared to the eMARS for September and October 2017, Resident #6 had two FSBS values documented on the October 2017 eMAR but not recorded in the resident's glucometer history, one extra FSBS value recorded in the glucometer's history but not documented on the resident's October 2017 eMAR (corresponding to a value documented Resident #3's eMAR for October 2017 but not recorded in Resident #3's glucometer history), and 1 FSBS value documented on the September 2017 eMAR not recorded in Resident #6's glucometers history (A FSBS value recorded in Resident #7's glucometer history and not documented on Resident #7's eMAR corresponded to the FSBS missing value). Refer to interview on 10/10/17 at 8:50am with a night shift Medication Aide (MA). Refer to interview on 10/10/17 at 9:00am with a first shift MA. Refer to interview on 10/9/17 at 4:40pm with the Resident Care Coordinator (RCC). Refer to interview on 10/9/17 at 4:40pm and 10/10/17 at 9:30 am with the Administrator. _____ Interview on 10/10/17 at 8:50am with a night shift Medication Aide (MA) revealed:	D932		

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	hal002004	A. BUILDING: _____ B. WING _____	R-C 10/11/2017

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D932	Continued From page 65 -She had worked as a MA at the facility for 3 years. -The facility policy was to not share glucometers. -She used alcohol wipes to clean the entire glucometer after she checked a resident's FSBS. -The glucometers were labeled with the assigned resident's name. -She did not recall a time when she shared a glucometer between residents. -She did not know how FSBS reading would be missing or extra in a glucometer unless the glucometer was accidentally used for another resident due to a staff person being in a hurry and overlooked changing the glucometer between residents. Interview on 10/10/17 at 9:00am with a first shift MA revealed: -She had been a MA for 3 months. -She checked residents' FSBS when she worked. -Two residents received FSBS checks more than one time a day and 2 residents received FSBS checks once daily. -Each resident had a glucometer assigned to them for checking FSBS and should not be used for another resident. -When she cleaned a glucometer, she used alcohol to clean the glucometer. -She did not recall a time when she shared a glucometer between residents. -She always checked the resident's name on the glucometer before she used the glucometer for the FSBS check on the resident. Interview on 10/9/17 at 4:40pm with the RCC revealed: -The facility staff routinely clean glucometers with alcohol wipes. -Staff had been instructed that glucometers should not be shared between residents.	D932		

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D932	Continued From page 66 -The facility had disinfecting wipes but did not use the wipes on the glucometers. -The RCC provided a container of disinfecting wipes on 10/9/17 at 4:45pm that were stored in the medication room. Interview with the Administrator on 10/9/17 at 4:40pm and 10/10/17 at 9:30 am revealed: -The facility policy was each resident had a glucometer assigned to the resident and should be used only for that resident's FSBS. -There was no system in place to routinely monitor the residents' glucometers' history compared to the FSBS values documented on the residents' eMARS. -The glucometers should not need to be disinfected since each resident had an assigned glucometer. _____ The facility failed to implement proper infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control for 3 of 4 sampled residents (#3, #4, #6 and #7) with orders for FSBS monitoring. By allowing the sharing of glucometers between residents, including Resident #4 with a diagnosis of hepatitis C, without proper disinfection, the facility exposed residents to the risk of contracting serious blood borne illnesses, including hepatitis, which is detrimental to the health and safety of the residents which constitutes a Type B Violation.	D932		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of	D980		

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D980	Continued From page 67 this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, nutrition and food service, infection control, and controlled substances. The findings are: Interview on 10/10/17 at 9:40am with the Administrator revealed: -The Administrator was in the facility five days per week. -He provided oversight for medication and treatment orders, nutrition and food service, and had in-serviced the staff on proper infection prevention measures. -The RCC was responsible to manage medication aides and assure medications were administered as ordered. -The RCC was responsible to assure medication aides were documenting administration of medications on the residents' eMARs. -He was not aware medication aides were	D980		

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D980	Continued From page 68 documenting administration of "PRN" controlled medications on the Controlled Substance Count Sheet but not documenting for date and time administered, reason given, medication aide administering the medication, and the effectiveness of the medication for all prn medications, especially controlled substances, on the MARs. Non-compliance identified during the survey included: A. Based on observations, interviews, and record reviews, the facility failed to ensure all therapeutic diets for 6 of 6 sampled residents (Resident #3, #5, #9, #10, #11, and #12) were served as ordered related to puree, honey thick liquids, no concentrated sweets, vegetarian, lactose free, and chopped meat diet orders. [Refer to Tag 310 10A NCAC .0904(e)(4) Nutrition and Food Service (Type A2 Violation.)] B. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters between residents for 4 of 4 sampled residents, (#3, #4, #6 and #7). [Refer to Tag 932 G.S. 131D-4.4(A)(b) ACH infection Prevention Requirements (Unabated Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 sampled residents during the medication pass related to errors in medication administration of oral inhalers, Ventolin HFA and Atrovent, to Resident #8, and hydrocortisone cream topically to Resident #4; lisinopril and potassium chloride to	D980		

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D980	Continued From page 69 Resident #4 after the medications had been discontinued. [Refer to Tag 358 10A NCAC .1004(a) Medication Administration (Type B Violation.)] D. Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 (#2 and #8) sampled residents related to documenting PRN (as needed) administration for Percocet (Oxycodone-Acetaminophen is generic for Percocet). [Refer to Tag 367 10A NCAC .1004(j) Medication Administration.] E. Based on observations, interviews, and record reviews, the facility failed to protect all food being stored, prepared, and served by the facility from contamination. [Refer to Tag 282 10A NCAC .0904(a)(1) Nutrition and Food Services.] F. Based on observations, interviews, and record review, the facility failed to ensure at least a three-day supply of perishable food and a five-day supply of non-perishable food was in the facility based on the menus for regular, no concentrated sweets, and vegetarian therapeutic diets. [Refer to Tag 285 10A NCAC .0904(a)(4) Nutrition and Food Service.] G. Based on interviews and record reviews, the facility failed to assure that a known drug diversion was reported to the local law enforcement as required by state law. [Refer to Tag 399 10A NCAC .1008(h) Controlled Substances.] _____ The Administrator's failure to provide oversight and monitor the facility for all licensure rule areas	D980		

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D980	Continued From page 70 resulted in 2 residents not receiving 5 medications as ordered; exposing residents to the risk of of contracting serious blood borne illnesses when glucometers were shared; placing 6 residents at risk when therapeutic diets were not served as ordered which included the hospitalization of Resident #5 after the facility served a meal without following the physician orders for thickened liquids and a pureed diet; inaccurate documentation of prn controlled medication; law enforcement not notified for drug diversion; inappropriately storing and thawing food; and an insufficient supply of food to meet the menus. The failure of management in providing oversight in these areas exposed residents to substantial risk that death or serious physical harm or neglect would occur and constitutes a Type A2 Violation. _____ The Plan of Protection provided by the facility on 10/11/17 revealed: -The Administrator will work with all staff to assure all violations are addressed, correct and maintained going forward. -A staff meeting will be conducted to educate all staff of any problems in order to correct them and to get and remain in compliance. -The Administrator wand the Resident Care Coordinator will continue to monitor all the issues and continue to work on all areas until correct. -The areas out of compliance will be monitor to assure they remain in compliance.	D980		