Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068025	A. BUILDING: ______ B. WING ______	04/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

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D 000	Initial Comments The Adult Care Licensure Section and the Orange County Department of Social Services conducted an anual survey on April 11-13, 2018 with an exit via telephone on April 13, 2018.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the physician for 1 of 5 sampled residents (Resident #4) with orders to contact the physician if fingerstick blood sugar (FSBS) was over 301. The findings are: Review of Resident #4's current FL2 dated 10/25/2017 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, type 2 diabetes, obesity, and chronic pain. -There was an order for Novolog insulin FlexPen, check FSBS before meals and at bedtime, use sliding scale as follows: 71-150= 0 units; 151-200= 4 units; 201-250= 8 units; 251-300=12 units. Review of a subsequent physician's order dated 1/10/2018 revealed an order for Novolog insulin FlexPen, inject 3 times daily after meals and at	D 273		

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bedtime per sliding scale: If FSBS 71-150= 0 units; 151-200= 4; 201-250= 8; 251-300= 12; over 301 give 14 units and call MD; Hold insulin if resident does not eat.

Review of Resident #4's February 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog insulin FlexPen, 3 times daily after meals and at bedtime per sliding scale: If FSBS 71-150= 0 units; 151-200= 4 units; 201-250= 8 units; 251-300= 12 units; FSBS greater than 301 Give 14 units and call physician *Hold insulin if resident does not eat*.
-There were entries for Novolog insulin to be administered per sliding scale at 8:00 am, 1:00 pm, 6:00 pm, and 10:00 pm.
-Resident #4's FSBS ranged from 110 to 555.
-Resident #4's FSBS was documented as 301 or greater 32 times with examples as follows:
-On 02/12/2018, FSBS was documented as 333 at 8:00 am and there was no documentation Resident #4's physician had been called.
-On 02/16/2018, FSBS was documented as 388 at 8:00 am, 315 at 1:00 pm, and 555 at 6:00 pm; There was no documentation Resident #4's physician had been called.
-On 02/23/2018, FSBS was documented as 329 at 8:00 am, 433 at 6:00 pm and 331 at 10:00 pm; There was no documentation Resident #4's physician had been called.

Review of Resident #4's March 2018 eMAR revealed:
-There was an entry for Novolog insulin FlexPen, 3 times daily after meals and at bedtime per sliding scale: If FSBS 71-150= 0 units; 151-200= 4 units; 201-250= 8 units; 251-300= 12 units; FSBS greater than 301 Give 14 units and call physician *Hold insulin if Resident does not eat*.

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D 273	Continued From page 2 -There were entries for Novolog insulin to be administered at 7:00 am or 8:00 am, 12:00 pm or 1:00 pm, 5:00 pm or 6:00 pm, and 9:00 pm or 10:00 pm. -Resident #4's FSBS ranged from 112 to 581. -Resident #4's FSBS was documented as 301 or greater 50 times with examples as follows: -On 03/04/2018, FSBS was documented as 468 at 8:00 am, 358 at 1:00 pm, and 321 at 6:00 pm; There no documentation Resident #4's physician had been called. -On 03/16/2018, FSBS was documented as 458 at 7:00 am, 581 at 12:00 pm, 371 at 5:00 pm, and 303 at 9:00 pm; There was no documentation Resident #4's physician had been called. -On 03/17/2018, FSBS was documented as 359 at 7:00 am, 481 at 5:00 pm and 410 at 9:00 pm; There was no documentation Resident #4's physician had been called. Review of Resident #4's April 2018 eMAR revealed: -There was an entry for Novolog insulin FlexPen, 3 times daily after meals and at bedtime per sliding scale: If FSBS 71-150= 0 units; 151-200= 4 units; 201-250= 8 units; 251-300= 12 units; FSBS greater than 301 Give 14 units and call physician *Hold insulin if Resident does not eat*. -There were entries for Novolog insulin to be administered at 8:00 am, 1:00 pm, 6:00 pm, and 9:00 pm. -Resident #4's FSBS ranged from 213 to 440. -Resident #4's FSBS was documented as 301 or greater 8 times with examples as follows: -On 04/03/2018, FSBS was documented as 335 at 8:00 am and there was no documentation Resident #4's physician had been called. -On 04/05/2018, FSBS was documented as 440 at 8:00 am and 320 at 1:00 pm; There was no documentation Resident #4's physician had been	D 273		

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called.
-On 04/07/2018, FSBS was documented as 399 at 8:00 am and there was no documentation Resident #4's physician had been called.

Review of progress notes for February 2018 for Resident #4 revealed staff documented contact with Resident #4's physician 1 time on 02/25/2018 "due to resident's sugar," but did not indicate if the FSBS was 301 or greater.

Review of progress notes for March 2018 for Resident #4 revealed no documented contact with Resident #4's physician regarding FSBS 301 or greater.

Review of progress notes for April 2018 for Resident #4 revealed no documented contact with Resident #4's physician regarding FSBS 301 or greater.

Interview with the Assisted Living Care Manager (AL CM) on 4/12/2018 at 7:05 pm revealed:
-She was responsible for completing eMAR audits.
-The eMAR audits were completed by using a list of discrepancies generated by the eMAR system
-The facility physician had staff print off Resident #4's documented FSBS and he reviewed them each Wednesday when he visited the facility.
-No one reviewed Resident #4's documented FSBS other than the physician when he visited the facility..
-The MAs should have followed the physician's order to contact the physician for FSBS greater than 301.
-The MAs should have documented in the progress notes when the physician was contacted.

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Interview with a second shift MA on 04/12/2018 at 8:15 pm revealed:
-She administered medication to Resident #4 during her shift including sliding scale insulin.
-Resident #4 had an order for FSBS checks 4 times daily with insulin administered according to the sliding scale.
-She documented Resident #4's FSBS and insulin administration on the eMAR after she administered it.
-She thought the sliding scale insulin order for Resident #4 was to call the doctor if FSBS was greater than 350.
-She documented Resident #4's FSBS was greater than 301 before.
-She had contacted the physician when Resident #4's FSBS was greater than 301, but did not document it anywhere.

Interview with the Administrator on 04/12/2018 at 8:23 pm revealed:
-The MA received medication administration training through an online training system.
-The facility contracted nurse provided medication training including sliding scale insulin prior to MAs administering medication.
-Resident #4's physician should have been contacted if her FSBS was over the parameters.
-She expected medication to be administered as ordered.

Interview with a medical coordinator at Resident #4's physician's practice on 04/13/2018 at 10:33 am revealed:
-Resident #4 was ordered Novolog sliding scale insulin due to her diagnoses of diabetes mellitus.
-The facility staff had contacted the Resident #4's physician's practice 4 times in February, 2 times in March and 3 times in April 2018 regarding FSBS being over 301.

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D 273	Continued From page 5 -"Each time the facility contacts us, we have to document the encounter." -"They have to let us know if Resident #4's Blood Glucose gets high so we can send a flag to the doctor." Interview with Resident #4's physician on 04/13/2018 at 11:14 am revealed: -Resident #4 was ordered Novolog sliding scale insulin due to her diagnoses of diabetes mellitus. -The facility printed Resident #4's FSBS off for him when he visited the facility weekly and he reviewed the FSBS during those visits. -Resident #4's FSBS normally ran high and he would be visiting Resident #4 "next week" and possibly adjusting her insulin. -Resident #4 had been hospitalized for hypoglycemia around December 2017 so he would rather see her blood sugars high rather than too low. -He expected to be contacted by the facility and for medication to be administered as ordered. -The physician did not indicate whether or not he expected the facility to contact him each time the FSBS was over 301.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.	D 287		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure all residents received a place setting consisting of a non-disposable knife, fork and spoon.

The findings are:

Interview with the Administrator on 04/11/2018 at 9:15 am revealed the current census was 68 residents; including 28 residents in the special care unit (SCU).

1. Observation of the lunch meal preparation and setup on 04/11/2018 from 12:00 pm to 1:15 pm revealed:
-There were 25 place settings in the SCU dining room.
-Of the 25 residents, there were 2 residents with disposable spoons.

Observation of the breakfast meal preparation and setup on 04/12/2018 from 7:00 am to 8:20 am revealed:
-There were 25 place settings in the SCU dining room.
-Of the 25 residents, there were 17 residents with disposable spoons.

Observation of the lunch meal preparation and setup on 04/11/2018 from 12:00 pm to 1:15 pm revealed:
-There were 25 place settings in the SCU dining room.
-Of the 25 place settings in the SCU dining room, 8 residents only had a spoon, 8 residents only had a fork, and 9 residents only had a fork and spoon.

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-None of the residents were provided a knife.

Observation of the breakfast meal preparation and setup on 04/12/2018 from 7:00 am to 8:20 am revealed:
-There were 25 place settings in the SCU dining room.
-Of the 25 place settings in the SCU dining room, 10 residents only had a spoon, 2 residents only had a fork, and 12 residents only had a fork and spoon.
-None of the residents were provided a knife.

Interview with first shift personal care aide (PCA) on 4/12/2018 at 3:15 pm revealed:
-Resident #8 required complete assistance with eating during mealtimes.
-The SCU had been short on spoons for the last few weeks.
-At one time the facility had enough utensils but recently they had been short.
-The SCU resident's were never given knives due to safety concerns.

Interview with a dietary cook on 04/12/2018 at 3:30 pm revealed:
-The PCAs and the Medication Aides (MA) prepared the place setting for residents.
-SCU residents received a fork and spoon.
-He did not know the SCU residents were provided plastic spoons and did not have enough utensils for each resident.
-The SCU staff should let him know when they need additional silverware.

Interview with the SCU Manager on 04/12/2018 at 4:05 pm revealed:
-All residents should be provided a fork, knife, and spoon at all meals.
-Residents in the SCU only received a fork and

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spoon due to safety concerns.
-The SCU staff cut up any food that needed to be cut up for the residents.
-The Administrator ordered spoons, but was unable to recall the date.

Interview with the Administrator on 04/12/2018 at 4:30 pm revealed:
-She started working at the facility as the Administrator on 01/22/2018.
-A fork, knife, and spoon should be provided to all SCU resident's.
-She did not know each resident in the SCU was not provided non-disposable fork, knife and spoon.
-She had ordered silverware when she first started working at the facility.
2. Observation of the lunch meal service in the assisted living (AL) dining hall on 04/11/2018 from 12:30 to 1:30 pm revealed:
-There were 35 residents present for the lunch meal service.
-There were 27 residents who received plastic knives, 7 residents received plastic spoons, and 8 residents did not have a knife.

Observation of the breakfast meal service in the AL dining hall on 04/12/2018 from 7:30 am to 8:30 am revealed 36 residents were present and all residents had a non-disposable knife, spoon, and fork.

Observation of the lunch meal service in the AL dining hall on 4/12/2018 from 12:30 to 1:30 revealed 37 residents had a non-disposable knife, spoon, and fork.

Interviews with 4 residents on 04/11/2018 at 12:47 pm revealed:
-The facility ran out of silverware including knives

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and spoons "at times."
-Residents sometimes received plastic knives and spoons with their meals.
-They wanted to use silverware with all meals.

Interview with the cook on 04/12/2018 at 1:30 pm revealed:
-The personal care aides (PCA) and the medication aides (MA) prepared the place settings for residents.
-The place settings included a spoon, a knife, and a fork.
-He did not know plastic utensils were being used in the AL dining hall.
-He would not know that additional utensils were needed unless staff told him.

Interview with a PCA on 04/12/2018 at 3:12 pm revealed:
-PCAs were responsible for setting the table with table service that included a water cup, tea glass, coffee cup, napkin, fork, spoon, and sometimes a knife.
-She did not know all residents should have a fork, spoon, and knife at their place setting.
-She had set the tables in the AL dining hall for dinner meal service with a spoon and fork.
-She did not know who put the plastic knives and spoons out at the breakfast meal service on 4/12/18.

Interview with a MA on 04/12/2018 at 3:20 pm revealed:
-She set the table for residents during her shift.
-She included a fork and spoon in the table service and gave a knife to some residents.
-She felt like it was not safe for some residents to have a knife.
-She was told by the Administrator on Monday, 04/09/18 that all residents should have a knife,

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D 287	Continued From page 10 spoon, and fork at their place setting. -There were not any residents who had a physician's order not to have a knife. -She had never seen plastic utensils in the place setting for residents during any meal service. Interview with a second MA on 04/12/2018 at 4:15 pm revealed: -The place setting included a knife, fork, and spoon. -"We don't have enough silverware." -"When we run out of silverware, we use plastic utensils. Interview with the Administrator on 04/12/2018 at 4:24 pm revealed: -The place setting included a plate, 3 cups, a spoon, knife, and fork. -She had ordered silverware when she first started working at the facility in January 2018. -She did not know staff were placing plastic utensils at the table service for residents. -Her expectations were that all residents were served with silverware at each meal.	D 287		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record	D 312		

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reviews, the facility failed to assure 2 of 2 residents (#7 and #8) who required assistance with eating, were assisted upon receipt of the meal in a timely manner.

The findings are:

1. Review of Resident #7's current FL2 dated 09/13/2017 revealed:
-Diagnoses included vascular dementia, depression, seizures, and schizophrenia.
-A diet order for mechanical soft.
-The resident was semi-ambulatory.
-The resident was constantly disoriented.
-The resident required assistance with eating.

Observation of Resident #7 during the lunch meal service on 04/11/2018 from 12:15 pm-1:15 pm revealed:
-The plate was delivered covered.
-She was served roast beef, carrots, potatoes, iced tea and water.
-She required complete assistance with eating and drinking throughout the lunch meal.
-Staff set the plate of food in front of the resident at 12:15 pm, but did not provide assistance with eating until 12:45 pm.
-The plate was not reheated.
-She ate 75% of the roast beef, 75% of carrots, and 75% of potatoes with staff assistance.
-She was not assisted with eating by staff until 30 minutes after delivery of her meal.

Observation of Resident #7 during the breakfast meal service on 04/12/2018 at 7:20 am-8:20 am revealed:
-The plate was delivered to the table covered.
-She was served sausage, grits, and eggs.
-She required complete assistance with eating and drinking throughout the breakfast meal.

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-Staff set the plate of food in front of the resident at 7:20 am, but did not provide assistance with eating until 7:55 am.
-The plate was not reheated.
-She ate 75% of the sausage, 75% of the grits, and 75% of the eggs with staff assistance.
-She was not provided assistance with eating by staff until 35 minutes after delivery of her meal.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

Attempted telephone interview with Resident #7's responsible party on 04/13/2018 at 12:10 pm was unsuccessful.

Interview with a PCA on 04/12/2018 at 3:15 pm revealed:
-Resident #7 required complete feeding assistance at all meals.
-Resident #7 usually received the meal after the entire meal was passed out to the residents who did not require assistance.
-Two staff usually assisted the residents who required assistance with eating.

Interview with the SCU Manager on 04/12/2018 at 4:05 pm revealed:
-She was responsible for resident care in the Special Care Unit.
-She did not know Resident #7 was not provided assistance with eating for 30 to 35 minutes after the meal was served.

Interview with a medication aide (MA) on 04/12/2018 at 5:00 pm revealed:
-Resident #7 was usually assisted with eating their meals after the residents who did not require assistance received their meal.

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THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

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-Two staff usually assisted the residents who required assistance with eating.

Refer to interview with a personal care aide (PCA) on 04/11/2018 at 12:50 pm.

Refer to interview with a Hospice nurse on 04/12/2018 at 12:45 pm.

Refer to interview with the Administrator on 04/12/2018 at 4:30 pm.

2. Review of Resident #8's current FL2 dated 03/07/2018 revealed:
-Diagnoses included Alzheimer's dementia, macular degeneration, and cardiovascular accident.
-A diet order for mechanical soft, no tomatoes.
-The resident was non-ambulatory.
-The resident was intermittently disoriented.
-The resident required assistance with eating.

Observation of Resident #8 during the lunch meal service on 04/11/2018 from 12:15 pm to 1:15 pm revealed:
-The plate was delivered covered.
-She was served roast beef, carrots, potatoes, iced tea and water.
-She required complete assistance throughout the lunch meal.
-Staff set the plate of food in front of the resident at 12:15 pm, but did not provide feeding assistance until 12:50 pm.
-The plate was not reheated.
-She ate less than 25% of the lunch meal.
-She was not provided assistance with eating by staff until 35 minutes after delivery of her meal.

Observation of Resident #8 during the breakfast meal service on 04/12/2018 at 7:20 am to 8:20

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am revealed:
-The plate was delivered covered.
-She was served sausage, grits, and eggs.
-She required complete assistance throughout the breakfast meal.
-Staff set the plate of food in front of the resident at 7:20 am, but did not provide assistance with eating until 7:55 am.
-The plate was not reheated.
-She ate 100% of the breakfast meal.
-She was not provided assistance with eating by staff until 35 minutes after delivery of her meal.

Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.

Attempted telephone interview with Resident #8's responsible party on 04/13/2018 at 12:12 pm was unsuccessful.

Interview with a PCA on 04/12/2018 at 3:15 pm revealed:
-Resident #8 required complete feeding assistance at all meals.
-Resident #8 usually received the meal after the entire meal was passed out to the residents who did not require assistance.
-Two staff usually assisted the residents who required assistance with eating.

Interview with the SCU Manager on 04/12/2018 at 4:05 pm revealed:
-She was responsible for resident care in the Special Care Unit.
-She did not know Resident #8 was not provided assistance with eating for 35 minutes after the meal was served.

Interview with a medication aide (MA) on

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04/12/2018 at 5:00 pm revealed:
-Resident #8 were usually assisted with eating their meals after the residents who did not require assistance received their meal.
-Two staff usually assisted the residents who required assistance with eating.

Refer to interview with a personal care aide (PCA) on 04/11/2018 at 12:50 pm.

Refer to interview with a Hospice nurse on 04/12/2018 at 12:45 pm.

Refer to interview with the Administrator on 04/12/2018 at 4:30 pm.
____

Interview with a personal care aide (PCA) on 04/11/2018 at 12:50 pm revealed:
-One PCA passed out plates, one PCA passed out beverages, and one PCA assisted with eating of one of the resident's who required assistance eating.
-They had several resident's who came into the dining room at varied times to eat and some residents wandered during mealtime and "it is time consuming".
-The staff could use the microwave to reheat the food if needed.

Interview with a Hospice nurse on 04/12/2018 at 12:45 pm revealed:
-She came to the facility on Tuesday and Thursday each week.
-She provided feeding assistance to one of her residents while she was at the facility.
-There were 2 residents that required assistance with eating at all meals.

Interview with the Administrator on 04/12/2018 at 4:30 pm revealed:

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D 312	Continued From page 16 -She was responsible for the care at the facility. -The SCU Manager was responsible for making sure residents were provided assistance with eating meals. -She did not know 2 residents were not provided assistance with eating for 30 to 35 minutes after the meal was served.	D 312		
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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #4) with orders for insulin and an antidepressant. The findings are: Review of Resident #4's current FL2 dated 10/25/2017 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, chest pain, type 2 diabetes, obesity, and chronic pain.	D 358		

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a. Review of Resident #4's current FL2 dated 10/25/2017 revealed there was an order for Novolog insulin FlexPen 100 ml, check fingerstick blood sugar (FSBS) before meals and at bedtime, use sliding scale as follows: 71-150= 0 units; 151-200= 4 units; 201-250= 8 units; 251-300=12 units.

Review of a subsequent physician's order dated 1/10/2018 revealed an order for Novolog FlexPen 100ml insulin pen, inject 3 times daily after meals and at bedtime per sliding scale: If FSBS 71-150= 0 units; 151-200= 4; 201-250= 8; 251-300= 12; over 301 give 14 units and call MD; Hold insulin if resident does not eat.

Review of Resident #4's February 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog insulin FlexPen, 3 times daily after meals and at bedtime per sliding scale: If FSBS 71-150= 0 units; 151-200= 4 units; 201-250= 8 units; 251-300= 12 units; FSBS greater than 301 Give 14 units and call physician *Hold insulin if resident does not eat*.
-There were entries for Novolog insulin to be administered at 8:00 am, 1:00 pm, 6:00 pm, and 10:00 pm.
-Staff documented administration of Novolog insulin 28 of 112 opportunities.
-Staff documented 5 times "resident refused" Novolog insulin.
-Staff documented 10 times Novolog insulin was "withheld per doctor orders."
-Staff documented 1 time "out of facility."
-Staff documented 1 time "given by home health."
-FSBS was not documented 6 times with no documented reason why it was not entered on the eMAR. Without the 6 documented FSBS results it

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could not be determined how much Novolog insulin should have been administered.
-Resident #4's FSBS ranged from 110 to 555.

Review of Resident #4's March 2018 eMAR revealed:
-There was an entry for Novolog insulin FlexPen, 3 times daily after meals and at bedtime per sliding scale: If FSBS 71-150= 0 units; 151-200= 4 units; 201-250= 8 units; 251-300= 12 units; FSBS greater than 301 Give 14 units and call physician *Hold insulin if Resident does not eat*.
-There were entries for Novolog insulin to be administered at 7:00 am or 8:00 am, 12:00 pm or 1:00 pm, 5:00 pm or 6:00 pm, and 9:00 pm or 10:00 pm.
-Staff documented administration of Novolog insulin 60 of 124 opportunities.
-Staff documented 9 times Novolog insulin was "withheld per doctor orders."
-Staff documented 1 time "resident refused."
-Staff documented 3 times "out of facility."
-On 3/22/18 at 12:00 pm, FSBS was documented as 308, 7 units were documented as administered 14 units should have been given and the physician should have been notified.
-FSBS was not documented 6 times with no documented reason why it was not entered on the eMAR. Without the 6 documented FSBS results it could not be determined how much Novolog insulin should have been administered.
-Resident #4's FSBS ranged from 112 to 581.

Review of Resident #4's April 2018 eMAR revealed:
-There was an entry for Novolog insulin FlexPen, 3 times daily after meals and at bedtime per sliding scale: If FSBS 71-150= 0 units; 151-200= 4 units; 201-250= 8 units; 251-300= 12 units; FSBS greater than 301 Give 14 units and call

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physician *Hold insulin if Resident does not eat*.
-There were entries for Novolog insulin to be administered at 8:00 am, 1:00 pm, 6:00 pm, and 9:00 pm.
-Staff documented administration of Novolog insulin 29 of 41 opportunities.
-Staff documented 9 times "resident refused."
-Staff documented 2 times "withheld per doctor orders."
-Staff documented 1 time "out of facility."
-Resident #4's FSBS ranged from 213 to 440.

Interview with the Assisted Living (AL) Manager on 4/12/2018 at 7:05 pm revealed:
-She was responsible for completing MAR audits.
-The eMAR audits were completed by using a list of discrepancies generated by the eMAR system
-The facility physician had staff print off Resident #4's documented FSBS and he reviewed them at each Wednesday when he visited the facility.
-If the physician did not look at Resident #4's documented FSBS, then they did not get looked at.
-An audit was completed of Resident #4's record in March 2018 and the AL Manager was taught how to put the sliding scale calculator into the eMAR system.
-The sliding scale calculator identified how many units of insulin Resident #4 should receive when her FSBS was entered.
-The sliding scale calculator in the eMAR system was not used prior to March 2018.

Second interview with the AL Manager on 4/12/2018 at 7:32 pm revealed:
-Cart audits were completed weekly by the AL Manager.
-She did not know of missing entries for FSBS and insulin administration on the eMAR for multiple dates and times because they did not

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show up on the list of discrepancies generated by the eMAR system.

Interview with a second shift MA on 04/12/2018 at 8:15 pm revealed:
-She administered medication to Resident #4 during her shift including sliding scale insulin.
-Resident #4 had an order for FSBS checks 4 times daily with insulin administered according to the sliding scale.
-She documented Resident #4's FSBS and insulin administration on the eMAR after she administered it.
-She had not been notified that she has ever made any errors with checking FSBS or administering sliding scale insulin.
-She received training on fingerstick blood sugars and insulin when she was hired.
-The facility physician reviewed Resident #4's sliding scale insulin weekly when he came to the facility.
-To her knowledge, the physician had not notified facility staff with any issues with administration of Resident #4's sliding scale insulin.

Interview with the Administrator on 04/12/2018 at 8:23 pm revealed:
-The AL and Special Care Unit (SCU) Managers were responsible for reviewing the eMARs for accuracy.
-She expected the eMARs to be checked daily.
-The AL and SCU Managers were responsible for completing weekly medication cart audits.
-The MA received medication administration training through an online training system.
-The facility contracted nurse provided medication training including sliding scale insulin prior to MAs administering medication.
-The MAs received yearly diabetic training.
-She was not aware of the multiple times FSBS

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and insulin administration not documented on the eMAR
-She expected medications to be administered as ordered.

Interview with a representative at Resident #4's physician's office on 04/13/2018 at 10:33 am revealed:
-Resident #4 was ordered Novolog sliding scale insulin due to her diagnoses of diabetes mellitus.
-The facility staff were expected to contact the physician's practice if medication was not administered as ordered.
-The physician's practice had not been notified of any missed doses of medication including insulin.

Interview with Resident #4's physician on 04/13/2018 at 11:14 am revealed:
-Resident #4 was ordered Novolog sliding scale insulin due to her diagnoses of diabetes mellitus.
-The facility printed Resident #4's FSBS off for him when he visited the facility and he reviewed the FSBS during those visits.
-Resident #4's FSBS normally ran high and he would be visiting Resident #4 on next week and possibly adjusting her insulin.
-He did not know there was no documentation multiple times in February, March, and April 2018 that insulin was administered.
-He did not know resident #4's FSBS was over 500 at times with no documentation of medication administration.
-Resident #4 had been hospitalized for hypoglycemia around December 2017 so he would rather see her blood sugars high rather than too low.
-He expected to be contacted by the facility and for medication to be administered as ordered.

b. Review of Resident #4's current FL2 dated

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10/25/2017 revealed there was an order for duloxetine HCL 60 mg 1 capsule twice daily (used to treat depression and anxiety).

Review of Resident #4's electronic Medication Administration Record (eMAR) for February 2018 revealed:
-There was an entry for duloxetine HCL 60 mg 1 capsule twice daily at 9:00 am and 9:00 pm.
-Eleven doses of duloxetine were missed.
-On 02/01/18 through 02/04/18, duloxetine was documented as administered at 9:00 am and documented as not administered at 9:00 pm with the reason documented as "medication not in facility notify care manager."
-On 02/05/18, duloxetine was documented as not administered at 9:00 am and at 9:00 pm with the reason documented as "medication not in facility notify care manager" for both times.
-On 02/06/18 through 02/07/18, duloxetine was documented as not administered at 9:00 am and with the reason documented as "medication not in facility notify care manager" and documented as administered at 9:00 pm.
-On 02/08/18, duloxetine was documented as not administered at 9:00 am with the reason documented as "medication not in facility notify care manager" and documented as not administered at 9:00 pm with the reason documented as "resident refused."
On 02/09/18, duloxetine was documented as administered at 9:00 am and documented as not at ministered at 9:00 pm with the reason documented as "withheld per doctor's orders."

Review of Resident #4's eMAR for March and April 2018 revealed no missed doses of duloxetine HCL 60 mg.

Interview with a medication aide (MA) on

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04/11/2018 at 1:04 pm revealed:
-The medication cart had a scanner and medications were labeled with a barcode.
-The MA scanned the barcode on the medication and it was marked on the eMAR
-After medication was given, the MA clicked the save button and it recorded the medication as given.
-Medication refills were ordered when there was about 5 days of medication left.
-Medication refill requests were faxed to the pharmacy.

Interview with a MA on 04/12/2018 at 3:30 pm revealed:
-Medication orders were faxed to the pharmacy and a confirmation sheet was stapled to the medication order to show it was faxed, then put in the record.
-The AL Manager verified the medication orders in the eMAR.

Interview with the Assisted Living (AL) Manager on 4/12/18 at 7:05 pm revealed:
-She was responsible for completing MAR audits.
-The eMAR audits were completed by using a list of discrepancies generated by the eMAR system

Second interview with the AL Manager on 04/12/2018 at 7:32 pm revealed:
-Medication cart audits were completed weekly by the AL CM.
-Some medications were on cycle fill and were delivered to the facility by the pharmacy every 30 days.
-When medication was ordered, it was delivered to the facility on the say day or the next day depending upon the time the medication was ordered.
-Duloxetine was a cycle fill medication.

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-She had not reviewed any errors in the administration of duloxetine.
-She did not know duloxetine had been documented as administered and as not in the facility multiple times in the same day.
-She started doing cart audits about 2 weeks ago.

Interview with a second shift MA on 04/12/2018 at 8:15 pm revealed:
-She had received training on medication administration when she was hired.
-She had administered medication including duloxetine to Resident #4 during her shift.
-She did not remember medication not being in the facility.
-She did not know why duloxetine was documented as administered and out of the facility on the same day.
-The AL Manager was responsible for completing medication cart and eMAR audits, but she did not know how often.

Interview with the Administrator on 04/12/2018 at 8:23 pm revealed:
-The Managers were responsible for reviewing the eMARs for accuracy.
-She expected the eMARs to be checked daily.
-The AL and SCU Managers were responsible for completing weekly medication cart audits.
-MA received medication administration training through an online training system.
-The facility contracted nurse provided medication training prior to MAs administering medication.
-Once medication was reordered, it should be in the facility within 24 hours.
-She expected the MAs to let the AL and SCU Managers know that medication was not on the cart.
-She did not know that duloxetine was documented as being administered and

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D 358	Continued From page 25 documented as not being in the facility on the same day for multiple days in February. -She expected medication to be administered as ordered. Interview with Resident #4's physician on 04/13/2018 at 11:14 am revealed: -Resident #4 was ordered duloxetine due to anxiety. -He did not know duloxetine was documented as not administered on at least 1 of the 2 scheduled daily times multiple consecutive days in February 2018. -"I don't recall being notified about Resident #4 missing any doses of duloxetine. -"I expect to be contacted regarding missed doses of medication." -Missing doses on multiple days could have caused withdrawal effects, "but I did not notice any." Interview with a pharmacy representative on 04/13/2018 at 12:26 pm revealed: -The original order for duloxetine was 11/16/17. -Duloxetine was filled on 11/23/17, 12/23/17, 02/09/18, 3/16/18, and 3/28/18. -There were no refill orders for duloxetine in January 2018. -Once a medication was ordered, the pharmacy had 24 hours to get the medication to the facility.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following	D 375		

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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
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requirements are met:
(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and
(2) specific instructions for administration of prescription medications are printed on the medication label.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 residents (#4) with medication in her room had a physician's order to self-administer Ventolin (a medication used to treat wheezing and shortness of breath).

The findings are:

Review of Resident #4's current FL2 dated 10/25/2017 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, shortness of breath, hypoventilation syndrome, and obesity.
-There was an order for Ventolin 90 mcg inhaler, inhale two puffs every 6 hours as needed for wheezing.
-There were no physician's orders to self-administer Ventolin inhaler.

Review of Resident #4's electronic medication administration record (eMAR) for February 2018 revealed:
-There was an entry for Ventolin 90 mcg inhaler, inhale 2 puffs every 6 hours as needed for wheezing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068025	A. BUILDING: ______ B. WING ______	04/13/2018

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-Ventolin was documented as administered 1 time during the month of February 2018 on 02/10/2018.

Review of Resident #4's eMAR for March 2018 revealed:
-There was an entry for Ventolin 90 mcg inhaler, inhale 2 puffs every 6 hours as needed for wheezing.
-Ventolin was documented as administered 1 time during the month of March 2018 on 03/26/2018.

Review of Resident #4's electronic eMAR for April 2018 revealed:
-There was an entry for Ventolin 90 mcg inhaler, inhale 2 puffs every 6 hours as needed for wheezing.
-Ventolin was documented as administered 1 time during the month of April 2018 on 04/10/2018.

Review of Resident #4's physician's orders revealed no orders self-administer Ventolin inhaler.

Interview with Resident #4 on 04/11/2018 at 9:37 a.m. revealed:
-She had a diagnosis of COPD and used a Ventolin inhaler.
-She inhaled 2 puffs about 3 times daily.
-She kept her inhaler with her at all times.

Observation of Resident #4's room on 4/11/2018 at 9:40 a.m. revealed:
-Resident #4 pulled the Ventolin inhaler from her coat pocket.
-The Ventolin inhaler did not have Resident #4's name on it nor did it have instructions for use.

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D 375	Continued From page 28 Interview with Resident #4 on 4/12/2018 at 7:10 p.m. revealed: -She used the Ventolin inhaler when she got short of breath. -One of the Medication Aides (MA) gave her the Ventolin inhaler to keep with her. -"They are supposed to keep it on the cart, but I keep it." -"If I leave it on the cart then they can't find it when I need it." -"I ask for my inhaler, they give it to me and I take it and go on about my business." -"I can't keep running up and down that hall all night to get more out of breath. -"They told me I needed to get a letter from my doctor, but I keep forgetting to ask for it when the doctor comes to the facility." -She would inhale 2 puffs of Ventolin and wait 4-5 hours before she used the inhaler again. Interview with the Assisted Living (AL) Manager on 04/12/2018 at 7:32 p.m. revealed: -She knew Resident #4 had an order for an inhaler, but did not know that Resident #4 kept the inhaler in her room. -She did not know if Resident #4 had an order to self-administer Ventolin inhaler. -Residents who self-administered medication had to be evaluated by a nurse to assess their ability to self-administer medication. -Residents had to have an order from a physician prior to self-administration of medication. -The MAs would be responsible for obtaining self-administration orders from the physician. Observation of medication on hand for Resident #4 on 4/12/2018 at 7:54 p.m. revealed there was no Ventolin inhaler available for administration. Interview with a MA on 04/12/2018 at 8:15 p.m.	D 375		

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revealed:
-Resident #4 was ordered Ventolin 90 mcg inhaler, two puffs every 6 hours as needed.
-The Ventolin inhaler had been reordered from the pharmacy on 04/06/2018 and she did not know why the inhaler was not available for administration.
-She did not know where the labeled medication box was that Resident #4's Ventolin was packaged in.
-She administered the Ventolin inhaler to Resident #4 last week.
-In order for Resident #4 to keep her Ventolin in her room, she needed a physician's order to self-administer Ventolin.
-Resident #4 did not have a physician's order to self-administer medication.

Interview with the Administrator on 04/12/2018 at 8:23 p.m. revealed:
-She did not know Resident #4 had Ventolin inhaler in her room.
-She was not sure if Resident #4 had physician orders to self-administer medication.
-Resident #4 should have had a physician's order to self-administer Ventolin if kept in her room.

Telephone interview with a medical coordinator at Resident #4's physician's practice on 04/13/2018 at 10:33 a.m. revealed:
-Resident #4 did not have any physician's orders to self-administer Ventolin.
-The facility contacted the practice on 4/12/2018 at 8:10 pm and requested a physician's order to self-administer Ventolin inhaler.