PRINTED: 05/07/2018 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			A. BOILDING			
		HAL068025	B. WING		04/1	3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE STRA	ATFORD		LEVEL ROAD ILL, NC 27516			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	conducted an anual s	sure Section and the rtment of Social Services urvey on April 11-13, 2018 one on April 13, 2018.				
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273			
	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.					
	reviews, the facility fa for 1 of 5 sampled res	ns, interviews, and record iled to notify the physician sidents (Resident #4) with physician if fingerstick blood				
	The findings are:					
	chronic painThere was an order the check FSBS before making scale as follow 151-200= 4 units; 201 units.	chronic obstructive COPD) with acute diabetes, obesity, and for Novolog insulin FlexPen, neals and at bedtime, use vs: 71-150= 0 units; 1-250= 8 units; 251-300=12				
	1/10/2018 revealed a	ent physician's order dated n order for Novolog insulin es daily after meals and at				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL068025	B. WING		04/13/2018	
	NAME OF PROVIDER OR SUPPLIER THE STRATFORD STREET ADI 405 SMITH CHAPEL H					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	ETE
D 273	bedtime per sliding so units; 151-200= 4; 20 301 give 14 units and resident does not eat Review of Resident # medication administratevealed: -There was an entry for 3 times daily after mes sliding scale: If FSBS 4 units; 201-250= 8 units; 201-2018, FSB greater 32 times with -On 02/12/2018, FSB at 8:00 am and there resident #4's physicity -On 02/16/2018, FSB at 8:00 am, 315 at 1:000 There was no documphysician had been con 02/23/2018, FSB at 8:00 am, 433 at 6:000 There was no documphysician had been con 02/23/2018, FSB at 8:00 am, 433 at 6:000 There was no documphysician had been con 02/23/2018, FSB at 8:00 am, 433 at 6:000 There was no documphysician had been con 02/23/2018, FSB at 8:00 am, 433 at 6:000 There was an entry for stimes daily after mes sliding scale: If FSBS 4 units; 201-250= 8 un	cale: If FSBS 71-150= 0 1-250= 8; 251-300= 12; over call MD; Hold insulin if 4's February 2018 electronic ation record (eMAR) for Novolog insulin FlexPen, cals and at bedtime per 71-150= 0 units; 151-200= nits; 251-300= 12 units; 01 Give 14 units and call if resident does not eat*. For Novolog insulin to be ng scale at 8:00 am, 1:00 00 pm. ranged from 110 to 555. was documented as 301 or examples as follows: S was documented as 333 was no documentation an had been called. S was documented as 388 00 pm, and 555 at 6:00 pm; entation Resident #4's alled. S was documented as 329 00 pm and 331 at 10:00 pm; entation Resident #4's	D 273			

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physician *Hold insulin if Resident does not eat*.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
			1			
			D MINIC			
		HAL068025	B. WING		04/1	13/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		405 SMITH	LEVEL ROAD			
THE STRA	THE STRATFORD CHAPEL H		IILL, NC 27516			
	CLIMMA DV CT				TION	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR		DATE
				DEFICIENCY)		
D 273	Continued From none	- 0	D 273			
D 213	Continued From page	2	D 2/3			
	-There were entries for	or 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	6:00 pm, and 9:00 pm or				
	10:00 pm.	1				
	-	ranged from 112 to 581.				
		was documented as 301 or				
	greater 50 times with					
	_					
	-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.					
		S was documented as 458				
	· ·					
		::00 pm, 371 at 5:00 pm, and				
	• •	e was no documentation				
	Resident #4's physicia					
	1	S was documented as 359				
	· ·	00 pm and 410 at 9:00 pm;				
		nentation Resident #4's				
	physician had been c	alled.				
	Daview of Decident #	idle April 2040 eMAD				
	Review of Resident # revealed:	4 S April 2018 elviAR				
		ior Novelea inquiin FloyDon				
		for Novolog insulin FlexPen,				
	,	eals and at bedtime per				
	_	71-150= 0 units; 151-200=				
	· ·	nits; 251-300= 12 units;				
		01 Give 14 units and call				
	' '	n if Resident does not eat*.				
		or Novolog insulin to be				
		am, 1:00 pm, 6:00 pm, and				
	9:00 pm.					
		ranged from 213 to 440.				
		was documented as 301 or				
	greater 8 times with e	·				
	-On 04/03/2018, FSB	S was documented as 335				
	at 8:00 am and there	was no documentation				
	Resident #4's physici	an had been called.				
	_ · · · · · · · · · · · · · · · · · · ·	S was documented as 440				
	1	t 1:00 pm; There was no				

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documentation Resident #4's physician had been

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 3 calledOn 0.4/07/2018, 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's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for Resident #4's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for 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:	STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER THE STRATFORD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG COMMITTER TAG Continued From page 3 called. -On 04/07/2018, FSBS was documented as 399 at 8:00 am and there was no 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's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for Resident #4's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for Resident #4's physician regarding FSBS 301 or greater. Review of progress notes for March 2018 for Resident #4's physician regarding FSBS 301 or greater. Review of progress notes for March 2018 for Resident #4's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for Resident #4's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for Resident #4's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for Resident #4's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for 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:			HAI 068025	B. WING		04/13/2018	
THE STRATFORD 405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516 CAPEL HILL, NC 27516 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 273 Continued From page 3 Called.				1		04/13/2016	
CHAPEL HILL, NC 27516 CAPID SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF P	ROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE	THE STRA	ATFORD					
calledOn 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's physician regarding FSBS 301 or greater. Review of progress notes for April 2018 for 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:	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE	
-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 facilityNo one reviewed Resident #4's documented FSBS other than the physician when he visited the facilityThe MAs should have followed the physician's order to contact the physician for FSBS greater than 301The MAs should have documented in the progress notes when the physician was contacted.	D 273	calledOn 04/07/2018, FSB at 8:00 am and there Resident #4's physici Review of progress in Resident #4 revealed with Resident #4's pho2/25/2018 "due to reindicate if the FSBS via Review of progress in Resident #4 revealed with Resident #4 revealed with Resident #4's phor greater. Review of progress in Resident #4 revealed with Resident #4 revealed with Resident #4's phor greater. Interview with the Ass (AL CM) on 4/12/2018 -She was responsible auditsThe eMAR audits we of discrepancies generates -The facility physician #4's documented FSB each Wednesday when one reviewed ReFSBS other than the the facilityThe MAs should havorder to contact the puthan 301The MAs should havorderess notes when	S was documented as 399 was no documentation an had been called. otes for February 2018 for staff documented contact ysician 1 time on esident's sugar," but did not was 301 or greater. otes for March 2018 for no documented contact ysician regarding FSBS 301 otes for April 2018 for no documented contact ysician regarding FSBS 301 sisted Living Care Manager 8 at 7:05 pm revealed: 6 for completing eMAR ere completed by using a list erated by the eMAR system of had staff print off Resident as and he reviewed them en he visited the facility. sident #4's documented physician when he visited re followed the physician's hysician for FSBS greater re documented in the	D 273			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL068025	B. WING		04/13/2018
NAME OF B		070557.40		TE 710 0005	•
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
THE STRATFORD 405 SMITH		I LEVEL ROAD			
	CHAPEL H		HILL, NC 27516	5	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
.,.0		,		DEFICIENCY)	
D 273	Continued From none	- 1	D 273		
D 213	Continued From page	÷ 4	02/3		
		nd shift MA on 04/12/2018 at			
	8:15 pm revealed:				
		edication to Resident #4			
		ling sliding scale insulin.			
		order for FSBS checks 4			
	_	n administered according to			
	the sliding scale.	sident #4's ESPS and			
	-She documented Resident #4's FSBS and insulin administration on the eMAR after she				
	administration on the ewar after she				
	-She thought the sliding scale insulin order for				
	_	all the doctor if FSBS was			
	greater than 350.				
	-She documented Re	sident #4's FSBS was			
	greater than 301 before	ore.			
		ne physician when Resident			
	_	er than 301, but did not			
	document it anywhere	э.			
	Intonvious with the Adr	ministrator on 04/12/2019 at			
	8:23 pm revealed:	ministrator on 04/12/2018 at			
	•	edication administration			
	training through an or				
	•	d nurse provided medication			
	-	ing scale insulin prior to MAs			
	administering medica	-			
	-Resident #4's physic	ian should have been			
	contacted if her FSBS	S was over the parameters.			
	-She expected medic	ation to be administered as			
	ordered.				
	Intended to 10	and an auditoration of Books (
		cal coordinator at Resident			
	#4's pnysician's pract am revealed:	ice on 04/13/2018 at 10:33			
		ered Novolog sliding scale			
		gnoses of diabetes mellitus.			
		contacted the Resident #4's			
	-	times in February, 2 times			
		in April 2018 regarding			

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FSBS being over 301.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL068025	B. WING		04/13/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE STRA	TEODD	405 SMITH	I LEVEL ROAD			
THE STRE	ATT OND	CHAPEL I	HILL, NC 27516			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
D 273	Continued From page 5		D 273			
	-"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 mellitusThe facility printed Resident #4's FSBS off for him when he visited the facility weekly and he reviewed the FSBS during those visitsResident #4's FSBS normally ran high and he would be visiting Resident #4 "next week" and possibly adjusting her insulinResident #4 had been hospitalized for hypoglycemia around December 2017 so he would rather see her blood sugars high rather than too lowHe expected to be contacted by the facility and for medication to be administered as orderedThe physician did not indicate whether or not he expected the facility to contact him each time the FSBS was over 301.					
D 287	Service 10A NCAC 13F .0904 (b) Food Preparation Homes: (2) Table service shall non-disposable place a knife, fork, spoon, p	ns may be made on an shall be based on	D 287			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
			_			
		HAL068025	B. WING		04	/13/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE STRA	ATFORD		I LEVEL ROAD IILL, NC 27516			
	CLIMMADV CT			PROVIDER'S PLAN OF CO	DDECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 287	Continued From page	e 6	D 287			
	interviews, the facility received a place setti non-disposable knife, The findings are: Interview with the Adr 9:15 am revealed the residents; including 2 care unit (SCU). 1. Observation of the setup on 04/11/2018 revealed: -There were 25 place room.	ns, record reviews, and failed to assure all residents ng consisting of a				
	and setup on 04/12/2 am revealed: -There were 25 place roomOf the 25 residents, disposable spoons. Observation of the luisetup on 04/11/2018 revealed: -There were 25 place roomOf the 25 place settin 8 residents only had a	eakfast meal preparation 018 from 7:00 am to 8:20 settings in the SCU dining there were 17 residents with settings in the scu dining from 12:00 pm to 1:15 pm settings in the SCU dining ags in the SCU dining room, a spoon, 8 residents only dents only had a fork and				

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HAL068025 B. WING 04/13/2018	3/2018		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		
	<u> </u>	04/1		B. WING	HAL068025		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516				LEVEL ROAD	THE STRATFORD 405 SMITH		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	(X5) COMPLETE DATE	BE	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX
D 287 Continued From page 7 -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. -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 residents 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 4:06 pm revealed: -All residents should be provided a fork, knife, and spoon at all meals.				D 287	eakfast meal preparation 018 from 7:00 am to 8:20 e settings in the SCU dining ngs in the SCU dining room, a spoon, 2 residents only sidents only had a fork and s were provided a knife. If personal care aide (PCA) pm revealed: d complete assistance with nes. short on spoons for the last ty had enough utensils but en short. were never given knives due ry cook on 04/12/2018 at Medication Aides (MA) etting for residents. wed a fork and spoon. SCU residents were ns and did not have enough dent. d let him know when they ware. U Manager on 04/12/2018 at be provided a fork, knife,	-None of the residents Observation of the broand setup on 04/12/2 am revealed: -There were 25 place roomOf the 25 place settir 10 residents only had had a fork, and 12 residentsNone of the residents Interview with first shi on 4/12/2018 at 3:15 -Resident #8 required eating during mealtimeThe SCU had been seen seen weeksAt one time the facility recently they had beenThe SCU resident's with a dietal 3:30 pm revealed: -The PCAs and the Minimal properties of the place seen seen seenHe did not know the provided plastic spoon utensils for each resident should the seen seen seen seen seen seen seen se	D 287

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-Residents in the SCU only received a fork and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SI COMPLE		
		HAL068025	B. WING		04/1	3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE STRA	ATFORD	405 SMITH	LEVEL ROAD			
THE OTTO		CHAPEL H	IILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 287	7 Continued From page 8		D 287			
D 287	spoon due to safety of The SCU staff cut up cut up for the residen The Administrator on unable to recall the day of the Administrator on unable to recall the day of the Administrator on 01/2 and the Administrator on	concerns. In any food that needed to be ats. Idered spoons, but was ate. Idered spoons at the facility as the facility as the facility as the spoonshould be provided to all other resident in the SCU was posable fork, knife and idered spoons and spoons at the facility. Identify a facility and form the facility. Identify a facility and form the facility and form the facility. Identify a facility and form the	D 287			
	AL dining hall on 04/1 8:30 am revealed 36	eakfast meal service in the 12/2018 from 7:30 am to residents were present and in-disposable knife, spoon,				
	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 residuals	dents on 04/11/2018 at				

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-The facility ran out of silverware including knives

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL068025	B. WING		04/13/2018
NAME OF D	ROVIDER OR SUPPLIER	QTDEET AF	DRESS, CITY, STA	TE ZIR CODE	
NAME OF T	NOVIDER OR SOLT LIER				
THE STRATFORD		H LEVEL ROAD			
	CHAPEL I		HILL, NC 27516		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 287	Continued From page	9	D 287		
	and spoons "at times.	"			
	•	s received plastic knives			
	and spoons with their				
	-	silverware with all meals.			
	•				
	Interview with the coorevealed:	ok on 04/12/2018 at 1:30 pm			
	-The personal care ai	des (PCA) and the			
	medication aides (MA				
	settings for residents.				
-The place settings included a spoon, a knife, and					
	a fork.				
	•	stic utensils were being used			
	in the AL dining hall.				
		hat additional utensils were			
	needed unless staff to	old him.			
	Interview with a PCA revealed:	on 04/12/2018 at 3:12 pm			
	-PCAs were responsi	ble for setting the table with			
		uded a water cup, tea glass,			
	coffee cup, napkin, fo	rk, spoon, and sometimes a			
	knife.				
	-She did not know all	residents should have a			
	fork, spoon, and knife				
		es in the AL dining hall for			
	dinner meal service w	•			
		o put the plastic knives and			
	•	akfast meal service on			
	4/12/18.				
	Interview with a MA o	n 04/12/2018 at 3:20 pm			
	revealed:				
		residents during her shift.			
		and spoon in the table			
	_	nife to some residents.			
		ot safe for some residents to			
	have a knife.				
	-She was told by the	Administrator on Monday,			

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04/09/18 that all residents should have a knife,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL068025	B. WING		04/13/2018	3
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	,	
THE STRA	TFORD		I LEVEL ROAD IILL, NC 27516			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMP	(5) PLETE TE
D 287	Interview with a second pm revealed: -The place setting incomposition spoon"We don't have enough the second pm revealed: -The place setting incomposition spoon"When we run out of utensils. Interview with the Adra 4:24 pm revealed: -The place setting incomposition spoon, knife, and fork-she had ordered silv started working at the second pm second p	eir place setting. residents who had a to have a knife. plastic utensils in the place luring any meal service. and MA on 04/12/2018 at 4:15 cluded a knife, fork, and agh silverware." silverware, we use plastic ministrator on 04/12/2018 at cluded a plate, 3 cups, a cluded a plat	D 287			
D 312	Service 10A NCAC 13F .0904 (f) Individual Feeding Homes: (2) Residents needin assisted upon receipt assistance shall be un	nhurried and in a manner ances each resident's	D 312			
	Based on observation	ns, interviews and record				

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STATE FORM 6899 EHR511 If continuation sheet 11 of 30

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		HAL068025	B. WING		04/13/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
THE STRA	ATFORD	405 SMITH	LEVEL ROAD		
		CHAPEL H	IILL, NC 27516	·	
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 312	2 Continued From page 11		D 312		
	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 roas	et 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL068025	B. WING		04/1	3/2018
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
THE STRA	ATFORD		LEVEL ROAD ILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 312	at 7:20 am, but did not eating until 7:55 am. -The plate was not re -She ate 75% of the eggs -She was not provide staff until 35 minutes Based on observation reviews it was determinerviewable. Attempted telephone responsible party on unsuccessful. Interview with a PCA revealed: -Resident #7 required assistance at all meal-Resident #7 usually entire meal was pass did not require assistance with the SC 4:05 pm revealed: -She was responsible Special Care UnitShe did not know Reassistance with eating the meal was served. Interview with a medio 04/12/2018 at 5:00 pm revealed:	food in front of the resident of provide assistance with heated. fausage, 75% of the grits, with staff assistance. d assistance with eating by after delivery of her meal. his, interviews, and record hined Resident #7 was not hinterview with Resident #7's 04/13/2018 at 12:10 pm was hinder feeding his. It complete feeding his hine received the meal after the end out to the residents who hinder hine his hinder hinder hinder hine his hinder	D 312	DEFICIENCY)		
	their meals after the r assistance received the	esidents who did not require heir meal.				

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STATE FORM 6899 EHR511 If continuation sheet 13 of 30

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND LEAN	. John Londin	SERVIN IO MICH MONIBER.	A. BUILDING: _	A. BUILDING:		
		HAL068025	B. WING		04/13/	2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE STRA	ATFORD		LEVEL ROAD			
			ILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 312	Continued From page	e 13	D 312			
	-Two staff usually ass required assistance w	sisted the residents who vith eating.				
	Refer to interview with (PCA) on 04/11/2018	h a personal care aide at 12:50 pm.				
	Refer to interview with a Hospice nurse on 04/12/2018 at 12:45 pm.					
	Refer to interview with 04/12/2018 at 4:30 pr	h the Administrator on m.				
	03/07/2018 revealed:	nt #8's current FL2 dated Alzheimer's dementia,				
	macular degeneration accident.					
	-A diet order for mech -The resident was no	nanical soft, no tomatoes. n-ambulatory.				
		ermittently disoriented. d assistance with eating.				
	service on 04/11/2018 revealed:	ent #8 during the lunch meal 8 from 12:15 pm to 1:15 pm				
	-The plate was delive -She was served roas iced tea and water.	red covered. st beef, carrots, potatoes,				
	the lunch meal.	ete assistance throughout				
	at 12:15 pm, but did rassistance until 12:50) pm.				
	•					
	Observation of Reside	ent #8 during the breakfast 2/2018 at 7:20 am to 8:20				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL068025	B. WING	B. WING		3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1	
THE STRA	ATFORD		LEVEL ROAD			
	Г		ILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 312	Continued From page	e 14	D 312			
	the breakfast mealStaff set the plate of at 7:20 am, but did no eating until 7:55 amThe plate was not re -She ate 100% of the -She was not provide staff until 35 minutes Based on observation reviews it was determinterviewable. Attempted telephone	sage, grits, and eggs. Ite assistance throughout food in front of the resident of provide assistance with heated. breakfast meal. d assistance with eating by after delivery of her meal. as, interviews, and record hined Resident #8 was not interview with Resident #8's				
	responsible party on 04/13/2018 at 12:12 pm was					

Division of Health Service Regulation

Interview with a medication aide (MA) on

STATE FORM 6899 EHR511 If continuation sheet 15 of 30

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		HAL068025	B. WING		04	1/13/2018
NAME OF P	ROVIDER OR SUPPLIER	405 SMIT	DDRESS, CITY, STATE TH LEVEL ROAD HILL, NC 27516	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 312	04/12/2018 at 5:00 progression of the resident was their with a personal of the resident with the resident with the resident with the resident with the resident was their meals after the resident with the resident with the resident was the resident was the resident was the resident was the resident with the resident was the resident with a Hospital the resident while she was the residents while she was the residents while she was the residents while she was the resident at all means the resident with eating at all means the resident with a the resident with eating at all means the resident was the	m revealed: ually assisted with eating residents who did not require heir meal. sisted the residents who with eating. In a personal care aide at 12:50 pm. In a Hospice nurse on om. In the Administrator on m. In the Administrator on m. In the Administrator on m. In the PCA assisted with eating I's who required assistance Is sident's who came into the times to eat and some luring mealtime and "it is the microwave to reheat the Ility on Tuesday and I g assistance to one of her reas at the facility. Ints that required assistance	D 312			

Division of Health Service Regulation

STATE FORM 6899 EHR511 If continuation sheet 16 of 30

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		HAL068025	B. WING		04	1/13/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
THE STR	ATFORD		TH LEVEL ROAD L HILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 312	-She was responsibl -The SCU Manager sure residents were eating mealsShe did not know 2	e for the care at the facility. was responsible for making provided assistance with residents were not provided ng for 30 to 35 minutes after	D 312			
D 358	(a) An adult care ho preparation and adm prescription and non by staff are in accord (1) orders by a licen which are maintained	14 Medication Administration ome shall assure that the ninistration of medications, 1-prescription, and treatments	D 358			
	reviews, the facility f were administered a prescribing practition	t as evidenced by: ons, interviews, and record failed to assure medications s ordered by a licensed her for 1 of 5 sampled #4) with orders for insulin and				
	10/25/2017 revealed -Diagnoses included pulmonary disease (chronic obstructive COPD) with acute pain, type 2 diabetes,				

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			(X3) DATE SURVEY COMPLETED		
				D WING	
		HAL068025	B. WING		04/13/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	, ZIP CODE	
THE STRA	TEOPD	405 SMIT	H LEVEL ROAD		
THE STRA	AIFORD	CHAPEL	HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page	: 17	D 358		
	10/25/2017 revealed to Novolog insulin FlexP blood sugar (FSBS) b use sliding scale as for	t #4's current FL2 dated there was an order for en 100 ml, check fingerstick efore meals and at bedtime, ollows: 71-150= 0 units; -250= 8 units; 251-300=12			
	1/10/2018 revealed at 100ml insulin pen, inje and at bedtime per sli 0 units; 151-200= 4; 2	ent physician's order dated n order for Novolog FlexPen ect 3 times daily after meals ding scale: If FSBS 71-150= 201-250= 8; 251-300= 12; s and call MD; Hold insulin if			
	medication administrative revealed: -There was an entry for 3 times daily after meastiding scale: If FSBS 4 units; 201-250= 8 units; 201-250= 201-	or Novolog insulin FlexPen, als and at bedtime per 71-150= 0 units; 151-200= nits; 251-300= 12 units; 251-300= 12 units; 21 Give 14 units and call in if resident does not eat*. Or Novolog insulin to be am, 1:00 pm, 6:00 pm, and ministration of Novolog ortunities. imes "resident refused"			

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STATE FORM 6899 EHR511 If continuation sheet 18 of 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL068025	B. WING		04/13/	/2018
NAME OF PROVIDER OR SUPPLIER THE STRATFORD	405 SMITH	DRESS, CITY, STA LEVEL ROAD IILL, NC 27516			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
Review of Resident #4 revealed: -There was an entry fo 3 times daily after mea sliding scale: If FSBS 7 4 units; 201-250= 8 units; 201-250= 8 units SBS greater than 301 physician *Hold insulin -There were entries for administered at 7:00 at 1:00 pm, 5:00 pm or 6: 10:00 pmStaff documented adminsulin 60 of 124 opporting-Staff documented 9 times withheld per doctor on staff documented 1 times at 12:00 pm as 308, 7 units were documented 14 units at 14 units and the physician shouter SBS was not documented reason when the first without the 6 documented reason when the first without the 6 documented for the first staff documented reason when the first staff	ed how much Novolog en administered. anged from 110 to 555. 's March 2018 eMAR Ir Novolog insulin FlexPen, als and at bedtime per 71-150= 0 units; 151-200= its; 251-300= 12 units; I Give 14 units and call if Resident does not eat*. If Novolog insulin to be m or 8:00 am, 12:00 pm or 100 pm, and 9:00 pm or 100 pm, and 9:00 pm or 101 ministration of Novolog Irtunities. Imes Novolog insulin was Ir novolog insulin to Ir novolog insulin FlexPen, Ir novo	D 358			

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FSBS greater than 301 Give 14 units and call

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l l	I
HAL068025 B. WING	04/13/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED	IN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETE D TO THE APPROPRIATE DATE CIENCY)
D 358 Continued From page 19 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 pmStaff documented administration of Novolog insulin 29 of 41 opportunitiesStaff documented 9 times "resident refused." -Staff documented 9 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 auditsThe 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 facilityIf the physician did not look at Resident #4's documented FSBS, then they did not get looked atAn 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 systemThe sliding scale calculator identified how many units of insulin Resident #4 should receive when her FSBS was enteredThe 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 ManagerShe did not know of missing entries for FSBS and insulin administration on the eMAR for	

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multiple dates and times because they did not

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DIVISION	or riealth Service Negu	ialion	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	1 ' '	X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
		HAL068025	B. WING		04/1	3/2018	
NAME OF D		OTDEETAD		TE 7/D 00DE			
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,			
THE STRA	ATFORD		I LEVEL ROAD				
		CHAPEL I	HILL, NC 27516	5			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE	
IAG		,	IAG	DEFICIENCY)			
D 250	0	- 00	D 358				
D 358	Continued From page	20	D 358				
	show up on the list of	discrepancies generated by					
	the eMAR system.						
		nd shift MA on 04/12/2018 at					
	8:15 pm revealed:	edication to Resident #4					
		ling sliding scale insulin.					
	_	order for FSBS checks 4					
		n administered according to					
	the sliding scale.	in dariii ilotored dooording to					
		sident #4's FSBS and					
		on the eMAR after she					
	administered it.						
	-She had not been no	otified that she has ever					
	made any errors with						
	administering sliding	_					
		g on fingerstick blood sugars					
	and insulin when she	was hired.					
	-The facility physician	reviewed Resident #4's					
	sliding scale insulin w	eekly when he came to the					
	facility.						
		ne physician had not notified					
	,	ssues with administration of					
	Resident #4's sliding	scale insulin.					
	Intervious with the Adr	ministrator on 04/12/2018 at					
	8:23 pm revealed:	111111Strator or 04/12/2016 at					
		Care Unit (SCU) Managers					
	· -	reviewing the eMARs for					
	accuracy.						
		MARs to be checked daily.					
		inagers were responsible for					
	completing weekly me	•					
		edication administration					
	training through an or						
		ed nurse provided medication					
		ing scale insulin prior to MAs					
	administering medica						
	-The MAs received ye	early diabetic training.					
		of the multiple times FSBS					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL068025	B. WING		04/1	3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE STRA	ATFORD	405 SMITH	LEVEL ROAD			
		CHAPEL H	ILL, NC 27516		ı	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	21	D 358			
	eMAR	ation not documented on the ations to be administered as				
	physician's office on 0 revealed: -Resident #4 was ord insulin due to her diag-The facility staff were physician's practice if administered as order-The physician's practice.					
	insulin due to her diagarthe facility printed Rhim when he visited to the FSBS during those-Resident #4's FSBS would be visiting Respossibly adjusting here. He did not know there multiple times in Februthat insulin was adminible times with not administration. -Resident #4 had been hypoglycemia around would rather see here than too low. -He expected to be contained the side of the side	am revealed: ered Novolog sliding scale gnoses of diabetes mellitus. esident #4's FSBS off for the facility and he reviewed e visits. normally ran high and he tident #4 on next week and r insulin. the was no documentation ruary, March, and April 2018 histered. dent #4's FSBS was over documentation of medication				

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

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DIVISION	n nealth Service Regu	alion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			_			
			P WING			
		HAL068025	B. WING		04/1	3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			LEVEL ROAD			
THE STRA	TFORD					
		CHAPEL H	ILL, NC 27516			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	JAIE	DAIL
D 358	Continued From page	22	D 358			
	. •					
		there was an order for				
	duloxetine HCL 60 mg	g 1 capsule twice daily (used			ľ	
	to treat depression ar	nd anxiety).				
	Review of Resident #	4's electronic Medication				
	Administration Record	d (eMAR) for February 2018				
	revealed:					
	-There was an entry f	or duloxetine HCL 60 mg 1				
		9:00 am and 9:00 pm.				
	-Eleven doses of dulo	•				
		02/04/18, duloxetine was				
	•	nistered at 9:00 am and				
		dministered at 9:00 pm with				
		ed as "medication not in				
	facility notify care mai	_				
		tine was documented as not				
		am and at 9:00 pm with the				
		s "medication not in facility				
	notify care manager"					
	-On 02/06/18 through	02/07/18, duloxetine was				
	documented as not a	dministered at 9:00 am and				
	with the reason docur	mented as "medication not				
	in facility notify care n	nanager" and documented				
	as administered at 9:0	00 pm.				
	-On 02/08/18, duloxet	tine was documented as not				
	administered at 9:00					
		ication not in facility notify				
	care manager" and do					
	administered at 9:00					
	documented as "resid					
		ne was documented as				
	•	am and documented as not				
	at ministered at 9:00					
	documented as "with	neld per doctor's orders."				
		4's eMAR for March and				
	April 2018 revealed n					
	duloxetine HCL 60 mg	g.				
						1

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Interview with a medication aide (MA) on

STATE FORM 6899 EHR511 If continuation sheet 23 of 30

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
		HAL068025	B. WING		04/1	3/2018
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
THE STRA	ATFORD		LEVEL ROAD ILL, NC 27516			
0(4) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ı	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	23	D 358			
	04/11/2018 at 1:04 pr -The medication cart medications were lab -The MA scanned the and it was marked on -After medication was save button and it rec givenMedication refills we about 5 days of medic -Medication refill requ pharmacy. Interview with a MA o revealed: -Medication orders we and a confirmation sh medication order to si the record.	n revealed: had a scanner and eled with a barcode. barcode on the medication the eMAR s given, the MA clicked the corded the medication as				
	on 4/12/18 at 7:05 pm -She was responsible -The eMAR audits we of discrepancies gene Second interview with 04/12/2018 at 7:32 pr -Medication cart audit the AL CMSome medications w delivered to the facilit daysWhen medication was to the facility on the s	for completing MAR audits. For completed by using a list erated by the eMAR system In the AL Manager on				

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-Duloxetine was a cycle fill medication.

STATE FORM 6899 EHR511 If continuation sheet 24 of 30

Division o	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		0.4/4.0/0.04.0	
		HAL068025	B. WIIVO		04/1	3/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		405 SMITH	I LEVEL ROAD	1		
THE STRA	TFORD		HLL, NC 27516			
		CHAPEL	TILL, NC 2/510			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
D 358	Continued From page	e 24	D 358			
	Cha had not noviews	d annu annana in tha				
	-She had not reviewe	=				
	administration of dulo					
	-She did not know du				ļ	
		nistered and as not in the				
	facility multiple times					
	-She started doing ca	ırt audits about 2 weeks ago.				
	Interview with a secon	nd shift MA on 04/12/2018 at				
	8:15 pm revealed:					
	-She had received tra	nining on medication				
	administration when s	she was hired.				
	-She had administere	ed medication including				
	duloxetine to Resider					
	-She did not remember medication not being in					
	the facility.					
	-She did not know wh	ny duloxetine was				
		nistered and out of the				
	facility on the same d					
	•	s responsible for completing				
		eMAR audits, but she did not				
	know how often.	ewalt addits, but she did not				
	Know now oilen.					
	lasta muia vuusitla tlaa. Aalm					
		ministrator on 04/12/2018 at				
	8:23 pm revealed:					
	•	responsible for reviewing				
	the eMARs for accura					
		MARs to be checked daily.				
		nagers were responsible for				
	completing weekly me					
		tion administration training				
	through an online trai				ļ	
		ed nurse provided medication			ļ	
	training prior to MAs a	administering medication.				
	-Once medication wa	s reordered, it should be in				
	the facility within 24 h	ours.				
		As to let the AL and SCU				
	•	medication was not on the				
cart.						

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-She did not know that duloxetine was documented as being administered and

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
HAL068025		B. WING		04/13/2018		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE OTO	TEODD	405 SMITH	LEVEL ROAD			
THE STRA	AIFORD	CHAPEL H	ILL, NC 27516	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 25	D 358			
	documented as not being in the facility on the same day for multiple days in FebruaryShe 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 anxietyHe 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 375	10A NCAC 13F .1005 Medications	5(a) Self-Administration Of	D 375			
	10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to					

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self-administer their medications if the following

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
HAL068025		B. WING	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E ZIP CODE	1	1/13/2018	
			TH LEVEL ROAD	2,211 0002			
THE STRA	ATFORD		HILL, NC 27516				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 375	prescribe medication documented in the re (2) specific instruction	t: ation is ordered by a rson legally authorized to s in North Carolina and	D 375				
	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 obesityThere was an order for Ventolin 90 mcg inhaler, inhale two puffs every 6 hours as needed for wheezingThere were no physician's orders to self-administer Ventolin inhaler.						
	administration record revealed:	4's electronic medication (eMAR) for February 2018 for Ventolin 90 mcg inhaler, s hours as needed for					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL068025	B. WING		04/1	3/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE			
THE STRA	ATFORD		TH LEVEL ROAD . HILL, NC 27516				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
D 375	Continued From page	e 27	D 375				
	-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 wheezingVentolin 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 wheezingVentolin 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 inhalerShe inhaled 2 puffs about 3 times dailyShe 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 pocketThe Ventolin inhaler did not have Resident #4's name on it nor did it have instructions for use.						

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DIVISION	n Health Service Regu	ialion	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
		D MING				
		HAL068025	B. WING		04/1	3/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			LEVEL ROAD			
THE STRA	TFORD					
		CHAPEL	IILL, NC 27516			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MAIL	DAIL
				,		
D 375	Continued From page	28	D 375			
		1.114 1/10/2010 1.7.10				
		nt #4 on 4/12/2018 at 7:10				
	p.m. revealed:					
		n inhaler when she got short				
	of breath.					
		n Aides (MA) gave her the				
	Ventolin inhaler to kee	•				
	-"They are supposed	to keep it on the cart, but I				
	keep it."					
	-"If I leave it on the ca	art 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 fa					
		ouffs of Ventolin and wait 4-5				
	hours before she use					
	nours before one account minutes again.					
	Interview with the Ass	sisted Living (AL) Manager				
	on 04/12/2018 at 7:32	• , ,				
		#4 had an order for an				
		low that Resident #4 kept				
	the inhaler in her roor	•				
		Resident #4 had an order to				
	self-administer Ventol					
		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.					
	=					
		esponsible for obtaining				
	seit-administration ord	ders from the physician.				
	Observation for "	ation on bond for D. 11. 1				
		ation on hand for Resident				
		54 p.m. revealed there was				
	no Ventolin inhaler available for administration.					

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Interview with a MA on 04/12/2018 at 8:15 p.m.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL068025		B. WING		04/13/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THE STRA	TEOPD	405 SMITH	LEVEL ROAD			
THE STRA	AIFORD	CHAPEL H	IILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 375	Continued From page	29	D 375			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					

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