STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual survey on 05/09/2018 through 05/11/2018.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there were no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire for 1 of 3 sampled staff (Staff C), a Personal Care Aide (PCA) . The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 04/30/2018 as a personal care aide (PCA). -There was documentation a Health Care Personnel Registry Check (HCPR) was completed on 05/09/2018 with no substantiated findings. Interview with the Executive Director (ED) on 05/10/2018 at 10:17 am revealed: -Staff C was hired as a PCA. -The business office manager was responsible for ensuring that the HCPR was checked upon	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 137	Continued From page 1 hire for new staff. -She did not know the HCPR had not been checked for Staff C until 05/09/2018. -She had expected for the HCPR to be checked for Staff C upon hire. Interview with the business office manager on 05/10/2018 at 10:22 am revealed: -She was responsible for completing HCPR checks for new staff. -She knew the HCPR should be checked for new staff upon hire. -She had not check the HCPR for Staff C until 05/09/2018. Interview with Staff C on 05/11/2018 at 4:41 pm revealed: -She was hired as a PCA. -Her first day of work at the facility was on 04/30/2018. -She did not work again until the following Monday, 05/07/2018. -She did not know if the HCPR had been checked for her upon hire.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to assure 2 of 3 staff sampled (Staff B and C), a medication aide (MA) and a personal	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 139	Continued From page 2	D 139		

care aide (PCA), had a criminal background check completed upon hire.

The findings are:

1. Review of Staff B's personnel record revealed:
-The date of hire was 05/03/2018.
-She wwa hired as a MA.
-There was documentation a statewide criminal background check was requested on 05/09/2018.

Interview with the business office manager on 05/10/2018 at 10:22 am revealed:
-She was responsible for completing criminal background checks for new staff.
-She knew that criminal background checks should have been completed for new staff upon hire.
-She had not requested criminal background checks for Staff B until 05/09/2018.

Attempted interview with Staff B on 05/11/2018 at 5:15 pm was unsuccessful.

Refer to interview with the Executive Director (ED) on 05/10/2018 at 10:17 am.

2. Review of Staff C's personnel record revealed:
-The date of hire was 04/30/2018.
-She was hired as a PCA.
-There was documentation a statewide criminal background check was requested on 05/09/2018.

Interview with the business office manager on 05/10/2018 at 10:22 am revealed:
-She was responsible for completing criminal background checks for new staff.
-She knew that criminal background checks should have been completed for new staff upon hire.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 139	Continued From page 3 -She had not requested criminal background checks for Staff C until 05/09/2018. Interview with Staff C on 05/11/2018 at 4:41 pm revealed: -Her first day working at the facility as a MA was on 04/30/2018. -She did not remember if she had a criminal background check prior to working in the facility. Refer to interview with the ED on 05/10/2018 at 10:17 am. Interview with the ED on 05/10/2018 at 10:17 am revealed: -The business office manager was responsible for ensuring that the criminal background checks were completed upon hire for new staff -She did not know criminal background checks had not been completed for 2 staff until 05/09/2018. -She had expected criminal background checks to be completed for staff upon hire. The facility failed to ensure 2 of 3 sampled staff had a state-wide criminal background check upon hire resulting in the facility being unaware of any potential criminal background findings for Staff B (a MA) and Staff C (a PCA) which is detrimental to the welfare and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/10/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25, 2018	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 273	Continued From page 4	D 273		
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 2 of 3 sampled residents regarding a renewal order for tramadol for continued complaints of pain (Resident #3), and physician orders for daily weights (Resident #2). The findings are: 1. Review of Resident #3's current FL-2 dated 10/30/17 revealed diagnoses included an unspecified fracture of the upper left humerus, difficulty walking, and muscle weakness. Review of Resident #3's signed physician's orders dated 02/21/18 revealed diagnoses included type 2 diabetes mellitus with neuropathy, myasthenia gravis, anxiety, Chronic Obstructive Pulmonary Disease (COPD), epilepsy, and hypertension. Review of Resident #3's physician's orders dated 03/15/18 revealed an order for tramadol 50 mg take 1 tablet every 6 hours as needed for pain. Review of pharmacy dispensing records revealed: -Tramadol 50 mg, 60 tablets were dispensed on	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 273	Continued From page 5	D 273		

04/04/18.
-Oxycodone 5/325 mg, 15 tablets were dispensed on 04/30/18.

Observation on 05/10/18 at 2:00 pm of the medications on hand for Resident #3 revealed:
-There was no tramadol 50 mg available for administration.
-There was no oxycodone 5/325 mg available for administration.

Review of Resident #3's April 2018 electronic medication administration record (eMAR) revealed:
-An entry for tramadol 50 mg, give 1 tablet every 6 hours as needed for pain.
-Tramadol was documented as administered on 04/06/18, 04/07/18, 04/08/18, 04/09/18, 04/10/18, 04/11/18, 04/12/18, 04/13/18, 04/14/18, 04/15/18, 04/16/18, 04/17/18, 04/18/18, 04/19/18, 04/20/18, 04/21/18, 04/22/18, 04/23/18, 04/24/18, 04/25/18, 04/26/18, and 04/27/18.
-Tramadol was last documented as administered on 04/28/18 at 5:33 am and 2:58 pm.

Review of Resident #3's May 2018 electronic medication administration record (eMAR) revealed:
-An entry for tramadol 50 mg, give 1 tablet every 6 hours as needed for pain.
-Tramadol was not documented as administered at all in the month of May.
-An entry for oxycodone 5/325 mg, 1 tablet every 8 hours as needed for pain.
-Oxycodone was documented as administered from 05/01/18 to 05/06/18.

Interview on 05/11/2018 at 2:31 pm with Resident #3 revealed:
-She received tramadol every 6 hours as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 6	D 273		

for pain in her feet and legs.
-She had been out of tramadol since the end of April 2018.
-She was having a lot of pain in her feet and legs.
-She had to go to the emergency room on 04/29/18 because she was in so much pain that "it caused her blood pressure to be high."
-The emergency room had given her a prescription for oxycodone (used for severe pain) but she finished that prescription on 05/06/18 and was now receiving nothing for pain.
-She had asked to switch doctors back to the in-house physician because it was hard for her to get to appointments outside the facility.
-She had not been seen by a physician in May.
-She had told staff that she was in pain.
-Tramadol did not control her pain.

Telephone interview on 05/11/18 at 2:36 pm with the contracted pharmacy revealed:
-Tramadol 50 mg tablets were dispensed on 04/04/18 for 60 tablets.
-They had not received a refill request or a new prescription for tramadol for Resident #3.
-They had received a fax from the facility of a medication clarification form signed by Resident #3's orthopedist stating to discontinue tramadol 50 mg along with 2 other medications on 05/11/18 "after lunch."
-They had called the facility for clarification because the discontinue order was not from the same provider that prescribed the tramadol.

Interview on 05/11/18 at 1:00 pm with the MA revealed:
-Resident #3 had been out of tramadol for "a few days" but she had ordered more.
-She did not remember when she ordered more.
-She did not remember exactly how long Resident #3 had been out of medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 7	D 273		

-She had received a fax back from Resident #3's orthopedist discontinuing the tramadol.
-Resident #3 complained that the tramadol didn't work.
-Resident #3 had received a prescription from the emergency room for oxycodone but was out of that as well.
-Resident #3 complained of pain "all the time," even when she did receive pain medication.
-She had not contacted the physician to report Resident #3's complaints of pain.

Review of the faxed copy of the medication clarification form revealed:
-A request to discontinue 3 medications, including tramadol.
-It was signed by the MA.
-The request to discontinue the tramadol was handwritten in pen on the faxed form in between the printed writing.
-The words "OK discontinue" were handwritten in pen under the request to discontinue tramadol.
-The faxed copy was signed by the orthopedist and dated 05/10/18.

Telephone interview on 05/11/18 at 1:40 pm with a medical assistant from Resident #3's orthopedist office revealed:
-The orthopedist did not discontinue tramadol for Resident #3 because he did not prescribe it.
-They did not receive a medication clarification form from the facility requesting to discontinue tramadol.
-They had faxed over a signed medication clarification form on 05/11/18 stating to discontinue a prescribed analgesic cream only.
-They would fax another copy of the signed medication clarification form that they had sent, showing that it was only concerning the analgesic cream and no other medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 8 -The resident's record showed an order from the emergency room for oxycodone on 04/30/18, but there was no record of Resident #3 being prescribed tramadol in their system. -The orthopedist had prescribed the analgesic cream for pain but discontinued it because insurance would not cover it. -The orthopedist had also prescribed gabapentin (a nerve pain medication) for pain in the resident's feet and legs but did not know the resident was already taking gabapentin, so discontinued the additional prescription as well. -The orthopedist was not aware that Resident #3 did not have any medications for pain other than the gabapentin prescribed by a previous physician. -The orthopedist had not been contacted by the facility regarding current complaints of pain from Resident #3. Review of the faxed copy of the medication clarification form received from the orthopedist revealed: -It was a facility medication clarification form. -It was signed by the MA. -It was a request to discontinue an analgesic cream. -There were no other medications listed on the form. -The form was signed by the orthopedist and dated 05/10/18. Second interview on 05/11/18 at 3:20 pm with the MA revealed: -She had received the first faxed medication clarification form off the fax machine that morning. -It was her handwriting and signature on the form. -She did not know why the request to discontinue tramadol was written in pen on the printed copy.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 9	D 273		

-She did not know why "Ok to discontinue" was written in pen on the printed copy.
-"I pulled it off the fax machine like that."
-She did not know why the copy sent from the orthopedist on 05/11/18 at 2:00 pm did not have the request to discontinue tramadol on it.

Interview on 05/11/18 at 4:00 pm with the Executive Director revealed:
-She did not know about the medication clarification fax requesting to discontinue tramadol.
-Looking at both faxed copies, it was clear that the copy discontinuing tramadol had been altered with a pen after being received.
-She did not know why any staff would alter a received document.
-MA staff were responsible for requesting refills for medications.
-The MAs worked with the Resident Care Director (RCD) to coordinate appointments and address concerns for residents, but her RCD was currently on leave.
-Resident #3 still had tramadol listed on her eMAR but was out of the medication.
-Resident #3 had been receiving oxycodone from 05/01/18 to 05/06/18 for pain.
-Resident #3 did not have any medication for pain since finishing the oxycodone on 05/06/18.
-She did not know why a request for pain medication had not been sent to the provider.

2. Review of Resident #2's current FL-2 dated 04/04/2018 revealed:
-Diagnoses included dementia, chronic kidney disease, congestive heart failure, hypertension, diabetes, obstructive sleep apnea, chronic obstructive pulmonary disease, cirrhosis, chronic liver disease, and cardiomyopathy.
-Attached to the FL-2 was a "Medication Review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 10	D 273		

Report," printed from Resident #2's previous facility, which listed all of Resident #2's current medications and treatments.

Review of the "Medication Review Report" dated 04/03/2018 revealed an order to obtain weights weekly and report to the physician if there was a 5 pound weight gain within a week.

Review of Resident #2's record revealed no subsequent orders for weights.

Review of Resident #2's electronic Medication Administration Record (eMAR) for April 2018 revealed:
-There was an entry to weigh daily and to contact the physician if there was a 2-3 pound overnight gain.
-There was documentation Resident #2 was weighed on 04/17/18 and 04/18/18.
-There was no documentation Resident #2 was weighed from 04/04/18 through 04/16/18 and 04/19/18 through 04/30/18.
-There was documentation "Resident Refused" from 04/19/218 through 04/23/18.
-There was documentation "Withheld per Dr/RN Orders" from 04/25/18 through 04/26/18.
-There was documentation "Physically Unable to Take" on 04/30/18.

Review of Resident #2's eMAR for May 2018 revealed:
-There was an entry to weigh daily and to contact the physician if there was a 2-3 pound overnight gain.
-There was no documentation Resident #2 was weighed from 05/01/18 through 05/11/18.
-There was documentation, "Physically Unable to Take," from 05/01/18 through 05/02/18.
-There was documentation, "Resident Refused,"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 11	D 273		

on 05/04/18.
-There was documentation, "Withheld per Dr/RN Orders," on 05/05/18.
-There was documentation, "Physically Unable to Take," from 05/06/18 through 05/11/18.

Interview with a first shift Medication Aide (MA) on 05/09/2018 at 3:58 pm revealed:
-Resident #2 was supposed to be weighed every day.
-"I tried to weigh him, but he doesn't have strength in his legs to stand and I about dropped him."
-She had called Resident #2's physician a few weeks ago to let him know that she was unable to obtain a daily weight on Resident #
2.
-"Contacts with physicians should be documented in residents' charts."
-She had documented that weights were "Withheld per Dr/RN Orders" and "Physically Unable to Take" but there was no physician's order to withhold daily weights.
-Resident #2 had a doctor's appointment on 05/08/2018, but she did not send any documentation notifying the physician that daily weights were not obtained because she forgot.

Interview with the Executive Director (ED) on 05/09/2018 at 4:18 pm revealed:
-She did not know Resident #2 had physician orders for daily weights and did not know Resident #2 was not being weighed as ordered.
-The MA would be responsible for obtaining daily weights for Resident #2.
-A MA had just told her staff was not able to weigh Resident #2.
-She expected for the MA to tell the Resident Care Director (RCD) and document in the 24 hour nurses notes when Resident #2 refused to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 12	D 273		

be weighed or was not weighed for any reason.
-The RCD was not working in the facility this week.

Interview with a nurse at Resident #2's primary care physician's (PCP) office on 05/11/2018 at 9:28 am revealed:
-She was the liaison between the facility and Resident #2's physician.
-There was a current order for daily weights due to Resident #2's diagnosis of congestive heart failure.
-She had not been contacted by the facility and did not know the facility was not checking Resident #2's weight daily.
-She expected for the facility to contact her if Resident #2 was not being weighed daily as ordered.
-Not monitoring Resident #2's daily weights could lead to exacerbation of congestive heart failure and fluid on the lungs.

Interview with a clinical services representative at the facility's physician's office on 05/11/2018 at 10:38 am revealed:
-The facility notified the physician's office on 04/21/2018 that Resident #2 was new to the facility.
-Resident #2 was seen for the first time since being admitted to the facility on 04/25/2018 by a facility physician's assistant.
-Resident #2 was also seen by the facility physician's assistant on 05/02/2018.
-The physician's assistant was not the physician who wrote the order for daily weights.
-Weights were being taken daily at Resident #2's previous facility.
-On 04/25/18, the physician's assistant had asked current facility staff if they had been weighing Resident #2 daily and was told that the facility did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13	D 273		

not have the proper equipment to weigh Resident #2.
-The physician's assistant did not write any orders for weights during the 04/25/2018 or 05/02/2018 visit.

Observation of a notice posted in the medication room on 05/11/18 at 4:10 revealed steps to take when there were new orders included: clarify all doctor's orders and fax orders to the pharmacy.

Interview with Resident #2 on 05/11/2018 at 4:12 pm revealed:
-He did not know if he had a physician's order to be weighed daily.
-The facility was not weighing him daily and he did not remember the last time he had been weighed at the facility.

Attempted interview with the RCD on 05/11/18 at 4:20 pm was unsuccessful.

Interview with a second shift MA on 05/11/2018 at 4:41 pm revealed:
-She did not know Resident #2 had an order to be weighed daily.
-She had not seen anyone attempt to weigh Resident #2.
-She had never weighed Resident #2 because he could not stand to bear weight.

The facility failed to notify the physician for 2 of 3 sampled residents regarding a renewal order for tramadol for continued complaints of pain (Resident #3), and physician orders for daily weights (Resident #2). This failure led to increased and unresolved pain for Resident #3, and an exacerbation of congestive heart failure for Resident #2, which was detrimental to the health and safety of the residents and constitutes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 273	Continued From page 14 a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/07/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25, 2018	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was a matching therapeutic diet breakfast menu for 2 of 3 sampled residents (#1 and #3) with physician's orders for a No Concentrated Sweets (NCS) diet. The findings are: 1. Review of Resident #1's current FL2 dated 02/26/2018 revealed: -Diagnoses included insulin dependent diabetes mellitus. -There was a physician's order for a diabetic diet. Review of a subsequent physician's diet order dated 02/28/18 revealed an order for a NCS diet. Review of the therapeutic diet list posted in the	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 296	Continued From page 15 kitchen revealed Resident #3 was to be served a NCS diet. Review of the therapeutic diet menus revealed there was a NCS diet menu for lunch and dinner, but there was not a NCS diet menu for breakfast. Review of the regular breakfast menu for 05/10/18 revealed residents were to be served 1 bowl of oatmeal, 1 slice of bacon, fresh fruit, toast with jelly, 1 cup of juice, milk, water, or coffee. Observation of the breakfast meal service on 05/10/18 at 8:15 am revealed Resident #1 was served cereal with milk, 1 boiled egg, 1 slice of toast with jelly, a serving of mixed fruit, milk, and orange juice. Review of the regular breakfast menu for 05/11/18 revealed residents were to be served 2 scrambled eggs, hash browns, sausage, toast with jelly, 1 cup of juice, millk, water, or coffee. Observation of the breakfast meal service on 05/11/2018 at 8:05 am revealed Resident #1 was served a bowl of grits, a serving of fruit cocktail, 2 slices of toast with jelly, coffee and water. Interview with Resident #1 on 05/09/2018 at 3:55 pm revealed: -He did not know if he was on a special diet or not. -The doctor had told him not to eat any sugar. Interview with a clinical service representative at the facility's physician's office on 05/10/2018 at 9:29 am revealed Resident #1 should be on a NCS diet for all meals due to a diagnosis of diabetes mellitus.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

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D 296	Continued From page 16 Refer to interview with the Dietary Manager (DM) on 05/09/2018 at 12:25 pm. Refer to interview with the Executive Director (ED) on 05/09/2018 at 1:10 pm Refer to interview with the facility contracted registered dietician (RD) on 05/09/2018 at 2:16 pm. Refer to interview with the DM on 05/10/2018 at 8:23 am. 2. Review of Resident #3's current FL2 dated 10/30/2017 revealed: -Diagnoses included unspecified fracture of upper left humorous, unspecified fall, muscle weakness, and difficulty walking. -There was a physician's order for a Carbohydrate Controlled Diet (CCD), and a Regular No Added Salt (NAS) diet. Review of signed physician's orders dated 02/21/18 for Resident #3 revealed diagnoses included diabetes type 2. Review of a subsequent physician's diet order dated 11/22/17 revealed an order for a NCS diet. Review of the therapeutic diet list posted in the kitchen revealed Resident #3 was to be served a NCS diet. Observation of the breakfast meal service on 05/10/18 at 8:15 am revealed Resident #3 did not eat breakfast. Revivew of the regular breakfast menu for 05/11/18 revealed residents were to be served 2 scrambled eggs, hash browns, sausage, toast	D 296		

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 296	Continued From page 17 with jelly, 1 cup of juice, millk, water, or coffee. Observation of the breakfast meal service on 05/11/18 at 8:05 am revealed Resident #3 was served a bowl of oatmeal, a serving of fruit cocktail, 1 slice of toast with jelly, diet cranberry juice, milk, and water. Interview Resident #3 on 05/11/2018 at 1:19 pm revealed: -She was diabetic, but did not think she was on a special diet. -"I don't eat much sweet stuff." Interview with a clinical service representative Interview at the facility's physician's office on 05/10/2018 at 9:29 am revealed Resident #3 should be on a NCS diet for all meals due to diagnoses of diabetes mellitus. Refer to interview with DM on 05/09/2018 at 12:25 pm. Refer to interview with ED on 05/09/2018 at 1:10 pm Refer to interview with the facility contracted RD on 05/09/2018 at 2:16 pm. Refer to interview with the DM on 05/10/2018 at 8:23 pm. _____ Interview with the DM on 05/09/2018 at 12:25 pm revealed: -She was responsible for preparing and serving all meals. -The facility offered regular and NCS diets. -There was a menu available for NCS diets for lunch and dinner, but not for breakfast. -She has been using the regular breakfast menu	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 296	Continued From page 18	D 296		

for regular and NCS diets for about 4 months.
-The registered dietician was in the facility on last week and told her to continue using the regular breakfast menu for regular and NCS diets.
-She did not ask the ED or the RD about having a NCS breakfast menu available in the facility.

Interview with the ED on 05/09/2018 at 1:10 pm revealed:
-She was responsible for ensuring that therapeutic menus were in place for residents who were on therapeutic diets.
-The facility offered only regular and NCS diets.
-She did not know that a NCS diet menu was needed for the breakfast meal service.
-She was told that she only needed a NCS diet menu for the lunch and dinner meal services.
-She had been working on getting the menus in place and would get a NCS diet breakfast menu in place for residents on a NCS diet.

Interview with the facility contracted RD on 05/09/2018 at 2:16 pm revealed:
-The facility needed a NCS diet menu for the daily breakfast meal service.
-It was not her intentions for residents who were on a NCS diet to follow the regular menu for the breakfast meal service.
-Residents who had NCS diet orders needed a NCS menu for breakfast, lunch and dinner.
-"I have to get that to them. I will work on that right now."

Interview with the DM on 05/10/2018 at 8:23 am revealed:
-She thought there should have been a separate breakfast menu in place for residents on NCS diets, but she did not say anything.
-She served residents, who had orders for a NCS diet, sugar free jelly, diet and no sugar added

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 296	Continued From page 19 juices, and unsweetened tea.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 residents (#1 and #3) with physician's orders for a therapeutic diet of No Concentrated Sweets (NCS) therapeutic diet were served as ordered. The findings are: 1. Review of Resident #1's current FL2 dated 02/26/2018 revealed: -Diagnoses included insulin dependent diabetes mellitus. -There was a physician's order for a diabetic diet. Review of ta subsequent physician's diet order dated 02/28/18 revealed an order for a NCS diet. Review of the therapeutic diet list posted in the kitchen revealed Resident #3 was to be served a NCS diet. Review of the therapeutic diet menus revealed there was a NCS diet menu for lunch and dinner, but there was not a NCS diet menu for breakfast.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 310	Continued From page 20 Review of the regular breakfast menu for 05/10/18 revealed residents were to be served 1 bowl of oatmeal, 1 slice of bacon, fresh fruit, toast withjelly, 1 cup of juice, milk, water, or coffee. Observation of the breakfast meal service on 05/10/18 at 8:15 am revealed Resident #1 was served cereal with milk, 1 boiled egg, 1 slice of toast with jelly, a serving of mixed fruit, milk, and orange juice. Revivew of the regular breakfast menu for 05/11/18 revealed residents were to be served 2 scrambled eggs, hash browns,sausage, toast with jelly, 1 cup of juice, millk, water, or coffee. Observation of the breakfast meal service on 05/11/18 at 8:05 am revealed Resident #1 was served a bowl of grits, 1 slice of bacon, a serving of fruit cocktail, 2 slices of toast with jelly, coffee and water. It could not be determined if Resident #1 was served the appropriate meal due to no NCS menu available for the breakfast meal for staff guidance. Interview with Resident #1 on 05/09/18 at 3:55 pm revealed: -He did not know if he was on a special diet or not. -The doctor had told him not to eat any sugar. Interview with a clinical service representative Interview at the facility's physician's office on 05/10/2018 at 9:29 am revealed Resident #1 should be on a NCS diet for all meals due to diagnoses of diabetes mellitus. Refer to interview with the Dietary Manager (DM)	D 310		

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 310	Continued From page 21 on 05/09/18 at 12:25 pm. Refer to interview with the Executive Director (ED) on 05/09/18 at 1:10 pm Refer to interview with the facility contracted registered dietician (RD) on 05/09/18 at 2:16 pm. Refer to interview with the DM on 05/10/2018 at 8:23 am. 2. Review of Resident #3's current FL2 dated 10/30/2017 revealed: -Diagnoses included unspecified fracture of upper left humorous, unspecified fall, muscle weakness, and difficulty walking. -There was a physician's order for a Carbohydrate Controlled Diet (CCD), and a Regular No Added Salt (NAS) diet. Review of the diet order dated 11/22/2017 revealed an order for a NCS diet. Review of a signed provider orders dated 02/21/18 for Resident #2 revealed diagnoses included diabetes type 2. Review of the therapeutic diet list posted in the kitchen revealed Resident #3 had an order for a NCS diet. Observation of the breakfast meal service on 05/10/2018 at 8:15 am revealed Resident #3 did not eat breakfast. Revivew of the regular breakfast menu revealed residents were to be served 2 scrambled eggs, hash browns,sausage, toast with jelly, 1 cup of juice, millk, water, or coffee.	D 310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 310	Continued From page 22 Observation of the breakfast meal service on 05/11/2018 at 8:05 am revealed Resident #3 was served a bowl of oatmeal, 1 slice of bacon, a serving of fruit cocktail, 1 slices of toast with jelly, diet cranberry juice, milk, and water. Interview Resident #3 on 05/11/2018 at 1:19 pm revealed: -She was diabetic, but did not think she was on a special diet. -"I don't eat much sweet stuff." Interview with a clinical service representative Interview at the facility's physician's office on 05/10/2018 at 9:29 am revealed Resident #3 should be on a NCS diet for all meals due to diagnoses of diabetes mellitus. Refer to interview with the DM on 05/09/2018 at 12:25 pm. Refer to interview with the ED on 05/09/2018 at 1:10 pm Refer to interview with the facility RD on 05/09/2018 at 2:16 pm. Refer to interview with the DM on 05/10/2018 at 8:23 am. _____ Interview with the DM on 05/09/2018 at 12:25 pm revealed: -She was responsible for preparing and serving all meals. -The facility offered regular and NCS diets. -She served residents who had physician's orders for NCS diets according to the NCS diet menu for lunch and dinner. -Residents who had physician's orders for NCS	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 310	Continued From page 23	D 310		

diet were served regular breakfast meals from the regular breakfast menu because she did not have a NCS diet menu for breakfast.
-She did not ask the ED or the RD about having a NCS breakfast menu available in the facility.

Interview with the ED on 05/09/2018 at 1:10 pm revealed:
-The facility offered only regular and NCS diets.
-She was responsible for ensuring that therapeutic diets were served as ordered by the physician.
-Residents who were on a NCS diet were being served a regular breakfast because she did not know a NCS diet menu was need for the breakfast meal service.
-She was told that she only needed a NCS diet menu for the lunch and dinner meal services for residents on a NCS diet.

Interview with the facility's contracted registered dietician on 05/09/2018 at 2:16 pm revealed:
-The facility needed a NCS diet menu for the daily breakfast meal service.
-It was not her intentions for residents who were on a NCS diet to follow the regular menu for the breakfast meal service.
-Residents who had NCS diet orders needed a NCS menu for breakfast, lunch and dinner.
-"I have to get that to them. I will work on that right now."

Interview with the DM on 05/10/2018 at 8:23 am revealed:
-She thought Residents who had physician's orders for a NCS diet should have been served a NCS diet for the breakfast meal in addition to the lunch and dinner meals.
-She did not say anything because she was told to serve residents who were on a NCS from the

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 310	Continued From page 24 regular breakfast menu. -She served residents, who had orders for a NCS diet, sugar free jelly, diet and no sugar added juices, and unsweetened tea.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents with orders for an antibiotic, an angiotensin II receptor blocker, a beta blocker, and an angiotensin converting enzyme (ACE) inhibitor (Resident #2); an anxiolytic and pain medication (Resident #3). The findings are: 1. Review of Resident #2's current FL-2 dated 04/04/2018 revealed: -Diagnoses included chronic kidney disease, congestive heart failure, hypertension, diabetes	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 358	Continued From page 25 mellitus, cirrhosis of the liver, chronic liver disease, and cardiomyopathy a. Review of Resident #2's hospital discharge summary dated 04/28/2018 revealed: -Resident #2 was admitted to the hospital on 04/27/18 and discharged on 04/28/18. -Resident #2's discharge diagnosis included healthcare-associated pneumonia. -There was an order to start cefpodoxime 200 mg (an antibiotic) 1 tablet every 12 hours for 7 days. Review of Resident #2's electronic Medication Administration Record (eMAR) for April 2018 revealed: -There was no entry for cefpodoxime 200 mg 1 tablet every 12 hours. -There was no documentation cefpodoxime had been administered as ordered. Review of Resident #2's eMAR for May 2018 revealed: -There was no entry for cefpodoxime 200 mg 1 tablet every 12 hours. -There was no documentation cefpodoxime had been administered as ordered. Interview with Executive Director (ED) on 05/11/18 at 12:56 pm revealed: -The Resident Care Director (RCD) was responsible for reviewing discharge summaries for changes in medications and then the medication aides (MAs) review them as a follow up. -The new order for cefpodoxime 200 mg should have been faxed or called into the pharmacy to be filled after the discharge summary was reviewed. -She did not know why cefpodoxime was not filled.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 358	Continued From page 26 -The RCD was not working in the facility this week. Interview with a MA on 05/11/18 at 2:24 pm revealed: -The RCD or the MAs reviewed discharge summaries for residents who returned to the facility from the hospital. -She did not remember if she had reviewed the discharge summary dated 4/28/18 for Resident #2. -If there had been a new order for medication, the physician's order or hospital discharge would have been sent to the pharmacy by the MA or RCD so the medication could be filled and added to the eMAR. -Resident #2 was not currently on an antibiotic. Interview with a second shift MA on 05/11/18 at 4:48 pm revealed: -The RCD was responsible for reviewing discharge summaries for changes in orders including medications. -She did not know there was an order on the 04/28/18 hospital discharge summary for Resident #2 to start taking cefpodoxime 200 mg. -Cefpodoxime 200 mg was not on Resident #2's eMAR and she had not administered cefpodoxime to Resident #2. Interview with the contracted pharmacist on 05/11/18 at 11:38 am revealed he had never received or filled a physician's order for cefpodoxime. Interview with a nurse at Resident #2's Primary Care Physician's (PCP) office on 05/11/18 at 2:52 pm revealed: -She did not know cefpodoxime had been ordered for Resident #2.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27 -She was not notified by the facility about the physician's order for Resident #2 to start taking cefpodoxime and she had not received a copy of the discharge summary dated 4/28/18. Interview with Resident #2's pharmacy through PCP on 05/11/18 at 3:33 pm revealed they had never received or filled a physician's order for cefpodoxime. Interview with Resident #2 on 05/11/18 at 4:12 pm revealed: -He did not know all of the medications that were administered to him. -He did not know of any new medications ordered for him to start taking after his hospitalization in April 2018. -He was hospitalized again about a week after the April 2018 hospitalization. Attempted interview with the RCD on 05/11/18 at 4:20 pm was unsuccessful. b. Review of a subsequent hospital discharge summary for Resident #2 dated 05/03/2018 revealed: -Resident #2 was admitted to the hospital on 05/02/2018 and discharged on 05/03/2018. -Resident #2's discharge diagnosis included acute on chronic systolic heart failure, chronic obstructive pulmonary disease, chronic elevated troponin, chronic atrial fibrillation, and chronic nonischemic cardiomyopathy. -There was an order to start entresto 24-26 mg (an angiotensin II receptor blocker used for chronic heart failure) 2 tablets twice daily. Review of Resident #2's record revealed a prescription dated 05/03/18 for entresto 24-26 mg, 2 tablets twice daily.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

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D 358	Continued From page 28 Review of Resident #2's electronic Medication Administration Record (eMAR) for May 2018 revealed: -There was no entry for entresto 24-26 mg tablets twice daily on the eMAR. -There was no documentation entresto had been administered from 05/03/18 through 05/09/18. Interview with the Executive Director (ED) on 05/11/18 at 12:56 pm revealed: -The Resident Care Director (RCD) was responsible for reviewing discharge summaries for changes in medications and then the medication aides (MAs) review them as a follow up. -New medication orders on discharge summaries should have been faxed or called into the pharmacy to be filled after discharge summary was reviewed. -She did not know why entresto 24-26 mg was not filled. Interview with a MA on 05/11/18 at 2:24 pm revealed: -The RCD or the MA reviewed discharge summaries for residents who returned to the facility from the hospital. -She had reviewed the discharge summary dated 05/03/18 from Resident #'s2 hospitalization. -If there had been a new order for medication, the physician's order or hospital discharge would have been sent to the pharmacy by the MA or RCD so the medication could be filled and added to the MAR. -She faxed the discharge summary to Resident #2's Primary Care Physician's (PCP) office on 05/07/18, but has not gotten a response. -She had not heard from the PCP's nurse and had not followed up with the PCP's nurse to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 358	Continued From page 29	D 358		

inform her that Resident #1 had not been taking entresto as ordered on the hospital discharge. She did not fax a copy of the hospital discharge orders to the pharmacy.

Interview with a nurse at Resident #2's PCP's office on 05/11/18 at 2:52 pm revealed:
-She had not received a copy of the 05/03/18 hospital discharge from the facility for Resident #2.
-She had not received any calls from the facility regarding changes in medications or missed doses of medication.
-She requested a copy of the 05/03/18 hospital discharge from the hospital on 05/08/18.
-Resident #2's PCP had reviewed changes in medication from the 05/03/18 hospital discharge and had sent a copy of the 05/03/18 hospital discharge to Resident #2's cardiologist since entresto was used to treat functions of the heart.

Interview with a second shift MA on 05/11/18 at 4:48 pm revealed:
-The RCD was responsible for reviewing discharge summaries for changes in orders including medications.
-She did not notice any changes in medication for Resident #2 after his 05/02/18 - 05/03/18 hospitalization.
-She had not seen entresto in the medication cart and had not administered entresto since his 05/02/18 - 05/03/18 hospitalization.

Interview with Resident #2 on 05/11/18 at 4:12 pm revealed:
-He did not know all of the medications that were administered to him.
-He did not know of any new medications ordered for him to start taking after his hospitalization in May 2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 30 Attempted interview with the RCD on 05/11/18 at 4:20 pm was unsuccessful. c. Review of Resident #2's current FL-2 dated 04/04/2018 revealed a physician's order for carvedilol 3.125 mg (a beta blocker used to treat high blood pressure and heart failure) 1 tablet twice daily. Review of a subsequent hospital discharge summary for Resident #2 dated 05/03/2018 revealed: -Resident #2 was admitted to the hospital on 05/02/2018 and discharged on 05/03/2018. -Resident #2's discharge diagnosis included acute on chronic systolic heart failure, chronic obstructive pulmonary disease, chronic elevated troponin, chronic atrial fibrillation, and chronic nonischemic cardiomyopathy. -There was a physician's order to increase carvedilol 3.125 mg to carvedilol 6.25 mg 1 tablet twice daily with meals. Review of Resident #2's record revealed a prescription dated 05/03/18 for carvedilol 6.25 mg 1 tablet twice daily with meals. Review of Resident #2's electronic Medication Administration Record (eMAR) for May 2018 revealed: -There was an entry for carvedilol 3.125 mg 1 tablet twice daily. -Carvedilol 3.125 mg was documented as administered at 8:00 am from 05/04/18 to 05/11/18 and at 8:00 pm from 05/03/18 to 05/10/18. -There was not an entry for carvedilol 6.25 mg 1 tablet twice daily with meals. -There was no documentation carvedilol 6.25 mg	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 31	D 358		

had been administered from 05/03/18 through 05/11/2018.

Interview with Executive Director (ED) on 05/11/18 at 12:56 pm revealed:
-The Resident Care Director (RCD) was responsible for reviewing discharge summaries for changes in medications and then the medication aides (MAs) review them as a follow up.
-New medication orders on discharge summaries should have been faxed or called into the pharmacy by the MA or RCD to be filled after the discharge summary was reviewed.
-She did not know why the change in the order for carvedilol was not submitted to the pharmacy.

Interview with a MA on 05/11/18 at 2:24 pm revealed:
-The RCD or the MA reviewed discharge summaries for residents who returned to the facility from the hospital.
-She had reviewed the discharge summary dated 05/03/18 from Resident #2's hospitalization.
-If there had been a new order for medication, the physician's order or hospital discharge would have been sent to the pharmacy so the medication could be filled and added to the eMAR.
-She faxed the discharge summary to Resident #2's PCP's office on 05/07/18, but had not gotten a response.
-She had not heard from the PCP's nurse and had not followed up with the PCP's nurse to inform her that Resident #1 had not been taking carvedilol as ordered on the hospital discharge.
-She did not fax a copy of the hospital discharge orders to the pharmacy.

Interview with Resident #2's Primary Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 32 Physician's nurse on 05/11/18 at 2:52 pm revealed: -She had not received a copy of the 05/03/18 hospital discharge from the facility for Resident #2. -She had not received any calls from the facility regarding changes in medications or missed doses of medication. -She requested a copy of the 05/03/18 hospital discharge from the hospital on 05/08/18. -Resident #2's PCP had reviewed changes in medication from the 05/03/18 hospital discharge summary and made changes in carvedilol dosage on Resident #2's medication list at the PCP's office. -Resident #2 should have been administered carvedilol 6.25 mg twice daily as ordered on the hospital discharge. Interview with a second shift MA on 05/11/18 at 4:48 pm revealed: -The RCD was responsible for reviewing discharge summaries for changes in orders including medications. -She did not notice any changes in medication for Resident #2 after his 05/02/18 - 05/03/18 hospitalization. -Resident #2 was currently administered carvedilol 3.125 mg. Interview with Resident #2 on 05/11/18 at 4:12 pm revealed: -He did not know all of the medications that were administered to him. -He did not know of any new medications ordered for him to start taking after his hospitalization in May 2018. Attempted interview with the RCD on 05/11/18 at 4:20 pm was unsuccessful.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 33 d. Review of Resident #2's current FL-2 dated 04/04/2018 revealed there was a physician's order for Lisinopril 2.5 mg (used to treat high blood pressure) 1 tablet every day at 12:00 pm. Review of a subsequent hospital discharge summary for Resident #2 dated 05/03/2018 revealed: -Resident #2 was admitted to the hospital on 05/02/2018 and discharged on 05/03/2018. -Resident #2's discharge diagnosis included acute on chronic systolic heart failure, chronic obstructive pulmonary disease, chronic elevated troponin, chronic atrial fibrillation, and chronic nonischemic cardiomyopathy. -There was a physician's order to discontinue lisinopril 2.5 mg. Review of Resident #2's electronic Medication Administration Record (eMAR) for May 2018 revealed: -There was an entry for lisinopril 2.5 mg 1 tablet daily at noon. -There was documentation lisinopril was administered from 05/04/18 through 05/09/18. -Lisinopril had not been discontinued as ordered. Interview with Executive Director (ED) on 05/11/18 at 12:56 pm revealed: -The Resident Care Director (RCD) was responsible for reviewing discharge summaries for changes in medications and then the medication aides (MAs) review them as a follow up. -New medication orders on discharge summaries should have been faxed or called into the pharmacy to be filled after discharge summary was reviewed. -She did not know why the Lisinopril was not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 34 discontinued as ordered on the discharge summary. Interview with a MA on 05/11/18 at 2:24 pm revealed: -The RCD or the MA reviewed discharge summaries for residents who returned to the facility from the hospital. -She had reviewed the discharge summary dated 05/03/18 from Resident #2's hospitalization. -She faxed the discharge summary to Resident #2's Primary Care Physician's (PCP) office on 05/07/18, but had not gotten a response. -The fax machine did not print out confirmations of sent and recieved faxes. -She had not heard from the PCP's nurse and had not followed up with the PCP's nurse to inform her Resident #1 was continuing to be administered lisinopril although it was ordered to be discontinued. -She did not fax a copy of the hospital discharge orders to the pharmacy. Interview with a nurse at Resident #2's PCP's office on 05/11/18 at 2:52 pm revealed: -She had not received a copy of the 05/03/18 hospital discharge from the facility for Resident #2. -She had not received any calls from the facility regarding changes in medication or discontinuation of medication. -She requested a copy of the 05/03/18 hospital discharge from the hospital on 05/08/18. -Resident #2's PCP had reviewed changes in medication from the 05/03/18 hospital discharge summary and had discontinued lisinopril on Resident #2's medication list at the PCP's office. -Lisinopril should have been discontinued as ordered on the hospital discharge.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 35 Interview with a second shift MA on 05/11/18 at 4:48 pm revealed: -The RCD was responsible for reviewing discharge summaries for changes in orders including medications. -She did not notice any changes in medications for Resident #2 after his 05/02/18 - 05/03/18 hospitalization. -Resident #2 was currently administered lisinopril 3.125 mg. Interview with Resident #2 on 05/11/18 at 4:12 pm revealed: -He did not know all of the medications that were administered to him. -He did not know of any medications ordered for him to stop taking after his hospitalization in May 2018. Attempted interview with the RCD on 05/11/18 at 4:20 pm was unsuccessful. 2. Review of Resident #3's current FL-2 dated 10/30/17 revealed diagnoses included an unspecified fracture of the upper left humerus, difficulty walking, and muscle weakness. Review of Resident #3's signed physician's orders dated 02/21/18 revealed diagnoses included type 2 diabetes mellitus with neuropathy, myasthenia gravis, anxiety, chronic obstructive pulmonary disease (COPD), epilepsy, and hypertension. Review of Resident #3's physician's orders revealed there was an order dated 04/17/18 for alprazolam 0.5 mg, take 1 tablet daily as needed for anxiety. Review of Resident #3's April 2018 electronic	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 36	D 358		

medication administration record (eMAR) revealed:
-Alprazolam was administered once daily at 8:07 pm on 04/17/18.
-Alprazolam was administered once daily at 8:33 am on 04/19/18.
-Alprazolam was administered once daily at 8:43 pm on 04/20/18.
-Alprazolam was administered once daily at 8:30 am on 04/21/18.
-Alprazolam was administered once daily at 8:31 am on 04/22/18.
-Alprazolam was administered once daily at 8:36 am on 04/23/18.
-Alprazolam was administered once daily at 8:42 am on 04/24/18.
-Alprazolam was administered once daily at 9:12 am on 04/25/18.
-Alprazolam was administered once daily at 8:31 am on 04/26/18.
-Alprazolam was administered once daily at 7:40 am on 04/28/18.
-Alprazolam was administered once daily at 8:05 am on 04/29/18.
-Alprazolam was administered once daily at 8:30 pm on 04/30/18.

Review of Resident #3's May 2018 eMAR revealed:
-Alprazolam was administered once daily at 8:07 am on 05/01/18.
- Alprazolam was administered once daily at 8:18 am on 05/02/18.
-Alprazolam was administered once daily at 7:46 pm on 05/04/18.
-Alprazolam was administered twice on 05/05/18, at 8:16 am and again at 8:52 pm.
-Alprazolam was administered twice on 05/06/18, at 8:28 am and again at 11:30 pm.
-Alprazolam was administered once daily at 5:35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 37	D 358		

pm on 05/08/18.
-Alprazolam was administered once daily at 7:45 am on 05/09/8.
-Alprazolam was administered once daily at 8:00 am on 05/10/18.

Observation on 05/10/18 at 2:00 pm of the medications on hand for Resident #3 revealed there was no alprazolam 0.5 mg available for administration.

Interview on 05/11/2018 at 2:30 pm with Resident #3 revealed:
-She received alprazolam once a day when she needed it, which was almost every day.
-She had been out of alprazolam for "a couple days."
-She did not know how many days exactly.
-She took alprazolam for anxiety.

Telephone interview on 05/11/18 at 2:36 pm with the facility's contracted pharmacy revealed:
-Alprazolam 0.5 mg tablets were dispensed on 04/17/18 for 30 tablets.
-If administered correctly, Resident #3 should have had 7 tablets remaining.
-They had not received a refill request for alprazolam.

Interview on 05/11/18 at 3:20 pm with a MA revealed:
-Resident #3 was ordered alprazolam 0.5 mg once a day for anxiety.
-She always gave the medicine as ordered.
-Resident #3 was out of alprazolam, but she had ordered more from the pharmacy.
-She did not know the exact day she had reordered the medication.

Interview on 05/11/18 at 4:30 pm with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 38 Executive Director (ED) revealed: -She was a licensed professional nurse (LPN). -She sometimes worked night or weekend shifts if she did not have a MA to cover the shift. She had worked the weekend night shift the weekend of 05/05/18 and 05/06/18. -She had administered a second dose of alprazolam to Resident #3 on 05/05/18 and 05/06/18 because she thought the order said, "one tablet daily and then as needed for anxiety." Attempted telephone interview on 05/11/18 at 3:45 pm with Resident #3's mental health provider was unsuccessful. 3. Review of Resident #3's current FL-2 dated 10/30/17 revealed diagnoses included an unspecified fracture of the upper left humerus, difficulty walking, and muscle weakness. Review of Resident #3's signed physician's orders dated 02/21/18 revealed diagnoses included type 2 diabetes mellitus with neuropathy, myasthenia gravis, anxiety, Chronic Obstructive Pulmonary Disease (COPD), epilepsy, and hypertension. Review of Resident #3's physician's orders dated 03/15/18 revealed an order for tramadol 50 mg take 1 tablet every 6 hours as needed for pain. Review of pharmacy dispensing records revealed tramadol 50 mg 60 tablets was dispensed on 04/04/18. Observation on 05/10/18 at 2:00 pm of the medications on hand for Resident #3 revealed there was no tramadol 50 mg available for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 39 Review of Resident #3's April 2018 electronic medication administration record (eMAR) revealed: -An entry for tramadol 50 mg give 1 tablet every 6 hours as needed for pain. -Tramadol was administered on 04/06/2018 at 6:20 pm. -Tramadol was administered on 04/07/2018 at 4:29 am, 12:11 pm, and 8:15 pm. -Tramadol was administered on 04/08/2018 at 6:39 am, 2:50 pm, and 10:50 pm. -Tramadol was administered on 04/09/18 at 6:50 am and 5:02 pm. -Tramadol was administered on 04/10/18 at 2:45 am, 11:45 am, and 8:43 pm. -Tramadol was administered on 04/11/18 at 8:55 am and 5:30 pm. -Tramadol was administered on 04/12/18 at 3:40 am, 12:01 pm, and 8:00 pm. -Tramadol was administered on 04/13/18 at 5:33 am, 12:51 pm, 1:55 pm, and 9:00 pm. -Tramadol was administered on 04/14/18 at 8:58 am and 5:10 pm. -Tramadol was administered on 04/15/18 at 11:55 am and 9:00 pm. -Tramadol was administered on 04/16/18 at 10:12 am and 9:25 pm. -Tramadol was administered on 04/17/18 at 5:57 am, 2:10 pm, and 10:10 pm. -Tramadol was administered on 04/18/18 at 5:03 am, 1:07 pm, and 8:08 pm. -Tramadol was administered on 04/19/18 at 8:34 am and 6:36 pm. -Tramadol was administered on 04/20/18 at 12:37 am, 10:10 am, and 4:40 pm. -Tramadol was administered on 04/21/18 at 5:18 am, 1:34 pm, and 7:35 pm. -Tramadol was administered on 04/22/18 at 1:35 am, 2:05 pm, and 8:16 pm. -Tramadol was administered on 04/23/18 at 1:53	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 40	D 358		

pm and 8:05 pm.
-Tramadol was administered on 04/24/18 at 3:44 am and 2:31 pm.
-Tramadol was administered on 04/25/18 at 2:51 am and 4:04 pm.
-Tramadol was administered on 04/2618 at 1:09 am, 8:32 am, 2:31 pm, and 9:55 pm.
-Tramadol was administered on 04/27/18 at 6:02 am and 1:53 pm.
-Tramadol was administered on 04/28/18 at 5:33 am and 2:58 pm.

Review of Resident #3's May 2018 electronic medication administration record (eMAR) revealed:
-An entry for tramadol 50 mg, give 1 tablet every 6 hours as needed for pain.
-Tramadol was not documented as administered at all in the month of May.

Interview on 05/11/2018 at 2:31 pm with Resident #3 revealed:
-She received tramadol every 6 hours as needed for pain.
-She had been out of tramadol since the end of April 2018.
-She was having a lot of pain in her feet and legs.
-She had to go to the emergency room on 04/29/18 because she was in so much pain that "it caused her blood pressure to be high."
-The emergency room had given her a prescription for oxycodone but she finished that prescription on 05/06/18 and was now receiving nothing for pain.

Telephone interview on 05/11/18 at 2:36 pm with the facility's contracted pharmacy revealed:
-Tramadol 50 mg tablets were dispensed on 04/04/18 for 60 tablets.
-They had not received a refill request or a new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 41	D 358		

prescription for tramadol for Resident #3.
-They had received a fax from the facility of a medication clarification form signed by Resident #3's orthopedist stating to discontinue tramadol 50 mg along with 2 other medications on 05/11/18 "after lunch."
-They had called the facility for clarification because the discontinue order was not from the same provider that prescribed the tramadol.

Interview on 05/11/18 at 1:00 pm with a MA revealed:
-Resident #3 had been out of tramadol for "a few days" but she had ordered more.
-She did not know the exact day Resident #3 ran out of tramadol.
-She did not know the exact day she ordered more from the pharmacy.
-She had received a fax back from Resident #3's orthopedist discontinuing the tramadol.
-Resident #3 had received a prescription from the emergency room for oxycodone but was out of that as well.
-She had not contacted the physician to report Resident #3's complaints of pain.
-Resident #3 complained of pain "all the time," even when she did receive pain medication.

Review of the faxed copy of the medication clarification form revealed:
-A request to discontinue 3 medications, including tramadol.
-It was signed by the MA.
-The request to discontinue the tramadol was handwritten in pen on the faxed form in between the printed writing.
-The words "OK discontinue" were handwritten in pen under the request to discontinue tramadol.
-The faxed copy was signed by the orthopedist and dated 05/10/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 42 Telephone interview on 05/11/18 at 1:40 pm with a representative from Resident #3's orthopedist office revealed: -The orthopedist did not discontinue tramadol for Resident #3 because he did not prescribe it. -They did not receive a medication clarification form from the facility requesting to discontinue tramadol. -They had faxed over a signed medication clarification form on 05/11/18 stating to discontinue a prescribed analgesic cream only. -They would fax another copy of the signed medication clarification form that they had sent, showing that it was only concerning the analgesic cream and no other medications. -The resident's record showed an order from the emergency room for oxycodone on 04/30/18, but there was no record of Resident #3 being prescribed tramadol in their system. Review of the faxed copy of the medication clarification form received from the orthopedist revealed: -It was a facility medication clarification form. -It was signed by the MA. -It was a request to discontinue an analgesic cream. -There were no other medications listed on the form. -The form was signed by the orthopedist and dated 05/10/18. Second interview on 05/11/18 at 3:20 pm with the MA revealed: -She had received the first faxed medication clarification form off the fax machine that morning. -It was her handwriting and signature on the form. -She did not know why the request to discontinue	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 43 tramadol was written in pen on the printed copy. -She did not know why "Ok to discontinue" was written in pen on the printed copy. -"I pulled it off the fax machine like that." -She did not know why the copy sent from the orthopedist on 05/11/18 at 2:00 pm did not have the request to discontinue tramadol on it. Interview on 05/11/18 at 4:00 pm with the Executive Director revealed: -She did not know about the medication clarification fax requesting to discontinue tramadol. -Looking at both faxed copies, it was clear that the copy discontinuing tramadol had been altered with a pen after being received. -She did not know why any staff would alter a received document. -Resident #3 still had tramadol listed on her eMAR but was out of the medication. -Resident #3 had been receiving oxycodone from 05/01/18 to 05/06/18 for pain. -Resident #3 did not have any medication for pain since finishing the oxycodone on 05/06/18. -She did not know why a request for pain medication had not been sent to the provider. -She did not know why a refill for tramadol had not been received from the pharmacy yet. -MAs were responsible for ordering medication refills from the pharmacy. _____ The facility failed to administer alprazolam and tramadol to Resident #3; and cefpodoxime, entresto, carvedilol, and lisinopril to Resident #2 as ordered which resulted in Resident #3 having increased pain, and Resident #2 being placed at increased risk of worsening of pneumonia infection, heart failure, heart attack, and uncontrolled high blood pressure and constitutes	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 44 a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/11/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 10, 2018	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, record reviews, and	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 45	D 367		

interviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate for 1 of 3 sampled residents (#2) regarding furosemide (used to treat high blood pressure).

The findings are:

Review of Resident #2's current FL-2 dated 04/04/2018 revealed:
-Diagnoses included chronic kidney disease, congestive heart failure, hypertension, diabetes, obstructive sleep apnea, chronic obstructive pulmonary disease, cirrhosis, chronic liver disease, and cardiomyopathy.
-There was not an order for furosemide on the FL2.

Review of a physician's order sheet created by the pharmacy dated 04/18/18 revealed an order for furosemide 80 mg 1 tablet 2 times daily.

Review of Resident #2's record revealed no previous orders for furosemide.

Review of a facility medication clarification form dated 04/24/18 revealed an order to discontinue furosemide.

Review of a copied form titled, "Drugs Returned to Pharmacy," revealed:
-One bottle of Furosemide 80 mg had been returned to the pharmacy on 04/25/18.
-The contracted pharmacist's stamped signature was on the form.

Review of progress notes for Resident #2 revealed:
-Documentation dated 04/16/18 "Spoke with Primary Care Physician's (PCP) pharmacy in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 46	D 367		

regards to [Resident #2's] furosemide 80 mg, 1 by mouth twice daily. PCP's pharmacy will overnight furosemide and it should be arrive in the morning."
-Documentation dated 04/17/18 "Furosemide is still not here. Called PCP's pharmacy to see if we could get from a back-up pharmacy. Pharmacy representative said it was sent out on 04/16/18.
-Documentation dated 04/17/18 "Called back to the PCP's pharmacy. We will have to pick furosemide up at the PCP's pharmacy."
-Documentation dated 04/25/18 "Saw facility physician assistant today, furosemide 80mg was discontinued."
-There were no other notes regarding furosemide.

Review of Resident #2's electronic Medication Administration Record (eMAR) for April 2018 revealed:
-An entry for furosemide 80 mg 1 tablet twice daily at 8:00 am and 8:00 pm.
-The original date of the order for furosemide was documented as 04/09/18.
-Furosemide was documented as administered twice daily from 04/17/18 at 8:00 pm to 04/25/18 at 8:00 am.
-Documentation for 04/25/18 at 8:00 pm "Withheld per Dr/RN Orders."
-Furosemide was documented as administered on 04/26/18 at 8:00 am.
-Documentation from 04/26/18 at 8:00 pm to 04/28/18 at 8:00 am resident was "Out of Facility."
-Furosemide was documented as administered on 04/30/18 at 8:00 am.

Review of Resident #2's eMAR for May 2018 revealed:
-An entry for furosemide 80 mg 1 tablet twice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 47	D 367		

daily at 8:00 am and 8:00 pm.
-Furosemide was documented as administered on 05/01/18 at 8:00 am.
-Furosemide was documented as administered on 05/02/18 at 8:00 am.
-Documentation for 05/03/18 at 8:00 am resident was "Out of Facility."
-Furosemide was documented as administered twice daily from 05/04/18 at 8:00 am to 05/07/18 at 8:00 am.
-Documentation for 05/08/18 at 8:00 am "Withheld per Dr/RN Orders."
-Documentation for 05/09/18 at 8:00 am "Withheld per Dr/RN Orders."
-Documentation for on 05/10/18 at 8:00 am "Withheld per Dr/RN Orders."
-Documentation for on 05/10/18 at 8:00 pm "Physically Unable to Take."
-Furosemide was documented as administered on 05/11/18 at 8:00 am.

Observation on 05/10/18 at 4:30 pm of Resident #2's medications on hand at the facility revealed furosemide was not available for administration.

Interview with a second shift Medication Aide (MA) on 05/10/18 at 4:35 pm revealed:
-Furosemide 80 mg 1 tablet twice daily was on the May 2018 eMAR.
-She was not sure why furosemide was not on the medication cart or if it had been discontinued.
-She did not administer furosemide to Resident #2 in May 2018, and she could not remember if she administered furosemide to Resident #2 in April 2018.
-If she did not administer a medication, she left the space empty and did not document anything.
-There were several days during the month of May that she had not documented that furosemide was not administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 48 -She did not know she was supposed to document on the eMAR why a medication had not been administered. -She did not know why furosemide had been documented as administered when it had been sent back to the pharmacy. Interview with a first shift MA on 05/11/18 at 9:07 am revealed: -Furosemide 80 mg 1 tablet twice daily was on the May 2018 eMAR. -The contracted pharmacy was responsible for creating and making medication changes to the eMAR. -The facility physician's assistance wrote the order to discontinue furosemide. -Furosemide was "probably" still on the eMAR because the order was not sent to the contracted pharmacy. -The order to discontinue furosemide should have been faxed to the contracted pharmacy by the so that it could be taken off of the eMAR. -The MA who received the order to discontinue furosemide was responsible for faxing the order to the facility contracted pharmacy. -She did not know when the last time furosemide was administered. -She documented this morning, 05/11/18, furosemide was administered to Resident #2. -She did not know why she had documented that furosemide was administered when it had not been. -"I was not paying attention when I documented giving furosemide." -The Resident Care Director (RCD) and MAs were responsible for reviewing the eMARs for accuracy. -She and the RCD completed medication cart audits weekly which included comparing what was on the eMAR to the medication in the	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 49	D 367		

medication cart.
-She did not know why the eMARs were not accurate for administration of furosemide for April and March 2018.

Interview with a nurse at Resident #2's PCP's office on 05/11/2018 at 9:28 am revealed:
-She did not know that furosemide 80 mg had been discontinued.
-Sometimes the facility contracted physician saw Resident #2 and made changes in his medication.
-She had not been contacted by the facility or notified of any changes in medication for Resident #2.

Interview on with the facility contracted pharmacist on 05/11/18 at 10:12 am revealed:
-He did not fill the order for furosemide.
-He received a returned bottle of furosemide from the facility on 04/25/18, but did not have an order to discontinue furosemide on the eMAR.
-He received a phone call from facility staff on today, 05/11/18 to discontinue furosemide on the eMAR.
-He did not have a verbal or written order from a physician to discontinue furosemide.
-He did not know the original date of the order for furosemide.

Interview with clinical services representative at the facility's physician's office on 05/11/18 at 10:38 am revealed:
-The physician's assistant saw Resident #2 on 04/25/17 and discontinued furosemide.
-There must have been an error in documentation of the date, 04/24/17, on the order to discontinue furosemide.

Interview with Resident #2's pharmacy on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 50 05/11/18 at 3:33 pm revealed furosemide was filled and picked up by the facility on 04/17/2018. Interview with Resident #2 on 05/11/18 at 4:12 pm revealed he did not know if furosemide had been discontinued. Attempted interview with the RCD on 05/11/18 at 4:20 pm was unsuccessful. Interview with the Executive Director (ED) on 05/11/18 at 4:34 pm revealed: -She did not know that furosemide was being documented as administered when it was not in the building. -The RCD was responsible for reviewing the eMAR for accuracy, but the ED was now responsible due to the RCD's absence in the facility. -The eMARs were reviewed weekly. -The eMARs and medication on the medication cart were audited once a week. -The pharmacy was responsible for making changes to the eMAR when medication orders were sent in. -She did not know if the physician's order to discontinue furosemide was sent to the facility contracted pharmacy so that the eMAR could be updated. -The MA or the RCD was responsible for sending physician's orders to the pharmacy.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 51	D 392		

records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records of controlled substances and failed to account for the use and administration of controlled substances for 1 of 3 sampled residents (#3), related to alprazolam (used to treat anxiety) and tramadol (used to treat pain).

The findings are:

1. Review of Resident #3's current FL-2 dated 10/30/17 revealed diagnoses included an unspecified fracture of the upper left humerus, difficulty walking, and muscle weakness.

Review of Resident #3's signed physician's orders dated 02/21/18 revealed diagnoses included type 2 diabetes mellitus with neuropathy, myasthenia gravis, anxiety, Chronic Obstructive Pulmonary Disease, epilepsy, and hypertension.

Review of Resident #3's physician's orders revealed:
-There was an order dated 04/17/18 for alprazolam 0.5 mg, take 1 tablet daily as needed for anxiety.
-There was an order dated 03/15/18 for tramadol 50 mg, take 1 tablet every 6 hours as needed for pain.

Review of pharmacy dispensing records revealed:
-Alprazolam 0.5 mg, 30 tablets, was dispensed 04/17/18.
-Tramadol 50 mg, 60 tablets, was dispensed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 52 04/04/18. a. Observation on 05/10/18 at 2:00 pm of the medications on hand for Resident #3 revealed there was no alprazolam 0.5 mg available for administration. Review of Resident #3's April 2018 electronic medication administration record (eMAR) revealed: -Alprazolam was administered once daily at 8:07 pm on 04/17/18. -Alprazolam was administered once daily at 8:33 am on 04/19/18. -Alprazolam was administered once daily at 8:43 pm on 04/20/18. -Alprazolam was administered once daily at 8:30 am on 04/21/18. -Alprazolam was administered once daily at 8:31 am on 04/22/18. -Alprazolam was administered once daily at 8:36 am on 04/23/18. -Alprazolam was administered once daily at 8:42 am on 04/24/18. -Alprazolam was administered once daily at 9:12 am on 04/25/18. -Alprazolam was administered once daily at 8:31 am on 04/26/18. -Alprazolam was administered once daily at 7:40 am on 04/28/18. -Alprazolam was administered once daily at 8:05 am on 04/29/18. -Alprazolam was administered once daily at 8:30 pm on 04/30/18. Review of Resident #3's May 2018 eMAR revealed: -Alprazolam was administered twice on 05/05/18, at 8:16 am and 8:52 pm. -Alprazolam was administered twice on 05/06/18,	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 53	D 392		

at 8:28 am and 11:30 pm.
-Alprazolam was administered once daily at 8:07 am on 05/01/18.
- Alprazolam was administered once daily at 8:18 am on 05/02/18.
-Alprazolam was administered once daily at 7:46 pm on 05/04/18.
-Alprazolam was administered once daily at 5:35 pm on 05/08/18.
-Alprazolam was administered once daily at 7:45 am on 05/09/8.
-Alprazolam was administered once daily at 8:00 am on 05/10/18.

There was a total of 22 doses of alprazolam 0.5 mg documented as administered on the eMAR between 04/17/18 and 05/10/18.

Review of the controlled substance count sheet (CSCS) #1 for Resident #3's alprazolam tablets dispensed on 04/17/18 revealed:
-The prescription label on the CSCS matched the order with instructions to take 1 tablet once a day as needed for anxiety.
-A medication aide signed that 30 alprazolam tablets were received on 04/17/18.
-The first entry on the CSCS was 1 alprazolam 0.5 mg tablet administered on 04/17/18 at 8:08 pm.
-The last entry on the CSCS was 1 alprazolam 0.5 mg administered on 04/28/18 at 7:00 am which left 15 tablets remaining on hand.
-On 04/19/18 at 3:00 pm, one dose of alprazolam was documented as "fell out" and signed by two MAs.
-On 04/22/18 at 7:15 am, one dose of alprazolam was signed by two MAs but no explanation was documented.
-On 04/22/18 at 8:25 am, a second dose of alprazolam was documented as administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 392	Continued From page 54 -On 04/27/18 at 8:30 am, there were two entries documenting administration of alprazolam. The second entry was marked through and "error" was written beside it. There was no counter signature by a second MA. -A total of 15 doses were documented as administered or discarded on the CSCS #1. Review of the CSCS #2 for Resident #3's alprazolam tablets dispensed on 04/17/18 revealed: -There was no prescription label on the CSCS. -The resident's name and prescription information had been handwritten in the label section. -There was no total doses received documented on the CSCS. -The count started at 12 pills available. -The first entry on the CSCS was 1 alprazolam 0.5 mg tablet administered on 04/30/18 at 8:33 pm. -The last entry on the CSCS was 1 alprazolam 0.5 mg administered on 05/10/18 at 8:00 am which left 0 tablets remaining on hand. -Alprazolam 0.5 mg was documented as administered on 05/03/18 at 7:20 am. -Alprazolam 0.5 mg was documented as administered on 05/05/18 at 8:20 am. - On 05/05/18, documented at 7:00 am but underneath the 8:20 am dose, a second dose was documented as administered and then marked through and "error" written beside it. There was no counter signature by a second MA. -On 05/05/18 at 8:59 pm, a third dose of alprazolam 0.5 mg was documented as administered. -A total of 12 doses were documented as administered or discarded on the CSCS #2. There was a total of 27 doses of alprazolam 0.5 mg documented as administered or discarded	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 55	D 392		

from 04/17/18 through 05/10/18 on CSCSs #1 and #2. By this count, a total of 3 tablets should have been remaining.

Based on dispensing records, if administered correctly, Resident #3 should have had 7 tablets of alprazolam remaining.

Interview on 05/11/2018 at 2:30 pm with Resident #3 revealed:
-She received alprazolam once a day when she needed it, which was almost every day.
-She had been out of alprazolam for "a couple days."
-She took alprazolam for anxiety.

Telephone interview on 05/11/18 at 2:36 pm with the facility's contracted pharmacy revealed:
-Alprazolam 0.5 mg tablets were dispensed on 04/17/18 for 30 tablets.
-If administered correctly, Resident #3 should have had 7 tablets remaining.

Interview on 05/11/18 at 3:20 pm with a MA revealed:
-She did not know why the CSCS counts did not match the eMARs.
-She did not know what happened on 05/05/18 when alprazolam was documented as administered at 8:20, then 7:00 am, and the 7:00 am dose was marked through.
-It was her signature on the CSCS documenting the error.
-She always gave the medicine as ordered.

Interview on 05/11/18 at 4:30 pm with the Executive Director (ED) revealed:
-She did not know where the unaccounted for alprazolam was.
-She had administered a second dose of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 56	D 392		

alprazolam to Resident #3 on 05/05/18 and 05/06/18 because she thought the order said, "one tablet daily and then as needed for anxiety."
-She did not know why the CSCSs and eMAR did not match.

Attempted telephone interview on 05/11/18 at 3:45 pm with Resident #3's mental health provider was unsuccessful.

Refer to interview on 05/10/18 at 4:00 pm with the ED.

b. Observation on 05/10/18 at 2:00 pm of the medications on hand for Resident #3 revealed there was no tramadol 50 mg available for administration.

Review of Resident #3's April 2018 electronic medication administration record (eMAR) revealed:
-Tramadol was documented as administered on 04/06/2018 at 6:20 pm.
-Tramadol was documented as administered on 04/07/2018 at 4:29 am, 12:11 pm, and 8:15 pm.
-Tramadol was documented as administered on 04/08/2018 at 6:39 am, 2:50 pm, and 10:50 pm.
-Tramadol was documented as administered on 04/09/18 at 6:50 am and 5:02 pm.
-Tramadol was documented as administered on 04/10/18 at 2:45 am, 11:45 am, and 8:43 pm.
-Tramadol was documented as administered on 04/11/18 at 8:55 am and 5:30 pm.
-Tramadol was documented as administered on 04/12/18 at 3:40 am, 12:01 pm, and 8:00 pm.
-Tramadol was documented as administered on 04/13/18 at 5:33 am, 12:51 pm, 1:55 pm, and 9:00 pm.
-Tramadol was documented as administered on 04/14/18 at 8:58 am and 5:10 pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 57 -Tramadol was documented as administered on 04/15/18 at 11:55 am and 9:00 pm. -Tramadol was documented as administered on 04/16/18 at 10:12 am and 9:25 pm. -Tramadol was documented as administered on 04/17/18 at 5:57 am, 2:10 pm, and 10:10 pm. -Tramadol was documented as administered on 04/18/18 at 5:03 am, 1:07 pm, and 8:08 pm. -Tramadol was documented as administered on 04/19/18 at 8:34 am and 6:36 pm. -Tramadol was documented as administered on 04/20/18 at 12:37 am, 10:10 am, and 4:40 pm. -Tramadol was documented as administered on 04/21/18 at 5:18 am, 1:34 pm, and 7:35 pm. -Tramadol was documented as administered on 04/22/18 at 1:35 am, 2:05 pm, and 8:16 pm. -Tramadol was documented as administered on 04/23/18 at 1:53 pm and 8:05 pm. -Tramadol was documented as administered on 04/24/18 at 3:44 am and 2:31 pm. -Tramadol was documented as administered on 04/25/18 at 2:51 am and 4:04 pm. -Tramadol was documented as administered on 04/2618 at 1:09 am, 8:32 am, 2:31 pm, and 9:55 pm. -Tramadol was documented as administered on 04/27/18 at 6:02 am and 1:53 pm. -Tramadol was documented as administered on 04/28/18 at 5:33 am and 2:58 pm. There was a total of 58 doses of tramadol 50 mg documented as administered on the eMAR between 04/06/18 and 04/28/18. Review of the controlled substance count sheet (CSCS) #1 for Resident #3's tramadol tablets dispensed on 04/04/18 revealed: -The prescription label on the CSCS matched the order with instructions to take 1 tablet every 6 hours as needed for pain.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 58 -A medication aide signed that 60 tramadol 50 mg tablets were received on 04/04/18. -15 tablets were documented as placed in overstock and the CSCS was started at 45 tablets available. -The first entry on the CSCS was 1 tramadol 50 mg tablet administered on 04/06/18 at 6:20 pm. -The last entry on the CSCS was 1 tramadol 50 mg administered on 04/28/18 at 3:03 pm which left 15 tablets remaining on hand. -On 04/16/18 at 8:24 pm, one dose of tramadol was documented as administered. -On 04/16/18 at 8:25 pm, another dose of tramadol was documented as administered by the same MA. -On 04/19/18 at 2:30 pm, one dose of tramadol was documented as administered which was not recorded on the eMAR. -A total of 45 doses were documented as administered on the CSCS #1. Review of the CSCS #2 for Resident #3's tramadol tablets dispensed on 04/04/18 revealed: -There was no prescription label on the CSCS. -The resident's name and prescription information had been handwritten in the label section. -There was no total doses received documented on the CSCS. -The count started at 15 pills available. -The first entry on the CSCS was 1 tramadol 50 mg tablet administered on 04/23/18 at 1:55 pm. -The last entry on the CSCS was 1 tramadol 50 mg tablet administered on 04/28/18 at 3:03 pm which left 0 tablets remaining on hand. - On 04/24/18 at 8:35 pm, one dose of tramadol was documented as administered which was not recorded on the eMAR -A total of 15 doses were documented as administered on the CSCS #2.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 392	Continued From page 59 There was a total of 60 doses of tramadol 50 mg documented as administered from 04/06/18 through 04/28/18 on CSCSs #1 and #2, and a total of 58 doses documented as administered on the April 2018 eMAR, leaving 2 doses of tramadol unaccounted for. Interview on 05/11/2018 at 2:31 pm with Resident #3 revealed: -She received tramadol every 6 hours as needed for pain, but it was not effective. -She had been out of tramadol since the end of April. Telephone interview on 05/11/18 at 2:05 pm with a representative of Resident #3's orthopedist revealed: -He had not prescribed the tramadol and could not renew the prescription. -He had not received a request to refill any medications from the facility. Telephone interview on 05/11/18 at 11:30 am with a representative of Resident #3's former primary care physician revealed: -She had written the order for tramadol originally on 03/16/18. -Resident #3 had transferred out from her care in April and was seeing a different provider. -They had not received a refill request for tramadol. -The tramadol was ordered as needed for pain every 8 hours. -The tramadol was ordered to replace the narcotic pain medication oxycodone. Telephone interview on 05/11/18 at 2:36 pm with the facility's contracted pharmacy revealed tramadol 50 mg tablets were dispensed on 04/04/18 for 60 tablets.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 60 Interview on 05/11/18 at 3:22 pm with a MA revealed: -She did not know why the CSCS counts did not match the eMARs. -She always gave the medicine as ordered. -Resident #3 had been out of tramadol for "a few days" but she had ordered more. -She did not know what day she ordered more. -She did not know exactly how many days Resident #3 had been out of tramadol. Interview on 05/11/18 at 4:31 pm with the Executive Director (ED) revealed: -She did not know where the unaccounted for tramadol was. -She did not know why the CSCSs and eMAR did not match. Refer to interview on 05/10/18 at 4:00 pm with the ED. _____ Interview on 05/10/18 at 4:00 pm with the ED revealed: -She had controlled substances go missing for this resident before. -She thought she had identified and terminated the employees responsible. -The policy was that the MA staff had to count each controlled substance at the beginning of each shift and ensure the CSCS matched the amount of medication on hand. -If it did not match, the MA staff was to report the discrepancy to her or the RCD. -No discrepancies had been reported to her.	D 392		
D914	G.S. 131D-21(4) Declaration of Residents' Rights	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D914	Continued From page 61 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free of neglect and exploitation as related to medication administration, infection prevention requirements, criminal background checks and health care referral and follow-up. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents with orders for an antibiotic, an angiotensin II receptor blocker, a beta blocker, and an angiotensin converting enzyme (ACE) inhibitor (Resident #2); an anxiolytic and pain medication (Resident #3). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 diabetic residents sampled (Residents #1, #2, #3) with orders for blood sugar monitoring resulting in sharing of glucometers and lancing devices between residents. [Refer to Tag 932 131D-4.4(b) Ach Infection Prevention Requirements (Type A2 Violation)].	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D914	Continued From page 62 3. Based on record reviews and interviews the facility failed to assure 2 of 3 staff sampled (Staff B and C) had a criminal background check completed upon hire. [Refer to Tag 139 10A NCAC 13F .0407(a)(7) Criminal Background Check (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to notify the physician for 2 of 3 sampled residents regarding a renewal order for tramadol for continued complaints of pain (Resident #3), and physician orders for daily weights (Resident #2). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 63 d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 diabetic residents sampled (Residents #1,	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 64 #2, #3) with orders for blood sugar monitoring resulting in sharing of glucometers and lancing devices between residents. The findings are: Observation on 05/09/18 at 11:05 am revealed: -The facility had 2 medication carts containing 6 residents' glucometers. -The glucometer pouches were labeled with residents' names. -The glucometer pouches contained glucometers (Brand A and Brand B) which were not labeled with a resident's name. -The glucometer pouches contained lancing device pens which were not labeled with residents' names. -There were 3 lancing device pens which contained used lancing needles and were visibly contaminated with blood. Review of the CDC guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the manufacturer's user manual of the Brand A glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended. Review of the manufacturer's user manual of the Brand B glucometer revealed it was approved for use with multiple residents when properly	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 65	D932		

disinfected. Disinfection with 70% isopropyl alcohol; a mixture of 1 part ammonia, 9 parts water; or a mixture of 1 part household bleach, 9 parts water was recommended.

Review of the facility's infection control policy revealed:
-There was no specific information regarding glucometer use or disinfection.
-The policy prohibited using needles or syringes on more than one resident.

Observation on 05/09/18 at 11:05 am of a fingerstick blood sugar (FSBS) check revealed:
-The medication aide (MA) wore gloves for the procedure.
-The MA did not clean the glucometer or the lancet pen prior to use.
-The lancet pen contained a used lancet needle, which the MA removed and replaced with a new lancet needle before use on the resident.
-The MA cleaned the resident's finger with a cotton ball soaked in rubbing alcohol before lancing.
-After using the lancet pen, the MA removed the used lancet needle and discarded it in the biohazard container.
-After using the Brand A glucometer, the MA placed it back in the glucometer bag without cleaning or disinfecting it.

Interview on 05/09/18 at 2:45 pm with a MA revealed:
-The facility had 6 residents receiving finger stick blood sugar (FSBS) checks.
-Resident #2 had a diagnosis of a blood borne pathogen disease.

1. Review of Resident #1's current FL2 dated 02/26/18 revealed diagnoses included type 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D932	Continued From page 66 diabetes mellitus. Review of Resident #1's physician orders revealed an order dated 02/28/18 to measure fingerstick blood sugar (FSBS) before meals and at bedtime. Observation on 05/09/18 at 11:05 am of Resident #1's glucometer and pouch revealed: -The pouch was labeled with Resident #1's name. -The Brand A glucometer located in the pouch was not labeled with the resident's name. -The date and time was set correctly. -There was a lancet pen in the glucometer pouch with a used lancet in it and visible blood on the edge of the pen where it came in contact with the skin. Review of Resident #1's May 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS four times daily scheduled for 7:00 am, 11:00 am, 5:00 pm, and 8:00 pm. -FSBS values were documented four times daily with a FSBS range from 82 to 190. Review of Resident #1's Brand A glucometer's history revealed: -FSBS values recorded in the glucometer's history compared to values documented on Resident #1's May 2018 eMAR were inconsistent for values documented on the eMAR. -FSBS values documented on Resident #1's May 2018 eMAR were not recorded in Resident #1's glucometer's history. Review of Resident #1's Brand B glucometer's history compared to the eMAR for May 2018 revealed:	D932		

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 67 -Resident #1 had 1 FSBS value of 101 recorded in the glucometer's history on 05/09/18 at 7:20 am and not documented on the eMAR. -Resident #1 had 9 FSBS values documented on the MAR that did not match the corresponding values in the glucometer. -On 05/01/18 at 7:33 am the glucometer reading was 138 and 186 was recorded on the eMAR at 7:00 am. -On 05/01/18 at 11:55 am the glucometer reading was 109 and 103 was recorded on the eMAR at 11:00 am. -On 05/02/18 at 12:01 pm the glucometer reading was 169 and 156 was recorded on the eMAR at 11:00 am. -On 05/02/18 at 7:29 pm the glucometer reading was 86 and 98 was recorded on the eMAR at 8:00 pm. -On 05/05/18 at 6:56 am the glucometer reading was 147 and 146 was recorded on the eMAR at 7:00 am. -On 05/05/18 at 6:46 pm the glucometer reading was 115 and 190 was recorded on the eMAR at 8:00 pm. -On 05/06/18 at 7:26 am the glucometer reading was 1104 and 118 was recorded on the eMAR at 7:00 am. -On 05/06/18 at 3:40 pm the glucometer reading was 154 and 142 was recorded on the eMAR at 5:00 pm. -On 05/07/18 at 7:29 am the glucometer reading was 109 and 103 was recorded on the eMAR at 7:00 am. Interview on 05/09/18 at 1:27 pm with Resident #1 revealed: -He did not know what brand of glucometer was used to check his FSBS. -He had his own glucometer. -He did not know if staff used a new needle in the	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 68	D932		

lancet pen each time.
-He did not know if lancet pens were shared because they all looked the same.
-He had never seen staff clean the glucometers or lancet pens.
-He had seen staff leave a used lancet needle in the pen and place it back in the glucometer bag.

Refer to interview on 05/09/18 at 4:30 pm with the Executive Director.

Refer to interview on 05/09/18 at 11:15 am with a medication aide (MA).

Refer to interview on 05/09/18 at 11:30 am with a second MA.

Refer to observation of FSBS check on 05/09/18 at 11:40 am.

Refer to second interview on 05/09/18 at 11:45 am with a second MA.

2. Review of Resident #2's current FL2 dated 04/04/18 revealed diagnoses included type 2 diabetes mellitus.

Review of Resident #2's signed provider orders dated 04/03/18 revealed a diagnosis of unspecified viral hepatitis C.

Observation on 05/09/18 at 11:05 am of Resident #2's glucometer and pouch revealed:
-The pouch was labeled with Resident #2's name.
-The Brand B glucometer located in the pouch was not labeled with the resident's name.
-The date and time was set correctly.
-There was a lancing device pen in the glucometer pouch with a used lancet in it and visible blood on the edge of the pen where it

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 69 came in contact with the skin. Review of Resident #2's May 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS daily. -FSBS values were documented at 6:30 am on 05/02/18, 05/04/18, 05/05/18, 05/06/18, and 05/07/18. -FSBS was documented as refused on 05/08/18 and 05/09/18. -FSBS was not documented as administered on 05/03/18 due to the resident being out of the facility. Review of Resident #2's Brand B glucometer's history revealed: -FSBS values recorded in the glucometer's history compared to values documented on Resident #2's May 2018 eMAR were inconsistent for values documented on the eMAR. -FSBS values documented on Resident #2's May 2018 eMAR for 05/06/18 was not recorded in Resident #2's glucometer's history. Review of Resident #2's Brand B glucometer's history compared to the eMAR for May 2018 revealed: -Resident #2 had 1 FSBS value of 122 documented on the eMAR and not recorded in the glucometer's history on 05/06/18 at 6:30 am. -Resident #2 had 3 FSBS values documented on the MAR that did not match the corresponding values in the glucometer. -On 05/01/18 at 6:08 am the glucometer reading was 140 and 123 was recorded on the eMAR at 6:30 am. -On 05/05/18 at 4:54 am the glucometer reading was 107 and 122 was recorded on the eMAR at 6:30 am.	D932		

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D932	Continued From page 70 -On 05/07/18 at 5:59 am the glucometer reading was 233 and 142 was recorded on the eMAR at 6:30 am. Interview on 05/09/18 at 3:58 pm with Resident #2 revealed: -He did not know what brand of glucometer was used to check his FSBS. -He had his own glucometer. -Staff used a lancet pen for his finger sticks. -He had never viewed staff cleaning his glucometer or lancet pen. -He had seen staff leave the needle in the lancet pen and place the pen back in the glucometer bag after use. Refer to interview on 05/09/18 at 4:30 pm with the Executive Director. Refer to interview on 05/09/18 at 11:15 am with a medication aide (MA). Refer to interview on 05/09/18 at 11:30 am with a second MA. Refer to observation on 05/09/18 at 11:40 am. Refer to second interview on 05/09/18 at 11:45 am with a second MA. 3. Review of Resident #3's signed provider's orders dated 02/21/18 revealed diagnoses included type 2 diabetes mellitus with neuropathy. Review of Resident #3's physician orders revealed an order dated 02/14/18 to check fingerstick blood sugars (FSBS) once a week on Mondays. Observation on 05/09/18 at 11:05 am of Resident	D932		

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D932	Continued From page 71 #3's glucometer and pouch revealed: -The pouch was labeled with Resident #3's name. -The Brand A glucometer located in the pouch was not labeled with the resident's name. -The date and time was set correctly. -There was a lancing device pen in the glucometer pouch that was unlabeled. Review of Resident #3's April 2018 eMAR revealed: -There was an entry to check FSBS once a week on Mondays at 8:00 am. -FSBS check on 04/16/18 was documented as 154 at 8:00 am. -FSBS check on 04/23/18 was documented as 112 at 8:00 am. -FSBS check on 04/30/18 was documented as 98 at 8:00 am. Review of Resident #3's Brand A glucometer's history revealed: -FSBS values recorded in the glucometer's history compared to the values and dates documented on Resident #3's April 2018 eMAR was inconsistent for the values documented on the eMAR. -The glucometer reading for a FSBS value on 04/16/18 at 7:55 am was 151, and 154 on the eMAR. -The glucometer reading for a FSBS value on 04/21/18 at 1:30 pm was 136. -A FSBS result was documented on the eMAR on 04/23/18 at 8:00 am as 112. There was no corresponding glucometer reading for this date. -The glucometer reading for a FSBS value on 04/29/18 at 2:17 pm was 109. -A FSBS was documented on the eMAR on 04/30/18 at 8:00 am as 98. There was no corresponding glucometer reading for this date.	D932		

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D932	Continued From page 72 Review of Resident #3's May 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS once a week on Mondays at 8:00 am. -There was one entry for a FSBS check on 05/07/18 documented as 98 at 8:00 am. Review of Resident #3's Brand A glucometer's history revealed: -FSBS value recorded in the glucometer's history compared to the value documented on Resident #3's May 2018 eMAR was inconsistent for the value documented on the eMAR. -The glucometer reading on 05/07/18 at 8:29 am was 123. -The FSBS result for 05/07/18 at 8:00 am was documented on the eMAR as 98. Interview on 05/09/18 at 1:25 pm with Resident #3 revealed: -She did not know what brand of glucometer was used to check her FSBS. -She had her own glucometer. -She thought staff used the same glucometer every time. -Staff changed the lancet needle every time. -She had not seen staff clean the glucometers or lancet pens. Refer to interview on 05/09/18 at 4:30 pm with the Executive Director. Refer to interview on 05/09/18 at 11:15 am with a medication aide (MA). Refer to interview on 05/09/18 at 11:30 am with a second MA. Refer to observation on 05/09/18 at 11:40 am.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 73 Refer to second interview on 05/09/18 at 11:45 am with a second MA. Interview on 05/09/18 at 1:50 pm with the Executive Director (ED) revealed: -The facility policy was one glucometer assigned to a resident and no sharing glucometers between residents. -The medication aide on duty was responsible to assure each resident had an assigned glucometer and the glucometer was in working order. -Staff were supposed to disinfect glucometers after use with an approved disinfecting wipe. -Staff were expected to use a new disposable lancet needle in each individual lancet pen with each FSBS, and dispose of it in a biohazard container after use. -She did not know staff were sharing glucometers between residents. -She did not know why the eMAR and glucometer results did not match. Interview on 05/09/18 at 11:15 am with a medication aide (MA) revealed: -She routinely worked the day shift. -She obtained FSBS checks for residents scheduled before breakfast and before lunch. -She wiped residents' glucometers with alcohol wipes when the glucometer was visibly soiled. -She was unsure of the facility's exact policy because she was a new employee. -She did not know if there were any approved disinfecting wipes available to clean equipment with. -She used a new lancet needle for each FSBS. -She did not share glucometers or lancet pens between residents. -She only removed one resident's glucometer	D932		

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 74 equipment from the medication cart at a time. Interview on 05/09/18 at 11:30 with a second MA revealed: -She worked the day shift from 7:00 am to 3:00 pm. -During that shift, she routinely checked FSBS for residents as scheduled. -She did not know of any staff sharing glucometers between residents. -She had not had an occasion to share glucometers between residents. -She did not know why the glucometer readings and eMAR did not match. -She cleaned the glucometers and lancet pens everyday with an approved disinfecting wipe. -The disinfecting wipes were kept in the bottom drawer of the medication cart. Observation on 05/09/18 at 11:40 am revealed: -A container of disinfecting wipes was stored in the bottom drawer of the second medication cart. -The instructions on the container required keeping the disinfectant in contact with the surface to be cleaned for 3 minutes, then allowing to air dry. -The second MA wiped a glucometer with the wipe and then disposed of it in the trashcan. Second interview on 05/09/18 at 11:45 am with a second MA revealed: -She had not read the disinfecting wipe container. -She did not know the disinfectant had to remain in contact with the surface for 3 minutes to be effective. -She would now wipe down FSBS equipment and then wrap it in the disinfectant wipe for 3 minutes before disposing of the wipe. The facility failed to implement infection control	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D932	Continued From page 75 procedures consistent with CDC guidelines placing residents receiving finger stick blood sugar checks with glucometers and lancet pens at risk due to possible exposure of blood borne pathogens diseases for Residents #1, #2, and #3. This failure resulted in substantial risk of physical harm to the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/09/18. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, June 10, 2018.	D932		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D992	Continued From page 76 controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was performed for 1 of 3 sampled staff (Staff C, a CNA) that was hired after 10/01/2013. The findings are: Review of Staff C's personnel file revealed: -Staff C was hired on 4/30/2018 as a Personal Care Aide (PCA). -There was documentation that Staff A had completed a drug screen on 05/09/2018. Interview with the Executive Director on 05/10/2018 at 10:17 am revealed: -Staff C was hired as a PCA. -The business office manager was responsible for ensuring that the drug screening was completed upon hire. -"Drug screens should be completed before hire." -She did not know Staff C's drug screen had not	D992		

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	HAL080020	A. BUILDING: _____ B. WING _____	05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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
D992	Continued From page 77 been completed upon hire. Interview with the business office manager on 05/10/2018 at 10:22 am revealed: -She was responsible for setting up drug screening for new staff. -Staff C had worked on 04/30/2018 and then did not work again until 05/07/18. -She did not know why Staff C's drug screening was not completed until 05/09/2018. Interview with Staff C on 05/11/2018 at 4:41 pm revealed: -She was hired as a PCA. -Her first day of work was on 04/30/2018. -She did not work again until the following Monday, 05/07/2018. -She did not have a drug screening prior to her first day of work -She had not been asked to complete a drug screening upon hire and did not know that she needed a drug screening upon hire.	D992		