FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL043026 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) {D 000} Initial Comments {D 000} The Adult Care Licensure Section conducted a follow-up survey on March 13,14 and 15, 2018. D 344 10A NCAC 13F .1002(a) Medication Orders D 344 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility: (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify and verify medication orders for 1 of 5 residents (#4) sampled who stopped receiving a long-acting insulin at bedtime in November 2017 without an order to discontinue the insulin and no documentation to clarify if the resident should have continued to receive the bedtime dose of insulin. The findings are: Sure. C Review of Resident #4's current FL-2 dated 11/01/17 revealed: -Diagnoses included dementia, diabetes mellitus, Division of Health Service Regulation LABORATORY DIRECTORS OR DE TATIVE'S SIGNATURE TITLE (X6) DATE STATE FORM

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ear infection. -There was an order morning. (Levemir hour duration of act sugar.) -There was an order bedtime. Review of Resident orders sheet dated for Levemir 18 units 18 units at bedtime order sheet. Review of a community of the fact Resident #4 revealed the pharmacy to the fact Resident sinsurance or the resident's insurance or	er for Levemir 18 units every is long-acting insulin, up to 24 tion, used to lower blood er for Levemir 18 units at #4's six month physician's 11/12/17 revealed both orders in the morning and Levemir were included on the signed unication form from the cility dated 11/06/17 for ed: ed Levemir 18 units every is was not covered by the exaction change request to Lantus which was covered by ance. (Lantus is long-acting the hours, used to lower blood unentation on the form related in 18 units at bedtime. Onded on 11/13/17 and wrote my morning for diabetes. Imentation regarding the vemir.	D 344	Otherding does and faxed to pharmacy for proper input will assur that the pro added the	will sed
	daily at 8:00 a.m.	for a bedtime dose of Lantus			3.16.18

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AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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D 344	Continued From pa	ge 2	D 344	- Prince Committee Land		
	-The resident's block from 01/01/18 - 01/	od sugar ranged from 62 - 361 31/18.				
	Review of Resident	#4's February 2018 MAR				
	-There was an entr	y for Lantus 18 units every				
	morning and it was daily at 8:00 a.m.	documented as administered				
	-There was no entr	y for a bedtime dose of Lantus				
	or Levemir.	od sugar ranged from 72 - 487				
	from 02/01/18 - 02/2	28/18.				
	revealed:	#4's March 2018 MAR				
	-There was an entry	for Lantus 18 units every				
	daily at 8:00 a.m. fro	documented as administered om 03/01/18 - 03/13/18.				
	-There was no entry or Levemir.	for a bedtime dose of Lantus				
	-The resident's bloo 330 from 03/01/18 -	d sugar ranged from 123 - 03/13/18.				
	Observation of Resident #4's medications on hand on 03/14/18 revealed:					
	instructions to inject	of Lantus insulin with 18 units every morning.				
	medication cart.	mir or any other Lantus in the				
1.	revealed:	#4's physician's orders				
1	units at bedtime.	to discontinue Levemir 18				
	units at bedtime to L	to change the Levemir 18 antus at bedtime.				
1	 There was no order 	to clarify whether the				
	resident was suppos long-acting insulin at	ed to continue to receive a bedtime.				
daion of the						

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL043026 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 3 D 344 D 344 Review of Resident #4's pharmacy recommendation notes dated 01/22/18 revealed: -The pharmacist noted the bedtime dose of Levemir had not been changed when the morning dose was changed to Lantus. -The pharmacist indicated the bedtime dose needed to be clarified. Interview with the Care Coordinator (CC) on 03/13/18 at 5:00 p.m. revealed: -She had not noticed the bedtime dose for Resident #4's Levemir had not been changed when the morning dose was changed to Lantus in November 2017. -She was not aware of an order to discontinue the bedtime dose of Levemir but she would look for -She had not contacted the primary care provider (PCP) to clarify the order for Levemir 18 units at bedtime. -She or the MAs were responsible for clarifying medication orders. -She would check with the PCP about the bedtime insulin. Telephone interview with a pharmacist from the facility's primary pharmacy on 03/14/18 at 4:34 p.m. revealed: -Levemir 18 units in the morning and Levemir 18 units at bedtime was included on Resident #4's FL-2 dated 11/01/17. -The resident's insurance did not cover the Levemir so the pharmacy sent a form to the facility dated 11/13/17 to get the order changed to Lantus. -The pharmacy sent a form to change the morning dose of Levemir to Lantus. -It did not appear a form to change the bedtime dose of Levemir to Lantus was sent. -He did not know why a form for the bedtime dose

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D 344	switched to Lantus dose of Levemir w -There was no ord bedtime dose of Le-There was no ord resident should ha long-acting insulin Interview with Resp.m. revealed: -She was diabetic -She used to get in stopped giving it to agoShe did not know insulin at bedtimeHer primary care about discontinuing	e of Levemir should have been s at the same time the morning as changed to Lantus. er on file to discontinue the evemir. er on file to clarify if the ve continued to receive a	D 344		
{D 358}	primary care provide p.m. was unsuccess. Review of a clarific on 03/15/18 for Rediscontinue the Level 10A NCAC 13F .10 Administration. 10A NCAC 13F .10 (a) An adult care in preparation and additional care in preparation additional care in preparation and additi	ation order faxed to the facility sident #4 revealed an order to wemir 18 units at bedtime. 004(a) Medication 004 Medication Administration to me shall assure that the ministration of medications, on-prescription, and treatments	{D 358}	Meditech Sur Pary Mattr Corptrainer	istiator- pervisor. news;

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(D 358)	Continued From pa	ge 5	{D 358}	for an medti	ecins
	which are maintaine	nsed prescribing practitioner ed in the resident's record; and ction and the facility's policies		on 3.15.18 2 has on demonstra Pharmacy has Conducted an	ands tion salso
	This Rule is not me FOLLOW-UP TO T	et as evidenced by: YPE B VIOLATION		on med admi	nistration
	Based on these find Violation was not at	lings, the previous Type B pated.		for all med +	Lean,
	Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 4 residents (#1, #4) observed during the medication passes including errors with timing of insulin administration (#1, #4) and an antibiotic ear drop (#1); and for 3 of 5 residents (#1, #2, #4) sampled including errors			Deing passed being passed of paper ma proper training new procedu	res.
	hold scheduled insu	ray) sampled including errors isulin (#1, #2) and failure to ulin for low blood sugar ien resident did not eat meals		Will facility Will be re-e for competen	2 Varuato
	The findings are:			Unanina educ	ationi
	opportunities during	rror rate was 10% as servation of 3 errors out of 28 the 8:00 a.m. and 11:30 a.m. ion passes on 03/14/18.	•	Supervision admin Imed to Supervisor a	nd
	a. Review of Reside 11/01/17 revealed dia	nt #4's current FL-2 dated agnoses included dementia, pertension, depression		Pharmacy st Facility wi replace med as needed by	11
ision of Hor	revealed an order da	4's physician's orders ted 03/05/18 for Humalog		upon Compei	rency

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{D 358}	Continued From pa		{D 358}	Decima		
	insulin inject 3 unit	s 3 times daily with breakfast,		Raciuna	r ocetir	reig
	lunch, and dinner:	hold if blood sugar is less than at does not eat. (Humalog is		Checkman	S for	,
	rapid-acting insulin	used to lower blood sugar		accuracy	han	
	The manufacturer recommends Humalog be taken within 15 minutes before eating a meal.)			Provide ar	21100	ded
	raken within 15 mir	lutes before eating a meal.)		produce a	19 1166	CICCI
	Review of Resident	t #4's March 2018 medication		training p	permo	4
	administration reco	rd (MAR) revealed:		checks to	c level	
	with breakfast lunc	y for Humalog inject 3 units th, and dinner; hold for blood		ensure ai		
- 1	sugar < 110 or resid	ent does not eat that meal		Ara a ==	\cdots	, >
	-mullialog was sche	eduled to be administered at		are accur	rate	
	7.30 a.m., 11:30 a.r	n., and 5:00 n m		according	40 TH	2
	330 from 03/01/18 -	od sugar ranged from 123 - - 03/13/18.	1	physicians	= ard	3/
1	Intondou			and madia	JUICA	20
	03/14/18 at 12:01 p.	edication aide (MA) on		and medic	204160	5
	-Lunch was usually	served at 12:30 n m	1	we given	tri ra	- salas
	one usually started	checking fingerstick blood	(a coording a	10 Cin	h
	sugars (FSBS) and 12:00 noon each da	administering insulin around		Orders.	- sac	4)
						Į.
0	Observation during t 03/14/18 revealed:	the medication pass on		uny order	51104	
	Resident #4 was in	her room		Clear of 1	t5 int	ent
-	The MA checked Re	esident #4's blood sugar at	1	will be	310 - 6	·
1	2.13 p.m. and it wa	s 165	h.		- ICU 1+	red
to	o the resident at 12:	ed 3 units of Humalog insulin	1	by the att	endind	3
		140	7	physician		フル
	bservation of Resid	dent #4 on 03/14/18 revealed:	7			
-	The resident was se	erved lunch at 12:41 nm ac		All will h		
111	iouiii.	ng Humalog, a rapid-acting	-	supervised	d by T	2cc,
	The resident did not	receive Humalog insulin	r	admin I RO	C 6.	
1 **	itti tile tileal as orde	ered.	C	Danage	- 2h	pery;
m	l ne resident ate app neal.	proximately 75% of her lunch	1	· manyer.		
	th Service Regulation				3.10	0.10

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **ALZHEIMER'S RELATED CARE** 217 JONESBORO ROAD **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) {D 358} Continued From page 7 {D 358} Interview with the MA on 03/14/18 at 1:10 p.m. revealed: -The FSBS and insulin usually "popped" up on the electronic MARs at 12:00 noon. -The lunch meal was usually served on time at 12:30 p.m. and they usually waited to serve the meal until all residents were in the dining room. -She thought the facility's policy was to administer insulin 15 to 20 minutes prior to the meal. -She had not noticed the order for Resident #4's insulin was to administer it with meals. -The resident sometimes refused to eat meals but she had no way of knowing if the resident was going to eat the meal before she administered the insulin. Interview with the Care Coordinator (CC) on 03/14/18 at 1:30 p.m. revealed: -The MAs had been trained on administering insulin and the facility's policy. -The facility's policy was to administer insulin ordered with meals right before the resident went into the dining room with the meal already on the -Lunch was usually served at 12:30 p.m. but it sometimes ran late. -The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat. -The MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recently. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed: -She was diabetic and got insulin before meals. -She usually got insulin about 30 minutes before she received her meals. -She did not recall any times when she felt her

Division of Health Service Regulation

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{D 358}	Continued From pa	ge 8	{D 358}			
	blood sugar had go waiting to receive h	tten too low while she was				
	Attempted telephon primary care provide p.m. was unsuccess	e interview with Resident #4's er (PCP) on 03/14/18 at 4:10 sful.				
	06/12/17 revealed of dementia, diabetes, cerebrovascular acc	ent #1's current FL-2 dated liagnoses included vascular hypertension, cident, depression, ropathy, and atrial fibrillation.				
	revealed an order di insulin inject 5 units if blood sugar is less does not eat. (Novo insulin used to lower	mends eating a meal within 5				
	administration record -There was an entry with meals; hold for does not eat that me	for Novolog inject 3 units blood sugar < 110 or resident eal.				
3 3	-The resident's blood from 03/01/18 - 03/1	sugar ranged from 52 - 430				
	03/14/18 at 12:01 p.r -Lunch was usually s -She usually started	erved at 12:30 p.m. checking fingerstick blood administering insulin around				

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	T	DUNN, N	C 28334			
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{D 358}	Continued From pa	ge 9	{D 358}			
	O3/14/18 revealed: -Resident #1 was ir -The MA checked F 12:20 p.m. and it was -The MA did not asl to eat lunchThe MA administer to the resident at 12 Observation of Res -The resident was s minutes after receiv insulinThe resident did not the meal as ordered -The resident ate as meal. Interview with the M revealed: -The FSBS and insu the electronic MARs -The lunch meal was 12:30 p.m. and they meal until all resider -She thought the fac insulin 15 to 20 minus -She had not noticed insulin was to adminus -Resident #1 usually Interview with the Ca 03/14/18 at 1:30 p.mThe MAs had been insulin and the facilit -The facility's policy ordered with meals re-	Resident #1's blood sugar at as 184. It the resident if she was going red 8 units of Novolog insulin 2:24 p.m. Ident #1 on 03/14/18 revealed: rerved lunch at 12:41 p.m., 17 ring Novolog, a rapid-acting of receive Novolog insulin with a proximately 90% of her lunch at 12:00 noon. Is usually "popped" up on at 12:00 noon. It usually waited to serve the nest were in the dining room. It is usually waited to serve the nest were in the dining room. It is usually waited to serve the nest were in the dining room. It is usually waited to serve the nest were in the dining room. It is usually waited to serve the nest were in the dining room. It is usually waited to serve the nest were in the dining room. It is a conditional to the order for Resident #1's nester it with meals. If the order for Resident #1's nester it with meals. If are Coordinator (CC) on the revealed: trained on administering				

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(D 358)	Continued From pa	age 10	{D 358}	AND THE PARTY OF T			
	table.		(D 330)				
		y served at 12:30 p.m. but it					
	sometimes ran late	e.					
	-The MAs should v	vait until the food was on the					
	table and then adm	ninister the insulin just prior to					
	Resident #1 entering	ng the dining room to eat.					
	reviews Resident	ions, interviews, and record					
1	Toriows, resident	#1 was not interviewable.				E.	
İ	Attempted telephor	ne interview with Resident #1's					
	primary care provid	er (PCP) on 03/14/18 at 4:10					
	p.m. was unsucces	sful.					
	- D- :	a water					
	c. Review of Resid	ent #1's physician's orders					
	0.2% 1 drop in both	lated 03/05/18 for Cipro Otic ears 3 times a day for 2					
1	weeks for ear infect	tion. (Cipro Otic is an					
	antibiotic ear drop u	ised to treat ear infections.)					
1							
	Review of Resident	#1's March 2018 medication					
1	autilities l'allon recor	d (MAR) revealed.					
	instill 1 drap into be	for Cipro Otic 0.2% solution,					
	days.	th ears 3 times a day for 14					
		eduled to be administered at					
	5.00 a.m., 2:00 p.m.	. and 8:00 n m	-				
100	Ine first dose of Cit	pro Otic was documented as					
8	administered at 2:00	p.m. on 03/06/18.	1				
10	Observation of the m	a a dia a dia a	1				
	at 8:56 a.m. revealed	nedication pass on 03/14/18					
-	Resident #1 was sit	ting straight up on her bed.					
1 -	The medication aids	(MA) did not sek the					
1 1	esident to tilt her he	ad or to lie down prior to			İ		
0	diffinistering 1 drop	of Cipro Otic in the loft one					
a	ind then putting a pi	ece of cotton ball in the left					
-	al.						
-	ar drop go into he	the resident if she felt the					
	th Service Regulation	ear, the resident stated, "No".				1	

STATEME AND PLAN	of Health Service F NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED	
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NAME OF	PROVIDER OR SUPPLIEF				1 03/	15/2018	
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(D 358)	Continued From p	age 11	{D 358}				
	so the drop could a container 3 times or resident's right ear. The resident was bed and the MA ne her head so the ear resident's ear canarathe MA put a piece right ear. Interview with the Market revealed: She had training or but she could not reshe was aware she	still sitting straight up on the ever asked the resident to tilt ar drops could go down into the al. See of cotton in the resident's MA on 03/14/18 at 1:00 p.m. In how to administer ear drops ecall when. The was supposed to have the					
	drops but the residual she was not award be tilted or the residual she was not award be tilted or the residual she was not award be tilted or the residual she was not award to	nd prior to administering the ear ent was impatient. The the resident's head should dent should remain lying on the after the medication was	0				
	03/14/18 at 1:27 p.r -She and the MAs I administered ear dr when.	nad been trained on how to ops but she could not recall					
	their nead and then number of drops. Then they were suithe resident's ear autheir head tilted to the could not recashould remain tilted administered.	ed to have the resident tilt administer the required pposed to put a cotton ball in and have the resident keep ne side. Il how long the resident's head after the ear drop was					

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AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-	-	HAL043026	B. WING			R 15/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, S	TATE ZIP CODE	1 00/	10/2010
ALZHE!!	MER'S RELATED CAP		ESBORO ROA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
(D 358)	Continued From pa	age 12	{D 358}	100 A 100 A		
	2. Review of Resident 11/01/17 revealed of diabetes mellitus, hypothyroidism, and Review of Resident revealed: -There was an order insulin 3 units at bree 6 units at dinner. (No insulin used to lower manufacturer reconstant to 10 minutes after 10 minutes after 10 minutes after 10 minutes and 10 minutes after 10 minutes and 10 minutes after 10 minutes and 10 minutes after 10 minutes and 10 minutes after 10 minutes and 10 minutes after 10 minutes and 10 minutes after 10 minutes and	t #4's physician's orders er dated 11/12/17 for Novolog eakfast, 6 units with lunch, and Novolog insulin is rapid-acting er blood sugar. The inmends eating a meal within 5 the injection.) r dated 11/13/17 to change ealog insulin due to the enot covering Novolog insulin. In order of the injection of the enot covering Novolog insulin. It is insulin used to lower eanufacturer recommends within 15 minutes before or dated 11/13/17 to hold if the fingerstick blood sugar and (<) 110 or if the resident or dated 03/05/18 for Humalog 3 times daily with breakfast, and if blood sugar is < 110 or if the resident or if the resident or if the fingerstick blood sugar is < 110 or if the resident or if the resident refused to in				
- e	01/15/18 (2pm - 10p at dinner.	om): The resident refused to				

PRINTED: 04/03/2018

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BUILDING:		CON	MPLETED
-		HAL043026	B. WING		03	R /15/2018
NAME OF	PROVIDER OR SUPPLIER	STREETA	DORESS CITY S	STATE, ZIP CODE		10/2010
AL ZHEIR	MER'S RELATED CA		ESBORO ROA			
, CEITEII	MER O RELATED CA		IC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From p	age 13	{D 358}			
	-01/25/18: The rea	idt£	1- 555)			
	today The Care C	ident refused to eat her lunch				
	a meeting with the	Coordinator and the owner had				
	of eating her meals	resident about the importance s. The resident stated she was				
	on a "hunger strike	s. The resident stated she was				
	-01/25/18 (2pm - 1	0pm): The resident refused to				
	eat dinner because	her mouth was hurting.				
	-01/26/18 (8:10 a.r	n.): The resident refused to eat				
	ner breakfast. She	would only take her				
	medications, drink	coffee, and smoke			590	
	-01/26/18 (2pm - 1	0pm): The resident refused to				
	eat dinner, she clai	med she was fasting for the				
	next several days.	Staff explained to her the				
1	importance of eatin	ig supper.				
	-01/28/18 (/am): T	he resident refused breakfast.				
	Pavious of Pasidan	1 #41 - 1				
İ	medication adminis	t #4's January 2018				
	-There was an entr	stration record (MAR) revealed: y for Humalog inject 3 units at				
	breakfast 6 units w	with lunch, and 6 units at dinner				
	(hold if FSBS < 110	or resident does not eat that				
	meal).	or resident does not eat that				
		eduled to be administered at		*		
	8:00 a.m., 12:00 p.t	m., and 5:00 p.m.				
1.	 The resident's FSE 	SS was documented as < 110				
1.5	on 5 occasions in J	anuary 2018.				
	The resident's FSE	3S was 102 on 01/11/18 at				11
	12:00 p.m., 99 on 0	1/17/18 at 5:00 p.m. 62 on				
	01/20/18 at 5:00 p.r	n., 103 on 01/23/18 at 5:00	-			
	p.m., and 78 on 01/	30/18 at 5:00 p.m.				
	Humalog insulin wa	as documented as				
	110 instead of bald	5 occasions the FSBS was <			× 1	
	110 instead of held	as ordered.				
	administered on 0 ~	Humalog insulin was ccasions when staff had				
	ocumented in the	ourses' notes that				
1	did not eat the most	nurses' notes that the resident				
	as ordered.	instead of holding the insulin				
		mented as administered				
	3 Mag adda	id not eat breakfast on			4	

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {D 358} Continued From page 14 {D 358} 01/26/18 and 01/28/18. -Humalog was documented as administered when the resident did not eat lunch on 01/25/18. -Humalog was documented as administered when the resident did not eat dinner on 01/05/18, 01/15/18, 01/23/18, 01/25/18, and 01/26/18. -The resident's FSBS ranged from 62 - 361 from 01/01/18 - 01/31/18. Review of Resident #4's February 2018 MAR revealed: -There was an entry for Humalog inject 3 units at breakfast, 6 units with lunch, and 6 units at dinner (hold if FSBS < 110 or resident does not eat that -Humalog was scheduled to be administered at 8:00 a.m., 12:00 p.m., and 5:00 p.m. -The resident's FSBS was documented as < 110 on 4 occasions when insulin should have been held in February 2018. -The resident's FSBS was 98 on 02/01/18 at 8:00 a.m., 90 on 02/12/18 at 12:00 p.m., 72 on 02/21/18 at 5:00 p.m., and 96 on 02/27/18 at 5:00 p.m. -Humalog insulin was documented as administered on all 4 occasions the FSBS was < 110 instead of held as ordered. -The resident's FSBS ranged from 72 - 487 from 02/01/18 - 02/28/18. Review of Resident #4's March 2018 MAR revealed the resident's FSBS ranged from 123 -330 from 03/01/18 - 03/13/18 and Humalog would not have been required to be held. Interview with a medication aide (MA) on 03/14/18 at 1:10 p.m. revealed: -If insulin or any other medication was held, the MAs would documented it as withheld per doctor's orders on the MAR.

Division of Health Service Regulation

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {D 358} Continued From page 15 {D 358} -She did not recall holding Humalog insulin for Resident #4. -She usually administered insulin 15 to 20 minutes prior to the meal. -Resident #4 sometimes refused to eat meals but she had no way of knowing if the resident was going to eat the meal before she administered the insulin. Interview with a second MA on 03/14/18 at 1:18 p.m. revealed: -Resident #4 sometimes ate her meals and sometimes she did not -The MAs were supposed to hold the resident's insulin and document it as held if the resident did not eat. -About a month ago, the Care Coordinator (CC) told the MA that staff was not documenting that the insulin was being held as ordered. -She started documented "withheld per doctor's orders" from the drop down menu after that. Interview with a third MA on 03/14/18 at 5:14 p.m. revealed: -If she held a dose of any medication, it would be documented as "withheld per doctor's orders" on the MAR. -She did not recall holding any insulin for Resident #4. -Resident #4 skipped meals sometimes. -She did not know if Resident #4 was going to eat the meal so she usually waited for the food to be available and ready before she administered the insulin. Interview with the Care Coordinator (CC) on 03/14/18 at 1:30 p.m. revealed: -The MAs had been trained on administering insulin and the facility's policy. -The facility's policy was to administer insulin Division of Health Service Regulation

HAL043026 B. WING O3/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD DUNN, NC 28334 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CONDENSES PLAN OF CORRECTION (X5)	STATEMEI AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD DUNN, NC 28334 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG (D 358) Continued From page 16 ordered with meals right before the resident went into the dining room with the meal already on the tableThe MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eatThe MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recentlyIf Resident #4 was not going to eat or if the FSBS was < 110, the insulin should be held as orderedShe had not noticed that the MAs were not holding the insulin when the resident did not eat or if the resident's FSBS was < 110She checked the MARs sometimes but there was no set system to review the MARs to assure medication orders were being followed. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed:			HAL043026				
ALZHEIMER'S RELATED CARE 217 JONESBORO ROAD DUNN, NC 28334 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (D 358) Continued From page 16 ordered with meals right before the resident went into the dining room with the meal already on the table. -The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat. -The MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recently. -If Resident #4 was not going to eat or if the FSBS was < 110, the insulin should be held as ordered. -She had not noticed that the MAs were not holding the insulin when the resident did not eat or if the resident's FSBS was < 110. -She checked the MARs sometimes but there was no set system to review the MARs to assure medication orders were being followed. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed:	NAME OF	PROVIDER OR SUPPLIER		DRESS OFFICE	TATE NO COLO	03/	15/2018
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECODED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) (D 358) Continued From page 16 ordered with meals right before the resident went into the dining room with the meal already on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat. -The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat. -The MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recently. -If Resident #4 was not going to eat or if the FSBS was < 110, the insulin should be held as ordered. -She had not noticed that the MAs were not holding the insulin when the resident did not eat or if the resident's FSBS was < 110. -She checked the MARs sometimes but there was no set system to review the MARs to assure medication orders were being followed. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed:			STREET AD				
TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (D 358) Continued From page 16 ordered with meals right before the resident went into the dining room with the meal already on the table. -The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat. -The MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recently. -If Resident #4 was not going to eat or if the FSBS was < 110, the insulin should be held as ordered. -She had not noticed that the MAs were not holding the insulin when the resident did not eat or if the resident's FSBS was < 110. -She checked the MARs sometimes but there was no set system to review the MARs to assure medication orders were being followed. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed:	~	WER'S RELATED CA					
ordered with meals right before the resident went into the dining room with the meal already on the table. -The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat. -The MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recently. -If Resident #4 was not going to eat or if the FSBS was < 110, the insulin should be held as ordered. -She had not noticed that the MAs were not holding the insulin when the resident did not eat or if the resident's FSBS was < 110. -She checked the MARs sometimes but there was no set system to review the MARs to assure medication orders were being followed. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FILL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
ordered with meals right before the resident went into the dining room with the meal already on the table. -The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat. -The MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recently. -If Resident #4 was not going to eat or if the FSBS was < 110, the insulin should be held as ordered. -She had not noticed that the MAs were not holding the insulin when the resident did not eat or if the resident's FSBS was < 110. -She checked the MARs sometimes but there was no set system to review the MARs to assure medication orders were being followed. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed:	{D 358}	Continued From pa	age 16	{D 358}		***************************************	
-She usually got insulin about 30 minutes before		ordered with meals into the dining roor table. -The MAs should we table and then administrated the machine. -The MAs should a going to eat because skipping some meals of the meals of the machine. -If Resident #4 was FSBS was < 110, to ordered. -She had not notice holding the insuling wor if the resident's FSB checked the Mas no set system medication orders with revealed. -She was diabetic as table to a system was diabetic as the machine with Resident.	s right before the resident went m with the meal already on the wait until the food was on the minister the insulin just prior to ng the dining room to eat. It is the resident if she was see Resident #4 had been als recently. It is not going to eat or if the he insulin should be held as red that the MAs were not when the resident did not eat FSBS was < 110. MARs sometimes but there to review the MARs to assure were being followed. Ident #4 on 03/14/18 at 5:23				
	3	Attempted telephone or imary care provide or	e interview with Resident #4's er (PCP) on 03/14/18 at 4:10 sful. nt #1's current FL-2 dated diagnoses included vascular				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {D 358} Continued From page 17 {D 358} dementia, diabetes and atrial fibrillation, hypertension, and depression. a. Review of Resident #1's physician's orders dated 02/16/18 revealed: -There was an order for Coumadin 3.5mg on Mondays and Tuesdays and 3 mg on Wednesdays, Thursdays, Fridays, Saturdays and Sundays (Coumadin is a medication used to thin the blood. INR is a lab used to determine the effectiveness of the Coumadin and is usually recommended to be between 2 and 3.) -On 02/16/18, the resident's INR was 3.1, recheck the INR on 02/23/18. -There was an order dated 02/23/18 to hold the Coumadin for 3 days, recheck the INR in 3 days on 02/27/18. -On 02/23/18 the residents INR was 3.7 (above therapeutic range) Review of Resident #1's electronic medication administration record (e-MAR) for February 2018 revealed: -There was an entry for Coumadin 3mg take one -There was a second entry for Coumadin 1mg tag take 1/2 tab (.5mg) on Monday's and Tuesday's. -The order to hold Coumadin was not included on the e-MAR. -Coumadin 3mg was initialed as administered every day in the month of February. Interview with the Medication Aide (MA) on 03/14/18 at 1:07 p.m. revealed: -If there was a hold on a medication the screen for that medication will be gray and you cannot -She did not remember the Coumadin being held in February 2018. -If she initialed the Coumadin she would have

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 18 {D 358} {D 358} administered it. -She thought the pharmacy entered the hold orders on the e-MAR for medications to be held. Interview with a second MA on 03/15/18 at 10:45 a.m. revealed: -She did not remember holding the Coumadin for Resident #1. -If she gave a medication it would be initialed on the e-MAR. Interview with the Care Coordinator on 03/14/18 at 1:40 p.m. revealed: -She usually tracked the INRs for changes but not always. -The facility's pharmacy puts medications on hold on the e-MAR. -She did not always see all the new orders, sometimes they were faxed to the pharmacy from the doctor's office and sometimes the facility faxed them. -She was not sure if the order from 02/23/18 was faxed to the pharmacy. Telephone Interview with a pharmacist from the facility's pharmacy on 03/14/18 at 4:35 p.m. revealed: -As a general rule, the pharmacy did not put hold orders in the e-MAR. -The facility can temporarily enter orders including hold orders into the e-MAR. -The pharmacy expected the facility to enter hold orders in the e-MAR. Attempted telephone interview on 03/14/18 at 4:10 p.m. and on 03/15/18 at 11:00 a.m. with Resident #1's primary care provider (PCP) was unsuccessful. Attempted interview with Resident #1 on 03/14/18 Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER; A. BUILDING: _ COMPLETED HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALZHEIMER'S RELATED CARE 217 JONESBORO ROAD **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {D 358} Continued From page 19 {D 358} at 5:00 p.m. revealed the resident was not interviewable. Review of Resident #1's physicians orders revealed: -Resident #1's next INR was drawn on 02/27/18 and the results were 1.4 (below therapeutic range) -There was an order dated 02/27/18 for Coumadin 3mg daily. b. Review of a physician's order for Resident #1 dated 08/21/17 revealed an order for Novolog 8 units inject subcutaneous with meals. Hold parameters if FSBS is less than 110 or if resident does not eat that meal. (Novolog is a fast acting insulin used to lower blood sugar.) Review of Resident #1's electronic medication administration record (e-MAR) for January 2018 -There was an entry for Novolog 8 units with meals hold if FSBS is less than 110 or does not -There were 13 ocassions in January 2018 when the resident's FSBS was less than 110 and the Novolog should have been held but was documented as administered. -The FSBS on 01/2/18 at 8:00 a.m. was 81, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/4/18 at 12:00 p.m. was 91, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/6/18 at 12:00 p.m. was 84, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/7/18 at 8:00 a.m. was 91, there was documentation that 8 units of Novolog were administered. Division of Health Service Regulation

STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED R HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {D 358} Continued From page 20 {D 358} -The FSBS on 01/8/18 at 8:00 a.m. was 91, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/12/18 at 8:00 a.m. was 90, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/13/18 at 8:00 a.m. was 83, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/15/18 at 8:00 a.m. was 104, there was documentation that 8 units of Novolog were administered -The FSBS on 01/18/18 at 8:00 a.m. was 104, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/19/18 at 8:00 a.m. was 102, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/20/18 at 8:00 a.m. was 71, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/22/18 at 8:00 a.m. was 74, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/24/18 at 8:00 a.m. was 91, there was documentation that 8 units of Novolog were administered. -Resident #4's FSBS range was 74-538 in the month of January 2018. Review of Resident #1's e-MAR for February 2018 revealed: -There was an entry for Novolog 8 units with meals hold if FSBS is less than 110 or does not -There were 3 occasions in February 2018 when the resident's FSBS was less than 110 and Novolog should have been held but was documented as administered. -The FSBS on 02/22/18 at 8:00 a.m. was 106,

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {D 358} Continued From page 21 {D 358} there was documentation that 8 units of Novolog were administered. -The FSBS on 02/26/18 at 12:00 p.m. was 76, there was documentation that 8 units of Novolog were administered. -The FSBS on 02/27/18 at 12:00 p.m. was 89, there was documentation that 8 units of Novolog were administered. -Resident #1's FSBS range was 58-456 in the month of February 2018. Review of Resident #1's e-MAR for March 2018 revealed: -There was an entry for Novolog 8 units with meals hold if FSBS is less than 110 or does not eat -There were 2 occasions from March 1-13 2018 when the residents FSBS was less than 110 and Novolog should have been held but was documented as administered. -The FSBS on 03/2/18 at 8:00 a.m. was 102, there was documentation that 8 units of Novolog were administered. -The FSBS on 03/7/18 at 8:00 a.m. was 107, there was documentation that 8 units of Novolog were administered. -Resident #1's FSBS range was 52-382 from March 1-13 2018. Interview with a Medication Aide (MA) on 03/14/18 at 10:45 a.m. revealed: -He did not always read the whole order each time he had to administer insulin to Resident #1. -He had started reading the whole insulin order today (03/14/18) after the Care Coordinator talked with him about the insulin orders. -He had administered insulin to Resident #1 when it should have been held because he had not read the whole order.

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY
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NAME OF	PROVIDER OR SUPPLIER				03/	15/2018
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(D 358)	Continued From pa	age 22	{D 358}			
	Interview with a sep.m. revealed: -She knew that ins-She was not sure insulin when a blood-"If I initialed a med Attempted telephor 4:10 p.m. and on 0 Resident #1's Primunsuccessful. c. Review of a curro 06/12/17 for Reside check Finger Stick meals and administ to the following slidi 201-250 = 1 unit: 25 units; 351-400 = 4 p.m.	cond MA on 03/14/18 at 5:20 ulin dropped the blood sugar. why she had initialed giving od sugar was lower than 110. dication, then I gave it." ne interview on 03/14/18 at 3/15/18 at 11:00 a.m. with ary Care Provider was ent physician's order dated ent #1 revealed an order to Blood Sugar (FSBS) with ter Novolog insulin according ing scale: less the 200 = 0; 51-300 = 2 units; 301-350 = 3 units; 401-450 = 5 units. acting insulin used to lower	(0.336)			
	medication administrevealed: -There was an entry to the following sliding 201-250 = 1 unit; 25 units; 351-400 = 4 units; 351-400 = 4 units; 351-400 = 5 units administered. The FSBS was 275 and would have required would have required would have required to the FSBS was 275 and would have required would have required to the fasting blood signed to the month of Januar the fasting blood signed would have required to the fasting blood signed to the month of Januar the fasting blood signed to the month of Januar the fasting blood signed to the fasting to the fasting blood signed to the fasting blood signed to the fasting blood signed to the fasting the fasting blood signed to the fasting blood signed to the fasting blood signed to the fasting the f	#1's January 2018 electronic tration record (e-MAR) for Novolog insulin according ng scale: less than 200 = 0; i1-300 = 2 units; 301-350 = 3 inits; 401-450 = 5 units. I on 01/21/18 at 5:00 p.m. and I 3 units of insulin but there were documented as in on 01/25/18 at 12:00 p.m. uired 1 unit of insulin but 4 ted as administered. ugars ranged from 74-538 for y 2018.			, al	

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) {D 358} Continued From page 23 {D 358} 03/14/18 at 10:45 a.m. revealed: -He was hired as a MA on 06/15/17 -He was not always reading the whole order each time he had to administer insulin to Resident #1. -He had administered the amount of insulin he documented on the e-MAR. -He thought he remembered the amount of insulin the resident should receive without reading the order each time. Attempted interview with Resident #1 on 03/14/18 at 5:00 p.m. revealed the resident was not interviewable Interview with the Care Coordinator on 03/14/18 at 1:20 p.m. revealed: -She did not usually check the MARs for accuracy. -She expected the MA's to read the insulin sliding scale orders before administering the sliding scale insulin dose. Attempted telephone interview on 03/14/18 at 4:10 p.m. and on 03/15/18 at 11:00 a.m. with Resident #1's Primary Care Provider (PCP) was unsuccessful. 4. Review of Resident #2's FL-2 dated 7/24/17 revealed. - Diagnoses included vascular dementia, atrial fibrillation, hypothyroidism and hypertension. -There was orders for diabetic glucose testing 2 times a day at 8:00am and 5:00pm. -There was an order for Lantus insulin, inject 10 units subcutaneous at bedtime (Lantus is used to lower blood sugar). -There was an order for Tradjenta 5mg by mouth 1 time a day (Tradjenta is used to lower blood sugar).

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY {D 358} Continued From page 24 {D 358} Review of a local hospital discharge summary dated 3/2/18 revealed: -Resident #2's admission diagnoses included diabetes mellitus 2, uncontrolled and urinary tract infection. -The resident's initial glucose (blood sugar) was 791 and today [2/28/18] her glucose was 77 (target glucose ranges are 70 - 130 for diabetics) and her A1c level was 10.1 (typical A1c level for diabetic is 5). -The [resident] should not be on an oral hypoglycemic agent, but should be on regular insulin with blood sugar checks 4 times a day. -Contact the primary medical provider for an appointment. Review of Resident #2's primary medical provider's visit report dated 3/5/18 revealed orders to discontinue Tradjenta and to start Humalog insulin 4 units with meals, hold if blood glucose is less than 120 or if patient does not eat that meal.(Humalog is a fast acting insulin used to treat used to lower blood sugars). Review of Resident #2's medication administration record (MAR) for March 2018 revealed: -There were preprinted instructions to check blood sugars (BS) twice a day before breakfast and supper at 8:00am and 5:00pm. BS values were documented as checked at 8:00am and 5:00pm. -There were preprinted instructions for Humalog insulin, inject 4 units subcutaneously three times a day with meals. Hold if BS was less than 120 or if resident does not eat meal. The scheduled administration times were 8:00am, 2:00pm and 8:00pm. -Humalog insulin (4 units) was documented as administered at 8:00am, 2:00pm and 8:00pm.

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{D 358}	Continued From pa	ge 26	{D 358}			
	-The MA was aware insulin, was ordered meals, the resident before the medicatifollowed the instruction. The MA did not clapharmacy or primare at 4:33pm revealed endowned. Normally when a new sentered into the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy, administed in the pharmacy in the pharmacy in the pharmacy to change in the pharmacy to change in the pharmacy in t	e if a medication, including of to be administered with should be eating a meal on was administered but she tions on the MAR instead, rify the MAR with the y medical provider. acility's pharmacist on 3/14/18: ew medication or treatment electronic MARS by the tration times were entered, lluding insulin, was ordered hinistration times would be malog administration times er meal times (7:30am, m). have changed the times to not 5:30pm or contacted the extention times. ation order dated 3/15/18 or start fingersticks for blood or before meals at 7:00am, m. ent's March 2018 MAR og insulin administration times to 7:30am, 12:30pm and				

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	The facility did not a ordered for 3 diabet and 4) with orders funstable blood sugablood thinner as orden put the resident facility's continued finedications as orden health, safety, and vonstitutes an Unab	administer medications as ic residents (Residents #1, 2 or insulin, which can cause ars. The facility did not hold a lered for Resident #1 which at risk for bleeding. The ailure to administer ered was detrimental to the velfare of the residents and ated Type B Violation.	(U 358)			
	Administrator and/or Supervisor. -The Corporate Train all MAs on 03/15/18 demonstration.	Medication Aide (MA) ner will conduct in-service for with hands on	e e			
	at 10:00 a.m. on med MAs. -Beginning 03/16/18 pass, the facility will in proper training of new proper training of new proper training of new property. -Ongoing education / Administrator, MA Sustaff. -Replace MAs as new provide training as new	supervision by CC, supervisor, and pharmacy				

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age 28	{D 358}		
ed by CC, Administrator, MA			
04 Medication Administration nedication administration be accurate and include the dication or treatment order; dication or treatment order; sage or quantity of medication administering the medication administering the medication of the administration of the administration of the administration; administration; of any omission of ments and the reason for the refusals; and, of the person administering eatment. If initials are used, a to those initials is to be anintained with the medication of (MAR).	D 367	RCC Will OSSWE THOUS Orders are un Proper by and who be cla by the mo of Sent to the p from proper on the mars that all ma are docume according to the given or provide training need	orther iary is rified and pharmacy input source edtecns enting ders. ontinue anu
	HAL.043026 STREET A 217 JON	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043026 STREET ADDRESS, CITY 217 JONESBORD RE 217 JON	X(2) PROVIDERSUPPLIERCLIA DENTIFICATION NUMBER X2) MULTIPLE CONSTRUCTION A BUILDING: B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD DUNN, NC 28334 DPROVIDERS PLAN OF CORRECT Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY) DEFICIENCY) PREFIX TAG CROSS-REFERENCED TO THE APPR DEFICIENCY) DOWN AND ADDRESS OF THE APPR DEFICIENCY DOWN ADDRESS OF THE APP

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		NOTE AND DELIVER.	D 367	will be	SLEDEY	Lins
	orally and being ad unavailable to be a	ication being administered iministered when it was dministered (#4).	440	by the pomanager.	1 wink	•,
	The findings are:					
T T T T T T T T T T T T T T T T T T T	11/01/17 revealed	dent #4's current FL-2 dated diagnoses included dementia, sypertension, depression, dear infection.				
	1ml topical daily. (N	an's order dated 03/09/18 for ed an order for Medihoney gel, Medihoney is a topical treat hard to heal wounds and				
	administration recor -There was an entry daily.	for Medihoney 1ml by mouth				
	administered by mo 03/10/18 - 03/13/18 -There was no entry	Medihoney had been uth to Resident #4 from (4 days). on the MAR for the plied topically as ordered.				
	Observation of medi	cations on hand for Resident	*			9
	3/13/18 at 5:30 p.m	lication aide (MA) on . revealed:		No. 10		
l P	MAR.	er if he gave the Medihoney though he initialed it on the		Completed.	by 3.14	2-18
5	yrup.	ihoney might be a cough				
1 11	If he gave it, he wou nouth because that th Service Regulation	ld have administered it by was the instructions on the			July	l

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 367 Continued From page 30 D 367 MAR. -He could not find any in the medication cart. Interview with the Care Coordinator (CC) on 03/13/18 at 5:35 p.m. revealed: -She was not aware the Medihoney was not available in the facility. -She just found a slip of paper from the pharmacy on the desk at the nurses' station indicating the Medihoney was temporarily out of stock. -She was not aware the instructions on the MAR indicated to administer the Medihoney by mouth instead of topically as ordered. -The pharmacy usually entered new orders into the electronic MAR system. -She sometimes checked the MARs for accuracy but there was no set system for checking them. -The MAs should have documented that the Medihoney was unavailable due to waiting on pharmacy on the MAR. -The MAs have been trained on how to document and they were not supposed to document a medication was administered if it was not. -The resident went to a wound clinic last week for a wound on her foot and that was when she received the order for Medihoney. -She would notify the wound clinic that the Medihoney had not been applied to the resident's -She would check with the pharmacy about correcting the instructions on the MAR for the Medihoney. Review of a pharmacy communication slip for Resident #4 revealed: -There was a medication label affixed to the slip of paper dated 03/10/18 with Medihoney apply 1ml to affected area every day printed on the -There was a note on the slip indicating

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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	Medihoney was ter would be sent on o	mporarily out of stock and or before 03/13/18.	1)			
	facility's primary ph p.m. revealed: -They received the	w with a pharmacist from the narmacy on 03/14/18 at 4:34 order dated 03/09/18 for				
	Medihoney apply 1 03/10/18 at 2:12 a.	ml topically once a day on				
	the e-MAR system orders temporarily	but the facility could also enter				
	-It appears the orde entered incorrectly was changed by ph medication being so -There was a delay	er for Medihoney was originally into the e-MAR system but tarmacy staff prior to the ent to the facility on 03/13/18. In sending the Medihoney trying to determine if they	2			
	could use the paste -It may have also be had to order the Me -They received a ca to use the paste.	e instead of gel. een delayed if the pharmacy edihoney from their supplier. all from the facility on 03/12/18				
3	facility on 03/13/18.	ste was delivered to the				
	a.m. revealed:	dent #4 on 03/13/18 at 10:30				
	nurse was dressing often.	on her foot that a home health but she was not sure how				
1	o her foot wound.	acility staff applying anything				
ı	evealed:	C on 03/14/18 at 11:00 a.m. honey came in the pharmacy				
I	ote last night and w	as on hand in the medication				

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AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY
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D 367	Continued From pa	ige 32	D 367		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
	cart.					
	-She received a rev	rised order for the Medihoney				
	dated 03/09/18 for	it to be applied 3 times a				
	week.					
= -	 A home health nur Medihoney. 	se would be applying the				
	wedinoney.					
	Review of an order	Review of an order dated 03/09/18 for Resident				
	#4 revealed an order for Medihoney to be applied					
	to left plantar foot 3	times per week.				
	2. Review of Resident #1's current FL-2 dated					
	06/12/17 revealed diagnoses included vascular dementia, hypertension, diabetes, hyperlipidemia,					
	neuropathy and atria	sion, diabetes, hyperlipidemia,				
	Review of Resident	#1's physician's order dated				
	Ub/12/1/ revealed a	n order for sliding scale				
	Novolog insulin ched	ck blood sugar with meals				
1	ror readings under	200 = 0 units $201 - 250 = 1$				
	351-400 = 4 units 4	its, 301-350 = 3 units,				
	a rapid acting insulin	01-450 = 5 units. (Novolog is used to lower blood sugar)				
		### ### ### #### #### ################				
	Review of Resident	#1's physician's order dated				
	on 17/17 revealed th	ere was an order for Novolca			1	
1 1	risulin inject 8 units :	Subcutaneous with moole			1	
f	inger stick blood au	-5:00 p.m. hold parameter if				
ľ	esident does not ear	gar is less than 110 or if				
1						
F	Review of Resident #	1's January 2018 electronic				
1.0	nedication administr	ation record (e-MAR)				
	evealed:					
-	ith most balling	for Novolog inject 8 units				
V	viun meal, hold if FSE	3S is less than 110 or the				
1	esident does not eat	the meal.				
a	dministered at 8-00	was scheduled to be a.m., 12:00 p.m. and 5:00				
p	.m.	a.ii., 12.00 p.m. and 5:00				
	th Service Regulation					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 367 Continued From page 33 D 367 -There was an entry for Novolog sliding scale with meals according to the following scale: less than 220 = 0 units, 201-250 = 1 unit, 251-300 = 2 units, 301-350 = 3 units, 401-450 = 5 units. -The Novolog sliding scale was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 -The routine Novolog was documented as administered at all times except held on 01/30/18 at 12:00 p.m. per doctor's order. -Eight units of Novolog were documented as administered on 20 occasions under the entry for the Novolog sliding scale insulin. -The resident's blood sugar was less than 200 on 12 occasions the 8 units were documented for the Novolog sliding scale. -The Novolog sliding scale did not have any parameters that would have required 8 units of insulin to be administered. -The routine 8 units of Novolog was also documented as administered on those 12 occasions, which appeared the resident received 16 units of Novolog on those occasions. -No sliding scale would be required on those -Staff double documented the routine Novolog insulin administration under the routine Novologentry and under the sliding scale Novolog entry on the MAR. -The resident's FSBS range for January 2018 was 74-538. Review of Resident #1's February 2018 e-MAR revealed: -There was an entry for Novolog inject 8 units with meal, hold if FSBS is less than 110 or the resident does not eat the meal. -The routine Novolog was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

Division of Health Service Regulation

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AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY
The state of the s	ta	HAL043026	B. WING			R
IAME OF PROVIDER OR SUPPLIER STREET A			DRESS CITY S	STATE, ZIP CODE	1 03/	15/2018
ALZHEI	MER'S RELATED CAR		SBORO ROA			
		DUNN, NO				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 367	Continued From pa	age 34	D 367			-
	-There was an entry meals according to 220 = 0 units, 201-; units, 301-350 = 3 in The Novolog sliding administered at 8:0 p.m. -The routine Novolog administered all time occasions per doctor less than 110. -Eight units of Novolog sliding FSBS was less than 15 the Novolog sliding parameters that wo insulin to be administered as admoccasions, which apparameters that wo insulin to be administered on 15 the Novolog sliding parameters that wo insulin to be administration occasions, which apparameters that wo insulin sof Novolog No sliding scale wo occasions. -Staff double documination administration entry and under the on the MAR. -The residents FSBS was 58-456. Review of Resident in revealed: -There was an entry with meal, hold if FS	y for Novolog sliding scale with the following scale: less than 250 = 1 unit, 251-300 = 2 units, 401- 450 = 5 units. It is gescale was scheduled to be 0 a.m., 12:00 p.m. and 5:00 and 5:00 and 5:00 are sexcept for held on 9 are sorder when the FSBS was also when the resident's a 200. It is gescale did not have any uld have required 8 units of stered. It is a scale when the resident received and those occasions. It is a scale when the resident received and those occasions. It is a scale when the resident received and those occasions. It is a scale when the resident received and those occasions. It is a scale when the routine Novolog in under the routine Novolog sliding scale Novolog entry and a scale when the routine Novolog sliding scale Novolog entry and a scale when the routine Novolog sliding scale Novolog entry and a scale when the scale when the routine Novolog sliding scale Novolog entry and a scale when the scale when the routine Novolog in under the routine Novolog entry and a scale when the scale with t	D 367			
-	revealed: There was an entry with meal, hold if FS resident does not ea. The routine Novologadministered at 8:00 p.m.	for Novolog inject 8 units BS is less than 110 or the				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 367 Continued From page 35 D 367 meals according to the following scale: less than 220 = o units, 201-250 = 1 unit, 251-300 = 2 units, 301-350 = 3 units, 401-450 = 5 units. -The Novolog sliding scale was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 p.m. -The routine Novolog was documented as administered at all times except held on three occasions per doctor order. -Eight units of Novolog were documented as administered on 9 occasions under the entry for the Novolog sliding scale insulin. -The Novolog sliding scale did not have any parameters that would have required 8 units of insulin to be administered. -The routine 8 units of Novolog was also documented as administered on those 9 occasions, which appeared the resident received 16 units of Novolog on those occasions. -No sliding scale would be required on those occasions. -Staff double documented the routine Novolog insulin administration under the routine Novolog entry and under the sliding scale Novolog entry on the MAR. -The residents FSBS for March 1-13, 2018 was 52-383. Interview with a medication aide (MA) on 03/15/18 at 10:45 a.m. revealed: -When he initialed the e-MAR it meant he had administered the medication -He was not aware he was initialing the routine Novolog in the wrong section until the Care Coordinator spoke to him on 03/14/18. -He did not administer 16 units of Novolog on those occasions. -He had administered 8 units of Novolog insulin on those occasions. Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ R HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 367 Continued From page 36 D 367 Interview with a second MA on 3/14/18 at 5:20 p.m. revealed: -She had not administered 8 units of Novolog sliding scale insulin. -She initialed the wrong spot on the MAR she thought she was documenting the scheduled dose of insulin. Interview with the Care Coordinator on 03/14/18 at 1:40 p.m. revealed: -She had not checked the e-MARs for accuracy of documentation. -The scheduled dose of Novolog should not be documented with the sliding scale Novolog. Attempted interview on 03/14/18 at 4:10 p.m. and on 03/15/18 at 11:00 a.m. with Resident #1's primary care provider was unsuccessful. (D912) G.S. 131D-21(2) Declaration of Residents' Rights {D912} G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration.

The findings are:

DQK813

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL043026 B. WING 03/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 217 JONESBORO ROAD ALZHEIMER'S RELATED CARE **DUNN, NC 28334** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {D912} Continued From page 37 {D912} Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 4 residents (#1, #4) observed during the medication passes including errors with timing of insulin administration (#1, #4) and an antibiotic ear drop (#1); and for 3 of 5 residents (#1, #2, #4) sampled including errors with sliding scale insulin (#1, #2) and failure to hold scheduled insulin for low blood sugar parameters and when resident did not eat meals (#1, #4). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)]. Division of Health Service Regulation

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