PRINTED: 06/07/2018 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	COMP	SURVEY LETED
		HAL080020	B. WING	A. Carrier and A. Car	05/	11/2018
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, S			
ANGELS A	AT HEART ASSISTED LIV	ING	OUTH MAIN STR GROVE, NC 280			
(X4) ID		ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF COR	RECTION	(X5)
TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION 6 CROSS-REFERENCED TO THE AU DEFICIENCY)	HOULD BE	COMPLETE
	Annual survey on 05/05/11/2018. 10A NCAC 13F .0407 Qualifications 10A NCAC 13F .0407 (a) Each staff person shall: (5) have no substantil North Carolina Health according to G.S. 131 This Rule is not met a Based on interviews a facility falled to ensure Substantiated findings	7 (a)(5) Other Staff 7 Other Staff Qualifications at an adult care home ated findings listed on the Care Personnel Registry E-256; as evidenced by: and record reviews, the ethere were no silsted on the North	D 000	Angels at Heart Assisted Liviaccording to the rules/regulation according to the rules/regulation according to the rules/regulation according to the rules/regulation according to the rules are personnel Registry be unlicensed health care personnel (N.C. § 131). Future potential employees we HCPR and a national Criminal Check BEFORE the date of health care and a second and a second and the facility. Upon review of findings, the Manager conducted and audit files to ensure that all employed HCPR and national Criminal Check contained in their file. Audits will be conducted by the second according to the conducted by the second according to the rules according	ons y employers h Care fore hiring E-256 B). ill have the l Background ire, and residents Office of employee ees have a Background	Projected Completion Date: 05/11/2018 and Ongoing
	upon hire for 1 of 3 sa Personal Care Aide (F	Personnel Registry (HCPR) Impled staff (Staff C), a PCA) .		Director on a quarterly basis to compliance with this procedur	e.	E.
	-Staff C was hired on care side (PCA)There was document Personnel Registry Ch	ersonnel record revealed; 04/30/2018 as a personal ation a Health Care neck (HCPR) was 018 with no substantiated		Angels at Heart Assisted Livir contracted with an outside con provide quarterly audits, ongo administrative staff, quality as improvement measures and encompliance with state and federegulations and guidelines.	sultant to ing training to surance and sure	
4	05/10/2018 at 10:17 at -Staff C was hired as a -The business office m for ensuring that the H				e T	
dalon of Heali	h Service Regulation	PUR HE RESENTATIVE'S SIGNATURE		TITLE DIVECT	or	CA 21/10

Addendum: The Datt of correction for all non-compliance cited will be 6/1/18- Discussed with farette angle on 6/22/18 via telephone by Carolin Harrison 6/22/18- Received and organised Carolin Harrison Carolin Harrison

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL080020	B. WING		05	5/11/2018
AME OF P	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E. ZIP CODE		
	APT APPIETED	1114 SOL	UTH MAIN STREET			
NGELS ,	AT HEART ASSISTED I	LIVING	GROVE, NC 28023			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLE*
D 137	Continued From page	ige 1	D 137			
J	hire for new staff.					
J		the HCPR had not been				
J	checked for Staff C	until 05/09/2018.				
J	-She had expected	for the HCPR to be checked	2			
	for Staff C upon hire					
		ousiness office manager on				
J	05/10/2018 at 10:22	2 am revealed:				
J		ble for completing HCPR				
J	checks for new staff					
J		PR should be checked for new				
7	staff upon hire.					
	-She had not check 05/09/2018.	k the HCPR for Staff C until				
	revealed:	C on 05/11/2018 at 4:41 pm				
	-She was hired as a					
	04/30/2018.	rk at the facility was on				
	Monday, 05/07/2018					
	-She did not know if for her upon hire.	if the HCPR had been checked				
	10A NCAC 13F .040 Qualifications	407(a)(7) Other Staff	D 139			
	GCGGIIII SEE					
		07 Other Staff Qualifications				
	(a) Each staff persor	on at an adult care home shall :				
		background check in				
7	accordance with G.S	S. 114-19.10 and 131D-40;				
	This Rule is not met TYPE B VIOLATION					
	Based on record rev	views and interviews the				

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facility failed to assure 2 of 3 staff sampled (Staff B and C), a medication aide (MA) and a personal

STATE FORM

PRINTED: 06/07/2018 **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 HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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 was 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

Division of Health Service Regulation

background check was requested on 05/09/2018.

Interview with the business office manager on

-She was responsible for completing criminal

-She knew that criminal background checks should have been completed for new staff upon

05/10/2018 at 10:22 am revealed:

background checks for new staff.

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 HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (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) D 139 Continued From page 3 D 139 -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

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2018

this violation.

accordance with G.S. 131D-34 on 05/10/18 for

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25,

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	
			A. BUILDING	G:	COMP	PLETED
HAL080020			B. WING		05/	/11/2018
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CIT	ΓΥ, STATE, ZIP CODE		11,20.0
ANGELS	AT HEART ASSISTED		OUTH MAIN			
		CHINA	GROVE, NO	28023		
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY	ID	PROVIDER'S PLAN OF CORRECTION (EAC	ЭН	(X5)
TAG	FULL REGULATO INFORMATION)	DRY OR LSC IDENTIFYING	PREFIX TAG	CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETE
D 273	Continued From page	ge 4	D 273	Any residents who reside at Angels at	Heart	Projected
D 273	10A NCAC 13F .09	02(b) Health Care	D 273	Assisted Living who complain of pain	to staff	Completion Date:
			D 213	(Medication Aids and Resident Care		05/11/2018 at
	10A NCAC 13F .09	02 Health Care		Coordinator) will have the complaint		Ongoing
	(b) The facility shall	assure referral and follow-up		immediately reported to the residents'		
	to meet the routine a	and acute health care		physician. Staff (Medication Aids and		
	needs of residents.			Resident Care Coordinator) will ensur	re that	
	This Dule is not and			no resident is without pain medication		
	This Rule is not met	as evidenced by:		prescribed by the physician.		
	reviews, the facility f	ons, interviews, and record				
	physician for 2 of 3	sampled residents		Refusal of residents to comply with or	refuse	
	regarding a renewal order for tramadol for			aid regarding BP, Finger Sticks, and w	eights	
	continued complain	nts of pain (Resident		will be immediately reported to the res	idents'	
	#3), and physician	orders for daily weights		physician and the Director/Supervisor	on duty	
	(Resident #2).	, ,		Refusal/ noncompliance will be docum	ented	
	The findings are:			in the residents' record.		
	rite infulligs are.			Angels of Head A. S. 1711	90200	
	1. Review of Resider	nt #3's current EL 2		Angels at Heart Assisted Living Medic	ation	
	dated 10/30/17 revea	aled diagnoses included		Aids and Resident Care Director has be	en	
	an unspecified fractu	re of the upper left		reoriented to the policy and procedures	on	
	humerus, difficulty wa	alking, and muscle		healthcare, follow-up, and medication		
,	weakness.			administration.		
	David - 15			Physician will be notified imme	ediately	
	review of Resident #	3's signed physician's		 Follow-up on all medication error 	ors or	
	polyded type 2 disher	8 revealed diagnoses		missed doses		
1;	ncluded type 2 diabet	tes mellitus with		 Implement plan for back-up Phase 	armacy	
	neuropathy, myasthe Chronic Obstructive F	nia gravis, anxiety,		if such urgency arises or preven	t anv	
	COPD), epilepsy, an	d hypertension		further occurrences.		
		d Hypertension.				
F	Review of Resident #	3's physician's orders		Angels at Heart Assisted Living will con	nduct	
C	lated 03/15/18 reveal	led an order for tramadol		monthly audits of electronic medication		
5	0 mg take 1 tablet ev	very 6 hours as needed		administration records (eMAR) to ensur	e	
fo	or pain.			compliance.		
re	Review of pharmacy of evealed:			The RN will be responsible for this task.		
-	Framadol 50 mg, 60 f	tablets were dispensed on		addendum- Monthly resident record aud	lits	
Of Hoalth	Service Regulation			will be conducted to ensure any health ca		

Division of Health Service Regulation	FORM APPROVE
	issues are addressed with the MD and orders such labs, medications, appointments, weights, BP orders have been processed and/or clarified with the MD. The RCD will be responsible for this task. Discussed with Ms. Laretta Angle via telephone on 06/21/18 by Carolyn Harrison)

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: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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.

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#3 revealed:

Interview on 05/11/2018 at 2:31 pm with Resident

-She received tramadol every 6 hours as needed

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: __ COMPLETED HAL080020 B. WING_ 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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 legsShe had been out of tramadol since the end of April 2018She was having a lot of pain in her feet and legsShe 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 #3They had received a fax from the facility of a medication clarification form signed by Resident #3's orthopedist stating to discontinue tramadol			
-	b0 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			
1	nterview on 05/11/18 at 1:00 pm with the MA			
	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			

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C80311

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED. HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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 -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.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY	
			A. BUILDING:	A. BUILDING:		COMPLETED
		HAL080020	B. WING		0!	5/11/2018
AME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		2010
NGELS	AT HEART ASSISTED		OUTH MAIN STREE			
			GROVE, NC 28023			
(X4) ID PREFIX	SUMMARY :	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	
TAG	REGULATORY O	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDRE	COMPLET DATE
D 273	Continued From page	ge 8	D 273			
	-The resident's reco	ord showed an order from the				
	emergency room for	r oxycodone on 04/30/18, but				
	there was no record	of Resident #3 being				
	prescribed tramadol	in their system.				
	-The orthopedist had	d prescribed the analgesic				
	cream for pain but d	iscontinued it because				
	insurance would not	cover it.				
	-The orthopedist had	d also prescribed gabapentin				
	(a nerve pain medic	ation) for pain in the				
	resident's feet and le	egs but did not know the				
	discontinued the add	taking gabapentin, so				
	-The orthonedist was	ditional prescription as well. s not aware that Resident #3				
	did not have any me	dications for pain other than				
	the gabapentin preso	cribed by a previous				
	physician.	oned by a previous				
		not been contacted by the				
	facility regarding cur	rent complaints of painfrom				
	Resident #3.					
	Review of the faxed	copy of the medication				
	clarification form rece	eived from the orthopedist				
	revealed:	W 17 02 5				
	-it was a facility medi -It was signed by the	cation clarification form.				
		liscontinue an analgesic				
	cream.	iscontinue an analgesic				
		medications listed on the				
	form.	medications listed on the				
184	The form was signed	by the orthopedist and				
(dated 05/10/18.	•				
	Second interview on t	05/11/18 at 3:20 pm with the				
1	MA revealed:	oo, i ii io at 3.20 pm with the	-			
100		e first faxed medication				
C	clarification form off th	ne fax machine that				
r	norning.					
-	It was her handwritin	g and signature on the form.				
-	She did not know wh	y the request to discontinue				
tı	ramadol was written i	in pen on the printed copy.				

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 B. WING NAME OF PROVIDER OR SUPPLIER 05/11/2018 STREET ADDRESS, CITY, STATE, ZIP CODE ANGELS AT HEART ASSISTED LIVING 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE S COMPL	
		HAL080020	B. WING		05/1	1/2018
	PROVIDER OR SUPPLIER	LIVING 1114 SO	ADDRESS, CITY, STATE OUTH MAIN STREE GROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 273	Report," printed from facility, which listed a medications and treat Review of the "Medic 04/03/2018 revealed weekly and report to 5 pound weight gain. Review of Resident and Subsequent orders for Review of Resident and Administration Reconsequent orders for Review of Resident and Administration Reconsequent orders for Review of Resident and	n Resident #2's previous all of Resident #2's current atments. cation Review Report" dated d an order to obtain weights of the physician if there was a within a week. #2's record revealed no for weights. #2's electronic Medication and (eMAR) for April 2018 It to weigh daily and to contact the was a 2-3 pound overnight entation Resident #2 was 8 and 04/18/18. mentation Resident #2 was 1/18 through 04/16/18 and 1/30/18. Intation "Resident Refused"	D 273	DEPICIENC!)		
	Take," from 05/01/18					

C80311

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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 -"I tried to weigh him, but he doesn't have strength in his legs to stand and I about dropped -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 # -"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

-A MA had just told her staff was not able to weigh

-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

weights for Resident #2.

Resident #2.

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 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 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION **PREFIX** (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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 -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

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 273 | Continued From page 13 D 273 not have the proper equipment to weigh Resident -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

PRINTED: 06/07/2018 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: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (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) D 273 Continued From page 14 D 273 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 296 10A NCAC 13F .0904(c)(7) Nutrition And D 296 Angels at Heat Living Center will ensure Projected **Food Service** Completion residents have a matching therapeutic diet Date: menu for residents with physician's orders 05/11/2018 and 10A NCAC 13F .0904 Nutrition And Food Service that meets his or her daily nutritional and Ongoing (c) Menus in Adult Care Homes: specialized nutritional needs per 10A (7) The facility shall have a matching therapeutic NCAC 13F .0904(c)(7) Nutrition And diet menu for all physician-ordered therapeutic diets for guidance of food service staff. Food Service. NCS breakfast, lunch and dinner menus This Rule is not met as evidenced by: have been developed by the Angels at Heart Based on observations, interviews, and record Assisted Living Dietician. reviews, the facility failed to ensure there was a matching therapeutic diet breakfast menu Angels at Heart Assisted Living dietician for 2 of 3 sampled residents (#1 and #3) with will develop specialized menus for residents physician's orders for a No Concentrated with elevated cholesterol, low sodium salt Sweets (NCS) diet. free and diabetic conditions. The findings are: Dietary Manager will be responsible for 1. Review of Resident #1's current FL2 dated assuring that menus are coordinated daily 02/26/2018 revealed: and dietary staff are following diet per Dr's

Review of the therapeutic diet list posted in the Division of Health Service Regulation

mellitus.

-Diagnoses included insulin dependent diabetes

-There was a physician's order for a diabetic diet.

dated 02/28/18 revealed an order for a NCS diet.

Review of a subsequent physician's diet order

Request. The Dietary Manager has begun to

post the menus daily in the kitchen/dining

area for the residents. The menus are now available in the kitchen to be utilized for

staff guidance for preparing the meals.

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 (X4) ID 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 COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 296 Continued From page 15 D 296 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 -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.

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 296 Continued From page 16 D 296 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

2. Review of Resident #3's current FL2 dated 10/30/2017 revealed:

8:23 am.

-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

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PR

AND PLAN OF CORRECTION IDENTIFICATION NUMB		IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		05/	11/2018
	PROVIDER OR SUPPLIER	IVING 1114 SC	ADDRESS, CITY, STAT DUTH MAIN STREE GROVE, NC 28023	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 296	with jelly, 1 cup of juil Observation of the bi 05/11/18 at 8:05 am served a bowl of oatr cocktail, 1 slice of toa juice, milk, and water Interview Resident #5 revealed: -She was diabetic, bu special diet"I don't eat much sw Interview with a clinic Interview at the facilit 05/10/2018 at 9:29 at should be on a NCS diagnoses of diabetes Refer to interview with 12:25 pm.	reakfast meal service on revealed Resident #3 was meal, a serving of fruit ast with jelly, diet cranberry 3 on 05/11/2018 at 1:19 pm at did not think she was on a leet stuff." al service representative y's physician's office on m revealed Resident #3 diet for all meals due to	D 296	DEPICIENCY)		
	on 05/09/2018 at 2:16 Refer to interview with 8:23 pm. Interview with the DM revealed:	on 05/09/2018 at 12:25 pm for preparing and serving				
	-There was a menu av lunch and dinner, but	vailable for NCS diets for				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5)TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY
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		HAL080020	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET	10000000		05	/11/2018
			OUTH MAIN ST	STATE, ZIP CODE		
ANGELS	AT HEART ASSISTED		GROVE, NC 28			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	REGULATORY O	NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RE	(X5) COMPLETE DATE
D 296	Continued From pa	ge 19	D 296			
	juices, and unsweet	tened tea.				
D 310	104 NCAC 125 00	24/ // 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/				
5 010	Food Service	04(e)(4) Nutrition and	D 310	Angels at Heat Living Center will	ensure	Projected
				residents have a matching therapeu	tic diet	Completion Date:
	10A NCAC 13F .09	04 Nutrition and Food Service		menu for residents with physician's that meets his or her daily nutrition	orders	05/11/2018 and Ongoing
	(4) All therapeutic di	s in Adult Care Homes: iets, including nutritional		specialized nutritional needs per 10	A	Oligonig
	supplements and thi	ickened liquids, shall be		NCAC 13F .0904(c)(7) Nutrition	And	
	served as ordered b	y the resident's physician.		Food Service.	7.000 T	
				NCS breakfast, lunch and dinner m	enus	
	This Pulo is not met			have been developed by the Angels	at Heart	
	This Rule is not met Based on observation	ons, interviews, and record		Assisted Living Dietary Manager.		
	reviews, the facility	failed to ensure 2 of 3		Angels of Heart A III.		
	residents (#1 and #	with physician's orders tof No Concentrated		Angels at Heart Assisted Living Di- will develop specialized menus for	etician	
	Sweets (NCS) thera	peutic diet were served as		with elevated cholesterol, low sodiu	m salt	
	ordered.	product were served as		free and diabetic conditions.	iii sait	
	The findings are:			Dietary Manager will be responsible	e for	
	1. Review of Residen	nt #1's current FL2 dated		assuring that menus are coordinated	daily	
	02/26/2018 revealed:			and dietary staff are following diet	per Dr's	
	-Diagnoses included	insulin dependent diabetes		Request. (Addendum-The Dietary Manager v	.11.1	
	mellitus. -There was a physicia	an'a ardar fa a dialantan		responsible to ensure diets are serve	vill be	
	more was a priysicia	an's order for a diabetic diet.		ordered. Twice weekly, the ED will	observe	
	Review of ta subsequ	ent physician's diet order		a meal service to ensure the meals a	re being	
	dated 02/28/18 revea	led an order for a NCS diet.		served as ordered and ongoing. Disc	ussed	
1	Review of the therape	eutic diet list posted in the		with Ms. Laretta Angle on 06/21/18		- 110
1	ditchen revealed Resi	dent #3 was to be served a		Carolyn Harrison).	(1)	21118
1	NCS diet.					
F	Review of the therape	eutic diet menus revealed				
t	here was a NCS diet	menu for lunch and dinner				
	out there was not a No	CS diet menu for breakfast.				- 1

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PRFFIX (X5)TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 310 Continued From page 20 D 310 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, milk, 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) Division of Health Service Regulation

C80311

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 B. WING NAME OF PROVIDER OR SUPPLIER 05/11/2018 STREET ADDRESS, CITY, STATE, ZIP CODE ANGELS AT HEART ASSISTED LIVING 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 310 Continued From page 21 D 310 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

Division of Health Service Regulation

not eat breakfast.

juice, milk, water, or coffee.

05/10/2018 at 8:15 am revealed Resident #3 did

Review of the regular breakfast menu revealed residents were to be served 2 scrambled eggs, hash browns, sausage, toast with jelly, 1 cup of

PRINTED: 06/07/2018 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 HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 310 Continued From page 22 D 310 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 -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:

-Residents who had physician's orders for NCS Division of Health Service Regulation

all meals.

lunch and dinner.

-She was responsible for preparing and serving

-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

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 B. WING NAME OF PROVIDER OR SUPPLIER 05/11/2018 STREET ADDRESS, CITY, STATE, ZIP CODE ANGELS AT HEART ASSISTED LIVING 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 -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 Division of Health Service Regulation

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 310 Continued From page 24 D 310 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 358 10A NCAC 13F .1004(a) Medication D 358 Angels at Heart Assisted Living will follow Projected Administration all policy and procedure for medication Completion Date: administration as outlined in 10A NCAC 10A NCAC 13F .1004 Medication Administration 05/11/2018 and 13F .1004(a) Medication Administration (a) An adult care home shall assure that the Ongoing preparation and administration of medications, prescription and non-prescription, and treatments All staff (Medication Aids and Resident by staff are in accordance with: Care Coordinator) were reoriented to the (1) orders by a licensed prescribing practitioner agency medication management policy and which are maintained in the resident's record; and procedure. (2) rules in this Section and the facility's policies and procedures. The resident's medication administration record (MAR) shall be accurate and include the following: This Rule is not met as evidenced by: (1) resident's name: TYPE A2 VIOLATION (2)name of the medication or treatment order; Based on observations, interviews and record strength and dosage or quantity reviews, the facility failed to assure of medication administered; medications were administered as ordered by instructions for administering the a licensed prescribing practitioner for 2 of 3 medication or treatment; sampled residents with orders for an (5)reason or justification for the antibiotic, an angiotensin II receptor blocker, administration of medications or treatments a beta blocker, and an angiotensin converting enzyme (ACE) inhibitor (Resident #2); an as needed (PRN) and documenting the anxiolytic and pain medication (Resident #3). resulting effect on the resident; date and time of administration; The findings are: (7)documentation of any omission

04/04/2018 revealed:

1. Review of Resident #2's current FL-2 dated

-Diagnoses included chronic kidney disease,

congestive heart failure, hypertension, diabetes

(8)

refusals; and,

of medications or treatments and the

administering the medication or treatment.

name or initials of the person

reason for the omission, including

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	If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). Angels at Heart Assisted Living will conduct monthly audits of electronic medication administration records (eMAR) to ensure compliance. The RN will be responsible for this task

PRINTED: 06/07/2018 **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 HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 25 D 358 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

filled. Division of Health Service Regulation

reviewed.

-The new order for cefpodoxime 200 mg should have been faxed or called into the pharmacy to be filled after the discharge summary was

-She did not know why cefpodoxime was not

PRINTED: 06/07/2018 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 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 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 26 D 358 -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.

pm revealed:

ordered for Resident #2.

Interview with a nurse at Resident #2's Primary Care Physician's (PCP) office on 05/11/18 at 2:52

-She did not know cefpodoxime had been

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PI

		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL080020	B. WING		05/11/2018	
	ROVIDER OR SUPPLIER	VING 1114 SO	ADDRESS, CITY, STAT UTH MAIN STREE GROVE, NC 28023	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	
	-She was not notified physician's order for a cefpodoxime and she the discharge summa. Interview with Reside PCP on 05/11/18 at 3 never received or filled cefpodoxime. Interview with Reside pm revealed: -He did not know all conditions of a for him to start taking April 2018He was hospitalized April 2018 hospitali	by the facility about the Resident #2 to start taking had not received a copy of any dated 4/28/18. Int #2's pharmacy through 1:33 pm revealed they had do a physician's order for the medications that were my new medications ordered after his hospitalization in again about a week after the tion. If the RCD on 05/11/18 at 4:12 at 1:12 at 1:	D 358	DETICITION .		
		03/18 for entresto 24-26				

PRINTED: 06/07/2018 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: HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 28 D 358 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 -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

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to the MAR.

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

-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

C80311

PRINTED: 06/07/2018 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 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

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

Division of Health Service Regulation

May 2018.

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STATEMEN AND PLAN	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		HAL080020	B. WING		05/	11/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E ZIP CODE		
ANGELS	AT HEART ASSISTED		OUTH MAIN STREE			
	AT HEART ASSISTED		GROVE, NC 28023			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN REGULATORY O	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 30	D 358			
	Attempted interview 4:20 pm was unsuc	with the RCD on 05/11/18 at cessful.				
	04/04/2018 revealed carvedilol 3.125 mg	ent #2's current FL-2 dated d a physician's order for (a beta blocker used to treat and heart failure) 1 tablet				
	summary for Reside revealed:	uent hospital discharge nt #2 dated 05/03/2018				
	05/02/2018 and disc -Resident #2's disch acute on chronic sys obstructive pulmonal	Imitted to the hospital on harged on 05/03/2018. arge diagnosis included tolic heart failure, chronic ry disease, chronic elevated al fibrillation, and chronic				
	-There was a physici	an's order to increase to carvedilol 6.25 mg 1 tablet				
	Review of Resident # prescription dated 05 1 tablet twice daily wi	t2's record revealed a /03/18 for carvedilol 6.25 mg th meals.				
r	Administration Record revealed:	2's electronic Medication d (eMAR) for May 2018				
- t	tablet twice daily. -Carvedilol 3.125 mg	or carvedilol 3.125 mg 1 was documented as				
0	administered at 8:00 a 05/11/18 and at 8:00 p 05/10/18.	om from 05/03/18 to				
ta	ablet twice daily with	try for carvedilol 6.25 mg 1 meals. entation carvedilol 6.25 mg				

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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 -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.

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Interview with Resident #2's Primary Care

PRINTED: 06/07/2018 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 32 D 358 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 -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.

4:20 pm was unsuccessful. Division of Health Service Regulation

May 2018.

-He did not know of any new medications ordered for him to start taking after his hospitalization in

Attempted interview with the RCD on 05/11/18 at

PRINTED: 06/07/2018 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL080020 B. WING NAME OF PROVIDER OR SUPPLIER 05/11/2018 STREET ADDRESS, CITY, STATE, ZIP CODE ANGELS AT HEART ASSISTED LIVING 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 33 D 358 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

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PRINTED: 06/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 34 D 358 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.

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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

-She had not received any calls from the facility

-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

regarding changes in medication or discontinuation of medication.

ordered on the hospital discharge.

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

ANGELS AT HEADT ACCIOTES

1114 SOUTH MAIN STREET

ANGELS AT HEART ASSISTED LIVING 1114 SOUTH MAIN STREET						
MANAGEMENT OF THE PARTY OF THE		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) COMPLET DATE		
D 358	Continued From page 35	D 358				
	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 31 D					
	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					
1	revealed there was an order dated 04/17/18 for					
1	alprazolam 0.5 mg, take 1 tablet daily as needed					
1	for anxiety.					
F	Review of Resident #3's April 2018 electronic					
of Health	Service Regulation					

05/11/2018

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

(X3) DATE SURVEY COMPLETED

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	SUMMARY STATEMENT OF DEFICIENCIES		VE, NC 28023		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET 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,				
1	at 8:16 am and again at 8:52 pm.				
-	Alprazolam was administered twice on 05/06/18.				
8	at 8:28 am and again at 11:30 pm.				
	Alprazolam was administered once daily at 5:35 Service Regulation				

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES 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) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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.

Interview on 05/11/18 at 4:30 pm with the Division of Health Service Regulation

-She took alprazolam for anxiety.

04/17/18 for 30 tablets.

once a day for anxiety.

reordered the medication.

alprazolam.

revealed:

have had 7 tablets remaining.

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

-If administered correctly, Resident #3 should

-They had not received a refill request for

Interview on 05/11/18 at 3:20 pm with a MA

-Resident #3 was ordered alprazolam 0.5 mg

-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

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 38 D 358 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.

Division of Health Service Regulation

administration.

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

	IT OF DEFICIENCIES					
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE	
		IDENTIFICATION NOMBER.	A. BUILDING:		COMP	LETED
		HAL080020	B. WING		05/	11/2018
NAME OF S	200//050 00 00 00 00				05/	11/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
ANGELS	AT HEART ASSISTED L	IVING 1114 SO	UTH MAIN STREE	т		
350002-1000W6015			GROVE, NC 28023			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(VE)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO	N SHOULD BE	(X5) COMPLETE
TAG	REGULATURY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH		DATE
				DEFICIENCY	1	
D 358	Continued From page	e 39	D 358			
	Review of Resident t	t3's April 2019 electronia				
	medication administr	ation record (cMAD)				
		ation record (elviAR)				
		1 50 mg give 1 tablet even 6				
		istered on 04/00/2016 at				
		pistered on 04/07/2019 at				
		10.00 of 047007 to at 0.00				
		nistered on 04/10/18 at 2:45				
	am. 11:45 am. and 8:	43 pm				
	am and 5:30 pm.					
	-Tramadol was admin	nistered on 04/12/18 at 3:40				
	am, 12:01 pm, and 8:	00 pm.				
		istered on 04/14/18 at 8:58				
		istered on 04/15/18 at 11:55				
		istered on 04/16/18 at 10:12				
		:				
	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 painTramadol was administered on 04/06/2018 at 6:20 pmTramadol was administered on 04/07/2018 at 4:29 am, 12:11 pm, and 8:15 pmTramadol was administered on 04/08/2018 at 6:39 am, 2:50 pm, and 10:50 pmTramadol was administered on 04/09/18 at 6:50 am and 5:02 pmTramadol was administered on 04/10/18 at 2:45 am, 11:45 am, and 8:43 pmTramadol was administered on 04/11/18 at 8:55 am and 5:30 pmTramadol was administered on 04/12/18 at 3:40 am, 12:01 pm, and 8:00 pmTramadol was administered on 04/13/18 at 5:33 am, 12:51 pm, 1:55 pm, and 9:00 pmTramadol was administered on 04/14/18 at 11:55 am and 9:00 pmTramadol was administered on 04/15/18 at 11:55 am and 9:00 pmTramadol was administered on 04/16/18 at 10:12 am and 9:25 pmTramadol was administered on 04/16/18 at 5:57 am, 2:10 pm, and 10:10 pmTramadol was administered on 04/18/18 at 5:03 am, 1:07 pm, and 8:08 pmTramadol was administered on 04/19/18 at 8:34 am and 6:36 pmTramadol was administered on 04/19/18 at 8:34 am and 6:36 pmTramadol was administered on 04/20/18 at 12:37 am, 10:10 am, and 4:40 pmTramadol was administered on 04/21/18 at 5:18					
						1
		istered on 04/20/18 at 12:37				
	am, 1:34 pm, and 7:35					
		istered on 04/22/18 at 1:35				- 1
	am, 2:05 pm, and 8:16					1
		stered on 04/23/18 at 1:53				

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED	
	HAL080020		B. WING		O!	5/11/2018	
IAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E ZIP CODE	-		
NGELS	AT HEART ASSISTED	4444.00	OUTH MAIN STREE				
MOLLS	AT HEART ASSISTED	LIVING	GROVE, NC 28023				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		PROVIDEDIO DI ANI GERO			
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
D 358	Continued From page	ge 40	D 358				
	pm and 8:05 pm.						
		ninistered on 04/24/18 at 3:44					
	am and 2:31 pm.	inistered on 04/24/18 at 3:44					
		inistered on 04/25/18 at 2:51					
	am and 4:04 pm.	mistered on 04/25/16 at 2.51					
		inistered on 04/2618 at 1:09					
	am, 8:32 am, 2:31 p	m. and 9:55 pm					
	-Tramadol was administered on 04/27/18 at 6:02						
	am and 1:53 pmTramadol was administered on 04/28/18 at 5:33						
	am and 2:58 pm.	The state of the s					
	Povious of Booldant	#21- N 0040					
	medication administ	#3's May 2018 electronic					
	revealed:	ration record (eMAR)					
	The state of the s	ol 50 mg, give 1 tablet every					
	6 hours as needed for	or nain					
	-Tramadol was not d	locumented as administered					
	at all in the month of	May.					
	Interview on 05/11/2	018 at 2:31 pm with Resident					
		dol every 6 hours as needed					
	for pain.	doi every o flours as needed					
		f tramadol since the end of					
	April 2018.						
	-She was having a lo	t of pain in her feet and legs.					
	-She had to go to the	emergency room on					
	04/29/18 because sh	e was in so much pain that					
li.	"it caused her blood p	pressure to be high."					
	The emergency roor	n nad given her a					
	prescription on 05/06	odone but she finished that					
	nothing for pain.	/18 and was now receiving					
	T-1						
	l elephone interview o	on 05/11/18 at 2:36 pm with					
1	Tramadal 50	d pharmacy revealed:					
	04/04/18 for 60 tablet	ets were dispensed on					
		s. ed a refill request or a now					
1 7	THEY HAU HOL TECHIVE	I A LETIII FECULARI OF A DOW	1				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 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) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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

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the printed writing.

and dated 05/10/18.

handwritten in pen on the faxed form in between

-The words "OK discontinue" were handwritten in pen under the request to discontinue tramadol. -The faxed copy was signed by the orthopedist

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 HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 Continued From page 42 D 358 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 -The form was signed by the orthopedist and dated 05/10/18.

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MA revealed:

morning.

Second interview on 05/11/18 at 3:20 pm with the

-It was her handwriting and signature on the form. -She did not know why the request to discontinue

-She had received the first faxed medication clarification form off the fax machine that

PRINTED: 06/07/2018 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:** A. BUILDING: _ COMPLETED B. WING HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (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) D 358 Continued From page 43 D 358 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.

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

The facility failed to administer alprazolam and tramadol to Resident #3; and cefpodoxime,

-She did not know why any staff would alter a

-Resident #3 still had tramadol listed on her eMAR but was out of the medication.

-Resident #3 had been receiving oxycodone from

-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

received document.

05/01/18 to 05/06/18 for pain.

refills from the pharmacy.

infection, heart failure, heart attack, and uncontrolled high blood pressure and constitutes

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 HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 44 D 358 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, D 367 10A NCAC 13F .1004(j) Medication D 367 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

PRINTED: 06/07/2018 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: A. BUILDING: COMPLETED B. WING HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 367 Continued From page 45 Angels at Heart Assisted Living will follow Projected D 367 Completion all policy and procedure for medication interviews, the facility failed to assure the Date: administration as outlined in 10A NCAC electronic Medication Administration Records 05/11/2018 and 13F .1004(a) Medication Administration (eMARs) were accurate for 1 of 3 sampled Ongoing residents (#2) regarding furosemide (used to treat high blood pressure). All staff (Medication Aids and Resident Care Coordinator) were reoriented to the The findings are: agency medication management policy and procedure. Review of Resident #2's current FL-2 dated 04/04/2018 revealed: The resident's medication administration -Diagnoses included chronic kidney disease, record (MAR) shall be accurate and congestive heart failure, hypertension, diabetes, include the following: obstructive sleep apnea, chronic obstructive pulmonary disease, cirrhosis, chronic liver (1)resident's name: disease, and cardiomyopathy. (2) name of the medication or -There was not an order for furosemide on the treatment order: FL2. strength and dosage or quantity of medication administered; Review of a physician's order sheet created by instructions for administering the the pharmacy dated 04/18/18 revealed an order medication or treatment; for furosemide 80 mg 1 tablet 2 times daily. reason or justification for the (5)administration of medications or treatments Review of Resident #2's record revealed no previous orders for furosemide. as needed (PRN) and documenting the resulting effect on the resident; Review of a facility medication clarification form (6)date and time of administration; dated 04/24/18 revealed an order to discontinue (7) documentation of any omission furosemide. of medications or treatments and the reason for the omission, including refusals; and, Review of a copied form titled, "Drugs Returned name or initials of the person to Pharmacy," revealed: administering the medication or treatment. -One bottle of Furosemide 80 mg had been returned to the pharmacy on 04/25/18. If initials are used, a signature equivalent to -The contracted pharmacist's stamped signature those initials is to be documented and

Division of Health Service Regulation

was on the form.

Review of progress notes for Resident #2

-Documentation dated 04/16/18 "Spoke with Primary Care Physician's (PCP) pharmacy in

C80311

maintained with the medication administration record (MAR).

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION S:	(X3) DATE S	
		HAL080020	B. WING		05/1	11/2018
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
ANGELS	AT HEART ASSISTED	1114 50	UTH MAIN STE			
ANGELS	AT HEART ASSISTED		GROVE, NC 28	023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	by mouth twice daily overnight furosemid the morning." -Documentation dat still not here. Called could get from a bac representative said -Documentation dat the PCP's pharmacy furosemide up at the -Documentation dat physician assistant discontinued." -There were no other furosemide. Review of Resident Administration Recorevealed: -An entry for furosemide was documented as 04/0-Furosemide was documented as 04/0-Furosemide was documentation for 0 "Withheld per Dr/RN -Furosemide was doon 04/26/18 at 8:00 am Facility." -Furosemide was doon 04/30/18 at 8:00 am Facility." -Furosemide was doon 04/30/18 at 8:00 am Facility."	t #2's] furosemide 80 mg, 1 y. PCP's pharmacy will le and it should be arrive in ed 04/17/18 "Furosemide is PCP's pharmacy. Pharmacy it was sent out on 04/16/18. led 04/17/18 "Called back to y. We will have to pick le PCP's pharmacy." led 04/25/18 "Saw facility today, furosemide 80mg was er notes regarding #2's electronic Medication led 80 mg 1 tablet twice le 8:00 pm. led order for furosemide was ley/18. lecumented as administered leg/18 at 8:00 pm leg/18 at 8:00 pm led/26/18 at 8:00 pm led/26/18 at 8:00 pm led/26/18 at 8:00 pm led/26/18 at 8:00 pm leg/18 at 8	D 367	Angels at Heart Assisted Living with conduct monthly audits of electron medication administration records to ensure compliance. The RN will be responsible for this	ic (eMAR)	
	revealed:	rz's eMAR for May 2018 nide 80 mg 1 tablet twice				

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

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.			

Division of Health Service Regulation

PRINTED: 06/07/2018 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL080020	B. WING		05/44/0040	
NAME OF F	PROVIDER OR SUPPLIER	CTDEET	100000000000000000000000000000000000000		05/	11/2018
			ADDRESS, CITY, STAT			
ANGELS	AT HEART ASSISTED L	TYING	OUTH MAIN STREE			
(VA) ID	CUINMA DV O		GROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 367	Continued From pag	e 48	D 367			
	-She did not know sh					
	document on the eM	AR why a medication had				
	not been administere	ad medication had				
		ny furosemide had been				
	documented as admi	inistered when it had been				
	sent back to the phar	macy				
	The same to the phan	macy.				
	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 phan	-The contracted pharmacy was responsible for				
	creating and making	medication changes to the				
	eMAR.					
	-The facility physician	's assistance wrote the				
	order to discontinue fr	urosemide.				
	-Furosemide was "pro	obably" still on the eMAR				
		s not sent to the contracted				
	pharmacy.					
	heen faved to the con	nue furosemide should have				
	that it could be taken	tracted pharmacy by the so				
	-The MA who received	d the order to discontinue				
	furosemide was respo	nsible for faxing the order				
	to the facility contracte	ed pharmacy				
	-She did not know who	en the last time furosemide				
	was administered.					
25	-She documented this	morning, 05/11/18,				
1.5	furosemide was admir	nistered to Resident #2.				
	-She did not know why	she had documented that				
	furosemide was admin	nistered when it had not				
100	been.					
-	was not paying atte	ntion when I documented				
	giving furosemide."					
1.	were responsible for	rector (RCD) and MAs				
V	were responsible for re	eviewing the eMARs for				
	She and the BCD com	and a feet of the second				
-	and the KCD com	pleted medication cart				
V	vas on the eMAR to th	cluded comparing what				
	Service Regulation	e medication in the			2	

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 _ HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

1114 SOUTH MAIN STREET

ANGELS AT HEART ASSISTED LIVING 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 discontinuedSometimes 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 eMARHe 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			94			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CONSTRUCTION		SURVEY
		Navious selection of a model as superior of the resource of the appropriate of the	A. BUILDING:		CONT	LETED
		HAL080020	B. WING		05	/11/2018
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE		
NGELS	AT HEART ASSISTED	1114 80	UTH MAIN STRE			
		CHINA	GROVE, NC 2802	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETE DATE
D 367	Continued From pa	age 50	D 367			
	05/11/18 at 3:33 pr	m revealed furosemide was				
	filled and picked up	by the facility on 04/17/2018.				
				11		
		dent #2 on 05/11/18 at 4:12				
	been discontinued.	not know if furosemide had				
	a san aloooniiiidod.					
	Attempted interview	with the RCD on 05/11/18 at				
	4:20 pm was unsuc	ccessful.				
		xecutive Director (ED) on				
	05/11/18 at 4:34 pm revealed: -She did not know that furosemide was being					
		nat furosemide was being ninistered when it was not in				
	the building.	ministered when it was not in				
	-The RCD was resp	oonsible for reviewing the				
		, but the ED was now				
	facility.	the RCD's absence in the				
	-The eMARs were r	eviewed weekly				
	-The eMARs and m	edication on the medication				
	cart were audited or					
		responsible for making R when medication orders				
	were sent in.	when medication orders				
	-She did not know if	the physician's order to				
	discontinue furosem	nide was sent to the facility				
	updated.	y so that the eMAR could be				
) was responsible for sending				
	physician's orders to	the pharmacy.				
D 392	10A NCAC 13F .100	08(a) Controlled	D 392	Angels at Heart Assisted Living will	fallow	
	Substances		a	Angels at Heart Assisted Living will all policy and procedure for medicati	on	Implementat
18			a	dministration as outlined in 10A NO	CAC	n Date: 05/11/2018 a
	10A NCAC 13F .100	08 Controlled Substances	1	3F .1004(a) Medication Administr	ration	Ongoing
	(a) An adult care hor	me shall assure a readily		11		
	retrievable record of	controlled substances by		All staff (Medication Aids and Resid	lent	
n of Hoalt				Care Coordinator) were reoriented to	o the	

documenting the receipt, administration and disposition of controlled substances. These

agency medication management policy and procedure.

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;
- instructions for administering the medication or treatment;
- reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident:
- date and time of administration;
- documentation of any omission (7) of medications or treatments and the reason for the omission, including refusals; and,
- 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).

Control sheets for this incident were identified as being overstock. Medications were found to NOT be missing and the count was correct. Count sheets were forwarded to reviewer

STATEMENT	ivision of Health Service Regulation TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080020			LE CONSTRUCTION	(X3) DATE S COMPL	
			B. WING		05/	11/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ANGELS	AT HEART ASSISTED L	IVING	OUTH MAIN STR			
THE DESCRIPTION OF		CHINA	GROVE, NC 280			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON SHO	JLD BE	(X5) COMPLETE DATE
D 392	records shall be ma	intained with the resident's an order that there can be	D 392	Angels at Heart Assisted Living all policy and procedure for med administration as outlined in 104 13F .1004(a) Medication Admi	ication A NCAC nistration	Project Implementatio n Date: 05/11/2018 and Ongoing
	reviews, the facility retrievable records and failed to accou	ons, interviews, and record failed to assure readily of controlled substances ant for the use and		All staff (<i>Medication Aids and Lare Coordinator</i>) were reorien agency medication management procedure.	ted to the policy and	
	of 3 sampled resid	controlled substances for 1 ents (#3), related to o treat anxiety) and treat pain).		The resident's medication admin record (MAR) shall be accurate include the following: (1) resident's name; (2) name of the medication	e and	
	The findings are:			treatment order;		
	10/30/17 revealed of unspecified fracture	ent #3's current FL-2 dated liagnoses included an of the upper left humerus, and muscle weakness.		 (3) strength and dosage quantity of medication adminit (4) instructions for adminimedication or treatment; (5) reason or justification 	stered; nistering the	
	orders dated 02/21/ included type 2 diab myasthenia gravis,	#3's signed physician's 18 revealed diagnoses etes mellitus with neuropathy, anxiety, Chronic Obstructive , epilepsy, and hypertension.		administration of medications of as needed (PRN) and document resulting effect on the resident; (6) date and time of administration;	r treatments	
	revealed: -There was an orde alprazolam 0.5 mg, for anxietyThere was an orde 50 mg, take 1 table pain.	#3's physician's orders r dated 04/17/18 for take 1 tablet daily as needed r dated 03/15/18 for tramadol t every 6 hours as needed for y dispensing records		(7) documentation of an of medications or treatments a reason for the omission, include refusals; and, (8) name or initials of the administering the medication or If initials are used, a signature e those initials is to be documented maintained with the medication	and the ling e person treatment. quivalent to	
	revealed:	30 tablets, was dispensed		administration record (MAR).		

04/17/18.

Control sheets for this incident were

Division of Health Service Regulation -Tramadol 50 mg, 60 tablets, was dispensed on identified as being overstock. Medications were found to NOT be missing and the count was correct. Count sheets were forwarded to reviewer (Addendum- Count sheets will be utilized to ensure correct narcotic counts and shift counts of narcotics has always been in place. The RCD will review count sheets and compare with the eMARs weekly and ongoing. Discussed with Ms. Angle on 06/21/18 by Carolyn Harrison via telephone.)

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PI

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		05/	11/2018
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		- 1
ANGELS	AT HEART ASSISTED I	LIVING	OUTH MAIN STREE GROVE, NC 28023	50.50		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	WE)
PREFIX TAG	(EACH DEFICIENC	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From pag	ge 52	D 392			
	04/04/18.					
	medications on hand	05/10/18 at 2:00 pm of the nd for Resident #3 revealed zolam 0.5 mg available for				
	medication administration revealed:	t #3's April 2018 electronic stration record (eMAR)				
	pm on 04/17/18.	dministered once daily at 8:07				
	am on 04/19/18.	dministered once daily at 8:33				
	pm on 04/20/18.	dministered once daily at 8:43 dministered once daily at 8:30				
	am on 04/21/18.	3 10 10 10 10 10 10 10 10 10 10 10 10 10				
	am on 04/22/18.	dministered once daily at 8:31				
	am on 04/23/18.	Iministered once daily at 8:36				
	am on 04/24/18.	Iministered once daily at 8:42				
	am on 04/25/18.	Iministered once daily at 9:12				
	am on 04/26/18.	Iministered once daily at 8:31				
	am on 04/28/18.	ministered once daily at 7:40				
	am on 04/29/18.	ministered once daily at 8:05				
	-Alprazolam was adn pm on 04/30/18.	ministered once daily at 8:30				
	revealed:	#3's May 2018 eMAR				
9	at 8:16 am and 8:52					
1	-Alprazolam was adn	ministered twice on 05/06/18,				

(X2) MULTIPLE CONSTRUCTION

PRINTED: 06/07/2018 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 HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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 -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.

documented.

-On 04/22/18 at 7:15 am, one dose of alprazolam was signed by two MAs but no explanation was

-On 04/22/18 at 8:25 am, a second dose of alprazolam was documented as administered.

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 05/11/2018 HAL080020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 392 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 -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

FORM APPROVED 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: __ HAL080020 B. WING _ 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

(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) COMPLETI 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 tabletsIf 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 eMARsShe 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 errorShe 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 C		(X3) DATE COMPI		
		HAL080020	B. WING		05/	11/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
ANCELO	AT UEADT ADDIOTED	1114 SO	UTH MAIN STREE	Т		
ANGELS	AT HEART ASSISTED L		GROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From pag	e 56	D 392		WI .	
	05/06/18 because sh "one tablet daily and	ent #3 on 05/05/18 and ne thought the order said, then as needed for anxiety." hy the CSCSs and eMAR did				
		interview on 05/11/18 at nt #3's mental health essful.				
	Refer to interview on ED.	05/10/18 at 4:00 pm with the				
	medications on hand	5/10/18 at 2:00 pm of the I for Resident #3 revealed ol 50 mg available for				
2	Review of Resident # medication administr revealed:	#3's April 2018 electronic ation record (eMAR)				
	04/06/2018 at 6:20 p					
	04/07/2018 at 4:29 a	mented as administered on m, 12:11 pm, and 8:15 pm. mented as administered on				
	04/08/2018 at 6:39 a	m, 2:50 pm, and 10:50 pm. mented as administered on				
	-Tramadol was docur 04/10/18 at 2:45 am, -Tramadol was docur	mented as administered on 11:45 am, and 8:43 pm. mented as administered on				
	04/12/18 at 3:40 am, -Tramadol was docur	and 5:30 pm. mented as administered on 12:01 pm, and 8:00 pm. mented as administered on 12:51 pm, 1:55 pm, and				

Division of Health Service Regulation

-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 A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL080020	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	D 392		
	-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 pmTramadol 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.			

Division of Health Service Regulation

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PR

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
aconvoica niavoso.			A. BUILDING:		COMP	LETED
HAL080020		B. WING		05/	11/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	_	
411051.0		1114 SO	UTH MAIN STREE	No. of the Control of		
ANGELS	AT HEART ASSISTED L		SROVE, NC 28023			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		DDOMDEDIS DI AN OS	CORRECTION	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From pag	ne 58	D 392			
	-A medication aide s	igned that 60 tramadol 50 mg				
	tablets were received					
		umented as placed in				
		SCS was started at 45 tablets				
	available.					
	-The first entry on the	e CSCS was 1 tramadol 50				
		ed on 04/06/18 at 6:20 pm.				
		e CSCS was 1 tramadol 50				
		04/28/18 at 3:03 pm which				
	left 15 tablets remain					
		pm, one dose of tramadol				
	was documented as					
		pm, another dose of				
	same MA.	ented as administered by the				
		pm, one dose of tramadol				
		administered which was not				
	recorded on the eMA	77 (77)				
	-A total of 45 doses v					
	administered on the	CSCS #1.				
	Review of the CSCS					
		ensed on 04/04/18 revealed:				
		ription label on the CSCS.				
		and prescription information				
	had been handwritter					
	on the CSCS.	loses received documented				
	-The count started at					
		CSCS was 1 tramadol 50				
	mg tablet administere	ed on 04/23/18 at 1:55 pm.				
		CSCS was 1 tramadol 50				
	mg tablet administere	ed on 04/28/18 at 3:03 pm				
	which left 0 tablets re					
		pm, one dose of tramadol				
		administered which was not				
	recorded on the eMA					
	-A total of 15 doses wadministered on the 0					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		05/1	1/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ANGELS	AT HEART ASSISTED L	IVING	JTH MAIN STREE	Т		
			ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 392	Continued From pag	e 59	D 392			
	documented as adm through 04/28/18 on total of 58 doses doc	60 doses of tramadol 50 mg inistered from 04/06/18 CSCSs #1 and #2, and a cumented as administered on R, leaving 2 doses of tramadol				
	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 effectiveShe had been out of tramadol since the end of April.					
	a representative of F revealed: -He had not prescrib not renew the prescri	a request to refill any				
	[1] - 이 시간 (MAN SEE #6) (1) 10 Per Profession (2017) 전 10 10 10 10 10 10 10 10 10 10 10 10 10	on 05/11/18 at 11:30 am with Resident #3's former primary	8			
	-She had written the on 03/16/18.	order for tramadol originally				
	April and was seeing -They had not receiv tramadol.	ansferred out from her care in g a different provider. red a refill request for ordered as needed for pain				
	every 8 hours.	ordered to replace the				
	the facility's contract	on 05/11/18 at 2:36 pm with ed pharmacy revealed ets were dispensed on ets.		v		

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		HAL080020	B. WING		05	/11/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
ANGELS	AT HEART ASSISTED L		TH MAIN STREE	Т		
ANGLES	TILAKI AGGIGTED E	CHINA GE	ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From pag	e 60	D 392			
		8 at 3:22 pm with a MA				
		hy the CSCS counts did not				
		e medicine as ordered.				
	days" but she had or	en out of tramadol for "a few dered more.				
	-She did not know w	hat day she ordered more.				
	-She did not know ex Resident #3 had bee	cactly how many days en out of tramadol.				
	Interview on 05/11/1/ Executive Director (E	8 at 4:31 pm with the				
		here the unaccounted for				
	tramadol wasShe did not know why the CSCSs and eMAR did not match.					
	not maton.					
	Refer to interview on ED.	05/10/18 at 4:00 pm with the				
	Interview on 05/10/1	8 at 4:00 pm with the ED				
	revealed: -She had controlled this resident before.	substances go missing for				
	-She thought she ha	d identified and terminated				
	the employees responsible. The policy was that	the MA staff had to count				
	each controlled subs	stance at the beginning of				
	each shift and ensur amount of medicatio	e the CSCS matched the				
		ne MA staff was to report the				
	discrepancy to her o	r the RCD.				
	-No discrepancies ha	ad been reported to her.				
D914	G.S. 131D-21(4) De	claration of Residents' Rights	D914			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I St. Maria and and	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY
		HAL080020	B. WING		05	/11/2018
ANGELS A	PROVIDER OR SUPPLIER AT HEART ASSISTED L	STREET A 1114 SO CHINA (ADDRESS, CITY, S DUTH MAIN STE GROVE, NC 28	REET		1112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	G.S. 131D-21 Declar Rights Every resider rights: 4. To be free of ment neglect, and exploitated. This Rule is not met as Based on observation reviews, the facility were free of neglect related to medication prevention requirem background checks and follow-up. The findings are: 1. Based on observation reviews, the facility fawere administered as prescribing practitioner residents with orders angiotensin II receptor and an angiotensin Control (Resident #2 medication (Resident #2 medication (Resident MCAC 13F .1004(a) M (Type A2 Violation)]. 2. Based on observation reviews, the facility fainfection control policy Centers for Disease Control procedures for 3 of 3 diabetic resident #2, #3) with orders for mental policy for the procedures for 3 of 3 diabetic resident #2, #3) with orders for mental reviews for the procedures for 3 of 3 diabetic resident #2, #3) with orders for mental reviews for the procedures for 3 of 3 diabetic resident #2, #3) with orders for mental reviews for the procedures for 3 of 3 diabetic resident #2, #3) with orders for the procedure for 3 of 3 diabetic resident #2, #3) with orders for the procedure for 3 of 3 diabetic resident #2, #3) with orders for the procedure for 3 of 3 diabetic resident #2, #3) with orders for the procedure for 3 of 3 diabetic resident #2, #3) with orders for the procedure for 3 of 3 diabetic resident #2.	ration of Residents' Int shall have the following Ital and physical abuse, Italian. as evidenced by: Ins, interviews, and record failed to assure residents It and exploitation as Italian and health care referral Italian and health care referral	D914	Angels at Heart Assisted Livin ensure the rights of our resider violated. Medication errors are occurrence and inevitable in the however we attempt at all cost staff (Medication Aids and Re Coordinator) adequately and exprevent such errors. All facilities must maintain an medication error rate below 5 preventile with which the facility of this end, Angels at Heart Liewill reorient all staff (Medication Resident Care Coordinator) to and procedures related to medicate administration, infection prever requirements, criminal background health care referral and fol avoid undesirable outcomes income adverse drug reactions, drug-drinteractions, lack of efficacy, supatient adherence and poor qual and patient experience. As previously stated, the facility conduct regularly scheduled (queviews and audits to ensure conthese and other areas. Quality Assurance and Improving Director in conjunction with the Manager will be responsible for the second of the second o	ants are not a common are field, a to train our esident Care effectively to a train of the area of the policy ication and checks allow-up to a cluding a trug and a lity of life of the area of the ar	
		dents. [Refer to Tag 932		reviews and audits.	romanemig	

Division	Requirements (Type A2 Violation)].	Angels at Heart Assisted Living has
		contracted with an outside consultant to
		provide quarterly audits, ongoing training to
		administrative staff, quality assurance and improvement measures and ensure
		compliance with state and federal
		regulations and guidelines.
1.0		

PRINTED: 06/07/2018 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D914 Continued From page 62 D914 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)]. Project Angels at Heart Assisted Living has D932 G.S. 131D-4.4A (b) ACH Infection Prevention D932 Implementatio provided new glucose meters for all Requirements n Date: residents who require diabetic testing and 05/11/2018 and Ongoing each meter has been labeled with the G.S. 131D-4.4A Adult Care Home Infection **Prevention Requirements** residents' name. Previous machines were discarded. (b) In order to prevent transmission of HIV. hepatitis B, hepatitis C, and other bloodborne Facility held an in-service training on pathogens, each adult care home shall do all of 6/01/2018 for (Medication Aids and the following, beginning January 1, 2012: Resident Care Coordinator) relating to (1) Implement a written infection control policy Infectious Control Measures: consistent with the federal Centers for Disease Control and Prevention guidelines on infection Blood sugar and appropriate use of control that addresses at least all of the following: glucometer before and after use. a. Proper disposal of single-use equipment used How to document reading correctly

Division of Health Service Regulation

supplies.

to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable

b. Sanitation of rooms and equipment, including

cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and

patient care items that are used for multiple

clean properly.

Sani-Cloth Bleach Wipes will be used to

Training was conducted by a RN, trained

clean machines and lancet pens for 3 seconds (soaked) per cleaning solution to

through the state of NC on 06/01/18.

PRINTED: 06/07/2018 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY)

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.

D932

The RCD will be responsible for reviewing glucometer entries on a weekly basis ongoing to compare FSBS results in glucometer history with FSBS results on the eMARs. Lancing pens were discarded and purchased disposable lancets on 05/09/18. (Addendum added on 06/21/18 via telephone with Ms. Laretta Angle and Carolyn Harrison.)

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,

05/11/2018

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANGELS AT HEART ASSISTED LIVING

1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

4) ID	SUMMARY STATEMENT OF DEFICIENCIES	GROVE, NC 28023		_
REFIX FAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
D932	Continued From page 64	D932		
	#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' glucometersThe glucometer pouches were labeled with			
	residents' namesThe 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' namesThere 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.			
r	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.			
E	Review of the manufacturer's user manual of the Brand B glucometer revealed it was approved for use with multiple residents when properly			

PRINTED: 06/07/2018 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 HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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 -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.

pathogen disease.

-Resident #2 had a diagnosis of a blood borne

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

Division of Health Service Regulation STATEMENT OF DEFICIENCIES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		SURVEY
		HAL080020	B. WING	05	05/11/201 <mark>8</mark>	
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E ZIR CODE	- 00	111/2016
ANCELS	AT UEART ASSISTED		OUTH MAIN STREE			
ANGELS	AT HEART ASSISTED	LIVING	GROVE, NC 28023			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DDECTION	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D932	Continued From page	ge 66	D932			
	diabetes mellitus.					
	Review of Resident revealed an order day	#1's physician orders ated 02/28/18 to measure gar (FSBS) before meals and				
	#1's glucometer and -The pouch was labe -The Brand A glucor was not labeled with -The date and time v -There was a lancet with a used lancet in	eled with Resident #1's name. neter located in the pouch the resident's name.				
	Medication Administration revealed: -There was an entry	#1's May 2018 electronic ration Record (eMAR)				
	and 8:00 pm.	documented four times daily om 82 to 190.				
	history revealed: -FSBS values record	t1's Brand A glucometer's ed in the glucometer's values documented on				
	Resident #1's May 20 for values documente -FSBS values docum	018 eMAR were inconsistent				
ŀ	nistory compared to the evealed:	1's Brand B glucometer's he eMAR for May 2018				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A DEVICE PORTOR DOUBLE STATE OF	(X2) MULTIPLE CONSTRUCTION		
		BENTI TOATTON NOWBER.	A. BUILDING:	COMPL	EIED	
		HAL080020	B. WING	05/	11/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
ANGELS	AT HEART ASSISTED LI	1114 SO	UTH MAIN STREE	т		
ANOLLO	AT TILAKT ASSISTED L		SROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D932	Continued From page	e 67	D932			
D932	-Resident #1 had 1 F in the glucometer's hi am and not documen -Resident #1 had 9 F the MAR that did not values in the glucome -On 05/01/18 at 7:33 was 138 and 186 was 7:00 amOn 05/01/18 at 11:5 was 109 and 103 was 11:00 amOn 05/02/18 at 12:0 was 169 and 156 was 11:00 amOn 05/02/18 at 7:29 was 86 and 98 was re 8:00 pmOn 05/05/18 at 6:56 was 147 and 146 was 7:00 amOn 05/05/18 at 6:46 was 115 and 190 was 8:00 pmOn 05/06/18 at 7:26 was 1104 and 118 was 7:00 amOn 05/06/18 at 3:40 was 154 and 142 was 5:00 pm.	SBS value of 101 recorded istory on 05/09/18 at 7:20 ated on the eMAR. SBS values documented on match the corresponding eter. am the glucometer reading is recorded on the eMAR at 15 am the glucometer reading is recorded on the eMAR at 16 am the glucometer reading is recorded on the eMAR at 17 pm the glucometer reading is recorded on the eMAR at 18 pm the glucometer reading is recorded on the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading is recorded in the eMAR at 19 pm the glucometer reading in the eMAR at 19 pm the glucometer reading in	D932			
	was 109 and 103 was 7:00 am. Interview on 05/09/18 #1 revealed:					
		aff used a new needle in the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		HAL080020				
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
ANGELS	AT HEART ASSISTED	4444.00	UTH MAIN STREE			
	W NEAR AGGIGTED		GROVE, NC 28023	i		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	PECTION	2007
PREFIX TAG	(EACH DEFICIEN REGULATORY C	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE
D932	Continued From page 68		D932			
	lancet pen each tim					
	-He did not know if lancet pens were shared because they all looked the same.					
	-He had never seen	staff clean the discometers				
	-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.					
		3				
	Refer to interview on 05/09/18 at 4:30 pm with the					
	Executive Director.					
	Refer to interview o medication aide (MA	n 05/09/18 at 11:15 am with a A).				
	Refer to interview of second MA.	n 05/09/18 at 11:30 am with a				
	Refer to observation at 11:40 am.	n of FSBS check on 05/09/18				
	Refer to second inte am with a second M	erview on 05/09/18 at 11:45 IA.				
	2. Review of Reside 04/04/18 revealed d diabetes mellitus.	ent #2's current FL2 dated iagnoses included type 2				
	Review of Resident	#2's signed provider orders				
	dated 04/03/18 reve	aled a diagnosis of				
	unspecified viral hep	patitis C.				
	Observation on OF/O	9/18 at 11:05 am at Danishant				
	Observation on 05/09/18 at 11:05 am of Resident #2's glucometer and pouch revealed:					
	The pouch was labe	eled with Resident #2's name.				
	The Brand B glucon	neter located in the pouch				
	was not labeled with	the resident's name.				
	-The date and time was set correctly.					
	There was a lancing					
	glucometer pouch wi	th a used lancet in it and				
,	visible blood on the e	edge of the pen where it				

PRINTED: 06/07/2018 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING: B. WING HAL080020 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D932 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

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6:30 am.

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

-On 05/01/18 at 6:08 am the glucometer reading was 140 and 123 was recorded on the eMAR at

-On 05/05/18 at 4:54 am the glucometer reading was 107 and 122 was recorded on the eMAR at

values in the glucometer.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		05/11/2018		
NAME OF P	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	T 710.000	- 03	11/2016	
MGELS	AT HEART ASSISTED L		UTH MAIN STREE				
MOLLS	AT HEART ASSISTED L						
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	GROVE, NC 28023				
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLE DATE	
D932	Continued From page 70		D932				
	-On 05/07/18 at 5:59	am the glucometer reading s recorded on the eMAR at	5552				
I S	#2 revealed: -He did not know wha used to check his FSB						
	 He had never viewed glucometer or lancet p 	en for his finger sticks . I staff cleaning his pen.					
	pen and place the per bag after use.	eve the needle in the lancet in back in the glucometer					
	Refer to interview on 0 Executive Director.	05/09/18 at 4:30 pm with the					
	Refer to interview on 0 medication aide (MA).	05/09/18 at 11:15 am with a					
	Refer to interview on 0 second MA.	5/09/18 at 11:30 am with a					
		n 05/09/18 at 11:40 am.					
	Refer to second intervious Refer to second MA.	ew on 05/09/18 at 11:45					
0	3. Review of Resident a orders dated 02/21/18 included type 2 diabete	#3's signed provider's revealed diagnoses as mellitus with neuropathy.					
fi	Review of Resident #3's evealed an order dated ngerstick blood sugars londays.	s physician orders d 02/14/18 to check s (FSBS) once a week on					
O Control of Manual to	bservation on 05/09/1	8 at 11:05 am of Resident					

PRINTED: 06/07/2018 **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: A. BUILDING: COMPLETED HAL080020 B. WING 05/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D932 Continued From page 71 D932 #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.

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-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

-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.

04/29/18 at 2:17 pm was 109.