Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 18-19, 2018.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of 1 of 3 sampled residents (Resident #1) with an order for laboratory tests. The findings are: Review of Resident # 1's current FL2 dated 10/10/17 revealed diagnoses included diabetes mellitus, hypertension, and history of cerebrovascular accident (CVA). Review of Resident #1's record revealed an order dated 07/19/18 to obtain a hemoglobin A1C (measure of sugar level in the blood in diabetics), a vitamin B 12 level (for level of vitamin B 12 in the system), and vitamin D 25 hydroxy (OH) level (used to determine if vitamin D supplements should be continued). Review of Resident 1's record revealed the most current laboratory test results documented in the	D 273	See Attached Corrective Action Page 1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Walter J Rumple

TITLE: Administrator

(X6) DATE: 11/20/2018

Reviewed and accepted 11/27/18 MP

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record for hemoglobin A1C was dated 04/19/18 with result of 6.0 (normal range 4.1-6.2) documented in the record.

Review of Resident 1's record revealed the most current laboratory test results documented in the record for vitamin D 25 OH was dated 06/01/18 with result of 52 (normal range 30 - 100) documented in the record.

Review of Resident 1's record revealed no laboratory values for vitamin B 12 level were documented in the record for review.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Interview on 10/19/18 at 3:20 pm with the Manager revealed:
-Resident #1 had medication orders processed on the same order as the laboratory request.
-She had not seen the laboratory request order written on 10/19/18; somehow it was overlooked.
-She was responsible to process all provider laboratory request, including filling out the laboratory request sheet and leaving it in the designated area for the laboratory technician to know to obtain a laboratory test.
-She reviewed orders that came from providers for medications and laboratory test.
-The laboratory technician routinely came to the facility weekly.

Telephone interview on 10/19/18 at 3:30 pm with Resident #1's primary care provider's office nurse revealed:
-The laboratory tests were ordered to monitor current levels vitamin B 12, and vitamin D 25 OH in order to see if the resident should remain on

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D 273	Continued From page 2 vitamin supplements or if the number of medications the resident was receiving could be decreased by discontinuing the supplements. -The hemoglobin A1C test was to see if Resident #1's diabetes was controlled. -There was no documentation the primary care provider had been notified the laboratory tests had not been collected as ordered. Interview on 10/19/18 at 3:45 pm with a medication aide revealed: -The medication aides did not routinely fill out a laboratory request sheet for the laboratory technician. -All orders received for laboratory test were sent to the Manager. -The medication aides were not responsible to track laboratory request. Interview on 10/19/18 at 4:00 pm with the Administrator revealed: -He did not know Resident #1's laboratory tests had not been collected as ordered. -The Manager was responsible to assure laboratory tests were collected as ordered.	D 273		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination	D 299	See Attached Corrective Action Page 2	

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during mixing and the lower nutritional value of the product if too much water is used.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served twice daily to residents.

The findings are:

Review of the registered dietitian's menu for 10/18/18 revealed 8 ounces of 2% milk was to be served to the residents for the breakfast and dinner meals.

Observation of the dinner meal on 10/18/18 between 5:10 pm and 5:55 pm revealed:
-There were 22 residents seated at tables in the dining room.
-There were no glasses of milk on the tables.
-No residents were served an 8 ounce glass of milk with their meal; no resident was offered a glass of milk to drink with their meal.
-The residents were served water and iced tea.

Interview on 10/18/18 at 5:20 pm with 3 residents seated at the 1st table revealed:
-The residents were not served milk with their meal; the residents were not asked if they wanted milk to drink with their meal.
-Two of the 3 residents would like to have a glass of milk to drink with their meal.

Interview on 10/18/18 at 5:30 pm with 5 residents at the 2nd table revealed:
-The residents had not been served milk with their meal; the residents had not been asked if they wanted milk to drink with their meal.
-Staff did not usually serve milk at meals except at breakfast; residents needed to ask for milk if

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D 299	Continued From page 4 they wanted to have a glass of milk at other meal. -Three of the 5 residents would like a glass of milk to drink with their dinner, but they were not were not aware they needed to ask for milk. Interview on 10/18/18 at 5:35 pm with 5 residents seated at the 3rd table revealed: -The residents had not been served milk with their meal; the residents had not been asked if they wanted milk to drink with their meal. -Residents did not receive a glass of milk for dinner unless they asked for it. -One resident stood up and said, "I really would like to have a glass of milk with my dinner!" Observation on 10/18/18 at 5:40 pm of the kitchen refrigerator revealed there were 10 unopened gallons of 2% milk on the shelves. Interview on 10/18/18 at 5:35 pm with the Dietary Aide revealed: -Residents were offered milk at every meal by asking residents if they wanted milk. -Residents had a choice of beverages at meals; the residents liked tea. Interview on 10/18/18 at 5:37 pm with the Dietary Manager (DM) revealed: -Residents were served milk at breakfast. -"If residents were not asked if they wanted a glass of milk at dinner, they could certainly have a glass of milk if they asked for it." Observation of the breakfast meal on 10/19/18 between 8:00 am and 8:45 am revealed: -There were 23 residents seated at tables in the dining room. -There was an 8 ounce glass of milk served with each resident's meal.	D 299		

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D 299	Continued From page 5 Interview on 10/19/18 at 2:30 pm with the DM revealed: -The Administrator shopped for milk on Tuesdays, Wednesdays, and as needed. -The amount of milk needed was determined by the week's menus. -There was always milk on hand; sometimes milk was thrown out because the date on the carton had expired. -Dietary aides were trained by the DM to read the menus and to correctly serve residents' meals. -The dietary aide who worked last evening (10/18/18) knew milk was listed on the menu for dinner; she was supposed to serve an 8 ounce glass of milk to the residents with their meal. -The DM did not know milk was not served at dinner, she was preparing residents' plates. -The DM knew milk was to be served to residents twice a day according to the registered dietitian's menu; an 8 ounce glass of milk was to be served to residents at the breakfast and dinner meals. -As the DM, she was responsible for staff following the menus and serving the milk, as per the dietitian's menu of 2, 8 ounce servings per day. Interview on 10/19/18 at 3:20 pm with the Administrator revealed: -He was responsible for grocery shopping once a week and routinely bought 8 to 10 gallons of milk. -He ordered the dietitian's menus from his food service supplier and knew milk was on the menu for two meals each day. -Dietary staff were expected to read the menus when preparing and serving beverages at meals. -He was not aware an 8 ounce glass of milk was to be served to residents twice a day. -The DM was responsible to monitor the food service.	D 299		

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D 358	Continued From page 6	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as prescribed to 1 of 3 sampled residents (Resident #1) related to incorrect administration of a blood thinner. The findings are: Review of Resident #1's current FL2 dated 10/10/17 revealed diagnoses included diabetes mellitus, hypertension, and history of cerebrovascular accident (CVA). Review of Resident #1's record revealed a physician's order dated 07/03/18 ordering Coumadin (warfarin is generic) 7.5 mg every day except on Monday give Coumadin 5.0 mg based on an international normalized ratio (INR) value of	D 358	See Attached Corrective Action Page 3	

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D 358	Continued From page 7 2.7. (Coumadin is a blood thinner. INR is a lab value used to monitor Coumadin therapy and is generally recommended to be 2.0 to 3.0 for most clinical situations.) Review of Resident #1's record revealed a subsequent physician's order dated 08/14/18 ordering warfarin 7.5 mg every day except on Monday give warfarin 5.0 mg based on an INR 2.5. Continued review of Resident #1's record revealed a subsequent physician's order dated 09/11/18 ordering warfarin 7.5 mg every day except on Monday give warfarin 5.0 mg based on an INR value of 2.0. Review of Resident #1's medication containers labels and doses available for administration on 10/19/18 revealed: -Resident #1 had 22 tablets of warfarin 5 mg remaining from 30 tablets dispensed on 10/10/18. -Resident #1 had 26 tablets of warfarin 2.5 mg remaining for 30 tablets didpensed on 10/05/18. Review of Resident #1's July 2018 and August 2018 Medication Administration Records (MARs) revealed: -There was a preprinted entry for warfarin 5 mg take one tablet daily at bedtime. -There was a preprinted entry for warfarin 2.5 mg take one tablet daily except on Monday. -The MARs had the area for documentation crossed out for the Mondays on the warfarin 2.5 mg entries for July 2018 and August 2018. -Warfarin 5.0 mg was documented as administered every day. -Warfarin 2.5 mg was documented as administered every day except Mondays.	D 358		

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Review of Resident #1's September 2018 MAR revealed:
-There was a preprinted entry for warfarin 5 mg take one tablet daily at bedtime.
-There was a preprinted entry for warfarin 2.5 mg take one tablet daily except on Monday.
-The MAR did not have the area for documentation crossed out for the Mondays on the warfarin 2.5 mg entries for September 2018.
-Warfarin 5 mg and warfarin 2.5 mg were documented as administered every day from 09/01/18 to 09/30/18.
-The resident was not supposed to receive warfarin 2.5 mg on 09/03/18, 09/10/18, 09/17/18, and 09/24/18 (Mondays).

Review of Resident #1's record revealed a physician's order dated 10/08/18 from Resident #1's warfarin clinic with INR result listed as 1.5, and warfarin was ordered as follows:
-On Monday 10/8/18 give 10 mg of warfarin.
-On Tuesday 10/09/18 restart warfarin 7.5 mg daily except warfarin 5 mg on Mondays.
-Recheck INR on Monday, 10/22/18, was included on the order.

Review of Resident #1's record revealed there were no subsequest physician's orderes for warfarin for Resident #1 after10/08/18.

Review of Resident #1's October 2018 MAR revealed:
-There was a preprinted entry for warfarin 5 mg take one tablet daily at bedtime.
-There was a preprinted entry for warfarin 2.5 mg take one tablet daily except on Monday.
-The MAR did not have the area for documentation crossed out for the Mondays on the warfarin 2.5 mg entries for October 2018.
-On Monday 10/01/18, warfarin 7.5 mg was

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documented as administered, and the resident and should have received warfarin 5 mg.
-On 10/02/18 through 10/07/17, warfarin 7.5 mg was documented as administered (as ordered).
-On Monday 10/08/18, warfarin 10 mg was documented administered (as ordered).
-On 10/09/18, 10/10/18, 10/11/18, warfarin 7.5 mg was documented as administered (as ordered).
-On 10/12/18, "HOLD" was handwritten on the entries for warfarin 5 mg and warfarin 2.5 mg along with discontinued in the remaining area for documentation after 10/12/18.
-On 10/13/18 and 10/14/18, there was a handwritten entry for Warfarin 3 mg one daily and documented administration of warfarin 3.0 mg daily at 8:00 pm. (The order was discontinued on the MAR on 10/15/18).
-On 10/15/18, there was a handwritten entry for warfarin 5 mg one tablet daily with documentation for administration on 10/15/18, 10/16/18, and 10/17/18..
-On Monday 10/15/18, there was a handwritten entry for warfarin 2.5 mg one tablet daily except on Monday with documented administration on 10/16/18 and 10/17/18. (Mondays dated 10/16/18, 10/22/18 and 10/29/18 were marked out on the MAR.)
-Warfarin 7.5 mg was documented as administered on 10/16/18 and 10/17/18 at 8:00 pm.

Based on record reviews and interviews, Resident #1 was ordered warfarin 7.5 mg every day except on Monday give warfarin 5.0 mg. Resident #1 was documented as administered the 8 incorrect warfarin doses. On 09/03/18, 09/10/18, 09/17/18, 09/24/18, and 10/01/18 warfarin 7.5 mg was documented as administered and the resident should have

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D 358	Continued From page 10 received warfarin 5 mg; on 10/12/18, wafarin was held; and, on 10/13/18 and 10/14/18 warfarin 3 mg was documented as administered and the resident should have received warfarin 7.5 mg. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Interview on 10/19/18 at 11:30 am with the Manager revealed: -She was responsible for assuring medications were administered as ordered. -She was responsible for month to month comparison of the residents' MARs. -She had a medication aide (MA) who assisted her with the month to month MAR verification for accuracy until the end of September 2018. -The MA routinely reviewed Resident #1's MAR and marked out the Monday doses of warfarin 2.5 mg to help assure Resident #1 received warfarin 5 mg not 7.5 mg on Mondays. -The Manager did not catch that Resident #1 did not have the Monday doses of warfarin 2.5 mg crossed out for September 2018 and October 2018. -The other medication aide staff were supposed to read the instructions for administration on all medications before administering and should not have administered warfarin 2.5 mg on Monday whether or not the day had been pre-marked on the MAR. -She did not know Resident #1 had received warfarin 7.5 mg instead of warfarin 5 mg 09/03/18, 09/10/18, 09/17/18, 09/24/18 and 10/01/18. -She randomly audited residents' MARs for accuracy but most have overlooked Resident #1's warfarin error.	D 358		

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D 358	Continued From page 11 Later interview on 10/19/18 at 3:30 pm with the Manager revealed: -The warfarin clinic monitored 2 of the facilities residents. -On Friday 10/12/18, the Manager received a phone call from a nurse at the warfarin clinic regarding changing an order for warfarin for a resident after she had left the facility. -The Manager called to the facility to have the MA on duty start the new order for warfarin for another resident but not Resident #1. -When the Manager returned to the facility on Monday, 10/15/18, she corrected the MAR for Resident #1. -Resident #1 was due to have another INR check today (10/19/18). Interview on 10/19/18 at 3:45 pm with the MA who received the phone call from the Manager revealed: -She had gotten the call from the Manager on 10/12/18 to change a resident's warfarin. -She understood from the information she received, the MA was to hold Resident #1's warfarin for 10/12/18 and start the new dose of 3 mg warfarin the next day. -She worked the weekend and understood the Manager changed the warfarin dosage back on the MAR on Monday. -She did not work on Mondays so she would not have administered warfarin 7.5 mg on Mondays instead of warfarin 5 mg. Interview on 10/19/18 at 3:50 pm with a second MA revealed: -She worked the evening shift routinely. -She was aware Resident #1 had been receiving warfarin 7.5 mg daily except for warfarin 5 mg on Monday for a long time. -Resident #1's MAR was usually marked out for	D 358		

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D 358	Continued From page 12 warfarin 2.5 mg on Monday but since it had not been marked out in September 2018 and October 2018, she may have overlooked the day of the week and administered warfarin 7.5 mg on the Mondays she worked. Interview on 10/19/18 at 4:00 pm with the Administrator revealed: -He was not aware Resident #1 had not received warfarin correctly for 4 doses in September 2018, and 4 doses in October 2018. -He routinely checked residents' MARs at the end of the month for completeness but not for comparing the MARs to current orders. -The Manager was responsible to assure medications were administered as ordered. -He would put a system in place to better monitor medication administration. _____ The failure of the facility to administer medications as ordered to 1 of 3 sampled residents (Resident #1), who had a history of a cardiovascular accident, related to not administering warfarin (a blood thinner) correctly for 8 doses in September 2018 and October 2018 placed the resident at risk for blood clots or prolonged clotting time and was detrimental to the health, safety, and welfare of the resident which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/19/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 3, 2018.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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
D912	Continued From page 13	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as prescribed to 1 of 3 sampled residents (Resident #1) related to incorrect administration of a blood thinner. [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912	See Attached Corrective Action Page 3	

Best of Care Assisted Living

234 Northdale Ave. Kannapolis, NC 28081
PHONE (704)933-4339 FAX (704)933-4427

Non-Compliance Identified

Rule/Statute Number: NCAC 10A 13F .0902 Health Care

Rule/Statutory Reference: (b) The facility shall assure referral and follow-up to meet routine and acute health needs of the resident.

Facility failed to complete routine laboratory test in sufficient time.

Facility plan for correction and/or prevention:	**Date plan to be completed:**
- Our facility will implement a laboratory request form for physicians to complete separate from physician's orders, to ensure laboratory test request are not missed. Laboratory orders will be marked with scheduled date or physician's time frame for collection. If no time frame is indicated, labs will be done by next physicians visit. The Manager will be responsible for dating labs, Administrator will check and backup Manager in this task.	November 20th 2018

Non-Compliance Identified

Rule/Statute Number: NCAC 10A 13F .0904 (d)(3)(A) Nutrition And Food Service

Rule/Statutory Reference: (d) Food Requirements in Adult Care Homes: (3)Daily menus for regular diets shall include the following: (A) One cup (8 ounces) of pasteurized milk at least twice a day.

Facility plan for correction and/or prevention:	**Date plan to be completed:**
Our Facility has retired the practice of asking if residents would like a glass of milk with dinner to providing a glass of milk at every place setting at dinner, unless resident or resident's POA has requested otherwise.	October 22nd 2018
The facility has purchased additional glassware to ensure each place setting has water, tea, and milk at dinner. Dietary Manager has met with dietary staff about the addition of milk to the dinner place settings and has performed spot checks on dinner meals that She the Dietary Manager has not been assigned to work.	October 29th 2018

Non-Compliance Identified

Rule/Statute Number: NCAC 10A 13F .1004(a) Medication Administration

Rule/Statutory Reference: (a) An adult care home shall assure that the preparation and administration of medications, prescriptions and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this section and the facility's policies and procedures.

Facility plan for correction and/or prevention:	**Date plan to be completed:**
Our Facility will implement a monthly audit of 5 random medication administration records (MARs) done by the Manager and /or Administrator, to help insure accuracy and completeness of our staff's medication administration. In addition any new medication or treatment orders provided by a physician will be check by the Manager and /or Administrator and transcribed by the Manager or Med-Tech on duty. If medication or treatment orders are transcribed by a Med-Tech, the Med-Tech will repeat back to the Manager or Administrator with the resident involved and medication or treatment order transcribed to ensure completeness of the physician's order.	November 5th 2018
Management has also met with each Med-Tech on duty about the importance of correctly transcribing medication orders and for Med-Techs to come to the Manager or Administrator for clarification if they are uncertain about a physician's medication or treatment order. Management has stressed to our Med-Techs to ask questions if they are unsure about anything in the MAR.	November 20th 2018