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LIVEWELL ASSISTED LIVING	6720 PAULINE DRIVE CHAPEL HILL, NC 27514

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on November 20, 2018 through November 21, 2018.	C 000		
C 174	10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents 10A NCAC 13G .0505 Training On Care Of Diabetic Residents A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; appropriate administration times; and (g) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and Staff B) had completed training on the care of the diabetic resident prior to the administration of insulin.	C 174		

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C 174	Continued From page 1 The findings are: 1. Review of the Staff A, supervisor-in-charge/medication aide's (SIC/MA) personnel record revealed: -There was no hire date listed for Staff A. -There was no documentation of training on the care of the diabetic resident found in the Staff A's personnel record. Review of a resident's Medication Administration Record for September 2018, October 2018, and November 2018 revealed: -The resident's blood sugar was checked two times daily. -There was documentation Staff A administered sliding scale insulin 7 times in September 2018, 5 times in October 2018, and 0 times in November 2018. Interview with Staff A on 11/21/18 at 6:57 pm revealed: -She was the house manager and worked as a SIC/MA. -There was one resident in the facility who had orders for fingerstick blood sugar (FSBS) checks and insulin. -She had checked FSBS and administered insulin to the resident. -She completed diabetic training in 2013 or 2014. -She did not receive a certificate for the diabetic training. -The Administrator was responsible for ensuring the diabetic training was completed. Refer to interview with the Administrator on 11/21/18 at 6:23 pm 2. Review of Staff B, medication aide's (MA) personnel record revealed:	C 174		

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C 174	Continued From page 2 -Staff B was hired on 03/29/18. -There was no documentation of training on the care of the diabetic resident found in the Staff A's personnel record. Review of a resident's Medication Administration Record for September 2018, October 2018, and November 2018 revealed: -The resident's blood sugar was checked two times daily. -There was documentation Staff B administered sliding scale insulin 5 times in September 2018, 7 times in October 2018, and 4 times in November 2018. Interview with Staff B on 11/21/18 at 5:55 pm revealed: -She was hired at the facility in March 2018 as a MA/Personal Care Aide (PCA). -There was one resident who had fingerstick blood sugar (FSBS) checks twice daily and administered insulin once daily. -She had checked FSBS and administered insulin during her shift. -She thought she had diabetic training when she was hired with the nurse who was working at the facility during that time. -She did know if she was provided a certificate or not for the diabetic training. Refer to interview with the Administrator on 11/21/18 at 6:23 pm. Interview with the Administrator on 11/21/18 at 6:23 pm revealed: -The human resources manager, who was no longer emplyed at the facility, had been responsible for making sure the diabetic care training was completed. -Diabetic care had been included in previous	C 174		

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C 174	Continued From page 3 trainings, but there had not been a separate training specific to diabetic care. -She did not know there needed to be separate training for diabetic care.	C 174		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for staff guidance for 1 of 1 sampled residents (Resident #2) who had an order for a high fiber diet. The findings are: Review of Resident #2's current hospital FL2 dated 04/05/18 revealed: -Diagnoses included dementia, hypertension, thyroid disease, hyperlipidemia, gastroesophageal reflux disease, and chronic lymphocytic thyroiditis. -There was no diet order indicated. Review of a hospital discharge summary dated 04/05/18 revealed: -Resident #2 had a hospital admitting diagnoses of fecal impaction in the rectum and aspiration pneumonia due to vomit. -There were no special nutritional needs or diet	C 270		

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C 270	Continued From page 4 order indicated. Review of a physician's order for Resident #2 dated 05/15/18 revealed an order for a regular high fiber diet. Observation of the kitchen on 10/20/18 between 9:00 am and 10:00 am revealed: -There was no therapeutic diet list posted. -There was a regular menu and a no concentrated sweets (NCS) menu posted on the refrigerator. -There was no therapeutic menu for a high fiber diet. Interview with the house manager on 11/20/18 at 11:20 am revealed: -There was a census of 5 residents. -Four residents were on a regular diet and one resident was on a therapeutic (NCS) diet. -The NCS diet was the only therapeutic diet in the facility. -There were only two menus in the facility for staff guidance, a regular and a NCS menu. Observation of the lunch meal service on 11/20/18 between 12:26 pm and 1:15 pm revealed Resident #2 was served barbeque chicken skillet, potato salad, coleslaw, garlic toast, chocolate ice cream, sweet tea, and water. Observation of the lunch meal service on 11/21/18 between 12:30 pm and 1:30 pm revealed Resident #2 was served fish sticks, potatoes, carrots, a roll, baked apple bread, sweet tea, and water. It could not be determined if Resident #2 was served the appropriate meals due to no therapeutic menu available for staff guidance.	C 270		

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C 270	Continued From page 5 Interview with a medication aide (MA)/personal care aid (PCA) on 11/20/18 at 5:49 pm revealed: -She was responsible for preparing and serving meals during her shift. -All residents were on a regular diet except for one resident who was on a NCS diet. -Resident #2 was on a regular diet and she served him a regular diet. -There was only a regular menu and a NCS menu available in the facility. -She did not know Resident #2 had a physician's order for a high fiber diet. Telephone interview with a nurse at Resident #2's primary care physician's (PCP) office on 11/21/18 at 12:48 pm revealed she did not see any information regarding diet orders for Resident #2. Based on observations and record reviews, it was determined Resident #2 was not interviewable. Interview with Resident #2's family member on 11/21/18 at 12:55 pm revealed: -She thought Resident #2 was on a regular diet. -Resident #2 ate the same meals as the other residents. -She did not know if Resident #2's primary care provider (PCP) ordered a high fiber diet for him. Interview with the house manager on 11/21/18 at 2:55 pm revealed: -Staff used a list created by the facility's contracted nurse, Administrator, and herself to provide fiber to Resident #2. -She did not know how many grams of fiber Resident #2's PCP expected for Resident #2 to have. -Resident #2 ate shredded wheat for breakfast, brown rice, whole grain breads, and peanuts.	C 270		

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C 270	Continued From page 6 -She had started creating a menu for Resident #2's high fiber diet after the diet order was received. -She, the facility contracted nurse, and the Administrator decided it was okay to use the high fiber diet guide. -The facility had not contacted a registered dietician regarding a high fiber diet. Review of the high fiber diet guide provided by the house manager revealed: -Resident #2 should have whole grain pasta, brown rice, fiber cereal, may have 1-2 fiber snacks per day, whole grain bread, pears, apples, strawberries, grapes, almonds, walnuts, pistachios, spinach, peas, carrots, and broccoli. -There were no serving sizes specified. Interview with the facility contracted nurse on 11/21/18 at 3:20 pm revealed: -She was not involved with residents' diets or meal planning. -She had not assisted with creating the high fiber diet guide. -She did not know Resident #2 had a physician's order for a high fiber diet. Interview with the facility contracted registered dietician on 11/21/18 at 4:44 pm revealed: -He had not created a menu for the facility for a regular high fiber diet. -He had not been asked by the facility to create a high fiber diet menu. -He could work on creating a high fiber diet menu for the facility, but he would need to know specifically how many grams of fiber the PCP considered to be high fiber. Telephone interview with the Administrator on 11/21/18 at 6:23 pm revealed:	C 270		

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C 270	Continued From page 7 -She knew Resident #2 had an order for a high fiber diet, but she thought it had been discontinued by the PCP. -There was not a menu available in the facility for a high fiber diet. -She would be in contact with the facility's contracted registered dietician and the PCP.	C 270		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 residents sampled (#2) who had an order for a high fiber diet. The findings are: Review of Resident #2's current hospital FL2 dated 04/05/18 revealed: -Diagnoses included dementia, hypertension, thyroid disease, hyperlipidemia, gastroesophageal reflux disease, and chronic lymphocytic thyroiditis. -There was no diet order indicated. Review of a hospital discharge summary dated 04/05/18 revealed: -Resident #2 had a hospital admitting diagnoses of fecal impaction in the rectum and aspiration	C 284		

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pneumonia due to vomit.
-There were no special nutritional needs or diet order indicated.

Review of a physician's order for Resident #2 dated 05/15/18 revealed an order for a regular high fiber diet.

Observation of the kitchen on 10/20/18 between 9:00 am and 10:00 am revealed:
-There was no therapeutic diet list posted.
-There was a regular menu and a no concentrated sweets (NCS) menu posted on the refrigerator.
-There was no therapeutic menu for a high fiber diet.

Interview with the house manager on 11/20/18 at 11:20 am revealed:
-There was a census of 5 residents.
-Four residents were on a regular diet and one resident was on a therapeutic (NCS) diet.
-The NCS diet was the only therapeutic diet in the facility.
-There were only two menus in the facility for staff guidance, a regular and a NCS menu.

Observation of the lunch meal on 11/20/18 between 12:26 pm and 1:15 pm revealed Resident #2 2as served barbeque chicken skillet, potato salad, coleslaw, garlic toast, chocolate ice cream, sweet tea, and water.

Observation of the lunch meal on 11/21/18 between 12:30 pm and 1:30 pm revealed Resident #2 was served fish sticks, potatoes, carrots, a roll, baked apple bread, sweet tea, and water.

Interview with a medication aide (MA)/personal

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care aid (PCA) on 11/20/18 at 5:49 pm revealed:
-She was responsible for preparing and serving meals during her shift.
-All residents were on a regular diet except for one resident who was on a NCS diet.
-Resident #2 was on a regular diet and she served him a regular diet.
-There was no a high fiber diet menu available in the facility.
-She did not know Resident #2 had a physician's order for a high fiber diet.

Telephone interview with a nurse at Resident #2's primary care physician's (PCP) office on 11/21/18 at 12:48 pm revealed she did not see any information regarding diet orders for Resident #2.

Based on observations and record review, it was determined Resident #2 was not interviewable.

Interview with Resident #2's family member on 11/21/18 at 12:55 pm revealed:
-She thought Resident #2 was on a regular diet.
-Resident #2 ate the same meals as the other residents.
-She did not know if Resident #2's PCP ordered a high fiber diet for him.

Interview with the house manager on 11/21/18 at 2:55 pm revealed:
-Staff used a list created by the facility contracted nurse, Administrator, and herself to provide fiber to Resident #2.
-She did not know how many grams of fiber Resident #2's PCP expected for Resident #2 to have.
-Resident #2 ate shredded wheat for breakfast, brown rice, whole grain breads, and peanuts.
-She spoke to Resident #2's PCP on 05/15/18 who stated Resident #2 could receive a regular

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diet.
-She received an order from Resident #2's PCP on 05/15/18 a regular high fiber diet.
-She had not called Resident #2's PCP back to ask why the order was written for a high fiber diet.
-She had started creating a menu for Resident #2's high fiber diet.
-She, the facility contracted nurse, and the Administrator decided it was okay to use the high fiber diet guide.

Review of the high fiber diet guide provided by the house manager revealed:
-Resident #2 should have whole grain pasta, brown rice, fiber cereal, may have 1-2 fiber snacks per day, whole grain bread, pears, apples, strawberries, grapes, almonds, walnuts, pistachios, spinach, peas, carrots, and broccoli.
-There were no serving sizes specified.
-There was no indication of grams of fiber for each food item.

Interview with the facility's contracted nurse on 11/21/18 at 3:20 pm revealed:
-She was not involved with residents' diets or meal planning.
-She had not assisted with creating the high fiber diet guide.
-She did not know Resident #2 had a physician's order for a high fiber diet.

Interview with the facility contracted registered dietician on 11/21/18 at 4:44 pm revealed:
-He had not created a menu for the facility for a regular high fiber diet.
-He had not been asked by the facility to create a high fiber diet menu.
-He could work on creating a high fiber diet menu for the facility, but he would need to know specifically how many grams of fiber the PCP

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C 284	Continued From page 11 considered to be high fiber. Telephone interview with the Administrator on 11/21/18 at 6:23 pm revealed: -She knew Resident #2 had an order for a high fiber diet, but she thought it had been discontinued by the PCP. -The house manager was responsible for contacting the PCP regarding Resident #2's diet order. The Administrator submitted a communication log provided by Resident #2's PCP which revealed the PCP wanted Resident #2 to continue a regular diet with high fiber due to a history of constipation.	C 284		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #2) related to a medication to treat peptic ulcers/drooling and a medication used to treat mental/mood disorders.	C 330		

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C 330	Continued From page 12 The findings are: Review of Resident #2's current hospital FL2 dated 04/05/18 revealed: -Diagnoses included dementia, hypertension, thyroid disease, hyperlipidemia, gastroesophageal reflux disease, and chronic lymphocytic thyroiditis. -There was an order for glycopyrrolate 2 mg 1 tablet every day. (Used to treat drooling) -There was an order for glycopyrrolate 1 mg 1 tablet every day as needed. (Used to treat drooling) a. Review of an after visit summary from Resident #2's primary care physician (PCP) dated 10/17/18 revealed: -Instructions from the PCP were to change how glycopyrrolate was taken. -Glycopyrrolate 2mg was changed to 1 tablet (2mg) once daily as needed and glycopyrrolate 1 mg 1 tablet evey day as needed was removed from the order. -Instructions were to "continue taking this medication and follow the instructions you see here". Review of Resident #2's Medication Administration Record (MAR) for October 2018 revealed: -There was an entry for glycopyrrolate 2 mg 1 tablet every day for drooling (give separately) and scheduled for administration at 9:00 am. -Glycopyrrolate 2 mg was documented as administered 31 times from 10/01/18 to10/31/18. -There was an entry for glycopyrrolate 1 mg 1 tablet once daily as needed for drooling (give separately). -Glycopyrrolate 1 mg was not documented as administered in October 2018.	C 330		

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C 330	Continued From page 13 -There was no enrty for glycopyrrolate 2mg 1 tablet once daily as needed on the MAR. Review of Resident #2's MAR for November 2018 revealed: -There was an entry for glycopyrrolate 2 mg 1 tablet every day for drooling (give separately) and scheduled for administration at 9:00 am. -Glycopyrrolate 2 mg was documented administered 19 times from 11/01/18 to 11/20/18. -There was an entry for glycopyrrolate 1 mg 1 tablet once daily as needed for drooling (give separately). -Glycopyrrolate 1 mg was not documented as administered in November 2018. -There was no enrty for glycopyrrolate 2mg 1 tablet once daily as needed on the MAR. Observation of medications on hand on 11/21/18 at 5:28 pm revealed: -Glycopyrrolate 2 mg was on hand with instructions to administer 1 tablet every day. -Glycopyrrolate 1 mg was on hand with instruction1 tablet every day as needed was on hand. Interview with a nurse at Resident #2's primary care provider's (PCP) office on 11/21/18 at 12:48 pm revealed: -There was a physician's order on 10/17/18 to discontinue glycopyrrolate 1 mg as needed. -The current physician's order dated 10/17/18 was glycopyrrolate 2 mg daily as needed. -She did not see any notes which indicated the facility contacted the PCP's office to clarify medication or to inform Resident #2 was not being administered glycopyrrolate 2mg according to the new orders. -Resident #2 should take glycopyrrolate 2mg daily	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL068028	A. BUILDING: _____ B. WING _____	11/21/2018

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C 330	Continued From page 14 as needed as ordered by the physician. Based on observations and record reviews, it was determined Resident #2 was not interviewable. Interview with the house manager on 11/21/18 at 2:55 pm revealed: -She, the Administrator or the facility contracted nurse were responsible for reviewing the physician visit summaries for changes in medication orders. -She had tried contacting Resident #2's PCP for change of orders for glycopyrrolate, but it was difficult to speak to the physician. -She had left messages for Resident #2's PCP, but had not gotten a response. -She had not documented her attempts to contact Resident #2's PCP. -The order dated 10/17/18 had not been sent in to the pharmacy. Interview with the facility's contracted nurse on 11/21/18 at 3:20 pm revealed: -She reviewed resident records for changes in medication orders. -She did not know about the changes in glycopyrrolate orders because the PCP changed the medication orders after her last review of Resident #2's record. Interview with a medication aide (MA)/personal care aide (PCA) on 11/21/18 at 5:55 pm revealed: -She administered medication during her shift. -She administered glycopyrrolate during her shift. -The house manager or the Administrator were responsible for making that medication orders were sent to the pharmacy to be put on the FL2 and for making sure that medication was administered as ordered. -She did not know of any changes in Resident	C 330		

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C 330	Continued From page 15 #2's medications. Telephone interview with the Administrator on 11/21/18 at 6:23 pm revealed: -The house manager was responsible for reviewing new medication orders and making sure new orders were sent to the pharmacy to update the MAR. -The house manager has had problems communicating with Resident #2's physician by phone. -She expected for medications to be administered as ordered by the physician. b. Review of Resident #2's current hospital FL2 dated 04/05/18 revealed there was an order for risperidone 0.5 mg 1 tablet twice a day. Review of a physician's order for Resident #2 dated 05/15/18 revealed an order for risperidone 0.5 mg 1 tablet (0.5 mg) twice daily and one-half tablet (0.25 mg) every morning. Review of an after visit summary from Resident #2's primary care physician (PCP) dated 10/17/18 revealed: -Instructions from the PCP were to change how risperidone was taken. -Risperidone 0.5 mg was changed to one-half a tablet (0.25 mg) in the morning and 1 tablet (0.5 mg) in the evening. Review of Resident #2's Medication Administration Record (MAR) for October 2018 revealed: -There was an entry for risperidone 0.5 mg 1 tablet twice a day and scheduled for administration 12:00 pm and 7:00 pm. -Risperidone 0.5 mg was documented as administered 62 times from 10/01/18 to10/31/18.	C 330		

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C 330	Continued From page 16 -There was an entry for risperidone 0.25 mg 1 tablet every morning and scheduled for administration 9:00 am. -Risperidone 0.25 mg was documented as administered 31 times 10/01/18 to 10/31/18. Review of Resident #2's MAR for November 2018 revealed: -There was an entry for risperidone 0.5 mg 1 tablet twice a day and scheduled for administration 12:00 pm and 7:00 pm. -Risperidone 0.5 mg was documented as administered 39 times 11/01/18 to 11/20/18. -There was an entry for risperidone 0.25 mg 1 tablet every morning and scheduled for administration 9:00 am. -Risperidone 0.25 mg was documented as administered 19 times 11/01/18 to 11/20/18. Observation of medications on hand on 11/21/18 at 5:28 pm revealed: -Risperidone 0.5 mg was on hand with instructions to administer 1 tablet at 12:00 pm and 8:00 pm. -Risperidone 0.25 mg was on hand with instructions to administer 1 tablet every morning. Interview with a nurse at Resident #2's primary care provider's (PCP) office on 11/21/18 at 12:48 pm revealed: -There was a physician's order on 10/17/18 to change the order for risperidone to 1 tablet (0.5 mg) once daily in the evening and one-half tablet (0.25 mg) once daily in the morning. -She did not see any notes which indicated the facility contacted the PCP's office to clarify medication or to inform Resident #2 was not being administered risperidone according to the new orders. -Resident #2 should be taking risperidone daily as	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 17 ordered by the physician. Based on observations and record reviews, it was determined Resident #2 was not interviewable. Interview with the house manager on 11/21/18 at 2:55 pm revealed: -She, the Administrator or the facility contracted nurse were responsible for reviewing the physician visit summaries for changes in medication orders. -She had tried contacting Resident #2's PCP about the change in orders for risperidone, but it was difficult to speak to the physician. -She had left messages for Resident #2's PCP, but had not gotten a response. -She had not documented her attempts to contact Resident #2's PCP. -The order dated 10/17/18 had not been sent in to the pharmacy. -She and the Administrator were responsible for ensuring medications were administered as ordered by the physician. Interview with the facility's contracted nurse on 11/21/18 at 3:20 pm revealed: -She reviewed resident records for changes in medication orders. -She did not know about the changes in risperidone orders because the PCP changed the medication orders after her last review on 08/31/18 of Resident #2's record. Interview with a medication aide (MA)/personal care aide (PCA) on 11/21/18 at 5:55 pm revealed: -She administered medication during her shift. -She administered risperidone to Resident #2 during her shift. -The house manager or the Administrator were responsible for making sure that orders were sent	C 330		

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C 330	Continued From page 18 to the pharmacy to be put on the FL2 and making sure medication was administered as ordered by the physician. -She did not know of any changes in Resident #2's medications. Telephone interview with the Administrator on 11/21/18 at 6:23 pm revealed: -The house manager was responsible for reviewing new medication orders and making sure new orders were sent to the pharmacy to update the MAR. -The house manager has had problems communicating with Resident #2's physician by phone. -She expected for medications to be administered as ordered by the physician.	C 330		