STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

(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 and the Buncombe County Department of Social Services conducted an annual and follow-up survey on 11/28/18 and 11/29/18 with an exit conference via telephone on 11/30/18.	D 000		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure each table place setting included a knife in 1 of 2 resident dining rooms (Laurels dining room). The findings are: Observation of the lunch meal service in the Laurels dining room on 11/28/18 at 12:00 to 12:50pm revealed: -There were 13 residents who were being served in the dining room. -The table place setting consisted of a fork and spoon, with no knife. -The residents were served 1 piece of salisbury steak with gravy, 1 serving of rice, 1 serving of	D 287		

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field peas, 1 roll, and a fruit cobbler dessert.
-One resident held the piece of salisbury steak to his mouth in both hands to eat it.
-A second resident asked for staff assistance to cut up the salisbury steak, but was otherwise able to feed themselves.

Interview with a resident on 11/28/18 at 12:15pm revealed:
-The resident had not received a knife.
-The resident would like to have a knife, "so I don't feel like a child."
-The resident routinely received a fork and spoon.

Observation of the breakfast meal service in the Laurels dining room on 11/29/18 at 8:05am to 8:35am revealed:
-There were 11 residents who were being served in the dining room.
-The table place setting consisted of a fork and spoon, with no knife.
-The residents were served 1 serving of scrambled eggs, 1 slice of bacon, 1 slice of toast, orange juice, milk, and coffee.
-The residents did not appear to have any trouble eating the items served to them.

Interview with the Dietary Manager on 11/29/18 at 9:55am revealed:
-"We were told not to send a knife."
-Management had made them stop sending knives to the Laurels dining room "last year."
-The staff would cut the meat up for residents who needed assistance.

Observation of the kitchen on 11/29/18 at 10:05am revealed:
-There were 12 butter knives in a box in storage.
-There were 3 butter knives in the silverware holder.

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D 287	Continued From page 2 -There were 30 butter knives in the dishwasher basket. -There were 11 butter knives in place settings in the Emerald dining room. -There were a total of 56 butter knives on hand in the facility. Interview with a personal care aide on 11/29/18 at 10:15am revealed: -The residents on the Laurels hall received a fork and spoon at meals. -Meats were served "sliced pretty thin" making them easy to cut. -"Normally, we do not have to cut up their meat." -"The residents are able to do it themselves." -"If they need help, they will ask me." Interview with the Administrator on 11/29/18 at 3:11pm revealed: -She was hired as facility Administrator in October 2017 and there were residents "that should not have been here." -The previous management, due to safety concerns, had obtained a physician's order to discontinue use of all case knives. -Over the past year, the resident population had changed and knives were being given to all residents again. -The Dietary Manager had been employed during the same time period when knives had not been allowed, but later left for another job. -The Dietary Manager had just returned to work in the facility "two weeks ago." -The Dietary Manager had not known it was now acceptable for all the residents to have knives.	D 287		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service	D 306		

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D 306	Continued From page 3 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: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served to residents in 1 of 2 facility dining rooms (Laurels dining room). The findings are: Observation on 11/28/18 from 12:00pm to 12:50pm of the lunch meal service revealed: -Beverages served to residents included sweet tea, milk, nutritional supplements, and coffee. -There were 13 residents in the Laurels dining room who were not served water. -There were three staff serving food and beverages to the residents in Laurels dining room including the Administrator and two personal care aides (PCAs). Observation on 11/29/18 from 8:05am to 8:35am of the breakfast meal service revealed: -Beverages served to residents included orange juice, milk, and coffee. -There were 11 residents in the Laurels dining room who were not served water. -There were four staff serving food and beverages to the residents in the Laurels dining room including the Resident Care Coordinator, the day shift supervisor, and two PCAs. -There was a pitcher of orange juice and a partial gallon of milk on ice on the meal cart, but no water pitcher.	D 306		

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D 306	Continued From page 4 Interview with four residents on 11/29/18 at 8:34am revealed 1 of 4 residents would have drank water if it had been served with the lunch meal service. Interview with a PCA on 11/29/18 at 9:50am revealed: -Water was not served to each resident with each meal in the Laurels dining room. -"The residents usually just ask for it." -There were two or three residents that ate in the Laurels dining room that would ask for water with their meals. -If water was brought over by the kitchen staff, it would be in a pitcher on the cart with the meal trays. Interview with the Dietary Manager on 11/29/18 at 9:55am revealed: -He would send a water pitcher to the Laurels dining room on the meal cart, however the staff would send it back. -The staff were supposed to the keep the water pitcher and change out the water every two hours. Interview with a second PCA on 11/29/18 at 10:10am revealed: -Water was served at meals to residents. -The water pitcher came over "most of the time" on the breakfast cart and staff would "change it out at lunch and dinner." Interview with the Administrator on 11/29/18 at 3:11pm revealed: -The cook "normally" placed a pitcher of ice water on the meal tray cart at breakfast so staff could offer it to the residents. -She would let the Dietary Manager know the water pitcher had not been placed on the cart that	D 306		

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D 306	Continued From page 5 morning. -The residents on Laurel hall were offered water frequently during the day including at meal times, activities, and at snack time.	D 306		
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 administer medications as ordered by a physician for 2 of 9 residents (Residents #6 and #4) observed during the medication pass including administering Novolog without an order (#6) and gabapentin not available for administration (#4); and 1 of 5 sampled residents (Resident #1) regarding metformin and methocarbamol. The findings are:	D 358		

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D 358	Continued From page 6 1. Review of Resident #1's current FL2 dated 10/26/18 revealed diagnoses included fibromyalgia, anxiety, seizures, and diabetes. Review of Resident #1's Resident Register revealed an admission date of 10/26/18. a. Review of Resident #1's primary care physician's (PCP) visit summary dated 11/05/18 revealed a physician's order for metformin (used to treat diabetes) 500mg take ½ tablet once daily. Review of Resident #1's physician order sheet dated 11/28/18 revealed no physician's order for metformin 500mg take one-half tablet once daily. Review of Resident #1's November 2018 electronic Medication Administration Record (eMAR) revealed there was no computer generated entry for metformin 500mg take one-half tablet once daily. Observation of Resident #1's medications on hand on 11/29/18 at 3:04 pm revealed: -There was a bottle of metformin 500mg with 43 and one-half tablets available to be administered to Resident #1. -There was 45 tablets of metformin dispensed to Resident #1 on 11/05/18 based on the prescription label. -The bottle was not stored in the medication cart but was stored with Resident #1's extra medications in a storage room behind the nursing station. Interview with Resident #1 on 11/29/18 at 3:39pm revealed: -He was not followed by the facility's contracted provider.	D 358		

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D 358	Continued From page 7 -He was followed by an outside provider for primary care and mental health. -His PCP had prescribed metformin at his office visit on 11/05/18. -He had went to the pharmacy and picked up the metformin and brought it back to the facility on 11/05/18. -He gave the metformin to the Resident Care Coordinator (RCC) when he returned from his primary care physician (PCP) visit. -He gave the facility any new medication orders that were started at the visit and a visit summary every time he returned from a physician's appointment. -He did not know he had not been receiving the metformin. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/29/18 at 11:45am revealed: -All residents from the facility did not get their medications dispensed from the facility's contracted pharmacy. -The pharmacy did not dispense medications to Resident #1. -The pharmacy was responsible for entering orders in the eMAR software for all residents at the facility. -The pharmacy would enter orders into the eMAR software from a signed physician's order or from a bottle dispensed from a resident's pharmacy. -The facility was responsible for faxing the physician's orders to the pharmacy to be entered on the eMAR. Interview with the medication aide (MA) on 11/28/18 at 11:40am and 11/29/18 at 4:37pm revealed: -She had not administered metformin to Resident #1.	D 358		

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D 358	Continued From page 8 -Metformin was not listed on Resident #1's eMAR. -The MAs were not responsible for entering new orders or approving orders to be added to a resident's eMAR. -The RCC was responsible for approving new orders. Interview with the RCC on 11/29/18 at 9:23am revealed: -All new orders are faxed to the pharmacy to be entered on the eMAR. -She, the day shift supervisor or the Administrator were responsible for approving new orders to be added to the eMARs. -The MAs were not responsible for approving new orders. -She did not know what orders were faxed to the facility's contracted pharmacy to be used to update Resident #1's eMAR. -She would have to ask the Administrator what orders the pharmacy needed to update Resident #1's eMAR. -She did remember receiving a physician's visit summary report from Resident #1 but was not sure of the date. Interview with the day shift supervisor on 11/29/18 at 3:04pm revealed: -She had not administered metformin to Resident #1. -She did not know Resident #1 had a physician's order for metformin. Interview with the Administrator on 11/29/18 at 5:04pm revealed: -The facility was responsible for transporting Resident #1 to his physician appointments. -Resident #1 would not allow the facility staff to accompany him to his appointments.	D 358		

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-The facility was responsible for faxing an updated medication list for Resident #1 to the pharmacy after each physician visit to add new orders to the eMAR.
-She and the RCC had tried to call Resident #1's PCP's office to get a signed, updated physician's order sheet.
-Resident #1's PCP's office had not responded to their request.
-She contacted the facility's contracted provider to sign Resident #1's physician order sheet on 11/28/18.
-She did not know Resident #1 had a physician's order for metformin.

Telephone interview with a nurse from Resident #1's PCP office on 11/30/18 at 9:53am revealed:
-Resident #1 was prescribed metformin 250mg take 1 tablet daily on 11/05/18 because his HgA1c (lab value measuring blood sugar over the last 3 months) was elevated at 6.3% (normal range was <6%).
-Resident #1's pharmacy had dispensed a 90 day supply of metformin to the resident on 11/05/18.
-Resident #1 should be taking the metformin daily.
-The PCP did not know that Resident #1 was not receiving his metformin.
-Resident #1 was at risk for elevated blood sugars and his HgA1c to continue to rise progressing his diabetes if he did not take his medication as prescribed.
-The PCP "visit summary reports were electronically signed and was considered an active medication order."

b. Review of Resident #1's current FL2 dated 10/26/18 revealed a physician's order for methocarbamol (used to treat muscle spasms and pain) 750mg take 2 tablets 4 times daily for 4

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D 358	Continued From page 10 days. Review of Resident #1's medication list from the PCP's office dated 11/23/18 revealed a physician's order for methocarbamol 500mg take 1 tablet 3 times daily as needed. Review of Resident #1's physician's order sheet dated 11/28/18 revealed a physician's order for methocarbamol 500mg take 2 tablets 3 times daily as needed for muscle spasms or pain. Review of Resident #1's October 2018 eMAR revealed: -There was a computer generated entry for methocarbamol 500mg take 2 tablets 3 times daily as needed for muscle spasms or pain. -There were 2 tablets of methocarbamol documented as administered on 10/27/18 at 1:51pm and 7:42pm, 10/29/18 at 2:11pm, and 10/30/18 at 7:48pm. Review of Resident #1's November 2018 eMAR revealed: -There was a computer generated entry for methocarbamol 500mg take 2 tablets 3 times daily as needed for muscle spasms or pain. -The entry was dated from 11/01/18 to 11/26/18. -Methocarbamol was documented as administered 17 times from 11/01/18 to 11/25/18. -Methocarbamol was documented as administered at least once daily 13 times from 11/01/18 to 11/20/18. -No methocarbamol was documented as administered from 11/21/18 to 11/25/18. -This order was documented as discontinued on 11/26/18. -There was a computer generated entry for methocarbamol 500mg take 1 tablet 3 times daily as needed for muscle spasms or pain with a start	D 358		

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date of 11/26/18.
-There were 2 tablets of methocarbamol documented as administered on 11/26/18 at 3:36pm and 11/28/18 at 1:32pm.

Interview with Resident #1 on 11/29/18 at 3:39pm revealed:
-He knew his methocarbamol was scheduled "as needed" and he had to ask for the medication to receive a dose.
-The order was supposed to be written to take 2 tablets at a time.
-He was out of his methocarbamol for at least 3 days before he picked up the medication after a physician's appointment on 11/26/18.
-The facility staff told him it was his responsibility to check with his physician to figure out why the medication could not be refilled.
-He was in chronic pain and had a "high pain threshold."
-He had several past surgeries to have metal plates placed in his head and foot.

Interview with the MA on 11/29/18 at 4:37pm revealed:
-Resident #1 asked for his pain medication daily.
-She or the day shift supervisor was responsible for ordering medication refills for the residents.

Interview with the Administrator on 11/29/18 at 5:04pm revealed:
-The facility were responsible for faxing an updated medication list for Resident #1 to the pharmacy after each physician visit to add new orders to the eMAR.
-The MAs or the day shift supervisor were responsible for ordering medication refills.
-The Day Shift Supervisor was responsible for auditing the medication carts monthly.
-She or the RCC should be notified of a missed

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medication.
-The RCC was responsible for monitoring the missed medication report monthly and investigating any missed doses.

Telephone interview with a nurse from Resident #1's PCP office on 11/30/18 at 9:53am revealed:
-Resident #1's first office visit with PCP was 10/24/18.
-Resident #1 was a new patient for the PCP's office because he was followed by an out of state provider.
-Resident #1 was a chronic pain patient and needed his pain medication.
-The PCP had prescribed methocarbamol to Resident #1 on 11/26/18 with the directions take 1 tablet 3 times daily as needed.

2. The medication error rate was 8% as evidenced by 2 errors out of 25 opportunities observed during the medication passes on 11/28/18 at 11:52am and 11/29/18 at 8:13am.

a. Review of Resident #6's current FL2 dated 11/14/18 revealed:
-Diagnoses included diabetes, hypertension, schizophrenia, and generalized weakness.
-There was a physician's order for Novolog (used to treat diabetes) check blood sugar before meals twice daily and give sliding scale insulin subcutaneously <70 treat low glucose, 70-150 0 units, 151-200 2 units, 201-250 4 units, 251-300 6 units, 301-350 8 units, 351-400 11 units, >400 give 13 units.

Observation of the medication pass on 11/28/18 at 11:52am revealed:
-Resident #6's blood sugar was checked by the medication aide (MA) in the resident's room.
-The blood sugar was recorded as "high" on

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D 358	Continued From page 13 Resident #6's glucometer. -The MA administered 13 units of Novolog to Resident #6. -She verified the Novolog was due to be administered to Resident #6 by the prescription label on the bottle. Review of Resident #6's November 2018 electronic Medication Administration Record (eMAR) revealed: -A computer generated entry for Novolog check blood sugar before meals twice daily and give sliding scale insulin subcutaneously <70 treat low glucose, 70-150 0 units, 151-200 2 units, 201-250 4 units, 251-300 6 units, 301-350 8 units, 351-400 11 units, >400 give 13 units scheduled to be administered at 7:30am and 4:30pm. -Novolog was documented as administered for 40 of 57 opportunities from 11/01/18 to 11/29/18 based on sliding scale parameters. -Blood sugar was documented as 125-276 at 7:30am and 127-466 at 4:30pm from 11/01/18 to 11/30/18. -Blood sugar was documented as 276 at 7:30am on 11/28/18 and 155 at 4:30pm on 11/28/18. -The blood sugar reading observed during the medication pass on 11/28/18 was not documented on the eMAR. Review of Resident #6's medication on hand 11/28/18 at 11:52am revealed: -There were 2 partially used 10 ml vials of Novolog available to be administered to the resident. -The vials were dispensed to the resident on 07/23/18 and 10/15/18. -The vial dispensed on 07/23/18 had an opened date written on the vial of 08/10/18. -The vial dispensed on 10/15/18 had no open date noted on the vial.	D 358		

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D 358	Continued From page 14 Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/28/18 at 11:23am revealed: -There was a physician's order for Novolog check blood sugar before meals twice daily and give sliding scale insulin subcutaneously <70 treat low glucose, 70-150 0 units, 151-200 2 units, 201-250 4 units, 251-300 6 units, 301-350 8 units, 351-400 11 units, >400 give 13 units. -A 10ml vial of Novolog was dispensed to Resident #6 on 10/15/18, 07/23/18, 06/09/18, and 04/16/18. -Novolog had a shelf-life of 28 days once the vial had been opened. -Each Novolog vial should be replaced every 28 days to prevent bacterial contamination. Interview with the medication aide (MA) on 11/29/18 at 4:37pm revealed: -She knew that Resident #6 had an order to check her blood sugar twice daily. -She did not know why she checked Resident #6's blood sugar before lunch on 11/28/18. -She usually checked Resident #6's blood sugar before breakfast and dinner. Interview with Resident #6's Nurse Practitioner on 11/29/18 at 11:35am revealed: -Resident #6's blood sugar should be checked before breakfast and dinner. -Resident #6 did not have an order to administer Novolog before lunch. -Each resident had specific sliding scale orders that should be followed by the facility staff. Interview with the Administrator on 11/29/18 at 5:04pm revealed: -She was notified that Resident #6 received Novolog before lunch without a physician's order.	D 358		

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-She had reviewed the process for medication administration with the medication aides on 11/29/18 once she had received notification of the medication error.
-The MA was responsible for removing the medication from the medication cart and comparing the medication with the eMAR to ensure the correct medication was pulled.
-The MA was responsible for administering the medications to the residents.
-The MAs were responsible for checking the orders on the eMAR before administering any medications.
-The MA should not document a medication had been administered until they returned from administering the medication to the resident.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.

b. Review of Resident #4's current FL2 dated 02/22/18 revealed a diagnoses of dementia and major neurocognitive disorder.

Review of Resident #4's record revealed a physician's order dated 06/06/18 for gabapentin (used to treat nerve pain and seizures) 300mg take 1 capsule 3 times daily for anxiety.

Observation during the morning medication pass on 11/29/18 at 8:33am revealed no gabapentin 300mg was available to be administered to Resident #4.

Review of Resident #6's November 2018 eMAR revealed:
-There was a computer generated entry for gabapentin 300mg take 1 capsule 3 times daily for pain and anxiety scheduled to be administered

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at 8:30am, 1:30pm, and 8:30pm.
-Gabapentin was documented as administered for 82 of 85 opportunities from 11/01/18 to 11/29/18.

Interview with the MA on 11/29/18 at 8:33am revealed:
-She could not find gabapentin in the medication cart to administer to Resident #4.
-She was going to notify the facility's contracted pharmacy to refill the medication.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/29/18 at 10:11am revealed:
-Gabapentin was filled on a monthly cycle without the facility requesting the medication around the 4th of each month.
-A 30 day supply of gabapentin was last dispensed to Resident #4 on 11/04/18.
-Resident #4 should not be out of gabapentin.

Observation of the nursing station on 11/29/18 at 11:30am revealed the facility's contracted backup pharmacy delivered 15 capsules of gabapentin to Resident #4.

Review of Resident #6's record revealed no documentation in the Nurse's Notes regarding missed dose of gabapentin the morning of 11/29/18.

Interview with the Administrator on 11/29/18 at 5:04pm revealed:
-She or the Resident Care Coordinator (RCC) should be notified if a resident missed a dose of a medication.
-She knew there was no gabapentin available to be administered for Resident #4 during the morning medication pass on 11/29/18.

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D 358	Continued From page 17 -She was notified by the Day Shift Supervisor. -The day shift supervisor had contacted the backup pharmacy to have the medication delivered to Resident #4. -The RCC was responsible for monitoring a missed medication report and auditing the eMARs monthly. -The RCC was responsible for investigating each missed medication. -The day shift supervisor was also responsible for auditing the medication carts monthly and the eMARs. _____ The facility failed to administer medications as ordered to 2 of 9 residents observed during the medication passes related to Novolog insulin (Resident #6) increasing the risk of low blood sugars, gabapentin (Resident #4) not available to treat anxiety; and 1 of 5 sampled resident related to not administering metformin and methocarbamol (Resident #1) increasing the risk for elevated blood sugars and increased pain, which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2019.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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D 367	Continued From page 18 (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 observations, interviews, and record reviews, the facility failed to ensure electronic medication administration records (eMARs) were accurate for 2 of 5 sampled residents (Resident #1 and #3). The findings are: 1. Review of Resident #3's current FL2 dated 04/17/18 revealed diagnoses included diabetes mellitus type II, hypertension, dementia with behavioral disturbance, neuropathy, and muscle weakness.	D 367		

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D 367	Continued From page 19 Review of Resident #3's Resident Register revealed an admission date of 04/17/18. a. Review of Resident #3's physician's order sheet dated 09/17/18 revealed an order for glipizide (used to control blood sugar) 10mg 1 tablet twice a day before meals. Review of Resident #3's October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for glipizide 10mg 1 tablet twice daily before meals scheduled at 7:30am and 4:30pm. -Glipizide was documented as administered for 28 of 29 opportunities from 10/01/18 to 10/31/18 at 7:30am. -Glipizide was documented as administered for 31 of 31 opportunities from 10/01/18 to 10/31/18 at 4:30pm. Review of Resident #3's November 2018 eMAR revealed: -There was an entry for glipizide 10mg 1 tablet twice daily before meals scheduled at 7:30am and 4:30pm. -Glipizide was documented as administered for 16 of 29 opportunities from 11/01/18 to 11/29/18 at 7:30am. -Glipizide was documented as administered for 28 of 28 opportunities from 11/01/18 to 11/28/18 at 4:30pm. Observation of medications on hand for Resident #3 on 11/29/18 at 11:20am revealed: -There were 15 tablets of glipizide 10mg available to be administered to the resident. -The glipizide was dispensed to Resident #3 on 11/04/18.	D 367		

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D 367	Continued From page 20 Interview with a medication aide (MA) on 11/29/18 at 11:00am revealed: -The eMAR had intermittent connectivity issues during medication administration passes. -When the eMAR system came back up, the staff were able to proceed with medication administration. -The eMAR system did allow staff to administer a medication late if necessary after the resolution of a connectivity issue with the eMAR system. Interview with Resident #3 on 11/29/18 at 11:40am revealed: -He received his medications on time from staff. -He had not run out of any of his medications as far as he knew. -He was not able to identify his medications as to what each was named and what each was used to treat. -He had recently had some high blood sugars, but those were caused by the foods he had eaten. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/29/18 at 11:45am and 2:00pm revealed: -There could be a lapse of time between when a medication was documented as administered in the eMAR system and when the documentation would appear on a printed copy of the eMAR. -The documented missed doses of glipizide on Resident #3's printed eMAR however had been uploaded and appeared to be actual missed doses of the medication. -Resident #3's glipizide 10mg quantity of 60 were dispensed on 10/31/18 and were to be started in the facility on 11/04/18. -Resident #3 should have a four day supply (8 tablets) of glipizide 10mg left on hand. -The facility could have some of the supply of	D 367		

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medications left over during a cycle, however the facility had been instructed to send all medications not used during a cycle back to the pharmacy when they receive the new cycle fill for the month.

Interview with the Administrator on 11/29/18 at 3:11pm revealed:
-There were issues with their current eMAR system which their pharmacy had been unable to explain or correct.
-She was confident Resident #3 had received the doses of glipizide based on the amount of medication still available on the medication cart.
-The documentation of the missed doses of glipizide on the resident's eMAR were inaccurate.
-Due to the problems with the current eMAR system, they planned to change to a different eMAR system in January 2019.

b. Review of Resident #3's physician's order sheet dated 09/17/18 revealed an order for fenofibrate (used to treat high cholesterol) 134mg 1 capsule every morning before breakfast.

Review of Resident #3's October 2018 eMAR revealed:
-There was an entry for fenofibrate 134mg 1 capsule every morning before breakfast scheduled at 7:00am.
-Fenofibrate was documented as administered for 28 out of 31 opportunities from 10/01/18 to 10/31/18 at 7:00am.

Review of Resident #3's November 2018 eMAR revealed:
-There was an entry for fenofibrate 134mg 1 capsule every morning before breakfast scheduled at 7:00am.
-Fenofibrate was documented as administered for

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D 367	Continued From page 22 9 out of 29 opportunities from 11/01/18 to 11/29/18 at 7:00am. Observation of medications on hand for Resident #3 on 11/29/18 at 11:20am revealed: -There were 8 capsules of fenofibrate 134mg available to be administered to the resident. -The fenofibrate was dispensed to Resident #3 on 11/04/18. Interview with a MA on 11/29/18 at 11:00am revealed: -The eMAR had intermittent connectivity issues during medication administration passes. -When the eMAR system "came back up," the staff were able to proceed with medication administration. -The eMAR system did allow staff to administer a medication late if necessary after the resolution of a connectivity issue with the eMAR system. Interview with Resident #3 on 11/29/18 at 11:40am revealed: -He received his medications on time from staff. -He had not run out of any of his medications as far as he knew. -He was not able to identify his medications as to what each was named and what each was used to treat. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/29/18 at 11:45am and 2:00pm revealed: -There could be a lapse of time between when a medication was documented as administered in the eMAR system and when the documentation would appear on a printed copy of the eMAR. -The documented missed doses of fenofibrate on Resident #3's printed eMAR however had been uploaded and appeared to be actual missed	D 367		

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doses of the medication.
-Resident #3's fenofibrate 134mg quantity of 30 were dispensed on 10/31/18 and were to be started in the facility on 11/04/18.
-Resident #3 should have a four day supply (4 capsules) of fenofibrate 134mg left on hand.
-The facility could have some of the supply of medications left over during a cycle, however the facility had been instructed to send all medications not used during a cycle back to the pharmacy when they receive the new cycle fill for the month.

Interview with the Administrator on 11/29/18 at 3:11pm revealed:
-There were issues with their current eMAR system their pharmacy had been unable to explain or correct.
-She was confident Resident #3 had received the doses of fenofibrate based on the amount of medication still available on the medication cart.
-The documentation of the missed doses of fenofibrate on the resident's eMAR were inaccurate.
-Due to the problems with the current eMAR system, they planned to change to a different eMAR system in January 2019.

2. Review of Resident #1's current FL2 dated 10/26/18 revealed diagnoses included fibromyalgia, anxiety, seizures, and diabetes.

Review of Resident #1's Resident Register revealed an admission date of 10/26/18.

Review of Resident #1's primary care physician's (PCP) visit summary dated 11/05/18 revealed a physician's order for diltiazem 240mg take 1 capsule daily.

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D 367	Continued From page 24 Review of Resident #1's active medication list from the PCP's office dated 11/23/18 revealed a physician's order for diltiazem 240mg take 1 capsule daily. Review of Resident #1's physician's order sheet dated 11/28/18 revealed a physician's order for diltiazem 120mg take 1 tablet daily. Review of Resident #1's October 2018 eMAR revealed: -There was a computer generated order for diltiazem 120mg take 1 capsule daily for heart and blood pressure scheduled to be administered at 8:30am. -Diltiazem 120mg was documented as administered for 4 of 5 opportunities from 10/27/18 to 10/31/18. Review of Resident #1's November 2018 eMAR revealed: -There was a computer generated order for diltiazem 120mg take 1 capsule daily for heart and blood pressure scheduled to be administered at 8:30am. -Diltiazem 120mg was documented as administered for 27 of 28 opportunities from 11/01/18 to 11/28/18. Observation of medications on hand for Resident #1 on 11/29/18 at 3:04pm revealed: -There was 68 capsules of diltiazem 240mg was available to be administered to resident. -Diltiazem was dispensed to Resident #1 on 11/05/18. Interview with Resident #1 on 11/29/18 at 3:39pm revealed: -He was not followed by the facility's contracted provider.	D 367		

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-He was followed by an outside provider for primary care and mental health.
-His PCP had increased his diltiazem dose at his office visit on 11/05/18.
-He had went to the pharmacy and picked up the diltiazem and brought it back to the facility on 11/05/18.
-He gave the diltiazem to the Resident Care Coordinator (RCC) when he returned from his PCP visit.
-He gave the facility staff any new medication orders that were started at the visit and a visit summary every time he returned from a physician's appointment.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/29/18 at 11:45am revealed:
-All residents from the facility did not get their medications dispensed from the facility's contracted pharmacy.
-The pharmacy did not dispense medications to Resident #1.
-The pharmacy was responsible for entering orders in the eMAR software for all residents at the facility.
-The pharmacy would enter orders into the eMAR software from a signed physician's order or from a bottle dispensed from a resident's pharmacy.
-The facility was responsible for faxing the physician's orders to the pharmacy to be entered on the eMAR.

Interview with the medication aide (MA) on 11/29/18 at 3:04pm revealed she was administering the diltiazem that was available in the medication cart to Resident #1.

Interview with the day shift supervisor on 11/29/18 at 3:04pm revealed she did not know the

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CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

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D 367	Continued From page 26 diltiazem listed on the eMAR for Resident #1 did not match the medication, available to administer. Interview with the RCC on 11/29/18 at 9:23am revealed: -All new orders were faxed to the pharmacy to be entered on the eMAR. -She, the day shift supervisor or the Administrator was responsible for approving new orders to be added to the eMARs. -The MAs were not responsible for approving new orders. -She did not know what orders were faxed to the facility's contracted pharmacy to be used to update Resident #1's eMAR. -She would have to ask the Administrator what orders the pharmacy needed to update Resident #1's eMAR. Interview with the Administrator on 11/29/18 at 5:04pm revealed: -The facility staff were responsible for faxing all new orders to the pharmacy to update the eMAR for each resident. -The MA was responsible for removing the medication from the medication cart and comparing the medication with the eMAR to ensure the correct medication was pulled. -The MA's were responsible for checking the orders on the eMAR before administering any medications. -The MA was responsible for administering the medications to the residents. -The MA should not document a medication had been administered until they returned from administering the medication to the resident. -The RCC and the day shift supervisor were responsible for auditing the eMARs monthly. -The day shift supervisor was responsible for auditing the medication carts monthly.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011262	A. BUILDING: _____ B. WING _____	C 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 observations, interviews and record reviews, the facility failed to assure residents received care and services that are 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 administer medications as ordered by a physician for 2 of 9 residents (Residents #6 and #4) observed during the medication pass including administering Novolog without an order (#6) and gabapentin not available for administration (#4); and 1 of 5 sampled residents (Resident #1) regarding metformin and methocarbamol. [Refer to Tag D0358, 10A NCAC 13F. 1004(a) Medication Administration (Type B Violation)].	D912		