Division of	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
HAL068025			B. WING		12/2	20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
			H LEVEL ROAD			
THE STRA	ATFORD		HILL, NC 27516			
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N	(VE)
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				DEI IOIERO I)		
D 000	Initial Comments		D 000			
	The Adult Care Licen	sure Section conducted a				
	complaint investigation	on on 12/19/18-12/20/18.				
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273			
	404 NOAO 40E 0000	21114- 0				
	10A NCAC 13F .0902	z Health Care assure referral and follow-up				
	· ·	nd acute health care needs				
	of residents.	nd deate fieditif edie fieeds				
	This Rule is not met	as evidenced by:				
	TYPE A2 VIOLATION					
	Based on observation	ns, interviews, and record				
		illed to assure immediate				
		sician regarding 1 of 5				
	sampled residents (R	, •				
	feeling lethargic, slee	nmate's medication and				
	reening lethargic, siee	py and weak.				
	The findings are:					
	3					
	Review of Resident #	1's current FL2 dated				
	10/25/18 revealed dia					
	•	allergic rhinitis, atrial flutter,				
		tus, esophageal stricture,				
	macular degeneration	coronary artery disease and				
	macaiai acycnicialloi	1.				
	Review of Resident #	1's hospital discharge			l	
	summary report dated					
	-Resident #1 was bro	ought to the emergency			l	
	department at 6:00pn	n due to "drug overdose."				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL068025	B. WING		C 12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER	405 SMITH	DRESS, CITY, STATE I LEVEL ROAD IILL, NC 27516			
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D 273	-"[Resident #1] was a another residents me medication pass." -"Resident #1 complas sluggish and staff repwithdrawn." -In the emergency de "tired." -Staff at the facility sa administered his own -"[Resident #1's] blood to the resident not ge Lantus." Interview with Reside practitioner (PCP) on revealed: -On 12/07/18 at 4:47 Coordinator (MCC) readministered his roor included psychotropic -The resident was fee -The staff was advise Resident #1 to emerg -Prior to 4:47pm, no of their office to notify his administered his roor Resident #1 was not Telephone interview on 12/19/18 at 12:40 -The facility staff called 12/07/18 to inform his going to the hospital sadministered the wro-No one at the facility on 12/07/18 to inform administered his roor and administered his roor administered his roor administered his roor and administered his roor administere	ccidentally administered dications during the morning anined of weakness, feeling forted the resident was partment Resident #1 was not medications this morning." d sugar was over 350, due titing the morning dose of 12/19/18 at 11:44 am pm the Memory Care Unit exported Resident #1 was neate's medications, which is medications. Eling lethargic. d to immediately send gency department. One from the facility called im Resident #1 was neate's medication or that at his normal baseline. With Resident #1's Guardian pm revealed: ed him after 5:00 pm on that Resident #1 was necessary medications. called him in the morning him that Resident #1 was called him in the morning him that Resident #1 was necessary medications.	D 273			

Division of Health Service Regulation

medications administered, but informed him that

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DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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		HAL068025	B. WING		12/20/2018	
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INE SIKA	MIFORD	CHAPEL	HILL, NC 27510	3		
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				DEFICIENCY)		
D 273	Continued From page	e 2	D 273			
	Danisland #4					
	Resident #1 was not					
		he hospital Resident #1 was				
	tired and sleepy.					
	-The hospital gave the	e resident insulin due his				
	blood sugar being hig	ıh.				
	0 0	,				
	Interview with Reside	nt #1 on 12/19/18 at 4:00				
		11t #1 011 12/13/10 at 4.00				
	pm revealed:	dianting side (NAA) segreta				
		dication aide (MA) came to				
		I him a cup with multiple				
	pills.					
	-He had observed the	number of medications				
	looked to be more that	an he normally was				
		did not question the MA and				
	took all the medicatio	-				
	-	e was not administered his				
	morning Lantus.					
		medications and trusted				
	facility staff to adminis	ster the correct medications				
	to him.					
	-Between 9:15 am an	d 9:30 am, the MA in charge				
		d told him that he had been				
	administered the wro					
		uld check on him throughout				
		r know if he start to feel bad.				
		called was being sleepy and				
	having a difficult time					
	-He did not tell anyon	e how be felt because he				
	could not stay awake	long enough to talk to				
	anyone.	-				
	-	for two days and did not				
	remember eating mea					
		ons were administered in the				
		nd dinner time when he went				
	to the hospital.					
	Interview with Reside	nt #1's roommate on				
	12/19/18 at 3:55 pm r					
		2/07/18 a MA came to the				
			1	I .	1	

Division of Health Service Regulation

room to administer medications to him and his

STATE FORM B6WC11 If continuation sheet 3 of 26

Division of Health Service Regulation							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY	
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		CHAPEL	HILL, NC 27516				
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D 273	Continued From page	e 3	D 273				
	roommato						
	roommate.						
	-	ent to the room and told					
		vas administered the wrong					
	medications.						
		nt #1 that she would keep an					
	•	her know if he felt sick.					
		Resident #1 a few times					
	-	new Resident #1 was tired					
	and was not his usua						
		day and did not eat meals,					
	which was very unus	ual for Resident #1.					
	-It was close to dinne	r time and Resident #1 was					
	sleeping hard and he	had a hard time waking the					
	resident up.						
	-Resident #1 was adr	ministered his medications in					
	the morning after 9:00	0 am, the resident was sent					
	to the hospital at dinn	er time, which was 5:00 pm.					
	•	•					
	Interview with the Adr	ministrator on 12/19/18 at					
	3:19 pm with the Adm	ninistrator revealed:					
		n 5:00pm and 6:00pm he					
		from the MCC stating					
	•	edication pass Resident #1					
	was administered the						
		the physician was not					
	notified in the morning						
		the MA in charge did not					
	-	the hospital after the incident					
		the hospital after the incident					
	happened.	policy that MAs were to					
		-					
	report incidents quick						
	Latera de la constitue de la Cara	t -1:# NAA 40/40/40 -t					
		t shift MA on 12/19/18 at					
	4:51 pm revealed:	Alexander and the second secon					
	_	the morning medication					
	pass Resident #1's ro						
		gave the wrong medications					
	to Resident #1.						
	-She told Resident #1 he was administered the						

Division of Health Service Regulation

wrong medications, which were his roommate's

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER	DIVISION	or riealin Service Regu	iialion					
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wrong medicationsShe gave Resident #1 his roommate's medications, which included several psychotropic medicationsShe did not contact Resident #1's PCP or Guardian, because she thought the MA in charge was going to contact the PCP and document because it was her medication pass and she was only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		am revealed:						
-She gave Resident #1 his roommate's medications, which included several psychotropic medicationsShe did not contact Resident #1's PCP or Guardian, because she thought the MA in charge was going to contact the PCP and document because it was her medication pass and she was only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		-She accidentally adn	ninistered Resident #1 the					
medications, which included several psychotropic medications. -She did not contact Resident #1's PCP or Guardian, because she thought the MA in charge was going to contact the PCP and document because it was her medication pass and she was only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		wrong medications.						
medicationsShe did not contact Resident #1's PCP or Guardian, because she thought the MA in charge was going to contact the PCP and document because it was her medication pass and she was only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		-She gave Resident #	#1 his roommate's					
-She did not contact Resident #1's PCP or Guardian, because she thought the MA in charge was going to contact the PCP and document because it was her medication pass and she was only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		medications, which in	cluded several psychotropic					
Guardian, because she thought the MA in charge was going to contact the PCP and document because it was her medication pass and she was only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		medications.						
was going to contact the PCP and document because it was her medication pass and she was only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		-She did not contact I	Resident #1's PCP or					
because it was her medication pass and she was only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		Guardian, because sl	he thought the MA in charge					
only helping out. Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		was going to contact	the PCP and document					
Attempted telephone interview on 12/20/18 at 10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		because it was her m	edication pass and she was					
10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		only helping out.	•					
10:50 am with the second shift MA was not successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the								
successful. The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		Attempted telephone	interview on 12/20/18 at					
The facility failed to immediately follow-up with the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		10:50 am with the sec	cond shift MA was not					
the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		successful.						
the physician after accidentally administering Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the								
Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the		The facility failed to in	nmediately follow-up with					
Resident #1 the wrong morning medication causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the								
causing the resident to feel weak, lethargic, tired and not being sent to the hospital until the								
and not being sent to the hospital until the			-					
at substantial risk for serious harm and								
constitutes a Type A2 Violation.								
		11						
The facility provided a plan of protection on		The facility provided a	a plan of protection on					
01/15/19 in accordance with G.S. 131D-34 for								

Division of Health Service Regulation

STATE FORM B6WC11 If continuation sheet 5 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY IPLETED	
		HAL068025	B. WING		12	C 2/20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE STRA	ATFORD		TH LEVEL ROAD . HILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273		je 5 E FOR THE TYPE A2 NOT EXCEED JANUARY 19,	D 273			
D 358	(a) An adult care ho preparation and adm prescription and non by staff are in accord (1) orders by a licer which are maintaine	14 Medication Administration ome shall assure that the ninistration of medications, 1-prescription, and treatments	D 358			
	reviews, the facility f medications as orde residents (#1 and #4 receiving his roomm	ons, interviews, and record ailed to administer red for 2 of 5 sampled b) related to a resident ate's medication (Resident ecciving the incorrect dosage				

Division of Health Service Regulation

STATE FORM B6WC11 If continuation sheet 6 of 26

DIVISION	or riealiti Service Regu	ilation	_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
HAL068025			B. WING		12/2	20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		405 SMIT	H LEVEL ROAD			
THE STRA	AIFORD	CHAPEL	HILL, NC 27516	6		
	011111111111111111111111111111111111111					
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
170		,	1/0	DEFICIENCY)		
D 358	Continued From page	e 6	D 358			
	1. Review of Residen	t #1's current FL2 dated				
	10/25/18 revealed:					
	-Diagnoses included	myocardial-infarction				
	_	flutter, type II diabetes				
	_	* ·				
		stricture, hyperlipidemia,				
	and coronary artery d	lisease and macular				
	degeneration.					
	-Physician's orders for	or medications included:				
	Lantus 5 units at bed	time (low acting human				
		liabetes), metformin 500mg				
		ed to treat diabetes), aspirin				
		ed as a blood thinner),				
	, ,	•				
		ng three times daily (used to				
	_ · · · · · · · · · · · · · · · · · · ·	metoprolol 12.5mg once				
	daily (used to lower b	lood pressure), multiple				
	vitamin once daily (vit	tamin deficiency), vitamin D3				
	1.000 units once daily	y, and citrucel fiber laxative				
		sed to treat constipation).				
		ermittently disoriented.				
	- The resident was into	errinterity disorierited.				
	Review of Resident #					
	revealed medication	orders as follows:				
	-A hospital summary	report dated 11/26/18 with a				
	new medication order	r for Humalog 4 units three				
	times daily (long-actir	ng human insulin used to				
	, , ,	ler to increase Lantus to 14				
		he bedtime administration to				
	morning administration					
		of subsequent order that				
	changed Humalog to	3 units three times daily.				
	Review of Resident #	1's hospital discharge				
		uested by the surveyor)				
	dated 12/07/18 revea					
		ought to the emergency				
		m due to "drug overdose."				
		ccidentally administered				
	another residents me	dications."				
	-Facility staff verbally	informed the medications				

Division of Health Service Regulation

STATE FORM B6WC11 If continuation sheet 7 of 26

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		HAL068025	B. WING		12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
		405 SMI	TH LEVEL ROAD	·		
THE STRATFORD CHAP			HILL, NC 27516			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				,		
D 358	Continued From page	e 7	D 358			
	accidentally administe	ered to Resident #1				
		20mg (used to treat acid				
		4mg (used to relax the				
	muscle in the prostate	e and bladder), tizanidine				
	4mg (used to treat sp	asticity and relax muscle				
		used to thin the blood),				
		ed to soften stool), and				
	• .	used to treat nerve pain).				
		esident #1 complained of				
		ggish and staff reported the				
	resident was withdray					
	"tired."	partment Resident #1 was				
		ot administered his own				
	medications this morr					
		d sugar was over 350, due				
		tting his morning dose of				
	Lantus."	3				
	Review of Resident #	1's December 2018				
		Administration Records				
	(eMARs) revealed:					
	-Medication schedule					
	documented as admir	5 units once daily at 7:00 am				
	was printed on the el	•				
	•	nted administered daily at				
	7:00 am from 12/01/1	_				
		wing medications was				
	printed on the eMARs	•				
	-Metformin 500mg on	ce daily at 8:00 am,				
	·	ng three times at 8:00 am,				
		ily, daily-vite once daily at				
		e 500mg twice daily at 8:00				
		three times daily at 8:00 am				
	•	05/18), Humalog 3 units daily				
		m (started on 12/06/18),				
	vitamin D3 1,000 unit	•				
	-Documentation all the above medications were		1			

administered on 12/07/18 at 7:00 am or 8:00 am.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		С	
		HAL068025			12/20/	/2018
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
THE STRA	ATFORD		LEVEL ROAD ILL, NC 27516			
	CLIMMAN DV CT		·			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 8	D 358			
	of medication or medion the eMARs or in R					
	Review of Resident #1's roommate (Resident #2) December 2018 eMARs revealed on 12/07/18 morning medications documented as administered to Resident #1 included aspirin 81mg, ciprofloxacin 250mg, duloxetine 30mg (used to treat depression), gabapentin 1200mg, omeprazole 20mg, tamsulosin 0.4mg, tizanidine					
	4mg and Oxycodone 30mg (used to treat pain). Interview with Resident #1's primary care practitioner (PCP) on 12/19/18 at 11:44 am revealed: -On 12/07/18 at 4:47 pm the Memory Care Unit Coordinator (MCC) reported Resident #1 was administered his roommate's medications, which included psychotropic medications. -The resident was feeling lethargic. -The staff was advised to immediately send Resident #1 to emergency department.					
Telephone interview with Resident #1's Guardian on 12/19/18 at 12:40 pm revealed: -The facility staff called him after 5:00 pm on 12/07/18 to inform him that Resident #1 was going to the hospital because he was administered the wrong medications. -The facility staff did not tell him the name of the medications administered, but informed him that Resident #1 was not acting at baseline. -When he arrived at the hospital Resident #1 was tired and sleepy. -Resident #1 was observed at the hospital for close to 3 hours and then discharged back to the facility. -The hospital gave the resident insulin due his						

Division of Health Service Regulation

blood sugar being high.

STATE FORM B6WC11 If continuation sheet 9 of 26

OTATEMENT OF DEFICIENCIES (VA) PROVIDED CURRILLED (C. I.A. (VA) MULTIPLE CONTROLLATION	
	SURVEY PLETED
	С
HAL068025 B. WING 12	/20/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE STRATEORD 405 SMITH LEVEL ROAD	
THE STRATFORD CHAPEL HILL, NC 27516	
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358 Continued From page 9 D 358	
-To his knowledge this was the first time Resident #1 was administered the wrong medications.	
Interview with Resident #1 on 12/19/18 at 4:00 pm revealed:	
-On 12/07/18 the medication aide (MA) came to the room and handed him a cup with multiple	
pillsHe had observed the number of medications	
looked to be more than he usually were	
administered, but he did not question the MA and	
took all the medications.	
-To his remembrance, he was not administered his morning Lantus.	
-He did not know his medications and trusted	
facility staff to administer the correct medications	
to himBetween 9:15 am and 9:30 am, the MA in charge	
came to the room and told him that he had been administered the wrong medications.	
-The MA said she would check on him throughout	
her shift and to let her know if he start to feel bad.	
-The only thing he recalled was being sleepy and	
having a difficult time staying awake. -He did not mention how he was feeling to	
anyone because he was unable to stay awake	
long enough to verbalize how he was feeling.	
-He slept long hours for two days and did not	
remember eating meals.	
Interview with Resident #1's roommate on	
12/19/18 at 3:55 pm revealed:	
-Around 9:00 am on 12/07/18 a MA came to the room to administer medications to him and his	
roommate.	
-He was in the bathroom when the MA came to	
the room, so the MA gave medications to his	

-When he came out of the bathroom the MA handed him a cup with multiple medications.

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		C	
HAL068025			B. WING		12/2	0/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE. ZIP CODE		
		405 SMIT	H LEVEL ROAD	,		
THE STRA	TFORD		HILL, NC 27516			
			HILL, NC 27510			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
iAO		,	170	DEFICIENCY)		
D 358	Continued From page	e 10	D 358			
	-He knew all of his mo	edications, the exact names,				
		ion times of his medications.				
		he medications in the cup				
	were not his medicati	•				
		were his medications and				
	•					
	argued with him to tal					
		ne medications and told the				
		to see the MA in charge.				
		the medications to the MA				
	that was in charge an	id snowed her the				
	medications.	bine the meedications in the				
	~	him the medications in the				
	cup were not his corre					
	_	e correct medications.				
		nt to the room and told				
		vas administered the wrong				
	medications.	-1 444 th1 -1				
		nt #1 that she was going to				
	sick.	and to let her know if he felt				
		Decident #4 a few times				
		Resident #1 a few times				
		new Resident #1 was tired				
	and sleeping more the					
	•	day and did not eat meals,				
	which was very unus					
		r time and Resident #1 was				
		had a difficult time waking				
	the resident up.					
		cation room and told the				
	second shift MA on d					
		Resident #1 and shortly				
		dent #1 to the hospital.				
	-Resident #1 slept ha					
		t time he was accidentally				
	given the wrong medi					
		go the same thing happened				
	with another MA and	he refused to take the				
	medications					

Division of Health Service Regulation

-He was concerned for other residents in the facility who did not know they were administered

STATE FORM 6899 B6WC11 If continuation sheet 11 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL068025	B. WING		C 12/20/2018
NAME OF PRO	VIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	12/20/2016
THE STRATE	-ORD	405 SMITH	I LEVEL ROAD		
THE OTTOAL		CHAPEL I	HILL, NC 27516	5	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	11	D 358		
th	ne wrong medication	S.			
Ir 3 -	Interview with the Adn 1:19 pm revealed: On 12/07/18 betweer 1ot a phone call from morning medication publication publication error involutions are the one of the facility had eMAI was in the computer for the MA who administering medication error immedication error immedication, to report locument. He, nor the staff document. He, nor the staff document. Deservation of the medication cart. The MA typed in a redecident appeared on	ninistrator on 12/19/18 at 15:00 pm and 6:00 pm he the MCC stating during the ass Resident #1 was ag medications. mediately knew of the ving Resident #1 and his a report the incident to the ming staff. Rs and the resident's photo or the MA to view before tions. tered the medications was know the residents. olicy that MAs were to " ed to document the ediately and call the vithe facility's policy. "consulted" with the MA that minded her to remember to ohoto before administering incidents quicker and umented the incident on the at #1's record. edication cart on 12/28/18 at the ere on the top of the sident's and a picture of the the screen of the computer. Is medications came up on			

Division of Health Service Regulation

STATE FORM B6WC11 If continuation sheet 12 of 26

Division o	of Health Service Regu	ulation			FORM	/ APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
						,
		HAL068025	B. WING			20/2018
		HALU00023			1 12/2	20/2016
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE, ZIP CODE		
THE STRA	TEORD	405 SMIT	H LEVEL ROAD)		
		CHAPEL	HILL, NC 27510	6		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG	, REGOLATORI GIVE	iso ibentil tino ini orani, mon,	TAG	DEFICIENCY)	WIL	
D 050			D 050			
D 358	Continued From page	2 12	D 358			
	Interview with the first	t shift MA on 12/19/18 at				
	4:51 pm revealed:					
	-The facility had two r	medications carts with				
	computers and electro	onic medication				
	administration records					
		as a problem with the				
	computer on one of the					
		em caused her to be behind				
	in administering morn	~				
		iter in the RCC's office which				
		e building, so she asked				
	-					
	•					
	were administered.	No triat the modestions				
		ations this way was not the				
	facility's policy.	,				
		ninistering medication on				
		to get the medications				
	administered as soon	as possible.				
		nt #1's roommate and the				
		s's office and told her the MA				
	•					
	•	dications were				
		ident #1 his morning				
		I he was administered the				
	another MA on duty to -She prepared the method the cups to another M rooms and administer -She signed the eMAI were administeredAdministering medical facility's policyShe was behind administered as soon -On 12/07/18 and wanted administered as soon -On 12/07/18 Resider MA came to the RCC gave the wrong medical -She looked at the medical were did not give Resident -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave the soon -She did not give Resident -She gave -She g	o help pass the medications. edications in cups and gave MA to take to residents r the medications. Rs that the medications ations this way was not the ministering medication on to get the medications as possible. Int #1's roommate and the et's office and told her the MA cations to Resident #1. edications in the cup and edications were				

medications.

wrong medications, which were his roommate's

-She did not complete a medication error report

-She did not call Resident #1's PCP or guardian.
-She checked on Resident #1 every hour for the rest of her shift to see how he was doing.
-She thought the MA that gave the wrong

or document the medication error.

STATE FORM B6WC11 If continuation sheet 13 of 26

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		С
		HAL068025	B. WING		12/20/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		405 SMI	TH LEVEL ROAD		
THE STRA	ATFORD	CHAPEL	HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	. 13	D 358		
D 330	. •		D 550		
		to call Resident #1's PCP			
	and document the err	or. ith the MA to ensure it was			
	done.	in the MA to ensure it was			
		: Resident #1 slept more			
		ht the resident was okay.			
	-Later that day, on 12	/07/18, around 5:00 pm the			
		d her to inquire about			
		told the MA about the			
	medication error.				
	Interview with a secon	nd MA on 12/20/17 at 11:05			
		ne facility for two-three			
		e MA, mostly on the third			
		six-seven days per month			
	-	with the residents and their			
	medications.				
	-On 12/07/18, there w	-			
	computers being dow				
	morning medication p	as behind in completing her			
		assist her by taking the			
	medications to the res	, ,			
	-The MA in charge pu	it the medications in cups,			
	then told her the resid	dent name and room number			
	to administer the med				
		narked, so she put Resident			
		ne hand and his roommate's			
	medications in the oth	ner nand. ocess for administering			
	medications to all the				
	-When she got to Res				
	thought the correct m				
	administered to Resid				
		nate was in the bathroom.			

-When the roommate came out of the bathroom she tried to give him the cup with the medications and he refused stating those were not his

STATE FORM 6899 B6WC11 If continuation sheet 14 of 26

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	D
		HAL068025	B. WING		C	040
		HAL068025			12/20/2	018
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		405 SMIT	H LEVEL ROAD			
THE STRA	ATFORD	CHAPEL	HILL, NC 27516	i		
	CLIMMA DV CT		·			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 358	Continued From none	- 44	D 358			
טטט ט	Continued From page	2 14	D 336			
	medications.					
	-She did not realize th	nat she had mixed the				
	medications up.					
		ate, went to the MA in charge				
		dications and confirmed the				
	medications in cup we					
	medications.	CIC INCOIDCHE # 1 3				
	-The MA gave the roo	ammate the correct				
	medications, but did r					
	anymore medications	•				
	-She did not contact F					
	Guardian,.	Nesiderit #1 S F GF Oi				
	•	umant the arror or complete				
		ument the error or complete				
		oort because she thought				
		going do the notification.				
	•	in charge was going to				
		document because it was				
	·	and she was only helping				
	out.					
		ner residents got the correct				
		residents complained their				
	medications were inco	orrect.				
		C on 12/20/18 at 12:37 pm				
	revealed:					
		m on 12/07/18 and the MA				
		er Resident #1's roommate				
		on room and told her that				
		eping hard" and he could				
	hardly wake him up.					
	-The roommate told the					
	Resident #1 was adm	inistered the wrong				
	medications.					
	-She called Resident	#1's PCP and was informed				
	to send the resident to	o the emergency				
	department.					
	•	nistrator and informed him of				
	the incident					

Division of Health Service Regulation

document the incident.

-She did not do a medication error report or

STATE FORM B6WC11 If continuation sheet 15 of 26

STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION DISJOERS SURVEY COMPLETED A BUILDING	DIVISION	n nealth Service Regu	lation				
MALOS8025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				(X2) MULTIPLE	CONSTRUCTION	' '	
NAME OF PROVIDER OR SUPPLIER THE STRATFORD SUMMARY STATEMENT OF DEPCINCISES (A05 SMITH LEVEL ROAD CHAPPEL HILL, NC 27516 CHAPPEL PROVIDER SPAN OF CORRECTION (PROVIDER) SUMMARY STATEMENT OF DEPCINCISES (EACH COMPACT HILL), NC 27516 D 358 Continued From page 15 -She told the MA on the second shift to do the error report and document the incident. Attempt interview on 12/20/18 at 10:50 am with the second shift MA was not successful. 2. Review of Resident #4's current FLZ dated (D9/07/18 revealed an order for Novolog 100 units/ml, inject 5 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 10/24/18 revealed an order for Novolog 100 units/ml, inject 7 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 10/31/18 revealed an order for Novolog 100 units/ml, inject 5 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 10/31/18 revealed an order for Novolog 100 units/ml, inject 5 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 10/31/18 revealed an order for Novolog 100 units/ml, inject 5 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 10/31/18 revealed an order for Novolog 100 units/ml, inject 5 units subcutaneously three times a day with meals. Review of Resident #4's subsequent order dated 12/05/18 revealed an order for Novolog 100 units/ml, inject 5 units subcutaneously three times a day with meals. Review of the October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog 100 units/ml, inject 5 units subcutaneously three times a day with meals.	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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CHAPEL HILL, NC 27516 (A4) (D)	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
CHAPEL HILL, NC 27516 (A4) (D)			405 SMITH	LEVEL ROAD)		
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Administration Record (eMAR) revealed: -There was an entry for Novolog 100 unit/ml, inject 5 units subcutaneously three times a day		,					
-There was an entry for Novolog 100 unit/ml, inject 5 units subcutaneously three times a day		Review of the Octobe	er 2018 electronic Medication				
-There was an entry for Novolog 100 unit/ml, inject 5 units subcutaneously three times a day		Administration Record	d (eMAR) revealed:				
inject 5 units subcutaneously three times a day							
		•	•				
6:30 pm.			a at 5.00 am, 1.00 pm and				
-Staff documented Novolog 5 units was			ovolog 5 units was				
administered from 10/17/18 at 6:30 pm through							

Division of Health Service Regulation

10/18/18 at 1:00 pm.

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL068025	B. WING		C 12/20/2018	
		TIAL SOUD 25			12/20/2010	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE STRA	TEOPD	405 SMIT	H LEVEL ROAD			
IIIL SIIV	ATT OND	CHAPEL	HILL, NC 27516	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 16	D 358			
	inject 10 units subcutafter meals scheduled 6:00 pm -Staff documented No administered from 10:10/31/18There was no entry finject 7 units subcutativith mealsThere was no entry finject 8 units subcutativith mealsResident #4's blood 575.	or Novolog 100 units/ml, neously three times a day for Novolog 100 units/ml, neously three times a day sugars ranged from 137 -				
	-There was an entry finject 10 units subcuta after meals scheduled 6:00 pmStaff documented No administered from 11There was no entry finject 8 units subcutat with mealsResident #4's blood 548. Review of the Decement -There was an entry finding the subcutant with meals.	ber 2018 eMAR revealed: for Novolog 100 units/ml, aneously three times a day d at 8:00 am, 1:00 pm, and byolog 10 units was //01/18 through 11/30/18. for Novolog 100 units/ml, neously three times a day sugars ranged from 134 - ber 2018 eMAR revealed: for Novolog 100 units/ml, aneously three times a day				
	after meals scheduled 6:00 pm. -Staff documented No administered from 12 -There was no entry f	d at 8:00 am, 1:00 pm, and				

-Resident #4's blood sugars ranged from 134 -

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Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 20125101		
		HAL068025	B. WING		C 12/20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE	
TUE OTD	NTEODD	405 SMIT	TH LEVEL ROAD		
THE STRA	AIFORD	CHAPEL	HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	: 17	D 358		
	568.				
	12/20/18 at 5:00 pm r -MAs could fax new or -MAs did not have the the eMARShe thought the Res (RCC) had the ability eMARShe thought the RCC -She was not sure whey -She did not know Re for 10 units of Novolo and November were i	rders to the pharmacy. e ability to change orders on ident Care Coordinator to change orders on the C completed eMAR audits. at the eMAR audit included. sident #4's eMAR entries g for the months of October			
	revealed: -She did not know Reincorrect amount of Nthrough December 20 -The Novolog orders system by the pharma-She rejected the Nov 10/24/18, and 10/31/1-She manually entere 10/18/18 for 10 units mealsShe did not know whentries and manually order.	were entered into the eMAR acy. volog entries from 10/17/18,			

-By the end of each week every resident in the building had been audited. -During audits she reviewed medications on hand, expired medications, and compared the

physician's orders to the eMAR.

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Division c	of Health Service Regu	ulation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	≣TED
					l c	
		HAL068025	B. WING		1	, 0/2018
		1			1	0/2010
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE		
THE STRA	ATFORD		TH LEVEL ROAD			
		CHAPEL	HILL, NC 27516			
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
	ı			DEFICIENCY)		ı
D 358	Continued From page		D 358			
D 000	. •					i
		orrect Novolog entries during				
	the audit.					i
	Lintamilare with the De	-iI Oliniaal Director on				i
	12/20/18 at 5:30 pm r	egional Clinical Director on				
		ne Novolog entries from				
	10/17/18, 10/24/18, a	•				
		hy the RCC rejected the				
	Novolog entries.					
	_	entered a Novolog order on				
		three times a day with				
	meals.					
		rejected it did not show up				
	on the eMAR.	manually entered by the				i
		manually entered by the macy would not be able to				i
	view it.	flacy would flot be able to				
	VICW IL.					ı
	Interview with the Adı	ministrator on 12/20/18 at				
	5:45 pm reveled:					
		sident #4 was receiving the				i
		Novolog from 10/18/18				ı
	through 12/05/18.	" Listhy DOOs				i
		its were completed by RCCs				i
	everyday. -The incorrect Novolc	og order should have been				i
	caught during medica	•				i
		Administrator were allowed				ı
		d enter orders in the eMAR				i
	system.					ı
						i
		ent #4 on 12/20/18 at 6:00				i
	pm revealed:	hat insulin about and				i
	how many units she w	hat insulin she received and				i
	_	Il medications including				i
	insulin.	ii iiicaicationo incidante				i
	i		I .			

Telephone interview with Resident #4's Primary Care Practitioner on 12/20/18 at revealed:

STATE FORM 6899 B6WC11 If continuation sheet 19 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
					_ c	;
		HAL068025	B. WING		12/2	0/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE STRA	TFORD		LEVEL ROAD ILL, NC 27516			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
D 358	Continued From page	e 19	D 358			
	Novolog 10 units thre since 10/18/18. -It was his intention for increased over time. -The staff had not cal Novolog was adminis amount from October 2018. -Administering an incrinsulin could cause hylle was not concerned administered an increfrom October 2018 the because her blood su	tered at the incorrect 2018 through December reased amount of Novolog ypoglycemia. ed Resident #4 was ased amount of Novolog rough December 2018				
	5 sampled residents radministered his room resulted in the resident room and administerin Novolog placed Resident hypoglycemia. The famedications were addetrimental to the heat residents and constitute. The facility provided at 12/19/18 in accordance.	cility's failure to assure ninistered as ordered was				
	3, 2019.	IOT EXCEED FEBRUARY				
D 366	10A NCAC 13F .1004 Administration	(i) Medication	D 366			

Division of Health Service Regulation

STATE FORM B6WC11 If continuation sheet 20 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BUILDING: _		
		HAL068025	B. WING		C 12/20/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	re. ZIP CODE	-
			H LEVEL ROAD		
THE STRA	ATFORD		HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 366	(i) The recording of the medication administration staff person who adminmediately following medication to the resistance of the recording of the re	he administration on the ation record shall be by the inisters the medication administration of the ident and observation of the ing the medication and prior of another resident's	D 366		
	facility failed to assure who prepared the me observed Resident #	and record reviews, the e the medication aide (MA) dications for administration 1 ingest his medications ent being administered his			
	allergic rhinitis, atrial mellitus, esophageal and coronary artery degenerationPhysician's orders for Lantus 5 units at bedinsulin used to treat dinsulin used to treat dinsulin used to treat day (use 81mg once a day (us acetaminophen 500m treat pain and fever), daily (used to lower by vitamin once daily (vitamin once dail	myocardial infarction, flutter, type II diabetes stricture, hyperlipidemia,			

Division of Health Service Regulation

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Division o	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLET	
		HAL068025	B. WING		C 12/20	/2018
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
THE STRA	ATEODD	405 SMIT	TH LEVEL ROAD			
INE SIKA	(IFORD	CHAPEL	HILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 366	Continued From page		D 366			
		sed to treat constipation). ermittently disoriented.				
	dated 12/07/18 revea -Resident #1 was bro department at 6:00 pr -Resident #1 was "ac another resident's me -The resident was not medications this morr -Resident #1's "blood the resident not gettin Lantus." Review of Resident #	brught to the emergency m due to "drug overdose." ccidentally administered edications." t administered his own ning. I sugar was over 350, due to ng his morning dose of edications."				
	documented as admir medication aide (MA)	nistered 12/07/18 by the in charge.				
	was printed on the eN	5 units once daily at 7:00 am MARs. nted administered daily at				
	7:00 am from 12/01/1	8 through 12/1918. wing medications was				
	-Metformin 500mg on acetaminophen 500m	nce daily at 8:00 am, ng three times at 8:00 am,				
	8:00 am, fiber laxative	aily, daily-vite once daily at e 500mg twice daily at 8:00 three times daily at 8:00 am				
	(discontinued on 12/0 three times at 8:00am	05/18), Humalog 3 units daily n (started on 12/06/18),				
		I the above medications				

8:00 am.

-There was no documentation of missed dosages of medication or medication errors documented

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DIVISION C	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			_	· · · · · · · · · · · · · · · · · · ·		
			D WING	D WING		;
		HAL068025	B. WING		12/2	0/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			I LEVEL ROAD	,		
THE STRA	ATFORD					
		CHAPEL I	HILL, NC 27516	j		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG		200 IDENTIFICATION OF CHARACTERS	TAG	DEFICIENCY)	IIAI L	
			+			
D 366	Continued From page	e 22	D 366			
	on the eMARs or in R	lesident #1's record.				
ļ	Interview with Reside					
ļ		12/19/18 at 11:44 am				
	revealed:					
ļ		pm the Memory Care Unit				
	, , ,	alled and told the PCP that				
	_	edication pass Resident #1				
		roommate's medications,				
	which included psych					
		icility staff did not administer				
	Resident #1 his morn	ing medications.				
	l <u>.</u>					ı
		ent #1 on 12/19/18 at 4:00				
	pm revealed:					
	-On 12/07/18 he was					
	roommates medicatio					
		is morning medications on				
	12/07/18.					
	-He did not receive hi	s insulin injection on				
	12/07/18.					
		nim why she did not give him				
		nedications, but he assumed				
		d already been administered				
	his roommate's medic	cations.				
	l					ı
	Interview with Reside					
	12/19/18 at 3:55 pm r					
		mmate (Resident #1) was				
	administered his med					
		formed Resident #1 he was				ı
		ng medications, but did not				ı
	give Resident #1 his i	usual morning medications.				ı
	Interview with the fire	t shift MA on 12/19/18 at				ı
	4:51 pm revealed:	t Shift MA OH 12/19/10 at				
		epared the medications in				
	I					
ļ	cups and gave the cu	ips to another MA to	-			

Division of Health Service Regulation

administer the medications to the residents. -She signed the eMARs that the medications

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	Y
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	
C C	
HAL068025 B. WING 12/20/201	18
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
405 SMITH LEVEL ROAD	
THE STRATFORD CHAPEL HILL, NC 27516	
	(X5)
	MPLETE DATE
DEFICIENCY)	
D 366 Continued From page 23 D 366	
were administered.	
-Administering medications this way was not the	
facility's policy, and she had never administered	
medications this way.	
-She was behind administering medications on	
12/07/18 and wanted to get the medications	
administered as soon as possible.	
-On 12/07/18 Resident #1 was administered his	
roommate's medication and was not administered	
his own medications.	
-She did not document on the eMAR to reflect	
Resident #1's medications were not administered.	
-She did not have a reason why she did not	
document accurately on the eMARs.	
Interview with a second MA on 12/20/17 at 11:05	
am revealed:	
-On 12/07/18, she helped the MA in charge	
administer morning medications.	
-The MA in charge put the medications in cups,	
then told her the resident name and room number	
to administer the medications.	
-She administered Resident #1 the wrong	
medications.	
-She did not know what was documented on the	
eMARs, because the MA that put the medications	
in the cup signed the eMARs.	
-To her knowledge Resident #1 was not	
administered his morning medication on	
12/07/18.	
Interview with the Administrator on 12/19/18 at	
3:19 pm revealed:	
-The MA in charge immediately knew of the	
medication error involving Resident #1 and his	
roommate.	
-The MA was not supposed to document on the	
eMARs as if residents' medications were not	
administered.	

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-He had not checked the eMARs to ensure the

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:									
					С						
		HAL068025	B. WING		12/20/2018						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
THE STRATEORD 405 SMITH LEVEL ROAD											
THE STRATFORD CHAPEL HILL, NC 27516											
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE						
D 366	Continued From page 24		D 366								
	MA had not documented Resident #1's medications were administered on 12/07/18 at 8:00am. -He, nor the staff documented the incident on the eMARs or in Resident #1's record. Interview with the MCC on 12/20/18 at 12:37 pm revealed: -Resident #1's roommate told the second shift MA that Resident #1 was not feeling well because he was administered the wrong medications. -She called the MA and found out Resident #1 was not administered his morning medications, but his roommate's medications. -The MA should have documented the error and completed a medication error report.										
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:		D912								
	facility failed to assure and services which w and in compliance wit	and record reviews, the e residents received care ere adequate, appropriate the federal and state laws and related to health care and ation.									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
		HAL068025	B. WING_		12	C (20/2018				
NAME OF PROVIDER OR SUPPLIER B. WING										
THE STRATFORD 405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516										
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE				
D912	1. Based on observatoreviews, the facility fat follow-up with the physampled residents (Radministered his roor feeling lethargic, slee 0273, 10A NCAC 13FA2 Violation).] 2. Based on observatoreviews, the facility fat medications as order residents (#1 and #4) receiving his roommat #1) and a resident recoif insulin for two months.	tions, interviews, and record ailed to assure immediate ysician regarding 1 of 5 tesident #1) being mmate's medication and app and weak. [Refer to Tag = .0902(b) Health Care (Type tions, interviews, and record ailed to administer ed for 2 of 5 sampled or related to a resident ate's medication (Resident ceiving the incorrect dosage aths (Resident #4). [Refer to C 13F .1004(a) Medication	D912							

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