Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011133	A. BUILDING: _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASE SAMARITAN ASSISTED LIVING	30 DALEA DRIVE 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 and complaint investigation on 12/13/18 to 12/14/18. The complaint investigation was initiated by the Buncombe County Department of Social Services on 11/15/18.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the building and all fire safety and electrical equipment were maintained in a safe condition related to the use of extension cords in three resident rooms. The findings are: Observation during the initial tour on 12/13/18 from 10:02am to 10:40am revealed: -There were Christmas lights, a fan, and a coffeepot plugged into two extension cords which were plugged into an electrical wall outlet in one resident's room. -There were Christmas lights plugged into an extension cord which was plugged into an electrical wall outlet in a second resident room. Interview with two residents on 12/13/18 at 10:02am and 10:40am revealed: -The residents had purchased the extension	D 105	Facility staff unaware that extension cords had been purchased and were being used by residents. Removed immediately and explained to residents that they were not allowed per the fire marshall. Maintenance supervisor to monitor resident rooms for hazardous items, such as extension cords. 12/14/18	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

SKay — facility director — 1/9/19

Reviewed and accepted 1/18/19 RP

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D 105	Continued From page 1 cords from a local store. -No one had told the residents extension cords could not be used. Interview on 12/13/18 at 2:10pm with the Executive Director revealed: -She knew extension cords should not be used. -Some residents buy extension cords. Interview on 12/14/18 at 10:00am with the Maintenance Director revealed: -He did not know how the residents got the extension cords. -When he saw extension cords in the facility, he removed them. Interview on 12/14/18 at 1:30pm the local Fire Marshall revealed: -The use of extension cords could cause the electrical circuit to overload. -Extension cords were a fire hazard and should not be used.	D 105		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to protect all food from contamination related to improper thawing of meat and a dirty stove.	D 283	Facility to ensure that all dietary staff members are aware of proper thawing techniques and following them. Cleaning schedule to be followed by dietary staff and monitored by Director and other management staff. 1/9/19	

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D 283	Continued From page 2 The findings are: Observation of the kitchen area on 12/13/18 at 11:20am revealed: -There were 2 packs of wrapped ham completely submerged in water in the first sink of a three compartment sink. -There was no water flowing into the sink. -There was a large amount of black greasy buildup surrounding the burners of the stove. -There were brown and white dried drips along the front of the oven door. Observation of the kitchen area on 12/13/18 at 1:56pm revealed: -There were approximately 40 pieces of unwrapped raw chicken completely submerged in water in the first sink of a three compartment sink. -There was no water flowing into into the sink. Interview with the Cook on 12/13/18 at 2:00pm revealed: -He had worked at the facility in the past and was rehired to start 12/13/18. -He had been trained by "other cooks" in the facility in the past. -He had not received Safe-Serve training. -The Cook had forgotten to take the ham out of the freezer on the evening of 12/12/18. -He always submerged frozen meat in water or left it in the refrigerator to thaw out. -There was a cleaning schedule posted "but this is my first day back (to work)". Observation of a kitchen cleaning schedule posted on a wall on 12/13/18 at 2:01pm revealed the stove and grill top were to be cleaned on Thursdays.	D 283		

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D 283	Continued From page 3 Interview with the Executive Director of 12/13/18 at 2:10pm revealed: -The Cook had worked in the facility in the past and had been trained. -The meat should have been left in the refrigerator to thaw or placed, in it's original packaging, in a bowl of water with a continuous flow of cold running water over it. -She expected the cleaning schedule to be followed and the kitchen cleaned as needed.	D 283		
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 for 6 of 6 sampled residents related to insulin (Resident #1),	D 358	Facility to ensure that all medications are administered according to the most current physician orders. Medication staff attended mandatory Diabetes Training the first week of December 2018, after the Director was made aware of the issue by AHS during visit. Staff meeting on 12/19/18 held to address and further review insulin administration and documentation. Resident Care Coordinator (RCC) and Lead Med Tech to monitor insulin documentation. Any staff member continuing to document incorrectly to be written up and could	

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D 358	Continued From page 4 omeprazole and doxycycline (Resident #2), insulin (Resident #3), eye drops (Resident #4), vitamin D3 (Resident #5), and vitamin D2 and vitamin D3 (Resident #6). The findings are: 1. Review of Resident #1's current FL2 dated 04/17/18 revealed: -Diagnoses included diabetes. -There was a physician order to check finger stick blood sugars (FSBS) four times daily. Review of physician orders dated 10/01/18 revealed there was an order for Fiasp (treats high blood glucose) Sliding Scale Insulin (SSI) four times daily; FSBS <70 = 0 units, 70 - 150 = 0 units, 151-200 = 1 unit, 201 -250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 6 units. Review of Resident #1's October 2018 Medication Administration Record (MAR) revealed: -There was a handwritten entry for Fiasp SSI four times daily after meals, for FSBS <70 = 0 units, 70-150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 6 units, with scheduled administrations times of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -On 10/16/18 at 4:00pm, the FSBS was 238 and 4 units of insulin was documented as administered. Review of a physician clarification order dated 11/05/18 revealed Fiasp SSI, for FSBS <70 = 0 units, 70-150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, >400 = 6 units.	D 358	potentially lose medication administration privelages. Director to monitor a sampling of residents weekly using attached form A. RCC and Lead MT to continue to audit med carts weekly checking for any items that need to be ordered including eye drops, PRN medications, etc. During this audit, staff to also check for any D/C'ed medication. Director provided training to RCC and Lead MT concerning physician order processing and clarification. Director to continue to monitor this area weekly for 4 weeks then monthly if improving per POP. Lead MT created system along with PCP so that all orders circulate back to the PCP after being processed for review at weekly visit. 1/9/19	

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D 358	Continued From page 5 Review of Resident #1's November 2018 MAR revealed: -There was a handwritten entry for Fiasp SSI four times daily after meals, for FSBS <70 = 0 units, 70-150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251 - 300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, >400 = 6 units, with administration times of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -On 11/05/18 at 8:00am, the FSBS was 209 and 3 units of insulin was documented as administered. -On 11/05/18 at 8:00pm, the FSBS was 196 and 2 units of insulin was documented as administered. -On 11/06/18 at 12:00pm, the FSBS was 161 and 2 units of insulin was documented as administered. -On 11/06/18 at 8:00pm, the FSBS was 228 and 3 units of insulin was documented as administered. -On 11/10/18 at 4:00pm, the FSBS was 284 and 4 units of insulin was documented as administered. -On 11/11/18 at 12:00pm, the FSBS was 247 and 3 units of insulin was documented as administered. -On 11/17/18 at 8:00am, the FSBS was 236 and 3 units of insulin was documented as administered. -On 11/21/18 at 8:00pm, the FSBS was 214 and 3 units of insulin was documented as administered. -On 11/27/18 at 8:00pm, the FSBS was 174 and 3 units of insulin was documented as administered. Review of Resident #1's December 2018 MAR revealed: -There was a handwritten entry for Fiasp SSI four	D 358		

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D 358	Continued From page 6 times daily after meals, for FSBS <70 = 0 units, 70-150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251 - 300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, <400 = 6 units, with administration times of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -On 12/08/18 at 4:00pm, the FSBS was 156 and 0 units of insulin was documented as administered. Review of a laboratory report for Resident #1 dated 11/05/18 revealed a hemoglobin A1C (blood test that measures a three month average of blood glucose) level was 7.3. [The American Diabetes Association recommends a hemoglobin A1C target level of less than 7%. (The A1C test gives you a picture of your average blood glucose [blood sugar] control for the past 2 to 3 months. The results give you a good idea of how well the resident's diabetes treatment plan is working).] Interview on 12/14/18 at 9:55am with the facility's contracted pharmacy revealed: -The pharmacy had received an order for Fiasp SSI four times daily before meals, FSBS 0-150 give 0 units, 151 -200 give 1 unit, 201-250 give 2 units, 251-300 give 3 units, 301-350 give 4 units, 351-400 give 5 units, >400 give 6 units. -The order was dated 11/05/18. -The pharmacy had no other Fiasp SSI orders. Refer to the interview on 12/14/18 at 9:10am with the Resident Care Coordinator. Refer to the interview on 12/14/18 at 10:10am with a first shift Medication Aide. Refer to the telephone interview on 12/14/18 at 10:55am with the Physician's Nurse Practioner.	D 358		

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D 358	Continued From page 7 Refer to the interview on 12/14/18 at 1:00pm with the Executive Director. Refer to the review of the facility's Medication Administration Policy and Procedure. 2. Review of Resident #3's current FL2 dated 01/19/18 revealed: -Diagnoses included diabetes with neurological complications, hyperlipidemia, seizures, chronic pain syndrome, and major depressive disorder. -There was a physician order for Novolog (treats high blood glucose) Sliding Scale Insulin (SSI) three times daily before meals and at bedtime; Finger Stick Blood Sugar (FSBS) 0-150 = 0 units of insulin, FSBS 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units. Review of Resident #3's October Medication Administration Record (MAR) revealed: -There was an entry for Novolog SSI three times daily before meals and at bedtime; FSBS 0-150 = 0 units, 151-200 = 1 units, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units of insulin with scheduled administration times of 8:00am, 12:00pm, 5:00pm and 8:00pm. -On 10/02/18 at 8:00pm, the FSBS was 390 and 5 units of insulin was documented as administered. -On 10/05/18 at 5:00pm, the FSBS was 410 and 7 units of insulin was documented as administered. -On 10/07/18 at 5:00pm, the FSBS was 318 and 7 units of insulin was documented as administered. -On 10/09/18 at 12:00pm, the FSBS was 149 and 1 units of insulin was documented as administered. -On 10/11/18 at 5:00pm, the FSBS was 378 and	D 358		

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D 358	Continued From page 8 2 units of insulin was documented as administered. -On 10/14/18 at 8:00am, the FSBS was 175 and 0 units of insulin was documented as administered. -On 10/17/18 at 5:00pm, the FSBS was 472 and 7 units of insulin was documented as administered. -On 10/19/18 at 5:00pm, the FSBS was 406 and 7 units of insulin was documented as administered. -On 10/21/18 at 8:00am, the FSBS was 410 and 7 units of insulin was documented as administered. -On 10/26/18 at 5:00pm, the FSBS was 209 and 3 units of insulin was documented as administered. -On 10/27/18 at 12:00pm, the FSBS was 162 and 2 units of insulin was documented as administered. -On 10/28/18 at 5:00pm, the FSBS was 109 and 1 unit of insulin was documented as administered. -On 10/29/18 at 8:00pm, the FSBS was 169 and 2 units of insulin was documented as administered. -On 10/30/18 at 5:00pm, the FSBS was 416 and 7 units of insulin was documented as administered. Review of Resident #3's November 2018 MAR revealed: -There was an entry for Novolog SSI three times daily before meals and at bedtime; FSBS 0-150 = 0 units, 151-200 = 1 units, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units of insulin with scheduled administration times of 8:00am, 12:00pm, 5:00pm and 8:00pm. -On 11/03/18 at 12:00pm, the FSBS was 211 and 9 units of insulin was documented as	D 358		

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D 358	Continued From page 9 administered. -On 11/03/18 at 8:00pm, the FSBS was 279 and 0 units of insulin was documented as administered. -On 11/04/18 at 8:00am, the FSBS was 481 and 7 units of insulin was documented as administered. -On 11/09/18 at 5:00pm, the FSBS was 136 and 2 units of insulin was documented as administered. -On 11/10/18 at 8:00am, the FSBS was 372 and 6 units of insulin was documented as administered. -On 11/11/18 at 8:00am, the FSBS was 178 and 2 units of insulin was documented as administered. -On 11/11/18 at 12:00pm, the FSBS was 229 and 4 units of insulin was documented as administered. -On 11/14/18 at 8:00am, the FSBS was 555 and 7 units of insulin was documented as administered. -On 11/23/18 at 5:00pm, the FSBS was 154 and 2 units of insulin was documented as administered. -On 11/25/18 at 12:00pm, the FSBS was 364 and 10 units of insulin was documented as administered. -On 11/28/18 at 12:00pm, the FSBS was 384 and 4 units of insulin was documented as administered. -On 11/28/18 at 5:00pm, the FSBS was 354 and 6 units of insulin was documented as administered. -On 11/28/18 at 8:00pm, the FSBS was 55 and 1 unit of insulin was documented as administered. -On 11/30/18 at 5:00pm, the FSBS was 365 and 5 units of insulin was documented as administered. Review of Resident #3's December 2018 MAR	D 358		

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D 358	Continued From page 10 revealed: -There was an entry for Novolog SSI three times daily before meals and at bedtime; FSBS 0-150 = 0 units, 151-200 = 1 units, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units of insulin with scheduled administration times of 8:00am, 12:00pm, 5:00pm and 8:00pm. -On 12/03/18 at 5:00pm, the FSBS was 285 and 4 units of insulin was documented as administered. -On 12/08/18 at 8:00am, the FSBS was 294 and 4 units of insulin was documented as administered. -On 12/09/18 at 8:00am, the FSBS was 355 and 6 units of insulin was documented as administered. -On 12/09/18 at 12:00pm, the FSBS was 109 and 1 unit of insulin was documented as administered. -On 12/09/18 at 5:00pm, the FSBS was 225 and 1 unit of insulin was documented as administered. -On 12/09/18 at 8:00pm, the FSBS was 270 and 4 units of insulin was documented as administered. Refer to the interview on on 12/14/18 at 9:10am with the Resident Care Coordinator. Refer to the interview on 12/14/18 at 10:10am with a first shift Medication Aide. Refer to the telephone interview on 12/14/18 at 10:55am with the Physician's Nurse Practitioner. Refer to the interview on 12/14/18 at 1:00pm with the Executive Director. Refer to the review of the facility's Medication Administration Policy and Procedure.	D 358		

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D 358	Continued From page 11 3. Review of Resident #4's current FL2 dated 01/21/18 revealed: -Diagnoses included dementia and depression. -There was a physician order for Refresh tears (treats dry eyes) 1 drop in each eye three times daily. Review of Resident #4's October, November, and December 2018 Medication Administration Record revealed the eye drops were documented as administered three times daily. Observation on 12/14/18 at 3:30pm of Resident #4's medications on hand revealed an unopened bottle of eye drops with a pharmacy fill date of 11/12/18. Interview on 12/14/18 at 3:30pm with the Medication Aide revealed: -The eye drops had been administered three times daily. -They had just run out of the last bottle of eye drops this morning (12/14/18). Telephone interview on 11/14/18 at 3:49pm with the facility's contracted pharmacy revealed: -The first bottle of Refresh eye drops was delivered to the facility on 07/16/18. -A second bottle was delivered on 08/02/18. -A third bottle was delivered on 11/12/18. -Each bottle was 15ml and was a 50 day supply if administered three times daily. -The doses from the second bottle of eye drops should have run out by 10/24/18. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.	D 358		

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D 358	Continued From page 12 Refer to the review of the facility's Medication Administration Policy and Procedure. 4. Review of Resident #2's current FL2 dated 05/02/18 revealed diagnoses included chronic obstructive pulmonary disease (COPD) exacerbation. a. Review of Resident #2's record revealed a physician's order for Resident #2 dated 05/06/18 for omeprazole 20mg take 1 capsule daily before breakfast (used to treat acid reflux). Review of Resident #2's primary care physician's (PCP) visit summary dated 10/03/18 revealed: -Resident #2 had a diagnosis for gastroesophageal reflux disease (GERD). -There was a physician's order to discontinue omeprazole 20mg dated on 07/26/18. Review of Resident #2's October 2018 Medication Administration Record (MAR) revealed: -There was a computer generated order for omeprazole 20mg take 1 capsule daily before breakfast scheduled to be administered at 8:00am. -Omeprazole was documented as administered daily from 10/01/18 to 10/31/18. Review of Resident #2's November 2018 MAR revealed: -There was a computer generated order for omeprazole 20mg take 1 capsule daily before breakfast scheduled to be administered at 8:00am. -Omeprazole was documented as administered daily from 11/01/18 to 11/30/18. Review of Resident #2's December 2018 MAR	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 13 revealed: -There was a computer generated order for omeprazole 20mg take 1 capsule daily before breakfast scheduled to be administered at 8:00am. -Omeprazole was documented as administered daily from 12/01/18 to 12/13/18. Observation of Resident #2's medication on hand on 12/14/18 at 10:00am revealed a medication card containing 30 capsules of omeprazole 20mg dispensed on 11/26/18 was available to be administered. Interview with Resident #2 on 12/14/18 at 4:35pm revealed: -He thought he was supposed to be taking omeprazole. -He did not know omeprazole had been discontinued in July 2018. Telephone interview with the facility's contracted pharmacy on 12/14/18 at 10:14am and 4:44pm revealed: -Omeprazole was a cycled medication for Resident #2 and automatically dispensed monthly. -A 30 day supply of omeprazole was dispensed to Resident #2 on 09/25/18, 10/24/18, and 11/26/18. -The pharmacy did not have a discontinuation order for omeprazole. -The facility or the physician was responsible for faxing medication orders to the pharmacy. -The pharmacy would make corrections on the MARs once they received a signed physician order. -The facility should be sending corrections to the MAR to the pharmacy monthly. Interview with the medication aide (MA) on	D 358		

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D 358	Continued From page 14 12/14/18 at 8:10am revealed: -She did not know that Resident #2 had a discontinuation order for omeprazole. -She and the Resident Care Coordinator (RCC) were responsible for processing new orders. -She was responsible for faxing medication orders to the pharmacy once the orders were received by the facility. -She was responsible for making the changes to the MAR for new medication orders. -She was responsible for auditing the medication cart and the MARs monthly when the "cycle fill was delivered from the pharmacy." -The medications on the medication cart were compared to the MARs during the audit process. -The facility's contracted provider was responsible for sending medication orders and visit summaries to the facility. Interview with the RCC on 12/14/18 at 7:51am revealed: -She and the MA were responsible for auditing the medication carts and MARs weekly. -The MARs were compared to the previous months MARs at the end of each month. -The medications on the medication cart were compared to the MARs monthly when the pharmacy delivered the medications on "cycle fill." -The MA was responsible for processing new orders for all male residents in the facility. -The MA was responsible for faxing new orders to the pharmacy and updating the MARs. Telephone interview with Resident #2's primary care physician (PCP) on 12/14/18 at 10:55am revealed: -She had discontinued omeprazole for Resident #2 on 07/26/18. -Resident #2 should not be taking omeprazole for	D 358		

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D 358	Continued From page 15 an extended period of time. -Resident #2 had an increased risk of vitamin D deficiency, osteoporosis, and Clostridium Difficile infection (bacterial infection in the intestines that cases severe diarrhea) due to receiving omeprazole for an extended period of time. Refer to interview with the Executive Director on 12/14/18 at 11:39am. b. Review of Resident #2's record revealed a physician's order dated 10/10/18 for doxycycline take 1 capsule twice daily with food and water (used to treat skin infections). Review of Resident #2's record revealed a physician's order dated 11/28/18 from Resident #2's dermatologist for doxycycline 1 capsule daily. Review of Resident #2's November 2018 Medication Administration Record (MAR) revealed: -There was a computer generated entry for doxycycline take 1 capsule twice daily with food and water scheduled to be administered at 8:00am and 5:00pm. -Doxycycline was documented as administered twice daily from 11/01/18 to 11/30/18. Review of Resident #2's December 2018 MAR revealed: -There was a computer generated entry for doxycycline take 1 capsule twice daily with food and water scheduled to be administered at 8:00am and 5:00pm. -Doxycycline was documented as administered twice daily from 12/01/18 to 12/13/18. Observation of Resident #2's medication on hand on 12/14/18 at 10:00am revealed:	D 358		

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D 358	Continued From page 16 -There was a medication card containing 8 capsules of doxycycline dispensed to Resident #2 on 11/14/18 available to be administered. -A small sticker with red writing was attached to the prescription label covering the directions with instructions "directions changed refer to chart." Telephone interview with the facility's contracted pharmacy on 12/14/18 at 10:14am and 4:44pm revealed: -A 30 day supply of doxycycline was dispensed to Resident #2 on 10/19/18 and 11/14/18 with the directions take 1 capsule twice daily. -A prescription was on file but never dispensed for doxycycline 100mg take 1 capsule daily dated 11/28/18. -The new prescription was not filled because it was too early for the insurance to pay for the medication. -The facility or the physician was responsible for faxing medication orders to the pharmacy. -The pharmacy would make corrections on the MARs once they received a signed physician order. -The facility should be sending corrections to the MARs to the pharmacy monthly. Interview with the medication aide (MA) on 12/14/18 at 8:10am revealed: -She did not know that Resident #2 had a physician's order changing the directions of doxycycline. -She usually worked first shift and administered the morning dose of doxycycline. -She and the Resident Care Coordinator (RCC) were responsible for processing new orders. -She was responsible for faxing medication orders to the pharmacy once the orders were received by the facility. -She was responsible for making changes to the	D 358		

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D 358	Continued From page 17 MARs when a new medication order was received. -The directions for the doxycycline should have been changed on the MAR. -She was responsible for auditing the medication cart and the MARs monthly when the "cycle fill was delivered from the pharmacy." -The medications on the medication cart was compared to the MARs during the audit process. -The facility's contracted provider was responsible for sending medication orders and visit summaries to the facility. Interview with the RCC on 12/14/18 at 7:51am revealed: -She and the MA were responsible for auditing the medication carts and MARs weekly. -The MARs were compared to the previous months MAR at the end of each month. -The medications on the medication cart were compared to the MARs monthly when the pharmacy delivered the medications on "cycle fill." -The MA was responsible for processing new orders for all male residents in the facility. -The MA was responsible for faxing new orders to the pharmacy and updating the MARs. -The MA was responsible for making changes to the MARs. Telephone interview with a nurse from Resident #2's dermatology office on 12/14/18 at 12:02pm revealed: -Resident #2's doxycycline dose was reduced at an office visit on 11/28/18. -Doxycycline was prescribed to treat Resident #2's skin rash with infected boils. -Resident #2's skin rash was stable and the dermatologist had lowered the dose of the doxycycline.	D 358		

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D 358	Continued From page 18 -The dermatologist was going to attempt to discontinue medication if Resident #2 continued to do well. -Long term use of antibiotics could increase the risk of bacterial resistance to the antibiotic. Interview with the Executive Director on 12/14/18 at 11:39am revealed: -She did not know that Resident #2's doxycycline order changed changed. -The order for doxycycline should have been processed and the change made on the MAR. Refer to interview with the Executive Director on 12/14/18 at 11:39am. 5. Review of Resident #5's current FL2 dated 05/01/18 revealed: -Diagnoses included vitamin D deficiency, anxiety, hypothyroidism, and major depressive disorder. -There was a physician's order for vitamin D3 50,000 IU take 1 capsule monthly. Review of a physician's order dated 08/16/18 revealed a discontinuation order for vitamin D2 50,000 IU and start vitamin D3 5,000 IU take 1 tablet daily. Review of Resident #5's record revealed a physician's order dated 08/23/18 to discontinue vitamin D3 5,000 IU and start vitamin D3 2,000 IU take 1 tablet daily. Review of Resident #5's October 2018 Medication Administration Record (MAR) revealed: -There was a computer generated entry for vitamin D3 2,000 IU take 1 tablet daily scheduled to be administered at 8:00am.	D 358		

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D 358	Continued From page 19 -Vitamin D3 2,000 IU was documented as discontinued on 08/24/18 and no vitamin D3 was documented as administered from 10/01/18 to 10/31/18. Review of Resident #5's November 2018 MAR revealed: -There was a computer generated entry for vitamin D3 2,000 IU take 1 tablet daily scheduled to be administered at 8:00am. -Vitamin D3 2,000 IU was documented as discontinued on 08/24/18 and no vitamin D3 was documented as administered from 11/01/18 to 11/30/18. Review of Resident #2's December 2018 MAR revealed: -There was a computer generated entry for vitamin D3 2,000 IU take 1 tablet daily scheduled to be administered at 8:00am. -Vitamin D3 2,000 IU was documented as discontinued on 08/24/18 and no vitamin D3 was documented as administered from 12/01/18 to 12/13/18. Observation of Resident #5's medication on hand on 12/14/18 at 3:00pm revealed no vitamin D3 2,000 IU was available to be administered to Resident #5. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 12/14/18 at 4:44pm revealed vitamin D3 2,000 IU was last dispensed to Resident #5 for a 30 day's supply on 08/22/18. Interview with the medication aide (MA) on 12/14/18 at 8:10am revealed: -She was responsible for processing medication orders for the female residents and the RCC was	D 358		

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D 358	Continued From page 20 responsible for the male residents. -She was responsible for faxing medication orders to the pharmacy once the orders were received by the facility. -She would make the correction on the MAR for new medication orders to take effect the following day after the medication had been delivered from the pharmacy. -The new medication order took effect when the medication was available for administration. -She was responsible for auditing the medication cart and the MARs monthly when the "cycle fill was delivered from the pharmacy." -Each medication on the medication cart was compared to the MAR during the audit process. -The facility's contracted provider was responsible for sending medication orders and visit summaries to the facility. Interview with the Resident Care Coordinator (RCC) on 12/14/18 at 7:51am revealed: -She did not know Resident #5 was supposed to be taking vitamin D3 2,000 IU. -The order to discontinue vitamin D3 5,000 IU and start vitamin D3 2,000 IU for Resident #5 was never processed. -She and the MA were responsible for auditing the medication carts and MARs weekly. -The MA was responsible for faxing new orders to the pharmacy and updating the MARs. -The MARs were compared to the previous months MAR at the end of each month. -The medications on the medication cart were compared to the MARs monthly when the pharmacy delivered the medications on "cycle fill." Interview with the Executive Director on 12/14/18 at 11:39am revealed: -The order to discontinue vitamin D3 5,000 IU	D 358		

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D 358	Continued From page 21 and start vitamin D3 2,000 IU for Resident #5 was missed and never processed. -The RCC and MA should be comparing the previous MAR to the current MAR to make sure medications are administered correctly. Attempted telephone interview with Resident #5's primary care physician on 12/14/18 at 4:28pm was unsuccessful. Refer to interview with the Executive Director on 12/14/18 at 11:39am. 6. Review of Resident #6's current FL2 dated 05/31/18 revealed: -Diagnoses included vitamin D deficiency, history of falls, and coronary artery disease. -There was a physician's order for vitamin D2 50,000 IU take 1 capsule every Thursday (supplement to replace vitamin D). Review of Resident #6's primary care physician's (PCP) visit summary dated 10/03/18 revealed: -There was a physician's order to discontinue vitamin D2 50,000 IU. -There was a physician's order to start vitamin D3 2,000 IU take daily only. Review of a physician's order dated 10/05/18 revealed vitamin D3 2,000 IU take 2 capsules daily. Review of Resident #6's October 2018 Medication Administration Record (MAR) revealed: -There was a computer generated entry for vitamin D3 2,000 IU take 2 tablets daily scheduled to be administered at 8:00am. -Vitamin D3 2,000 IU was documented as administered daily from 10/01/18 to 10/08/18	D 358		

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D 358	Continued From page 22 -Vitamin D3 2,000 IU was documented as discontinued on 10/08/18. -There was a hand written entry for vitamin D3 take 2 tablets daily scheduled to be administered at 8:00am. -Vitamin D3 2,000 IU was documented as administered daily from 10/09/18 to 10/31/18. -There was a computer generated entry for vitamin D2 50,000 IU take 1 capsule weekly on Thursday scheduled to be administered at 8:00am. -Vitamin D2 50,000 IU was documented as administered on 10/04/18, 10/11/18, 10/18/18, and 10/25/18. Review of Resident #6's November 2018 MAR revealed: -There was a computer generated entry for vitamin D3 2,000 IU take 2 tablets daily scheduled to be administered at 8:00am. -Vitamin D3 2,000 IU was documented as administered daily from 11/01/18 to 11/30/18. -There was a computer generated entry for vitamin D2 50,000 IU take 1 capsule weekly on Thursday scheduled to be administered at 8:00am. -Vitamin D2 50,000 IU was documented as administered on 11/01/18, 11/08/18, 11/15/18, 11/22/18, and 11/29/18. Review of Resident #6's December 2018 MAR revealed: -There was a computer generated entry for vitamin D3 2,000 IU take 2 tablets daily scheduled to be administered at 8:00am. -Vitamin D3 2,000 IU was documented as administered daily from 12/01/18 to 12/14/18. -There was a computer generated entry for vitamin D2 50,000 IU take 1 capsule weekly on Thursday scheduled to be administered at	D 358		

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D 358	Continued From page 23 8:00am. -Vitamin D2 50,000 IU was documented as administered on 12/06/18 and 12/13/18. Observation of Resident #6's medications on hand on 12/14/18 at 7:55am revealed: -There was a medication card with 4 capsules of vitamin D2 50,000 IU dispensed on 12/01/18 available to be administered to Resident #6. - There was a medication card with 60 tablets of vitamin D3 2,000 IU dispensed on 12/01/18 available to be administered to Resident #6. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/14/18 at 4:44pm revealed: -The pharmacy had last filled a 30 day supply of vitamin D3 2,000 IU take 1 tablet daily on 08/22/18. -The facility or the physician was responsible for faxing medication orders to the pharmacy. -The pharmacy would make corrections on the MARs once they received a signed physician order. -The facility should be sending corrections to the MARs to the pharmacy monthly. Interview with the medication aide (MA) on 12/14/18 at 8:10am revealed: -She was responsible for processing medication orders for the female residents and the RCC was responsible for the male residents. -She was responsible for auditing the medication cart and the MARs monthly when the "cycle fill was delivered from the pharmacy." -The medications in the medication cart were compared to the medications listed on the MARs. -The facility's contracted provider was responsible for sending medication orders and visit summaries to the facility.	D 358		

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D 358	Continued From page 24 -She was responsible for faxing medication orders to the pharmacy once the orders were received by the facility. -She was responsible for making corrections to the MARs when new medication orders were received. Interview with the Resident Care Coordinator (RCC) on 12/14/18 at 7:51am revealed: -She administered medications on the female hall most mornings. -She knew Resident #6 was being administered two different vitamin D medications. -She did not know Resident #6 should only be administered vitamin D 2,000 IU. -She and the MA were responsible for auditing the medication carts and MARs weekly. -The MA was responsible for faxing new orders to the pharmacy and updating the MARs. -The MARs were compared to the previous months MAR at the end of each month. -The medications on the medication cart were compared to the MARs monthly when the pharmacy delivered the medications on "cycle fill." Telephone interview with Resident #6's primary care physician (PCP) on 12/14/18 at 10:55am revealed: -She had discontinued Resident #6's vitamin D2 50,000 IU at a visit on 10/03/18 and reduced the dose to 2,000 IU daily. -She did not know Resident #6 was receiving both the vitamin D2 50,000 IU and the vitamin D3 2,000 IU. -She did not know Resident #6 had a physician's order for vitamin D2 50,000 IU weekly. -Resident #6 was at risk for vitamin D toxicity because of all the vitamin D she had received. -Vitamin D toxicity could result in constipation,	D 358		

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D 358	Continued From page 25 vomiting, decreased appetite, muscle weakness, and calcification of soft tissues. -The facility should not go by the signed MARs but by the physician orders and visit summaries to determine a resident's correct medications. Refer to interview with the Executive Director on 12/14/18 at 11:39am. Interview on 12/14/18 at 9:10am with the Resident Care Coordinator revealed: -The MAs had attended an insulin class on 12/07/18 from the pharmacy nurse. -The MAs had not read the sliding scale correctly. Interview on 12/14/18 at 10:10am with a first shift Medication Aide revealed: -She always compared her medication to the MAR "about three times". -The MAs had received diabetic training the first week in December. -She did not know how the errors had occurred. Interview on 12/14/18 at 10:55am with the Physician's Nurse Practitioner revealed: -Receiving the wrong dose of insulin put the resident at risk of hypoglycemia or hyperglycemia. -The residents should have received the correct doses of insulin as ordered. Interview with the Executive Director on 12/14/18 at 11:39am revealed: -The RCC and MA were responsible for faxing new medication orders to the pharmacy. -The RCC and MA were responsible for updating the MARs with medication changes. -The RCC and MA were responsible for auditing the medication carts weekly. -The RCC and MA were responsible for clarifying	D 358		

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	HAL011133	A. BUILDING: _____ B. WING _____	C 12/14/2018

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D 358	Continued From page 26 or correcting any problems with a medication order. Interview on 12/14/18 at 1:00pm with the Executive Director revealed: -The staff had attended "diabetic training" from the pharmacy nurse the first week of December. Review of the facility's Medication Administration Policy and Procedure revealed: -Medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practioner's orders. The facility failed to administer medications as ordered, including incorrect doses of insulin for Resident #1 which put the resident at risk of low or high blood glucose levels, medications for reflux and an antibiotic, which increased the risk of antibiotic resistance, for Resident #2, incorrect doses of insulin to Resident #3 which increased the risk of high or low blood glucose levels, eye drops for Resident #4 to prevent dry, irritated eyes, a vitamin supplement for vitamin D deficiency for Resident #5, and vitamin supplements for low blood levels for Resident #6 . The facility's failure to administer medications as ordered was detrimental to the health and welfare of the residents and constitutes a Type B Violation. The Facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/14/18. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2018	D 358		

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D 371	Continued From page 27	D 371		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure proper infection control measures were used for 1 of 10 residents (Resident #7) observed during a morning medication pass related to administering eye drops without wearing gloves and washing hands before and after administration. The findings are: Observation of the morning medication pass on 12/14/18 at 7:51am revealed: -Resident #7 received 5 oral medications and 1 eye drop. -The Resident Care Coordinator (RCC) popped Resident #7's oral medications into a medication cup. -The RCC carried the bottle of eye drops in her bare hand along with the medication cup containing the oral medications into Resident #7's room. -The RCC administered Resident #7's eye drops without wearing gloves. -Resident #7 was holding her eyes closed and the RCC used her fingers to hold Resident #7's eyelid open to administer the eye drops.	D 371	Facility will ensure that all medications are administered in accordance with Infection Control Policy. The appropriate use of gloves and hand sanitation reviewed at staff meeting on 12/29/18. 1/9/19	

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D 371	Continued From page 28 -The RCC put on gloves and checked Resident #7's fingerstick blood sugar (FSBS) after she administered the eye drops. -The RCC did sanitize her hands with an alcohol based gel after she checked Resident #7's FSBS. -The RCC did not wash her hands with soap and water before she administered medications to Resident #7, including eye drops. Observation of the medication cart on 12/14/18 at 8:01am revealed gloves were available for the RCC to wear for medication administration. Interview with Resident #7 on 12/14/18 at 2:30pm revealed: -The MAs usually wear gloves when they administered her eye drops. -The eye drops were prescribed for her dry eyes. -She was administered her eye drops every morning. Interview with the RCC on 12/14/18 at 9:27am revealed: -She had forgotten to put gloves on before she administered Resident #7's eye drops. -She knew she was supposed to wear gloves to administer eye drops. -She usually wore gloves to administer eye drops. Interview with the Administrator on 12/14/18 at 11:39am revealed: -The facility staff had received training in infection control procedures. -Training in infection control procedures was completed yearly. -The medication aides (MA) should wear gloves to administer eye drops. -The MAs should use hand sanitizer between in each resident.	D 371		

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D 371	Continued From page 29 Review of the facility's Medication Administration Policy and Procedure revealed the facility staff will administer medications in accordance with infection control measures.	D 371		
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 ensure resident received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration and qualifications of medication staff. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 6 of 6 sampled residents related to insulin (Resident #1), omeprazole and doxycycline (Resident #2), insulin (Resident #3), eye drops (Resident #4), vitamin D3 (Resident #5), and vitamin D2 and vitamin D3 (Resident #6). [Refer to Tag 0358, 10A 13F .1004(a) Medication Administration (Type B Violation).]	D912	Refer to response for D358 Refer to response for D935	

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D912	Continued From page 30 B. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled medication aides (Staff B and Staff C) successfully passed the written exam within 90 days of successfully completing the skills validation competency evaluation. [Refer to Tag 935, G.S. 131D - 4.5B(b) Medication Aides; Training and Competency (Type B Violation).]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program	D935	Facility will ensure that all staff administering medications have successfully passed the state med exam within the appropriate time frame. All Med Techs are signed up for the exam immediately after completing the required training. Due to the minimal amount of testing sites and dates, the facility does not always receive test dates within the window. However those staff members awaiting test dates will not be allowed to administer medications if the date is outside the allotted time frame. Any staff member that does not	

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D935	Continued From page 31 developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled medication aides (Staff B and Staff C) successfully passed the written exam within 60 days of successfully completing the skills validation competency evaluation. The findings are: 1. Review of Staff B's personnel file revealed: -She was hired on 04/26/17. -There was a Medication Clinical Skills Validation dated 09/06/18. -There was no documentation that Staff B had successfully passed the medication administration examination. Interview on 12/14/18 at 2:50pm with Staff B	D935	pass the state exam will be pulled immediately from med administration and signed up to retake the exam along with review and additional med administration training. Staff members will not be allowed to administer med s until passing the exam. 1/9/19	

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D935	Continued From page 32 revealed: -She had started as a medication aide (MA) about six months ago. -She had taken the MA test on 12/04/18. -She had last administered medications to residents on second shift 12/10/18. Review of a December 2018 Medication Administration Record revealed Staff B documented the administration of medications on 12/07/18, 12/09/18, and 12/12/18. Refer to the interview with the Resident Care Coordinator on 12/14/18 at 1:50pm. Refer to the interview with the Executive Director on 12/14/18 at 3:15pm. 2. Review of Staff C's personnel file revealed: -Staff C had a hire date of 08/22/18. -There was a Medication Clinical Skills validation dated 09/06/18. -There was no documentation that Staff C had successfully passed the medication administration examination. Interview on 12/14/18 at 3:30pm with Staff C revealed: -She was hired 08/25/18. -She had taken the MA test on 12/04/18 and failed it. -She did not know if the test had been rescheduled. -She had last administered medications to residents on 12/10/18 and 12/11/18. Review of a December 2018 Medication Administration Record revealed Staff C documented the administration of medications on 12//10/18 and 12/11/18.	D935		

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D935	Continued From page 33 Refer to the interview with the Resident Care Coordinator on 12/14/18 at 1:50pm. Refer to the interview with the Executive Director on 12/14/18 at 3:15pm. Interview with the Resident Care Coordinator on 12/14/18 at 1:50pm revealed: -Staff B and Staff C had failed the medication administration exam on 12/04/18 -She did not know Staff B and Staff C could not administer medications after failing the test. Interview with the Executive Director (ED) on 12/14/18 at 3:15pm revealed: -She had been on leave and returned to the facility 12/14/18. -She was told by staff today (12/14/18) that Staff B and Staff C had failed the medication administration exam. -She knew Staff B and Staff C should not administer medications until passing the exam. The facility failed to ensure all medication aides were qualified to administer medications to all residents. This failure placed all residents at risk and was detrimental to the health, safety, and welfare and constitutes a Type B Violation. The Facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/14/18. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2018.	D935		