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
	HAL099018	A. BUILDING: ______ B. WING ______	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	**409 HARRISON AVENUE YADKINVILLE, NC 27055**

(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 Yadkin County Department of Social Services conducted an annual survey on January 09 and 10, 2019 with an exit via telephone on January 11, 2019.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) was tested for tuberculosis upon hire. The findings are: Review of Staff C, Personal Care Aide (PCA)/Medication Aide's (MA) personnel record revealed: -Staff C was hired on 08/13/18 -There was documentation of a negative TB skin test dated 01/06/17. -There was documentation of a negative TB skin test dated 08/13/18. Interview on 01/10/19 at 3:28 pm with Staff C revealed:	D 131		

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-She did get one TB skin test placed after she was hired at the facility on 08/13/18.
-The Human Resources (HR) staff asked Staff C to get the 2nd TB skin test, but she forgot to get it done.
-The HR staff was responsible for maintaining the personnel records.
-She would get the 2nd TB skin test placed as soon as possible.

Interview on 01/10/19 at 3:05 pm with the Resident Care Coordinator (RCC) revealed:
-The personnel records were maintained by the HR staff who was currently unavailable.
-No one individual staff was fulfilling the duties of the HR staff in his absence, it was being done on an "as needed basis".
-She did not know Staff C needed a 2nd TB skin test.

Interview on 01/10/19 at 3:10 pm with the Administrator revealed:
-The HR staff was presently unavailable.
-The HR staff maintained the personnel records for accuracy and completion.
-She did not know Staff C needed a 2nd TB skin test.

D 164 — 10A NCAC 13F .0505 Training On Care Of Diabetic Resident — D 164

10A NCAC 13F .0505 Training On Care Of Diabetic Residents
An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:
(1) Training shall be provided by a registered nurse, registered pharmacist or prescribing

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practitioner.
(2) Training shall include at least the following:
(a) basic facts about diabetes and care involved in the management of diabetes;
(b) insulin action;
(c) insulin storage;
(d) mixing, measuring and injection techniques for insulin administration;
(e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;
(f) blood glucose monitoring; universal precautions;
(g) universal precautions;
(h) appropriate administration times; and
(i) sliding scale insulin administration.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled medication aides (Staff B) had completed training on the care of diabetic residents prior to obtaining fingerstick blood sugars and administering insulin.

The findings are:

Review of Staff B's, medication aide (MA) personnel record revealed:
-Staff B was hired on 11/08/18.
-There was no documentation of training on the care of the diabetic resident.

Review of the December 2018 Medication Administration Record (MAR) for an insulin dependent resident revealed Staff B documented eight fingerstick blood sugar (FSBS) checks and documented administration of insulin two times.

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Review of the January 2019 MAR for an insulin dependent resident revealed Staff B documented twelve fingerstick blood sugar (FSBS) checks and docmented administration of insulin five times.

Observation on 01/09/19 at 11:15 am revealed Staff B checked a resident's FSBS and then administered insulin to the same resident.

Interview with Staff B on 01/10/19 at 3:00 pm revealed:
-She had worked at the facility since early November 2018.
-She worked as a MA.
-She performed fingerstick blood sugar (FSBS) checks and administered insulin as needed to residents.
-She did not receive any training on the care of the diabetic resident at the facility, but had received training in the past.

Interview on 01/10/19 at 3:05 pm with the Resident Care Coordinator (RCC) revealed:
-The facility did not provide training on the care of the diabetic resident.
-She thought the training on diabetic care was annually and not prior to administering insulin.

Interview with the Administrator on 01/10/19 at 3:15 revealed:
-The Human Resource (HR) staff member was responsible for all the personnel files and knew what training was required.
-The HR staff had been out of work since early December 2018.
-The facility contrated pharmacy completed all staff training.
-The facility contracted pharmacy made the facility aware when training was due except for newly hired employees.

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D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all residents received a non-disposable place setting consisting of a knife, spoon, and a fork at each meal. The findings are: There was a census of 40 residents. Observation of the lunch meal service on 01/09/19 between 12:09 pm and 12:54 pm revealed: -Residents were served one slice of turkey, stuffing, greens, applesauce, tea, and water. -There were thirty-three residents present and six residents did not have knives, four residents did not have spoons, and two residents did not have a fork or a knife. -Two residents were unable to cut the turkey with their spoon so they picked the turkey up with their hands and ate it. -No knives, spoons, or forks were offered by staff to residents during the meal.	D 287		

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-No resident requested any silverware.

Interview with a resident in the dining room on 01/09/19 at 12:37 pm revealed:
-He was eating with his hands because he could hold it better with his hands than he could with a spoon.
-"I need a fork."

Interview with a second resident on 01/10/19 at 11:46 am revealed:
-He only had a spoon for the lunch meal on 01/09/19.
-He picked up his turrky and ate it with his hands because he could not cut it with a spoon.
-He would have liked to have had a knife and a fork during his meal, but he did not ask for a knife or a fork because the staff was busy.

Observation of the breakfast meal service on 01/10/19 between 7:30 am and 8:11 am revealed:
-Residents were served three strips of French toast with syrup, two sausage links, juice and coffee.
-There were twenty-seven residents present and twenty-seven residents had a non-disposable knife, spoon and fork.

Observation of the dining room on 01/10/19 at 11:43 am revealed:
-Prior to the lunch meal service, there was one table setting for six residents which included a knife, spoon and fork and five of six spoons were disposable plastic.
-All other table settings had a non-disposable knife, spoon and fork.

Interview with five residents on 01/10/19 between 10:41 am and 11:46 am revealed:
-Sometimes residents only received a

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non-disposable fork.
-"We usually only get a fork, but this morning (01/10/19) everyone had a [non-disposable] fork, knife and spoon."
-Residents sometimes received only a spoon, sometimes only a fork, and sometimes a spoon, fork and knife.
-"One time we had soup and I didn't have a spoon. I had to turn the bowl up and drink it. When I asked for a spoon, they told me they didn't have anymore."
-Sometimes residents receiveddisposable plastic utensils.
-Residents wanted a full set of non-disposable plateware with their meals.
-Residents preferred to eat their meals with non-disposable plateware rather than disposable plastic utensils.

Interview with a personal care aide (PCA) on 01/10/19 at 2:16 pm revealed:
-She set the tables in the dining hall during her shift.
-She did not know why all the tables were not set with a non-disposable knife, fork and spoon at the lunch meal on 01/10/19.
-There was usually enough non-disposable plateware for all the residents.
-She set the tables with today and used plastic spoons on 5 place settings because there were not enough regular spoons.
-She thought residents may have thrown some spoons away when they emptied their trays.
-She had to set the tables with disposable plastic forks and disposable plastic spoons before, because there was not enough non-disposable plateware.
-She had not heard anyone complain about having to use disposable plastic utensils.

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D 287	Continued From page 7 Interview with the Dietary Manager on 01/10/19 at 2:41 pm revealed: -The PCAs were responsible for setting the tables for meals. -The table setting should include a non-disposable knife, fork and spoon. -There were enough non-disposable forks, but they were running short on non-disposable spoons and knives. -She did not know why there were residents without a fork at the lunch meal service on 01/09/19. -She did not know residents were eating their meat with their hands, because they did not have a fork or a knife in their place setting. -Everyone normally did not come in for breakfast and everyone usually had all their utensils at the breakfast meal. -Staff had used disposable plastic utensils everyday within the last two weeks, because there was not enough plateware. -There were forty-seven non-disposable forks, thirty-four non-disposable spoons, and thirty-nine non-disposable knives available in the facility. -She was in the process of submitting a request to order more utensils. Interview with the Administrator on 01/10/19 at 3:37 pm revealed: -She did not know there was not enough knives, forks, and spoons until today, 01/10/19. -She did not know residents were eating with their hands on 01/09/19 due to not having a fork or knife. -She knew disposable plastic utensils should not be used during meal times. -She had extra non-disposable plateware in her office in the sister facility and would get the plateware in this facility. -All residents should have a knife, spoon and fork	D 287		

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D 287	Continued From page 8 at their table setting.	D 287		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the failed to assure water was served to 33 of 33 residents observed during the breakfast meal. The findings are: Observation on 01/10/19 from 7:30 am to 8:11 am of the breakfast meal revealed: -Beverages served to residents included coffee, juice, nutritional supplements and milk. -None of the residents were offered or served water. Interview with five residents on 01/10/19 between 10:41 am and 11:46 am revealed: -Water was never available on the table. -Staff would provide water if residents asked for it. -"If I want water, I have to ask for it." -"It was highly unusual when they offered us water at lunch on yesterday (01/09/19)." -Once in a while staff would ask residents if they wanted water. -Residents would like to have water with each meal.	D 306		

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Interview with a personal care aide (PCA) on 01/10/19 at 2:16 pm revealed:
-She helped with meals in the dining room during her shift.
-Her duties in the dining room included setting the table, serving beverages and serving meals to residents.
-She did not serve water or offer water for the breakfast meal on 01/09/19, because milk and juice used up all the cups leaving no cups for water.
-She did not remember ever serving or seeing other staff serve water for breakfast since she started working at the facility 4 to 5 months ago.
-If a resident were to ask for water at breakfast then she would give it to them.

Interview with the Dietary Manager (DM) on 01/10/19 at 2:41 pm revealed:
-The PCAs were responsible for serving beverages at each meal.
-She knew residents should be served water at every meal.
-"They should be asked if they want water."
-She did not know why water was not offered at the breakfast meal on 01/10/19.
-There were not enough smaller cups, but there were enough 12 ounce cups available for each resident to be served water in addition to other beverages at every meal.

Interview with the Administrator on 01/10/19 at 3:37 pm revealed:
-She knew water should be served at every meal.
-She just found out today on 01/10/19, that it was not being served at every meal.
-She did not know why water was not served at the breakfast meal on 01/10/19
-"I told them not to pre-pour the other drinks and I

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D 306	Continued From page 10 guess they misunderstood me."	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 7 sampled residents (#7) with physician's orders for a low concentrated sweets LCS diet with double portions (#7). The findings are: Review of Resident #7's current FL2 dated 08/12/18 revealed: -Diagnoses included diabetic neuropathy, diabetes mellitus, and chronic obstructive pulmonary disease. -There was an order for a NCS diet with double portions and a nutritional supplement with meals. Review of a physician's diet order for Resident #7 dated 11/16/18 revealed an order for a low	D 310		

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concentrated sweets (LCS) diet with double portions.

Review of the therapeutic diet list posted in the kitchen on 01/09/18 revealed Resident #1 was listed to be served a LCS diet with double portions at meal times.

Review of the LCS menu for the lunch meal on 01/10/19 revealed roast turkey, red bliss potatoes, creamed spinach, buttered breadstick, half portion of apple brown betty, poultry gravy, margarine, and coffee/tea were to be served.

Observation of the lunch meal service on 01/10/19 between 12:00 pm and 1:00 pm revealed:
-Resident #7 was served one slice of turkey, one serving of greens, one serving of stuffing, one serving of applesauce, tea, and a nutritional supplement.
-Resident #7 was served the same portion sizes as the other residents.
-Resident #7 ate about 75% of his meal.

Review of the LCS menu for the breakfast meal on 01/10/19 revealed French toast, turkey links, syrup, margarine, juice of choice, 2% milk, and coffee/tea were to be served.

Observation of the breakfast meal service on 01/10/19 between 7:30 am and 8:11 am revealed:
-Resident #7 was served three French toast sticks and two turkey sausage links, coffee, and a nutritional supplement.
-All residents present for the breakfast meal on 01/10/19 received three French toast sticks and 2 turkey sausage links.
-Resident #7 ate about 70% of his meal.

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Interview with Resident #7 on 01/10/19 at 10:41 am revealed:
-He was supposed to have double portions and mighty shakes with all of his meals because he was 20 pounds under weight for his height at one point.
-He did not know what his current weight was.
-He did not receive double portions of his meals, but if he did he would probably eat it if he liked what was being served.
-He did not know why he was not served double portions as ordered by his primary care provider (PCP).
-He asked for double portions in the past and was told that if he needed any more then staff would give him more.

Attempted telephone interview with Resident #7's PCP on 01/10/19 at 2:16 pm was unsuccessful.

Interview with the Dietary Manager (DM) on 01/10/19 at 2:41 pm revealed:
-She knew Resident #7 had physician's orders for a LCS diet with double portions.
-Double portions were not served to Resident #7 because he did not eat double portions of his meals.
-The staff asked Resident #7 if he wanted more food after everyone was served.
-Resident #7 usually did not request more food.
-She had not let the Resident Care Coordinator (RCC) know Resident #7 was not receiving double portions as ordered by his physician.

Interview with the RCC on 01/10/19 at 3:31 pm revealed:
-The DM was responsible for making sure meals were served as ordered by the physician.
-She knew Resident #7 had an order for double portions of his meals, but did not know Resident

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D 310	Continued From page 13 #7 was not being served double portions. Interview with the Administrator on 01/10/19 at 3:37 pm revealed: -The DM was responsible for making sure meals were served as ordered by the physician. -She knew Resident #7 had an order for double portions of his meals. -"If there is an order for double portions, they should put double portions on his plate." -She expected for Resident #7 to be served a LCS diet with chopped meats as ordered by the physician.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure residents' rights were guaranteed and maintained without hindrance related to reasonable response to requests related to serving milk.	D 338		

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PATRIOT LIVING OF YADKINVILLE	**409 HARRISON AVENUE YADKINVILLE, NC 27055**

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D 338	Continued From page 14 The findings are: Based on observations and interviews, the facility failed to assure 1 resident (Resident #7) received a reasonable response to requests related to a serving of milk at the lunch meal. [Refer to G.S. 131D-21(7) Declaration of Resident Rights]	D 338		
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: Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (#1 and #6) related to a topical pain relieving gel and eye drops for dry eyes (#1) and cough medicine (#6).	D 358		

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The findings are:

1. Review of Resident #1's current FL-2 dated 07/30/18 revealed diagnoses included leukocytosis, backache, and dysuria.

a. Review of resident #1's physician's order dated 08/29/18 revealed restasis eyedrops (used to treat dry eyes) one drop in both eyes twice a day. Written in parenthesis on the order was (Patient may refuse due to expense.)

Review of Resident #1's November 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for restasis one drop in both eyes twice a day scheduled at 8:00 am and 8:00 pm.
-Restasis was not documented as administered for 4 of 30 opportunities at the 8:00 pm administration time due to documentation of resident refusal.

Review of Resident #1's December 2018 eMAR revealed:
-There was an entry for restasis one drop in both eyes twice a day scheduled at 8:00 am and 8:00 pm.
-Restasis was not documented as administered for 8 of 31 opportunities at the 8:00 pm administration time due to documentation of resident refusal.

Review of Resident #1's January 2019 eMAR revealed:
-There was an entry for restasis one drop in both eyes twice a day scheduled at 8:00 am and 8:00 pm.
-Restasis was not documented as administered for 3 of 8 opportunities at the 8:00 pm

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administration time due to documentation of resident refusal.

Observation of Resident #1's medications on hand on 01/10/19 at 10:05 pm revealed one bottle of restasis eyedrops was available for administration.

Interview with Resident #1 on 01/10/19 at 3:05 pm revealed:
-Restasis was supposed to be administered twice a day for dry eyes.
-Sometimes the medication aides (MA) on first and second shifts forgot to give her restasis eyedrops.
-She did not ask for restasis because she did not want to offend the MAs.
-Her eyes did not get too dry when she missed a dose of restasis.
-She was administered restasis this morning, but did not receive the 8:00 pm dose on 01/09/19.
-She did not refuse any of her medication.

Interview with a representative from the contracted pharmacy on 01/10/19 at 10:23 am revealed:
-The original order for restasis was dated 08/29/18.
-Restasis was filled by the pharmacy on 08/29/18, 09/24/18, 10/14/18, 11/10/18. 12/11/18, and 01/10/19.
-A 15 day supply (one box of individual 30 vials) was dispensed to the facility on each fill date.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 01/10/19 at 2:16 pm was unsuccessful.

Interview with a first shift MA on 01/10/19 at 3:16 pm revealed:

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-Resident #1 had a physician's order for restasis eye drops one drop in each eye twice a day.
-She administered restasis to Resident #1 during her shift.
-Resident #1 had not refused restasis and she had not missed giving Resident #1 restasis that she was aware of.

Interview with a second shift MA on 01/10/19 at 4:26 pm revealed:
-She had only administered restasis twice to Resident #1, because Resident #1 said she did not need it.
-She did not contact the doctor about Resident #1 refusing restasis.
-"The doctor checks the eMARs and if they refuse so many times, then he will discontinue the medication."
-She documented on the eMAR when Resident #1 refused eye drops.
-She did not know why she documented on the eMAR that restasis was administered when it was not.
-She did not know what the policy was when a medication was not administered or when a resident refused medication.

Interview with the Resident Care Coordinator (RCC) on 01/10/19 at 3:31 pm revealed:
-She knew it had been documented Resident #1 refused restasis, but she did not know there were fifteen documented refusals between 10/01/18 and 01/09/18 were documented by the same MA.
-The physician had not been notified because she thought the original order said that it was okay for Resident #1 to refuse.
-Resident #1's PCP had reviewed and signed off on Resident #1's refusals while in the faciilty, but she did not know where the documentation was.

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Interview with the Administrator on 01/10/19 at 4:13 pm revealed:
-The Administrator and the RCC were responsible for reviewing resident records and eMARs.
-There was not a scheduled time frame for reviewing records, but eMARs were reviewed daily including a report of refused medication for each resident.
-She knew it had been documented Resident #1 refused restasis, but she did not know there were fifteen documented refusals between 10/01/18 and 01/09/18 were documented by the same MA.
-She did not know Resident #1 denied refusing eye drops.
-She was not sure what was going on, but she would talk to Resident #1 to find out whether her eye drops were being administered as ordered.

b. Review of Resident #1's record revealed a physician's order for biofreeze (a topical pain reliever) for neuropathy one application at night to bilateral feet for relief of neuropathic pain.

Review of Resident #1's November, December and January 2019 electronic Medication Administration Record (eMAR) revealed there was not an entry for biofreeze.

Observation of Resident #1's medications on hand on 01/10/19 at 10:05 am biofreeze was not available for administration.

Interview with a representative from the contracted pharmacy on 01/10/19 at 10:23 am revealed the pharmacy had not received an order for biofreeze.

Interview with Resident #1 on 01/10/19 at 11:08 am revealed:
-She did not remember her PCP ordering

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biofreeze for her.
-She had burning in her feet and her feet were painful and sore when she first got up out of bed.
-She had never received biofreeze, but she would like to have some to relieve the pain in her feet in the mornings.

Attempted interview with Resident #1's PCP on 01/10/19 at 2:16 pm was unsuccessful.

Interview with a first shift medication aide (MA) on 01/10/19 at 3:16 pm revealed:
-Resident #1 had not complained to her about pain in her feet.
-She did not know about the order for biofreeze dated 08/29/18.
-Biofreeze was not on Resident #1's eMAR.
-The Resident Care Coordinator (RCC) was responsible for reviewing new physician's orders.
-The RCC or a MA sent the new order to the pharmacy to be filled and to be put on the eMAR.

Interview with a second shift MA on 01/10/19 at 4:26 pm revealed she did know Resident #1 had a physician's order for biofreeze.

Interview with the Resident Care Coordinator (RCC) on 01/10/19 at 3:31 pm revealed:
-She was responsible for reviewing new physician's orders.
-Once a new physician's order was received she reviewed the order, sent the order to the pharmacy to be added to the eMAR, checked the eMAR to make sure it was entered correctly, and then approved the order on the eMAR.
-She did not see the physician's order dated 08/29/18 for biofreeze and the order was not sent to the pharmacy to fill or to be added to the eMAR.
-All records, including Resident #1's, were

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audited in December 2018 by an outside auditor.
-She did not know how the order for biofreeze was overlooked.

Interview with the Administrator on 01/10/19 at 4:13 pm revealed:
-The RCC was responsible for reviewing new physician's orders.
-When a new physician's order was received, the RCC faxed the order to the pharmacy to place on the eMAR, the RCC reviewed the order on the eMAR comparing it to the actual order, and then approved it with the pharmacy if it was accurate.
-She did not know about the physician's order for biofreeze.
-She did not know the physician's order for biofreeze had not been sent to the pharmacy and had not been administered to Resident #1 as ordered.
-She expected for medications to be administered as ordered by the physician.
2. Review of Resident #6's current FL-2 dated 05/11/18 revealed diagnoses included hypertension, Chronic Obstructive Pulmonary Disease, Osteoarthritis, degenerative disk disease, and major depression.

Review of a subsequent physician's order for Resident #6 dated 10/19/18 revealed an order for benzonatate 100mg three times daily (used to treat coughing) for two weeks then discontinue. (There were no other orders for benzonatate the record)

Review of Resident #6's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for benzonatate 100mg to be administered at 8:00 am, 2:00 pm and 8:00 pm with a start date of 10/20/18.

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-Benzonatate 100mg was documented as administered at 8:00 am, 2:00 pm and 8:00 pm from 10/20/18 to 10/31/18.

Review of Resident #6's November 2018 eMAR revealed:
-There was an entry for benzonatate 100mg to be administered at 8:00 am, 2:00 pm and 8:00 pm.
-Benzonatate 100mg was documented as administered as ordered at 8:00 am, 2:00 pm and 8:00 pm from 11/01/18 to 11/02/18.
-The last dose of benzonatate according to the order would have been administered at 8:00 pm on 11/02/18.
-There was no documentation the order for benzonatate 100mg had been renewed.
-The benzonatate was administered an additional eighty-four times from 11/03/18 to 11/30/18 without a prescription in November.

Review of Resident #6's December 2018 eMAR revealed:
-There was an entry for benzonatate 100mg to be administered at 8:00 am, 12:00 pm and 8:00 pm.
-There was no documentation of a new order for benzonatate 100mg to be administered.
-The benzonatate was administered ninety-three times from 12/01/18 to 12/31/18 without a prescription.

Review of Resident #6's January 2019 eMAR revealed:
-There was an entry for benzonatate 100mg to be administered at 8:00 am, 2:00 pm and 8:00 pm.
-There was no documentation of a new order for benzonatate 100mg to be administered.
-The benzonatate 100mg was administered twenty-eight times from 01/01/19 to 01/10/19 without a prescription.

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Observation of Resident #6's medications available for administration on 01/10/19 at 7:10 am revealed benzonatate 100 mg was available for administration.

Interview with a medication aide (MA) on 01/10/19 at 2:10 pm revealed:
-She had worked at the facility for 5 weeks.
-She often worked day shift and administered medications to Resident #6.
-She did not know there was no current order for the benzonatate 100mg.
-The Resident Care Coordinator (RCC) was responsible for verifying orders.

Interview with the RCC on 01/10/19 at 9:00 am revealed:
-She did not know the physician's order for benzonatate 100mg was ordered for only 14 days.
-She was responsible for reviewing new physician's orders.
-Once a new physician's order was received she reviewed the order, sent the order to the pharmacy to be added to the eMAR, checked the eMAR to make sure it was entered correctly, and then approved the order on the eMAR.
-When orders were sent directly from the pharmacy from the physician's office, the pharmacy would email a copy of the order to the facility. The facility used the email to confirm orders on the eMAR.
-She was responsible for ensuring medications were administered as ordered by the physician.
-She had overlooked the benzonatate order being prescribed for only 14 days.
-A new system for verifying orders was put in place at the beginning of November 2018.

Interview with the pharmacy representative from

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the contracted pharmacy on 01/10/19 at 12:04 pm revealed:
-The pharmacy entered in all orders for the facility onto the eMAR.
-The facility was responsible for verifying all the orders on the eMAR.
-The pharmacy did not audit or review the eMARs.
-The pharmacy entered the benzonatate as an ongoing prescription; they overlooked that it should had been fourteen days only.
-The pharmacy continued to send the benzonatate without an order.
-The pharmacy will notify the prescribing physician of the error.

Attempted telephone interview with the physician on 01/10/19 at 12:15 was unsuccessful.

Interview with the Administrator on 01/10/19 at 2:20 pm revealed:
-When a new physician's order was received, the RCC faxed the order to the pharmacy to place on the eMAR, the RCC reviewed the order on the eMAR comparing it to the actual order, and then approved it with the pharmacy if it was accurate.
-She did not know about the physician's order for benzonatate.
-The RCC was responsible for verifying all orders.
-A new process had been put in place at the beginning of November to help prevent oversight of orders.
-There were no set schedules for completing eMAR audits.
-When audits were completed, they only looked for missed medications and holes on the eMAR.
-She expected for medications to be administered as ordered by the physician.

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D917	G.S. 131D-21(7) Declaration of Resident's Rights	D917		

G.S. 131D-21 Declaration of Resident's Rights
Every resident shall have the following rights:
7. To receive a reasonable response to his or her requests from the facility administrator and staff.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure 1 resident (Resident #7) received a reasonable response to requests related to a serving of milk at the lunch meal.

The findings are:

Review of Resident #7's current FL2 dated 08/12/18 revealed:
-Diagnoses included diabetic neuropathy, diabetes mellitus, and chronic obstructive pulmonary disease.
-There was an order for a no concentrated sweets (NCS) diet with double portions.

Review of Resident #7's record revealed:
-There was a physician's order for a low concentrated sweets (LCS) diet with double portions and a nutritional supplement with meals.
-There were no documentation of any dietary restrictions.

Observation of the kitchen on 01/09/19 at 10:35 am revealed there were 20 unopened gallons of milk and an opened ½ gallon container of milk in the refrigerator.

Review of the menus for regular and therapeutic diets revealed milk was listed to be served at the breakfast and dinner meals.

Observation of the lunch meal service on

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01/09/19 between 12:00 pm and 12:24 pm revealed:
-At 12:19 pm, Resident #7 requested a glass of milk from a personal care aide (PCA) who was assisting in the dining room.
-Resident #7 was told by the PCA he could not have milk because milk was not on the menu for lunch.
-Resident #7 started raising his voice and demanded milk.
-The PCA told Resident #7 she would ask the Dietary Manager (DM) if he could have milk.
-The PCA did not serve Resident #7 milk at this time nor did she respond to Resident #7's request.

Interview with the PCA assisting in the dining room on 01/09/19 at 12:25 pm revealed:
-She talked to the DM who said Resident #7 could not have milk because it was not on the menu.
-"We only serve milk when it is on the menu."

Interview with the DM on 01/09/19 at 12:27 pm revealed:
-Staff did not serve milk during the lunch at all.
-Milk was only served when it was on the menu at breakfast and at dinner.
-"It got to the point a lot of them were asking for milk when it wasn't on the menu, so we stopped serving it during lunch."

Observation of lunch meal service on 01/09/19 between 12:28 pm and 1:00 pm revealed:
-At 12:42 pm, the PCA asked Resident #7 if he wanted anything.
-Resident #7 responded to the PCA, "All I want is some milk which I'm supposed to get."
-The PCA told Resident #7, "I'll go ask the DM again."

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-At 12:45 pm the Administrator approached Resident #7 and said to him, "You know milk is not on the menu."
-After Resident #7 raised his voice again and continued to demand milk, the Administrator said to him, "If a glass of milk will make you happy, I'll go get you a glass of milk."
-Resident #7 was served a glass of milk at 12:47 pm.
-After Resident #7 drank the glass of milk, he left the dining hall.

Interview with the PCA pm 01/10/19 at 7:20 am revealed:
-She assisted in the dining hall during breakfast, lunch, and dinner.
-Residents usually did not ask for milk during lunch.
-The DM told her if a food or beverage item was not on the menu, then staff did not serve it.
-She did not give milk to Resident #7 because milk was not on the menu for lunch.
-She gave milk to Resident #7 when she was directed to do so by the Administrator.
-Anytime a resident asked for something that was not on the menu, she asked the DM if it was okay to give to the resident.

Interview with five residents between on 01/10/19 between 10:41 am and 11:46 am revealed:
-Residents used to be able to get milk at breakfast, lunch, and dinner but were no longer allowed to have milk during lunch.
-"We all have asked for milk during lunch and we can't get it."
-Residents have not been given any explanation why they can't have milk during lunch.
-Residents were told they could only get milk at breakfast and dinner.
-"They can't afford to give us milk three times a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: ______ B. WING ______	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(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
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day."
-"I don't know why it's that way. I guess they're trying to cut costs."
-"They say they run out of milk or just don't have enough to give out at lunch."
-The residents would like to have milk when they asked for it.

Interview with the DM on 01/10/19 at 2:41 pm revealed:
-Milk was limited to 16 ounces a day and residents received 8 ounces at breakfast and 8 ounces at dinner.
-Milk used to be served at breakfast, lunch, and dinner if residents wanted it, but it had gotten out of hand and milk was being wasted.
-"Residents were told they could not have milk and they have been fine with it."
-Her supervisors instructed her not to give milk during lunch.
-Milk had not been served during the lunch meal for six to eight months.

Interview with the Administrator on 01/10/19 at 3:37 pm revealed:
-Milk used to be served three times a day, but was stopped three times a day because everyone was asking for it.
-"They were requesting milk constantly."
-"I thought we were fine as long as we were serving milk twice a day."