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
	HAL080020	A. BUILDING: _____ B. WING _____	R 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a complaint investigation on November 8, 2018 through November 9, 2018. The complaint was initiated by the Rowan County Department of Social Services on September 19, 2018.	{D 000}		11/16/2018 completed
D 228	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule: (1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule; (2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident; (3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or (4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to identify appropriate reasons for issuing a discharge notice to 1 of 3 sampled	D 228	Please see attachment	

Addendum: Corrective action, complete dates, measures to prevent the problem, and person responsible for monitoring was added to all tags.

Recieved and Accepted Keisha Banks 01/25/2019

(Page 1) .0702 (D228) DISCHARGE OF RESIDENT

Moving forward when Administrative staff is discharging a resident from AAHALF, Administrator will use the appropriate reasons per rule and regulations (**10ANCAC 13f.0702**). All discharge notices shall only be given to residents for these reasons. Administrator and ED will also consultant with the facility local ombudsman if there's any question or concerns regarding discharge notices.

Resident #2 was never discharged from facility; her notice was voided and null on **November 16, 2018** resident still resides here at the facility.

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D 228	Continued From page 1 residents (Resident #2) . The findings are: Review of Resident #2's current FL2 dated 10/25/18 revealed diagnoses included diabetes with peripheral vascular disease, malignant hypertension, latent effects of cerebral vascular accident, and degenerative disk disease. Review of a Notice of Transfer/Discharge dated 10/15/18 for Resident #2 revealed: -The reason for discharge was "the resident has failed to pay the cost of services and accommodations according to the resident contract" and "the resident is non-compliant with physicians' order". -"The facility plans to discharge you" was checked. No name of facility, address or location was given as to where Resident #2 would be discharged to. -The document was signed by the Administrator and dated 10/15/18. Review of Resident #2's nurses notes on 11/08/18 revealed: -On 10/09/18, Resident #2 went to the store to purchase a cinnamon supplement, but did not have enough money to pay for it. She had $6 with her at that time. -There was no documentation in the nurses notes the physician had been contacted about the resident being unable to purchase cinnamon supplements. Review of Resident #2's Resident Personal Funds Ledger revealed the resident's account balance was up to date with a $0 balance owed to the facility for September 2018 and October 2018.	D 228		

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D 228	Continued From page 2 Review of Resident #2's Verbal Warning Form dated 08/18/18 revealed: -The warning was the first warning for Resident #2. -The verbal warning was issued for the resident being non-compliant with physician's order as the resident failed to supply her medications. -Explanation given by the resident was she did not want to use the facility pharmacy and she would get her own medications. -The verbal warning was signed by the Administrator. -There were no verbal warnings issued for unpaid pharmacy bills in which the facility had to pay for medications. Review of Resident #2's Verbal Warning Form dated 10/09/18 revealed: -The warning was the second warning for Resident #2. -The verbal warning was issued for the resident being non-compliant with physician's order as the resident failed to supply her medications in a timely manner. -Explanation given by the resident was she did not want to spend her last $6. -The resident declined to sign the verbal warning. -The verbal warning was signed by the Administrator. -There were no verbal warnings issued for unpaid pharmacy bills in which the facility had to pay for medications. Review of Resident #2's Verbal Warning Form dated 10/15/18 revealed: -The warnings were dated 10/07/18 and 10/09/18. -The verbal warning was issued for non-compliance with physician's order.	D 228		

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D 228	Continued From page 3 -There was no explanation given by the resident and she walked away. -The resident declined to sign the verbal warning. -The verbal warning was signed by the Administrator -This warning had a note attached to it. -The first note attached to the form was dated 10/07/18 and was written by the Administrator. -The Administrator informed Resident #2 that she was not in compliance with her medications and that she was out of acetaminophen and had been using house stock and out of cinnamon and needed to purchase some that day. -The resident purchased acetaminophen but not cinnamon as she did not want to spend her last $6. -The second note attached to the form was dated 10/15/18 and was written by the Executive Director. -It was noted that she had went to the store to purchase the resident's medications and the resident was out of compliance and refused to get her medication to the facility in a timely manner. -The Executive Director informed the resident of the facility's policy and she was responsible for her own medications. Interview with Resident #2 on 11/08/18 at 11:47 am and 11/09/18 at 6:00 pm revealed: -She was given a verbal discharge notice on 10/15/18 and would be leaving on 11/14/18. -She was not given a copy of the discharge. -She did not know she could appeal the facility's decision. -She was told "she could not appeal the decision for 2 weeks after discharge". -The Administrator kept telling her that she was not in compliance with her medication order because she did not want to spend her last $6 on	D 228		

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D 228	Continued From page 4 the cinnamon supplement. -She asked the Administrator what would happen if she did not find another facility to go to and the Administrator said "she will call the cops and have her delivered to the nearest shelter". Interview with Resident #2's family member on 11/09/18 at 11:55 am revealed: -The facility staff had told Resident #2 that she was being discharged, but she did not find out until 10/25/18. -She tried talking with the Administrator, but the Administrator would not listen or give her any information until she had the power of attorney for the resident even after the resident said it was okay to give the family member the information. -She had filed an emergency appeal on behalf of the resident. -The family member had tried to resolve the issue. -The discharge form had been revised, during her meeting with the Administrator and the ED on 11/09/18, to show that the family member received a copy of the discharge notice. Interview with the Administrator on 11/09/18 at 4:10 pm revealed: -She gave Resident #2 a copy of the discharge notice when she informed the resident she would be discharged from the facility. -The discharge notice was given to Resident #2 on 10/15/18 and the Business Office Manager (BOM) was a witness. -The resident was being discharged because she had not paid her pharmacy bills and was non-compliant with physician's orders for cinnamon supplements and acetaminophen as needed. -The resident did not like to buy her cinnamon supplement or her acetaminophen over the	D 228		

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D 228	Continued From page 5 counter. -The resident did eventually purchase her acetaminophen she took as needed but the facility had to buy the cinnamon supplements. -She informed the resident that the facility only called the police if she had behaviors and would not leave the facility after her discharge. -The Administrator commented "[expletive] if you do and [expletive] if you don't" and walked off. Interview with the BOM on 11/09/18 at 6:36 pm revealed: -Currently Resident #2 did not owe anything. -The facility had purchased her cinnamon supplements. -She witnessed the Administrator give the discharge notice to the resident on 10/15/18. Interview with the Executive Director on 11/09/18 at 7:00 pm revealed: -The facility had purchased acetaminophen for Resident #2 in the past and she had used house stock. -The resident was current with her room and board charges. -She purchased cinnamon supplements for the resident on 10/09/18 for $11 and had been paid back by the resident. -She had issues in the past year with the resident buying her acetaminophen which was ordered to take as needed. -The resident kept her cinnamon supplement at the bedside and had an order for self-administration. -She thought the facility had to keep up with the resident taking her own cinnamon supplements. -The facility had not notified the physician of the issue with the cinnamon supplements or the acetaminophen.	D 228		

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D 228	Continued From page 6 Attempted telephone interview with the physician on 11/09/18 at 1:50 pm was unsuccessful. Review of the facility Transfer/Discharge Policy revealed a resident could be discharged for the following reasons: -Charges for the resident's accommodations and services had not been paid within 30 days after the date on which they came due. -The resident required a level of care that the facility was unable to provide. -The health, safety, or welfare of the resident or another resident required discharge. -The owner closed the facility. -For the health, safety, or welfare of an individual who resides in the home but is not a resident for whom supervision or personal services are provided.	D 228		
{D 238}	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by:	{D 238}	please see attachment	11/12/2018 completed

(Page 7) .0703 (D238) TUBERCULOSIS TEST, MEDICAL EXMAMINATION

In the event if resident's FL2 and medications are unclear and need clarification. MA, Administrator/ED and will contact resident's physician immediately to assure that the safety and the well-being of the resident's medications is in compliance.

MA/ED and Administrator will also contact physician if the route and dose of resident's medications are incorrect as well. A new FL2 was updated and completed by MA and faxed to resident's physician on **11-12-2018** , to assure that resident's medications is clear and sufficient so that facility can meet resident's need by administering correct medications prescribed by physician.

Administrator and MA will be responsible for conducting a weekly audit of all resident's current medications. Administrator will be fully responsible for making sure all FL2's are up to date and medications are listed correctly. This will be an on-going task.

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{D 238}	Continued From page 7 Based on interviews, and record reviews, the facility failed to assure medication orders were included on the current FL2s for 1 of 5 sampled residents (Resident #3). The findings are: Review of Resident #3's FL2 dated 08/25/18 revealed: -Diagnoses included Alzheimer's Dementia, mental and developmental disabilities, depression with suicidal ideation, chronic obstructive pulmonary disease, emphysema, anemia, insulin dependent diabetes mellitus, and degenerative disk disease. -There were no medications listed on the FL2. -The medication section of the FL2 did not refer to an attached list. -There was a medication list attached to the FL2 which had been printed on 09/11/18, but had not been signed. Review of 6 month physician's orders dated July 2018 revealed: -There was an order for lopressor (used to treat blood pressure) 75 mg two times a day. -There was an order for amlodipine (used to treat blood pressure) 10 mg daily. -There was an order for folic acid (used to treat vitamin B deficiency) 1 mg daily. -There was an order for Januvia (used to treat diabetes) 100 mg daily. -There was an order for ranitidine (used to treat gastric reflux) 150 mg daily. -There was an order for vitamin B12 (used to treat vitamin B deficiency) 1000mcg daily. -There was an order for vitamin D3 (used to treat vitamin D deficiency) 1000 units daily. -There was an order for venlafaxine (used to treat depression) 150 mg daily.	{D 238}	please see attachment NOV 19 2018	

(Page 8) .0703 (D238) continued from **TUBERCULOSIS, MEDCAL EXMAMINATION**

Facility consultant conducted training for MA's on how to correctly fill out an FL2; the training was taken place on **November 10th 2018.**
The facility consultant will continue to educate all on coming MA's on how to fill out an FL2 correctly, this task will be on-going and as need, Consultant is available and able to answer any concerns thru email and phone concerning FL2's.

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{D 238}	Continued From page 8 Review of Resident #3's record revealed there was no documentation the physician was contacted for clarification of medication orders. Interview with a medication aide (MA) on 11/09/18 at 9:23 am revealed: -She had noticed some of the FL2s did not have any medications listed on them. -The Resident Care Director (RCD) or the Administrator filled out the FL2s. -She did not know if a medication administration record (MAR) could be printed and attached to the FL2 or not. -She did not think a MAR could be printed and attached to the FL2 after it had been signed. -She had faxed physician's orders to the physician on 11/01/18 but was unsure if they were misfiled and did not know why they were not in the record. Interview with a second MA on 11/09/18 revealed: -She had only filled out 1 or 2 FL2s. - The RCD or the Administrator usually filled out the FL2s. -The medications should be listed on the FL2. -If medications were not listed on the FL2, it should say "see attached". -She had seen an FL2 without medications listed on it and the Executive Director was aware. Interview with a pharmacy representative from the contracted pharmacy on 11/09/18 at 9:15 am revealed: -Orders were filled by whatever was sent to them. -The first signed physician orders they received was dated July 2018 and were 6 month physician's orders. Interview with the Administrator on 11/09/18 at	{D 238}		

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{D 238}	Continued From page 9 4:10 pm revealed: -The FL2s were filled out by the MAs. -She had never filled out an FL2. -Medications were supposed to be listed on the FL2. -She double checked all orders when they came in. -She did not know why the FL2 did not have medications listed on it. -She did not know why a copy of current orders had been printed on 09/11/18 and attached to the MAR a few weeks after the FL2 had been signed. -Current orders were printed and sent to the physician when a resident had an appointment. -She removed the printed current orders attachment from the FL2. -She and the Executive Director audited records on a weekly basis. Interview with the Executive Director on 11/09/18 at 7:00 pm revealed: -The RCD and the Administrator were responsible for completing the FL2s. -Medications were supposed to be listed on the FL2s. -She did not know why the FL2 did not have medications listed on it. -She did not know why a copy of the current orders had been printed and attached to the signed FL2 a few weeks later. -She and the Administrator were responsible for completing record audits.	{D 238}		
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	D 310		

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D 310	Continued From page 10 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 1 sampled resident (Resident #2) with a physician's order for a no concentrated sweets (NCS) diet with no calcium. The findings are: Review of Resident #2's current FL2 dated 10/25/18 revealed: - Diagnoses included diabetes with peripheral vascular disease, malignant hypertension, latent effects of cerebral vascular accident, and degenerative disk disease. -There was a physician's order for weekly fingerstick blood sugars once on Wednesdays. -There was a physician's order for a no concentrated sweets diet with no calcium. Review of Resident #2's physician's orders revealed: -There was an order dated 09/17/18 to discontinue any calcium containing medications and multivitamins. -There was a diet order dated 10/3/18 for a low concentrated sweets (LCS) diet. Review of Resident #2's record revealed no	D 310	Please see attachment NOV 20, 2018	

Page 11). (D310) .0904 NUTRITION AND FOOD SERVICE

Dietary Manager conducted an in-service staff meeting with all dietary staff on November 20, 2018. The in-service/ training consist of therapeutic diets and menus. Training will be on-going and will take place quarterly. So that all current dietary staff will be knowledgeable of resident's preferences and therapeutic diets. Dietary manager/ ED will continue to train all new employees during orientation upon hiring, to assure that all residents who reside here at AAHALF receive their arcuate diets according to resident's diet plan, per physician's orders.

All diet orders will be monitored by Administrator once a week. Rules and Regulations have been posted in workplace and are visible pertaining to diets. All diet sheets were revised according to diets offered by facility. All forums were faxed to resident's physicians by MA, on 1-3-2019 and have been updated and signed by resident's physicians and filed in resident's chart.

MA, Administrator and ED will continue to use corrected diets sheets, according to the therapeutic diets that are **only** offered by facility.

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D 310	Continued From page 11 documentation the physician was contacted for clarification of the diet order. Review of the therapeutic diet list posted in the kitchen revealed Resident #2 was to be served a low concentrated sweets diet (a regular diet with regular desserts at one-half portion). Review of the therapeutic diet menus revealed there was a LCS diet menu used for all diabetic meals. Review of Resident #2's medication administration record (MAR) for September 2018 revealed a blood sugar range of 130 - 191. Review of Resident #2's MAR for October 2018 revealed a blood sugar range of 140 - 245. Review of Resident #2's MAR for November 2018 revealed a blood sugar of 179. Observation of the lunch meal service on 11/08/18 at 12:05pm revealed: -Resident #2 was served water, a grilled cheese sandwich, cucumber and tomato salad with Italian dressing, and no added sugar vanilla ice cream. -The resident ate 100% of the meal. Review of the ingredients label on the cheese package revealed that one slice of cheese provided 25% daily value of calcium based on a 2000 calorie diet. Review of the ingredients label on the no added sugar ice cream revealed that one serving provided 6% daily value of calcium based on a 2000 calorie diet. Interview with Resident #2 on 11/08/18 at	D 310		1/3/2019 completed

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D 310	Continued From page 12 12:30pm revealed: -She was a diabetic and took medications to control her diabetes. -She had her blood sugar checked once a week on Wednesdays by staff. -To her knowledge, she should be on a diabetic diet, but was not supposed to have calcium. -At meal time, all residents got the same dessert, but they were in different colored bowls. -The desserts she received at meals were always in a white bowl. Interview with the Dietary Manager (DM) on 11/08/18 at 2:00 pm revealed: -He thought Resident #2 was on a LCS diet. -If a resident's diet order changed, management should have provided him with a new diet order. -The facility had LCS diet menus that were used for all diabetics, but the facility did not have NCS menus. -Desserts in white bowls were used for diabetic residents and desserts in red bowls were used for residents on a regular diet. Interview with the Administrator on 11/09/18 at 4:10 pm revealed: -She knew Resident #2 had a problem with calcium. -She double checked orders when the orders came in. -The facility only used LCS menus and did not have NCS menus to use for staff guidance for preparing meals. Attempted telephone interview with the physician on 11/09/18 at 1:50 pm was unsuccessful.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders	D 344		

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	HAL080020	A. BUILDING: _____ B. WING _____	R 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 344	Continued From page 13 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure clarification of medication orders for 2 of 4 sampled residents (Resident #1 and #2) including refresh gel drops (#1) and a diuretic and a laxative (#2). The findings are: 1. Review of Resident #1's current FL2 dated 08/21/18 revealed diagnoses included pre-diabetes, atrial fibrillation, anemia, cardiac pacemaker, chronic kidney disease three and hypertension. Review of Resident #1's medication clarification form dated 10/04/18 revealed: -Documentation on the form included "Pt. has severe dry eye with erosion OS (left eye)." -There was a physician's order to start refresh gel	D 344	please see attachment 11/9/2018 completed	

(Page .14) .1(D344) 002 MEDICATION ORDERS

All medications that are unclear and needs clarification from physician, MA, Or Ed and Administrator will contact physician immediately. A medication clarification form will be faxed to physician and a follow-up phone call will take place to assure that the safety and well-being of the resident medications is being administered according to physician's orders.

Administrator clarified Resident's order was on 11-9-2018. Per resident physician medication order was only recommended, and not an order, it was resident's right to receive medication or not. Resident was not interested in taking medication recommended by physician, Facility honored Resident's right.

(Page .20) (D358) .1004 (a) MEDICATION ADMINSTRATION

All new medication orders will be faxed immediately to pharmacy directly after reviewing new orders from Physician. MA's will contact Pharmacy directly to confirm that order is correct and has been received and a confirmation has taken place. MA's will be advised per (AAHALF policy) to fill out medication tracking forums to assure that medication orders has been processed.

All medication has been clarified and resident is receiving medication prescribed by physician. . Administrator/MA's will monitor new medications orders daily.

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D 344	Continued From page 14 drops (treat dry eyes) four times daily OS. Review of Resident #1's electronic Medication Administration Records (MARs) for October and November 2018 revealed no entry for refresh gel drops. Observation of medications on hand for Resident #1 on 11/08/18 at 5:22pm revealed refresh gel drops were not available for administration. Interview with a medication aide (MA) on 11/08/18 at 5:26pm revealed: -She did not recall seeing an order for refresh gel drops. -Resident #1 had a problem with dry eyes and was previously put on an eye lubricant, but she did not recall seeing the gel drops. -When orders were received the MA on duty was to log the order in the medication tracking book. -The Administrator was responsible for reviewing the orders and making sure they were clear and sent to the pharmacy. -When the medication was received from the pharmacy the MA on duty checked the pharmacy label with the order to ensure the medication was filled and dispensed according to the physician's instructions. -There was no documentation regarding the refresh gel drops and she did not know how the refresh gel drops got missed. -If the MA did not understand the order it should be clarified with the resident's physician. Interview with Resident #1 on 11/09/18 at 11:11am revealed: -Currently, she had use of her left eye only because her right eye was artificial. -Sometimes she had very dry eyes and needed something for her left eye.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 15 -She was previously ordered an eye lubricant that was very thick and she was unable to see after the medication was administered, so staff administered the medication at bedtime. -Currently, she had artificial tears, which she kept in her room at her bedside and used as needed. -She did not recall getting an eye gel administered four times daily. Interview with the Executive Director on 11/09/18 at 11:15am revealed: -When medication orders were received the MA on duty should log the order and send the prescription to the pharmacy. -If the physician did not send a prescription for the refresh gel drops the MA may not have considered the refresh an order. -The MA should have contacted the physician in October 2018 to clarify the order. Interview with the Administrator on 11/09/18 at 8:10pm revealed: -When orders were received that were not clear or missing information the MA on the first shift should follow-up with the primary care provider (PCP) to clarify the order. -She reviewed medication orders after the MA to ensure medications were administered as ordered. -She had reviewed the order for refresh gel drops four times daily for Resident #1, but did not consider the refresh gel drops to be an order because the physician did not hand write a prescription. -She knew the facility needed an order for all medications even as needed (recommended) medications. -She did not clarify the refresh gel drops four times daily with Resident #1's physician.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 16 Interview on 11/09/18 at 1:50 pm with the nurse at Resident #1's PCP's office revealed: -Due to Resident #1's age she had chronic dry eyes. -The physician wrote to start refresh gel drops four times daily, but did not write a prescription for the medication because the medication could be purchased over-the-counter. -Since there was no written prescription for the refresh gel drops, the facility should have contacted the PCP's office to clarify the order. 2. Review of Resident #2's current FL2 dated 10/25/18 revealed diagnoses included diabetes with peripheral vascular disease, malignant hypertension, latent effects of cerebral vascular accident, and degenerative disk disease. -There was a physician's order for furosemide (a diuretic) 1 tablet every morning (no dosage listed). -There was a physician's order for polyethylene glycol (a laxative) 3350 powder (no dosage or frequency listed). Review of a fax cover sheet dated 10/15/18 revealed that a medication aide (MA) asked the pharmacy to add polyethylene glycol powder 17 grams every day to the medication administration record (MAR). Review of Resident #2's physician's orders revealed there was a medication order dated 10/17/18 for polyethylene glycol 3350 powder 1 dose as needed. Review of Resident #2's record revealed there was no documentation the facility staff had contacted Resident #2's physician to clarify the orders for polyethylene glycol and furosemide listed on the FL2 dated 10/25/18.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 17 Review of Resident #2's physician's 6 month orders dated 09/19/18 revealed: -There was a physician's order for furosemide 40 mg every morning. -There was no physician's order for polyethylene glycol 3350 powder. Review of Resident #2's September 2018 Medication Administration Record (MAR) revealed: -There was an entry for furosemide 40 mg once daily which had been documented as administered. -There was no entry for polyethylene glycol. Review of Resident #2's October 2018 MAR revealed: -There was an entry for furosemide 40 mg once daily which had been documented as administered. -There was an entry for polyethylene glycol powder 17 grams once daily which had been documented as administered. -There was a second entry for polyethylene glycol powder 17 grams as needed for constipation which had not been documented as being administered. Review of Resident #2's November 2018 MAR revealed: -There was an entry for furosemide 40 mg once daily which had been documented as administered. -There was an entry for polyethylene glycol powder 17 grams once daily which had not been documented as administered. -There was a second entry for polyethylene glycol powder 17 grams as needed for constipation which had not been documented as administered.	D 344		

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D 344	Continued From page 18 Interview with Resident #2 on 11/08/18 at 3:15 pm revealed: -She used a mail order pharmacy to get her prescriptions filled. -Staff gave her a fluid pill daily. -She only used the polyethylene glycol as needed, but she used to take it daily. Interview with a medication aide (MA) on 11/09/18 at 9:23 am revealed: -She did not know Resident #2's medication had not been clarified on the FL2. -The Resident Care Director (RCD) usually obtained clarifications from the physician. -Resident #2 used a mail order pharmacy to get her prescriptions filled but it took 7 - 10 days to get the medications after ordering them. -The RCD was no longer employed at the facility and the Administrator had taken over the RCD's duties. Interview with the Administrator on 11/09/18 at 4:10 pm revealed: -She double checked all orders when they came in. -The FL2 was usually filled out by a MA. -She had never filled out an FL2. -The FL2 should had been clarified by the MA's. -She did not know why the FL2 had not been clarified. Interview with a pharmacy representative from Resident #2's pharmacy on 11/09/18 at 4:20 pm revealed: -The pharmacy filled prescriptions for Resident #2. -The pharmacy did not use Resident #2's FL2 to fill prescriptions. -The physician sent prescriptions directly to the	D 344		

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D 344	Continued From page 19 pharmacy. -The last order the pharmacy had for furosemide was for 40 mg daily. -The last order for polyethylene glycol was for 17 grams daily. -The prescriptions were filled with a 90 day supply. Attempted telephone interview with the physician on 11/09/18 at 1:50 pm was unsuccessful.	D 344		
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 practicing practitioner for 1 of 5 sampled residents (Resident #1) with a physician's order for refresh gel drops.	D 358	please see attachment	

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D 358	Continued From page 20 The findings are: Review of Resident #1's current FL2 dated 08/21/18 revealed diagnoses included pre-diabetes, atrial fibrillation, anemia, cardiac pacemaker, chronic kidney disease three and hypertension. Review of Resident #1's medication clarification form dated 10/04/18 revealed: -Documentation on the form included "Pt. has severe dry eye with erosion OS (left eye)." -There was a physician's order to start refresh gel drops (treat dry eyes) four times daily OS. Review of Resident #1's electronic Medication Administration Records (MARs) for October and November 2018 revealed no entry for refresh gel drops. Observation of medications on hand for Resident #1 on 11/08/18 at 5:22 pm revealed refresh gel drops were not available for administration. Interview with a medication aide (MA) on 11/08/18 at 5:26 pm revealed: -She did not recall seeing an order for refresh gel drops. -Resident #1 had a problem with dry eyes and was previously put on an eye lubricant, but she did not recall seeing the gel drops. -When orders were received the MA on duty was to log the order in the medication tracking book. -The Administrator was responsible for reviewing the orders and making sure they were clear and sent to the pharmacy. -There was no documentation regarding the refresh gel drops were received or administered. Interview with Resident #1 on 11/09/18 at 11:11	D 358		

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D 358	Continued From page 21 am revealed: -Currently, she had use of her left eye only because her right eye was artificial. -Sometimes she had very dry eyes and needed something for her left eye. -She was previously ordered an eye lubricant that was very thick and she was unable to see after the medication was administered, so staff administered the medication at bedtime. -Currently, she had artificial tears, which she kept in her room at her bedside and used as needed. -She did not recall getting an eye gel administered four times daily. Interview with the Executive Director on 11/09/18 at 11:15 am revealed: -All medications should be administered as ordered. -When medication orders were received the medication aide (MA) on duty should log the order and send the prescription to the pharmacy. -If the physician did not send a prescription for the refresh gel drops the MA may not have considered the refresh an order. -The MA should have contacted the physician in October 2018 to clarify the order. Interview with the Administrator on 11/09/18 at 8:10 pm revealed: -Refresh gel drops were not currently being administered to Resident #1. -She reviewed medication orders after the MA to ensure medications were administered as ordered. -She had reviewed the order for refresh gel drops four times daily for Resident #1, but did not consider the refresh gel drops to be an order because the physician did not hand write a prescription. -The refresh gel drops were never administered.	D 358		

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D 358	Continued From page 22 -She knew the facility needed an order for all medications even as needed (recommended) medications. Interview on 11/09/18 at 1:50 pm with the nurse at Resident #1's PCP's office revealed: -Due to Resident #1's age she had chronic dry eyes. -The physician wrote to start refresh gel drops four times daily, but did not write a prescription for the medication because the medication could be purchased over-the-counter. -Since there was no written prescription for the refresh gel drops, the facility should have contacted the PCP's office to clarify the order.	D 358		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure there were two witness signatures on the Resident Personal Funds Ledger to verify the accuracy of transactions and disbursement of personal funds for 3 of 4 sampled residents (Residents #1, #2 and #4).	D 421	please see attachment	1/11/2019

Page 23 (D421) .1104 ACCOUNTING FOR RESIDENT'S PERSONAL FUNDS

Page 23 (D421) .1104 Accounting for Resident's personal Funds

Any Resident who resides at AAHALF, when receiving his or her personal funds will be accompanied by two or more staff. Facility revised ledgers forums on January 1, 2019 .Transactions will be monitored by Administrator and ED once a month.

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D 421	Continued From page 23 The findings are: 1. Review of Resident #1's current FL2 dated 08/21/18 revealed diagnoses included pre-diabetes, atrial fibrillation, anemia, cardiac pacemaker, chronic kidney disease three and hypertension. Review of the September 2018 Resident Personal Fund Ledger for Resident #1 revealed: -The begining balance for September 2018 was $80.00. -Resident #1 had 1 transaction in September 2018 for receipt of $20.00 in personal funds. -There was 1 signature line for Resident #1 and staff to sign. -The ending balance for September 2018 was $60.00. -Resident #1 signed confirming she received $20.00 in September 2018. -There were no witness signatures in September 2018. Review of the October 2018 Resident Personal Fund Ledger for Resident #1 revealed: The begining balance for October 2018 was $60.00. -Resident #1 had 1 transaction in October 2018 for receipt of $20.00 in personal funds. -There was 1 signature line for t.Resident #1 and staff to sign. -The ending balance for October 2018 was $40.00. -Resident #1 signed confirming she received $20.00 in October 2018. -There were no witness signatures in October 2018. Interview with Resident #1 on 11/09/18 at 8:08 pm revealed:	D 421		

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D 421	Continued From page 24 -She paid for her cost of care from personal funds. -Her family member brought money to the facility each month for her to use as needed. -She could get money from the facility when she wanted to. -The Business Office Manager (BOM) or the Executive Director (ED) gave her money when she requested it and she had not seen anyone witness her signature when she signed the Resident Personal Ledger. Attempted telephone interview with the BOM on 11/09/18 at 5:06 pm was unsuccessful. Interview with the Executive Director on 10/09/18 at 5:28 pm revealed: -Resident #1 was private pay and paid for her cost of care. Resident #1 did not receive Special Assistance funds. -She or the Business Office Manager were responsible for signing and had signed as a witness when transactions were made for private pay residents. -She thought it was okay for the resident and 1 witness to sign off on the Resident Personal Fund Ledger. -She did not know 2 witness signatures were required for transactions. -She did not know why there was not a witness signature on the Resident Fund Ledger when money was given to Resident #1. 2. Review of Resident #2's current FL2 dated 10/25/18 revealed diagnoses included diabetes with peripheral vascular disease, malignant hypertension, latent effects of cerebral vascular accident, and degenerative disk disease. Review of the September 2018 Resident	D 421		

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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 421	Continued From page 25 Personal Fund Ledger for Resident #2 revealed: -The begining balance for September 2018 was $1436.00. -Resident #2 had 3 transactions in September 2018 for payment of $1200.00 for cost of care, a payment of $40.00 for medication costs, and receipt of $200.00. -Resident #2 should have received $196.00, but an extra $4.00 was given to Resident #2 in error. -There was 1 signature line for Resident #2 and staff to sign for the September 2018 transactions. -Resident #2 signed confirming payment of $1200.00, $40.00 and receipt of $200.00 on 09/26/18, but there were no witness signatures. Review of the October 2018 Resident Personal Fund Ledger for Resident #2 revealed: The begining balance for October 2018 was $1436.00. -Resident #2 had 3 transactions in October 2018 for payment of $1200.00 for cost of care, payment of $117.77 and $61.80 for medication charges. -There was 1 signature line for Resident #2 and staff to sign for both September and October 2018 transactions. -The ending balance for October 2018 was $56.43. -Resident #2 signed confirming payment of $1200.00, on 10/26/18, but she did not sign confirming medication payments of $117.77 and $61.80 on 10/26/18. -There were no witness signatures on the Resident Personal Ledger. Review of the Resident Personal Fund Ledger notebook of Resident #2 revealed: -There was a signed letter written by the Business Office Manager to Resident #2. -There was an outstanding balance for	D 421		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	R 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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 421	Continued From page 26 medication ($117.77 and $61.80) which Resident #2 agreed to pay. -Resident #2 signed the letter confirming she received $56.43 on 11/01/18. -The Business Office Manager signed confirming she gave Resident #2 $56.43 on 11/01/18, but there were no witness signatures. Interview with Resident #2 on 11/09/18 at 6:40 pm revealed: -She received money from the facility monthly after her medication costs were paid. -She usually had $236 left after paying for her cost of care and before paying for her medication. -She signed the Resident Personal Fund Ledger when she paid for her cost of care and when she received money. -Usually there was 1 signature on the Resident Personal Fund Ledger besides hers and not 2 witness signatures. Attempted telephone interview with the Business Office Manager on 11/09/18 at 5:06 pm was unsuccessful. Interview with the Executive Director on 10/09/18 at 5:28 pm revealed: -Resident #2 was private pay and paid for her cost of care. Resident #2 did not receive Special Assistance funds. -She or the Business Office Manager were responsible for signing and had signed as a witness when transactions were made for private pay residents. -She thought it was okay for the resident and 1 witness to sign off on the Resident Personal Fund Ledger. -She did not know 2 witness signatures were required for transactions. -There was not a signature from Resident #2 or	D 421		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	R 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 421	Continued From page 27 witness on 10/26/18 for $117.77 for medication or $56.43 cash on the Resident Personal Fund Register, because Resident #2 did not receive cash on that day due to her wanting a money order to pay an apartment complex. -Resident #2 did not provide the information for the money order for the apartment complex, but requested to receive and was given $56.43 in cash on 11/01/18. 3. Review of Resident #4's current FL2 dated 08/25/18 revealed diagnoses included schizoaffective disorder, depression, insulin dependent diabetes, gastroesophageal refulux disease, and thrombocytopenia. Review of the September 2018 Resident Personal Fund Ledger for Resident #4 revealed: -Resident #4 received Special Assistance funds. -The begining balance for September 2018 was $66.00. and -Resident #4 was given $38.11 after having an advance of $2.00 debited for cigaretts and paying a pharmacy bill of $25.89 in September 2018. -The ending balance for September 2018 was $0. -There was a signature line for Resident #4, the Administrator, and a staff/witness. -The Resident Personal Fund Ledger for Resident #4 was signed by Resident #4 and the Business Office Manager on 09/06/18. -There was not a second witness signature. Review of the October 2018 Resident Personal Fund Ledger for Resident #4 revealed: -The begining balance for October 2018 was $66.00. -There were no transactions. -Resident #4 was given $66 in October 2018. -The ending balance for October 2018 was $0. -There was a signature line for the Resident #4,	D 421		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 421	Continued From page 28 the Administrator, and a staff/witness. -The Resident Personal Fund Ledger for Resident #4 was signed by Resident #4 and the Business Office Manager on 10/08/18. -There was not a second witness signature. Review of the November 2018 Resident Personal Fund Ledger for Resident #4 revealed: -The beginning balance for November 2018 was $66. -Resident #4 was given $66 in November 2018. -The ending balance for November 2018 was $0. -There was a signature line for the Resident #4, the Administrator, and a staff/witness. -The Resident Personal Fund Ledger for Resident #4 was signed by Resident #4 and the Business Office Manager on 11/06/18. -There was not a second witness signature. Interview with Resident #4 on 10/08/18 at 11:58 am revealed: -He received a $66 Special Assistance allowance every month. -If he had medication costs, he received what was left over after paying for medication. Interview with the Resident #4 on 10/09/18 at 8:11 pm revealed: -He signed the Resident Personal Fund Ledger when he received money every month. -There was only one other person who signed when he signed and that was either the Director or the Business Office Manager. Attempted telephone interview with the Business Office Manager on 11/09/18 at 5:06 pm was unsuccessful. Interview with the Executive Director on 10/08/18 at 10:03 am revealed:	D 421		

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D 421	Continued From page 29 -Resident #4 received Special Assistance funds. -Resident #4 received $66 in personal allowance each month. Interview with the Executive Director on 10/09/18 at 5:28 pm revealed: -She and the Business Office Manager were responsible for signing as a witness when money was given to residents. -She or the Business Office Manager had signed as a witness when residents received the Special Assistance personal needs allowance or personal funds. -She thought it was okay for the resident and 1 witness to sign off on the Resident Personal Fund Ledger. -She did not know 2 witness signatures were required when Special Assistance personal needs allowance was given to residents.	D 421		