STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 Home Licensure Section conducted an annual survey on 04/17/19.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, B, and C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired 01/10/19 as a Personal Care Aide (PCA). -There was no documentation that a HCPR check had been completed upon hire. Review of a HCPR check for Staff A dated 04/17/19 revealed there were no substantiated findings. Refer to the interview with the Business Office Manager (BOM) on 04/17/19 at 5:10pm.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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D 137	Continued From page 1 Refer to the interview with the Administrator on 04/17/19 at 5:15pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 12/20/18 as a Medication Aide (MA). -There was no documentation that a HCPR check had been completed upon hire. Review of a HCPR check for Staff B dated 04/17/19 revealed there were no substantiated findings. Refer to the interview with the BOM on 04/17/19 at 5:10pm. Refer to the interview with the Administrator on 04/17/19 at 5:15pm. 3. Review on Staff C's personnel record revealed: -Staff C was hired on 12/19/18 as a PCA. -There was no documentation that a HCPR check had been completed upon hire. Review of a HCPR check for Staff C dated 04/17/19 revealed there were no substantiated findings. Refer to the interview with the BOM on 04/17/19 at 5:10pm. Refer to the interview with the Administrator on 04/17/19 at 5:15pm. _____ Interview with the Business Office Manager (BOM) on 04/17/19 at 5:10pm revealed: -The BOM was responsible for the personnel files. -The BOM did not know what the HCPR checks	D 137		

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	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 137	Continued From page 2 were or that they needed to be completed. Interview with the Administrator on 04/17/19 at 5:15pm revealed: -She knew that staff needed HCPR checks upon hire. -She did not know the HCPR had not been completed. -The BOM was responsible for completing them. -The BOM had been hired in January 2019. -She did not know why the HCPR were not completed. The facility failed to ensure 3 of 3 staff (Staff A, B, and C) had a HCPR check completed prior to hire. This failure resulted in the facility not knowing if staff had substantiated findings on the HCPR which was detrimental to the health, safety, 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 04/17/19 for this violation. CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 1, 2019.	D 137		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 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	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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D 164	Continued From page 3 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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled Medication Aides (Staff B, D, and E) who administered insulin and obtained finger stick blood sugars for residents completed training on the care of diabetic residents prior to the administration of insulin. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 12/20/18 as a Medication Aide. -There was no documentation of training on the care of a diabetic resident. Review of a March and April 2019 Medication Administration Record (MAR) revealed:	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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D 164	Continued From page 4 -Staff B documented administering insulin on 03/04/19 - 03/06/19, 03/11/19 - 03/14/19, 03/18/19, 03/20/19, 03/21/19, 03/25/19, 03/27/19, and 03/28/19 at 8:00pm. -Staff B documented administering insulin on 04/01/19, 04/03/19 - 04/04/19, 04/08/19 - 04/10/19, and 04/15/19 at 8:00pm. Telephone interview with Staff B on 04/17/19 at 4:30pm revealed: -She had worked full time in the facility as a Medication Aide since December 2018. -She had checked finger stick blood sugars and administered insulin to residents in the facility. -She had received diabetic training at another facility prior to her hire date at this facility. -She did not have any paper work on the diabetic training. -Shehad not received any diabetic training at this facility. Refer to the interview with the facility Nurse on 04/17/19 at 5:20pm. Refer to the interview with the Administrator on 04/17/19 at 5:15pm. 2. Review of Staff D's personnel record revealed: -Staff D was hired on 03/01/18 as a Medication Aide. -There was no documentation of training on the care of a diabetic resident. Review of a March and April 2019 MAR revealed: -Staff D documented administering insulin on 03/01/19 - 03/03/19, 03/07/19 - 03/10/19, 03/15/19 - 03/17/19, 03/19/19, 03/23/19, 03/24/19, 03/26/19, and 03/29/19 - 03/31/19 at 8:00pm. -Staff D documented administering insulin on	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 164	Continued From page 5 04/02/19, 04/05/19 - 04/07/19, 04/12/19 - 04/14/19, and 04/16/19 at 8:00pm. Telephone interview with Staff D on 04/17/19 at 4:50pm revealed: -She was initially hired at the facility as a personal care aide (PCA). -She started working as a MA "around the end of June 2018." -She was trained by the facility nurse as a MA before she administered medications. -She administered insulin and checked finger stick blood sugar for the residents. -She did not remember the facility offering any diabetic training. -She had completed some continuing education in diabetes on her own. Refer to the interview with the facility Nurse on 04/17/19 at 5:20pm. Refer to the interview with the Administrator on 04/17/19 at 5:15pm. 3. Review of Staff E's personnel record revealed: -Staff E was hired on 02/21/17 as a Medication Aide. -There was no documentation of training on the care of a diabetic resident. Review of a March and April 2019 MAR revealed: -Staff E documented obtaining fingerstick blood sugars and administering insulin on 03/02/19, 03/05/19, 03/09/19, 03/10/19, 03/16/19, 03/17/19, 03/24/19, 03/30/19, and 03/31/19 at 7:30am, 11:30am, and 4:30pm. -Staff E documented obtaining fingerstick blood sugars and administering insulin on 04/06/19 at 7:30am, 11:30am, and 4:30pm, 04/13/19 at 7:30am and 11:30am, and 4:30pm, and 04/14/19	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 164	Continued From page 6 at 7:30am and 4:30pm. Telephone interview with Staff E on 04/17/19 at 5:14pm revealed: -She was hired as a MA in February 2016. -She was trained as an MA before she started working at the facility. -She administered insulin and checked finger stick blood sugar for the residents. -She shadowed another MA before she worked alone. -She was observed by the facility nurse on proper techniques for administering insulin before administering medication. -She did not remember being trained in diabetic care at the facility. Refer to the interview with the facility Nurse on 04/17/19 at 5:20pm. Refer to the interview with the Administrator on 04/17/19 at 5:15pm. Interview with the facility Nurse on 04/17/19 at 5:20pm revealed: -She was responsible for the training for the Medication Aides and knew they needed diabetic training. -She had not been working in the facility at the time Staff B, D, and E were hired. -The nurse did not know the MAs had not completed diabetic training. Interview with the Administrator on 04/17/19 at 5:15pm revealed: -The nurse was responsible for all the training for all the MAs. -She did not know Staff B, D, and E had not completed the diabetic training.	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 164	Continued From page 7 The facility failed to ensure all medication aides received training on the care of diabetic residents before administering insulin. This failure placed all diabetic residents at risk of high or low blood glucose levels and was detrimental to the health, safety, 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 04/17/19 for this violation. CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 1, 2019.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider for 1 of 3 sampled residents (Resident #3) related to the refusal of multiple medications, including a vision supplement for eye health, a supplement for bone health, a cholesterol lowering supplement, a supplement for joint health, and a supplement for heart health.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 273	Continued From page 8	D 273		

Review of Resident #3's current FL2 dated 05/01/18 revealed:
-Diagnoses included diabetes, macular degeneration, dyspnea with exertion, and osteoporosis.
-There was a physician's order for Preservision AREDS multivitamins (used to promote eye health) take 1 tablet daily with lunch.
-There was a physician's order for vitamin D3 2000 units (supplement used to improve bone health and energy) take 2 tablets daily with lunch.
-There was a physician's order for red yeast rice 600mg (supplement that may lower cholesterol) take 2 capsules daily with lunch.
-There was a physician's order for glucosamine/chondroitin 500/400mg (supplement for joint health) take 3 tablets daily.
-There was a physician's order for coenzyme Q10 100mg (supplement used for heart health) take 1 capsule daily.

a. Review of Resident #3's February 2019 Medication Administration Record (MAR) revealed:
-There was a computer generated entry for Preservision AREDS take 1 tablet daily with lunch scheduled to be administered at 12:00pm.
-Preservision AREDS was documented as refused by Resident #3 for 13 out of 28 opportunities from 02/01/19 to 02/28/19.

Review of Resident #3's March 2019 MAR revealed:
-There was a computer generated entry for Preservision AREDS take 1 tablet daily with lunch scheduled to be administered at 12:00pm.
-Preservision AREDS was documented as refused by Resident #3 for 12 out of 31 opportunities from 03/01/19 to 03/31/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 273	Continued From page 9	D 273		

Review of Resident #3's April 2019 MAR revealed:
-There was a computer generated entry for Preservision AREDS take 1 tablet daily with lunch scheduled to be administered at 12:00pm.
-Preservision AREDS was documented as refused by Resident #3 for 13 out of 16 opportunities from 04/01/19 to 04/16/19.

Observation of medications on hand for Resident #3 at 2:30pm on 04/17/19 revealed a partially used medication card containing Preservision AREDS was available for administration.

Interview with Resident #3 on 04/17/19 at 5:04pm revealed:
-She had macular degeneration and was followed by an ophthalmologist.
-She did not feel like she needed her vitamins every day.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/17/19 at 3:59pm revealed it was not good for Resident #3 to refuse her Preservision AREDS because she would miss out on the benefits of the medication for her eye health.

Telephone interview with a nurse from Resident #3's ophthalmologist's office on 04/17/19 at 5:00pm revealed:
-The ophthalmologist did not know Resident #3 was refusing the Preservision AREDS.
-Resident #3 had "terrible vision" and the Preservision AREDS were important to preserve eye health.
-The supplement would not reverse vision loss.

Attempted telephone interview with Resident #3's primary care provider on 04/17/19 at 3:44pm was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 273	Continued From page 10 unsuccessful. Refer to the interview with the Resident Care Coordinator on 04/17/19 at 4:20pm. Refer to the interview with the facility nurse on 04/17/19 at 4:30pm. Refer to the interview with the Administrator on 04/17/19 at 4:38pm. b. Review of Resident #3's February 2019 Medication Administration Record (MAR) revealed: -There was a computer generated entry for vitamin D3 2000 units take 2 tablets daily with lunch scheduled to be administered at 12:00pm. -Vitamin D3 was documented as refused by Resident #3 for 10 of 28 opportunities from 02/01/19 to 02/28/19. Review of Resident #3's March 2019 MAR revealed: -There was a computer generated entry for vitamin D3 2000 units take 2 tablets daily with lunch scheduled to be administered at 12:00pm. -Vitamin D3 was documented as refused by Resident #3 for 12 of 31 opportunities from 03/01/19 to 03/31/19. Review of Resident #3's April 2019 MAR revealed: -There was a computer generated entry for vitamin D3 2000 units take 2 tablets daily with lunch scheduled to be administered at 12:00pm. -Vitamin D3 was documented as refused by Resident #3 for 13 of 16 opportunities from 04/01/19 to 04/16/19. Observation of medications on hand for Resident	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 273	Continued From page 11 #3 at 2:30pm on 04/17/19 revealed a partially used medication card with 2 tablets of Vitamin D3 in each bubble was available for administration. Interview with Resident #3 on 04/17/19 at 5:04pm revealed she did not feel like she needed her vitamins every day. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/17/19 at 3:59pm revealed: -Pharmacy started providing medications to the facility at the beginning of April 2019. -Resident #3 would be at an increased risk of low vitamin D levels if she was not taking the supplement as prescribed. Attempted telephone interview with Resident #3's primary care provider on 04/17/19 at 3:44pm was unsuccessful. Refer to the interview with the Resident Care Coordinator on 04/17/19 at 4:20pm. Refer to the interview with the facility nurse on 04/17/19 at 4:30pm. Refer to the interview with the Administrator on 04/17/19 at 4:38pm. c. Review of Resident #3's February 2019 Medication Administration Record (MAR) revealed: -There was a computer generated entry for red yeast rice 600mg take 2 capsules daily with lunch scheduled to be administered at 12:00pm. -Red yeast rice was documented as refused by Resident #3 for 12 of 28 opportunities from 02/01/19 to 02/28/19.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 273	Continued From page 12 Review of Resident #3's March 2019 MAR revealed: -There was a computer generated entry for red yeast rice 600mg take 2 capsules daily with lunch scheduled to be administered at 12:00pm. -Red yeast rice was documented as refused by Resident #3 for 12 of 31 opportunities from 03/01/19 to 03/31/19. Review of Resident #3's April 2019 MAR revealed: -There was a computer generated entry for red yeast rice 600mg take 2 capsules daily with lunch scheduled to be administered at 12:00pm. -Red yeast rice was documented as refused by Resident #3 for 13 of 16 opportunities from 04/01/19 to 04/16/19. Observation of medications on hand for Resident #3 at 2:30pm on 04/17/19 revealed a partially used medication card containing red yeast rice 600mg was available for administration. Interview with Resident #3 on 04/17/19 at 5:04pm revealed she did not feel like she needed her vitamins every day. Attempted telephone interview with Resident #3's primary care provider on 04/17/19 at 3:44pm was unsuccessful. Refer to the interview with the Resident Care Coordinator on 04/17/19 at 4:20pm. Refer to the interview with the facility nurse on 04/17/19 at 4:30pm. Refer to the interview with the Administrator on 04/17/19 at 4:38pm.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 273	Continued From page 13 d. Review of Resident #3's February 2019 Medication Administration Record (MAR) revealed: -There was a computer generated entry for glucosamine/chondroitin 500/400mg take 3 tablets daily scheduled to be administered at 12:00pm. -Glucosamine/Chondroitin was documented as refused by Resident #3 for 12 of 28 opportunities from 02/01/19 to 02/28/19. Review of Resident #3's March 2019 MAR revealed: -There was a computer generated entry for glucosamine/chondroitin 500/400mg take 3 tablets daily scheduled to be administered at 12:00pm. -Glucosamine/Chondroitin was documented as refused by Resident #3 for 11 of 31 opportunities from 03/01/19 to 03/31/19. Review of Resident #3's April 2019 MAR revealed: -There was a computer generated entry for glucosamine/chondroitin 500/400mg take 3 tablets daily scheduled to be administered at 12:00pm. -Glucosamine/Chondroitin was documented as refused by Resident #3 for 12 of 16 opportunities from 04/01/19 to 04/16/19. Observation of medications on hand for Resident #3 at 2:30pm on 04/17/19 revealed a partially used medication card containing glucosamine/chondroitin was available for administration. Interview with Resident #3 on 04/17/19 at 5:04pm revealed she did not feel like she needed her vitamins every day.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 273	Continued From page 14 Attempted telephone interview with Resident #3's primary care provider on 04/17/19 at 3:44pm was unsuccessful. Refer to the interview with the Resident Care Coordinator on 04/17/19 at 4:20pm. Refer to the interview with the facility nurse on 04/17/19 at 4:30pm. Refer to the interview with the Administrator on 04/17/19 at 4:38pm. e. Review of Resident #3's February 2019 Medication Administration Record (MAR) revealed: -There was a computer generated entry for coenzyme Q10 100mg take 1 capsule daily scheduled to be administered at 12:00pm. -Coenzyme Q10 was documented as refused by Resident #3 for 13 out of 28 opportunities from 02/01/19 to 02/28/19. Review of Resident #3's March 2019 MAR revealed: -There was a computer generated entry for coenzyme Q10 100mg take 1 capsule daily scheduled to be administered at 12:00pm. -Coenzyme Q10 was documented as refused by Resident #3 for 13 out of 31 opportunities from 03/01/19 to 03/31/19. Review of Resident #3's April 2019 MAR revealed: -There was a computer generated entry for coenzyme Q10 100mg take 1 capsule daily scheduled to be administered at 12:00pm. -Coenzyme Q10 was documented as refused by Resident #3 for 13 out of 16 opportunities from	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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D 273	Continued From page 15 04/01/19 to 04/16/19. Observation of medications on hand for Resident #3 at 2:30pm on 04/17/19 revealed a partially used medication card containing coenzyme Q10 was available for administration. Interview with Resident #3 on 04/17/19 at 5:04pm revealed she did not feel like she needed her vitamins every day. Attempted telephone interview with Resident #3's primary care provider on 04/17/19 at 3:44pm was unsuccessful. Refer to the interview with the Resident Care Coordinator on 04/17/19 at 4:20pm. Refer to the interview with the facility nurse on 04/17/19 at 4:30pm. Refer to the interview with the Administrator on 04/17/19 at 4:38pm. _____ Interview with the Resident Care Coordinator (RCC) on 04/17/19 at 4:20pm revealed: -She started working at the facility in January 2019. -She did not think she needed to contact Resident #3's provider because she was refusing "only vitamins." -She did not notify Resident #3's provider that she was refusing multiple medications. -She would have called Resident #3's provider if she was refusing her "real medications." -Resident #3 was having problems with her stomach and did not want to take her medications if her stomach "did not feel good." -Prior to January 2019, the facility did not have a	D 273		

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	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 273	Continued From page 16 procedure to follow when a resident refused a medication. -She or the medications aides (MA) were responsible for contacting the provider regarding medication refusals. -The resident's provider should be contacted after a resident refuses 3 consecutive doses of a medication. -She and the MAs were responsible for documenting medication refusals on a 24 hour report. -The 24 hour report was a communication tool to pass information to each shift. -The medication refusals would stay on the report until the provider had been called and a response was documented. Interview with the facility nurse on 04/17/19 at 4:30pm revealed: -She did not know Resident #3 was refusing medications. -She was "okay" with a resident refusing medications if the resident "had a good reason" such as they were experiencing a side effect from the medication. -If a resident was refusing an essential medication like an antibiotic or insulin then the provider should be contacted immediately. -The RCC was responsible for contacting the provider for all "consistent medication refusals." Interview with the Administrator on 04/17/19 at 4:38pm revealed: -She did not know Resident #3 was refusing her lunch time medications on most days. -The MAs and the RCC were responsible for making sure the residents received their medications. -The MAs and the RCC should be encouraging the resident to take their medications.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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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 and interviews, the facility failed to ensure foods being stored by the facility were protected from contamination related to meat being improperly thawed, open food packages not labeled or dated, and expired foods stored in the refrigerator and on a rack in the kitchen. The finding are: Review of the facility kitchen sanitation report dated 01/28/19 revealed: -The facility received a score of 94. -The facility was cited for Ready-To-Eat Potentially Hazardous Food (Time/Temperature Control for Safety Food). Observation of the kitchen area on 04/17/19 at 10:01am revealed there was a large plastic container on the counter top with raw chicken pieces submerged in blood tinged water. Interview with the cook on 04/17/19 at 10:02am revealed: -She had worked as the cook at the facility for 15 years. -She did not remember who had trained her as a cook. -She had received her ServSafe certification in	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 283	Continued From page 18 October 2018. -The menu for lunch on 04/17/19 consisted of fried chicken, collard greens, twice baked potatoes, pound cake for regular diets, and fresh fruit for low concentrated sweets diet. -She had planned on using the chicken in the plastic container on the counter top for lunch. Observation of a rolling rack in the kitchen used to store cans of food on 04/17/19 at 10:11am revealed: -There was a large can of corned beef hash with no expiration date. -There was a second large can of corned beef hash with an expiration date of 10/13/18. -There was a large can of jalapenos with an expiration date of 08/27/18. -There were 2 large cans of chow mein noodles with an expiration date of 10/27/18. -There was a large can of jellied cranberry with the expiration date of 03/06/19. Interview with the cook on 04/17/19 at 10:19am revealed: -She knew that the large cans of food stored on the rolling rack in the kitchen were expired. -The expired canned foods were from the facility's previous food supply company. -"We probably need to just get rid of them. We don't use them". Observation of the refrigerator in the kitchen on 04/17/19 at 10:22am revealed: -There was a metal container holding an open package of bacon that was not labeled with an open date. -There was a plastic container holding half of a 5lb package of hamburger meat stored in a Ziploc bag with an open date of 04/15/19 and expiration or freeze by date 03/17/19.	D 283		

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	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 283	Continued From page 19 -There was a metal container with pork chops stored in a large Ziploc bag with an open date 04/13/19, and a 2.41 pound sealed package with an expiration or freeze by date 04/16/19. -There was a clear plastic container covered with plastic wrap labeled "field" peas with a date 04/08/19. -There was a metal container with cooked broccoli covered in plastic wrap dated 04/10/19. -There was a black plastic container of what appeared gravy with yellow discolored areas around the edges covered with plastic wrap dated 04/11/19. Interview with the Administrator on 04/17/19 at 11:17am revealed: -The cook was also the Food Service Director. -The Food Service Director was responsible for the training of staff in the kitchen. -The cook had her ServSafe Certification. -The facility policy was for open foods to be covered and labeled with the open date. -All the kitchen staff had been trained on how to properly thaw meat, and date, label, and store foods. -She did know there were expired cans of food in the kitchen and the expired canned food "will be thrown out today". -She did not know that the raw chicken was sitting in a container of water on the counter. -She did know how to properly thaw meat and it had to be thawed either in the refrigerator or under continuous running cold water in the sink. Interview with the cook on 04/17/19 at 11:28am revealed: -She had been informed by the Administrator to discard the chicken. -The chicken pieces were in a brine that she had made of salt and water.	D 283		

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	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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D 283	Continued From page 20 -She did not know why the chicken could not be cooked and served since the chicken had been left sitting out on the counter in the kitchen. -She knew the technique to properly thaw meat.	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: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents related to a medication for blood pressure (Resident #2), a medication for shortness of breath (Resident #1), and a medication used to treat high blood glucose levels (Resident #3). The findings are:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 358	Continued From page 21 1. Resident #2's current FL2 dated 01/09/19 revealed: -Diagnoses included diabetes and hypertension. -A medication order for valsartan (used to treat high blood pressure) 160mg 1 tablet daily. Review of Resident #2's Medication Administration Record for April 2019 revealed: -There was an entry for valsartan 160mg one tablet daily with an administration time of 8:00am. -There was documentation the valsartan was not administered 04/09/19 - 04/17/19 due to the medication not being available. -There was documentation of a weekly blood pressure on 04/05/19 of 138/70 and on 04/12/19 of 140/78. Observation of Resident #2's medications on hand on 04/17/19 at 2:00pm revealed there was no valsartan available for administration. Interview with the facility nurse on 04/17/19 at 2:07pm revealed: -Resident #2's medications were dispensed from a local veteran's hospital pharmacy. -The pharmacy had not sent any valsartan. -She had requested the valsartan a second time on 04/16/19 from the pharmacy. -She had not called the facility's back up pharmacy because the Resident would have to pay for the medication himself. -She had notified the Resident's physician that the Resident was out of the valsartan. Telephone interview with the facility's local back up pharmacy on 04/17/19 at 2:35pm revealed: -The facility should have notified the contracted pharmacy which would then notify the back up pharmacy a medication was needed. -The pharmacy had received no requests from	D 358		

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	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 358	Continued From page 22 the facility for valsartan. Telephone interview with the facility's contracted pharmacy on 04/17/19 at 2:45pm revealed: -The facility should have notified the pharmacy they needed valsartan for Resident #2. -The pharmacy had received no requests from the facility for valsartan. Telephone interview with Resident #2's physician's nurse on 04/17/19 at 3:00pm revealed: -A staff member from the facility had notified the physician on 04/09/17 that a renewal of valsartan was needed. -Resident #2 was on another blood pressure medication as well as valsartan. -An increase in Resident #2's blood pressure was possible without taking the valsartan. Interview with Resident #2 on 04/17/19 at 3:10pm revealed: -He knew the facility was "having trouble" getting the valsartan. -He felt like his blood pressure was in control. Interview with the Administrator on 04/17/19 at 3:15pm revealed: -The nurse should have notified the back up pharmacy the medication was needed. -The nurse had worked in the facility since January 2019 and had been trained to call the back up pharmacy when medication was out. 2. Review of Resident #1's current FL2 dated 01/23/19 revealed diagnoses included dementia, anxiety, depression, and dyspnea.	D 358		

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	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 358	Continued From page 23 Review of signed physician's orders for Resident #1 revealed a medication order dated 01/23/19 for Anoro Ellipta (used to treat chronic obstructive pulmonary disease) one inhalation daily. Review of Resident #1's February 2019 medication administration record (MAR) revealed there was no entry for Anoro Ellipta. Review of Resident #1's March 2019 MAR revealed there was no entry for Anoro Ellipta. Review of Resident #1's April 2019 MAR revealed there was no entry for Anoro Ellipta. Observation of Resident #1's medications on hand on 04/17/19 at 2:30pm revealed there was no Anoro Ellipta inhaler available for administration. Interview with the facility nurse on 04/17/19 at 2:50pm revealed: -There was not an order to discontinue Anoro Ellipta for Resident #1. -The Anoro inhaler had "never been on the MARs" for Resident #1. -She did not call Resident #1's physician to verify the order for Anoro inhaler because she did not work at the facility at the time the order was written. Attempted telephone interview with Resident #1's physician on 04/17/19 at 3:00pm was unsuccessful. Interview with Resident #1 on 04/17/19 at 3:41pm revealed: -He did not remember if he had ever experienced shortness of breath. -He smoked cigarettes for many years when he	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 358	Continued From page 24	D 358		

was younger.
-He did not know if he had used inhalers before to help with shortness of breath.

Telephone interview with the facility's previous contracted pharmacy on 04/17/19 at 3:58pm revealed they did not have an order for Anoro Ellipta inhaler for Resident #1.

Interview with the Administrator on 04/17/19 at 4:03pm revealed:
-She did not know anything about the medication order for Anoro inhaler for Resident #1.
-The RCC and facility nurse were responsible for processing new medication orders.

Interview with the RCC on 04/17/19 at 4:05pm revealed:
-A different pharmacy dispensed medications for Resident #1 before 04/08/19.
-There had never been an entry on the MAR to administer Anoro inhaler to Resident #1.

Attempted telephone interview with the facility's current contracted pharmacy on 04/17/19 at 4:12pm was unsuccessful.

Interview with the facility nurse on 04/17/19 at 5:15pm revealed:
-She created a new FL2 for any resident that incurred a significant change and would fax it to the physician to make any necessary changes and sign the orders.
-When the physician's office faxed the FL2 back to the facility the LPN or her, she would review the orders on the FL2.
-Medications ordered would be compared to the MAR and the MAR would be changed to match the new physician orders.
-She would write any new physician's orders on a

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	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

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D 358	Continued From page 25	D 358		

physician order sheet and fax it to the pharmacy to have the medications dispensed or discontinued by the pharmacy.
-She did not work at the facility when the Anoro Ellipta inhaler for Resident #1 was ordered by the physician.
-She did not know how the medication order for Anoro inhaler for Resident #1 was missed.
-She did not know why the medication order for Anoro inhaler for Resident #1 was not faxed to the pharmacy.

3. Review of Resident #3's current FL2 dated 05/01/18 revealed:
-Diagnoses included diabetes, macular degeneration, dyspnea with exertion, and osteoporosis.
-There was a physician's order for Humalog (insulin used to treat diabetes) Kwikpen (device used to administer insulin) inject per sliding scale directions 3 times daily; 0-100=0units, 101-150=2units, 151-200=4units, 201-250=6units, 251-300=8units, 301-350=12units, 351-400=14units, 401-450=16units.
-There was a physician's order to check finger stick blood sugar (FSBS) before meals and as needed.

Review of Resident #3's February 2019 Medication Administration Record (MAR) revealed:
-There was a computer generated entry for Humalog Kwikpen inject three times daily before meals per sliding scale; 0-100=0units, 101-150=2units, 151-200=4units, 201-250=6units, 251-300=8units, 301-350=12units, 351-400=14units, 401-450=16units scheduled to be administered at 7:30am, 11:30am, and 4:30pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 358	Continued From page 26 -Sliding scale insulin was documented as administered 3 times daily from 02/01/19 to 02/28/19. -On 02/12/19 at 11:30am, the FSBS was recorded as 264 and 6 units of insulin was documented as administered. -On 02/20/19 at 11:30am, the FSBS was recorded as 362 and 12 units of insulin was documented as administered. -On 02/20/19 at 4:30pm, the FSBS was recorded as 197 and 8 units of insulin was documented as administered. -On 02/25/19 at 7:30am, the FSBS was recorded as 120 and 4 units of insulin was documented as administered. -On 02/27/19 at 7:30am, the FSBS was recorded as 132 and 4 units of insulin was documented as administered. Review of Resident #3's March 2019 MAR revealed: -There was a computer generated entry for Humalog Kwikpen inject three times daily before meals per sliding scale; 0-100=0units, 101-150=2units, 151-200=4units, 201-250=6units, 251-300=8units, 301-350=12units, 351-400=14units, 401-450=16units scheduled to be administered at 7:30am, 11:30am, and 4:30pm. -Sliding scale insulin was documented as administer 3 times daily from 03/01/19 to 03/31/19. -On 03/01/19 at 7:30am, the FSBS was recorded as 146 and 4 units of insulin was documented as administered. -On 03/04/19 at 7:30am, the FSBS was recorded as 146 and 4 units of insulin was documented as administered. -On 03/13/19 at 7:30am, the FSBS was recorded as 131 and no units of insulin was documented	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	04/17/2019

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D 358	Continued From page 27 as administered. -On 03/21/19 at 4:30pm, the FSBS was recorded as 149 and 4 units of insulin was documented as administered. -On 03/22/19 at 7:30am, the FSBS was recorded as 145 and no units of insulin was documented as administered. -On 03/27/19 at 7:30am, the FSBS was recorded as 138 and 4 units of insulin was documented as administered. Review of Resident #3's April 2019 MAR revealed: -There was a computer generated entry for Humalog Kwikpen inject three times daily before meals per sliding scale; 0-100=0units, 101-150=2units, 151-200=4units, 201-250=6units, 251-300=8units, 301-350=12units, 351-400=14units, 401-450=16units scheduled to be administered at 7:30am, 11:30am, and 4:30pm. -Sliding scale insulin was documented as administered 3 times daily from 04/01/19 through 11:30am on 04/17/19. -On 04/01/19 at 7:30am, the FSBS was recorded as 158 and 2 units of insulin was documented as administered. -On 04/04/19 at 11:30am, the FSBS was recorded as 209 and 4 units of insulin was documented as administered. -On 04/10/19 at 4:30pm, the FSBS was recorded as 237 and 8 units of insulin was documented as administered. -On 04/11/19 at 7:30am, the FSBS was recorded as 153 and 2 units of insulin was documented as administered. -On 04/11/19 at 11:30am, the FSBS was recorded as 274 and 4 units of insulin was documented as administered.	D 358		

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D 358	Continued From page 28 Interview with Resident #3 on 04/17/19 at 5:04pm revealed: -The facility staff checked her blood sugar three times daily. -She was not sure how much insulin she was supposed to receive. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/17/19 at 3:59pm revealed: -The pharmacy began providing medications to the facility at the beginning of April 2019. -The pharmacy had dispensed 1 pen of Humalog Kwikpen to Resident #3 on 04/09/19 with the directions inject per sliding scale three times daily; 0-100=0units, 101-150=2units, 151-200=4units, 201-250=6units, 251-300=8units, 301-350=12units, 351-400=14units, 401-450=16units. -Resident #3 was at an increased risk of having low blood sugar if the facility staff were administering more insulin than ordered by the physician. -Low blood sugar would cause the resident to have cold sweats, fatigue, lightheadedness, and be shaky. Interview with the Resident Care Coordinator (RCC) on 04/17/19 at 5:20pm revealed: -She was a licensed practical nurse (LPN). -She administered medications during first shift on most days. -She did not know Resident #3 had been administered the incorrect dose of sliding scale insulin multiple times during February, March, and April. -She had administered the sliding scale insulin to Resident #3 incorrectly multiple times. -She had "probably just misread the directions." -The facility did not have a procedure for auditing	D 358		

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D 358	Continued From page 29 the MARs. -She was in the process of developing some auditing procedures. -Medications should be administered as ordered by a physician. Interview with the facility nurse on 04/17/19 at 5:38pm revealed: -She did not know Resident #3 had received the incorrect dose of sliding scale insulin. -The RCC and medications aides (MA) were responsible for administered medications as ordered by a physician. -She had instructed the MAs how to give sliding scale insulin during their medication aide checklist observation. Interview with the Administrator on 04/17/19 at 5:32pm revealed: -She did not know Resident #3 had been administered the incorrect dose of sliding scale insulin. -The RCC and MAs were responsible for administering medications as ordered by a physician. -She would audit random MARs weekly to make sure all medications had been administered and review new orders. -She "probably needed to start looking over the MARs more often." Attempted telephone interview with Resident #3's primary care provider on 04/17/19 at 3:44pm was unsuccessful.	D 358		
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:	D912		

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D912	Continued From page 30 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Other Staff Qualifications, Training on Care of Diabetic Residents, and Adult Care Home Medication Aides; Training and Competency.

The findings are:

A. Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, B, and C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag 137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)].

B. Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled Medication Aides (Staff B, D, and E) who administered insulin and obtained finger stick blood sugars for residents completed training on the care of diabetic residents prior to the administration of insulin. [Refer to Tag 164 10A NCAC 13F .0505 Training on Care of Diabetic Residents (Type B Violation)].

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D912	Continued From page 31 C. Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled medication aides (Staff B, D, and E) had completed their 5, 10, or 15 hour state approved medication training. [Refer to Tag 935 G.S. 131D-4.5B(b) ACH 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 developed by the Department that includes	D935		

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D935	Continued From page 32 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 3 of 3 sampled medication aides (Staff B, D, and E) had completed their 5, 10, or 15 hour state approved medication training. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 12/20/18. -There was documentation Staff B had successfully completed the medication exam on 09/30/14. -The Medication Administration Clinical Skills Checklist was completed on 02/28/19. -There was no documentation of prior MA employment verification. -There was no documentation of the 5, 10, or 15 hour training requirement.	D935		

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D935	Continued From page 33 Telephone interview with Staff B on 04/17/19 at 4:30pm revealed: -She had received the 15 hours of medication training at another facility. -She did not know where the paperwork was. Refer to the interview with the facility nurse on 04/17/19 at 5:20pm. Refer to the interview with the Administrator on 04/17/19 at 5:15pm. 2. Review of Staff D's personnel record revealed: -Staff D was hired as a MA on 03/01/18. -There was documentation Staff D had successfully completed the medication exam on 06/18/18. -The Medication Administration Clinical Skills Checklist was completed on 07/06/18. -Five hours of the required training was completed 07/06/18. -There was no documentation of the additional 10 hours of training required. Refer to the interview with the facility nurse on 04/17/19 at 5:20pm. Refer to the interview with the Administrator on 04/17/19 at 5:15pm. 3. Review of Staff E's personnel record revealed: -Staff E was hired as a MA on 02/21/17. -There was documentation Staff E had successfully completed the medication exam on 09/08/16. -The Medication Administration Clinical Skills Checklist was completed on 02/15/18. -Five hours of the required training was completed 02/21/17.	D935		

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D935	Continued From page 34 -There was no documentation of the additional 10 hours of training required. Refer to the interview with the facility nurse on 04/17/19 at 5:20pm. Refer to the interview with the Administrator on 04/17/19 at 5:15pm. Interview with the facility nurse on 04/17/19 at 5:20pm revealed: -She was hired in January 2019. -She was responsible for completing all required medication aide training. -She knew the MAs needed 5 hours of training but did not know they needed an additional 10 hours. Interview with the Administrator on 04/17/19 at 5:15pm revealed: -She was not aware that Staff B, D, and E had not completed the required training. -The previous facility nurse had been responsible for the MA training but she "didn't know enough about it (training)". -She did not know why the MA training had not been completed. The facility failed to ensure medication aides had completed the 15 hour state approved medication aide training which placed all residents at risk for medication errors. This failure was detrimental to the health, safety 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 04/17/19 for this violation. CORRECTION FOR THIS TYPE B VIOLATION	D935		

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D935	Continued From page 35 SHALL NOT EXCEED JUNE 1, 2019.	D935		