STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001002	A. BUILDING: _____ B. WING _____	05/10/2019

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BURLINGTON CARE CENTER	2201 BURCH BRIDGE ROAD BURLINGTON, NC 27217

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on May 9-10, 2019.	D 000		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the living room furnishings were clean and in good repair. The findings are: Observation of the living room on 05/09/19 at 9:09 am revealed: -There was an amber upholstered sofa, situated at the wall, near the doorway with one hole in the middle seat cushion, the edges of the cushion were worn and the white piping material was exposed on each seat cushion. -The wooden sofa arms and ends were scratched. -There were three pieces of brown leather furniture, a loveseat, recliner and sofa. -The back and seat cushions of the recliner were scratched and the leather was peeling exposing a lighter color portion of the cushions. -The seat cushions of the leather sofa were discolored, scratched and peeling exposing a lighter colored portion of the cushions. -The seat and back cushions of the loveseat were discolored, scratched and peeling exposing a	D 076		

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light colored portion of the cushions.
-The right seat of the loveseat tilted to the side and appeared disconnected from the center portion of the loveseat.
-There was a brown wooden coffee table, situated in front of the leather sofa with scratches on the top of the coffee table.

Interview with a resident on 05/09/19 at 9:32 am revealed:
-The upholstered sofa and the leather furniture were delivered to the facility several months ago (he could not remember when he first noticed them).
-He did not use the living room much and the medication aide (MA) cleaned the facility.
-The furniture in the living room needed to be replaced.

Interview with another resident on 05/09/19 at 10:49 am revealed:
-There were scratches on the leather furniture and the furniture was delivered in that condition.
-He used the living room sometimes, to use the phone or watch the television.

Interview with the Supervisor/MA on 05/10/19 at 11:40 am revealed:
-There were scratches, and peeling on the cushions of the leather furniture.
-The furniture was donated, with the scratches, peeling leather and broken loveseat, to the facility by the transportation staff, in 2018 about a year ago.
-The staff slept on the leather sofa and used a blanket and pillow.
-The furniture was damaged by the dogs owned by the transportation staff.
-She was responsible for cleaning the facility and dusted the living room area.

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D 076	Continued From page 2 -The residents sat in the living room before and after the current furniture was donated. -The old living room furniture was removed due to an insect infestation. Interview with the relief Supervisor/MA on 05/10/19 at 12:40 pm revealed: -The furniture in the living room was damaged already when it was brought into the facility. -She mentioned it to the Administrator when the furniture was placed into the facility in 2018 but did not receive a response about what would be done to replace the damaged furniture. Interview with the transportation staff on 05/10/19 at 1:10 pm revealed: -He was the staff who donated the furniture. -He knew the leather furniture had scratches and was peeling but due to financial restraints it was utilized. -He would assist the Administrator to locate other furniture to place in the living room. -He did not know about the reason the old furniture was removed from the living room. Interview with the previous Administrator/Owner on 05/10/19 at 1:30 pm revealed: -She knew the living room furniture was donated by the transportation staff with scratches, peeling seat and back cushions, scratched coffee table top and a broken loveseat. -The living room furniture was donated last year in 2018. -She was in the process of looking for replacement pieces so that the damaged furniture could be removed.	D 076		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings	D 083		

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D 083	Continued From page 3 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure window blinds were in good repair in 3 of 6 resident bedrooms to give residents privacy. The findings are: Observation of resident room #1 on 05/09/19 at 9:26 am revealed: -The room had two windows. -One window faced toward the side yard, a side street and had a blind. -The second window faced toward a busy road and had a blind that with one broken blade, one bent blade and blind brackets that were coming away from the wall. Interview with one of the residents who resided in resident room #1 on 05/09/19 at 9:35 am revealed: -He had resided in many rooms within the facility over 8 years and he had lived in this room for six months. -The blind blades were already broken when he moved into the room and he did not touch the blinds because he thought it might fall down. -He dressed in the bathroom and in the room. Observation of resident room #4 on 05/09/19 at	D 083		

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D 083	Continued From page 4 10:30 am revealed: -There was one window that faced a busy road. -The blind had broken blades and the blind brackets were not secured to the wall. Interview with the resident who resided in resident room #4 on 05/09/19 at 10:32 am revealed: -He used the blind and if it fell he placed it back up. -He had not told anyone about the blind brackets. -He dressed in the room and the bathroom. Observation of resident room #5 on 05/09/19 at 10:58 am revealed: -There were two windows in the room. -One window faced the side yard and a grove of trees and had a blind. -The other window faced a busy road and had a blind with broken blades and blind brackets that were coming away from the wall. Interview with a resident who resided in resident room #5 on 05/09/19 at 11:05 am revealed: -He had lived in this room since admission. -He did not pull the string that lifted and lowered the blinds because he may cause them to fall. -He dressed in the corner of the room so no one passing on the road saw him. Interview with the Supervisor/medication aide (MA) on 05/10/19 at 11:30 am revealed: -She was aware that resident rooms #1, #4, and #5 had blinds that were not secure on the wall and some had broken blades. -The blinds had not been replaced since she started working at the facility in 1997. -She talked with the previous Administrator/Owner about purchasing new blinds. -The previous Administrator/Owner knew about	D 083		

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D 083	Continued From page 5 the blinds and was responsible for purchases for the facility. Interview with the acting Administrator on 05/09/19 at 11:54 am revealed: -He knew about the broken blind blades in resident room #1,#4 and #5 and that the blind brackets were loosened and not secured to the wall. -He did not purchase blinds for the facility but he did measure all of the windows and gave the measurements to the previous Administrator/Owner. -The previous Administrator/Owner was responsible for purchasing new blinds and they were supposed to be purchased next week. Interview with the previous Administrator/Owner on 05/10/19 at 1:30 pm revealed: -She knew about the broken blinds and planned to replace the blinds. -She was responsible for replacing the blinds in the facility.	D 083		
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	D 238		

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D 238	Continued From page 6	D 238		

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:
Based on observations, record reviews and interviews, the facility failed to assure a diet order was indicated on the current FL-2 for 1 of 3 sampled residents (Resident #1).

The findings are:

Review of Resident #1's current FL-2 dated 09/24/18 revealed:
-Diagnosis included borderline mental retardation, schizoaffective disorder depressive type, hypertension and hypercholesteremia.
-No diet order was indicated by the physician.

Interview with Resident #1 on 05/09/19 at 11:05 am revealed:
-The resident had a regular diet.
-His physician did not tell him to eat a special type of diet.
-The Supervisor/medication aide (MA) fed him fruit, cookies and crackers for snacks and he ate sandwiches for meals.
.
Telephone interview with a representative at Resident #1's physician's office on 05/09/19 at 2:30 pm revealed:
-The physician did not indicate a specific diet in Resident #1's record.
-The physician wrote for Resident #1 to increase water intake, decrease sugar intake by not drinking sodas and eating desserts.

Interview with the Supervisor/MA on 05/09/19 at 2:27 pm revealed:
-All the residents were on a regular diet.

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D 238	Continued From page 7 -She knew they were all on a regular diet because she was told by the Administrator. -She did not review the residents' FL-2s and the Administrator reviewed the FL-2s. -Resident #1's diet order was for a regular diet and it was on his FL-2. -She had not looked at Resident #1's FL-2 and she just thought the diet order was on his FL-2. -She made the diet roster hanging in the kitchen and she updated the diet roster when there was a new admission. -She thought when Resident #1 was admitted someone told her he was on a regular diet. -She never called Resident #1's physician to ask for his diet order. -She should have checked the FL-2 and if she knew he did not have a diet order she would have called the physician. -Resident #1 was a picky eater and told her what he would and would not eat for each meal. Interview with the previous Administrator/Owner on 05/10/19 at 10:46 am revealed: -She was responsible for ensuring the FL-2 documentation was complete to include a diet order. -She did not know Resident #1 had no diet order. -She assumed the diet order was on the FL-2. -She needed to contact Resident #1's physician to request a diet order.	D 238		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and	D 276		

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D 276	Continued From page 8 (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure physician's orders were implemented for 1 of 3 sampled residents (#3) with orders for fingerstick blood sugar (FSBS) monitoring twice daily who was self-monitoring his blood glucose without staff supervision. The findings are: Review of Resident 3's current FL-2 dated 02/15/19 revealed: -Diagnoses included chronic kidney disease stage II, diabetes mellitus, mild hyperlipidemia, presbyopia, lipoprotein deficiency. -There was an order for FSBS twice daily before meals. -There was no order for Resident #3 to self-monitor his FSBS. Review of Resident #3's March 2019 medication administration record (MAR) revealed: -There was an entry for FSBS three times a day scheduled for 8:00 am, 2:00 pm, and 8:00 pm and the three was marked out and a handwritten two was placed over it. -The words "see diabetic sheet" were handwritten beside the scheduled times.	D 276		

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D 276	Continued From page 9 -There were no FSBS results documented. -On the reverse side of the MAR, there were no FSBS results documented. Review of Resident #3's April 2019 MAR revealed: -There was an entry for FSBS three times a day scheduled for 8:00 am, 2:00 pm, and 8:00 pm and the three was marked out and a handwritten two was placed over it. -The words "see diabetic sheet" were handwritten beside the scheduled times. -There were no FSBS results documented. -On the reverse side of the MAR, there were no FSBS results documented. Review of Resident #3's May 2019 MAR revealed: -There was an entry for FSBS three times a day scheduled for 8:00 am, 2:00 pm, and 8:00 pm and the three was marked out and a handwritten twos was placed over it. -There were staff initial documented from 05/01/19 to 05/08/19 at 8:00 and 8:00 pm and 05/09/19 at 8:00 am. -There were no FSBS results documented. -On the reverse side of the MAR, there were no FSBS documented. -There were handwritten strikes through 2:00 pm scheduled time. Interview with Resident #3 on 05/10/19 at 11:58 am revealed: -He monitored his FSBS without staff supervision and only did his FSBS once a day in the morning. -He kept the glucometer in his room. -He documented his FSBS and placed the results in a notebook. -The FSBS results he documented on the right side for the afternoon FSBS were made up the	D 276		

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D 276	Continued From page 10	D 276		

results and the documented results did not come from a FSBS.
-He told his physician that he was doing his own FSBS.
-He did the FSBS and then went to the dining room and told the medication aide (MA) the value.

Review of Resident #3's notebook May 2019 FSBS results revealed:
-There were two columns of FSBS values one for breakfast and one for supper.
-There was a column on the left side of the document for the date.
-There were values documented under the breakfast and supper columns.
-The FSBSs documented for breakfast were as follows: on 05/01/19 was 119, on 05/02/19 was 114, on 05/03/19 was 138, on 05/04/19 was 106, on 05/05/19 was 109, on 05/06/19 was 127, on 05/07/19 was 116, on 05/08/19 was 147, and 05/09/19 was 129.
-The FSBSs documented for supper were as follows: on 05/01/19 was 102, on 05/02/19 was 107, on 05/03/19 was 100, on 05/04/19 was 94, on 05/05/19 was 54, on 05/06/19 was 100, on 05/07/19 was 104, and on 05/08/19 was 105.

Observation of Resident #3's glucometer on 05/09/19 at 1:47 pm revealed:
-There was a FSBS of 129 on 05/09/19 at 6:25 am.
-There was no FSBS on 05/08/19 during the afternoon or evening hours.
-There was a FSBS of 147 on 05/08/19 at 7:07 am.
-There was no FSBS on 05/07/19 during the afternoon or evening hours.
-There was a FSBS of 116 on 05/07/19 at 6:26 am.

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D 276	Continued From page 11 -There was no FSBS on 05/06/19 during the afternoon or evening hours. -There was a FSBS of 127 on 05/06/19 at 6:32 am. -There was a FSBS of 54 on 05/05/19 (no time of FSBS value). -There was a FSBS of 109 on 05/05/19 (no time of FSBS value). -There was no FSBS on 05/04/19 during the afternoon or evening hours. -There was a FSBS of 106 on 05/04/19 (no time of FSBS value). -There was no FSBS on 05/03/19 during the afternoon or evening hours. -There was a FSBS of 138 on 05/03/19 at 6:13 am. -There was no FSBS on 05/02/19 during the afternoon or evening hours. -There was a FSBS of 114 on 05/02/19 at 6:18 am. -There was no FSBS on 05/01/19 during the afternoon or evening hours. -There was a FSBS of 119 on 05/01/19 at 6:50 am. Telephone interview with the relief Supervisor/medication aide (MA) on 05/10/19 at 1:57 pm revealed: -She administered medications to residents only when she was told to work at the facility. -Resident #3's FSBS were done by the resident and he came and told staff his FSBS results. -She did not know if Resident #5 physician knew he was self-monitoring FSBS. -She did not know Resident #3 was not performing the second FSBS and was just making up the result. -Resident #3 documented the FSBS results in a book that he kept in his room. -She did not review Resident #3's notebook.	D 276		

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D 276	Continued From page 12 Interview with another Supervisor/MA on 05/10/19 at 11:35 am revealed: -Resident #3 was a former resident at a sister facility where he did his own FSBS, so when he was admitted to this facility he did his own FSBS again. -She had not seen a physician's order indicating Resident #3 was supposed to self-monitor FSBS twice daily. -She did not know he was making up the supper FSBS results. -Resident #3 was in possession of his glucometer and came to her with his FSBS results. -She did not supervise him when he did his FSBS monitoring and she did not look at his notebook or glucometer. -She knew he was supposed to have FSBS twice daily. Attempted interview with Resident #3's physician on 05/10/19 at 9:35 am was unsuccessful. Interview with the previous Administrator/Owner on 05/10/19 at 1:25 pm revealed: -She knew Resident #3's did his own FSBS. -She did not know Resident #3 needed an order from the physician to self-monitor his FSBS. -She did not know Resident #3 was not monitoring his FSBS in the afternoon. -She assumed Resident #3 knew to do his FSBS twice daily. -She was responsible for ensuring physician orders were followed. -She planned to obtain an order for Resident #3 to self monitor his FSBS.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support	D 280		

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D 280	Continued From page 13 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure a quarterly Licensed Health Professional Support (LHPS) evaluation was completed for 2 of 3 sampled residents with LHPS tasks for finger stick blood sugars (FSBS), insulin injections, and ambulate with assistive devices (#2) and FSBS, insulin injections, and oxygen administration and monitoring (#3).	D 280		

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D 280	Continued From page 14 The findings are: 1. Review of Resident #2's current FL-2 dated 02/25/19 revealed: -Diagnoses included diabetes ketoacidosis, brain lesion, anemia, and acute renal failure. -There was an order for FSBS four times daily (fasting sugars and evening sugars). -There was documentation of ambulatory status as limited assistance; uses wheelchair as well. -There was a medication order for insulin 70/30 (used to treat diabetes) 15 units twice daily with meals. Review of Resident #2's physician orders revealed there was a physician order dated 03/18/19 to increase insulin 70/30 to 22 units twice daily with meals. Based on reviews there was no March 2019 medication administration record (MAR) for Resident #2 in the facility. Review of Resident #2's April 2019 MAR revealed: -There was a handwritten entry for FSBS three times a day before meals and at bedtime. -There was a handwritten note indicating "see diabetic sheet". -There was an entry for Novolog 70/30 22 units twice daily with meals. Review of Resident #2's May 2019 MAR revealed: -There was no entry for FSBS. -There was an entry for Novolog 70/30 22 units twice daily with meals. Review of the LHPS evaluations for Resident #2 revealed:	D 280		

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D 280	Continued From page 15 -There was documentation of a LHPS evaluation dated 02/28/18. -The personal care task indicated for Resident #2 was ambulation using assistive devices that required physical assistance. -There were no other LHPS evaluations for Resident #2. Review of Resident #2's FSBS documentation revealed: -There was notebook that contained Resident #2's FSBS results. -There was documentation of FSBS results four times daily for the months of April 2019, and May 2019. Observation of Resident #2's room on 05/09/19 at 10:43 am revealed: -There was a folded walker behind the door leaning against the wall. -The resident was sitting in the center of the room in a wheelchair. Interview with Resident #2 on 05/09/19 at 10:44 am revealed: -He used a walker prior to his hospitalization in February 2019. -He now used a wheelchair to move around the facility. -The Supervisor/medication aide (MA) obtained his FSBS four times a day. Refer to interview with the Supervisor/MA on 05/10/19 at 11:06 am. Refer to interview with the Administrator on 05/10/19 at 11:00 am. 2. Review of Resident 3's current FL-2 dated 02/15/19 revealed:	D 280		

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D 280	Continued From page 16 -Diagnoses included chronic kidney disease stage II, diabetes mellitus, mild hyperlipidemia, presbyopia, lipoprotein deficiency. -There was an order for FSBS twice daily before meals. -There was a medication order for Humulin N 25 units (used to treat diabetes) every morning and every evening. -There was an order for oxygen. Review of Resident #3's March 2019, April 2019, and May 2019 medication administration record (MAR) revealed: -There was an entry for FSBS three times a day scheduled for 8:00 am, 2:00 pm, and 8:00 pm and the three was marked out and a handwritten two was placed over it. -There was an entry for Humulin N 25 units every morning and every evening. Review of the LHPS evaluations for Resident #3 revealed: -There was documentation of LHPS evaluations dated 03/15/18 and 06/18/18. -The personal care tasks indicated for Resident #3 were medication administration through injections, and collecting and testing of fingerstick blood samples. -There were no other LHPS evaluations for Resident #3. Observation of Resident #3's room on 05/09/19 at 10:04 am revealed: -There was an oxygen tank in a oxygen tank holder resting near the closet. -There was an oxygen concentrator with oxygen tubing at the end of Resident #3's bed. Interview with Resident #3 on 05/09/19 at 10:05 am revealed:	D 280		

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D 280	Continued From page 17 -He received insulin and did FSBS to test his blood sugar. -He used oxygen at night and when he walked long distances. Refer to interview with the Supervisor/MA on 05/10/19 at 11:06 am. Refer to interview with the Administrator on 05/10/19 at 11:00 am. _____ Interview with the Supervisor/MA on 05/10/19 at 11:06 am revealed she was not responsible for the LHPS evaluations. Interview with the previous Administrator/Owner on 05/10/19 at 11:00 am revealed: -She was responsible for ensuring the residents were evaluated quarterly by a LHPS professional. -She did not know the last time she had completed the LHPS evaluations for Resident #2 and #3. -She thought she was up to date with the LHPS evaluations but forgot to do the LHPS evaluations.	D 280		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and	D 296		

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interviews, the facility failed to ensure there were matching therapeutic diet menus for 1 of 3 sampled residents (#2) with an order for a heart healthy/carbohydrate modified diet.

The findings are:

Review of Resident #2's current FL-2 dated 02/25/19 revealed:
-Diagnoses included diabetes ketoacidosis, brain lesion, anemia, and acute renal failure.
-There was a diet order for a heart health/carbohydrate modified diet.

Review of Resident #2's hospital discharge summary documents revealed:
-Resident #2 was admitted to the hospital for altered mental status and diagnosed with diabetes on 02/22/19.
-There was a diet listed under discharge instruction for low sodium heart health/carbohydrate modified.

Review of the facility's menus revealed there was not a menu available for use by the staff for a heart health/carbohydrate modified diet.

Observation of the dinner meal service on 05/09/19 at 4:30 pm revealed:
-Resident #2 was served two neck bones, boiled potatoes, a slice of white bread, a small bowl of peaches, and eight ounces of water.
-Resident #2 ate all of the meal and drank all of the water.

Observation of the lunch meal service on 05/10/19 at 11:20 am revealed:
-Resident #2 was served a chicken patty on a bun, green peas, boiled potatoes, a small bowl of peaches and a diet soda.

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D 296	Continued From page 19 -Resident #2 ate all of the meal and drank all of the diet soda. Interview with Resident #2 on 05/09/19 at 10:44 am revealed: -The food was good at the facility and he ate well. -His doctor told him he to drink diet sodas and sugar free desserts. -He was not sure what his blood sugars were but he took insulin. Interview with the Supervisor/medication aide (MA) on 05/09/19 at 2:27 pm revealed: -Resident #2 was served a regular diet because that was his diet order. -She knew Resident #2 was admitted to the hospital and diagnosed with diabetes. -She did not know Resident #2's diet order was heart healthy/carbohydrate modified. -The Administrator reviewed the FL-2s and informed her of residents' diet order changes. -She did not have a heart healthy/carbohydrate modified menu in the menu book in the dining room. -She did not call Resident #2's physician to clarify the diet order because she thought he was on a regular diet. Interview with the relief Supervisor/MA on 05/10/19 at 12:20 pm revealed: -Resident #2's diet was not changed that she knew about from his hospitalization. -She thought Resident #2 was on a regular diet. -She served Resident #2 a regular diet. Attempted interview with Resident #2's physician on 05/10/19 at 12:16 pm was unsuccessful. Interview with the acting Administrator on 05/10/19 at 10:00 am revealed:	D 296		

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D 296	Continued From page 20 -He was responsible for ensuring the correct diet was served to residents. -He did not know Resident #2's diet was heart healthy/carbohydrate modified. -There should be a menu for each diet in the kitchen diet book. -He planned to ask Resident #2's physician to clarify the diet order so the facility was able to serve Resident #2 the correct diet.	D 296		
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, record reviews, and interviews, the facility failed to assure medications were administered as ordered to 1 of 3 sampled residents (#1) who did not receive a monthly injection for psychotropic medication.	D 358		

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D 358	Continued From page 21 The findings are: Review of Resident #1's current FL-2 dated 09/24/18 revealed: -Diagnosis included borderline mental retardation, schizoaffective disorder depressive type, hypertension and hypercholesteremia. -There was a medication order for Invega Sustenna 234 mg/1.5 ml (used to treat schizophrenia) injection 234 mg monthly. Review of Resident #1's March 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Invega Sustenna 234 mg monthly, without documentation of a scheduled time of administration. -There was no documentation of administration. Review of Resident #1's April 2019 MAR revealed: -There was a handwritten entry for Invega Sustenna 234 mg monthly, without documentation of a scheduled time of administration. -There was no documentation of administration. Review of Resident #1's May 2019 MAR revealed there was no entry for Invega Sustenna 234 mg monthly. Review of Resident #1's record revealed: -There was a facility document indicating Resident #1 was administered Invega Sustenna 234 mg in the left deltoid on 03/13/19 signed by Resident #1's physician. -There was no documentation of administration of Invega Sustenna 234 mg for April 2019. -There was a facility document indicating Resident #1 was administered Invega Sustenna	D 358		

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D 358	Continued From page 22 234 mg on 05/09/19 signed by Resident #1's physician. Observation of Resident #1's medication on hand on 05/10/19 at 11:45 am revealed there were two boxes of Invega Sustenna 234 mg injections with dispensed dates of 04/01/19 and 04/26/19 available for administration. Interview with Resident #1 on 05/10/19 at 1:23 pm revealed: -The Administrator administered the injection of Invega Sustenna in the past and now he received the medication at the physician's office. -He received the last injection of Invega Sustenna 234 mg on 05/09/19 at the physician's office. -He did not recall receiving the medication in April 2019. Telephone interview with the facility contracted pharmacy on 05/10/19 at 9:08 pm revealed: -Medication orders were faxed and electronically sent to the pharmacy from the facility and/or Resident #1's physician. -Invega Sustenna was ordered and filled on 01/25/19; it was ordered on 02/13/19 then filled on 03/08/19; and it was ordered 03/27/19 then filled on 04/01/19 and 04/26/19. -There were no discontinue orders in the computer system. -The Invega Sustenna order was refilled when the facility staff called to refill it. -The pharmacy did not have the Invega Sustenna on a cycle fill because the pharmacy did not know the date the injection was administered to Resident #1. Attempted telephone interview with Resident #1's physician on 05/10/19 at 9:35 pm revealed:	D 358		

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D 358	Continued From page 23 Interview with the Supervisor/Medication Aide (MA) on 05/09/19 at 3:01 pm revealed: -There were two Invega Sustenna injections available for Resident #1. -She did not tell anyone that the medication was delivered from the pharmacy. -She thought the physician would know it was time to give the injection to Resident #1 since she ordered the medication. -She was told by the transportation staff that she was supposed to tell him when the injection was delivered from the contracted facility pharmacy so he could take the resident to the physician's office. -She did not know Resident #1 was going to the physician's office to have the injection administered. -She thought another nurse came to administer the injection to Resident #1. -The previous Administrator/Owner was giving the Invega Sustenna injection to Resident #1 but she did not tell her the injection was delivered from the pharmacy. -She had not seen Resident #1 receive the injections for March 2019, April 2019 and May 2019. -She would have to take responsibility for Resident #1 not receiving the injection in April 2019 Telephone interview with the relief Supervisor/MA on 05/10/19 at 11:40 am revealed: -She knew Resident #1 had two injections of Invega Sustenna on the medication cart and she discussed it with the transportation staff. -She thought the previous Administrator/Owner was administering the injection to Resident #1 but was told the physician was administering the Invega Sustenna injection. -She was told by the transportation staff in April	D 358		

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2019 that he had to locate a new person to give the injection to Resident #1 but she did not know why.
-She tried to take care of issues as she identified them but she did not get a chance to mention the injection to anyone else before she was moved to work at another facility.
-She had not seen Resident #1 receive the injections.

Telephone interview with the transportation staff on 05/10/19 at 1:00 pm revealed:
-It was his fault that Resident #1 missed his injection in April 2019.
-He was supposed to have the appointments for Resident #1 placed on the calendar so that Resident #1 was transported to the physician's office on the same day each month to receive the Invega Sustenna injection.
-He did not place the appointments on the calendar for Resident #1's Invega Sustenna injections.

Interview with the previous Administrator/Owner on 05/10/19 at 10:45 am revealed:
-She had arranged for Resident #1 to receive the injections of Invega Sustenna at his physician's office.
-Resident #1 was supposed to be taken over to the physician's office by the transportation staff to receive the injections.
-The physician was supposed to document the administration of the injection on a document provided by the facility.
-She did not know Resident #1 had not received the April 2019 injection of Invega Sustenna.
-The transportation staff was responsible for ensuring Resident #1 was transported to the physician's office to receive the Invega Sustenna as ordered by the physician.

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D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 3 residents sampled (#3) had physicians' orders to self-administer two inhalers. The findings are: Review of Resident 3's current FL-2 dated 02/15/19 revealed: -Diagnoses included chronic kidney disease stage II, diabetes mellitus, mild hyperlipidemia, presbyopia, lipoprotein deficiency. -There was a medication order for Breo inhaler (used to treat chronic obstructive pulmonary disease) one puff daily. -There was a medication order for Pro-Air inhaler (used to treat breathing problems) two puffs every six hours as needed. -There was no documentation on the order for	D 375		

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self-administration.

Review of Resident #3's subsequent physician order dated 05/31/18 revealed an order for self-administration of albuterol 0.083% nebulizer one vial four times a day as needed for wheezing and Perforomist 20 mcg/12 ml use one vial in nebulizer every twelve hours.

Observation on 05/09/19 at 10:23 am of medications on hand for administration kept in Resident #3's room revealed:
-The resident had a coded safe with medications stored inside.
-Resident #3 stored the medications in the original packaging from the pharmacy.
-There was a prescription box containing an inhaler of Breo inhale one puff daily dispensed on 04/17/19.
-There was another prescription box containing an inhaler of Pro-Air inhale two puffs every six hours as needed.

Review of Resident #3's March 2019, April 2019 and May 2019 medication administration records (MARs) revealed:
-There was a handwritten entry for Breo inhale one puff daily, scheduled for 8:00 am
-There was documentation of administration from 03/01/19 to 03/31/19 at 8:00 am, from 04/01/19 to 04/30/19 at 8:00 am, and from 05/01/19 to 05/09/19 at 8:00 am.
-There was a handwritten entry for Pro-Air inhale two puffs every six hours as needed, scheduled as prn.
-There was no documentation of administration of Pro-Air.
-There was no self-administration documentation.

Interview with Resident #3 on 05/09/19 at 10:05

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am revealed:
-He kept the Breo inhaler and Pro-Air inhaler in his room.
-He used the inhalers when he felt short of breath.
-He was told he could keep the inhalers in his room by the physician and the previous Administrator/Owner bought the safe for him to secure the inhalers.
-He thought the physician had written an order for him to self -administer the inhalers, but he was not sure.

Interview on 05/10/19 at 8:45 am with the Supervisor/medication aide (MA) revealed:
-She did not know of a facility policy for self-administration of medications.
-She did not know of any documentation on Resident #3's MARs to self-administer medications.
-She did not know of an assessment for Resident #3 to self-administer medications.
-She thought Resident #3 had a physician's order to self-administer the medications he had in his room.
-She knew Resident #3 had inhalers Breo and Pro-Air in his room.

Attempted telephone interview with a staff member at Resident #3's physician's office on 05/10/19 at 9:45 am was unsuccessful.

Interview on 05/10/19 at 12:32 pm with the relief Supervisor/MA revealed:
-Resident #3 had orders to self-administer the inhalers kept in his room.
-Resident #3 had been self-administering the inhalers since admission.
-The resident kept the medications secured in his room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001002	A. BUILDING: _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON CARE CENTER	2201 BURCH BRIDGE ROAD BURLINGTON, NC 27217

(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 375	Continued From page 28 -She had not observed him when he used the Breo inhaler or Pro-Air inhaler. -The Administrator was responsible for assuring residents' self-administration medications had current orders for self-administration. Interview on 05/09/19 at 11:00 am with the previous Administrator/Owner revealed: -Resident #3 was competent to self-administer inhalers. -She thought Resident #3 had a self-administration order for the inhalers. -She was responsible to monitor compliance with self-administration requirements.	D 375		