Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAI.004003	A. BUILDING: _____ B. WING _____	R 03/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

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D 000	Initial Comments The Adult Care Licensure Section and the Anson County Department of Social Services conducted an annual, follow up and complaint investigation survey on 03/13/19 through 03/15/19 and 03/18/19.	D 000	Responces to cited deficiences do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiency or Corrective Action Report; the Plan of Correction is prepared soley as a matter of compliance with State Law.	5/2/19
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures were maintained between 100 and 116 degrees (°) Fahrenheit (F) as evidenced by hot water temperatures lower than 100°F and higher than 116°F from eleven fixtures. The findings are: Observations on 03/13/19 between 3:18pm and 4:05pm revealed: -At 3:28pm, the hot water temperature at the shower in the common bath on the 100 hall was 96.0 degrees F. -At 3:36pm, the hot water temperature at the bathroom sink in room 114 was 90 degrees F. -At 3:40pm, the hot water temperature at the	D 113	Plan of correction (POC) May 2, 2019 Divisional Maintenance Director (DMD) with maintanenace team assessed the water temps to identify and correct any issues. Temporary signage posted in any area a resident had access to fluctuating water temps. Repairs completed 5/1/19. Maintanence team continues to monitor water temps weekly to ensure compliance. POC date: 5/2/19	

ABIDA (ABBEY) RAUF 6-10-19

Reviewed and accepted 11 June 2019

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D 113	Continued From page 1 shower in room 114 was 92 degrees F. -At 4:01pm, the hot water temperature at the bathroom sink in room 111 was 96 degrees F. -At 4:05pm, the hot water temperature at the shower in room 111 was 88 degrees F. Interview with the resident in room 114 on 03/13/19 at 3:40pm revealed: -The water temperature in the bathroom was "alright, warm enough". -Sometimes she had to adjust the hot water by turning the hot water back if she turned the shower knob all the way up, because the water would get too hot. -She knew how to adjust the hot water in her bathroom shower. Interview with the resident in room 111 on 03/13/19 at 4:05pm revealed: -She showered independently. -The water temperature at the shower got warmer than the sink. -The water temperature in the shower felt cold to her now and somebody might be using water. Interview with another resident on 03/15/19 at 9:02am revealed: -She had never seen anybody check water temperatures in her room. -She had never had to let anybody know the water temperature was too hot or too cold. Observations on 03/15/19 at 9:10am revealed the hot water temperature at the bathroom sink in room 114 was 117.8 degrees F. Observations on 03/15/19 at 9:13am revealed the hot water temperature at the bathroom shower in room 114 was 117.1 degrees F.	D 113		

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D 113	Continued From page 2 Interview with the resident in room 114 on 03/15/19 at 9:12am revealed she had washed her hands in the bathroom sink twice this morning and the water temperature was "fine". Observations of hot water temperatures on the 200 hall on 03/13/19 from 11:33am until 12:36pm revealed: -At 11:33am, the hot water temperatures in the adjoining resident bathroom for rooms 203 & 204 were as follows: Sink-86.6 ° F and Shower-87.9° F. -At 12:20pm, the hot water temperatures in the adjoining resident bathroom for rooms 221 & 223 were as follows: Sink-98.9 ° F and Shower-95.8° F. -At 12:36pm, the hot water temperatures in the adjoining resident bathroom for rooms 229 & 231 were as follows: Sink-99.5 ° F and Shower-97.8° F. Interview with the resident of room 204 on 03/13/19 at 11:33am revealed: -Sometimes the water was too warm and sometimes the water was not warm enough. -Most of the time, she would just run the hot water until it got warm enough and that usually took a while. Interview with the Maintenance Staff on 03/13/19 at 4:37pm revealed: -The hot water temperature were fluctuating because the screen on the mixing valve needed to be cleaned. -He knew because hot water temperatures had fluctuated in the past and cleaning the screen had fixed the problem. -He checked hot water temperatures in two to	D 113		

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D 113	Continued From page 3 three fixtures in each hall and the common areas every week. -Hot water temperatures had been fluctuating "a lot" recently, but he had not had time to clean the screen. -Last week's hot water temperatures were in the low 100° F range; he did document hot water temperatures on a log. -The last time the screen on the mixing valve had been cleaned was one year ago. Observations on 03/14/19 between 8:31 am and 8:45 am revealed: -At 8:31 am, the hot water temperatures in the adjoining resident bathroom for rooms 111 & 113 were as follows: Sink-95.4° F and Shower-95.5° F. -At 8:45 am, the hot water temperatures in the adjoining resident bathroom for rooms 203 & 204 were as follows: Sink-117.1° F and Shower-117.3° F. Interview with the Maintenance Staff on 03/14/19 at 8:56 am revealed: -We are working on the mixing valve for the water. -The water will be off for a while. Interview with the resident in room 114 on 03/14/19 at 8:40 am revealed: -The water temperature in the bathroom was "fine it just has to run forever for it to get warm". -She took a shower in the bathroom shower on the morning of 03/14/19. Interview with the Executive Director on 03/15/19 at 9:35am revealed: -She was aware the hot water temperatures were fluctuating.	D 113		

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D 113	Continued From page 4 -Maintenance work had been done on the hot water heater on 03/14/19. -She would make sure caution signs were posted throughout the facility alerting residents and staff of the fluctuating hot water temperatures. -Observations on 03/15/19 between 2:29 pm and 2:58pm revealed: -At 2:29pm, the hot water temperatures in the adjoining resident bathroom for rooms 112 & 114 were as follows: Sink-117.1° F and Shower-117.0° F. -At 2:35 pm, the hot water temperatures in the adjoining resident bathroom for rooms 104 & 106 were as follows: Sink-116.6° F and Shower-115.3° F. -At 2:58 pm, the hot water temperatures in the adjoining resident bathroom for rooms 229 & 231 were as follows: Sink-100.0° F and Shower-99.9° F. Interview with the resident in room 114 on 03/14/19 at 2:29 pm revealed: -She showered independently. -She would be cautious now since the water temp is higher than normal. Interview with the resident in room 221 on 03/14/19 at 2:45 pm revealed: -He showered with assistance. -The water temperature had been "okay". Interview with the Maintenance Staff on 03/15/19 at 9:20am revealed: -He had not checked any water temperatures today. -He cleaned the filter to the circulating pump valve yesterday. -It took time for the water temperatures to stabilize.	D 113		

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D 113	Continued From page 5 -The hot water tank thermostat was set at 104 yesterday. -He thought if the water temperatures were still fluctuating on today, a plumber may be needed because it might be the thermostat. -He did not know when a plumber had last been at the facility or when the hot water heater had last been serviced. Observations on 03/15/19 at 11:23am revealed there were no caution signs for fluctuating hot water temperatures posted in the facility. Interview with the ED on 03/15/19 at 3:10pm revealed: -The caution signs for fluctuating hot water temperatures had not been posted yet, but they would be by the end of the day. -The Maintenance Staff had checked the hot water temperatures and they were not "high". -The Maintenance Staff would be at the facility over the weekend of 03/16/19 and 03/17/19 to monitor hot water temperatures. -A plumber was scheduled to be at the facility on 03/18/19 to check the hot water heater.	D 113		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902	D 131		

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D 131	Continued From page 6 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 2 of 4 sampled staff (Staff C and D) had a two-step tuberculosis (TB) skin test was done upon employment in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Staff C's personnel record revealed: -She was employed as a personal care aide (PCA). -Staff C's hire date was documented as 07/09/18. -There was documentation of a negative TB skin test dated 07/26/18 and a 2nd test result of negative on 11/01/18 (116 days after hire date). 2. Review of Staff D's personnel record revealed: -She was employed as a medication aide (MA) and certified nursing assistant (CNA). -Staff A's hire date was documented as "May 2018". -There was no documentation of any TB skin tests. Interview with the Interim Executive Director (IED) on 03/18/19 at 11:15 am revealed: -Staff D had not received her 2 step TB skin test. -She had received her TB testing today (03/18/19) at 10:45am. -She was aware a 2 step TB was required before or upon hire. -The Business Office Manager (BOM) was responsible for personnel files and for assuring the 2 step TB skin test were done.	D 131	Regional Business Office Manager (RBOM), Regional Labor Specialist (RLS) and Regional Support Team audited all employee records to identify TB needs on 4/4/19. Registered Nurse (RN) initiated completion of required TB testing. All TB skin tests will be reviewed by ED upon hire. RN to administer and monitor step 2 of TB after hire. Business Office Manager (BOM) to ensure TB test results placed in employee record. A perpetual staff log was completed for each staff member to track TB tests and ensure compliance on 4/4/19. ED and/or BOM will audit random staff files weekly to monitor for issues and compliance. POC date: 5/2/19	

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D 131	Continued From page 7 -The BOM is currently out on leave. The facility failed to ensure all staff had a 2-step TB skin test upon hire which could potentially expose the residents to TB. 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 03/18/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2019.	D 131		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 4 staff sampled (B) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 01/12/19 as a medication aide and personal care aide. -Staff B had a criminal background check completed on 11/12/18. Interview with Staff B on 03/18/19 at 11:43 am	D 139	RBOM, RLS and Regional Support Team audited all staff records to identify compliance on 4/4/19. RBOM initiated training with BOM related to new hire process including but not limited to background screenings on 4/4/19. ED will review all background screeings upon hire to ensure compliance. POC date: 5/2/19	

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D 139	Continued From page 8 revealed: -She had been hired and left and came back around October or November 2018. -She is now working as a medication aide (MA) and personal care aide (PCA). Telephone interview with Staff B on 03/18/19 at 6:28 pm revealed: -She could not remember why her criminal background was done in November 2018 and she didn't start work until January 2019. -She "had started and stopped working a couple times and they finally put me on first shift". Interview with the Interim Executive Director (IED) on 03/18/18 at 11:25 am revealed: -The date of 11/12/18 for Staff B's criminal background was probably the most recent since Staff B was not hired until she received her tuberculosis skin test. -The business office manager (BOM) was responsible for the personnel files and assuring the criminal back ground checks were done prior to hire. -The BOM was currently out on leave.	D 139		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic	D 167	ED and Care Manager (CM) completed immediate review of schedule on 3.18.19 to ensure CPR coverage. RBOM, RLS and Regional Support Team audited all staff records to identify CPR needs. CPR training completed on 3/27/19. ED and/or BOM will monitor perpetual staff logs monthly to monitor for CPR needs. ED and/or CM will monitor schedule daily to ensure compliance. POC date: 5/2/19	

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D 167	Continued From page 9 First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 3 of 4 staff records (A,B, & D) had not completed an approved course of cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months and did not have at least one staff person was on the premises at all times who had completed an approved course of CPR and choking management within the last 24 months on third shift for 5 of 11 days and second shift for 1 of 11 sampled in March 2019. The findings are: 1. Review of Staff A, Medication Aide/Personal Care Aide's personnel record revealed: -Staff A was hired on 11/15/18. -There was no documentation of cardio-pulmonary resuscitation (CPR) training for Staff A. Interview with Staff A on 03/13/19 at 11:05am revealed: -She had been employed since November 2018. -She worked at the facility on the 7am to 3pm shift. Interview with the Interim Care Manager (ICM) on 03/18/19 at 11:05am revealed:	D 167		

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D 167	Continued From page 10 -She had contacted Staff A by telephone and Staff A sent her a screen shot of her CPR card dated 06/19/18 from an online provider. -Staff A had completed an online virtual CPR training course that included demonstration on how to perform CPR. -Staff A told her about the online course and she (CM) took the course as a refresher. -There was a return demonstration of skills associated with the online course. -The online CPR training included modules. -CPR training was scheduled by the protocol nurse. -There had been a CPR course conducted at the facility but she was not sure if Staff A had participated in that training. -She would need to look at the sign-in sheet to determine if Staff A participated in the CPR course conducted at the facility. Interview with the Interim Executive Director on 03/18/19 at 11:15am revealed: -Staff could elect to participate in the CPR training at the facility or get the CPR training where ever staff chose to. -Staff A had her CPR training before she came to work at the facility from an outside agency. -She was not aware of the state requirement for CPR training through any specific approved agency. -She was not familiar with the online agency for which Staff A had received her CPR training. 2. Review of Staff B's personnel record revealed: -Staff B was hired as a personal care aide (PCA) and medication aide (MA) on 01/12/19. -There was no documentation Staff B had training on cardio-pulmonary resuscitation (CPR). 3. Review of Staff D's personnel record revealed:	D 167		

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D 167	Continued From page 11 -Staff D was hired as a certified nursing assistant (CNA) and medication aide (MA) on 08/08/18. -There was no documentation Staff C had training on cardio-pulmonary resuscitation (CPR). Attempted telephone interview on 03/18/19 at 6:24 pm with Staff D, was unsuccessful. Interview with the Interim Executive Director (IED) on 03/18/19 at 5:06pm revealed: -She did know several staff had no CPR training. - The Business Office Manager (BOM) was responsible for the personnel records and ensuring required training, including CPR, was on file for staff. -The BOM and Resident Care Manager (RCM) oversee CPR to assure staff are trained and scheduled to have one staff on the schedule who is CPR trained. -The BOM was currently out on leave. -She would check for CPR training for all staff. -She knew third shift staffing with CPR was an issue. Review of personnel records, resident census reports, staffing schedules, and time punch detail reports was done after IED provided more CPR certifications for staff on 03/18/19. This review revealed: -There were no staff on third shift who had training on CPR for 5 of 11 days and second shift for 1 of 11 days. -The 1 day on second shift was 03/16/19. -The 5 days on third shift included, 03/07/19, 03/08/19, 03/11/19, 03/12/19 and 03/18/19. -The facility's census was between 49 - 50 residents during the 6 shifts when no staff were on duty who had CPR training. Interview with the Administrator (ADM) on	D 167		

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D 167	Continued From page 12 03/18/19 at 7:15 pm revealed: -They planned to have a CPR class with a tentative date of 04/25/19. -They would schedule it sooner if possible. Interview with the IED on 03/18/19 at 7:25 pm revealed: -Staffing for third shift on 03/18/19 included a CPR certified staff member. -Staffing for all three shifts on 03/19/19 included at least one CPR certified staff member on duty for each shift. -They would review all schedules to ensure at least one CPR certified staff member would be in the building each shift. The facility failed to assure there was staff on duty who had training on CPR in the last 24 months on third shift for 5 of 11 days sampled and on second shift for 1 of 11 days sampled. The facility's census was 49 - 50 residents during the 6 shifts when no staff were on duty who had CPR training. The failure to have staff on duty at all times who had training in CPR 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 03/18/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2019.	D 167		
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	D 273		

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D 273	Continued From page 13 of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure follow up as ordered by the primary care provider for 2 of 6 sampled residents (#6 and #8) including repeat blood sugar (BS) testing and reporting for elevated BS levels (#6) and a referral for a speech and swallowing evaluation (#8). The findings are: 1. Review of Resident #6's current FL-2 dated 08/18/18 revealed: -Diagnoses included diabetes mellitus, schizophrenic disorder and mild cognitive impairment. -There was an order for finger stick blood sugar (FSBS) checks three times daily before meals with Novolin sliding scale insulin (SSI): for blood sugar (BS) 150-200 give 0 units; BS 201-250 give 4 units; BS 251-300 give 6 units; BS 301-350 give 8 units; BS 351-400 give 11 units and check FSBS hourly for 2 hours, if not decreasing notify the primary care provider (PCP) and put FSBS result the blue folder for follow up the next day. Review of Resident #6's Resident Register revealed the resident was discharged from the facility on 02/15/19. Review of Resident #6's November 2018	D 273	ED and CM notified physician and obtained clarification of issues identified during survey on 3/14/19. Issues identified were corrected immediately. ED, CM and Regional Clinical Director (RCD) reviewed resident records on 3/19/19 to identify and correct any orders out of compliance. Order Processing System (Bucket System) initiated on 3/14/19. ED and CM received training on Bucket System from RCD on 3/14/19. CM initiated training to Medication Aides (MA) regarding Bucket System, proper medication administration process and procedures to include reporting and documentation on 3/14/19. CM will monitor and follow up with Bucket System daily to ensure orders processed accuretely and medication is in community. ED and CM will conduct random chart observations weekly to ensure proper medication administation, and order processing. POC date: 5/2/19	

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D 273	Continued From page 14 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks three times daily before meals with Novolin SSI: for BS 150-200 give 0 units; BS 201-250 give 4 units; BS 251-300 give 6 units; BS 301-350 give 8 units; BS 351-400 give 11 units and check FSBS hourly for 2 hours, If not decreasing notify the PCP and put FSBS result the blue folder for follow up the next day. -On 11/04/19 at 11:30am, staff documented Resident #6's BS was 352; there was no documentation of hourly FSBS rechecks for two hours. Review of Resident #6's December 2018 eMAR revealed: -There was an entry for FSBS checks three times daily before meals with Novolin SSI: for BS 150-200 give 0 units; BS 201-250 give 4 units; BS 251-300 give 6 units; BS 301-350 give 8 units; BS 351-400 give 11 units and check FSBS hourly for 2 hours, If not decreasing notify the PCP and put FSBS result the blue folder for follow the next day. -On 12/11/18 at 7:30am, staff documented Resident #6's BS was 55; there was no documentation of what was done for the resident's low BS result. -On 12/13/18 at 4:30pm, staff documented Resident #6's BS was 58; there was no documentation of what was done for the resident's low BS result. -On 12/15/18 at 7:30am, staff documented Resident #6's BS was 53; there was no documentation of what was done for the resident's low BS result. -On 12/21/18 at 4:30pm, staff documented Resident #6's BS was 411; there was no documentation of hourly FSBS rechecks for two	D 273		

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D 273	Continued From page 16 hours. -On 12/30/18 at 11:30am, staff documented Resident #6's BS was 386; there was no documentation of hourly FSBS rechecks for two hours. Review of an Order Confirmation form dated 01/04/19 for Resident #6 revealed: -There was an order to discontinue sliding scale insulin. -Resident #6's PCP signed and dated 01/10/19. Review of a Physician's Order Report dated 02/07/19 revealed: -There was an order for FSBS checks twice daily. -There was documentation the start date of the order was 01/16/19. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/18/19 at 4:54pm revealed she could find the original order for FSBS checks twice daily for Resident #6. Review of Resident #6's January 2019 eMAR revealed: -There was an entry for FSBS checks twice daily. -On 01/28/19 at 7:30pm, staff documented Resident #6's BS was 459; there was no documentation of what was done for the resident's high BS result. -On 01/30/19 at 7:30pm, staff documented Resident #6's BS was 440; there was no documentation of what was done for the resident's high BS result. -There was an entry for FSBS checks three times daily before meals with Novolin sliding scale insulin which was discontinued on 01/04/19. Review of Resident #6's February 2019 eMAR revealed:	D 273		

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D 273	Continued From page 16 -There was an entry for FSBS checks twice daily. -On 02/02/19 at 7:30am, staff documented Resident #6's BS was 402; there was no documentation of what was done for the resident's high BS result. -On 02/04/19 at 7:30am, staff documented Resident #6's BS was 370; there was no documentation of what was done for the resident's high BS result. -On 02/05/19 at 7:30pm, staff documented Resident #6's BS was 472; there was no documentation of what was done for the resident's high BS result. -On 02/08/19 at 7:30pm, staff documented Resident #6's BS was 356; there was no documentation of what was done for the resident's high BS result. -On 02/09/19 at 7:30pm, staff documented Resident #6's BS was 435; there was no documentation of what was done for the resident's high BS result. -On 02/10/19 at 7:30pm, staff documented Resident #6's BS was 414; there was no documentation of what was done for the resident's high BS result. -On 02/11/19 at 7:30pm, staff documented Resident #6's BS was 419; there was no documentation of what was done for the resident's high BS result. -On 02/12/19 at 7:30pm, staff documented Resident #6's BS was 429; there was no documentation of what was done for the resident's high BS result. -On 02/13/19 at 7:30pm, staff documented Resident #6's BS was 414; there was no documentation of what was done for the resident's high BS result. -On 02/14/19 at 7:30pm, staff documented Resident #6's BS was 360; there was no documentation of what was done for the	D 273		

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D 273	Continued From page 17 resident's high BS result. Review of electronic Resident Progress Notes revealed: -There were no entries prior to 12/19/18 at 8:33pm. -There was no documentation of FSBS rechecks for BS less than 60 or greater than 351 from 12/19/18 through 02/13/19. -There was no documentation Resident #6's PCP was notified of FSBS results less than 60 or greater than 351 from 12/19/18 through 02/13/19. -On 02/14/19 at 10:22pm, staff documented Resident #6's BS was 452 at 8:00pm, the residents shot was given and 30 minutes later the BS was 430. -Resident #6's BS was checked again and was 422; BS was checked at 10:00pm and was 360. Review of a Vitals Report form dated 01/09/19 at 11:33am for Resident #6 revealed: -There was documentation of 11 FSBS results from 01/01/19 at 7:13am through 01/04/19 at 11:42am ranging from 65 to 340. -There were initials documented on the form. Interview with a medication aide (MA) on 03/18/19 at 4:42pm revealed: -Whenever she did a BS recheck, she wrote the result on a sticky note and called the primary care provider (PCP). -She did not know where on the eMAR or in the resident's record MAs would document BS rechecks. Interview with a second MA on 03/18/19 at 4:42pm revealed: -Whenever she did a BS recheck, she wrote the result on a piece of paper and called the PCP. -She documented calling the PCP in the	D 273		

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D 273	Continued From page 18 electronic charting notes (Resident Progress Notes). Interview with the Resident Care Coordinator (RCC) on 03/18/19 at 12:50pm revealed: -BS checks "popped up" on the computer screen when it was time for staff to check a resident's BS. -If there was a PCP order to recheck a BS for certain parameters and the order did not "pop up" on the computer screen, staff probably just rechecked the resident's BS without documenting the recheck. -If the BS was not decreasing, the staff were expected to notify the PCP and document the notification in the resident's record. -The facility's procedure on reporting for BS was to contact the resident's PCP for BS greater than 300. -For BS less than 60, staff gave the resident two cups of orange juice and two packets of fructose. -Staff rechecked low BS after administering the OJ and fructose, but "they may get busy and forget to document" rechecking the BS. -For Resident #6's BS of 55 on 12/11/18, 58 on 12/13/18 and 53 on 12/15/18; If staff rechecked the BS and the BS did not go up then staff would have sent to resident to the emergency room (ER). -The MAs were responsible for documenting notification to the PCP. Review of ER physician documentation dated 12/12/18 for Resident #6 revealed the resident was seen in the ER for hypoglycemia and had a BS of 35 upon arrival in the ER. Review of ER physician documentation dated 12/24/18 for Resident #6 revealed the resident was seen for mental status changes and possible	D 273		

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D 273	Continued From page 19 urinary tract infection and found to have hypoglycemia. Review of a PCP visit note dated 12/24/18 for Resident #6 revealed: -Resident #6 was seen on 12/4/18 for a new evaluation. -There was documentation the PCP reviewed BS logs and noted BS had been mostly within range with exceptions of a few greater than 260 results. -Resident #6 had recent lower BS results at night. Telephone interview with Resident #6's PCP on 03/18/19 at 4:26pm revealed: -She could not remember if she was notified of Resident #6's BS results greater than 351 or less than 60. -If there no documentation in Resident #6's record, then she was probably not notified. -The facility had a protocol for high and low BSs, but she was not sure why she had not written parameters when the BS checks were changed to twice daily. -Resident #6 had changes to BS management because there were highs and lows; she expected staff to call her if Resident #6's BS were greater than 351 or less than 60. Interview with the Executive Director (ED) on 03/18/19 at 5:52pm revealed: -The BS process was by written PCP orders; the facility did not have a written policy and procedure. -Staff were expected to follow the PCP's orders for BS checks. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.	D 273		

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D 273	Continued From page 20 2. Review of Resident #8's current FL-2 dated 09/04/18 revealed -Diagnoses included dementia, hypothyroid, hyperlipidemia, and failure to thrive. -There was an order for a regular diet. Review of the Care Plan for Resident #8 dated 12/12/18 revealed: -The diet for Resident #8 was listed as regular. -There were no restrictions for the resident's diet. Review of a Physician Notification Form dated 02/11/19 and timed at 3:05pm revealed: -The Medication Aide (MA) documented the resident was "having issues with swallowing". -The MA requested to know if the resident could have a crush medication order and be evaluated for chopped food. -The Nurse Practitioner (NP) documented on the notification form "yes to both" and dated the response for 02/12/19. -There were no further instructions from the NP documented on the physician notification form. Review of Resident #8's therapy notes revealed no documentation of an evaluation for chopped foods. Interview with the MA, whose name was on the physician notification form dated 02/11/19, on 03/14/19 at 8:50am revealed: -Resident #8 "had some swallowing problems." -The resident's medications needed to be crushed. -The resident needed to have thickened liquids. -There was no timeframe given for when the swallowing problems occurred. Interview with a second MA on 03/15/19 at 12:08pm revealed:	D 273		

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D 273	Continued From page 21 -Resident #8 "had some swallowing problems back a while ago." -There was no further timeframe given for when the swallowing problems occurred. Interview with a third MA on 03/15/19 at 4:10pm revealed: -Resident #8 went from a regular diet to puree because he got choked about one month ago. -The MA was told the resident was trying to eat cake and got choked. -The MA thought Resident #8 was on thickened liquids now. -Resident #8 used to take medications whole, but now she crushed his medications all the time. -Resident #8 would spit his medications out. Interview with the Interim Resident Care Manager (ICM) on 03/18/19 at 12:20pm revealed: -She thought there was an order for Resident #8 to have a barium swallow. -Resident #8's Nurse Practitioner Provider (NP) was working on getting the barium swallow done. -She (ICM) did not know if the barium swallow had been done. -She had not spoken to the NP about the status of the barium swallow. -The Supervisor would "most likely" be communicating with the provider about any issues the resident was having daily. -There was a local rehab agency that came to the facility who did assessments, including speech therapy. Interview with the Rehab Director for the local rehab agency on 03/18/19 at 12:35pm revealed: -The rehab agency was not currently providing any therapy to Resident #8. -The rehab agency had not received the order dated 02/12/19 for Resident #8 to be evaluated	D 273		

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D 273	Continued From page 22 for chopped foods. -There would be documentation in the resident's record from the rehab agency if the agency had started the evaluation. Interview with Executive Director (ED) on 03/218/19 at 1:25pm revealed: -She did not know if the evaluation for a chopped diet had been completed. -The ICM would have been responsible to process the 02/12/19 order for the evaluation.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the kitchen and food storage areas were kept clean and free of contamination. The findings are: Observations of the kitchen on 03/14/19 from 9:07am until 9:15am revealed: -There was a thick accumulation of yellow and brown grease and food spillage build up on and around the burner knobs of the stove. -There was a thick accumulation of brown and dark brown grease build up on and around the ends of the oven handles and around the edges of the oven doors.	D 282	RCD notified ED and Dietary staff of cleaning requirements in kitchen on 3.18.19. Dietary Manager educated on importance of cleanliness. Cleaning log implemented to ensure compliance. ED and/or designee will perform weekly random observations of kitchen/dining room to ensure cleanliness and compliance. POC date: 5/2/19	

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D 282	Continued From page 23 -There was an accumulation of a black charred substance on the oven doors and on the walls and the bottom of the ovens. -There was a black substance on the kitchen floor along the edge of the stove, around the bases of the sink and counter stands and around the floor drains. -There was a thick accumulation of a brown substance and food debris on the pantry floor along the edges and under the shelves. -There was a black substance on the floor around the base of the pantry shelf. -The floor in the cooler was sticky and had a shiny substance with numerous foot prints visible. -There was food debris including onion shells and loose potatoes on the floor under the cooler shelves. -There was a thick brown substance on the floor along the edges in the cooler. -There were dark brown stains with food debris stuck to the stain on the freezer floor. -There pieces of cardboard, frozen food and an ice cream cup on the freezer floor. Interview with a cook on 03/14/19 at 9:08am revealed: -Kitchen staff wiped down the knobs on the stove and the oven handles every day. -She could not say how the grease and food accumulation occurred. -Kitchen staff did not clean the ovens. -Second shift kitchen staff was responsible for cleaning the kitchen, pantry, cooler and freezer floors. -The Kitchen Supervisor was responsible for supervising cleaning done by kitchen staff. Interview with a second cook on 03/14/19 at 5:15pm revealed: -She was responsible for sweeping and mopping	D 282		

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D 282	Continued From page 24 the floors in the kitchen, pantry and cooler each evening. -She was instructed by the Kitchen Supervisor when she was hired not to mop the freezer floor because the water and the mop would stick. -She was responsible for wiping the knobs and handles on the stove and oven each evening after she turned off the stove. -There was usually a dietary aide to help with kitchen cooking, serving and cleaning duties, but there had not been a dietary aide since November 2018. -The second shift kitchen staff was responsible for all of the cleaning and it was hard to get everything done and get out on time with only one staff in the kitchen. -There were only three staff for first and second shift kitchen staff, a cook for each shift and the Kitchen Supervisor. -The Kitchen Supervisor was aware cleaning was not being done due to time and staff constraints. Interview with the Kitchen Supervisor on 03/15/19 at 11:30am revealed: -The first shift kitchen staff spot mopped floors and the second shift kitchen staff completed a thorough cleaning of the kitchen and floors. -She was aware there were areas in the kitchen that had been neglected for thorough cleaning such as the stove, oven and floors. -She checked the cleanliness and organization of the kitchen daily when she arrived at work. -Whenever she identified cleaning tasks that had not been completed she addressed it with the staff responsible. Interview with the Executive Director (ED) on 03/14/19 at 2:14pm revealed: -The second shift staff was responsible for cleaning the floors in the kitchen, pantry, cooler	D 282		

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MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

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D 282	Continued From page 25 and freezer daily before they left. -The floors were also cleaned as needed. -The kitchen staff cleaned the stove and oven handles daily. -The ovens were cleaned monthly. -The Kitchen Supervisor was responsible for directly supervising the kitchen staff and she supervised the Kitchen Supervisor. -She usually checked the kitchen every day, but she had not noticed the stove and oven handles, oven and floors in the kitchen, pantry, cooler and freezer.	D 282		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 3 sampled residents (#8) had a primary care provider order for a mechanical soft diet and nectar thick liquids. The findings are: Review of Resident #8's current FL-2 dated	D 307	RCD inititated training to Dietary Manager (DM) on 3.18.19 regarding theraputic diets including correct consistencies as ordered by physician. Resident diet orders audited to ensure correct diet is noted in electronic medical record. Diet order report printed and provided to DM weekly or as needed by ED and/or designee. DM to provide training to all dietary staff regarding theraputic diets. ED will monitor for compliance. POC date: 5/2/19	

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D 307	Continued From page 26 09/04/18 revealed: -Diagnoses included dementia, hypothyroidism, failure to thrive, multidrug resistant staphylococcus aureus and hyperlipidemia. -There was an order for a regular diet. Observations during the breakfast meal on 03/14/19 at 8:10am revealed Resident #8 had a small amount of nectar thickened orange juice on the table in front of him. Interview with a personal care aide (PCA) on 03/14/19 at 8:10am revealed: -Resident #8 was on nectar thickened liquids. -Resident #8 had drank his thickened orange juice and did not drink thickened water. Interview with a cook on 03/14/19 at 8:05am revealed there was no list of residents receiving thickened liquids in the kitchen, but there was a diet list. Review of an undated diet list from the bulletin board in the kitchen revealed: -Resident #8 was on a mechanical soft diet. -There was no notation for nectar thickened liquids or any consistency of thickened liquids. Observations during the dinner meal on 03/14/19 at 5:05pm revealed: -Resident #8 had nectar thickened water and nectar thickened red juice on the table in front of him. -Resident #6 was served a plate of field peas, rice, a dinner roll and banana pudding. -A PCA cut up the baked chicken breast on Resident #6's plate. Interview with a second PCA on 03/14/19 at 5:05pm revealed:	D 307		

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D 307	Continued From page 27 -Staff "just knew" which residents were on thickened liquids and therapeutic diets such as chopped, mechanical soft and pureed. -If staff did not know, there was a diet list posted on the bulletin board in the kitchen. Interview with the Interim Resident Care Coordinator (RCC) on 03/14/19 at 3:04pm revealed: -She had been filling in for the RCC since 02/25/19. -Diet orders should be in each resident's record. -She did not know the diet order process. -She did not know if there was a list of residents on thickened liquids. Interview with the Kitchen Supervisor on 03/15/19 at 11:30am revealed: -There was only one resident on thickened liquids. -She had a paper that Resident #8 was on thickened liquids, but it was no longer in the dietary book. -The dietary book was where all updates for residents' diets were kept; the book was kept on the desk in the kitchen. -The RCC usually brought updated diet orders to the kitchen and kitchen placed in the book. A second interview with the Interim RCC on 03/18/19 at 12:50pm revealed: -She was in the process of contacting Resident #8's primary care provider regarding clarification of the resident's diet order. -She remembered seeing an order for thickened liquids and a mechanical soft diet for Resident #8 since 02/25/19, but she could not find it. -She did not know who had made the undated typed therapeutic diet list from the kitchen bulletin board.	D 307		

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D 307	Continued From page 28 -New dietary orders were entered into the computer system by the RCC, printed and then given to the kitchen staff. Review of Diet Order Report dated 03/14/19 revealed: -Resident #8 was on a regular diet. -There was no notation for chopped or mechanical soft foods. -There was no notation for nectar thickened liquids. Telephone interview with Resident #8's primary care provider (PCP) on 03/18/19 at 3:58pm revealed: -She saw Resident #8 in her office for his appointments and had not seen the resident in a couple of months. -She did not have access to her notes and orders for Resident #8 and did not know if she had written an order for nectar thickened liquids and a mechanical soft diet. -She would not be concerned if Resident #8 had been given nectar thickened liquids and a mechanical soft diet; with the resident's cognition and dementia it was "probably not a bad idea." -She depended on the facility staff to follow the orders she had written. Interview with the Executive Director (ED) on 03/18/19 on 12:21pm revealed: -It was an error on her part that Resident #8 was placed on thickened liquids. -There should be a list kept in the kitchen of which residents were on thickened liquids and/or therapeutic diets. -New dietary orders were entered into the computer system by the RCC. -She printed a new computer generated diet list each week and gave it to the kitchen staff.	D 307		

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D 307	Continued From page 29 -She did not know where the undated typed therapeutic diet list had come from; she had not created the list nor provided it to the kitchen staff. -Kitchen staff were expected to follow the computer generated diet list (Diet Order Report).	D 307	ED and CM notified physician and obtained clarification of issues identified during survey on 3/14/19. Issues identified were corrected immediately. ED, CM and Regional Clinical Director (RCD) reviewed resident records on 3/19/19 to identify and correct concerns. Order Processing System (Bucket System) initiated on 3/14/19. ED and CM received training on Bucket System from RCD on 3/14/19. CM initiated training to Medication Aides (MA) regarding Bucket System, proper medication administration process and procedures to include reporting and documentation on 3/14/19. RCD initiated medication administration training on 3/15/19. ED and CM provided education to staff on 3/26/29 regarding Bucket System and Diabetic Education.CM will monitor and follow up with Bucket System daily to ensure orders processed accuretely and medication is in community. ED and CM will conduct random chart observations weekly to ensure proper medication administation, and order processing. POC date: 5/2/19	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 8 residents (#3, #8, #9) observed during the medication passes, including errors in insulin administration (#3), an anti-anxiety medication (#9), crushing and administering medication that should not be crushed (#8); and 3 of 5 residents (#1, #3, #7)	D 358		

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D 358	Continued From page 30 Including errors with a cough suppressant (#1), insulin administration (#3), a thyroid hormone replacement and a narcotic pain medication (#7). The findings are: 1.The medication error rate was 9% as evidenced by the observation of 3 errors out of 32 opportunities during the 12:00pm medication pass on 03/13/19 and the 8:00am medication pass on 03/14/19. a. Review of Resident #3's current FL-2 dated 02/07/19 revealed diagnoses included diabetes mellitus. Observation of the medication pass on 03/13/19 at 11:31am revealed the medication aide (MA) prepared and administered Novolin R insulin 4 units to Resident #3 in the left lower quadrant of the abdomen after obtaining a finger stick blood sugar (FSBS) reading of 265 for the resident. Interview with the MA on 03/13/19 at 11:26am revealed: -Resident #3 was prescribed a Novolin R insulin sliding scale (SSI). -She administered the Novolin R insulin according to the parameters ordered by the prescribing provider. -Resident #3's parameters for administering the Novolin R SSI coverage began when the resident's blood sugar was 150. -If Resident #3's FSBS was greater than 300, the resident would be administered Novolin R insulin 5 units. Review of physician's orders for Resident #3's Novolin R insulin revealed: -There was a physician's order from a Physician	D 358		

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D 358	Continued From page 31 Assistant (PA) by a MA for "Humulin R sliding scale for blood sugar greater than 500 call MD, 401-500 give 8 units, 301-400 give 6 units, 201-300 give 4 units, 150-200 give 2 units, below 150 give 0 units. Check blood sugar ac and hs [before meals and at bedtime] four times a day". The physicians order was not dated or signed by a licensed practitioner. -There was a physician's order dated 01/02/19 for Novolin R "use same sliding scale as the one for Humulin R." -There was a physician's order dated 01/03/19 to decrease blood sugar checks before breakfast and at bedtime and "d/c [discontinue SSI [sliding scale insulin] protocol, if blood sugar greater than 300 give 5 units Novolin R, then increase water and check blood sugar hourly x3. If not decreasing put in MD book to be seen. Put copy of BS log in MD book weekly". -There was a physician's order dated 02/07/19 to check finger stick blood sugar (FSBS) before meals and at bedtime. If blood sugar greater than 300, give 5 units Novolin R (a short acting injectable medication used to lower blood sugar levels) then increase water and check blood sugar hourly for 3 checks. If not decreasing put in MD book to be seen and copy blood sugar log weekly. -There were no additional physician's order for Novolin R insulin. Review of the March 2019 electronic medication administration record (eMARS) for Resident #3 revealed: -There was an entry for a FSBS before meals and at bedtime. -There were "special instructions" to "check FSBS before meals and at bedtime. If BS was greater than 300, give 5 units Novolin R then increase water and check BS hourly for 3 checks.	D 358		

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D 368	Continued From page 32 If not decreasing put in MD [prescribing practitioner] book to be seen and copy BS log weekly." -There was a start/end date of "01/18/19 - open ended." -There was an entry for Novolin R regular insulin; amount to administer per sliding scale; if blood sugar is 150 to 200, give 2 units; if blood sugar is 201 to 300, give 4 units; if blood sugar is 301 to 400, give 6 units; if blood sugar is 401 to 500, give 8 units; if blood sugar is greater than 500, call MD (prescribing practitioner). -There were "special instructions" to "use per sliding scale before meals and at bedtime. Below 150=0 units, 150-200=2 units, 201-300=4 units, 301-400=6 units, 401-500=8 units, > [greater than] 500=call MD [prescribing practitioner]." -There was a start/end date of "02/22/19 - open ended." Continued review of the March 2019 eMARs revealed there was documentation for administration of Humulin R insulin 44 times out of 48 times when Resident #3's blood sugar reading was less than 300 and no insulin coverage was required. Examples are as follows: -On 03/02/19 at 4:30pm, Resident #3's blood sugar was documented as 181. There was documentation for Humulin R insulin 2 units administered. -On 03/04/19 at 7:30am, Resident #3's blood sugar was documented as 173. There was documentation for Humulin R insulin 2 units administered. -On 03/05/19 at 7:30am, Resident #3's blood sugar was documented as 172. There was documentation for Humulin R insulin 2 units administered. -On 03/05/19 at 11:30am, Resident #3's blood sugar was documented as 243. There was	D 368		

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D 358	Continued From page 33 documentation for Humulin R Insulin 4 units administered. -On 03/08/19 at 11:30am, Resident #3's blood sugar was documented as 267. There was documentation for Humulin R Insulin 4 units administered. -On 03/08/19 at 7:30am, Resident #3's blood sugar was documented as 194. There was documentation for Humulin R Insulin 2 units administered. -On 03/10/19 at 7:30am, Resident #3's blood sugar was documented as 183. There was documentation for Humulin R Insulin 2 units administered. -On 03/13/19 at 7:30am, Resident #3's blood sugar was documented as 155. There was documentation for Humulin R Insulin 2 units administered. Continued review of the March 2019 eMARs revealed there was documentation for administration of Humulin R Insulin 2 of 3 times when Resident #3's blood sugar reading was greater than 300 and more than Humulin R Insulin 6 units coverage was administered. Examples are as follows: -On 03/01/19 at 7:30am, Resident #3's blood sugar was documented as 324. There was documentation for Humulin R Insulin 6 units administered. -On 03/07/19 at11:30am, Resident #3's blood sugar was documented as 431. There was documentation for Humulin R Insulin 8 units administered. Review of the February 2019 electronic medication administration record (eMARS) for Resident #3 revealed: -There was an entry for a FSBS before meals and at bedtime.	D 358		

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D 358	Continued From page 34 -There were "special instructions" to "check FSBS before meals and at bedtime. If BS greater than 300, give 5 units Novolin R then increase water and check BS hourly for 3 checks. If not decreasing put in MD [prescribing practitioner] book to be seen and copy BS log weekly" with a start/end date of "01/18/2019 - open ended." -There was another entry for Humulin R Regular Insulin; amount to administer per sliding scale; if blood sugar is 150 to 200, give 2 units; if blood sugar is 201 to 300, give 4 units; if blood sugar is 301 to 400, give 6 units; if blood sugar is 401 to 500, give 8 units, if blood sugar is greater than 500, call MD with a start/end date of "01/06/2019-02/22/2019 (dc date)". -There was documentation for blood sugar checks four times a day for 02/01/19 through 02/28/19 scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. Continued review of the February 2019 eMARs revealed there was documentation for administration of Humulin R insulin 24 times out of 25 times when Resident #3's blood sugar reading was less than 300 and no insulin coverage was required. Examples are as follows: -On 02/22/19 at 4:30pm, Resident #3's blood sugar was documented as 282. There was documentation for Humulin R insulin 4 units administered. -On 02/22/19 at 8:00pm, Resident #3's blood sugar was documented as 194. There was documentation for Humulin R insulin 2 units administered. -On 02/23/19 at 11:30am, Resident #3's blood sugar was documented as 228. There was documentation for Humulin R insulin 4 units administered. -On 02/23/19 at 8:00pm, Resident #3's blood sugar was documented as 199. There was	D 358		

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D 358	Continued From page 35 documentation for Humulin R Insulin 2 units administered. -On 02/25/19 at 8:00pm, Resident #3's blood sugar was documented as 261. There was documentation for Humulin R Insulin 4 units administered. -On 02/26/19 at 7:30am, Resident #3's blood sugar was documented as 161. There was documentation for Humulin R Insulin 2 units administered. -On 02/26/19 at 8:00pm, Resident #3's blood sugar was documented as 232. There was documentation for Humulin R Insulin 4 units administered. -On 02/27/19 at 7:30am, Resident #3's blood sugar was documented as 152. There was documentation for Humulin R Insulin 2 units administered. -On 02/27/19 at 8:00pm, Resident #3's blood sugar was documented as 237. There was documentation for Humulin R Insulin 4 units administered. Continued review of the February 2019 eMARs revealed there was documentation for administration of Humulin R Insulin 3 of 3 times when Resident #3's blood sugar reading was greater than 300 and more than Humulin R Insulin 5 units coverage was administered. Examples are as follows: -On 02/26/19 at11:30am, Resident #3's blood sugar was documented as 452. There was documentation for Humulin R Insulin 8 units administered. -On 02/27/19 at11:30am, Resident #3's blood sugar was documented as 319. There was documentation for Humulin R Insulin 6 units administered. -On 02/28/19 at11:30am, Resident #3's blood sugar was documented as 303. There was	D 358		

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D 358	Continued From page 36 documentation for Humulin R Insulin 6 units administered. Review of the January 2019 electronic medication administration record (eMARS) for Resident #3 revealed: -There was an entry for a FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm with documentation of blood sugar reading from 01/01/19 through 01/06/19 at 11:30am. -There was another entry for Humulin R Regular Insulin; amount to administer per sliding scale; if blood sugar was 150 to 200, give 2 units; if blood sugar is 201 to 300, give 4 units; if blood sugar is 301 to 400, give 6 units; if blood sugar is 401 to 500, give 8 units, if blood sugar is greater than 500, call MD; and special instructions to check blood sugar before meals and at bedtime and give Humulin R per sliding scale range, with a start/end date of "12/22/2018 - 01/06/2019 (dc date)". -On 01/02/19 at 4:30pm, Resident #3's blood sugar was documented as 183. There was no documentation for Humulin R Insulin administration. The resident should have been administered Humulin R Insulin 2 units. -On 01/02/19 at 8:00pm, Resident #3's blood sugar was documented as 182. There was no documentation for Humulin R insulin administration. The resident should have been administered Humulin R Insulin 2 units. -There was a third entry for Humulin R Regular Insulin; amount to administer: 5 units and special instructions to check blood sugar before breakfast and at bedtime. If blood sugar is greater than 300 give 5 units of Novolin R, then increase water and check blood sugar hourly times 3, if not decreasing put in MD book to be seen, with a start/end date of "01/06/2019 -	D 358		

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D 358	Continued From page 37 01/18/2019 (dc date)". -There was documentation for blood sugar checks two times a day beginning 01/06/19 at 7:30pm through 01/17/19 at 7:30pm requiring Humulin R insulin administration one time when Resident #3's blood sugar was documented as 310 on 01/15/19 at 7:30pm. -There was documentation for blood sugar checks four times a day beginning 01/17/19 at 7:30am through 01/31/19 at 7:30pm. There was no physician's order found in the record for FSBS checks four times a day covering the timeframe of 01/17/19 through 01/31/19. Interview with the MA on 03/13/19 at 12:12pm revealed: -Medication orders were entered into the eMARs by the Resident Care Manager (RCM). -The MAs usually did not see new orders received. -She administered medications according to the eMARs. Observation of Resident #3 on 03/13/19 at 12:20pm revealed the resident was in the dining room eating her lunch meal. Interview with the MA on 03/13/19 at 12:20pm revealed she was calling the pharmacy to see if there was another order for Novolin R sliding scale for Resident #3. Interview with the Executive Director on 03/14/19 at 4:30pm revealed the facility did not had a medication administration policy, but had a "process". Review of the General Dose Preparation and Medication Administration, Assistance or Observation document provided on 03/15/19 at	D 358		

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D 358	Continued From page 38 10:00am revealed the process included: -The community staff should refer to the community's policies and procedures regarding medication administration, assistance or observation. -The community staff should verify that the medication name and dose are correct. Interview with the Executive Director (ED) on 03/13/19 at 4:55pm revealed: -She called the Primary Care Provider (PCP) today when the insulin issue with Resident #3 was discovered. -She had received a physician's order today from the PCP to make sure the sliding scale insulin order was discontinued. -There was a failure on the part of the facility to discontinue the sliding scale insulin in January 2019. -The RCM completed reviews of the EMARs and physician orders. -The provider pharmacy entered orders on the eMARs. -"Occasionally" the facility could manually enter orders to the eMARs, but "typically" all orders were faxed to the pharmacy to be entered to the eMARs. -She could not tell, without reviewing the eMARs, if the Novolin R insulin had been administered to Resident #3 since 01/03/19 based on the documented parameters printed on the eMARs without reviewing the resident's eMARs. -The eMARs were generated according to physician orders. -Once a physician's order was discontinued, the order would not populate on the eMARs. Interview with the Nurse Practitioner (NP) on 03/14/19 at 2:55pm revealed: -She had discontinued the sliding scale with	D 358		

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D 358	Continued From page 39 parameters on 01/03/19. -She thought a hospital provider had given the sliding scale order with parameters. -Resident #3 was only supposed to be administered Humulin R insulin if the resident's blood sugar was greater than 300. -Administering the Humulin R insulin to Resident #3 when her blood sugar was less than 300 placed the resident at risk for low blood sugar. -She expected facility staff to clarify any orders coming from the hospital with the provider following the resident at the facility. Interview with the Pharmacist from the contracting pharmacy on 03/14/19 at 5:30pm revealed: -She had a copy of the physician's order dated 01/03/19 when the FSBS checks were changed from four times a day to two times a day that included discontinuing the SSI order but the instructions to discontinue the SSI order was not on the pharmacy profile. -She did not know why the SSI order was not on the pharmacy profile. -The pharmacy had discontinued the sliding scale on 01/02/19 but got another order on 01/03/19 to use the same sliding scale as was previously ordered for Novolin R. -The pharmacy had not received another discontinue order after 01/02/19. -The pharmacy received an order on 03/13/19 to discontinue the sliding scale insulin. -The pharmacy entered orders on the eMARs. -She was not sure if the facility had to approve orders that were input by the pharmacy before the order was released the medication to be administered. Based on observation, interview, and record review, it was determined Resident #3 was not	D 358		

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D 358	Continued From page 40 Interviewable. b. Review of the current FL-2 for Resident #9 dated 07/19/18 revealed: -Diagnoses included bipolar disorder, cyclothymic disorder, hypothyroidism, and chronic obstructive pulmonary disease. -There was a physician's order for buspirone HCL (used to treat anxiety disorders) 7.5mg tablet twice a day. Review of subsequent physician's orders for Resident #9 revealed: -There was a Physician Order Report signed and dated 02/20/19 for buspirone 10mg tablet three times a day. -There was a physician visit summary and physician's order dated 02/20/19 to increase buspirone to 15mg three times a day. Observation of the medication pass on 03/14/19 at 8:15am revealed: -The MA removed a pharmacy labeled blister pack for buspirone HCL 7.5mg tablet from the medication storage cart. -The MA prepared buspirone 7.5mg one tablet for administration to Resident #8. -The MA reviewed the instructions printed on the eMAR for Resident #9's buspirone. Interview with the MA on 03/14/19 at 8:15am revealed: -The medication label instructions and the eMAR instructions did not match. -He did not really know what to do. -If he did not know what to do, he would ask someone what to do. Observation of the MA on 03/14/19 at 8:20am revealed:	D 358		

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D 358	Continued From page 41 -The MA discarded the buspirone 7.5mg tablet in the sharps container attached to the medication cart, locked the medication cart and walked down the hall to the Executive Director's office. -The MA told the ED the order printed on the eMAR and the pharmacy labeled blister pack of buspirone in the medication cart did not match. -The ED told the MA that Resident #9 was supposed to be administered two tablets of buspirone and was prescribed 15mg. -The ED instructed the MA to call Resident #9's physician to get the medication clarified before administering. -The MA returned to the desk and called the physician provider group. Interview with the MA on 03/14/19 at 8:24am revealed: -He would be waiting to hear back from the physician to get clarification for the buspirone, and an order would be faxed to the facility. -He would indicate on the eMAR that the buspirone 15mg was not given and awaiting clarification. Review of the March 2019 eMARs for Resident #9 printed on 03/14/19 at 9:41am revealed there was an entry for buspirone 15mg tablet take one tablet three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. Interview with the MA on 03/14/19 at 9:30am revealed: -He had not administered the buspirone 15mg to Resident #8 yet. -He was going to check on the clarification order in a minute. Interview with the MA on 03/14/19 at 2:50pm revealed:	D 358		

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D 358	Continued From page 42 -He never administered the scheduled 8:00am dose this morning of buspirone 15mg. -He could have administered buspirone 7.5mg two tablets to equal 15mg at 8:00am this morning but he was not sure since the printed instructions on the eMAR were for buspirone 15mg tablet take one tablet. Observations of Resident #9 on 03/15/19 at 9:40am revealed: -The resident was sitting in his room in a wheelchair, watching television. -The resident was rubbing both sides of his face. Interview with Resident #9 on 03/15/19 at 9:40am revealed: -He stayed nervous. -He had no idea what medications he was administered. -His medications were changed "every other day, every time you turn around." Interview with the Pharmacist from the facility's contracted pharmacy on 03/15/19 at 12:12pm revealed: -The current order for Resident #9 was Buspar 15mg one tablet three times a day dated 02/20/19. -The pharmacy dispensed buspirone 15mg tablet three times a day, quantity of 48, on 02/20/19 to last until the next cycle fill. -Giving two buspirone 7.5mg tablets would make sense, but it would be a good thing that the MA did not administer the buspirone 7.5mg tablet because the MA could not make a clinical call. -She would not see any problem clinically, with missing one dose of the buspirone 15mg. Interview with the Nurse Practitioner on 03/15/19 at 4:10pm revealed:	D 358		

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D 358	Continued From page 43 -The facility contacted her about the missed dose of buspirone on 03/14/19. -There would not really be any effect to Resident #9 by missing the one morning dose of buspirone 15mg tablet. Interview with the Interim Resident Care Manager on 03/14/19 at 2:15pm revealed: -She had instructed the third shift MA to administer Resident #9 two of the buspirone 7.5mg tablets until the buspirone 15mg tablets came to the facility today. -She did not provide a date for when she had instructed staff to administer Resident #9 two of the buspirone 7.5mg tablets. Interview with the Interim Resident Care Manager on 03/18/19 at 5:05pm revealed: -She expected medications to be administered according to physician orders. -She would have expected the MA to administer two buspirone 7.5mg tablets to equal buspirone 15mg if the medication on hand was buspirone 7.5mg tablets instead of buspirone 15mg tablets. -She got an order on 03/14/19 that Resident #9 may be administered buspirone 15mg by administering buspirone 7.5mg two tablets three times a day. -She had added the instructions on the 03/14/19 order, to the eMARs that Resident #9 may be administered buspirone 15mg by administering buspirone 7.5mg two tablets three times a day. Interview with the Executive Director on 03/14/19 at 4:30pm revealed the facility did not had a medication administration policy, but had a "process". Review of the General Dose Preparation and Medication Administration, Assistance or	D 358		

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D 358	Continued From page 44 Observation document provided on 03/15/19 at 10:00am revealed the process included: -The community staff should refer to the community's policies and procedures regarding medication administration, assistance or observation. -The community staff should verify that the medication name and dose are correct. Interview with the Executive Director on 03/18/19 at 5:15pm revealed: -She expected medication to be administered as ordered. -She would have expected the MA to administer buspirone 7.5mg two tablets to equal 15mg instead of the Resident #9 missing the dose of buspirone. c. Review of the current FL-2 for Resident #8 dated 09/04/18 revealed: -Diagnoses included dementia, hypothyroid, hyperlipidemia, and failure to thrive. -There was a physician's order for metformin (used to manage blood glucose levels) tablet extended release 24 hour 500mg tablet every day. Review of Standing House Orders For Medication and Treatments for Resident #9 dated 09/04/18 revealed there was a physician's order that included all medications may be crushed and to check do not crush list. Observation of the medication pass on 03/14/19 at 8:45am revealed: -The MA prepared six tablets and one capsule for administration to Resident #8, including metformin 500mg ER one tablet. -The MA placed the six tablets in a clear plastic bag.	D 358		

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D 358	Continued From page 45 -The MA paused, looked at the eMAR, and removed an aspirin 81mg EC tablet. -The MA crushed five of the six tablets, including the metformin 500mg ER tablet. Interview with the MA on 03/14/19 at 8:45am revealed: -He felt like, after looking at the eMAR again upon prompting, that the delayed release aspirin could not be crushed so he was going to remove it before crushing the pills. -He was going to crush the tablets, but would not crush the capsule he had prepared for administration. -The resident had an order to crush his medications. -He had never seen a list for medications that were not supposed to be crushed. Observation of the MA on 03/14/19 at 8:57am revealed the MA administered to Resident #8 the crushed medications, the sprinkled contents from inside the capsule, and the aspirin 81mg EC tablet mixed in applesauce. Review of the March 2019 eMAR for Resident #8 revealed: -There was an entry for aspirin tablet, delayed release (DR/EC) 81mg, with the only special instructions of take one tablet every day. -There was an entry for metformin tablet extended release 24 hour 500mg, with the only special instructions of take one tablet every day. Interview with the MA on 03/14/19 at 2:26pm revealed: -He had been crushing the metformin extended release tablet and enteric coated aspirin tablet until today. -He was not sure if there was a medication	D 358		

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D 358	Continued From page 46 administration policy in the facility, but thought there was. -He could not remember if he had seen a medication administration policy for the facility. -He administered medications according to the printed eMAR instructions. -The Resident Care Manager (RCM) entered orders in the eMAR system. Interview with the Executive Director on 03/14/19 at 4:30pm revealed the facility did not had a medication administration policy, but had a "process". Review of the General Dose Preparation and Medication Administration, Assistance or Observation document provided on 03/15/19 at 10:00am revealed the process included: -The community staff should refer to the community's policies and procedures regarding medication administration, assistance or observation. -The community staff should verify that the medication name and dose are correct. -The community staff may crush oral medications only in accordance with applicable law, pharmacy guidelines and/or community policy. -The medication administration record should indicate the need for crushing. -Enteric coated medication types precluded crushing. -Extended release medication types precluded crushing. Interview with the Executive Director on 03/15/19 at 10:00am revealed she had "pulled" the list of oral medications that should not be crushed from the cabinet at the "nurses" station. Interview with Resident #8 on 03/15/19 at 9:50am	D 358		

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D 358	Continued From page 47 revealed: -He occasionally had a stomachache, but not all the time. -He did not know what medications he was administered. Interview with the Pharmacist on 03/14/19 at 5:30pm revealed: -Metformin extend release was not supposed to be crushed and was made to dissolve slowly. -The resident could experience a low blood sugar, and later an elevated blood sugar, if metformin extend release was crushed. -Enteric coated aspirin was not supposed to be crushed and may cause upset stomach. Interview with the Nurse Practitioner on 03/15/19 at 3:30pm revealed: -If metformin extend release was crushed, the effect of lowering the resident's blood sugar would be immediate instead of over an extended period of time. -By crushing enteric coated aspirin, the resident could have irritation to the stomach. Interview with the MA on 03/13/19 at 12:12pm revealed: -Medication orders were entered into the eMARs by the Resident Care Manager (RCM). -The MAs usually did not see new orders received. -She administered medications according to the eMARs. Interview with the Interim Resident Care Manager dated 03/18/19 at 5:05pm revealed she expected medications to be administered according to physician orders. Interview with the Executive Director on 03/18/19	D 358		

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D 358	Continued From page 48 at 5:15pm revealed she expected medication to be administered as ordered. 3. Review of Resident #7's current FL-2 dated 02/21/19 revealed: -Diagnoses included chronic obstructive pulmonary disease, iron deficiency anemia, hypertension, gastro esophageal reflux disorder, insomnia, muscle weakness, and cognitive impairment. -There was an order for hydrocodone-acetaminophen table 7.5 - 325 mg take 1 tab by mouth three times daily at 8:00 am 2:00 pm and 8:00 pm. (Hydrocodone-acetaminophen is used to treat pain.) -There was an order for levothyroxine tablet 150 mcg take 1 tab by mouth every day once a morning at 6:00 am. (Levothyroxine is used to treat hypothyroidism.) a. Review of Resident #7's March 2019 medication administration record (MAR) revealed: -There was an electronic entry for hydrocodone-acetaminophen 7.5-325 mg three time a day at 8:00 am 2:00 pm and 8:00 pm. -There was documentation that revealed there were none available to be administered from 03/09/19 to 03/13/19. -There were 11 of 13 opportunities in which the hydrocodone was not administered from 03/09/19 to 03/13/19. -The MAR dated 03/12/19 at 2:00 pm had been signed for as administered. -The MAR dated 03/13/19 at 8:00 am had been signed for as administered. Interview with Resident #7 on 03/13/19 at 12:00 pm revealed: -She had been out of her pain medication	D 358		

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D 358	Continued From page 49 (hydrocodone) since Friday (03/08/19). -When she went without her pain medication, her "rheumatoid arthritis really bothers her". -She had told the Interim Executive Director (IED) on Monday (03/12/19) and the IED said she would call the pharmacy and the back-up pharmacy to get it for her. -She still had not received it. Second interview with Resident #7 on 03/15/19 at 2:35 pm revealed: -When she went without her pain medication (hydrocodone), her back, hips, and thighs get very painful. -The pain started after missing just one dose. -She "tells them (MA) when she is out of her pain medication and it takes them about a week to get it." -She did not remember how often she ran out of her medications. The facility provided a fax confirmation from the pharmacy dated 03/03/19 that revealed: -It was a refill request feedback date and time stamped on 03/03/19 at 2:41 pm. -Resident #7's hydrocodone had 0 tablets remaining and a new order would be needed. Interview with the pharmacy on 03/15/19 at 11:04 am revealed Resident #7 was issued hydrocodone-acetaminophen 7.5 mg-325mg #90 tablets on the following dates, 11/03/18, 12/07/18, 01/03/19, and 02/01/19. Interview with a medication aide (MA) on 03/13/19 at 5:25 pm revealed: -The hydrocodone for Resident #7 was out of stock since 03/12/19 that she knew of. -She was "waiting for pharmacy" to send a new prescription refill for the hydrocodone.	D 358		

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D 358	Continued From page 50 Interview with a second medication aide (MA) on 03/14/19 at 10:21 am revealed: -Resident #7 was supposed to have received hydrocodone-acetaminophen 7.5-325 mg three time a day at 8:00 am 2:00 pm and 8:00 pm. -Resident #7 had a new bottle of hydrocodone-acetaminophen available for administration this morning dated 03/13/19 (not sure when it arrived). -She opened the bottle on 03/14/19 during her 8:00 am medication pass. -She removed the seal from the bottle this morning 03/14/19 for the 8:00 am dose. -Her initials, on 03/13/19 at 2:00 pm, had been placed in parentheses to explain the medication was not given as it was not available for administration. -Her initials, on 03/13/19 at 8:00 am, should have been in to explain the medication was not given as it was not available for administration. -She had forgotten to put her initials in parentheses for 03/13/19 at 8:00 am. Interview with a third medication aide (MA) on 03/15/19 at 12:41 pm revealed: -Resident #7 was supposed to have received hydrocodone-acetaminophen 7.5-325 mg three time a day at 8:00 am 2:00 pm and 8:00 pm. -Resident #7 did not have any hydrocodone-acetaminophen available for administration. -Her initials, on 03/12/19 at 8:00 am, had been placed in parentheses to explain the medication was not given as it was not available for administration. -Her initials, on 03/12/19 at 2:00 pm, should have been in parentheses to explain the medication was not given as it was not available for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004003	A. BUILDING: _____ B. WING _____	R 03/18/2019

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D 358	Continued From page 51 -She had forgotten to put her initials in parentheses for 03/12/19 at 2:00 pm. -She had been off on the weekend when Resident #7 ran out of her hydrocodone-acetaminophen. -When she returned to work on 03/11/19, she reported that the resident had been out of hydrocodone-acetaminophen. -She would normally report medications needing to be refilled/ordered to the Resident Care Coordinator (RCC). -She was not sure to whom she reported to the morning of 03/11/19. Interview with the Interim Executive Director (IED) on 03/13/19 at 5:25 pm revealed: -There were no hydrocodone tablets in the community for any resident. -The pharmacy sent a fax dated 03/03/19 notifying the facility that a new prescription was needed for Resident #7's hydrocodone. -She had left a message for Resident #7's primary care provider (PCP) on 03/13/19 for a new prescription. Interview with Resident #7's Primary Care Physician (PCP) on 03/14/19 at 3:27 pm revealed: -The facility did not reorder Resident #7's medications on time. -She was in the building on 03/13/19 and no one said anything about reordering medications. -She had told the staff to use the red reorder tag and not to wait until there are two days' worth of medication remaining. -Her concern for the pain medication (hydrocodone) not being available/administered for 5 days would be that Resident #7's pain would not be controlled which could result in an Emergency Room visit.	D 358		

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D 358	Continued From page 52 -She felt the problem with the staff not renewing the medication in a timely matter was the staff turnover rate. -The staff she talked to about timely reordering were no longer employed at the facility. b. Review of Resident #7's January 2019 medication administration record (MAR) revealed: -There was an electronic entry for levothyroxine 150 mcg 1 tablet once a day. -Levothyroxine was scheduled for administration at 6:00 am. -There was documentation the levothyroxine was not administered on 01/29/19 through 01/31/19. -The reason levothyroxine was not given was listed as it was "not available" for administration. -The start date on the MAR was 01/05/19.Interview with the pharmacy on 03/15/19 at 11:04 am revealed that Resident #7 was issued #30 tablets of levothyroxine 150mcg on the following dates, 11/05/18, 12/05/18, 01/05/19, 02/05/19, and 03/05/19. Second Interview with Resident #7's PCP on 03/18/19 at 4:25 pm revealed: -She did not recall whether or not the facility had contacted her in January regarding Resident # 7 missing 3 days (doses) of levothyroxine (01/29/19, 01/30/19, and 01/31/19). -Resident #7 missing 3 doses of the levothyroxine did not concern her. -It would take more than missing 3 doses to cause any issues. The facility failed to assure insulin was administered as ordered to Resident #3 as observed during the 12:00pm medication pass on 03/13/19 and according to review of medication administration records for January 2019, February 2019, and March 2019 when the	D 358		

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D 358	Continued From page 53 medication aides documented administering insulin, which lowers the blood sugar, when insulin was not required. This failure of not administering medications, including insulin, was detrimental to the health and welfare of the residents and constitues a Type B Violation. The facility provided a plan of protection in accordance with G.S 131D-34 on 03/14/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2019.	D 358	ED and CM notified physician and obtained clarification of issues identified during survey. Issues identified were corrected immediately. ED, CM and Regional Clinical Director (RCD) reviewed resident records on 3/19/19 to identify and correct and other issues identified. Order Processing System (Bucket System) initiated on 3/14/19. ED and CM received training on Bucket System from RCD on 3/14/19. CM initiated training to Medication Aides (MA) regarding Bucket System, proper medication administration process and procedures to include reporting and documentation on 3/14/19. RCD initiated medication administration training on 3/15/19. ED and CM provided education to staff on 3/26/29 regarding Bucket System and Diabetic Education.CM will monitor and follow up with Bucket System daily to ensure orders processed accuretely, medication is in community and documentation of Medication administration is completed. ED and/or CM will conduct random observations of Medication Adminstartion records weekly to ensure proper medication administation and documentation. POC date: 5/2/19	
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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D 367	Continued From page 54 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure medication administration records for 1 of 6 sampled residents (#1) was accurate and included documentation of a prescription cough medication administered by staff. The findings are: Review of Resident #1's current FL-2 dated 2/19/2019 revealed diagnoses included abnormal electroencephalogram, Alzheimer's dementia, altered mental status, cervical dysplasia and tachycardia Review of a hospital order dated 02/21/19 for Resident #1 revealed an order for benzonatate 100mg three times daily as needed for (PRN) cough. (Benzonate is a cough suppressant.) Observation of medications on hand for Resident #1 on 03/15/19 at 3:20pm revealed: -The pharmacy label indicated 15 tablets were dispensed on 02/21/19. -There were 9 capsules remaining. Review of Resident #1's February 2019 electronic medication administration record (eMAR) revealed: -There was an entry for benzonate 100mg three times daily PRN for cough with a start date of 02/21/19.	D 367		

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D 367	Continued From page 55 -There was no documentation any doses had been administered to Resident #1. Review of Resident #1's March 2019 eMAR revealed: -There was an entry for benzonate 100mg three times daily PRN for cough. -There was no documentation any doses had been administered to Resident #1. Interview with Resident #1's family member on 03/15/19 at 3:24pm revealed: -They brought Resident #1's medications to the facility. -They were not aware that Resident #1 had a cough medication. -They "just picked the medications up from the pharmacy and brought them straight to the facility." -They did not take any of the medications out of the bottle. Interview with a medication aide (MA) on 03/15/19 at 3:20pm revealed: -She was unaware of the location of the 6 missing benzonate capsules. -She knew that there were 15 benzonate capsules dispensed from the pharmacy. -Resident #1's family member brought the medications to the facility. -Resident #1's family member had taken out medications of Resident #1's bottles in the past. -She did not know where these capsules went. -The MA checked the eMAR to see if any reasons were given for the discrepancy in the number of capsules. -She did not see, on the eMARs, that this medication had ever been administered to Resident #1.	D 367		

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D 367	Continued From page 56 Interview with the pharmacy on 03/15/19 at 3:25 pm revealed: -Resident #1's prescription for benzonate 100mg capsules was filled on 02/21/19. -The pharmacy dispensed 15 benzonate 100mg capsules in total. Interview with a medication aide (MA) on 03/18/19 at 12:01 pm revealed: -She did not know where the missing 6 benzonate 100mg capsules went for Resident #1. -She counted the benzonate capsules on hand for Resident #1, there were 9 capsules on hand. -She had never administered benzonate capsules to Resident #1. -She checked the eMARs and was not able to find where these capsules went. Interview with the Resident Care Coordinator (RCC) on 03/14/19 at 12:00 pm revealed: -She was in charge of monitoring medications. -She had been making sure that all medications that were supposed to be in the building were in the building. -If the medications were not in the building, she would find out why they were not. -She worked all three shifts to monitor all the staff. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	D912		

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D912	Continued From page 57 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration, test for tuberculosis and training on cardiopulmonary resuscitation. The findings are: 1. Based on record reviews and interviews, the facility failed to assure 2 of 4 sampled staff (Staff C and D) had a two-step tuberculosis (TB) skin test was done upon employment in compliance with control measures adopted by the Commission for Health Services [Refer to Tag 131 10A NCAC 13F .0406(a) Test for Tuberculosis (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to assure 3 of 4 staff records (A, B, & D) had not completed an approved course of cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months and did not have at least one staff person was on the premises at all times who had completed an approved course of CPR and choking management within the last 24 months on third shift for 5 of 11 days and second shift for 1 of 11 sampled in March 2019 [Refer to Tag 167 10A	D912	Residents will have the right to receive care and services which are adequate, appropriate, and in compliance with relevent federal and state laws and rules and regulations. Resident Rights training for staff initiated on 3/15/19 by Regional Support team. Staff received a copy of the "Declaration of Residents Rights." Staff signed acknowledging and receipt of "Declaration of Residents Rights". Ombudsman provided Resident Rights Training on 3/26/19 to staff. ED and/or designee will monitor for ongoing compliance through observations and resident council meetings. POC date: 5/2/19	

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D912	Continued From page 58 NCAC 13F .0507 Training on Cardiopulmonary Resuscitation (Type B Violation)]. 3.Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 8 residents (#3, #8, #9) observed during the medication passes, including errors in insulin administration (#3), an anti-anxiety medication (#9), crushing and administering medication that should not be crushed (#8); and 3 of 5 residents (#1, #3, #7) including errors with a cough suppressant (#1), insulin administration (#3), a thyroid hormone replacement and a narcotic pain medication (#7) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
D916	G.S. 131D-21(6) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 6. To have his or her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom the disclosure may be made, except as required by applicable state or federal statute or regulation or by third party contract. It is not the intent of this section to prohibit access to medical records by the treating physician except when the individual objects in writing. Records may also be disclosed with the written consent of the individual to agencies, institutions or individuals which are providing emergency medical services to the individual. Disclosure of information shall be limited to that which is necessary to meet the emergency. This Rule is not met as evidenced by:	D916	Residents will have the right to have his or her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian. Resident Rights training for staff initiated on 3/15/19 by Regional Support team. Staff received a copy of the "Declaration of Residents Rights." Staff signed acknowledging and receipt of "Declaration of Residents Rights". Ombudsman provided Resident Rights Training on 3/26/19 to staff. ED and/or designee with monitor for ongoing compliance through observations and resident council meetings. POC date: 5/2/19	

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D916	Continued From page 59 Based on observations, interviews and record reviews, the facility failed to assure personal and medical records for one of one sampled resident (#4) were kept confidential as evidenced by the resident's medication administration record being given to another resident at discharge. The findings are: Review of Resident #4's current FL-2 dated 01/22/2019 revealed diagnoses included chronic kidney disease, hard of hearing, moderate chronic obstructive pulmonary disease, osteoarthritis and Paroxysmal atrial fibrillation. Interview with another's resident's family member on 03/15/2019 at 8:30am revealed: -She received another resident's medication administration record (MAR) upon her family member's discharge. -The MAR included the name and medications of Resident #4. -She made numerous attempts to reach the Executive Director (ED) to make her aware of error; however, ED did not return her telephone calls. Review of faxed discharge documentation for the other resident revealed: -There was a January 2019 MAR for Resident #4. -There was documentation of Resident #4's name and four medications (omeprazole, fluoxetine, pravastatin and albuterol). -Part of the January 2019 MAR of Resident #4 was given to another resident upon his/her discharge. Interview with the Resident Care Coordinator (RCC) on 3/18/2019 at 4:32pm revealed: -She was not sure how Resident #4's MAR was	D916		

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D916	Continued From page 60 given to another resident upon that particular resident's discharge. -She listed all medication identified at the time of discharge on the Medication Release Form. -She only gave the Medication Release Form to the family of the discharged resident. -She did not give Resident #4's MAR to the discharged resident's family. -"Most of the time, when a new resident comes in, we complete a form that shows what medications they bring in with them." Interview with Resident #4 on 03/18/2019 at 6:14pm revealed: -He was informed on 03/18/2019 by the ED that his rights were violated. -His MAR, which included his name and names of his medications, were released to another resident at that particular resident's discharge from the facility. -The apology offered was sufficient for him. Interview with the ED on 3/18/2019 at 5:02pm revealed: -She did not know how the MAR of Resident #4 was given to another resident upon discharge. -She would advise Resident #4's family that his/her privacy was violated.	D916		

Washington, Bynithia T

From: Meadowview Terrace of Wadesboro, ADM - Rauf, Abbey <mtow.adm@affinitylivinggroup.com>
Sent: Monday, June 10, 2019 4:09 PM
To: Washington, Bynithia T
Cc: Terry Greer; Pate Wilkerson; Barbara Excell; Kathy Vidal
Subject: [External] Meadowview State POC page one and revised page 54
Attachments: Meadowviewstatepoc page1&revisedpage54.pdf

Importance: High

Dear Ms. Bynithia Washington ,

It was a pleasure speaking with you today. Per our conversation attach is page One and revised Page 54 for your review/approval .

If you have any questions please let us know .

Thanks in advance
Abbey Rauf

Abbey Rauf
Interim ED
Cell (704)477-5512
Office 994-9050