STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on May 15-17, 2019.	{D 000}		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to provide personal care assistance with nailcare to 1 of 5 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated 09/07/18 revealed diagnoses included organic brain disorder, status post cerebrovascular accident, gastro-esophageal reflux disorder, chronic obstructive pulmonary disorder, vitamin D deficiency, delirium/dementia. Review of Resident #5's care plan dated 09/07/18	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 1	{D 269}		

revealed:
-He needed staff assistance with bathing, shaving, mouth care, shampooing hair, and nailcare.
-He was supposed to receive staff assistance with bathing three times a week on Tuesday, Thursday, and Saturday on the 11:00pm to 7:00 am shift.
-He was supposed to receive staff assistance with nail care once a week on Mondays on the 7:00 am to 3:00 pm shift.

Observation of Resident #5 in his room on the Special Care Unit (SCU) on 05/15/19 at 10:19 am revealed:
-He was lying in his bed.
-He had impaired speech but was able to shake his head to indicate yes and no, and he was able to point to a piece of paper with terms on it beside him on the bed.
-He had left sided weakness and was able to reach items with his right hand.
-His left hand was contracted.
-The fingernails on his right hand were all trimmed except for the third finger.
-The fingernails on his left contracted hand were all long and the tips of the fingernails touched the palm of the left hand.
-The toenails on both feet were long but not curled.

Review of Resident #5's electronic documentation of activities of daily living (ADL) for May 2019 revealed there was documentation of nail care on 05/06/19 at 10:53 am and 05/13/19 at 10:50 am.

Interview with the personal care aide (PCA) on 05/17/19 at 4:26 pm revealed:
-She documented the nailcare for May 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 2	{D 269}		

Resident #5 because she had filed his fingernails.
-Sometimes Resident #5 refused nailcare and she should have chosen refused from the dropdown menu on the computer when she documented.
-She had not noticed his toenails.
-She knew Resident #5 was not able to speak but he could shake his head yes and no.

Interview with Resident #5 on 05/15/19 at 11:38 am revealed:
-No staff had cut his fingernails.
-A doctor had not seen or cut his fingernails or toenails.
-The fingernails on his left hands were pressing into his left palm.
-He did not feel the fingernails pressing into his left palm.

Interview with Resident #5's family member on 05/17/19 at 8:23 am revealed:
-She did not cut Resident #5's fingernails.
-She was told the staff cut his fingernails.
-Resident #5's nails had not been cut in a long time, and the last time she could recall staff cutting his nails was the Fall of 2018.
-She had spoken to the Special Care Unit (SCU) Resident Care Coordinator (RCC) about Resident #5's fingernails and shaving previously but she did not recall the date.

Interview with another PCA on 05/17/19 at 9:12 am revealed:
-There was a listing of personal care tasks on the computer that PCAs checked off when they were completed for residents.
-Residents received showers three times a week or as needed if incontinent.
-When she worked with Resident #5, he allowed her to assist with showers, shampoo his hair, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 3 cut his fingernails. -She had not worked on the SCU in a while. -The PCAs were told to not cut the fingernails of any resident who was a diabetic, but Resident #5 was not a diabetic. -The fingernail clippers were available for use and kept on the medication cart. -She knew Resident #5 was not able to speak, but he used a piece of paper with words on it to respond to questions. Interview with a third PCA on 05/17/18 at 9:46am revealed: -She was taught not to cut the residents' fingernails or toenails and to only clean and file the fingernails. -Resident #5 would use his body language to communicate and he was able to shake his head for yes or no. Interview with a fourth PCA on 05/17/19 at 10:07am revealed: -Resident #5 was assigned to the night shift shower schedule. -He was taught to not cut the fingernails or toenails of the residents by the staff who trained him. -He filed and cleaned the residents' fingernails if they allowed him to do so. -He did not know who cut the residents' fingernails. Interview with a medication aide (MA) on 05/17/19 at 8:44 am revealed: -The MAs made the assignments for the PCAs and the experienced PCAs filled in the assignment sheet for her to review for approval. -She knew Resident #5 was not a diabetic. -Resident #5 was not able to speak and he was able to shake his head for yes or no.	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 4 -She was told not to cut fingernails and toenails in a recent class she attended, but the fingernails could be cleaned and filed down. -She had not cut Resident #5's fingernails or toenails since his admission to the facility. -There was a fingernail clipper available to use for residents and some residents had their own nail clipper. -She had not discussed Resident #5's fingernails or toenails with anyone. -She did not know Resident #5's fingernails were long and pressing into his left palm. -She did not know Resident #5's toenails were long on each foot. Interview with the SCU RCC on 05/17/19 at 11:07am revealed: -The staff who worked on the SCU knew nail care was done for each resident once a week on the assigned day. -The residents' activities of daily living appeared on the electronic matrix on the computer system and had to be checked off by staff on the computer to indicate it was done. -Resident #5 was assigned nailcare on Mondays. -She did not know how long Resident #5's fingernails were on his left hand. -She saw Resident #5's fingernails on 05/17/19. -She expected staff to complete nailcare including cutting the fingernails of residents who were not diabetics as assigned in the computer system. -She knew about Resident #5's long toenails and he had a pending Podiatry consult. Interview with the Administrator on 05/17/19 at 12:44 pm revealed: -She was made aware on 05/17/19 of Resident #5's fingernail length. -She expected the staff to be responsible for completing nailcare for residents and even	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 5 purchased new fingernail kits for the SCU. -She planned to have the Registered Nurse be responsible for assessing and cutting residents' fingernails beginning 05/17/19. _____ The facility failed to provide personal care assistance with nailcare for 1 of 5 sampled residents as indicated on the resident's assessed care plan. The facility's failure to provide Resident #5, who could not verbally request the need for assistance with nailcare, personal care assistance resulted in Resident #5 having long fingernails on his left hand which was contracted, and the fingernails pressed into his left palm causing continued pressure to his left palm. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 06/07/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2019	{D 269}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 6 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure a podiatry consult was completed for 1 of 5 sampled residents (#5), who had calluses on his feet and long toenails on both feet. The findings are: Review of Resident #5's current FL-2 dated 09/07/18 revealed diagnoses included organic brain disorder, status post cerebrovascular accident, gastro-esophageal reflux disorder, chronic obstructive pulmonary disorder, vitamin D deficiency, delirium/dementia. Review of Resident #5's physician orders dated 02/26/19 revealed there was an order for Podiatry consult to treat calluses and onychomycosis. Observation of Resident #5 in his room on the Special Care Unit (SCU) on 05/15/19 at 11:42 am revealed: -He was sitting on his bed. -He had impaired speech but was able to shake his head to indicate yes and no, and he was able to point to a piece of paper with terms on it beside him on the bed. -He had left sided weakness and was able to reach items with his right hand. -His left hand was contracted. -There was a bunion on the second toe of his right foot. -The toenails on both feet were long but not curled. Interview with Resident #5 on 05/15/19 at 11:38 am revealed: -His right second toe was painful, but he did not know how long it had been in pain. -He had told the physician about the toe pain, but he had not seen the Podiatrist.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 7 Interview with a visiting family member of another resident on 05/15/19 at 11:42am revealed -Resident #5 had complained to her about his right toe hurting. -He told her about his right toes hurting some weeks ago and she told the Special Care Unit (SCU) Resident Care Coordinator (RCC). Interview with Resident #5's family member on 05/17/19 at 8:23 am revealed: -Resident #5 was complaining about toe pain and needing his toe nails cut. -He had complained for the past three weeks about his toe nails needing trimming and the pain in his right toe. -She was told by the RCC they were waiting for the Podiatrist to come to the facility. -She had not been told anything else by the SCU RCC and she had not been asked to sign a consent form. -She last visited Resident #5 on 05/13/19. Interview with Resident #5's physician on 05/16/19 at 12:00 pm revealed: -Resident #5 had complaints of right toe pain in February 2019. -He did not cut the residents' toe nails, and residents' toe nails were cut by the Podiatrist who came to the facility. -He ordered a Podiatrist consult for Resident #5 on the 02/26/19 visit. -He was told by the RCC to see Resident #5 again about his feet on 05/16/19. -He did not know Resident #5 had not been seen yet by the Podiatrist. -He had ordered callus remover for Resident #5 on 05/16/19. Interview with the SCU RCC on 05/17/19 at	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 8 11:00am revealed: -When the physician ordered a consult, he gave the order to her. -She would then begin arranging the appointment with whomever the consult indicated. -For Podiatry consults, she obtained a consent form and placed the resident on the Podiatrist list to be seen at the Podiatrist's next visit to the facility. -The Podiatrist visited the facility every three months and his last visit to the facility was 04/10/19. -Resident #5 was not seen at the time of the Podiatrist last visit on 04/10/19 because he was not on the list. -Resident #5's Power of Attorney (POA) had to sign a consent form for him to be seen by the Podiatrist. -She had called Resident #5's POA in March 2019 to sign the consent form, but the POA did not visit the facility when she said she would visit. -She called Resident #5's POA once more in March to sign the consent form, but was unable to get the consent form signed. -She had not had a chance to try to get the consent form signed again. -She was responsible for ensuring physician orders were followed. Interview with the Administrator on 05/17/19 at 12:44pm revealed: -She was made aware on 05/17/19 of Resident #5's Podiatry consult not being completed and he had not been seen by the Podiatrist during the last visit. -The SCU RCC and the physician were responsible for ensuring the consults were done for residents. -If she received phone calls or complaints related to consults she would arrange the consult herself.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 9 The facility failed to assure a podiatry consult, ordered in February 2019, was completed for Resident #5, who had long toenails on both feet and was unable to verbally express his needs to staff The facility's failure to a podiatry consult was completed as ordered by the primary care provider was detrimental to health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/17/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2019	{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, record reviews, and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination including the floors in the walk-in refrigerator and walk in freezer, can opener, and ice machine. The findings are: Observation of the ice machine on 05/16/19 at	{D 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 282}	Continued From page 10 8:40am revealed there was a thick layer of dust around the door and the gasket. Observation of the can opener mounted to a metal table on 05/16/19 at 8:53am revealed a thick blackish layer of film and food debris on the base, handle and blade. Observations of the walk-in refrigerator on 05/16/19 at 9:00am revealed: -There was a large brown, milky liquid, a cookie, a piece of lettuce and other food debris in the corner of the floor under a shelf in the walk-in refrigerator. -There was a dried brown liquid and paper in a second corner of the floor under a shelf in the walk-in refrigerator. -There was a dried yellow liquid, a tab from a bread wrapper and other debris under another shelf in the walk-in refrigerator. -There was a thick, glossy-white film along the base of the wall where the floor and the wall came together. Observations of the walk-in freezer on 05/16/19 at 9:07am revealed there was a thick layer of dust, food debris, cookie dough, cardboard, tape and paper on the floor under the shelves in the walk-in freezer. Review of the cleaning schedule on 05/16/19 at 9:11am revealed: -There was one cleaning schedule and it was separated into daily, weekly and monthly cleaning; there were areas to document dates and initials on the schedule. -There was nothing documented on the cleaning schedule. -The daily cleaning schedule included the can opener; the weekly cleaning schedule included	{D 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 282}	Continued From page 11	{D 282}		

the walk-in refrigerator and walk-in freezer and the monthly cleaning schedule included the ice machine.

Interview on 05/16/19 at 9:15am with the kitchen manager (KM) revealed:
-She was responsible for monitoring the sanitation in the kitchen.
-She used the cleaning schedule as a guide; she assigned "extra" cleaning duties to the kitchen staff on Fridays.
-She did not require the kitchen staff to document on the cleaning schedule when the assigned cleaning duties were completed.
-The ice machine was deep cleaned once a month and wiped off weekly; it had been deep cleaned earlier that week by the maintenance staff.
-The can opener was wiped off each time the table was wiped off; it was deep cleaned once a week.
-She did not realize the can opener needed to be cleaned; she had cleaned it about three to four weeks ago.
-The walk-in refrigerator and walk-in freezer were deep cleaned each Thursday; deep cleaning included sweeping and mopping once a week.
-She did not realize the floors and corners under the shelves in the walk-in refrigerator and freezer were dirty; the lighting in the walk-ins were bad.

Interview with a maintenance staff on 05/17/19 at 9:20am revealed:
-He deep cleaned the ice machine on Monday, 05/13/19; he did not know how often he deep cleaned the ice machine, but he thought once a month.
-He did not document on the cleaning schedule when he deep cleaned the ice machine.
-He cleaned any part of the ice machine that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 282}	Continued From page 12 touched the ice; he used a chemical designed to clean and sanitize ice machines. -He did not wipe down the door, the door gasket or the outside of the ice machine when he did his monthly cleaning because he thought the kitchen staff wiped those parts of the ice machine every day. Interview with the Administrator on 05/17/19 at 9:05am and 3:40 pm revealed: -She walked through the kitchen every morning; she checked for dates and labels on food and looked at the equipment to be sure it was clean. -She wiped off the can opener herself, but she did not know when; she did not know it "looked that bad". -The ice machine was deep cleaned by the maintenance staff on Monday, 05/13/19; she did not know if the door was part of what the maintenance staff cleaned. -She knew the floors in the walk-in refrigerator and walk-in freezers were cleaned each Thursday; she did not know the corners and the floors under the shelves were dirty. -There was a daily, weekly and monthly cleaning schedule for the kitchen staff to follow, but she did not know if the kitchen staff signed off on the schedule once cleaning was completed.	{D 282}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 310}	Continued From page 13	{D 310}		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to assure 1 of 5 sampled residents (#5) was served nutritional shakes as ordered by the physician.

The findings are:

Review of Resident #5's current FL-2 dated 09/07/18 revealed:
-Diagnoses included organic brain disorder, status post cerebrovascular accident, gastro-esophageal reflux disorder, chronic obstructive pulmonary disorder, vitamin D deficiency, delirium/dementia.
-There was no diet order.

Review of Resident #5 physician's order revealed there was a diet order dated 03/14/19 for a regular mechanical soft for meats only diet.

Review of Resident #5's record revealed a prescription dated 04/18/19 for nutritional shakes one shake three times a day with meals.

Observation of the lunch meal service on 05/16/19 at 12:40 pm revealed:
-Resident #5 was served chopped barbecue pork chop, sweet potatoes, green peas and carrots, a slice of toast, small bowl of peaches, water, milk, and tea.
-He did not receive a nutritional shake during the lunch meal service.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 310}	Continued From page 14 Observation of the dinner meal service on 05/16/19 at 5:17 pm revealed: -Resident #5 refused the dinner meal service. -He did not receive a nutritional shake at the dinner meal service. Review of Resident #5's April 2019 electronic medication administration records (eMARs) revealed: -There was an entry for nutritional shakes one can three times a day with meals, scheduled for 8:00 am, 4:00 pm, and 11:00 pm. -There were staff initials from 04/19/19 to 04/30/19 at 8:00 am, 4:00 pm, and 11:00 pm documented by the entry for nutritional shake, but several initials had an asterisk beside it. -The asterisks in the eMAR system indicated a note was documented in the electronic MAR system. -There was a note documented for 04/19/19 at 8:00 am of late administration. -There was a note documented for 04/21/19 at 8:00 am of refused. -There was a note documented for 04/21/19 at 4:00 pm of refused. -There was a note documented for 04/23/19 at 8:00 am of refused. -There was a note documented for 04/23/19 at 4:00 pm of refused. -There was a note documented for 04/24/19 at 8:00 am of refused. -There was a note documented for 04/26/19 at 8:00 am of refused. -There was a note documented for 04/26/19 at 4:00 pm of refused. -There was a note documented for 04/27/19 at 8:00 am of refused. -There was a note documented for 04/30/19 at 4:00 pm of refused.	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 310}	Continued From page 15 -There was a note documented from 04/19/19 to 04/30/19 at 11:00 pm of refused or sleeping. Review of Resident #5's May 2019 eMARs revealed: -There were staff initials from 05/01/19 to 05/14/19 at 8:00 am, 4:00 pm, and 11:00 pm documented by the entry for the nutritional shake, but several initials had an asterisk beside it. -There was a note documented for 05/01/19 at 4:00 pm of late administration. -There was a note documented for 05/02/19 at 4:00 pm of late administration. -There was a note documented for 05/05/19 at 4:00 pm of other. -There was a note documented from 05/01/19 to 05/03/19 at 11:00 pm, from 05/08/19 to 05/14/19 at 11:00 pm of recorded late, not administered due to condition, or sleep. Interview with a representative from the contracted pharmacy on 05/17/19 at 8:11 am revealed: -Nutritional supplements were placed on the eMAR because the pharmacy supplied the nutritional supplements. -Nutritional shakes were not supplied by the pharmacy but were entered under the resident's profile and appear on the resident's eMAR. -Resident #5 had a nutritional shake order written on 04/18/19 that was placed on the MAR. -The scheduled times for a medication or item ordered for administration "with meals" populated with the times provided by the staff. -The staff provided the pharmacy with the following times to use for a medication or item ordered for administration with meals: 8:00 am, 12:00 noon, and 5:00 pm . -Resident #5's nutritional shakes were scheduled for 8:00 am, 12:00 noon, and 5:00 pm.	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 310}	Continued From page 16 -The facility staff could change the scheduled times of a medication or item and the pharmacy would not be able to view the new scheduled times. Interview with Resident #5 on 05/17/19 at 9:20 am revealed: -He did not recall getting a nutritional shake during the breakfast meal service. -He did not recall anyone offering or giving him a nutritional shake. Interview with Resident #5's family member on 05/17/19 at 8:23 am revealed: -She was concerned about Resident #5's intake and brought nutritional supplements to him. -She was told by the Special Care Unit (SCU) Resident Care Coordinator (RCC) that the physician could order the nutritional supplements for Resident #5. -She had not been told that the physician had ordered a nutritional supplement for Resident #5. -She was still bringing nutritional supplements to Resident #5 so he could drink them during her visits with him. Interview with Resident #5's physician on 5/16/19 at 12:00 pm revealed: -He ordered the nutritional shakes for Resident #5 to increase Resident #5's calorie intake. -Resident #5 had complaints of a sore throat frequently because Resident #5 had a history of swallowing bleach. Interview with a third shift medication aide (MA) on 05/17/19 at 8:44 am revealed: -She had seen the scheduled time for Resident #5's nutritional shake in April 2019 to be administered at night. -She had overheard another third shift MA	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 310}	Continued From page 17	{D 310}		

mention the inaccurate times, 4:00 pm and 11:00 pm, to the SCU RCC in April 2019.
-She did not tell the SCU RCC herself about the inaccurate times.
-Resident #5 ate meals when he wanted and she had not noticed any changes in his weight or appearance.

Interview with another third shift MA on 05/17/19 at 10:19 am revealed:
-The residents' nutritional shake orders were copied, a copy was placed in the record, the order was faxed to the pharmacy, supplement orders were placed on the face sheet in the resident's record, a copy of the supplement order was given to the dining staff, and the dining staff supplied the nutritional shakes.
-When she had to give a resident a nutritional shake she walked over to the kitchen to get the nutritional shake.
-She had offered Resident #5 a nutritional shake this morning when he was walking back to his room from breakfast, and he refused.
-Resident #5 ate sometimes and refused meals when he wanted.
-He ate breakfast on 05/17/19.
-She had noted the times of his nutritional shakes before and the scheduled times were not accurate to the physician's order.
-The scheduled times for the nutritional shakes should have been 7:00 am, 12:00 pm, and 5:00 pm.
-She had mentioned it to the SCU RCC in April 2019 when the order started.
-The SCU RCC was responsible for approving the resident's orders in the eMAR system.

Interview with the SCU RCC on 05/17/19 at revealed:
-The facility's physician gave all orders to her, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 310}	Continued From page 18	{D 310}		

copied it (one copy goes into the resident's record and the other was saved in a folder), faxed it to the pharmacy; she reviewed the order once it was placed into the eMAR system and approved the order so that the MAs could begin administering the medication or item.
-When she approved orders within the eMAR system she could change the times for administration, and she could delete duplicate orders.
-She saw the times for the nutritional shake on 05/17/19 and realized the scheduled times were wrong.
-She may not have been the staff to approve the nutritional shake order for Resident #5.
-Resident #5's nutritional shake order was approved by the Assisted Living (AL) RCC.
-Resident #5's nutritional shakes scheduled times should have been 8:00 am, 12:00 pm, and 4:00 pm.
-She expected the MAs to tell her if a medication or order on the eMAR system was incorrect.
-She asked the physician to order the nutritional shakes for Resident #5 because Resident #5's family member wanted them ordered for him.
-The family member wanted the nutritional shakes for Resident #5 because she was bringing him nutritional supplements when she visited.
-She was not told by any of the staff about the incorrect scheduled times for Resident #5's nutritional shake order.

Interview with the Assisted Living (AL) RCC on 05/17/19 at 11:37 am revealed:
-She may have approved the order for Resident #5's nutritional shake order and not paid attention to the scheduled times.
-She had learned a lot more about the eMAR approval process since April 2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 310}	Continued From page 19 -She probably forgot to change the scheduled times for Resident #5's nutritional shake order. Interview with the Administrator on 05/17/19 at 12:44 pm revealed: -She was told of the inaccurate scheduled times for Resident #5's nutritional shakes on 05/17/19. -Both RCCs were responsible for processing nutritional shake orders and for their accurate time of administration on the eMARs.	{D 310}		
{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 observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 20	{D 358}		

prescribing practitioner for 2 of 5 sampled residents (Resident #4 and #3) medications not available for administration including Xarelto (Resident #4) and medication not available for administration including Paxil and Novolog insulin not administered after meals as ordered. (Resident #3).

The findings are:

1.Review of Resident #4's FL-2 dated 01/17/19 revealed diagnoses included dementia, chronic obstructive (COPD), hypoplastic coronary disease (HCAD), hyperlipidemia (HLD), hypertension (HTN) and sepsis.
-There was an order for Xarelto 20 mg tablets by mouth every day. (Xarelto is a blood thinner.)

Review of Resident #4's current FL-2 dated 05/02/19 revealed diagnosis included dementia, COPD, HCAD, HLD and HTN.
-There was an order for Xarelto 20 mg tablets by mouth every day.

Review of the cart audit dated 05/15/19 revealed Xarelto 20 mg was not available for administration and zero was documented as the number of Xarelto available.

Observation of Resident #4's medications on 05/17/19 at 9:30am revealed Xarelto 20 mg was not available for administration.

Review of Resident #4's May 2019 electronic Medication Administration Record (eMAR) revealed:
-There was documentation Resident #5 was not administered Xarelto as ordered for 10 of 17 opportunities from 05/01/19 through 05/17/19.
-There was documentation Resident #4 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 21 administered Xarelto as ordered on 05/03/19 at 8:00am, 05/07/19 at 8:00am, 05/08/19 at 8:00am, 05/09/19 at 8:00am, 05/10/19 at 8:00am, 05/11/19 at 8:00am, 05/12/19 at 8:00am, 05/15/19 at 8:00am, 05/16/17 at 8:00am and 05/17/19 at 8:00am due to "drug item unavailable." Review of Resident #4's record and eMAR charting notes revealed no documentation the pharmacist had been notified regarding Resident #4's Xarelto 20 mg not being available for administration. Interview with a medication aide (MA) on 05/17/19 at 10:30am revealed: -She noticed Resident #4's Xarelto was not available for administration at the 8:00am medication pass on 05/17/19. -She normally worked third shift. -She had just finished passing out medications. -She had not contacted the pharmacist about Xarelto not being available for administration for Resident #4. -She would make sure Xarelto was ordered for Resident #4 on 05/17/19. On 05/17/19 at 11:00am, the MA who did the chart audit dated 05/15/19 for Resident #4's Xarelto could not be contacted by telephone. Interview with the Special Care Coordinator (SCC) on 05/17/19 at 11:00am and 4:30pm revealed -She did not know Resident #4's Xarelto was not available for administration on 05/17/19. -She would call the pharmacist and fax Resident #4's order for Xarelto to the pharmacy. -The MAs were responsible for faxing orders to the pharmacy as soon as they find out a	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 22	{D 358}		

medication was not available.
-The MA would communicate with the next shift MA regarding the medication not being available.
-The MA should check the next day to see if the order had been filled by the pharmacist.
-The MA should send over another script within 24 hours if medications were not sent from the pharmacy.
-The MA should notify the SCC within 24 hours if medications were not sent by the pharmacy.
-"I do not understand why Xarelto had not been reordered from the pharmacy."
-If Resident #4 did not get Xarelto, she could have a blood clot.

Interview with the pharmacist on 05/17/19 at 11:09am revealed:
-Resident #4's last refill for Xarelto 20 mg tablets for 30 tablets was on 02/28/19.
-There had been no order on profile since 02/28/19 until 05/17/19.
-If Xarelto was not administered as ordered for Resident #4, she could have a heart attack, pulmonary embolism or stroke.

Interview with the Physician Assistant (PA) on 05/17/19 at 8:58am revealed:
-He had not been notified about Resident #4's Xarelto not being available for administration.
-The order should have been sent to the pharmacy on 05/02/19 the date of the FL-2.
-The resident had been in the hospital in March and April 2019, so she probably had Xarelto left over from the hospital visits.
-If Xarelto was not administered as ordered for Resident #4, she could have recurrent pulmonary embolisms, deep vein thrombosis (DVT), stroke, heart attack or obstruction in her body.

Interview with the Administrator on 05/17/19 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 23 3:45pm revealed: -She was notified on 05/17/19 by the SCC that Xarelto for Resident #4's was not available for administration. -The MA should have ordered Xarelto before the medication ran out. -Xarelto should have been ordered when there was a 3-4-day supply of medications left. -"I do not know what happened." -It Xarelto was not administered as order, Resident #4 could have a stroke. -The MA should have notified the pharmacist that Xarelto for Resident #4's was not available for administration. Based on observations, interviews and record reviews, it was determined Resident (#4) was not interviewable. 2. Review of Resident #3's current FL-2 dated 02/28/19 revealed diagnoses included cerebral infarction, iron deficiency, acute kidney failure, gastroesophageal reflux disease, major depression, lack of coordination, pain, anxiety, type 2 diabetes, and non-traumatic subdural hemorrhage. a. Review of Resident #3's current FL-2 dated 02/28/19 revealed an order for paroxetine HCl (a medication used to treat depression) 30 mg at bedtime. Review of Resident #3's electronic Medication Administration Record (eMAR) for May 2019 revealed: -There was an entry for paroxetine HCl 30 mg at bedtime scheduled at 8:00 pm. -Staff documented paroxetine HCl was not administered because the medication was not available for four of sixteen opportunities from on	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 24 05/13/19, 05/14/19, 05/15/19 and 05/16/19. Review of a cart audit report dated 05/15/19 revealed Resident #3 had zero paroxetine tablets available. Observation of Resident #3's medications on hand on 05/16/19 at 3:00pm revealed paroxetine HCl 30 mg was not available to be administered. Telephone interview with a representative with the contracted pharmacy on 05/17/19 at 8:25am revealed: -Paroxetine was an active order. -There were thirty tablets dispensed on 04/16/19. -There was one tablet dispensed on 05/09/19. -There were twenty-four tablets dispensed on 05/15/19. -Paroxetine was on a cycle fill that began on 05/10/19. Telephone interview with the pharmacist from the contracted pharmacy on 05/17/19 at 3:20pm revealed the outcomes for missing paroxetine for four or more days would include signs of depression, mood swings, changes in behavior, and disrupted sleep patterns including waking at night. Telephone interview with Resident #3's Physician Assistant (PA) on 05/17/19 at 9:52 am revealed: -He expected Resident #3's medication to be administered as ordered. -He did not know Resident #3 had missed four doses of paroxetine; facility staff had not contacted him about the missed paroxetine. -He had ordered Resident #3 to be administered paroxetine once daily at bedtime for depression; paroxetine also had a sedative affect. -He was concerned Resident #3 had not received	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 25	{D 358}		

her paroxetine for the last four days and the acute fluctuations in dosages.
-Not being able to sleep through the night would be an outcome of Resident #3 not being administered the medication as ordered.

Interview with Resident #3 on 05/16/19 at 3:55pm revealed:
-She had not been sleeping through the night for the last two to five nights; she would wake up in the middle of the night and not be able to go back to sleep.
-She did not know if she was out of any medications because she was given her medication "in a little cup".
-The medication aide (MA) usually told her when she was out of a medication for more than a couple of days; no one had told her she was out of a medication.

Interview with a MA on 05/16/19 at 3:15pm revealed:
-She saw Resident #3 was out of paroxetine on 05/16/19; more paroxetine should have been reordered three days before the last pill was administered.
-The Resident Care Cordinator (RCC) was responsible for ordering medication.
-The MAs should tell the RCC when a medication was running low or needed ordering.
-She did not let the RCC know the paroxetine needed to be ordered for Resident #3 because she worked first shift and did not administer medication in the evenings.

Interview with a second MA on 05/16/19 at 5:20 pm revealed:
-She reordered medication online from the pharmacy two to five days before the medication would run out; she did not print or keep a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 26	{D 358}		

confirmation of the online orders.
-She had ordered Resident #3's paroxetine from the pharmacy on 05/09/19 when she realized Resident #3 was running low.

Interview with the RCC on 05/16/19 at 3:40pm revealed:
-The MAs could reorder medication on the computer through the facility's contracted pharmacy's online ordering system; MAs were not required to print a confirmation of the refill order.
-No one had let her know Resident #3 was out of paroxetine; she did not know it was last administered on 05/12/19 and it was not available for administration.
-The MAs were responsible for conducting daily cart audits.
-There was a cart audit schedule the MAs followed; two residents' medications were reviewed each day.
-She did not review the eMAR notes or the cart audit results; the MAs should let her know when there were issues.

Interview with a second RCC on 05/17/19 at 11:40am revealed:
-MAs were responsible for reordering needed medication from the pharmacy; MAs used an online ordering process for medication.
-MAs should order medication one to two days before medications ran out.
-The PA should be called when a medication was not available for administering so the PA could put a "hold order" on the medication.

Interview with the Administrator on 05/17/19 at 9:05am revealed:
-She knew Resident #3 did not have paroxetine available for administering.
-Staff had told her it was not available for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 27	{D 358}		

administering the day before, 05/16/19.
-She expected the paroxetine to be delivered from the pharmacy that day, 05/17/19.
-Staff should have kept a record of the request for a refill for Resident #3's paroxetine.
-MAs and RCMs were responsible for reordering medication when needed; orders for refills should be placed before the residents ran out of a medication.
-The pharmacy took two to three days to deliver medications once a refill order was placed.

b. Review of Resident #3's current FL-2 dated 02/28/19 revealed an order for Novolog 100 units/mL (Novolog is an insulin used to regulate blood sugar levels) inject 10 units three times daily after meals.

Review of Resident #3's subsequent physician's orders dated 03/07/19 revealed an order to increase Novolog 100 units/mL inject 15 units three times daily after meals.

Review of Resident #3 progress note dated 05/17/19 at 10:19 am revealed:
-Resident #3 had informed multiple staff that she would rather take her insulin injection before meals as opposed to after her meals.
-The Physician's Assistant (PA) was notified of the request and the PA wanted Resident #3 to continue to take insulin after meals as ordered.
-The resident was informed of the order.

Review of Resident #3's March 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Novolog 15 units to be injected three times daily after meals at 9:00 am, 1:00 pm and 9:00 pm.
-Staff documented administration of Novolog on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 28 03/08/19 at 4:02 pm. -Staff documented administration of Novolog on 03/10/19 at 4:56 pm. -Staff documented administration of Novolog on 03/18/19 at 4:33 pm. -Staff documented administration of Novolog on 03/19/19 at 4:24 pm. -Staff documented administration of Novolog on 03/24/19 at 3:53 pm. Review of Resident #3's April 2019 eMAR revealed: -There was an entry for Novolog 15 units to be injected three times daily after meals at 9:00 am, 1:00 pm and 9:00 pm. -Staff documented administration of Novolog on 04/01/19 at 4:12 pm. -Staff documented administration of Novolog on 04/02/19 at 4:29 pm. -Staff documented administration of Novolog on 04/06/19 at 4:11 pm. -Staff documented administration of Novolog on 04/10/19 at 4:35 pm. -Staff documented administration of Novolog on 04/12/19 at 4:16 pm. -Staff documented administration of Novolog on 04/15/19 at 4:17 pm. -Staff documented administration of Novolog on 04/20/19 at 4:00 pm. -Staff documented administration of Novolog on 04/22/19 at 4:15 pm. -Staff documented administration of Novolog on 04/23/19 at 3:59 pm. -Staff documented administration of Novolog on 04/26/19 at 4:15 pm. -Staff documented administration of Novolog on 04/29/19 at 4:04 pm. Review of Resident #3's May 2019 eMAR revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 29 -There was an entry for Novolog 15 units to be injected three times daily after meals at 9:00 am, 1:00 pm and 9:00 pm. -Staff documented administration of Novolog on 05/04/19 at 4:37 pm. -Staff documented administration of Novolog on 05/14/19 at 4:13 pm. Interview with Resident #3 on 05/16/19 at 11:25am revealed: -Staff gave her insulin injections before every meal; she knew she was "supposed" to get her insulin after meals, but she preferred to get her insulin injections before her meals. -She got her insulin injection before lunch today, 05/16/19 at about 11:15 am. -She had not told the physician she wanted her insulin injection before meals. -She always watched what she ate at her meals and had snacks between meals. -She wanted to receive her insulin injections before her meals because "it took staff forever" to get to her to give her an injection after meals. Interview with a Medication Aide (MA) on 05/16/19 at 5:20pm revealed: -She started administering Resident #3's Novolog injections before meals when the dosage was increased in March 2019; Resident #3 wanted to receive her injections before meals. -She told the Resident Care Coordinator (RCC) when Resident #3 wanted to begin receiving her Novolog injections before meals; she also told Resident #3 to tell the PA she wanted to be administered her injections before meals. -She did not see a change in the order on the MAR; she did what Resident #3 requested because she thought the residents had rights to choose medication administration times.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 30 Interview with a second MA on 05/16/17 at 9:45 am and 3:15pm revealed: -She administered Resident #3's Novolog injection before meals because Resident #3 asked for her injections before meals. -She told the RCC Resident #3 requested and had been receiving her Novolog injections before meals; she told the RCC three weeks ago, but she did not remember what the RCC said about the injection time change. Interview with the RCC on 05/17/19 at 11:40am revealed: -She knew Resident #3's Novolog injections were administered before meals because a MA had told her; Resident #3 requested her injections before meals. -MAs could contact the PA to inform him Resident #3 requested to change the order for her Novolog injections to before meals. -She had not notified the PA Resident #3 requeted to changer the order for her Novolog injections to before meals and she did not know if the MAs had informed the PA. -She had not heard of any concerns about Resident #3 from any facility staff. -MAs did not always note on the MAR the time medications were administered. Telephone interview with Resident #3's PA on 05/17/19 at 9:52 am revealed: -He was not aware Resident #3's Novolog was administered before meals -He had ordered Resident #3's Novolog to be administered after meals and he expected the orders to be followed. -He was not aware Resident #3 requested Novolog to be administered before meals. -He did not want Resident #3's Novolog administered before meals because he was	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 31 concerned Resident #3 would not eat all of her meal and her "blood sugar would bottom out". -He was having a hard time regulating Resident #3's blood sugar; her blood sugars were consistently "high in the 200 range" and she had not had a hypoglycemic event. Interview with the Administrator on 05/17/19 at 9:20am revealed: -She knew staff had been administering Resident #3's Novolog injections before meals because Resident #3 "insisted" she receive her Novolog injections before meals. -Resident #3's PA had been informed Resident #3 had requested to receiver her Novolog injections before meals; the RCC had notified the PA, but she did not know when the PA was notified. -Resident #3's PA knew she was administered her Novolog injections before meals. The facility failed to assure medications were administered as ordered by a licensed prescribing practitioner related to missed administration of medication Xarelto for Resident #4 and missed administration of medication Paxil and Novolog insulin not administered after meals as order for Resident #3. The facility's failure to assure medications were available and administered as ordered by the prescribing physician 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 05/17/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2019.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D912}	Continued From page 32	{D912}		
{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 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 assure every resident had received care and services which were adequate, appropriate, and in compliance with relevant state laws and rules related to personal care and supervision, health care and medication administration. The findings are: 1.Based on observations, record reviews and interviews, the facility failed to provide personal care assistance with nailcare to 1 of 5 sampled residents (#5). [Refer to Tag D 269 10A NCAC 13F .0901(a) Personal and Supervision (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure a podiatry consult was completed for 1 of 5 sampled residents (#5), who had calluses on his feet and long toenails on both feet. [Refer to Tag D 273 10A NCAC 13F 10A NCAC .0902(b) Health Care (Type B Violation)].	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D912}	Continued From page 33 3. Based observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Resident #4 and #3) medications not available for administration including Xarelto (Resident #4) and medication not available for administration including Paxil and Novolog insulin not administered after meals as ordered. (Resident #3). [Refer to Tag D 358 10A NCAC 13F 10A NCAC .1004(a) Medication Administration (Type B Violation)].	{D912}		