STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078083	A. BUILDING: _____ B. WING _____	R 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED SPRINGS ASSISTED LIVING	1301 E. FOURTH AVENUE RED SPRINGS, NC 28377

(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 and the Robeson County Department of Social Services conducted an annual and a follow-up survey on September 25, 2019 and September 26, 2019.	D 000		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Base on observation and interviews, the facility failed to ensure all residents were provided a non-disposable knife at each meal. Observation of the first lunch meal on 09/25/19 at 11:30am revealed: -The meal consisted of cubed beef, rice, mixed vegetables, biscuit and sherbet. -The silverware place setting at each table consisted of a fork and a spoon. -A knife was not available on the table for residents to use with their meat. -The residents were using their spoon and fork to pull the beef apart into bite-sized pieces. Observation of the second lunch meal on 09/25/19 at 12:30 pm revealed:	D 287		

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D 287	Continued From page 1 -The meal consisted of cubed beef, rice, mixed vegetables, biscuit and sherbet. -The silverware place setting at each table consisted of a fork and a spoon. -A knife was not available on the table for residents to use with their meat. Interview with the dietary aide on 09/25/19 at 12:05 pm revealed: -She knew a knife was supposed to be part of the table place setting. -She did not put a knife on the table at mealtimes because residents take them back to their room or could use them as a weapon. -Residents didn't usually ask for knives but when they did, she gave it to them. -She had not put a knife on the table "for a long time". -Nobody had ever told her to stop putting a knife on the table, she just decided to do it on her own. Interview with the Executive Director on 09/25/19 at 1:10pm revealed: -She did not know knives were not being given at mealtime. -It was the company policy to provide knives at mealtime. -She expected the dietary staff to follow the company's policy and procedure. Interview with the Administrator on 09/26/19 at 3:28pm revealed: -He did not remember the last time he was in the facility. -He left the day-to-day operations of the facility up to the Executive Director. -He was unaware knives were not provided. -He expected the staff to follow company policy and procedure and state regulations.	D 287		

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D 338	Continued From page 2	D 338		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure residents were treated with respect, dignity and consideration for 2 of 2 sampled residents (#4 , #7) related to the Resident Care Coordinator signing resident documents requiring either their signature. their responsible party's signature or both, without first notifying either the resident or their responsible party.

1. Review of Resident #7's current FL2 dated 05/02/19 revealed:
-Diagnoses included traumatic brain injury, seizure disorder and hyperlipidemia.
-There was an order for a Geri-chair and bed rails to be used as restraints.

Review of Resident #7's Resident Register dated 05/10/17 revealed a family member was the power of attorney.

Review of Resident #7's Physician Restraint order dated 07/25/19 revealed:
-A Geri-Chair and bed rails were the type of restraint to be used.
-The resident signature line had been signed.
-The RCC signature line was blank.
-The RCC signed her name where the guardian signature was intended to be.

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D 338	Continued From page 3	D 338		

Review of Resident #7's consent For Physical Restraint Use dated 07/25/19 revealed:
-The resident signature line had been signed.
-The RCC signature line was blank.
-The RCC signed her name where the guardian signature was intended to be.

Interview with Resident #7's Power of Attorney on 09/26/19 at 3:42pm revealed:
-She was not aware that restraint forms existed.
-She wanted any paperwork for Resident #7 that needed consent to come through her.
-She expressed anger that the RCC had not contacted her regarding permission for the restraints.
-She thought that Resident #7 needed the restraints, but if she had been involved with a care plan meeting, she would likely have voiced some general concerns before signing the paperwork.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/26/19 at 10:56am.

Refer to the interview with the RCC on 09/26/19 at 3:51pm.

Refer to the interview with the Executive director on 09/26/19 at 3:58pm.

Refer to the interview with the Administrator on 09/26/19 at 3:28pm.

2. Review of Resident #4's current FL2 dated 04/18/19 revealed:
-Diagnoses included Alzheimer's dementia, coronary artery disease and hyperlipidemia.
-She was documented as intermittently disoriented.

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Review of Resident #4's Resident Register dated 07/10/12 revealed a family member was the legal representative.

Review of Resident #4's Physician Restraint order dated 07/25/19 revealed:
-A Geri-Chair was the type of restraint to be used.
-The resident signature line had been signed.
-The Resident Care Coordinator (RCC) signature line was blank.
-The RCC signed her name where the guardian signature was intended to be.

Review of Resident #4's Consent For Physical Restraint Use dated 07/25/19 revealed:
-The resident signature line contained a signature.
-The RCC signature line was blank.
-The RCC signed her name where the guardian signature was intended to be.

Review of Resident #4's initial hospice assessment dated 04/18/19 revealed:
-Resident #4 was documented as constantly confused.
-Resident #4 was documented as disoriented.

Interview with the RCC on 09/26/19 at 10:56am revealed:
-She signed Resident #4's name on her Consent for Physical Restraint Form.
-She did not know who Resident #4's responsible party was.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/26/19 at 10:56am.

Refer to the interview with the RCC on 09/26/19 at 3:51pm.

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D 338	Continued From page 5 Refer to the interview with the Executive director on 09/26/19 at 3:58pm. Refer to the interview with the Administrator on 09/26/19 at 3:28pm. _____ Interview with the Resident Care Coordinator (RCC) on 09/26/19 at 10:56am revealed: -She signed "everything" for residents when a resident's signature was needed on a document. -No one had ever told her that she could not sign a resident's name. Interview with the RCC on 09/26/19 at 3:51pm revealed: -The restraint record had a line for the resident's name, so she signed the residents name. -When she signed a resident's name on the form, she was not trying to make it look like the resident signed it even though all signatures looked differently. -She knew the guardian was supposed to sign the restraint form. -She "accidently" signed her name on the signature line intended for the resident's guardian, Power of Attorney or responsible party. -She did not get a guardian to sign the restraint record because she thought this was a quarterly form and signatures were not needed on a quarterly review. Interview with the Executive director on 09/26/19 at 3:58pm revealed: -She was aware that a guardian needed to sign the consent for restraint. -She was not aware that the RCC was signing on the guardian signature line and not getting the guardian to sign the consent form. -She was not aware that the RCC was signing the	D 338		

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D 338	Continued From page 6 resident's name. Interview with the Administrator on 09/26/19 at 3:28pm revealed: -He did not remember the last time he was in the facility. -He was available by phone if the ED had any concerns. -He was unaware that the RCC was signing resident signatures and not getting guardian signatures on restraint forms. -The ED was responsible for making sure staff were following the company policy in all areas of operations.	D 338		
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:	D 358		

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D 358	Continued From page 7 TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a physician for 3 of 6 residents (#1, #4, #5) related to delaying the start of an iron supplement to treat anemia (#5), administering the incorrect dose of fast acting insulin (#1), and continuing a medication for blood pressure following a written discontinuation order from the physician (#4). The findings are: 1. Review of Resident #5's current FL2 dated 10/08/19 revealed diagnoses included Alzheimer's Disease, depression, diabetes, and hypertension. Review of Resident #5's record revealed a physician's progress note dated 08/08/19 with a new diagnosis of anemia after a recent emergency room visit with a hemoglobin of 9.2 (normal range 12 to 15). Review of Resident #5's record revealed a signed physician's order dated 08/13/19 for ferrous sulfate 325mg take 1 tablet daily (supplement used to treat iron deficiency and anemia). Review of Resident #5's record revealed a hemoglobin lab value dated 08/22/19 of 8.5. Review of Resident #5's record revealed a signed physician's order dated 09/12/19 revealed another physician's order for ferrous sulfate 325mg take 1 tablet daily. Review of Resident #5's August 2019 electronic Medication Administration Record (eMAR)	D 358		

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revealed there was no computer-generated entry for ferrous sulfate 325mg.

Review of Resident #5's September 2019 eMAR revealed:
-There was a computer-generated entry for ferrous sulfate 325mg take 1 tablet daily scheduled to administer at 9:00am with a start date of 09/12/19.
-Ferrous sulfate was documented as administered daily from 09/13/19 to 09/25/19 at 9:00am.

Observation of medications on hand for Resident #5 on 09/26/19 at 10:24am revealed a medication card containing 8 tablets of ferrous sulfate 325mg dispensed on 09/12/19.

Telephone interview with a pharmacist from Resident #5's pharmacy on 09/26/19 at 10:05am revealed:
-The pharmacy did not have an order on file for ferrous sulfate 325mg dated 08/13/19.
-The pharmacy first filled 21 tablets of ferrous sulfate for Resident #5 on 09/12/19 from an order dated on the same day.
-The facility was responsible for faxing all new medication orders to the pharmacy.
-The pharmacy would enter the medication order into the eMAR.
-The facility was responsible for approving the order before it appeared on the eMAR.

Interview with a medication aide (MA) on 09/26/19 at 10:24am revealed she did not remember Resident #5 having a physician's order for ferrous sulfate in August 2019.

Interview with the Resident Care Coordinator (RCC) on 09/26/19 at 11:05am revealed:

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-She was not working on 08/13/19 when the order for ferrous sulfate was processed.
-The Executive Director (ED) had processed the medication order.
-She did not remember seeing the medication order.

Interview with the ED on 09/26/19 at 11:31am revealed:
-She did not remember seeing the medication order for ferrous sulfate dated 08/13/19.
-The RCC was responsible for auditing all medication orders processed when she was not in the facility.

Interview with the facility's contracted Nurse Practitioner on 09/26/19 at 9:15am revealed:
-Resident #5 was diagnosed with chronic anemia.
-The facility should have administered ferrous sulfate to Resident #5 starting on 08/12/19.
-She did not know Resident #5 did not receive the ferrous sulfate until 09/13/19 when she had reordered the medication.
-Resident #5's iron levels and hemoglobin were still low.
-Resident #5 was at risk of fatigue, weakness, and shortness of breath.
-She had noticed Resident #5 had been in the bed during her recent visits to the facility.
-Resident #5's increased sleepiness could be from the anemia or a combination of effects from the anemia and from behavior changes.

Interview with the Administrator on 09/26/19 at 3:20pm revealed he did not know the original order for ferrous sulfate was not processed and Resident #5 was not administered the medication until a month later.

Refer to the interview with a MA on 09/26/19 at

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D 358	Continued From page 10 10:24am. Refer to the interview with the RCC on 09/26/19 at 11:05am. Refer to the Interview with the ED on 09/26/19 at 11:31am. Refer to the interview with the Administrator on 09/26/19 at 3:20pm. 2. The medication error rate was 3% (percent) as evidenced by the observation of 1 error out of 32 opportunities during the 12:00pm medication pass on 09/26/19. Review of Resident #6's current FL2 dated 07/18/19 revealed: -Diagnoses included diabetes mellitus, hypertension, and stroke. -There was an order to check fingerstick blood sugars (FSBS) three times a day. -There was an order to administer glipizide (used to treat type 2 diabetes) 10mg by mouth twice a day with meals. -There was an order for Lantus (insulin used to treat diabetes) inject 12 units subcutaneously every day. Review of Resident #6's physician orders dated 09/26/19 revealed: -There was an order to inject Novolog (a fast-acting insulin used to treat type 2 diabetes) three times a day with meals. -There was an order for Novolog sliding scale insulin (SSI) with parameters 0-70 notify physician, 0-150= 0 units, 151-200= 2units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units.	D 358		

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D 358	Continued From page 11 Observation of medication administration to Resident #6 on 09/26/19 at 11:10am revealed: -Resident #6 was standing at the medication cart outside of her room. -The medication aide (MA) used hand sanitizer, put on latex gloves, and checked Resident #6's FSBS. -The MA stated Resident #6's FSBS was 325. -The MA cleaned Resident #6's left upper arm with an alcohol swab. -The MA primed Resident #6's Novolog flexpen with 2 units of insulin and discarded the 2 units. She turned the dial to 10 units. She placed her left hand on Resident #6's left upper arm and pinched up the skin and began to administer the 10 units of insulin. The MA was stopped from administering the 10 units of insulin. -The MA was informed that she was going to administer the incorrect amount of insulin to Resident #6. She looked at the physician order and said, "I am supposed to give 8". She adjusted the dial on the Novolog flexpen to 8 units and administered it to Resident #6 in her left upper arm. Review of Resident #6's electronic Medication Administration Record (eMAR) for September 2019 revealed: -There was an entry to check FSBS three times a day. Notify the physician if blood sugar was <60 or >400. -There was an entry for Novolog flexpen, check FSBS three times a day with SSI as follows: 0-70 notify physician, 0-150=0u, 151-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u. -There was an entry for FSBS value 325 documented for 09/26/19 at 11:30am. -There was documentation for administration of 8 units of Novolog insulin in the left upper arm on	D 358		

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D 358	Continued From page 12 09/26/19 at 11:30am. Interview with the MA on 09/26/19 at 11:32am revealed: -She had diabetic training provided to her by the facility. -She had turned the dial on the Novolog flexpen to 10 units for Resident #6 when she looked in the computer to see what the FSBS was documented as. Interview with the Resident Care Coordinator (RCC) on 09/26/19 at 11:45am revealed she did not know when the MA had completed her diabetic training. Interview with the Executive Director on 09/26/19 at 1:45pm revealed: -The MA had no medication errors in the past. -She did not know why the MA was about to administer the incorrect amount of insulin for Resident #6. Interview with the Nurse Practitioner for Resident #6 on 09/26/19 at 1:45pm revealed: -When the facility staff had administered the incorrect dosage of insulin to a resident in the past, they called and notified her. Then she instructed them what they needed to do for that resident. -She expected the facility staff to administer the correct dosage of insulin ordered. -If Resident #6 had been administered too much insulin, it could potentially decrease the blood glucose level too much. Refer to the interview with a MA on 09/26/19 at 10:24am. Refer to the interview with the RCC on 09/26/19	D 358		

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D 358	Continued From page 13 at 11:05am. Refer to the Interview with the ED on 09/26/19 at 11:31am. Refer to the interview with the Administrator on 09/26/19 at 3:20pm. 3. Review of Resident #4's current FL2 dated 04/18/19 revealed: -Diagnoses included Alzheimer's dementia, coronary artery disease and hyperlipidemia. -She was intermittently disoriented. -There was an order for metoprolol succinate 50mg to be given daily (a medication to treat high blood pressure). Review of Resident #4's physician orders revealed: -There was a clarification order dated 05/29/19 to discontinue blood pressure check prior to medication administration. -There was an order dated 05/29/19 to check blood pressure once daily and notify physician if blood pressure was less than (<) 90/60 or greater than (>)180/110. -There was an order dated 07/01/19 to check blood pressure at 6am and 2pm and call hospice if systolic blood pressure was <100. -There was an order dated 09/10/19 to discontinue metoprolol succinate. -There was an order dated 09/10/19 to check blood pressure every morning for one week and call physician if systolic blood pressure was <100 or diastolic was >90. Review of Resident #4's September 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol succinate	D 358		

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	HAL078083	A. BUILDING: _____ B. WING _____	R 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED SPRINGS ASSISTED LIVING	1301 E. FOURTH AVENUE RED SPRINGS, NC 28377

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50mg to be administered daily at 6:00am and to hold if blood pressure was <120.
-Metoprolol succinate 50 mg was documented as administered daily at 6:00am 09/01/19 to 09/25/19 for 25 of 25 opportunities.
-There was an entry for metoprolol succinate 50mg to be administered daily at 6:00am with a date of 09/10/19 to be discontinued.
-Metoprolol succinate 50 mg was documented as administered at 6:00am from 09/01/19 through 09/10/19.

Observation of medications on hand on 09/26/19 at 10:25am revealed:
-Metoprolol succinate 50mg was available for administration.
-Of the 28 tablets dispensed on 09/05/19, 9 were still available for administration.

Telephone interview with Resident #4's Nurse Practitioner (NP) on 09/26/19 at 9:05am revealed:
-She wrote an order on 09/10/19 to discontinue Resident #4's metoprolol succinate 50 mg.
-Resident #4 was receiving hospice services and her goal was to minimize lethargy.
-Metoprolol succinate had a side-effect of drowsiness.
-Resident #4 was lethargic and metoprolol succinate was no longer needed.
-If Resident #4 continued to receive metoprolol succinate she would continue to be lethargic.
-If resident #4 received extra doses of metoprolol succinate, her heart rate and blood pressure could have decreased which would be dangerous.

Interview with the medication aide (MA) on 09/26/19 at 10:20am revealed:
-Resident #4 had an order for metoprolol succinate 50 mg with parameters to hold if

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systolic blood pressure was < 120.
-Resident #4's eMAR contained an incorrect entry for metoprolol succinate 50mg that did not have blood pressure parameters listed with it.
-She thought the 09/10/19 order to discontinue metoprolol succinate 50mg was a clarification order not an order to eliminate the medication entirely.

Interview with the Executive Director on 09/26/19 at 10:25am revealed:
-Resident #4 still had an order for metoprolol succinate 50mg that contained parameters for checking blood pressure.
-She thought the order that was written on 09/10/19 to discontinue the metoprolol succinate 50mg was a clarification order.
-The eMAR "sometimes" contained inaccurate medication entries and they would have to get an order to discontinue the medication.
- Metoprolol succinate 50mg was listed on the August and September 2019 eMAR's 2 times and was documented it was administered but that was an error and that was why they needed the clarification order.
-Resident #4 only had one packet of metoprolol succinate so it was impossible for her to receive 2 doses.

Telephone interview with a representative from the facility's contracted pharmacy on 09/26/19 at 9:54am revealed:
-Resident #4 had an order dated 02/12/19 for metoprolol succinate 50mg.
-There were no blood pressure parameters written as a part of the prescription.
-The pharmacy had dispensed metoprolol succinate 50mg from February 2019 through August 2019.
-Resident #4 had an order dated 09/10/19 to

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D 358	Continued From page 16 discontinue metoprolol succinate 50mg. Refer to the interview with a MA on 09/26/19 at 10:24am. Refer to the interview with the RCC on 09/26/19 at 11:05am. Refer to the Interview with the ED on 09/26/19 at 11:31am. Refer to the interview with the Administrator on 09/26/19 at 3:20pm. _____ Interview with the medication aide (MA) on 09/26/19 at 10:24am revealed: -The MAs were responsible for administering medications according the electronic Medication Administration Record (eMAR). -The MAs were responsible for faxing medication orders to the pharmacy and for refilling all medications. -The pharmacy entered the medication order on the eMAR but the MA or the Resident Care Coordinator (RCC) must approve the order before the medication could be administered. -The MA or the RCC removed discontinued medications from the medication cart. -A copy of the medication order was kept in a "pending tray" until the medication was delivered. -Medication orders were compared to the entry on the eMAR before the orders are approved. Interview with the RCC on 09/26/19 at 11:05am revealed: -She was responsible for reviewing all medication orders. -She was responsible for faxing all medication orders to the pharmacy.	D 358		

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-Once the pharmacy entered the medication order on the eMAR, she or the MA was responsible for approving medication to appear on the eMAR.
-The medication orders were supposed to be placed in a "pending tray" until the order was approved on the eMAR and delivered by the pharmacy.
-She was responsible for auditing all new medication orders to make sure the order was processed correctly.
-The facility was supposed to fax medication discontinuation orders to the pharmacy for the pharmacy to discontinue the medication on the eMAR.
-She was responsible for discontinuing medications on the eMAR if the pharmacy did not make the change.
-She or the MAs were responsible for making sure discontinued medications were removed from the eMAR.

Interview with the Executive Director (ED) on 09/26/19 at 11:31am revealed:
-The RCC was responsible for faxing new medication orders and approving orders on the eMAR from Monday to Friday.
-After hours, the MAs were responsible for faxing and approving orders.
-All new medication orders should be placed in the "pending tray" for the RCC to review once she returned to the facility.
-If the RCC was out of the facility, it was her or the MAs responsibility to process new medication orders.
-The RCC was responsible for auditing all new medication orders.

Interview with the Administrator on 09/26/19 at 3:20pm revealed:

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D 358	Continued From page 18 -He did not remember the last time he was in the facility. -He was available by phone if the ED had any concerns. -The RCC was responsible for medication administration and should be following the company policy. -The ED was responsible for making sure the staff was following the company policy in all areas of operations. _____ The facility failed to administer medications as ordered for Resident #5 who was recently diagnosed with anemia and a medication order for ferrous sulfate was not administered increasing the risk of fatigue, weakness, and shortness of breath associated with low iron and hemoglobin levels, drawing up with the intention to administer the wrong dose of fast acting insulin to Resident #6 increasing the risk of low blood sugar, and not discontinuing a blood pressure medication for Resident #4 after the physician intended for the medication to stop. This failure was detrimental to the health, safety and welfare for the residents and constitutes a Type B violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 09/26/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:	D912		

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D912	Continued From page 19 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 residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to administering medication as ordered by a physician. The findings are: Based on observations, interviews and record reviews the facility failed to administer medications as ordered by a physician for 3 of 6 residents (#1, #4, #5) related to delaying the start of an iron supplement to treat anemia (#5), administering the incorrect dose of fast acting insulin (#1), and continuing a medication for blood pressure following a written discontinuation order (#4). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		