STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HUNTER HILL SENIOR LIVING	891 NOELL LANE ROCKY MOUNT, NC 27804

(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 an annual and follow up survey on October 2, 2019.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete a criminal background check on 1 of 3 sampled staff (Staff C). The findings are: Review of a personnel record for Staff C, personal care aide (PCA) revealed: -Staff C's date of hire was 09/25/19. -There was a release form for a criminal background check signed by Staff C on 09/24/19. -There was documentation on Staff C's release form that he lived in another state from January 2019 through September 2018. -There was documentation a state criminal background check was completed 09/24/19. -There was no documentation that a national criminal background check had been completed on Staff C. Attempted telephone interview with Staff C on 10/04/19 at 11:30am was unsuccessful. Interview with the Administrator on 10/04/19 at 11:40am revealed: -Staff C was hired and started working at the facility on 09/25/19.	D 139		

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D 139	Continued From page 1 -She was responsible for making sure the criminal background checks were completed upon hire for all staff. -A national criminal background check had not been completed on Staff C because she did not realize Staff C had not resided in the state for a least five years.	D 139		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 5 residents sampled (#4, #5) were tested for tuberculosis (TB) disease upon admission. The findings are: 1. Review of Resident #4's current FL-2 dated 06/08/19 revealed diagnoses included diabetes, acute ischemic stroke, hypertension, end stage renal disease, hypercholesterolemia, altered mental status, acute kidney injury, and anemia.	D 234		

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D 234	Continued From page 2 Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 09/09/17. Review of Resident #4's previous FL-2 dated 05/19/17 revealed a negative tuberculosis (TB) skin test on 05/19/17 with no date placed documented. Review of Resident #4's TB skin tests revealed: -There was documentation of a TB skin test placed on 11/15/18 and read as negative on 11/17/18. -There was no documentation of any TB skins test within 12 months of each other. -There was no documentation of any other TB skin tests for Resident #4. Interview with Resident #4 on 10/04/19 at 10:38am revealed: -He remembered getting tested for TB when he first came to the facility. -He thought he had two TB skin tests but he could not recall the dates or how close together he was tested. Interview with the Resident Care Coordinator (RCC) on 10/04/19 at 2:45pm revealed: -She was currently responsible for TB skin tests for residents. -Residents were supposed to have a one TB skin test upon admission and a second TB skin test 2 to 3 weeks after the first one. -She was not the RCC when Resident #4 was admitted to the facility in 2017 so she was not aware Resident #4 did not have two TB skin tests. 2. Review of Resident #5's current FL-2 dated	D 234		

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D 234	Continued From page 3 07/02/19 revealed diagnoses included diabetes mellitus type 2, hypertension, hypersensitivity lung disease, vitamin B12 deficiency, dermatosis papulosa nigra, long term use of medicine, ethyl alcohol abuse, hypertriglyceridemia, and hypomagnesemia. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 12/24/18. Review for Resident #5's record revealed: -There was documentation that a Tuberculosis (TB) skin test was placed on 12/19/18 and read as negative on 12/21/18. -There was no documentation a second step TB skin test was administered since Resident #5 was admitted to the facility on 12/24/18. Interview with Resident #5 on 10/03/19 at 11:09am revealed: -She had received a second TB skin test when she was admitted to the facility. -She received a third TB skin test on 10/03/19 between 9:00am-9:30am. -She was informed that another TB skin test as needed because her "paperwork was lost". Interview with the Resident Care Coordinator (RCC) on 10/03/19 at 11:16am revealed: -There was a second TB skin test placed for Resident #5 on 12/12/18. -The RCC was unable to provide documentation of a second step TB test for Resident #5. -She was the person responsible for ensuring all TB skin tests were completed. Interview with the Administrator on 10/03/19 at 11:26am revealed: -She was not aware the documentation for a	D 234		

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D 234	Continued From page 4 second TB skin test was missing from Resident #5's record. -She did not receive any residents' records from the previous owner. -The RCC was the person responsible for ensuring all TB skin tests were completed. -She expected TB skin tests to be completed.	D 234		
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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure that nutritional supplements were served as ordered for 2 of 2 sampled residents (#1 and #4). The findings are: 1. Review of Resident #1's FL-2 dated 06/11/19 revealed diagnoses included recurrent falls, mood disorder, anemia, hypertension, hyperlipidemia, osteoarthritis, and Parkinson's disease. Review of a physician's order for Resident #1 dated 09/10/19 revealed a nutritional supplement to be administered three times a day. Review of a physician's dietary order for Resident #1 dated 09/24/19 revealed: -There was an order for nutritional supplements (Brand A) to be administered three times a day	D 310		

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D 310	Continued From page 5 with meals. -If nutritional supplement (Brand A) was unavailable, then may substitute with nutritional supplement (Brand B). Review of Resident #1's September and October 2019 electronic medication administration records (eMARs) revealed there was no entry for the nutritional supplements on the eMARs. Interview with a medication aide (MA) on 10/03/19 at 9:40am revealed: -She did not know if Resident #1 had an order for nutritional supplements or how often the nutritional supplements were supposed to be served to Resident #1. -There was no documentation of the administration of nutritional supplements on Resident #1's eMAR. -Staff did not document nutritional supplements on the eMARs because nutritional supplements were not entered on the eMARs. Interview with a second MA on 10/03/19 at 9:43am revealed: -She did not know if Resident #1 had an order for nutritional supplements. -The dietary staff was responsible to ensure nutritional supplements were administered to the residents if they were ordered. -There was no documentation of administration of nutritional supplements on Resident #1's eMAR because the dietary staff was responsible for ensuring nutritional supplements were administered and not the MAs. -She did not know if dietary staff were giving nutritional supplements to Resident #1. -She did not know if dietary staff documented the administration of Resident #1's nutritional supplements.	D 310		

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D 310	Continued From page 6 Observation of the facility's therapeutic diet list dated 09/19/19 posted in the kitchen revealed there was no listing for nutritional supplements to be administered to Resident #1 as prescribed by her physician. Observation of the facility's nutritional supplement supply on 10/03/19 at 10:00am revealed: -There was an opened case of strawberry flavored nutritional supplements (Brand A) and a box of vanilla flavored nutritional supplement (Brand A) on the second shelf of a rack on the left side of the walk-in cooler in the kitchen. -There was a single eight-ounce bottle of chocolate flavored nutritional supplement (Brand B) on the top shelf of the rack in the walk-in cooler. Interview with a dietary aide on 10/03/19 at 10:00am and 10/04/19 at 1:07pm revealed: -He did not know if Resident #1 had an order for nutritional supplements. -Resident #1's family member brought in the chocolate flavored nutritional supplement (Brand B) for the resident to drink when Resident #1 did not eat well. -Resident #1 was offered a nutritional supplement (Brand B) staff notified the dietary staff that Resident #1 did not eat well during meal times. -He worked in the kitchen during the lunch meal on 10/04/19. -He could not remember giving Resident #1 a nutritional supplement with her lunch meal. Interview with the Resident Care Coordinator (RCC) on 10/03/19 at 10:45am revealed: -She did not know about Resident #1's physician's orders for nutritional supplements. -If Resident #1 had a physician's order for	D 310		

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D 310	Continued From page 7 nutritional supplements then she gave it to the dietary manager to implement. -The dietary staff were responsible to ensure Resident #1 received any ordered nutritional supplements. Observation during the lunch meal service on 10/03/19 from 12:55pm through 1:15pm revealed: -Resident #1 ate 25% overall of her lunch served. -A personal aide (PCA) called for the dietary staff to bring Resident #1 a nutritional supplement. -A dietary aide brought a nutritional supplement (Brand B) for Resident #1 from the kitchen to the PCA in the dining room area. -The PCA gave the nutritional supplement (Brand B) to Resident #1 and the resident drank 100% of the nutritional supplement. Interview with the PCA on 10/03/19 at 1:10pm revealed: -Resident #1 was given a nutritional supplement (Brand B) when she did not eat well during meal times or sometimes Resident #1 was given a nutritional supplement (Brand B) as a snack per request of Resident #1's family member. -Staff got the nutritional supplements from dietary staff in the kitchen. -She did not know Resident #1 had physician's orders for nutritional supplements (Brand A) three times a day with meals. -Resident #1 was not given nutritional supplements three times a day with meals. -Resident #1 received nutritional supplements (Brand B) about three or four times a week. -She did not know who was responsible to ensure nutritional supplements were given to Resident #1. Based on observations, interviews, and record reviews, it was determined Resident #1 was not	D 310		

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D 310	Continued From page 8 interviewable. Telephone interview with Resident #1's family member on 10/03/19 at 6:25pm revealed: -She did not know if Resident #1's physician had prescribed any nutritional supplements. -She brought nutritional supplements (Brand B) to the facility for Resident #1 because she had a poor appetite. -She did not know Resident #1 could get nutritional supplements from the facility if the physician ordered them. -She asked the staff to give Resident #1 the nutritional supplement (Brand B) when Resident #1 did not eat well during her meal times. -She usually brought six bottles of nutritional supplement (Brand B) to the facility and the six bottles lasted about a week for Resident #1. -Resident #1 did not drink a nutritional supplement with her meal when she visited during meal times at the facility. -She last visited the facility on 10/01/19 during dinner time. Observation during the lunch meal service on 10/04/19 from 12:40pm through 1:00pm revealed Resident #1 did not receive a nutritional supplement with her lunch meal. Interview with a second PCA on 10/04/19 at 1:05pm revealed: -Resident #1 did not receive a nutritional supplement with her lunch meal. -She did not know Resident #1 had a physician's order for nutritional supplements three times a day. -The dietary staff usually brought the nutritional supplements to the residents who had orders for nutritional supplements.	D 310		

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D 310	Continued From page 9 Interview with the Administrator on 04/10/19 at 10:40am revealed: -The dietary staff were responsible for ensuring Resident #1 received her nutritional supplements. -She did not know dietary staff were not giving Resident #1 her nutritional supplements (Brand A) three times a day with her meal. -She did not know Resident #1's family member was bringing nutritional supplements (Brand B) for Resident #1 to drink. -There was no system in place to ensure staff were administering nutritional supplements as ordered for the residents at the facility. Refer to interview with a second MA on 10/03/19 at 9:43am. Refer to interview with a PCA on 10/03/19 at 11:03am. Refer to interview with the Dietary Manager on 10/03/19 at 10:05am. Refer to interview with the RCC on 10/03/19 at 10:45am. Refer to second interview with the RCC on 10/04/19 at 12:53pm. 2. Review of Resident #4's current FL-2 dated 06/08/19 revealed: -Diagnoses included diabetes, acute ischemic stroke, hypertension, end stage renal disease, hypercholesterolemia, altered mental status, acute kidney injury, and anemia. -There was an order for a nutritional supplement (Brand C - a supplement designed specifically to meet the nutritional needs of those receiving dialysis) drink 1 can at bedtime.	D 310		

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D 310	Continued From page 10 Review of Resident #4's physician's order sheet dated 06/08/19 revealed: -There was an order entry for (Brand C) nutritional supplement drink 1 can at bedtime. -There was a handwritten note beside the (Brand C) nutritional supplement that noted "d/c (discontinue) provided by dietary". -There were no initials or date written beside the note. Review of Resident #4's care plan signed by the primary care provider (PCP) on 07/16/19 revealed one of the resident's dietary needs was documented as nutritional supplement (Brand D -a supplement designed to help manage blood sugar in diabetics) once daily. Review of Resident #4's diet order sheet dated 09/24/19 revealed: -There was an order for (Brand D) nutritional supplement once a day. -There was no order for any other nutritional supplements on the diet order sheet. Observation of the facility's therapeutic diet list dated 09/19/19 posted in the kitchen revealed (Brand D) nutritional supplement once daily was listed for Resident #4. Review of Resident #4's August 2019 - October 2019 electronic medication administration records (eMARs) revealed: -There was no entry for any nutritional supplement on the eMARs. -No supplements were documented as administered to the resident. Observation of the facility's nutritional supplement supply on 10/03/19 at 10:00am revealed there were two cases of (Brand D) nutritional	D 310		

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D 310	Continued From page 11 supplement on the top shelf of a rack on the left side of the walk-in cooler in the kitchen. Interview with a dietary aide on 10/03/19 at 10:00am revealed: -The (Brand D) nutritional supplements on the top shelf belonged to another resident and not Resident #4. -He did not know Resident #4 was supposed to be receiving nutritional supplements. -The Resident Care Coordinator (RCC) usually handled the ordering for residents' nutritional supplements. -He did not know if any nutritional supplements had been ordered for Resident #4. Observation during the first lunch meal service on 10/03/19 from 12:15pm through 12:38pm revealed Resident #4 was not offered a nutritional supplement during the lunch meal. Observation of the first dinner meal service on 10/03/19 at 5:14pm revealed Resident #4 was not offered a nutritional supplement during the dinner meal. Interview with a medication aide (MA) on 10/04/19 at 12:15pm revealed: -Nutritional supplements for residents used to be included and documented on the eMARs because the MAs were responsible for passing them out. -A few months ago, the nutritional supplements became the responsibility of dietary staff to pass out so the orders no longer appeared on the eMARs. -She did not know if Resident #4 was receiving (Brand D) nutritional supplement from dietary staff. -Resident #4 had brought some samples of	D 310		

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D 310	Continued From page 12 (Brand C) nutritional supplement from his dialysis appointment on Monday, 09/30/19. -There was a note on the bag with the (Brand C) nutritional supplements to give the resident 1 can per day. -She thought there were 5 cartons of the supplements and she had given the resident 1 carton on Monday and Tuesday nights (09/30/19 and 10/01/19) when she worked on those nights. -She did not document that she gave the (Brand C) nutritional supplements to Resident #4. -She did not notify the RCC she had received and administered the (Brand C) supplements to the resident. -There was 1 carton of (Brand C) supplement remaining. Observation of the medication cart on 10/04/19 at 12:15pm revealed: -There was a plastic bag with a logo from the dialysis center printed on the bag. -There was a yellow sticky note stapled to the front of the bag with Resident #4's name written on it. -There was a handwritten note, "give to med tech, 1 per day". -There was no other information written on the note. -There was one 8-ounce carton of (Brand C) nutritional supplement in the bag. Interview with Resident #4 on 10/04/19 at 10:38am revealed: -He used to get a nutritional supplement every week but that stopped "about a month ago". -He did not know why he was not receiving the nutritional supplement anymore. -His appetite was "good", and he thought his weight had been stable.	D 310		

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D 310	Continued From page 13 Interview with the RCC on 10/04/19 at 12:50pm revealed: -She was not aware Resident #4 was not receiving (Brand D) nutritional supplement as ordered on the dietary order sheet on 09/24/19. -She forwarded the orders to the dietary staff and dietary staff was responsible for implementing the order. -Nutritional supplement orders would not be listed on the eMARs since the MAs were not responsible for giving them to the residents. -She did not know if the dietary staff were documenting when they gave nutritional supplements to residents. -She was not aware Resident #4 had received samples of (Brand C) nutritional supplements from dialysis or that the MA had given the resident any. Telephone interview with a dietician at Resident #4's dialysis center on 10/04/19 at 3:25pm revealed: -At one time, (could not recall dates) Resident #4 was getting (Brand C) nutritional supplements but his insurance changed, and he could not afford it anymore. -She thought the resident's family was getting (Brand D) nutritional supplements as a substitution for (Brand C). -The resident should be getting (Brand D) nutritional supplements once a day. -She had sent about 10 sample cartons of (Brand C) nutritional supplement from dialysis to the facility with the resident in the last few weeks because she was concerned about the resident's recent weight loss. -She usually sent 5 cartons at a time. -The resident had lost 4% dry weight in the past 90 days based on weights taken at dialysis, so she sent the samples to help with the weight loss.	D 310		

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D 310	Continued From page 14 Attempted telephone interview with Resident #4's family member on 10/04/19 at 3:50pm was unsuccessful. Telephone interview with Resident #4's PCP on 10/04/19 at 9:53am revealed: -The order for (Brand D) nutritional supplement on Resident #4's dietary order form that she signed on 09/24/19 was based on a previous order that she thought originated from the resident's dialysis provider. -She expected the dietary order she signed to be implemented as ordered. -She had not been notified the resident was not receiving (Brand D) nutritional supplements. -She was not aware of any significant changes in the resident's weight. Refer to interview with a second MA on 10/03/19 at 9:43am. Refer to interview with a personal care aide (PCA) on 10/03/19 at 11:03am. Refer to interview with the Dietary Manager on 10/03/19 at 10:05am. Refer to interview with the RCC on 10/03/19 at 10:45am. Refer to second interview with the RCC on 10/04/19 at 12:53pm. Interview with a second MA on 10/03/19 at 9:43am revealed: -Residents' nutritional supplement orders were given to the dietary staff. -There was no documentation of residents' administration of nutritional supplements on the	D 310		

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D 310	Continued From page 15 eMAR because the dietary staff was responsible for ensuring nutritional supplements were administered and not the MAs. -Documentation of the administration of the residents' nutritional supplements were not done on their eMAR. -She did not know if dietary staff documented the administration of residents' nutritional supplements. Interview with a PCA on 10/03/19 at 11:03am revealed: -The residents' nutritional supplements were supplied by the dietary staff. -The MAs and PCAs were not responsible for ensuring residents received their nutritional supplements because the dietary staff were responsible for that. Interview with the Dietary Manager on 10/03/19 at 10:05am revealed: -He had been the Dietary Manager at the facility for approximately three weeks. -He did not process the physician's orders for nutritional supplements. -He received copies of the physician's orders for nutritional supplements from the RCC. -He filed the copies of the physician's orders in a notebook in his office. -The list of residents who received nutritional supplements was posted in the kitchen for the dietary staff to go by. -The dietary staff administered nutritional supplements according to the dietary list that was posted in the kitchen. -Nutritional supplements were sent from the kitchen to the staff in the dining room during meal times to give to the residents. -The dietary staff did not document administration of nutritional supplements to the residents.	D 310		

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D 310	Continued From page 16 -There was no process in place for dietary staff to ensure nutritional supplements were served to the residents as ordered by the physician. Interview with the RCC on 10/03/19 at 10:45am revealed: -She processed any physician's for nutritional supplements and gave them to the dietary staff. -She gave the physician's orders for residents' nutritional supplements to the dietary staff to implement. -Physician's orders for nutritional supplements to be administered to the residents were written for the dietary staff to implement. -She was responsible for getting the physician's orders for nutritional supplements to the dietary staff after they were written. -Dietary staff were responsible to ensure nutritional supplements were given and to document residents received nutritional supplements as ordered by the physician. -She did not check to see if the residents received their nutritional supplements as ordered because it was the responsibility of the dietary staff to make sure nutritional supplements were given. -She did not know where the dietary staff documented residents were given their nutritional supplements. -Nutritional supplements were not put on the residents' eMARs and she did not know how dietary staff documented when nutritional supplements were given to the residents. -There was no current process in place to ensure nutritional supplements were being served by the dietary staff and she did not follow-up with the dietary staff to ensure nutritional supplements were served as ordered. Second interview with the RCC on 10/04/19 at	D 310		

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D 310	Continued From page 17 12:53pm revealed: -The facility did not realize the dietary staff were not ensuring residents received nutritional supplements as ordered by the physician. -She and the Administrator were in the process of working out a plan to ensure nutritional supplements were administered to the residents as ordered by the physician.	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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record	D 358		

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D 358	Continued From page 18 reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 3 residents (#6) observed during the medication pass including errors with insulin and a liquid antipsychotic medication. The findings are: 1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 31 opportunities during the 9:00am medication pass on 10/03/19. Review of Resident #6's current FL-2 dated 04/30/19 revealed diagnoses included chronic allergic rhinitis, type 2 diabetes mellitus, hypertension, hyperlipidemia, and schizophrenia. a. Review of Resident #6's current FL-2 dated 04/30/19 revealed: -There was an order for Novolog insulin to be administered four times a day according to the following sliding scale: 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401- 450 = 12 units; 451-500 =14 units, >501= 15 units and call medical doctor. (Novolog insulin is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection. The Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. The needle must remain under the skin for at least 6 seconds to ensure the full dose has been injected.) Review of Resident # 6's October 2019 electronic medication administration record (eMAR)	D 358		

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D 358	Continued From page 19 revealed: -There was an entry for Novolog Flexpen sliding scale with scheduled administration times of 9:00am, 11:45am, and 5:00pm, and 9:00pm. -The resident's blood sugar ranged from 79-171 from 10/01/19-10/03/19. Observation of the 9:00am medication pass on 10/03/19 revealed: -The resident's blood sugar was 171 at 8:49am. -The medication aide (MA) administered 2 units of Novolog insulin into Resident #6's left side of the abdomen at 8:50am. -The MA did not dial and perform a 2 unit air shot prior to dialing and administering the 2 units of Novolog sliding scale insulin. -The MA pressed the dose button until the counter clicked and returned to zero and then immediately pulled the insulin pen from the resident's abdomen. -The MA did not hold the dose button for 6 seconds as required to ensure the complete dosage of insulin was administered. Interview with Resident #6 on 10/03/19 at 8:51am revealed the resident had already eaten breakfast. Interview with the MA at 1:58pm on 10/03/19 revealed: -She had completed diabetic training, but she could not recall when it was completed. -She usually administered Resident #6's insulin after breakfast because it was scheduled on the eMAR at 9:00am. -Breakfast was usually served at 7:00am. -She thought the Novolog insulin pen was only supposed to be primed once when the pen was first opened with a 2-unit air shot. -If an insulin pen needed to be primed before	D 358		

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D 358	Continued From page 20 each use, it was usually noted on the eMAR or label. -She did not know the insulin pen should be held in for 6 seconds when injected. Interview with Administrator on 10/03/19 at 2:14pm revealed: -Diabetic training was completed for MAs when the nurse completed their clinical skills checklist. -Diabetic training included the use of insulin pens. -The MAs were supposed to prime the pen before each use. -The MAs should know how to use the insulin pens. -The facility's policy was to check blood sugars and administer insulin before meals. Interview with Resident Care Coordinator (RCC) on 10/03/19 at 2:17pm revealed: -The MAs had a class on diabetes and were trained on how to use the insulin pens. -The MAs were supposed to prime the insulin pen with 2 units before each use. -She thought the insulin pen should be held in for 2 to 3 seconds. -Insulin should be administered before meals. -Breakfast was at 7:30am. -She was not aware Resident #6's Novolog was scheduled for 9:00am. -The Novolog scheduled time should be 7:15am. Interview with Resident #6 on 10/03/19 at 4:28pm revealed: -Her blood sugar was checked 3 to 4 times a day, sometimes before meals and sometimes after meals. -The MAs usually took the insulin pen out of her skin as soon as they injected it. Telephone interview with Resident #6's primary	D 358		

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D 358	Continued From page 21 care provider (PCP) on 10/04/19 at 9:53am revealed: -Resident #6's blood sugar should be checked before meals. -The resident's Novolog sliding scale insulin should be administered within 15 to 20 minutes before the resident ate a meal. -She was concerned if the resident's blood sugar was checked after a meal and Novolog was administered based on that reading, it would not accurately reflect the amount of insulin needed to cover the resident's fasting blood sugar. -The resident would require more insulin if based on the blood sugar after a meal because the blood sugar would tend to be higher after meals. -The Novolog insulin should be administered based on the blood sugar reading before meals. b. Review of Resident #6's physician's order dated 06/05/19 revealed an order for Haldol Concentrate 2mg/ml take 1ml (2mg) twice a day for management of psychotic behaviors. (Haldol Concentrate is an antipsychotic.) Review of Resident #6's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Haldol Concentrate 2mg/ml take 1 ml (2mg) twice a day with scheduled administration times of 9:00am and 9:00pm. -Haldol Concentrate was documented as administered from 10/01/19-10/03/19. Observation of the 9:00am medication pass on 10/03/19 revealed: -The medication aide (MA) used an oral 10 ml syringe to measure Resident #6's Haldol Concentrate. - The oral syringe had markings in 1-unit	D 358		

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D 358	Continued From page 22 increments from 1 ml to 10 ml. -The MA filled the oral syringe approximate 1/8th inch below the line marking 1 ml. -When asked how much Haldol was in the oral syringe the MA stated, "1 ml". -Surveyor intervened and asked MA again how much Haldol was in the syringe. -The MA again stated there was 1 ml in the syringe. -After surveyor showed the MA the marking for the 1 ml line on the syringe, the MA acknowledged the liquid Haldol she measured was below the 1 ml. -The MA then added enough Haldol Concentrate to measure the 1 ml marking. -The MA administered the Haldol Concentrate to Resident #6 at 9:22am. Interview with the MA on 10/03/19 at 2:08 pm revealed: -She had always used the same oral syringe to measure Resident #6's Haldol Concentrate. -She did not notice she measured below the 1 ml line that morning on 10/03/19. -She should have measured the liquid all the way to the 1ml line. Interview with the Administrator on 10/03/19 at 2:16pm revealed: -The MAs had been trained on how to measure liquid medications. -The MA should have measured the liquid Haldol to the line marking 1ml. Telephone interview with Resident #6's primary care provider (PCP) on 10/04/19 at 9:53am revealed: -She expected Resident #6 to be administered the ordered dose of Haldol. -The MAs should measure the Haldol liquid	D 358		

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D 358	Continued From page 23 dosage all the way to the 1ml marking on the oral syringe to ensure the resident received the full amount ordered. -She was not aware of any current behavior changes or issues with Resident #6.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure recording of the administration on the medication administration records was by the medication aide who actually administered 9:00am medications to 6 of 6 residents sampled (#2, #7, #8, #9, #10, #11) on 10/03/19. The findings are: Observation of the women's hall on 10/03/19 at 8:45am revealed: -There were 2 medication carts on the women's hall.	D 366		

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D 366	Continued From page 24 -There were 2 medication aides (MAs) on the women's hall administering medications. Interview with a MA on 10/03/19 at 9:15am revealed: -She was assigned to administer medications for the men's hall. -She had completed administration of the morning medications on the men's hall. -She was currently helping the MA who was assigned to the women's hall. A second interview with the MA assigned to the men's hall on 10/03/19 at 1:15pm revealed: -When she worked on the men's hall and finished first, she would go to the women's hall to help the other MA. -She did not usually sign into the electronic medication administration record (eMAR) when she administered medications on the women's hall because the other MA was already signed in. -If she signed into the e-MAR for the women's hall to document her initials, the MAs would have to count and reconcile the controlled substances, which would take too much time. -She could not sign into the eMAR unless the other MA signed out. -Since she was not signed in on the eMARs, any medications she clicked as administered would have the other MAs initials listed on the eMARs. -She administered 9:00am medications to Residents #2, #7, #8, #9, #10, and #11 that morning on 10/03/19. -She did not sign into the eMAR system for the women's hall since the other MA was already signed in. -The 9:00am medications on 10/03/19 for those 6 residents had the other MAs initials documented as administering those medications. -She actually administered the morning	D 366		

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D 366	Continued From page 25 medications for those 6 residents so the documentation on the eMARs was not correct. 1. Review of Resident #7's current FL-2 dated 07/23/19 revealed diagnoses included multiple sclerosis, depressive disorder, anxiety, gastroesophageal reflux disease, difficulty with walking, muscle weakness, history of impacted femoral fracture, and normal grief reaction. Observation of the 9:00am medication pass on 10/03/19 revealed: -The medication aide (MA) assigned to the men's hall administered medications to Resident #7 on the women's hall at 9:16am. -The MA clicked on the electronic medication administrated record (eMAR) that the medications had been administered after she observed the resident take the medications. Review of Resident #7's October 2019 electronic medication administration record (eMAR) revealed: -Fourteen medications scheduled for 9:00am were documented as administered on the morning of 10/03/19: Docusate Sodium 100mg (stool softener); Erythromycin EC 250mg (antibiotic for infection); Linzess 72mcg (for constipation); Loratadine 10mg (for seasonal allergies); Lorazepam 0.5mg (for anxiety); Magnesium Oxide 400mg (for low magnesium); Pantoprazole 40mg (for acid reflux); Probiotic Formula (for maintaining healthy digestive tract); Sertraline 100mg (for depression); Sucralfate 1gm (to treat and prevent stomach ulcers); Topiramate 25mg (for seizures or mood disorders); Triamcinolone nasal spray (for allergies); Vitamin B-12 500mcg (vitamin supplement); and Vitamin D3 1000 units (for Vitamin D deficiency).	D 366		

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D 366	Continued From page 26 -The initials of the MA assigned to the women's hall cart was documented for administering those 14 medications instead of the MA who actually administered them. Interview with Resident #7 on 10/03/19 at 2:12pm revealed the MA assigned to the men's hall administered the resident's 9:00am medications that morning on 10/03/19. Refer to interview with the Administrator on 10/03/19 at 2:16pm revealed: 2. Review of Resident #2's current FL-2 dated 05/28/19 revealed diagnoses included dementia, acute gastric ulcer, unspecified lack of coordination, atherosclerotic heart disease, chronic pain syndrome, chronic viral Hepatitis C, cognitive communication deficit, fracture of nasal bones, thrombocytopenia, major depressive disorder, anxiety disorder, cardiomegaly, constipation, dysphagia, intervertebral disc degeneration, and allergies. Review of Resident #2's October 2019 electronic medication administration record (eMAR) revealed: -Ten medications scheduled for 9:00am were documented as administered on the morning of 10/03/19: Amlodipine 5mg (lowers blood pressure); Capsaicin 0.025% cream (topical for arthritis pain); Cefuroxime 250mg (antibiotic for infection); Cetirizine 10mg (for seasonal allergies); Clopidogrel 75mg (prevents blood clots); Furosemide 20mg (diuretic for swelling), Linzess 72mcg (for constipation); Oxycodone 5mg (narcotic pain reliever); Potassium Chloride 20mEq (for low potassium); and Sertraline 100mg (for depression). -The initials of the medication aide (MA) assigned	D 366		

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(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 366	Continued From page 27 to the women's hall cart was documented for administering those 10 medications instead of the MA who actually administered the medications. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to interview with the Administrator on 10/03/19 at 2:16pm revealed: 3. Review of Resident #8's current FL-2 dated 05/03/19 revealed diagnoses included anxiety, hernia, hypertension, hyperlipidemia, mental retardation, and schizophrenia. Review of Resident #8's October 2019 electronic medication administration record (eMAR) revealed: -Seven medications scheduled for 9:00am were documented as administered on the morning of 10/03/19: Calcium with Vitamin D 600/400 (vitamin supplement); Capsaicin 0.025% cream (topical for arthritis pain); Docusate Sodium 100mg (stool softener); Loratadine 10mg (for seasonal allergies); Olanzapine 5mg (an antipsychotic); Paroxetine 20mg (for depression); and Tramadol 50mg (narcotic pain reliever). -The initials of the medication aide (MA) assigned to the women's hall cart was documented for administering those 7 medications instead of the MA who actually administered the medications. Interview with Resident #8 on 10/03/19 at 4:58pm revealed the MA assigned to the men's hall had administered the resident's morning medications that morning on 10/03/19. Refer to interview with the Administrator on 10/03/19 at 2:16pm revealed:	D 366		

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	HAL064032	A. BUILDING _____ B. WING _____	10/04/2019

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D 366	Continued From page 28 4. Review of Resident #9's current FL-2 dated 04/30/19 revealed diagnoses included acidosis, respiratory failure, anemia, depression, diabetes mellitus type 2, hypertension, injury of part of small intestine, laceration of spleen, and multiple sclerosis. Review of Resident #9's October 2019 electronic medication administration record (eMAR) revealed: -Ten medications scheduled for 9:00am were documented as administered on the morning of 10/03/19: Allopurinol 300mg (for gout); Calcium Citrate 200mg (calcium supplement); Colcrys 0.6mg (for gout); Cranberry 200mg (supplement for urinary health); Fluoxetine 40mg (for depression); Glipizide ER 2.5mg (for diabetes); Metoprolol 100mg (for high blood pressure); Tecfidera 240 mg (for multiple sclerosis); Victoza 18mg (for diabetes); and Vitamin D3 5000 units (for Vitamin D deficiency). -The initials of the medication aide (MA) assigned to the women's hall cart was documented for administering those 10 medications instead of the MA who actually administered the medications. Interview with Resident #9 on 10/03/19 at 5:01pm revealed the resident could not recall if she received medications that morning or who may have administered them. Refer to interview with the Administrator on 10/03/19 at 2:16pm revealed: 5. Review of Resident #10's current FL-2 dated 06/04/19 revealed diagnoses included schizophrenia, gastroesophageal reflux disease, and glaucoma.	D 366		

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D 366	Continued From page 29 Review of Resident #10's October 2019 electronic medication administration record (eMAR) revealed: -Three medications scheduled for 9:00am were documented as administered on the morning of 10/03/19: Loratadine 10mg (for seasonal allergies); Risperidone 4mg (an antipsychotic); and Simbrinza 1-0.2% suspension (eye drop for glaucoma). -The initials of the medication aide (MA) assigned to the women's hall cart was documented for administering those 3 medications instead of the MA who actually administered the medications. Interview with Resident #10 on 10/03/19 at 5:04pm revealed the MA assigned to the men's hall had administered the resident's morning medications that morning on 10/03/19. Refer to interview with the Administrator on 10/03/19 at 2:16pm revealed: 6. Review of Resident #11's current FL-2 dated 08/19/19 revealed diagnoses included bipolar disorder, seizures, sickle cell disease without crisis, hypothyroidism, chronic pain syndrome, Vitamin D deficiency, schizophrenia, gastroesophageal reflux disease, degenerated hips, chronic obstructive pulmonary disease, and hearing loss. Review of Resident #11's October 2019 electronic medication administration record (eMAR) revealed: -Ten medications scheduled for 9:00am were documented as administered on the morning of 10/03/19: Divalproex 250mg (for seizures or mood disorders); Docusate Sodium 100mg (stool softener); Folic Acid 1mg (vitamin supplement); Furosemide 20mg (diuretic for swelling); Percocet	D 366		

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D 366	Continued From page 30 5/325mg (narcotic pain reliever); Paliperidone ER 3mg (an antipsychotic); Miralax powder (laxative); Quetiapine 100mg (an antipsychotic); Senna Plus (laxative); and Vitamin B-12 500mcg (vitamin supplement). -The initials of the medication aide (MA) assigned to the women's hall cart was documented for administering those 10 medications instead of the MA who actually administered the medications. Interview with Resident #11 on 10/03/19 at 5:06pm revealed the MA assigned to the men's hall had administered the resident's morning medications that morning on 10/03/19. Refer to interview with the Administrator on 10/03/19 at 2:16pm revealed: Interview with the Administrator on 10/03/19 at 2:16pm revealed: -The MA who administered medications was supposed to be logged into the eMARs and document the administration of the medications. -If a MA assisted another MA on a hall they were not originally assigned, the MA not administering was supposed to log out of the eMAR system and the MA assisting should log into the eMAR system before administering medications. -The MAs had been trained on how to use the eMARs and the MAs knew to sign into the eMAR system anytime they administered medications. -If this was not done, the documentation on the eMAR would not be accurate. -She did not know the MAs were not logging in to the e-MAR system as required.	D 366		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935		

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D935	Continued From page 31 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in	D935		

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D935	Continued From page 32 accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 sampled medication aides (Staff A) who administered medication had successfully passed the state medication aide written exam within 60 days of hire. The findings are: Review of a personnel record for Staff A, medication aide/personal care aide (MA/PCA) revealed: -There was documentation Staff A was hired on 07/03/19. -There was documentation dated 07/09/19 that Staff A had completed the state-approved 15-hour medication administration training. -There was documentation dated 07/09/19 that Staff A had completed the medication clinical skills competency validation and was signed by a registered nurse. -There was no documentation Staff A had successfully passed the state written medication administration examination within 60 days of hire. Review of the residents' September 2019 electronic medication administration records (eMARs) revealed there was documentation that Staff A administered medications to all residents on 09/09/19, 09/12/19, 09/16/19, 09/20/19,	D935		

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D935	Continued From page 33 09/21/19, 09/22/19, 09/22/19, 09/27/19, 09/28/19, 09/29/19, and 09/30/19 during the 7:00am to 3:00pm shift. Review of the residents' October 2019 eMAR revealed there was documentation that Staff A administered medications to residents on 10/01/19 and 10/02/19 during the 7:00am to 3:00pm shift. Interview with a resident revealed Staff A administered medications to the resident. Interview with the Resident Care Coordinator (RCC) on 10/04/19 at 11:30am revealed: -Staff A had been working as a medication aide at the facility for approximately over one month. -Staff A was supposed to be scheduled to take the state written medication administration exam. -She was not sure of the date Staff A scheduled to take the state written medication administration exam. Interview with the Administrator on 10/04/19 at 9:50am revealed: -Staff A had been working at the facility for almost two months as a medication aide and should still be within ninety days of her date of hire for taking the state written medication aide exam. -Staff A was currently still administering medications because she had not reached ninety days from when she began training for a medication aide. -Staff A was scheduled to take her state written medication administration exam on 10/11/19. -She thought Staff A was "okay" to continue administering medications at the facility because she did not know about the rule that medication aides had to pass the state written administration test within sixty days of their hire date.	D935		

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D935	Continued From page 34 -She and the RCC were responsible for keeping up with the number of days staff worked prior to taking the state written medication administration exam. Interview with Staff A on 10/04/19 at 2:55pm revealed: -She started training as medication aide about a one week after she started working at the facility in July 2019. -She had administered medications to the residents at the facility since she completed her medication skill checklists until today (10/04/19). -She had not taken the state written medication administration exam yet because she had not registered for the examination or paid her registration fees. Second interview with the Administrator on 10/04/19 at 3:50pm revealed she was not aware Staff A was not scheduled to take the state written medication administration exam on 10/11/19.	D935		