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CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

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D 000	Initial Comments The Adult Care Licensure Section completed an Annual and a Follow-up survey on 03/03/20 and 03/04/20.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of physician's orders for 1 of 5 sampled residents (#2) with orders for laboratory tests. The findings are: Review of Resident #2's current FL2 dated 04/09/19 revealed: -Diagnosis included seizures, arthritis, hypertension, alcoholic cirrhosis, and Chronic Obstructive Pulmonary Disease (COPD). -Medications included Buspirone 15mg three times daily for anxiety, calcium (a supplement)	D 276		

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600mg daily, clonazepam 0.5mg twice daily for anxiety, colcrys 0.6mg every other day for gout, glipizide 10mg daily for diabetes, and lactulose (reduces ammonia) 30ml daily.

Review of Resident #2's signed physician's telephone orders dated 09/04/19 revealed a order for a CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), TSH (Thyroid Stimulating Hormone), and lipid panel for long term medication use.

Review of an electronically signed physician consultation note for Resident #2 dated 12/17/19 revealed:
-There was an order for a HgbA1C (measures average blood sugar level for 2 to 3 months) on the next lab draw.
-A date of 12/30/19 was printed at the top of the form.

Review of Resident #2's laboratory results revealed:
-A HgbA1C, BMP (basic metabolic panel), TSH, and a Vitamin D level had been collected on 08/22/18.
-A CMP, TSH, Vitamin B12, and CBC had been collected on 04/17/19.
-There were no other laboratory results.

Telephone interview with Resident #2's Physician's Assistant on 03/03/20 at 2:50pm revealed:
-The laboratory tests ordered 09/04/19 had been from a prior physician's office and there were no results in the resident's record.
-The laboratory tests ordered 12/17/19 had been ordered because Resident #2 was on glipizide for diabetes.
-Resident #2 needed laboratory testing because

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he was long term medications.
-The facility should have "caught that" order and ensured it had been completed.

Interview with the Resident Care Coordinator (RCC) on 03/03/20 at 3:00pm revealed:
-She had been the RCC for 3 to 4 weeks.
-She did not know why the laboratory tests ordered for Resident #2 on 09/04/19 and 12/17/19 had not been collected.
-She was responsible for ensuring the laboratory was notified when tests were ordered for residents.
-When the physician wrote an order for laboratory tests she would "immediately" call the laboratory.
-She did not have a system for auditing charts for laboratory testing orders.
-She had been attempting to "go through" resident charts at least once per week.
-The Assistant Administrator was still training the RCC.

Interview with the Assistant Administrator on 03/03/20 at 2:55pm revealed:
-The laboratory tests ordered for Resident #2 dated 12/17/19 had not been completed because it had not been on the usual form, physician's office letterhead with only the order on it, which would then be faxed to the facility.
-The laboratory tests ordered for Resident #2 dated 09/04/19 had not been completed because that had been the prior RCC's responsibility and she was no longer an employee.
-When the physician was in the facility and ordered laboratory tests they would notify the RCC or Assistant Administrator or leave the written order flagged in the chart.
-The laboratory would be notified on Tuesdays which residents needed tests because the laboratory would draw all tests on Wednesdays.

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D 276	Continued From page 3 -Chart audits would be completed as needed because he did not have time to do weekly audits.	D 276		
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 serve therapeutic diets as ordered for 2 of 3 residents related to a mechanical soft diet (Resident #2) and a mechanical soft, diabetic diet (Resident #3). The findings are: 1. Review of Resident #2's current FL-2 dated 04/09/19 revealed: -Diagnoses included hypertension, depression, and chronic lung disease. -The diet documented under nutritional status was mechanical soft. Observation of the diet list for residents in the kitchen on 03/03/20 revealed Resident #2 was on a mechanical soft diet. Review of the physician's orders dated 12/09/19 revealed Resident #2 was on a "No Concentrated Sweets/Mechanical Soft" diet.	D 310		

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Review of the lunch menu for 03/03/20 revealed this was a "Chef's choice" entrée.

Observation of the lunch meal on 03/03/30 at 12:15pm revealed:
-Resident #2 was eating the same meal as all the other residents.
-His lunch meal included 2 slices of cheese pizza divided into bite sized pieces, salad, rice, water and milk.
-He was observed to have no difficulty consuming his lunch.
-He declined the dessert of 4 peach slices from a can of sweetened peaches.

Refer to interview with the cook on 03/03/20 at 9:25am.

Refer to interview with the Dietary Manager (DM) on 03/04/20 at 9:20am.

Refer to interview with the Administrator on 03/04/20 at 10:00am.

2. Review of Resident #3's current FL-2 dated 02/26/20 revealed:
-Diagnoses included diabetes and hypertension.
-There was no entry that indicated his nutritional status.

Observation of the diet list for residents in the kitchen on 03/03/20 revealed Resident #3 was on a mechanical soft, diabetic diet.

Review of Resident #3's discharge orders from the hospital dated 02/26/20 revealed his diet order was "Heart Healthy (low saturated fat/no added salt), Diabetic/Consistent Carbohydrate."

Review of the lunch menu for 03/03/20 revealed

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D 310	Continued From page 5 this was a "Chef's choice" entrée. Observation of the lunch meal on 03/03/20 at 12:15pm revealed: -Resident #3 was eating the same meal as all the other residents. -His lunch meal included 2 slices of whole cheese pizza, salad, rice, water, milk, tea and peaches. -He ate 4 peach slices from a can of sweetened peaches. -He was observed having no difficulty consuming his lunch. Refer to interview with the cook on 03/03/20 at 9:25am. Refer to interview with the Dietary Manager (DM) on 03/04/20 at 9:20am. Refer to interview with the Administrator on 03/04/20 at 10:00am. _____ Interview with the cook on 03/03/20 at 9:25am revealed: -For mechanical soft diets, the dietary staff cut up the resident's food in small pieces. -The diabetic diets and the no concentrated sweets diets are the same and those residents get one-half portion of dessert. -They do not have a therapeutic diet list to follow. Interview with the DM on 03/04/20 at 9:20am revealed: -They had a therapeutic diet menu list that included mechanical soft, no concentrated sweets/diabetic and heart healthy among others. -When a resident was admitted, he received a dietary sheet from the Resident Care Coordinator with the admitting diet.	D 310		

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D 310	Continued From page 6 -When a current resident had a hospital admission, he received an updated diet upon their return if the diet had changed. -Resident #2 was supposed to be on a mechanical soft, no concentrated sweets diet. -Resident #3 was supposed to be on a mechanical soft, diabetic diet. -Resident's #2 and #3 should not have been served pizza on a mechanical soft diet. -Resident's #2 and #3 should have been served a chopped hamburger patty served on a bun. -A half portion of dessert should be given to residents on a diabetic diet or a no concentrated sweets diet. -He knew that Resident #3 recently had a hospitalization but had not received an updated dietary order from the Resident Care Coordinator (RCC). -He was unaware that Resident #3 had a diet change while he was hospitalized. Interview with the Administrator on 03/04/20 at 10:00am revealed: -He did not know why the therapeutic diets weren't being followed. -He was not aware Residents #2 and #3 were not receiving the ordered diet they were supposed to be receiving. -The RCC was responsible to make sure the DM received any dietary orders and changes. -He expected the staff to follow the physician's orders for therapeutic diets.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for	D 344		

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medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to contact the physician to clarify medication orders for 1 of 5 sampled residents (Resident #4) related to physician's orders for citalopram and Depakote.

The findings are:

Review of Resident #4's current FL2 dated 07/29/19 revealed diagnoses included dementia, peripheral vascular disease, and neuropathy.

a. Review of Resident #4's physician's order dated 01/06/20 revealed:
-There was a signed physician's order to discontinue citalopram (used to treat depression and anxiety) 10mg take 1 tablet daily.
-The physician's order was signed by the facility's contracted Nurse Practitioner (NP).

Review of Resident #4's subsequent physician's

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order dated 01/13/20 revealed:
-There was a list of active medication orders from Resident #4's outside provider dated 01/09/20.
-Citalopram 10mg take 1 tablet at bedtime was included on this medication list from Resident #4's outside provider.
-The medication list was reviewed and signed by the facility's contracted NP on 01/13/20.

Review of Resident #4's updated medication list dated 03/02/20 revealed:
-The medication list was from Resident #4's outside provider.
-Citalopram 10mg take 1 tablet daily was included on the medication list.
-The medication list was not signed by a provider.

Review of Resident #4's January 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for citalopram 10mg take 1 tablet at bedtime for depression scheduled to be administered at 9:00pm daily with an original order date of 07/29/19.
-Citalopram was administered at 9:00pm on 01/05/20.
-Citalopram was documented as refused from 01/01/20-01/04/20.
-Citalopram was documented as discontinued on 01/06/20.

Review of Resident #4's February 2020 eMAR revealed there was no computer-generated entry for citalopram 10mg take 1 tablet daily.

Review of Resident #4's March 2020 eMAR revealed:
-There was a computer-generated entry for citalopram 10mg take 1 tablet at bedtime for

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depression scheduled to be administered at 9:00pm daily.
-Citalopram had an original date of 03/02/20.
-There was no citalopram 10mg doses documented as administered on 03/02/20 or 03/03/20.

Telephone interview with Resident #4's primary care provider on 03/04/20 at 1:05pm revealed:
-She only followed Resident #4 for any emergencies.
-Resident #4 should be administered the medications prescribed by the outside provider.
-If citalopram was listed on the medication list from the outside provider then Resident #4 should be administered the medication.
-She reviewed and signed the medication orders from the outside provider when she came to the facility.
-She had discontinued the citalopram in January 2020 to start Resident #4 on another medication for mood.
-Resident #4 had seemed agitated and depressed when she evaluated him in January.

Refer to the interview with a medication aide (MA) on 03/04/20 at 10:37am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/04/20 at 1:35pm.

Refer to the interview with the Assistant Administrator on 03/04/20 at 9:05am.

b. Review of Resident #4's physician's order dated 01/06/20 revealed a physician's order to start Depakote Sprinkles (used to treat mood and depression) 125mg take 1 capsule every 12 hours.

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Review of Resident #4's subsequent signed physician's order dated 01/13/20 revealed no physician's order for Depakote.

Review of Resident #4's January 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated order for Depakote Sprinkles 125mg take 1 capsule every 12 hours for agitation/depression scheduled to administer daily at 9:00am and 9:00pm.
-Depakote was documented as administered at 9:00am and 9:00pm from 01/07/20 to 01/31/20.

Review of Resident #4's February 2020 eMAR revealed:
-There was a computer-generated order for Depakote Sprinkles 125mg take 1 capsule every 12 hours for agitation/depression scheduled to administer daily at 9:00am and 9:00pm.
-Depakote was documented as administered at 9:00am and 9:00pm from 02/01/20 to 02/29/20.

Review of Resident #4's March 2020 eMAR revealed:
-There was a computer-generated order for Depakote Sprinkles 125mg take 1 capsule every 12 hours for agitation/depression scheduled to administer daily at 9:00am and 9:00pm.
-Depakote was documented as administered at 9:00am and 9:00pm from 03/01/20 to 03/02/20.

Telephone interview with Resident #4's primary care provider on 03/04/20 at 1:05pm revealed:
-She only followed Resident #4 for any emergencies.
-Resident #4 should be administered the medications prescribed by the outside provider.
-She reviewed and signed the medication orders from the outside provider when she came to the

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facility.
-She had prescribed Depakote for Resident #4 in January 2020 because he seemed agitated and depressed.
-She did not know Depakote was not listed on the medication lists from the outside provider.
-Resident #4 should be administered Depakote even though it was not on the most recent signed medication list.

Refer to the interview with a medication aide (MA) on 03/04/20 at 10:37am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/04/20 at 1:35pm.

Refer to the interview with the Assistant Administrator on 03/04/20 at 9:05am.

_____

Interview with a medication aide (MA) on 03/04/20 at 10:37am revealed the Resident Care Coordinator (RCC) was responsible for processing all medication orders for the residents, including clarification of orders.

Interview with the RCC on 03/04/20 at 1:35pm revealed:
-She had worked as the RCC for about 3 to 4 weeks.
-She was responsible for contacting a resident's physician to clarify medication orders.
-She did not know when the facility's contracted Nurse Practitioner (NP) signed the medication list from an outside provider updated a resident's medication orders.
-She did not know she needed to contact the provider to clarify any medication orders for a resident if the signed medication list did not match the medications the resident was being administered.

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D 344	Continued From page 12 Interview with the Assistant Administrator on 03/04/20 at 9:05am revealed: -Resident #4 was being followed by the facility's contracted NP and an outside provider. -He had the facility's contracted NP review the medication list from the outside provider and sign off on the medication orders. -He did not review the medication orders from the outside provider. -He did not realize the signed medication orders from the outside provider were different then the medications on Resident #4's eMAR. -He did not fax the signed orders to the pharmacy from the outside provider. -He did not know this was an updated physician's order since the NP had signed the medication list. -Resident #4 had an appointment with his outside provider on 03/02/20 and it was not signed by either provider. -The medication list from the outside provider from 03/02/20 was faxed to the pharmacy and Resident #4's eMAR was adjusted to match this medication list.	D 344		