Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl035033	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HEART FAMILY CARE HOME	131 HUNTINGTON RD LOUISBURG, NC 27549

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey via off-site desk review from 06/22/20-06/26/20 and 06/29/20-06/30/20 with an exit conference via telephone on 06/30/20.	C 000	The community understands the importance of resident Safety. Resident #1 + 3# 14 Bay notice was given on 6/30/2020. On 7/1/2020 community reached out to DSS for Placement assisstance. DSS Provided a directory of Places that may have available beds stated they had available bed. On 7/8/2020 Both resident were assessed by RCC on 7/16/2020 Community received updated Flu + covid results from PCP, on 7/16/2020 necessary paperwork to Resident are expected to move in at 9am on 7/21/2020. In the future if a resident Capability change and are unable to evacuate, the community will perform necessary steps to place resident in a community that can accomadate them.	07/23/20
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the	C 007		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Cassandra Davis 7.21.20

Plan of Correction has been reviewed and accepted with addendums 07/21/20. KG Kathy Gray

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C 007	Continued From page 1 Division of Facility Services for review of any possible changes that may be required to the building. This Rule is not met as evidenced by: 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. Based on interviews and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the residents' evacuation capabilities were different from the evacuation capability listed on the home's license. Review of the facility's license with an effective date of 02/05/20 revealed the facility was licensed for a capacity of 6 ambulatory residents. Review of the daily census revealed 6 residents resided in the facility on 06/22/20. Review of fire drill logs revealed: -A fire drill was conducted on 05/11/20 at 1.18pm. -The maximum time for six residents to evacuate the facility was 8 minutes and 6 seconds. -All five of the facility staff were present and participated in the fire drill. Telephone interview with the Administrator on 06/30/20 at 10:06am revealed: -She had not notified construction of any residents with a change in their ambulatory status because she had the wrong definition of	C 007	the facility will begin doing monthly assessment form to note any change in the resident physical + Cognitive abilities. To aid in determining if FCH ~~ability~~ is the recommended placement or if other placement is needed. Form was Created on 7/20/2020 Addendum 07/21/20: The Administrator will notify DHSR immediately if any resident is not able to independently exit the facility during routine fire drills or when assessed with a change in condition that would prohibit the resident from exiting the facility independently.	07/23/20

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C 007	Continued From page 2 ambulatory. -She did not know she needed to notify construction; she thought as long as all the residents could walk, they were considered ambulatory. -She did not know the residents could not be prompted verbally to evacuate the building. Refer to Tag C022 10A NCAC 13G .0302(b) Design And Construction Tag 0022 (Type B Violation)	C 007	See page 1+2 for response	
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure that th residents' evacuation capabilities were in accordance with the evacuation capability listed on the home's license for 2 of 3 sampled residents (#1 and #3) residing in the facility that had cognitive impairments and required assistance with ambulation which could prevent the resident from independently evacuating the facility. The findings are:	C 022	Addendum 07/21/20: Same plan of correction as rule area .0206 capacity. Addendum 07/21/20: Fire drills will be held monthly to ensure all residents are able to independetly exit the facility without any assistance from staff.	07/23/20

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C 022	Continued From page 3 Review of the facility's license with an effective date of 02/05/20 revealed the facility was licensed for a capacity of 6 ambulatory residents. Review of the daily census revealed 6 residents resided in the facility on 06/22/20. Review of fire drill logs revealed: -A fire drill was conducted on 05/11/20 at 1:18pm. -The maximum time for six residents to evacuate the facility was 8 minutes and 6 seconds. -All five of the facility staff were present and participated in the fire drill. 1. Review of Resident #1's current FL-2 dated 03/31/20 revealed: -Diagnoses included dementia with behaviors, chronic schizophrenia, bronchial asthma, Parkinson's and dyslipidemia. -Resident #1 was intermittently disoriented. -Resident #1 was semi-ambulatory. Review of Resident #1's Resident Register revealed: -She was admitted to the facility on 03/24/20 -She required a walker and a wheelchair. Review of Resident #1's care plan dated 03/24/20 revealed: -She required extensive assistance with ambulation and transfers. -Resident #1 was always disoriented. -Resident #1 was ambulatory with the aid of devices including a walker and staff assistance. -Resident #1 required extensive assistance with ambulation and locomotion. -Resident #1 required extensive assistance with transferring.	C 022	See page 1+2 for response	

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C 022	Continued From page 4 Telephone interview with a personal care aide (PCA) on 06/24/20 at 6:36am revealed: -Resident #1 required assistance to stand from a sitting position. -She would take Resident #1 by the hands and count to three and then assist the resident to her feet or she used a gait belt to assist Resident #1 to stand. -Once Resident #1 was on her feet she could walk around on her own; Resident #1 did not use any assistive device when walking. Telephone interview with the Supervisor-in-Charge/Medication Aide (SIC/MA) on 06/24/20 at 2:30pm revealed: -Resident #1 required assistance with transferring and walking. -She would guide Resident #1's legs to the floor from the bed and assisted her to a standing position. -Resident #1 had to be cued and assisted to stand. -The SIC/MA had to walk hand in hand with Resident #1 or support Resident #1 under her arms to prevent her from falling. -Resident #1 could only walk 15 to 20 feet on her own before she would fall to the floor. -The SIC/MA conducted and participated in the fire drill on 05/11/20. -Resident #1 did not respond to the fire drill and had to be assisted to stand. -Resident #1 held onto the railing on the ramp that led into the yard while a facility staff held onto her on the other side. -Once Resident #1 was outside of the facility she was not able to walk in the driveway or yard by herself. Telephone interview with the Administrator on 06/23/20 at 4:18pm revealed:	C 022	See page 1+2 for response	

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C 022	Continued From page 5 -Resident #1 had to be assisted to a standing position and facility staff had to walk behind her to keep her from falling; once Resident #1 started walking she walked "just fine" by herself. -A wheelchair had been ordered by the primary care provider (PCP) to help her get around. Telephone interview with Resident #1's PCP on 06/30/20 at 9:29am revealed Resident #1 would need assistance to safely exit the facility in the event of an emergency. Based on interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to the telephone interview with the PCA on 06/24/20 at 7:19am. Refer to the telephone interview with the SIC/MA on 06/24/20 at 5:20pm. 2. Review of Resident #3's FL-2 dated 03/31/20 revealed: -Diagnoses included arterial hypertension, chronic schizophrenia, major neurocognitive disorder with behavioral disturbances and dementia. -Resident #3 was constantly disoriented. -Resident #3 was semi-ambulatory. Review of Resident #3's Resident Register dated 03/24/20 revealed: -He was admitted to the facility on 03/24/20. -He required a walker and a wheelchair. Review of Resident #3's care plan dated 03/24/20 revealed: -Resident #3 was always disoriented -He had significant memory loss and must be directed.	C 022	See page 1+2 for response	

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C 022	Continued From page 6 -Resident #3 was ambulatory with the aid of devices including a walker and a wheelchair. -He required limited assistance for ambulation and locomotion. -He required extensive assistance with transferring. Review of a physician's order for Resident #3 dated 03/24/20 revealed a wheelchair had been ordered. Review of progress notes for Resident #3 dated 03/31/20 and 04/01/20 revealed a wheelchair had been ordered. Telephone interview with a personal care aide (PCA) on 06/24/20 at 6:49am revealed: -Resident #3 used a walker to walk. -Resident #3's memory was the "worst" and he did not remember things from day to day. Telephone interview with the Supervisor-in-Charge/Medication Aide (SIC/MA) on 06/24/20 at 5:16pm revealed: -Resident #3 was constantly confused and could not find his way around the facility and did not know the current date. -Resident #3 required assistance with standing and getting out of the bed; sometimes he required two staff to assist him with standing. -She assisted Resident #3 to get out of bed by moving his legs out of the bed and to the floor. -Resident #3 required assistance getting out of his room because his walker had to be turned sideways to get it through the door and he could not turn the walker on his own -She conducted and participated in a fire drill on 05/11/20. -Resident #3 did notrespond to the alarm for the fire drill	C 022	See page 1+2 for response	

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C 022	Continued From page 7 -Resident #3 had to be assisted during the fire drill because he could not get out of his room without assistance and he could not step over the plate at the threshold to the front door. -Resident #3 refused to evacuate during the fire drill and was enticed with a piece of candy to participate. -Resident #3 would have to stop and rest every "three or four car lengths" -The longest part of the fire drill for the facility staff involved getting Resident #3 "out the door". Telephone interview with the Administrator on 06/23/20 at 4:24pm revealed: -Resident #3 used a walker to "get around". -The facility staff assisted Resident #3 when he walked through the facility to prevent him from falling. -Resident #3's memory was not good, and he could not remember events from the day before. Telephone interview with Resident #3's primary care provider (PCP) on 06/30/20 at 9:29am revealed: -Resident #3 had dementia and would not be able to follow directions. -Resident #3 would not be able to safely exit the facility in the event of an emergency without assistance. Based on interviews and record reviews, it was determined Resident #3 was not interviewable. Refer to the telephone interview with the PCA on 06/24/20 at 7:19am. Refer to the telephone interview with the SIC/MA on 06/24/20 at 5:20pm.	C 022	See page 1+2 for response	

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C 022	Continued From page 8 Telephone interview with the personal care aide (PCA) on 06/24/20 at 7.19am revealed: -She had participated in the fire drill held on 05/11/20 during the day shift. -She knew to lead the residents out in a "safe way". -The facility staff from all shifts participated in the fire drill and each staff had one resident to assist during the fire drill. -Residents #1 and #3 required the most assistance during the drill. Telephone interview with the Supervisor-in-Charge/Medication Aide (SIC/MA) on 06/24/20 at 5:20pm revealed: -She conducted a fire drill on 05/11/20. -Five facility staff participated in the fire drill. -The total time to get all the residents out of the facility was eight minutes and six seconds. The facility failed to ensure the evacuation capabilities of 2 of 6 residents (#1 and #3) were consistent with the current license status of 6 ambulatory residents. The facility's failure to ensure residents' ability to evacuate in an emergency without physical or verbal prompting. This failure was detrimental to the safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/24/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 21, 2020.	C 022	See page 1+2 for response	

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C 270	Continued From page 9	C 270		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to have a matching therapeutic diet menu for staff guidance for 1 of 1 sampled resident (#4) having a physician ordered 2 gram (gm) sodium (NA) diet. The findings are: Review of Resident #4's current FL2 dated 03/09/20 revealed: -Diagnoses included arterial hypertension, dementia, depressive disorder, and history of transient ischemic attacks (TIA) -There was an order for a 2gm NA diet. (A 2gm NA diet is very restrictive on sodium intake). Review of the facility's posted diet order list revealed Resident #4 was on a 2gm NA diet. Review of the facility's therapeutic diet menus revealed there was no 2gm NA diet menu available for guidance. Telephone interview with the Medication Aide (MA)/Supervisor in charge (SIC) on 06/29/20 at 5:45pm revealed: -She used the regular diet for guidance on preparing meals.	C 270	President was on a diet that the community did not offer. On 6/30/2020 resident PCP was contacted and made aware that resident current diet order was 2gm NA & the facility does not offer that diet. PCP was given a list on diets offered. PCP changed resident diet to low sodium. On 7/8/20 employees that prepare meals were inserviced on therapeutic diets. In the future the community will assure that diets that are ordered prior to admission can be supported at the community. If diet order can not be supported & PCP can not change to a diet that is offered we will not accept resident. The community understands the importance of abiding by therapeutic diets & the role it plays to keep residents healthy. ~~If a current resident diet change the will compare to diets offered~~	6/30/20

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C 270	Continued From page 10 -She knew Resident #4 was on a low sodium diet but she thought it was okay to follow the regular diet because she did not salt the food and did not serve processed foods. -She did not know there was a difference between low sodium and a 2gm NA diet. -She did not add any salt to any resident's food, she used a salt substitute -She did not use processed foods because they were high in sodium. -She did not know she needed to have a spreadsheet for guidance for a 2gm NA diet. Telephone interview with the Administrator on 06/29/20 at 5:51pm revealed: -She prepared meals for the residents using the spreadsheet prepared by the dietitian. -She did not use salt in preparing meals. -She thought a low sodium diet and a 2gm NA diet were the same diets. Telephone interview with Resident #4's primary care provider (PCP) on 06/30/20 at 9:29am revealed: -Resident #4 was on a 2gm NA diet because of high blood pressure. -She was not concerned Resident #4 had not been served a 2gm NA diet because Resident #4's blood pressure had been fine. Telephone interview with Resident #4 on 06/30/20 at 9:48am revealed: -She did not know she was on a 2gm NA diet. -She ate whatever she was served -She ate potato chips for a snack. -She had a sausage biscuit, hash browns, and orange juice for breakfast today, 06/30/20. -She did not add salt to her food at the table.	C 270	If residents diet order change as well as new admission a diet order form has been created. The created diet form the resident name will be documented. All diets orders that are offered are list on this form. Staff will initial beside the diet ordered. Below on the form is a place to list any accommodations needed, food allergies, restrictions or pertinent information concerning residents diet. The form is specific so there can not be any discrepancy in diets orders. This form will be completed upon admission & anytime there is a diet order change. This form was created on 7/20/2020.	

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C 315	Continued From page 11	C 315	The facility understands the importance of clear Physician orders + seeking Clarification. On 6/30/2020 Spoke with PCP nurse Lora making her aware clarification order was needed for this medication. On 7/6/2020 Contacted PCP office for response on this order as well as others, nurse was unavailable as well as PCP Receptionist State she would have to return call. Called PCP office again on 7/7/2020 Receptionist stated nurse was with a patient + message would be given. On 7/13/2020 Went sat at PCP office to get orders signed prior to calling told to return in 24hrs. 7/14/2020 Receptionist stated on phone call per nurse all forms would be completed by the end of the day + would receive a call. On 7/16/2020 spoke with nurse stated PCP had taken all paperwork that was sent + brought over from	07/23/20
C 315	10A NCAC 13G .1002(a) Medication Orders	C 315		
	10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for 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 interviews and record reviews, the facility failed to clarify a medication order for 2 of 3 sampled residents (#1 and #2) for medication used to treat asthma symptoms. The findings are: 1 Review of Resident 2's current FL-2 dated 05/06/20 revealed: -Diagnoses included hypertension, diabetes with complications, arthritis, obstructive sleep apnea, hyperthyroidism, dm neuropathy, and cognitive impairment with speech impairment. -There was an order for Fluticasone Furoate 100mcg/actuation inhale into the lungs daily. (Fluticasone Furoate is used to prevent and decrease wheezing and trouble breathing caused by asthma and ongoing lung disease. Review of Resident #2's Resident Register			

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C 315	Continued From page 12 revealed Resident #2 was admitted to the facility on 04/21/20. Review of Resident #2's medication administration record (MAR) for April 2020 revealed -There was a hand-written entry for Fluticasone Furoate 100mcg/actuation inhale into lungs daily. -There was documentation Fluticasone Furoate was administered at 8:00am daily from 04/22/20 through 04/30/20. Review of Resident #2's MAR for May 2020 revealed: -There was a hand-written entry for Fluticasone Furoate 100mcg/actuation inhale into lungs daily. -There was documentation Fluticasone Furoate was administered at 8:00am daily from 05/01/20 through 05/31/20. Review of Resident #2's MAR for June 2020 revealed: -There was a hand-written entry for Fluticasone Furoate 100mcg/actuation inhale into the lungs daily. -There was documentation Fluticasone Furoate was administered at 8:00am daily from 06/01/20 through 06/24/20. Telephone interview with a representative from the facility's contracted pharmacy on 06/24/20 at 11:30am revealed: -There was an order for Fluticasone Furoate 100mcg/actuation inhale into lungs daily received on 05/06/20. -The medication had not been dispensed because the order was incomplete; the order did not specify how many puffs were to be inhaled. -A clarification request would have been faxed to the facility.	C 315	facility. Nurse stated she would message PCP to call facility. Spoke with nurse again on 7/16/2020 nurse stated PCP has 10day to respond. Nurse was made aware that 6/30/2020 has stretched beyond 10 days. Nurse called community again on 7/16/2020 stating she was taking orders over this particular order was not sent. SIC returned to PCP office on 7/20/2020 Concerning order + other matter... ~~Ehurse~~ stated order would be faxed. A copy of order is attached to tracking order form that was created on 6/30/2020 and flagged in mar so order does not get overlooked. All measure taken documented on quality assurance report.	

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	fcl035033	A. BUILDING: _____ B. WING _____	06/30/2020

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C 315	Continued From page 13 -There had been no clarification received as of today's date, 06/24/20. Telephone interview with a medication aide (MA) on 06/24/20 at 3:30pm revealed Resident #2's medications on hand included a Fluticasone Furoate inhaler with a dispense date of 04/13/20 with a count of 17 puffs remaining. Telephone interview with the Supervisor-in-Charge (SIC) on 06/24/20 at 3:30pm revealed Resident #2 had "a couple" of Fluticasone Furoate inhalers when admitted to the facility. Telephone Interview with the SIC on 06/25/20 at 1:16pm revealed: -She had handwritten Fluticasone Furoate 100mcg/inhalation inhale into the lungs daily on the MAR because she knew Resident #2 had an active order. -She compared the hand-written MARs to the MARs provided by the pharmacy to make sure all of Resident #2's medications were being administered. -She administered 1 puff of Fluticasone Furoate 100mcg to Resident #2 every morning. A second telephone interview with the SIC on 06/25/20 at 3:42pm revealed she knew how many puffs to administer to Resident #2 because it was on the prescription box label. Telephone interview with a medication aide (MA) on 06/25/20 at 3:42pm revealed Resident #2 had a prescription box that contained a Fluticasone Furoate 100mcg inhaler dispensed on 04/13/20 with the directions of inhale 1 puff by mouth daily. Telephone interview with the Administrator on	C 315	See page 12+13 for resolution of C 315. Addendum 07/21/20: MAR audits will be completed prior to the next month to ensure all orders are complete and on the MAR by the SIC/MA. Orders will be faxed to the pharmacy immediately upon receipt and a tracking sheet will be completed that includes the date the order was received, the date and time faxed to pharmacy and when the medication was delivered to the facility. Any medications that are not delivered to the facility within 36-48 hours the SIC and/or the Administrator will contact the pharmacy. If clarification is needed the PCP will be contacted immediately. The Administrator will complete quarterly MAR audits to ensure accuracy.	07/23/20

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C 315	Continued From page 14 06/25/20 at 4:39pm revealed: -The SIC was responsible for checking MARs with the orders and if there were any discrepancies the SIC should contact the pharmacy or PCP. -She did not know Resident #2's Fluticasone Furoate order was not complete. Telephone interview with Resident #2 on 06/30/20 at 9:48am revealed: -She sometimes got short of breath. -She was administered 2 puffs of her inhaler every day. Telephone interview with the SIC on 06/30/20 at 10:06am revealed: -Resident #2 did not receive 2 puffs of her inhaler. -The inhaler was only actuated once but Resident #2 inhaled twice. -She had told Resident #2 she only had to inhale once, but she always inhaled twice. Telephone interview with Resident #2's primary care provider (PCP) on 06/30/20 at 9:29am revealed. -Resident #2 came from another facility and she continued her previously ordered medications. -No one had contacted her about Resident #2's Fluticasone Furoate. -Fluticasone Furoate was prescribed as a daily puff medication. -She would expect the SIC to call her if orders were not clear. 2. Review of Resident #1's current FL-2 dated 03/31/20 revealed diagnoses included dementia with behaviors, chronic schizophrenia, bronchial asthma, Parkinson's and dyslipidemia.	C 315	Response to C315 on page 12+13	

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C 315	Continued From page 15 Review of Resident #1's Resident Register revealed she was admitted to the facility on 03/24/20. Review of Resident #1's Physicians Orders dated 03/31/20 revealed there was an order for Albuterol (a bronchodilator used to treat or prevent bronchospasms) as needed. Review of Resident #1's medication administration record (MAR) for April 2020 revealed: -There was a hand-written entry for albuterol inhaler take as needed. -There was no documentation albuterol was administered during April 2020. Review of Resident #1's MAR for May 2020 revealed albuterol was not transcribed to the MAR. Review of Resident #1's MAR for June 2020 revealed: -There was a hand-written entry for albuterol inhaler 90 mcg inhale two puffs every four hours as needed. -There was no documentation albuterol was administered during May 2020. Telephone interview with a representative from the facility's contracted pharmacy on 06/24/20 at 10:14am revealed there was not an active order for an albuterol inhaler for Resident #1 and there was no record of an albuterol inhaler for Resident #1. Telephone interview with Resident #1's primary care provider (PCP) on 06/30/20 at 9:29am revealed:	C 315	On 6/30/20 faxed + called PCP requesting ProAir order be sent to omnicare pharmacy. Clarification order was sent over on 6/30/2020 to clarify as to when to administer proair Inhaler. Contacted PCP on 7/16/20 because community had not received Inhaler as of that date. On 7/16/2020 omnicare Seent form to PCP stating insurance does not cover inhaler. PCP have not responded. Community Created a tracking order form on 6/30/20 a copy of order is attached and flagged to ensure order does not get overlooked. on 7/17/20 PCP. Nurse stated PCP has 10 days to respond. on 7/20/2020	

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C 315	Continued From page 16 -Resident #1 had not had any problems with shortness of breath that she was aware of. -Resident #1's current order for her albuterol inhaler was to inhale 2 puffs every 4-hours as needed. -Resident #1's albuterol inhaler was considered a rescue inhaler when she was asthmatic and having difficulty breathing. Telephone interview with the Supervisor-in-Charge/medication aide (SIC/MA) for review of Resident #1's medications on hand on 06/24/20 at 2:26pm revealed albuterol was not available to be administered. Telephone interview with the SIC/MA on 06/24/20 at 2:26pm revealed Resident #1 did not have an albuterol inhaler when she was admitted to the facility and she currently did not have one on the medication cart. A second telephone interview with the SIC on 06/25/20 at 1:25pm revealed: -Resident #1 had a prior order for an albuterol inhaler for "complaints of shortness of breath or wheezing"; the order was prior to the resident's admission to the facility and was in paperwork from the admitting hospital. -The albuterol was not on Resident #1's FL-2. -She faxed a request for an order for the albuterol inhaler for Resident #1 to the PCP on 03/31/20. -The PCP signed the order on 03/31/20 and the PCP should have sent the order to the pharmacy. -She was not aware the albuterol for Resident #1 was not on the medication cart. -She kept a log to monitor orders she had faxed to the PCP and any medication awaiting delivery from the pharmacy but the albuterol for Resident #1 must have "slipped by" her. -Resident #1 had not had any complaints of	C 315	Office visit was made by SIC. nurse stated orders would be faxed over.	

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C 315	Continued From page 17 shortness of breath or wheezing since she was admitted. Telephone Interview with the Administrator on 06/25/20 at 4:37pm revealed: -The SIC/MA was responsible for medication cart and MAR audits, but she was not familiar with the process the SIC/MA used for the audits. -When there was a question or a concern with an order for a resident the order was faxed to the PCP by the SIC/MA for clarification. -The pharmacy would not fill a medication order if the order was incomplete and would notify the PCP or the facility. -The PCP would resend the order to the pharmacy. -She was not aware Resident #1 did not have an albuterol inhaler available to be administered. -Resident #1 had not had breathing problems since she had been admitted. Based on interviews and record reviews it was determined Resident #1 was not interviewable.	C 315	See page 16 + 17 for respn Si	
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2 To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations	C 912	Addendum 07/21/20: Residents are being relocated that were not able to evacuate independently.	07/23/20

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C 912	Continued From page 18 related to Design and Construction. The findings are: Based on interviews and record reviews the facility failed to ensure that residents' evacuation capabilities were in accordance with the evacuation capability listed on the home's license for 2 of 3 sampled residents (#1 and #3) residing in the facility that had cognitive impairments and required assistance with ambulation which could prevent the resident from independently evacuating the facility. [Refer to Tag 0022 10A NCAC 13G .0302(b) Design and Construction (Type B Violation)].	C 912	See page 1 & 2 for response	