

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL011002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 12/17/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BECKY'S REST HOME 1</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>316 LOWER BUSH CREEK ROAD FLETCHER, NC 28732</b>
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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 000	Initial Comments  The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 12/15/21 through 12/17/21. The complaint investigation was initiated by the Buncombe County Department of Social Services on 11/16/21.	D 000		
D 030	<p>10A NCAC 13F .0302 (b) Design And Construction</p> <p>10A NCAC 13F .0302 Design And Construction</p> <p>(b) Each facility shall be planned, constructed, equipped and maintained to provide the services offered in the facility.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure two resident rooms and a common shower room were used to provide services to residents.</p> <p>The findings are:</p> <p>Interview with the Administrator on 12/15/21 at 9:00am revealed there were eight residents who lived in the facility.</p> <p>Interview with one resident on 12/15/21 at 9:35am revealed:</p> <ul style="list-style-type: none"> <li>-A personal care aide (PCA) who worked on night shift lived in a resident room in the facility.</li> <li>-The PCA used the staff bathroom.</li> <li>-The staff bathroom did not have a shower.</li> <li>-The PCA used the resident common shower for bathing.</li> <li>-The live-in staff ate their meals in their rooms.</li> </ul>	D 030		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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D 030	<p>Continued From page 1</p> <p>Interview with a second resident on 12/15/21 at 9:30am revealed: -The night shift PCA lived in vacant resident room #7. -The Cook lived in vacant resident room #5. -The Dishwasher lived in vacant resident room #5. -The staff who lived in the vacant resident rooms were all homeless. -The staff who lived in the vacant resident rooms used the resident's common shower rooms.</p> <p>Observation of the Cook on 12/16/21 at 9:20am revealed he unlocked resident room 5 and went inside.</p> <p>Observation of the night shift PCA on 12/16/21 at 9:27am revealed: -She ate breakfast in the dining room in building #2. -There was one resident in the dining room also eating breakfast.</p> <p>Interview with the night shift PCA on 12/16/21 at 9:28am revealed: -She worked full-time as a PCA. -She routinely worked as a PCA on night shift in building #1. -She had just gotten off work.</p> <p>Interview with the Administrator on 12/17/21 at 11:55am revealed: -There were three staff members who lived in the facility. -The staff did not have transportation to get to work. -She did not think it was a problem for staff to live in vacant resident rooms as she only had eight residents living there and the three live-in staff did</p>	D 030		

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D 030	Continued From page 2  not put her over licensed capacity of 15. -Two male staff lived in resident room #5. -One of the male staff worked full-time in the kitchen. -The other male staff worked part-time in the kitchen. -One female staff lived in resident room #7. -The female staff worked full-time as a PCA. -The staff rooms were kept locked. -Residents were not allowed to go into the staffs' rooms. -The staff used the staff bathrooms. -The live-in staff showered in the resident common shower room.  Interview with one of the male live-in staff on 12/17/21 at 1:35pm revealed: -He worked full-time at the facility in the kitchen. -He and another male employee lived in a vacant resident room. -He had lived at the facility since 11/20/21. -He was working with an outside organization to find another place to stay. -He was trying to find another place to live as quickly as possible.	D 030		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service  10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult 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:	D 296		

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D 296	<p>Continued From page 3</p> <p>Based on observations, interviews, and record reviews, the facility failed to have a therapeutic diet menu for 2 of 3 sampled residents (Resident's #1 and #2) with a diet order for regular pureed diet (#2) and a regular chopped meat diet (#1).</p> <p>The findings are:</p> <p>1. Review of Resident #2's current FL2 dated 04/19/21 revealed there was an order for regular pureed diet.</p> <p>Review of the facility's therapeutic diet list on 12/15/21 revealed Resident #2 was to be served a pureed diet.</p> <p>Review of the facility's regular menu revealed it was for Fall/Winter 2016 week 3.</p> <p>Review of the facility's therapeutic menus revealed there was no pureed diet therapeutic menu for the 2016 menu system.</p> <p>Interview with the Relief Cook on 12/15/21 at 11:56am revealed there were no therapeutic menus available for the pureed diet.</p> <p>Observation of Resident #2's lunch meal service on 12/15/21 at 12:59pm revealed:</p> <ul style="list-style-type: none"> <li>-The resident was served lunch in his room.</li> <li>-The resident received assistance with eating.</li> <li>-The resident received mixed vegetables with diced potatoes in the large section of the divided plate, red gelatin in one smaller section of the divided plate, regular cottage cheese in another small section of the divided plate, a small cup of milk and a half of a glass of tea.</li> </ul> <p>Observation of Resident #2's breakfast meal</p>	D 296		

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D 296	<p>Continued From page 4</p> <p>service on 12/16/21 at 8:50am revealed: -The resident was served breakfast in his room. -The resident received assistance with eating. -The resident received a small bowl of scrambled egg and milk mixture with small pieces of egg in it, a small bowl of grits, and a small bowl of applesauce.</p> <p>Interview with the Cook on 12/16/21 at 9:25am revealed there were no therapeutic menus available for the pureed diet.</p> <p>Observation in the kitchen on 12/17/21 at 1:25pm revealed the staff had found a 2014 complete menu system which included therapeutic menus and recipes.</p> <p>Refer to the interview with the Administrator on 12/17/21 at 10:30am.</p> <p>Refer to the interview with the Cook on 12/17/21 at 1:35pm.</p> <p>Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.</p> <p>2. Review of Resident #1's current FL2 dated 02/10/21 revealed: -Diagnoses included chronic hypoxic respiratory failure, dementia, and chronic pitting edema. -There was an order for a regular diet.</p> <p>Review of Resident #1's primary care provider's (PCP) order dated 08/09/21 revealed there was an order for a regular diet with chopped meat.</p> <p>Observation of Resident #1 on 12/15/21 at 9:30am revealed: -The resident was lying in bed.</p>	D 296		

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D 296	<p>Continued From page 5</p> <p>-There was a bedside table pulled up to the left side of the resident's bed.</p> <p>-There was a meal tray on the table.</p> <p>-There was a plate on the tray which contained one-half piece of toast with jelly and two whole sausage links.</p> <p>Review of the facility's therapeutic diet list on 12/15/21 revealed Resident #1 was to be served a regular chopped meat diet.</p> <p>Review of the facility's regular menu revealed it was for Fall/Winter 2016 week 3.</p> <p>Review of the facility's therapeutic menus revealed there was no chopped meat therapeutic menu for the 2016 menu system.</p> <p>Interview with the Relief Cook on 12/15/21 at 11:56am revealed there were no therapeutic menus available for a chopped meat diet.</p> <p>Observation in the kitchen on 12/17/21 at 1:25pm revealed the staff had found a 2014 complete menu system which included therapeutic menus and recipes.</p> <p>Refer to the interview with the Administrator on 12/17/21 at 10:30am.</p> <p>Refer to the interview with the Cook on 12/17/21 at 1:35pm.</p> <p>Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.</p> <p>_____</p> <p>Interview with the Administrator on 12/17/21 at 10:30am revealed:</p> <p>-The facility had a complete menu system which</p>	D 296		

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D 296	Continued From page 6  included menus and recipes for therapeutic diets. -Staff were looking for the menu system. -Staff did not tell her they did not have a therapeutic menu to go by for guidance.  Interview with the Cook on 12/17/21 at 1:35pm revealed: -He would get with the Administrator to get food supplies to match the 2014 menu system. -He would begin using the 2014 menu system as soon as possible.	D 296		
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: TYPE B VIOLATION  Based on observations, record reviews and interviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 3 sampled residents (Residents #1 and #2) with diet orders for a regular pureed diet (#2) and with regular chopped meat (#1).  The findings are:  1. Review of Resident #2's current FL2 dated	D 310		

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D 310	<p>Continued From page 7</p> <p>10/13/21 revealed: -Diagnoses included dementia, cognitive disorder not competent, impaired gait debility, diabetes type 1 managed as type 2, gastroesophageal reflux disease, chronic kidney disease stage 3, and coronary artery disease. - There was an order for a regular pureed diet.</p> <p>Review of the facility's therapeutic diet list on 12/15/21 revealed Resident #2 was to be served a pureed diet.</p> <p>Interview with the Relief Cook on 12/15/21 at 11:56am revealed: -The regular lunch menu called for Italian meat sauce, buttered spaghetti, winter mix vegetables, garlic bread, margarine, iced pound cake, beverage of choice. -He did not have therapeutic diet menus for guidance for the pureed diet.</p> <p>Observation of Resident #2's lunch meal service on 12/15/21 at 12:59pm revealed the resident received mixed vegetables with diced potatoes in the large section of the divided plate, red gelatin in one smaller section of the divided plate, regular cottage cheese in another small section of the divided plate, a small cup of milk and a half of a glass of tea.</p> <p>Interview with the medication aide (MA) who provided feeding assistance to Resident #2 on 12/15/21 at 1:00pm revealed: -The food processor in the kitchen broke "a month ago." -She told the Administrator the food processor was broken. -Staff "mashed up" Resident #2's food before feeding it to the resident. -The kitchen staff knew it was supposed to be</p>	D 310		



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D 310	<p>Continued From page 8</p> <p>pureed.</p> <p>-The staff who provided feeding assistance to the resident "chop and mash" as much as they could before feeding the resident the food.</p> <p>-The Administrator told staff to serve Resident #2 regular consistency scrambled eggs mixed with cheese that morning (12/15/21) for breakfast.</p> <p>-Staff put milk in the scrambled eggs and "squish them up good."</p> <p>-"Sometimes" Resident #2 "chokes" as exemplified by the resident would cough, then cough again, and then clear his throat.</p> <p>-Resident #2 did "okay" with thin liquids.</p> <p>-Resident #2 has eaten really soft scrambled eggs, cottage cheese, and pudding without a problem.</p> <p>Observation of the medication aide who provided feeding assistance to Resident #2 on 12/15/21 at 1:04pm revealed she removed the plate with the non-pureed food items and returned it to the kitchen.</p> <p>Interview with the Relief Cook on 12/15/21 at 1:05pm revealed</p> <p>-He would remake Resident #2's pureed plate if the food processor was not broken.</p> <p>-The kitchen staff had been using a blender since the food processor broke.</p> <p>-Kitchen staff told the Administrator the food processor was broken and the Administrator replaced it with a blender.</p> <p>-He had already disposed of the broth the mixed vegetables were prepared in, so the Administrator had gone to buy broth to enable him to puree food to the correct texture for Resident #2.</p> <p>-He had been told to give Resident #2 cottage cheese and scrambled eggs.</p> <p>-Resident #2 was served applesauce every day and the resident would no longer eat it.</p>	D 310		

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D 310	<p>Continued From page 9</p> <p>-He had been unable to locate the therapeutic diet menus for reference.</p> <p>-The Administrator had been unable to find the recipe book to match the menu to provide guidance on preparation of pureed diet menu items.</p> <p>Observation of the food processor used to modify meals for therapeutic diets on 12/15/21 at 1:14pm revealed the plastic cylinder bowl on the food processor was cracked.</p> <p>Observation in the kitchen on 12/15/21 at 1:15pm revealed there was a blender available for staff to use to prepare modified texture diets.</p> <p>Observation on 12/15/21 at 2:10pm revealed: -Resident #2 was served one 8 ounce sized bowl of pureed turkey sandwich and one 8 ounce sized bowl of pureed mixed vegetables, half glass of tea with a straw, small glass of milk with a straw, half glass of water with a straw. -Resident #2 consumed 80% of the meal without signs or symptoms of choking.</p> <p>Observation of Resident #2's breakfast meal service on 12/16/21 at 8:50am revealed the resident received a small bowl of scrambled egg and milk mixture with small pieces of egg in it, a small bowl of grits, and a small bowl of applesauce.</p> <p>Observation of Resident #2 on 12/16/21 at 8:59am revealed: -An MA provided assistance with eating. -The resident coughed after eating one bite of the egg mixture.</p> <p>Interview with the Cook on 12/16/21 at 9:00am revealed he could not puree Resident #2's eggs</p>	D 310		

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D 310	<p>Continued From page 10</p> <p>because he could not find the blade for the blender.</p> <p>Interview with the MA on 12/16/21 at 9:10am revealed: -He had crushed all of Resident #2's morning medications and put them in the resident's egg mixture he received for breakfast. -He had given the resident a "couple" more bites of the egg mixture. -He had used the spoon and "chopped up" the eggs as "best" he could.</p> <p>Observation of Resident #2 on 12/16/21 at 9:16am revealed the resident strongly coughed.</p> <p>Interview with the Cook on 12/16/21 at 9:25am revealed there were no therapeutic menus available for guidance on how to prepare the pureed diet foods.</p> <p>Telephone interview with Resident #2's Nurse Practitioner (NP) on 12/16/21 at 11:45am revealed: -Resident #2 has had swallowing issues. -She gave staff clarification to keep Resident #2's head of bed up. -She had referred a dietician to assess Resident #2's as soon as possible. -She has ordered a speech therapist to do a bedside swallowing evaluation to recommend the best diet for the resident. -The Administrator was good to reach out to her for direction. -Staff did not report Resident #2 had coughed after one bite scrambled eggs this morning (12/16/21). -She had been at the facility when staff were feeding Resident #2 and the resident did not choke.</p>	D 310		

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D 310	<p>Continued From page 11</p> <p>-She did not see a prior swallow study in Resident #2's records.</p> <p>-The facility should continue a pureed diet until the resident could be evaluated by the speech therapist.</p> <p>Refer to the interview with the Administrator on 12/17/21 at 10:30am.</p> <p>Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.</p> <p>2. Review of Resident #1's current FL2 dated 02/10/21 revealed: -Diagnoses included chronic hypoxic respiratory failure, dementia, and chronic pitting edema. -There was an order for a regular diet.</p> <p>Review of Resident #1's primary care provider's (PCP) order dated 08/09/21 revealed there was an order for a regular diet with chopped meat.</p> <p>Review of the facility's therapeutic diet list on 12/15/21 revealed Resident #1 was to be served a regular chopped meat diet.</p> <p>Observation of Resident #1 on 12/15/21 at 9:30am revealed: -The resident was lying in bed. -There was a bedside table pulled up to the left side of the resident's bed. -There was a meal tray on the table. -There was a plate on the tray which contained one-half piece of toast with jelly and two whole sausage links.</p> <p>Review of the Therapeutic Diet list posted in the facility kitchen dated December 2021 revealed an order for Resident #1 for a regular diet with</p>	D 310		

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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 310	<p>Continued From page 12</p> <p>chopped meat.</p> <p>Interview with the Cook on 12/16/21 at 9:25am revealed there were no therapeutic menus available for guidance on how to prepare the chopped meat diet foods.</p> <p>Interview with the Administrator on 12/17/21 at 10:33am revealed: -The Relief Cook had prepared breakfast for Resident #1 on the morning of 12/15/21. -She had told all of the kitchen staff to "cut up" the meats for Resident #1.</p> <p>Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.</p> <p>Refer to the interview with the Administrator on 12/17/21 at 10:30am.</p> <p>_____ Interview with the Administrator on 12/17/21 at 10:30am revealed: -The floor staff were supposed to return any modified consistency food items that were not the correct consistency to the kitchen. -The facility had a complete menu system which included menus and recipes for therapeutic diets. -Staff were looking for the menu system. -Staff did not tell her they did not have a therapeutic menu to go by for guidance in preparing the modified consistency diets.</p> <p>_____ The facility failed to properly prepare the ordered pureed diet for Resident #2 which caused the resident to cough during the breakfast meal service on 12/16/21 and increased the resident's risk of aspiration pneumonia. This failure was detrimental to the health, safety, and welfare of Resident #2 and constitutes a Type B Violation.</p>	D 310		

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D 310	Continued From page 13  The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/21.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2022.	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 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 ensure orders were clarified for 1 of 3 sampled residents related to oxygen administration (#1).  The findings are:  Review of Resident #1's current FL2 dated 02/10/21 revealed: -Diagnoses included chronic hypoxic respiratory failure, dementia, and chronic pitting edema.	D 344		

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D 344	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>-There was an order for oxygen 2-5 liters per minute via nasal cannula as needed titrate for comfort.</li> <li>-There was an order for oxygen saturation (refers to how much oxygen is carried by the hemoglobin in your blood) to be checked monthly.</li> </ul> <p>Review of Resident #1's Care Plan dated 05/11/21 revealed:</p> <ul style="list-style-type: none"> <li>-Oxygen 2-3 liters per minute continuous via nasal cannula.</li> <li>-The resident was always disoriented with significant memory loss.</li> </ul> <p>Review of Resident #1's primary care provider (PCP) orders dated 08/09/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for oxygen 2-5 liters per minute via nasal cannula as needed titrate for comfort.</li> <li>-There was an order to check oxygen saturations weekly.</li> </ul> <p>Observation of Resident #1 on 12/15/21 at 9:30am revealed:</p> <ul style="list-style-type: none"> <li>-The resident was lying in bed wearing a nasal cannula with continuous oxygen.</li> <li>-There was an oxygen concentrator on the floor at the foot of the resident's bed.</li> <li>-The oxygen was set at 4.5 liters per minute.</li> </ul> <p>Interview with a medication aide (MA) on 12/15/21 at 11:39am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had a range order for her oxygen for 2-5 liters per minute as needed.</li> <li>-The Administrator told staff to turn up the oxygen when she checked Resident #1's oxygen saturation and it was "low."</li> </ul> <p>Interview with a MA on 12/15/21 at 4:58pm revealed:</p>	D 344		

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D 344	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>-Resident #1's oxygen order from August had not yet been clarified.</li> <li>-She had been instructed by the Administrator to check Resident #1's oxygen saturation "once or twice a day."</li> <li>-If Resident #1's oxygen saturation was below 90%, she was to turn the oxygen up to 4 liters per minute.</li> <li>-Resident #1's oxygen was "normally" set on 2 liters per minute continuous.</li> <li>-The lowest oxygen saturation she had ever had with Resident #1 was 92-93%.</li> <li>-The MAs and the Administrator were responsible for clarifying orders with the PCP.</li> </ul> <p>According to the National Institute of Health, an oxygen saturation level of 96-100% is considered normal.</p> <p>Interview with a second MA on 12/17/21 at 9:20am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's had been disoriented at 7:00am.</li> <li>-The resident had removed the oxygen.</li> <li>-The MA checked the resident's oxygen saturation and it was 85%.</li> <li>-The nasal cannula was put back on Resident #1.</li> <li>-The oxygen was set to 5 liters per minute.</li> </ul> <p>Second interview with the MA on 12/17/21 at 10:25am revealed:</p> <ul style="list-style-type: none"> <li>-The MA had rechecked Resident #1's oxygen saturation and it was 96%.</li> <li>-The oxygen was turned down to 4 liters per minute.</li> </ul> <p>Interview with the Administrator on 12/17/21 at 10:30am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's oxygen order dated 08/09/21 had not yet been clarified.</li> <li>-She had notified hospice on 12/15/21 the order</li> </ul>	D 344		



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D 344	<p>Continued From page 16</p> <p>needed to be clarified.</p> <ul style="list-style-type: none"> <li>-Hospice had not yet clarified the order, however the hospice Registered Nurse (RN) told her they planned to visit Resident #1 "today" (12/17/21).</li> <li>-Staff were going by the 2-5 liters per minute oxygen range.</li> <li>-Staff knew to "up" the oxygen if they got a low oxygen saturation level.</li> <li>-Staff knew they could call the hospice RN if they had any questions about managing Resident #1's oxygen liters per minute.</li> <li>-The staff were not required to document communications with hospice when seeking information on how to care for Resident #1.</li> <li>-Staff knew they could come to her if they had questions on how to care for Resident #1's oxygen levels.</li> <li>-The staff had always just checked Resident #1's oxygen saturation in the morning and throughout the day.</li> <li>-"We just go by what Hospice tells us to do."</li> <li>-She was available to staff 24 hours a day 7 days a week.</li> </ul> <p>Telephone interview with Resident #1's Hospice RN on 12/17/21 at 8:30am revealed:</p> <ul style="list-style-type: none"> <li>-She was Resident #1's Hospice RN and she saw Resident #1 "every other week."</li> <li>-The resident was under Hospice care for respiratory failure.</li> <li>-Resident #1 had actually been on 4-5 liters per minute flow of oxygen "for a while now."</li> <li>-The resident would remove the oxygen and it would take "a lot" to get the resident's oxygen saturation back up.</li> <li>-The order for weekly oxygen saturations must have been an order from the resident's PCP, because Hospice did not order oxygen saturation checks unless there was a need to check it.</li> <li>-The order to titrate oxygen for comfort was a</li> </ul>	D 344		

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D 344	Continued From page 17  "normal" order for any Hospice patient.  Interview with another Hospice RN on 12/17/21 at 11:25am revealed: -She was visiting Resident #1. -She did not usually see an oxygen titration order in assisted living facilities. -She would clarify the oxygen order for Resident #1 during her visit.  Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 344		
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: Based on observations, interviews, and record reviews, the facility failed to have prescription medications available for 1 of 3 sampled residents (#1) related to not having a supply of an as needed medication to treat insomnia, expired medications used to treat pain, expired medications to treat excess secretions.  The findings are:  Review of Resident #1's current FL2 dated	D 358		

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D 358	<p>Continued From page 18</p> <p>02/10/21 revealed diagnoses included chronic hypoxic respiratory failure, dementia, and chronic pitting edema.</p> <p>1. Review of Resident #1's primary care provider's (PCP) order dated 08/09/21 revealed there was an order for trazodone (used to treat insomnia) 50mg take one-half tablet (25mg) at bedtime as needed for insomnia.</p> <p>Observation of Resident #1's medications on hand on 12/16/21 at 12:06pm revealed there was no trazodone available.</p> <p>Review of Resident #1's October 2021 electronic Medication Administration Records (eMAR) revealed: -There was an entry for trazodone 50mg one-half tablet at bedtime as needed for insomnia. -There were no documented administrations of the trazodone from 10/01/21 to 10/31/21.</p> <p>Review of Resident #1's November 2021 eMAR revealed: -There was an entry for trazodone 50mg one-half tablet at bedtime as needed for insomnia. -There were no documented administrations of the trazodone from 11/01/21 to 11/30/21.</p> <p>Review of Resident #1's December 2021 eMAR revealed: -There was an entry for trazodone 50mg one-half tablet at bedtime as needed for insomnia. -There were no documented administrations of the trazodone from 12/01/21 to 12/15/21.</p> <p>Telephone interview with the facility's contracted pharmacy representative on 12/17/21 at 8:55am revealed: -They had an active order for Resident #1 for</p>	D 358		

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D 358	<p>Continued From page 19</p> <p>trazodone 50mg one-half tablet at bedtime as needed for insomnia dated 05/27/21. -They had dispensed a bubble card of 14 tablets or 28 doses on 05/23/21.</p> <p>Telephone interview with Resident #1's Hospice Registered Nurse (RN) on 12/17/21 at 8:30am revealed: -The trazodone was still an active as needed order in case the resident needed it. -The trazodone had been a scheduled order at one time; however, it made the resident very sleepy and the order was changed to as needed.</p> <p>Interview with the Administrator on 12/17/21 at 10:30am revealed: -She was not aware Resident #1 did not have any trazodone available. -There was one medication aide assigned to check the availability of all the resident's medication in the facility monthly. -She did not "stand over" the MA when she checked the medication availability for all the residents. -The MA was supposed to ensure all residents' medications were on the cart and none of the medications were expired.</p> <p>Interview with an MA on 12/17/21 at 1:09pm revealed: -She was responsible for monthly cart audits in the facility. -She did not check the availability of as needed medications during the monthly cart audits. -Medications which were ordered to be administered as needed were reordered by the MA when a new supply of the medication was needed or when the medications were about to expire.</p>	D 358		

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D 358	<p>Continued From page 20</p> <p>Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.</p> <p>2. Review of Resident #1's primary care provider's (PCP) order dated 08/09/21 revealed there was an order for morphine sulfate (used to treat pain and dyspnea) 100mg/5ml solution 0.25ml every four hours as needed for pain or dyspnea (difficult or labored breathing).</p> <p>Interview with a medication aide (MA) on 12/15/21 at 11:39am revealed: -Resident #1 had morphine ordered for pain or difficulty with breathing. -The morphine was not stored in the medication cart. -She would have to notify the Administrator if Resident #1 needed a dose of morphine.</p> <p>Observation of Resident #1's medication on hand on 12/15/21 at 11:40am revealed there was no morphine sulfate available.</p> <p>Review of Resident #1's October 2021 electronic Medication Administration Records (eMAR) revealed: -There was an entry for morphine sulfate 100mg/5ml give 0.25mg every four hours as needed for pain or dyspnea. -There was no documented administration of the morphine sulfate from 10/01/21 to 10/31/21.</p> <p>Review of Resident #1's November 2021 eMAR revealed: -There was an entry for morphine sulfate 100mg/5ml give 0.25mg every four hours as needed for pain or dyspnea. -There was no documented administration of the morphine sulfate from 11/01/21 to 11/30/21.</p>	D 358		

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D 358	<p>Continued From page 21</p> <p>Review of Resident #1's December 2021 eMAR revealed:                      -There was an entry for morphine sulfate 100mg/5ml give 0.25mg every four hours as needed for pain or dyspnea.                      -There was no documented administration of the morphine sulfate from 12/01/21 to 12/16/21.</p> <p>Interview with the Administrator on 12/15/21 at 5:21pm revealed:                      -Resident #1's morphine was not stored in the medication cart.                      -The morphine was stored in a fireproof cabinet in the business office.                      -The business office door was kept locked and the fireproof cabinet was kept locked.                      -There were certain MAs which had keys to the fireproof cabinet.                      -She and the Business Office Manager were the only staff who had a key to the business office.                      -Resident #1 did not ever need the morphine.                      -The MAs knew to come to her if Resident #1 needed the morphine.                      -She was available in the facility 24 hours a day 7 days a week.</p> <p>Observation of Resident #1's morphine in the fireproof cabinet in the business office on 12/15/21 at 5:45pm revealed:                      -There were four clear plastic bags with syringes inside.                      -Each bag was labeled with a pharmacy label with Resident #1's name, morphine sulfate 100mg/5ml, and directions to give 0.25ml (5mg) every four hours as needed for pain or dyspnea with an expiration date of 12/10/21.                      -The first bag contained 9 syringes with a white paper label preprinted with morphine sulfate 20mg/ml 0.25ml=5mg and an expiration date of</p>	D 358		

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D 358	<p>Continued From page 22</p> <p>01/22.</p> <p>-The second bag contained 10 syringes with a white paper label preprinted with morphine sulfate 20mg/ml 0.25ml=5mg and an expiration date of 01/22.</p> <p>-The third bag contained 10 syringes with a white paper label preprinted with morphine sulfate 20mg/ml 0.25ml=5mg and an expiration date of 01/22.</p> <p>-The fourth bag contained 10 syringes with a white paper label preprinted with morphine sulfate 20mg/ml 0.25ml=5mg and an expiration date of 01/22.</p> <p>-There was one loose syringe in the drawer with Resident #1's morphine sulfate supplies.</p> <p>-The syringe had a white paper label preprinted with morphine sulfate 20mg/ml 0.25ml=5mg and an expiration date of 01/22, but there was no name on the syringe as to which resident it was prescribed for or administration instructions.</p> <p>Telephone interview with the contracted facility pharmacy representative on 12/17/21 at 8:55am revealed:</p> <p>-The current order for Resident #1's morphine sulfate 100mg/5ml give 0.25ml every 4 hours as needed for pain or dyspnea was dated 12/10/20.</p> <p>-The pharmacy dispensed 40 doses of morphine sulfate for the resident on 12/10/20.</p> <p>-The pharmacy had not dispensed any other doses of morphine sulfate for the resident.</p> <p>-According to the pharmacy's records, the resident had not been administered morphine sulfate in the last six months.</p> <p>Telephone interview with Resident #1's Hospice Registered Nurse (RN) on 12/17/21 at 8:30am revealed:</p> <p>-She made visits to see Resident #1 "every other week."</p>	D 358		

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D 358	<p>Continued From page 23</p> <p>-There had been only one instance where staff had called her to let her know Resident #1 was having difficulty breathing.</p> <p>-She had asked staff to administer morphine sulfate to the resident.</p> <p>-It had only happened one time since August 2021.</p> <p>Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.</p> <p>3. Review of Resident #1's primary care provider's (PCP) order dated 08/09/21 revealed there was an order for hyoscyamine (used to treat secretions) 0.125mg 1 tablet under tongue every 4 hours as needed for secretions.</p> <p>Observation of Resident #1's medications on hand on 12/16/21 at 11:48am revealed:</p> <p>-There one bubble pack of hyoscyamine 0.125mg tablets with 44 tablets remaining of 45 tablets dispensed on 12/20/20.</p> <p>-The hyoscyamine had an expiration date of 12/10/21.</p> <p>Interview with the medication aide on 12/16/21 at 12:00pm revealed the hyoscyamine expired 5 or 6 days ago.</p> <p>Review of Resident #1's October 2021 electronic Medication Administration Records (eMAR) revealed:</p> <p>-There was an entry for hyoscamine 0.125mg 1 tablet every four hours as needed for secretions.</p> <p>-There was no documented administration of the hyoscamine from 10/01/21 to 10/31/21.</p> <p>Review of Resident #1's November 2021 eMAR revealed:</p>	D 358		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL011002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 12/17/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BECKY'S REST HOME 1</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>316 LOWER BUSH CREEK ROAD FLETCHER, NC 28732</b>
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D 358	<p>Continued From page 24</p> <p>-There was an entry for hyoscamine 0.125mg 1 tablet every four hours as needed for secretions. -There was no documented administration of the hyoscamine from 11/01/21 to 11/30/21.</p> <p>Review of Resident #1's December 2021 eMAR revealed: -There was an entry for hyoscamine 0.125mg 1 tablet every four hours as needed for secretions. -There was no documented administration of the hyoscamine from 12/01/21 to 12/16/21.</p> <p>Telephone interview with the facility's contracted pharmacy representative on 12/17/21 at 8:55am revealed: -The last order for hyoscyamine 0.125mg 1 tablet every four hours as needed for secretions dated 12/10/20. -They dispensed 45 hyoscyamine tablets on 12/10/20. -They had not dispensed any more hyoscyamine for Resident #1 since 12/10/20.</p> <p>Interview with the Administrator on 12/17/21 at 10:30am revealed: -She was not aware Resident #1 did not have any hyoscyamine available. -There was one medication aide assigned to check the availability of all the resident's medication in the facility monthly. -She did not "stand over" the MA when she checked the medication availability for all the residents. -The MA was supposed to ensure all resident's medications were on the cart and none of the medications were expired.</p> <p>Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.</p>	D 358		

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D 612	<p>10A NCAC 13F .1801 (c) Infection Prevention &amp; Control Program (temp)</p> <p>10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related appropriate use of personal protective equipment (PPE) surgical face masks by staff to reduce the risk of transmission and infection.</p> <p>The findings are:</p> <p>Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in long term care (LTC) facilities, updated 09/10/21, revealed:</p>	D 612		

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NAME OF PROVIDER OR SUPPLIER  <b>BECKY'S REST HOME 1</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>316 LOWER BUSH CREEK ROAD</b> <b>FLETCHER, NC 28732</b>
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D 612	<p>Continued From page 26</p> <ul style="list-style-type: none"> <li>-Healthcare personnel should wear well-fitting facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.</li> <li>-Healthcare personnel should wear facemasks when they are in areas of the healthcare facility where they could encounter patients (e.g., dining areas, common halls/corridors).</li> <li>-The CDC recommends use of facemasks recommended by OSHA.</li> <li>-OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared."</li> <li>-FDA-cleared surgical masks are designed to protect against splashes and sprays.</li> </ul> <p>Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities updated 11/19/21 revealed facilities should adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure.</p> <p>Review of the facility's personal protective equipment (PPE) policy dated revealed:</p> <ul style="list-style-type: none"> <li>-It is the facility's responsibility to provide appropriate PPE for staff.</li> <li>-The type of PPE used will vary based on the level of precautions required.</li> <li>-A surgical mask should be used for droplet precautions.</li> </ul> <p>Observation of a medication aide (MA) on 12/15/21 at 10:35am revealed:</p> <ul style="list-style-type: none"> <li>-The MA went into a resident room to deliver a food snack and beverage to a resident.</li> <li>-The MA was wearing a loose-fitting cloth mask over her nose and mouth.</li> </ul>	D 612		

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D 612	<p>Continued From page 27</p> <p>Observation in the facility kitchen on 12/15/21 at 11:59am revealed the Relief Cook wore a cloth mask over his nose and mouth.</p> <p>Observation of the medication cart on 12/15/21 at 12:20pm revealed there was a box of disposable face masks available on the cart.</p> <p>Interview with the Relief Cook on 12/17/21 at 9:20am revealed: -He could not wear the recommended surgical masks. -Particles of the lining of the surgical masks broke loose and he breathed in the particles causing him to have problems with his allergies. -His cloth mask had 3 layers of fabric and a filter. -He did not launder the cloth mask. -He sprayed the mask with a disinfectant solution after each shift and allowed it to air dry.</p> <p>Interview with the Administrator on 12/17/21 at 11:55am revealed: -Disposable surgical facemasks had been made available for staff use on the medication cart. -All staff were required to wear facemasks. -She had not specified staff were required to wear surgical facemasks. -She was unaware the CDC had specified surgical facemasks be worn in healthcare settings. -The facility had "plenty" facemasks, "some" of the staff chose to wear cloth facemasks.</p>	D 612		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with</p>	D912		

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D912	<p>Continued From page 28</p> <p>relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations as related to therapeutic diets.</p> <p>The findings are:</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 3 sampled residents (Residents #1 and #2) with diet orders for a regular pureed diet (#2) and with regular chopped meat (#1). [Refer to Tag 310 10A NCAC 13F .0904(e4) Nutrition and Food Service (Type B Violation)].</p>	D912		