STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026062	A. BUILDING: _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND VILLAGE ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on 02/15/23 to 02/17/23.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, observations and record reviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 1 of 5 sampled residents (#2) who had history of smoking while using his oxygen. The findings are: Review of the facility's Use of Tobacco Policy (not dated) revealed: -Residents who smoked would be required to use designated smoking areas. -Staff would supervise residents who smoke as needed. -Residents who were found to be unsafe with smoking materials would be not be allowed to keep their smoking materials in their possession. Review of Resident #2's FL-2 dated 03/04/22 revealed:	D 270		

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Diagnoses included chronic obstructive pulmonary disease (COPD), depression, post traumatic syndrome disorder, chronic pain syndrome, anxiety, and hyperlipidemia.
-He was semi ambulatory and used a rollator as an assistive device.
-His orientation was intermittent.

Review of Resident #2's care plan dated 04/20/22 revealed he needed limited assistance with ambulation.

Review of a physician order dated 09/22/22 revealed there was a written order for two-liter of oxygen via nasal cannula as needed (PRN) for shortness of breathe.

Review of Resident #2's care notes dated 12/17/22 at 1:25pm revealed:
-Resident #2 was "caught smoking" with his oxygen.
-The Administrator and Resident Care Coordinator (RCC) and Hospice provider were notified.
-Resident #2 had been redirected several times of the danger of smoking with his oxygen tank on his walker.

Review of Resident #2's care notes dated 12/17/22 at 1:58pm revealed the hospice nurse returned the phone call and stated the Physician would be contacted to develop a plan to prevent Resident #2 from smoking with his oxygen on his rollator.

Review of Resident #2's care notes dated 12/17/22 revealed:
-The physician visited Resident #2 at the facility.
-The physician gave orders to have to remove the oxygen while Resident #2 smoked.

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D 270	Continued From page 2 -Resident #2 verbalized he thought the oxygen shut off when the nasal cannula was removed. -Resident #2 was educated about the dangers of smoking with his oxygen on his rollator. Observation of Resident #2's room on 02/15/23 at 10:26am revealed: -Resident #2 was lying in bed using oxygen via a nasal cannula from a concentrator. -There was an oxygen tank housed in a bag attached to a rollator. Observations of Resident #2 on 02/16/23 at 4:25pm revealed: -Resident #2 was seated on a rollator walker in the smoking area outside the dining room area. -There was an oxygen cylinder attached to the back of the rollator walker. -There was another male resident smoking a cigarette and seated in a wheelchair approximately three feet in front of Resident #2. -There was no staff present in the smoking area. The Administrator was immediately contacted to come to the smoking area. Upon returning to the smoking area with the Administrator, Resident #2 was not in the smoking area. Interview with the Administrator on 02/16/23 at 4:30pm revealed: -Resident #2 smoked cigarettes. -The resident did not sit in the smoking area. -Resident #2 would sit by an exit door alone when he smoked. -Resident #2 did not smoke with the oxygen on. Interview with Resident #2 on 02/17/23 at 11:17am revealed: -He had smoked this morning after breakfast. -He usually smoked 1 to 2 cigarettes at a time at	D 270		

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least 2 to 3 times a daily.
-He only smoked in the designated area in the courtyard.
-He did have his oxygen tank attached to his rollator when he was outside smoking.
-He used his rollator as a seat when he smoked.
-He had not been asked to take his oxygen off his rollator and leave it inside the facility while he smoked.
-Staff had been outside in the courtyard monitoring the residents.
-Other residents who smoked tried to remain at least 6 feet away from him while he smoked.
-It was hard trying to keep the other residents at a distance when he smoked was hard because he was friends with some of the residents.
-Staff had not redirected the other residents who came up to him while he smoked.
-His oxygen would shut off automatically when he removed the nasal cannula.
-He knew the danger of smoking with his oxygen connected to his rollator.

Observation of Resident #2 on 02/17/23 at 1:17pm revealed:
-Resident #2 was seated on his rollator in the smoking area near the door.
-The oxygen tank was in a carrying bag hanging from Resident #2's rollator.
-Resident #2 was smoking a cigarette.
-There was another resident staying less than 6 feet away from Resident #2.
-The oxygen tank was not turned off.
-Resident #2 was not wearing the nasal cannual.
-Staff was not present to monitor the smoking area.

Interview with a Personal Care Aide (PCA) on 02/17/23 at 11:15am revealed:
-She had seen Resident #2 smoking outside the

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facility with the oxygen on.
-Resident #2 kept his cigarettes and cigarette lighter.
-It had been "a while ago" since she last saw Resident #2 outside smoking with the oxygen on.
-When she saw Resident #2 smoking with the oxygen on, she would remove the oxygen from Resident #2 and take the oxygen inside the facility.
-She would tell Resident #2 to come get the oxygen after he finished smoking.
-When she last saw Resident #2 smoking with the oxygen on, she notified the medication aide (MA).
-When she told the Administrator that Resident #2 smoked with the oxygen on (no date provided), the Administrator went out and removed the oxygen.

Interview with a MA on 02/17/23 at 1:37pm revealed:
-Resident #2 was a heavy smoker who smoked daily.
-She had talked to Resident #2 on several occasions about smoking with his oxygen tank attached to his rollator.
-She saw the resident smoking one day about one month ago with the oxygen cannula around his neck and the resident had a lit cigarette.
-She reported to the Administrator, RCC and the hospice provider that Resident #2 continued to smoke with his oxygen.
-She also told the RCC about Resident #2's smoking behaviors.
-She documented her observations in Resident #2's care notes and response to the resident's smoking behaviors.
-She would not always document when Resident #2 was observed smoking in the courtyard with his oxygen but she had checked to ensure the

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oxygen was turned off.
-Resident #2 did not have increased supervision while he smoked.
-She would "glance and look" in the smoking area when she passed by that area.
-Resident #2 would at times sit away from the other residents who smoked.
-She did not know if the oxygen was shut off when Resident #2 removed the nasal cannula.
-Resident #2 have been advised by staff and the home health agency about smoking with the oxygen tank present.

Interview with the RCC on 02/17/23 at 1:19 revealed:
-Resident #2 had refused to allow staff to remove the oxygen when he smoked.
-The nasal cannual shut off when Resident #2 removed it from his nose.
-Resident #2 was allowed to keep his smoking materials.
-Staff were to monitor the smoking area when residents were present.

Interview with the Primary Care Provider (PCP) on 02/17/23 at 11:51am revealed:
-Resident #2 was a chronic smoker.
-Resident #2 had continued to smoke even though the resident had COPD.
-Resident #2 has been told he was to turn the oxygen off and leave it in his room when he went outside to smoke.
-She did not have any knowledge of Resident #2 being outside in the smoking area with the oxygen.
-She thought the oxygen was "comfort" for the resident.
-Resident #2 could walk the length of the hallway without the oxygen.
-The facility was responsible to complete smoking

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D 270	Continued From page 6 assessments. -If Resident #2 was being non-compliant, the resident needed to be supervised and redirected. -She thought it would be a good idea for the facility to keep the resident's smoking materials if the resident was being non-compliant. -The resident could get burned or burn others if smoking with oxygen on. -If the oxygen tank blew up, it would "cover a good amount of space". Telephone interview with the Hospice Nurse dated 02/17/23 at 11:37am revealed: -Resident #2 was a chronic smoker. -She had informed Resident #2 to turn off his oxygen and leave it in the room when he went outside to smoke. -Resident #2 was able to walk to and from his room to the smoking area without the use of the oxygen. -She had been contacted by staff due to concerns of Resident #2 smoking with his oxygen (did not provide a date). -Resident #2 had been taught about the dangers of smoking with his oxygen. -She had not completed a smoking assessment training but had completed a smoking cessation with Resident #2.. -The oxygen did not shut off once the nasal cannula was removed. -She was not sure if staff had increased supervision for Resident #2 to monitor him while he smoked. -There was an order requesting Resident #2 to leave his oxygen in his room when he went to out smoke after being notified of his noncompliance. -There was a concern if Resident #2 continued to smoke with his oxygen attached to his rollator, he risked of an explosion causing harm to himself and/or other residents.	D 270		

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D 270	Continued From page 7 Telephone interview with a representative with the facility's oxygen supply company on 02/17/23 at 3:31pm revealed: -Resident #2 had an oxygen tank, regular, and a concentrator. -He had a nasal cannula and a mask. -The tank had a valve that turned off and on. -The nasal cannula shut off when removed. Interview with the Administrator on 02/17/23 at 3:39pm revealed: -The residents' PCP assessed the residents to determine if they were unsafe to smoke or have smoking materials. -She had not completed a smoking assessment for Resident #2. -The facility had a smoking policy but she was not familiar with the facility's smoking policy. -The staff had been trained on how to redirect the residents when they were noncompliant with the smoking policy and confiscating smoking materials. -The MAs and PCAs were to report residents who were noncompliant to the RCC. -It had never been reported to her that Resident #2 smoked with oxygen on, and if it had been reported to her, she would cut the oxygen off, counsel the resident, and notify the physician. -Resident #2 did not have an order to increased supervision to monitor his smoking. -She would get an order from the physician for increased supervision. -She notified the PCP about Resident #2 being in the smoking area with oxygen yesterday. -The PCP did not give any directions. -Resident #2 smoking in the courtyard with his oxygen placed himself and other residents at danger if the oxygen tank exploded. -She expected the staff to monitor all residents	D 270		

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D 270	Continued From page 8 while in the smoking area. _____ The facility failed to provide supervision for 1 of 5 sampled residents (#2) who smoked while having their oxygen attached to their rollator which resulted in substantial risk of serious phyiscial harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection on 02/17/23 in accordance with G.S. 131D-34 for this citation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 19, 2023.	D 270		
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 administer medications as ordered and in accordance with the facility's policies for 2 of 4 residents (#6, #7) observed during the medication passes including errors with a medication for hypertension (#6) and a medication for chronic obstructive pulmonary disease and /or asthma (#7).	D 358		

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D 358	Continued From page 9 The findings are: The medication error rate was 6% as evidenced by the observation of 2 errors out of 29 opportunities during the 8am and 10am medication passes on 02/16/23. a. Review of Resident #6's current FL-2 dated 06/03/22 revealed: -Diagnoses included hypertension, cerebrovascular accident, left sided weakness, hyperlipidemia, fall risk, unsteady gait, incontinence, and Vitamin D deficiency. -There was an order for Amlodipine 5mg take 1/2 tablet (2.5mg) by mouth daily. (Amlodipine is used to treat hypertension). Observation of the 8:00am medication pass on 02/16/23 revealed: -The medication aide (MA) prepared and administered 1 whole tablet of Amlodipine 5mg to Resident #6 at 8:24am. -The resident was administered Amlodipine 5mg instead of 2.5mg as ordered. Review of Resident #6's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Amlodipine 5mg take ½ tablet by mouth daily scheduled for 8:00am. -Amlodipine 5mg ½ tablet was documented as administered from 02/01/23 - 02/15/23. Observation of Resident #6's medications on hand on 02/16/23 at 12:51pm revealed: -There was a bottle of Amlodipine 5mg tablets dispensed on 12/26/22 dispensed by an outside pharmacy provider. -The instructions on the medication label were to	D 358		

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D 358	Continued From page 10 administer 1/2 tablet by mouth every day. Interview with the MA on 02/16/23 at 12:51pm revealed: -She normally administered 1/2 tablet of Amlodipine 5mg to Resident #6. -She realized she had given a whole tablet after Resident #6 asked why she was getting a whole tablet instead of a 1/2 tablet. -She did not read the order on the eMAR or medication label prior to administering. - She reported the medication error to Resident #6's primary care provider (PCP) who gave an order to check the resident's blood pressure. -The resident's blood pressure was 122/75 and her pulse was 70 at 9:30am. -Resident #6 denied symptoms of low blood pressure. Interview with the Resident Care Coordinator (RCC) on 02/16/23 at 1:24pm revealed: - The MA reported the error to with Resident#6's Amlodipine to her and the PCP was notified and ordered the resident's blood pressure to be checked. -The MAs should compare the medication to be administered with the medication label and eMAR. -Medications should be administered as ordered by the MA. -It could lower the resident's blood pressure if she received too much Amlodipine. Interview with the Administrator on 02/16/23 at 1:38pm revealed: -The MAs were expected to read the eMARs and compare with the medication labels. -The MAs should administer medications as	D 358		

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ordered.
-Receiving too much Amlodipine could have caused the resident's blood pressure to get too low.

Interview with Resident #6 on 02/16/23 at 12:33pm revealed:
-She usually received a half of the "small pill" every morning.
-She felt fine and denied dizziness or light headedness.

Interview with Resident #6's PCP on 02/17/23 at 11:38am revealed:
-The facility notified her that Resident #6 had received a double dose of Amlodipine on 02/16/23.
-She sent an order for the resident's blood pressure to be checked and it was normal.
-Resident #6's Amlodipine should be administered as ordered.
-Receiving too much Amlodipine could cause low blood pressure.

b. Review of Resident #7's current FL-2 dated 07/22/22 revealed:
-Diagnoses of right cerebrovascular accident, atrial fibrillation, chronic renal disease, congestive heart failure and cardiomyopathy.
-There was an order for Symbicort AER 80-4.5 mcg Inhale 2 puffs by mouth twice per day. (Symbicort is used to treat chronic obstructive pulmonary disease and/or asthma).

Review of Resident #7's physician's orders dated 01/18/23 revealed an order for Symbicort 80-4.5 inhale 2 puffs by mouth twice daily, rinse mouth after use.

Observation of the 10:00am medication pass on

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02/16/23 revealed:
-Resident #7 came to the medication cart.
-The medication aide (MA) shook the Symbicort inhaler and handed it to the resident.
-The MA did not instruct Resident #7 on how to use the inhaler.
-Resident #7 took two quick puffs in a row from the inhaler.
-Resident #7 did not inhale the medication and the medication vapors came back out of the resident's mouth.
-The MA did not instruct Resident #7 to exhale first then inhale as she was pressing down on the Inhaler.
-The MA did not instruct Resident #7 to hold her breath for 8-10 seconds after each puff.
-The MA did not instruct Resident #7 to wait at least 1 minute between puffs. (According to Guidelines for the Medication Administration Clinical Skills Checklist, waiting at least 1 minute between puffs may permit additional puffs to penetrate the lungs better).

Review of Resident #7's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort 80-4.5 Inhaler dispensed on 01/04/23.
-The instructions on the medication label were to administer 2 puffs by mouth twice a day, rinse mouth after use.

Interview with the MA on 02/16/23 at 1:05pm revealed:
-Resident #7 preferred to hold the Symbicort inhaler.
-Resident #7 took 2 puffs from the inhaler.
-She did not instruct Resident #7 on the proper use of the inhaler today, 02/16/23.
-Resident #7 had been instructed in the past on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND VILLAGE ASSISTED LIVING	1124 CEDAR CREEK ROAD FAYETTEVILLE, NC 28301

(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 358	Continued From page 13	D 358		

proper use of the inhaler.
-It had been a while since she had instructed Resident #7 on the proper use of her inhaler.
-She had never seen Resident #7 use her inhaler correctly.
-She told the primary care provider that Resident #7 preferred to hold her own inhaler.
-She sometimes saw the medication vapors come out of the resident's mouth when she used the inhaler.

Interview with Resident #7 on 02/16/23 at 1:00pm revealed:
-She preferred to hold the Symbicort inhaler herself.
-She had not been instructed by the MAs on how to use the inhaler.
-She always used 2 puffs in row.
-Sometimes her inhaler did not help.
-She had shortness of breath with activity sometimes.
-She denied current issues with shortness of breath.

Interview with the resident care coordinator (RCC) on 02/16/23 at 1:24pm revealed:
-The MAs had initial training for proper inhaler technique with a registered nurse.
-The MAs should instruct Resident #7 on the proper use of the inhaler.
-The PCP should be notified if the resident was not using the inhaler correctly.

Interview with the Administrator on 02/16/23 at 1:42pm revealed:
-The MAs were trained on the proper technique for the use of inhalers.
-The MAs should instruct residents on the proper technique of inhalers if the resident preferred to hold the inhaler for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026062	A. BUILDING: _____ B. WING _____	02/17/2023

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D 358	Continued From page 14 -The PCP should be notified if a resident is not using proper technique. Interview with Resident #7's PCP on 02/17/23 at 11:42am revealed: -The MAs should instruct Resident #7 on the proper technique for inhaler use. -The inhaler should be administered properly. -Improper administration of the inhaler could cause the resident to experience shortness of breath or coughing.	D 358		