

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-Up Survey and Complaint Investigation on 01/31/23-02/02/23.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 287	<p>10A NCAC 13F .0904(b)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide non-disposable table service utensils consisting of a knife, fork and spoon, plate and beverage containers used to assist the residents in eating their meals.</p> <p>The findings are:</p> <p>Observation of the breakfast meal in the Memory Care Unit (MCU) dining room on 02/01/23 at 11:37am revealed: -The tables were preset with a napkin. -There were 20 residents seated in the dining room for the meal. -Each resident was given a fork, knife and a spoon in a silverware bag.</p>	D 287	<p>Caswell House shall ensure that table service for Residents shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers.</p> <p>Executive Director (ED) in-serviced care staff on the importance of ensuring that any beverage served to Residents in the dining room is served in a non-disposable beverage container. Also reminding staff that supplements should be served to the Residents in a cup even when not in the dining room.</p> <p>Med Techs will ensure the Residents with orders for nutritional supplements will receive the supplements in a cup that has been poured for them. Med Techs will monitor the Residents once served to ensure the Resident consumes the supplement, or documents if the resident does not finish.</p> <p>Resident Care Coordinator/ Memory Care Coordinator/ ED will make intermittent rounds during meal and snack times to monitor compliance.</p>	<p>2/15/23</p> <p>3/19/23</p> <p>3/19/23</p>

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

Cassandra Nixon 03/07/23

Reviewed and acknowledged 03/16/23.

kg

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 287	<p>Continued From page 1</p> <ul style="list-style-type: none"> -Each resident was served their meal on a china plate and served their beverages of water, milk and iced tea in a reusable beverage container. -The medication aide (MA) placed a half pint carton of nutritional supplement at the place settings of seven residents. -The staff assisting in the dining room opened the cartons and placed them back on the table. -One resident picked the carton up and shook it but did not drink out of it; she drank 100 percent of her other beverages. -A second resident never drank from the carton of the nutritional supplement but moved it around on the table; she did drink 100 percent of her other beverages. -A third resident picked the open carton up and brought it to he lips but did not drink from the carton; she set it back down and drank the beverages in the cup. <p>Interview with the personal care aide (PCA) on 02/01/23 at 11:48am revealed:</p> <ul style="list-style-type: none"> -The MAs passed the cartons of nutritional supplements to the residents, but they did not open them. -The PCAs would open the cartons and give them to the residents. -The residents drank the nutritional supplements from the cartons; they had not poured them into a cup, and they had never been told to. <p>Interview with a MA on 02/02/23 at 8:31am revealed:</p> <ul style="list-style-type: none"> -She was never told to provide a cup when giving a resident a nutritional supplement in the dining room. -She provided cups when she passed nutritional supplements at bedtime because it was easier for the residents in the MCU to drink from a cup than from a carton. 	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 287	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Some of the residents could not hold a carton in their hands and would spill the supplement down the front of them. -She could also determine how much of the nutritional supplement the resident had drank when it was in a cup. -She had never used a non-disposable cup for supplements when the residents were in the dining room because the kitchen had never provided them, and she did not think to ask. -She would use disposable cups when she had to them to use but she had not had them on the cart recently. <p>Interview with the Dietary Manager on 02/02/23 at 10:am revealed:</p> <ul style="list-style-type: none"> -The dietary staff poured the residents' beverages in the kitchen and delivered them to the MCU. -The dietary staff sent the residents' supplements shakes in a pan and the medication aides passed them to the residents. -She did not provide extra beverage containers for the residents to drink their supplements out of. -The staff in the MCU had never asked her for reusable cups; she had plenty in the kitchen and could provide them. -She had never thought to provide a reusable cup for the residents to drink their nutritional supplements from. <p>Interview with the Memory Care Manager (MCM) on 02/02/23 at 2:55pm revealed:</p> <ul style="list-style-type: none"> -The nutritional supplements were sent from the kitchen with the meals. -The MAs passed the nutritional supplements to the residents at meal times. -Some of the residents wanted their nutritional supplements left in the disposable cartons. -The MAs made the decision to pour the supplements into cups for the residents; it 	D 287		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	--

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 287	Continued From page 3 depended on the resident and their mood for the day. -The kitchen did not provide a reusable cup for the nutritional shakes; the MAs would use a disposable cup if they needed a cup. Interview with the Administrator on 02/02/23 at 4:16pm revealed: -She was aware the residents were severed their nutritional supplements with their meals. -She had not noticed the MAs serving the supplements in the cartons. -She could understand why it might be difficult for some of the residents in the MCU to drink from a paper carton rather than a cup. -She had not thought about the nutritional supplements being served in a disposable carton but thought it was a dignity concern and they should be poured into a cup.	D 287		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve therapeutic diets as ordered by the physician for 2 of 5 sampled residents (#2 and #3), who had orders	D 310	Caswell House shall ensure that all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the Resident's physician. ED in-serviced Dietary Manager (DM) and cooks on Therapeutic Diets, as well as the importance of referring to the recipes to determine the appropriate food substitutions for mechanically altered diets. ED in-serviced care staff on therapeutic diets in the facility, as well as which residents are on therapeutic diets.	2/15/23 2/15/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023	
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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 4</p> <p>for a mechanical soft chopped diet.</p> <p>The findings are:</p> <p>Review of the facility's therapeutic diet lunch menus revealed:</p> <ul style="list-style-type: none"> -The regular lunch menu for 01/31/23 listed chicken alfredo with shells, Caesar salad, chef's [choice] steamed vegetables, breadsticks and chocolate cake. -The mechanical soft chopped diet lunch menu for 01/31/23 listed soft and bite sized chicken alfredo with shells, replace Caesar salad with a soft bit size vegetable, soft and bite sized steamed vegetables, and mechanical soft cake. -The regular lunch menu for 02/01/23 listed fried pollock, steak fries, green beans, hushpuppies and peaches. -The mechanical soft chopped diet lunch menu for 02/01/23 listed chopped fried pollock with tartar sauce, moistened steak fries, soft and bite sized green beans, moistened hushpuppies, mechanical soft peaches and beverage of choice. <p>1. Review of Resident #2's current FL2 dated 04/06/22 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included Alzheimer's dementia, osteopenia, obesity and chronic obstructive pulmonary disease (COPD). -Resident #2 was ordered a regular diet. <p>Review of Resident #2's diet order dated 09/08/22 revealed:</p> <ul style="list-style-type: none"> -Resident #2 had an order for a mechanical soft diet; entire meal with meats were chopped. -A mechanical soft diet was described as ordered for residents who had difficulty chewing but were able to tolerate more texture than a puree diet offered. 	D 310	<p>ED/ DM will ensure that all newly hired cooks are trained to understand therapeutic diets, as well as how to review the recipes for the "Special Diet Instructions".</p> <p>DM will ensure updated menus are printed and available for reference to enable cooks to provide appropriate substitutions for mechanically altered diets.</p> <p>ED or designee will randomly observe meal times to ensure staff are following proper procedure, as well as inspecting to ensure diets are prepared and served appropriately. Any noted concerns will be addressed with the DM and/ or Cook on duty immediately.</p>	<p>3/19/23</p> <p>3/19/23</p> <p>3/19/23</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/02/2023
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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 5</p> <p>Review of the facility's therapeutic diet list revealed Resident #2 was ordered a mechanical soft diet; entire meal with meats to be chopped.</p> <p>Observation of the lunch meal on 01/31/23 at 11:28am revealed: -Resident #2 was served chicken alfredo with noodles, Caesar salad, steamed vegetables, cut up breadsticks, and chocolate pudding. -Resident #2 ate 100 percent of her meal.</p> <p>Observation of the lunch meal on 02/01/23 at 11:37am revealed: -Resident #2 was served chopped breaded fish sticks, green beans, cut up steak fries, cut up hush puppies, and diced peaches. -Resident #2 ate 100 percent of her meal.</p> <p>Telephone interview with Resident #2's primary care provider (PCP) on 02/02/23 at 2:10pm revealed: -Resident #2 was ordered a mechanical soft chopped therapeutic diet because the staff reported she had difficulty chewing and swallowing. -Resident #2 had not had any choking incidents that she was aware of. -She expected the facility to follow the diet as ordered.</p> <p>Refer to interview with a cook on 02/01/23 at 3:31pm.</p> <p>Refer to the interviews with the Dietary Manager (DM) on 02/01/23 at 12:09pm.</p> <p>Refer to interview with the Memory Care Manager (MCM) on 02/02/23 at 2:55pm.</p> <p>Refer to interview with the Administrator on</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 6</p> <p>02/02/23 at 4:09pm.</p> <p>Based on observations, record reviews and interviews it was determined Resident #2 was not interviewable.</p> <p>2. Review of Resident #3's current FI-2 dated 12/07/22 revealed: -Diagnoses included dementia, type two diabetes, hyperlipidemia, unspecified Atrial fibrillation, and hypertension. -Resident #3 was ordered a regular diet. Review of Resident #3's diet order dated 01/18/23 revealed: -Resident #3 had an order for a mechanical soft diet; entire meal with meats were chopped. -A mechanical soft diet was described as ordered for residents who had difficulty chewing but were able to tolerate more texture than a puree diet offered.</p> <p>Review of the facility's therapeutic diet list revealed Resident #3 was ordered a mechanical soft diet; entire meal to be chopped.</p> <p>Observation of the lunch meal on 01/31/23 at 11:28am revealed: -Resident #3 was served chicken alfredo with noodles, Caesar salad, steamed vegetables, cut up breadsticks, and chocolate pudding. -Resident #3 ate 75 percent of his meal.</p> <p>Observation of the lunch meal on 02/01/23 at 11:41am revealed: -The Resident #3 was served chopped breaded fish sticks, green beans, cut up steak fries, cut up hush puppies, and diced peaches. -Resident #3 ate 85 percent of his meal.</p> <p>Telephone interview with Resident #3's primary</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 7</p> <p>care provider (PCP) on 02/02/23 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -She changed Resident #3's diet to a mechanical soft chopped therapeutic diet on 01/18/23, because the staff reported he had difficulty chewing and swallowing. -Resident #3 was not eating very well due to the difficulties so she changed the diet help him eat better. -Resident #3 had not had any choking incidents. -She expected the facility to follow the diet as ordered. <p>Refer to interview with a cook on 02/01/23 at 3:31pm.</p> <p>Refer to the interview with the Dietary Manager (DM) on 02/01/23 at 12:09pm.</p> <p>Refer to interview with the Memory Care Manager (MCM) on 02/02/23 at 2:55pm.</p> <p>Refer to interview with the Administrator on 02/02/23 at 4:09pm.</p> <p>Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable.</p> <hr/> <p>Interview with a cook on 02/01/23 at 3:31pm revealed:</p> <ul style="list-style-type: none"> -He followed the therapeutic diet list, so he knew which residents were ordered a mechanical soft chopped diet. -He had never seen the therapeutic diet menu; he had only seen and used the weekly menu to prepare meals. -The Dietary Manager (DM) had trained him to cook at the facility. -The DM had taught him to cut food into small 	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/02/2023
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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 8</p> <p>bite sized pieces when he prepared the meals for the mechanical soft chopped diet.</p> <p>Interview with the DM on 02/01/23 at 12:09pm revealed:</p> <ul style="list-style-type: none"> -She prepared the lunch meal on 02/01/23. -There was a therapeutic diet menu that included the [mechanical soft] chopped diet but she did not have it out for reference because she had not printed it for 02/01/23. -She had not printed the therapeutic menu because she new what needed to be done to prepare the meal for the mechanical soft chopped diet. -She had prepared this menu for lunch meal before and knew she needed to cut up the fish and the hushpuppies before she served them to the residents. -When the diet orders on the resident diet list had entire meal mechanical soft chopped, all the food for the meal was chopped into bite sized pieces. -She had prepared the lunch meal on 01/31/23. -She did not reference the therapeutic diet menu because she knew what to prepare for the mechanical soft chopped diet. -She did not know the breadsticks were supposed to be moistened; she thought she only needed to cut the breadstick into smaller pieces. -She was not aware the residents ordered a mechanical soft chopped diet were not supposed to be served the Caesar salad, she thought if she cut the pieces up small enough, she could still serve the salad to them. -She had been trained on how to prepare a mechanical soft chopped therapeutic diet somewhere else and thought it would be the same for the therapeutic diet menu at the facility. -She was not aware the therapeutic menu had specific food items for a mechanical soft chopped diet. 	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	--

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 9</p> <p>Interview with the Memory Care Manager (MCM) on 02/02/23 at 2:55pm revealed: -She placed the resident's diet orders on a diet list and gave the kitchen staff a copy of the diet list. -She monitored meals in the memory care unit (MCU) a few times each week. -She monitored the mechanical soft chopped diets to make sure they were chopped. -She did not reference the therapeutic diet menu when she looked at the mechanical soft chopped meals. -She thought if the food on the plate was chopped it was okay.</p> <p>Interview with the Administrator on 02/02/23 at 4:09pm revealed: -She tried to monitor meals a couple of times a week; the last time she had monitored a meal was the week before. -She looked at the food when it was served to make sure it looked correct. -The mechanical soft chopped diet included chopped meats and all other food on the plate was soft or chopped. -She did not reference the menu when she observed the [mechanical soft] chopped diet that was served. -She expected the kitchen staff to follow the therapeutic diet menu when preparing the meals. -She thought the kitchen staff was following the therapeutic diet menu for the mechanical soft chopped diet, so she thought the consistency was correct.</p>	D 310		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights</p>	D 338	<p>Caswell House shall ensure that the rights of all Residents guaranteed under the Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 338	<p>Continued From page 10</p> <p>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were treated with dignity and respect including a resident (#6) who was ordered a pureed diet and not served the same food items as the other residents.</p> <p>The findings are:</p> <p>Observation of the evening meal on 01/31/23 at 4:30pm revealed: -Resident #6 was served a pureed meal of pureed turkey and ham sandwich, pureed sweet potatoes and pureed cream of chicken soup that had also been thickened. -Resident #6 at 100 percent of her meal.</p> <p>Review of the pureed dinner menu for 01/31/23 revealed the meal consisted of a pureed grilled cheese sandwich, pureed sweet potatoes, and pureed and thickened roasted vegetable soup.</p> <p>Observation of the lunch meal on 02/01/23 at 11:38am revealed: -Resident #6 was served a pureed meal of pureed ham, mashed potatoes with gravy, and pureed roasted vegetables. -Resident #6 at 75 percent of her meal.</p> <p>Review of the pureed dinner menu for 02/01/23 revealed the meal consisted of pureed fried pollock with potatoes, pureed steak fries, pureed green beans and pureed hushpuppies.</p>	D 338	<p>Executive Director provided an in-service on Resident Rights for all staff.</p> <p>ED in-serviced DM and Cooks on the importance of serving therapeutic diets according to the daily menu. She also re-educated on the importance of treating all Residents with dignity and respect, ensuring that Residents on pureed or any other mechanically altered diet are served the same food items as other Residents.</p> <p>DM will ensure that menus are available and are accurate to allow cooks to reference recipes for appropriate food preparation or substitution for Residents on mechanically altered diets. DM will ensure that residents are not served left over food for meals as a result of not pureeing current meal items served to other Residents.</p> <p>ED or designee will make random rounds at meal time to ensure Residents are receiving appropriate meals, with correct food items.</p>	<p>3/7/23</p> <p>2/15/23</p> <p>3/19/23</p> <p>3/19/23</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 338	<p>Continued From page 11</p> <p>Review of Resident #6's current FL-2 dated 04/13/23 revealed diagnoses included Alzheimer's disease, type two diabetes, depression, sarcopenia and hypertension.</p> <p>Review of Resident #6's diet order dated 09/27/22 revealed an order for a pureed diet.</p> <p>Interview with the cook on 02/01/23 at 3:31pm revealed: -The residents ordered a pureed diet were served the same food as on the regular menu just pureed. -The residents ordered a pureed diet were not served pureed fish with potatoes at lunch on 02/01/23 because fish did not puree it only became "stringy".</p> <p>Interview with the Dietary Manager (DM) on 02/01/23 at 12:09pm revealed: -She prepared the meal on 01/31/23. -She prepared pureed turkey sandwich, pureed sweet potatoes and pureed and thickened cream of chicken soup for the pureed diet menu. -She did not puree a grilled cheese sandwich because it did not puree well so she prepared a pureed turkey sandwich instead. -She did not puree the roasted vegetable soup because she did not have enough to give the purees so pureed a can of cream of chicken soup instead. -She prepared the meal on 02/01/23. -She prepared pureed ham and gravy, roasted vegetables and mashed potatoes with gravy for the pureed diet menu. -She used left over roasted vegetables from the soup the night before and left-over zucchini along with green beans for the pureed roasted vegetables she served to the residents ordered a puree diet.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/02/2023
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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 338	<p>Continued From page 12</p> <ul style="list-style-type: none"> -She served pureed ham and gravy for the residents ordered a pureed diet because fish did not puree well. -She did not always serve the residents who were ordered a pureed diet the same menu items as the other residents because the food did not always puree well so she would serve left-overs or other items. -She did not thing about the residents ordered a pureed diet were not being served the same menu and food items as the residents on a regular menu. -She did not serve left-overs to any other residents and she did not substitute food items on the menu for other residents' diets. <p>Interview with the Administrator on 02/02/23 at 4:16pm revealed:</p> <ul style="list-style-type: none"> -She was not aware the residents who were ordered a pureed diet were not being served the same food items as the other residents even though they had the same items on their menu as well. -She expected the kitchen staff to provide the same meal to the residents ordered a pureed diet as the other residents who resided in the facility. -All the residents should get the same menu items unless the diet restricted them. -It was not acceptable to substitute items and to serve the residents who were ordered pureed diets left-overs. 	D 338		
D 344	<p>10A NCAC 13F .1002(a) Medication Orders</p> <p>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:</p>	D 344	<p>Caswell House shall ensure contact with the Resident's provider for verification or clarification of orders for medications and treatments.</p> <p>Area Clinical Director (ACD) in-serviced Care Managers and Med Techs on</p>	2/3/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023	
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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 344	<p>Continued From page 13</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 residents sampled (#3) who had an order for a daily pain medication.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL-2 dated 12/7/22 revealed: -Diagnoses included unspecified atrial fibrillation, hypertension, dementia, type 2 diabetes, hyperlipidemia, and iron deficiency anemia. -There was no order for acetaminophen 325mg (used for pain). -Resident #3 resided in the Special Care Unit.</p> <p>Review of Resident #3's six-month physician orders dated 12/07/22 revealed there was an order for acetaminophen 325mg 2 tablets at bedtime for toe pain.</p> <p>Review of Resident #3's FL-2 dated 05/05/22 revealed an order for acetaminophen 325mg 2 tablets at bedtime.</p> <p>Review of Resident #3's November 2022, December 2022, and January 2023 electronic</p>	D 344	<p>the 6 rights of medication administration, the importance of contacting the Provider to clarify orders that are incomplete or unclear, and the importance of following up on that clarification and ensuring documentation. Med Techs in-serviced on the importance of notifying the Care Managers when there is any delay in getting an order clarified and assistance is needed.</p> <p>Care Managers will monitor order processing folders daily to ensure there are not medication orders awaiting clarification. If such orders are present, Care Managers will work to assist in expediting the process.</p> <p>Care Managers will ensure accuracy when approving orders, making sure to follow all directions given in the original physician's order.</p> <p>Care Managers will pull EMAR compliance reports daily to review for accuracy and compliance. The report will be reviewed and discussed daily with the ED during management meeting for any needed follow-up.</p>	<p>3/19/23</p> <p>3/19/23</p> <p>3/19/23</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 344	<p>Continued From page 14</p> <p>medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for acetaminophen 325mg 2 tablets at bedtime for toe pain to be administered at 8:00pm. -There was documentation that acetaminophen 325mg had been administered in November 2022, December 2022, and January 2023 at 8:00pm. <p>Interview with Resident #3 on 02/01/23 9:15am revealed:</p> <ul style="list-style-type: none"> -He did not know if he took medication for pain in his toe. -His toe did not cause him pain now. <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/01/23 at 11:56pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 had an order for acetaminophen 325mg 2 tablets at bedtime dated 05/05/22. -The pharmacy did not receive an FL-2 for Resident #3 dated 12/07/22. -The pharmacy accepts signed FL-2's as physician's orders. -Had the pharmacy received the signed FL-2 dated 12/07/22 and the acetaminophen was not listed, the pharmacy staff would have clarified the acetaminophen with the Primary Care Provider (PCP). <p>Telephone interview with the PCP on 02/02/23 at 2:05pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 had his second left toe amputated several months ago. -Resident #3 received acetaminophen 325mg 2 tablets at bedtime for toe pain. -Resident #3 should no longer need acetaminophen for toe pain. -She was notified yesterday, 02/01/23, for 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 344	<p>Continued From page 15</p> <p>clarification of acetaminophen 325mg. -Acetaminophen 325mg 2 tablets at bedtime were discontinued yesterday, 02/01/23. -She signed the FL-2 that the facility staff completed.</p> <p>Interview with the Memory Care Manager (MCM) on 02/01/23 at 2:10pm revealed: -The FL-2 was completed by the MCM or the Clinical Supervisor. -The physician's order were printed off the eMAR and the FL-2 was completed using the current orders by the physician. -The FL-2 was given to the PCP to sign on her weekly visit to the facility. -She did not complete Resident #3's FL-2 dated 12/07/22. -She did not know acetaminophen 325mg 2 tablets at bedtime was not on the FL-2 but on the signed physician orders dated the same day.</p> <p>Interview with the Clinical Supervisor on 02/01/23 at 2:43pm revealed: -The FL-2 was completed by the Clinical Supervisor or the MCM. -The physician orders were printed and the medications listed on the physician order's were written on the FL-2. -It appeared the acetaminophen 325mg 2 tablets at bedtime was not written on the FL-2 as ordered on the physician's orders. -The staff completing the FL-2 was responsible for the accuracy of the FL-2. -Clarification was needed to see if the PCP wanted to continue administering or discontinuing the acetaminophen.</p> <p>Interview with the Administrator on 02/01/23 at 3:05pm revealed: -The MCM and Clinical Supervisor were</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 344	Continued From page 16 responsible for completing the FL-2. -The MCM or the Clinical Supervisor would print the physician's orders and complete the FL-2 based on the information on the most recently signed physician's orders. -All new orders written between the date of the last signed physician order and the day the FL-2 was being completed should be included on the FL-2. -The MCM and the Clinical Supervisor should review and compare the FL-2 with the signed physician's orders to ensure all medications were written on the FL-2.	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: Type B Violation Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 2 of 6 residents (#7 and #8) observed during the 8:00am morning medication pass including errors with the omission of an eye drop (#7) and an inhaler (#8); and for 2 of 5 sampled residents (#2 #4) for record review including an inhaler and a multivitamin (#2); and medication used to treat	D 358	Caswell House shall ensure the preparation and administration of medications and treatments by staff are according to Provider orders which are kept in the Resident's record, the facility's policies and procedures, and rule area .1004(a). Resident Care Coordinator (RCC) notified Resident #4's PCP of discrepancies with insulin administration. RCC printed 30 days of Resident blood sugars and the insulin orders and sent to the PCP for clarification. ACD in-serviced Med Techs on the 6 rights of medication administration, 3 required checks prior to medication administration, and the importance of paying close attention to diabetic orders with a focus on insulin administration. Care Managers will pull Medication Compliance Reports daily to ensure	2/2/23 2/3/23 3/19/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 17</p> <p>diabetes, a medicated shampoo, and a nasal spray (#4).</p> <p>The findings are:</p> <p>1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 29 opportunities during the 8:00am medication pass on 02/01/23.</p> <p>a. Review of Resident #7's current FL-2 dated 11/29/22 revealed diagnoses included dementia, type 2 diabetes, chronic kidney disease stage V, end-stage renal disease, unspecified atrial fibrillation, thoracic aortic aneurysm, and pulmonary embolism.</p> <p>Review of Resident #7's signed physician order dated 01/29/23 revealed an order for carboxymethylcellulose sodium eye drops 0.5% (used to treat dry, irritated eyes) instill one drop in each eye twice daily.</p> <p>Observation of the medication pass for Resident #7 on 02/01/23 at 8:00am revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) removed one bottle of eye drops, artificial tears, from the top drawer of the medication cart. -The MA administered one drop of artificial tears to each eye at 8:00am. -The MA returned the bottle of artificial tears to the medication cart. -The MA did not administer carboxymethylcellulose sodium eye drops during the 8:00am medication pass. <p>Review of Resident #7's February 2023 electronic medication administration record (eMAR) on 02/01/23 revealed:</p> <ul style="list-style-type: none"> -There was an entry for artificial tears one drop in 	D 358	<p>medications are administered per MD orders. Report will be brought to management meeting daily for review with ED for compliance. Any noted areas of concern will have follow-up as appropriate, including MD notifications, clarifications, and any intervention needed.</p> <p>Med Techs will complete MAR to cart audits per facility schedule to ensure availability and accuracy of medications on medication carts. The audits will be reviewed by Care Managers and ED for compliance, and to ensure accurate medications are on hand at all times.</p> <p>Care Managers will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate medication administration. Completed chart audits will be reviewed by the ED for compliance.</p>	<p>3/19/23</p> <p>3/19/23</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 18</p> <p>each eye every 4 hours while awake scheduled for 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am and 4:00am.</p> <p>-There was documentation artificial tears was administered during the 8:00am medication pass.</p> <p>-There was an entry for carboxymethylcellulose sodium eye drops 0.5% one drop in each eye twice daily scheduled for administration at 8:00am and 8:00pm.</p> <p>-There was documentation carboxymethylcellulose sodium eye drops were administered during the 8:00am medication pass on 02/01/23.</p> <p>Observation of Resident #7's medication on hand on 02/01/23 at 9:37am revealed a bottle of carboxymethylcellulose sodium eye drops 0.55 eye drops available for administration .</p> <p>Interview with the MA on 02/01/23 at 1:33pm revealed:</p> <p>-She administered artificial tears to Resident #7.</p> <p>-When she clicked "complete" on the eMAR, her initials were entered onto the eMAR for all 8:00am medications.</p> <p>-She did not administer carboxymethylcellulose sodium eye drops to Resident #7.</p> <p>-She thought Resident #7 only had one eye drop; she did not realize Resident #7 had two eye drops.</p> <p>-She should compare medication on the medication cart to the eMAR prior to administering medications to Resident #7.</p> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/01/23 at 1:33pm revealed:</p> <p>-Resident #7 had an order for carboxymethylcellulose sodium eye drops one drop in each eye twice daily.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/02/2023
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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	<p>Continued From page 19</p> <p>-The pharmacy dispensed a vial of carboxymethylcellulose sodium eye drops on 01/18/23. -The eye drops were used as a lubricant to relieve irritated eyes.</p> <p>Telephone interview with Resident #7's Primary Care Provider (PCP) on 02/02/23 at 2:02pm revealed: -Carboxymethylcellulose sodium eye drops were ordered for Resident #7 to relieve dry, itchy, irritated eyes. -Resident #7 would continue to have dry, itchy, irritated eyes if the medication was not administered as ordered.</p> <p>Interview with the Memory Care Manager (MCM) on 02/01/23 at 2:10pm revealed: -The MAs should read the PCP's order and administer the medication as ordered. -The MAs should compare each medication on the medication cart with the medications on the eMAR to ensure all medications were administered as ordered.</p> <p>Interview with the Clinical Supervisor on 02/01/23 at 2:43pm revealed: -The MAs should compare the resident's medication to the eMAR three times prior to administering the medication. -She expected the MAs to administer medication as ordered.</p> <p>Interview with the Administrator on 02/01/23 at 3:05pm revealed: -The MAs should be comparing each medication administered with the eMAR. -She expected the MAs to administered medications as ordered.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 20</p> <p>Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.</p> <p>b. Review of Resident #8's current FL-2 dated 06/15/22 revealed diagnoses included dementia, diabetes, paranoia, asthma, and hypertension.</p> <p>Review of Resident #8's signed six-month physician orders dated 12/24/22 there was an order for Symbicort inhaler 2 puffs twice a day rinse mouth with water and expectorate after each use.</p> <p>Observation of the medication pass for Resident #8 on 02/01/23 at 8:04am revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) removed Symbicort inhaler from the top drawer of the medication cart. -The MA gave the inhaler to the resident and instructed her to take two puffs. -The resident inhaled two puffs as instructed and returned the Symbicort inhaler to the MA. -The MA returned to the medication cart and placed the Symbicort inhaler in the top drawer. -The MA did not offer Resident #8 water to rinse her mouth. <p>Review of the facility policy for administering inhalant medication revealed the MAs should follow any special direction indicated by the pharmacy or prescribing physician, such as having the resident rinse their mouth out with water.</p> <p>Review of Resident #8's February 2023 electronic medication administration record (eMAR) on 02/01/23 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Symbicort inhaler 2 puffs twice a day rinse mouth with water and 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 21</p> <p>expectorate after each use with an administration time of 8:00am and 8:00pm. -There was documentation Symbicort inhaler was administered, and mouth rinsed with water and expectorated during the 8:00am medication pass.</p> <p>Interview with the MA on 02/01/23 at 1:33pm revealed: -She administered Symbicort inhaler to Resident #8 during the morning medication pass. -She did not offer Resident #8 water to rinse her mouth after she used the Symbicort inhaler. -She did not know she was suppose to offer Resident #8 water to rinse her mouth after she used the Symbicort inhaler. -She had not noticed "rinse mouth with water and expectorate" was part of the Symbicort administration order. -She needed to read the complete medication order prior to administering a medication.</p> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/01/23 at 1:33pm revealed: -Resident #8 had an order for Symbicort inhaler 2 puffs twice daily rinse mouth with water and expectorate. -Symbicort inhaler contained steroids and could cause thrush in the mouth if the mouth was not rinsed after use of the inhaler.</p> <p>Telephone interview with Resident #8's Primary Care Provider (PCP) on 02/02/23 at 2:02pm revealed: -Resident #8 was receiving Symbicort inhaler because of a diagnosis of asthma. -Symbicort contained steroids which could cause bacteria growth and thrush in Resident #8's mouth. -Resident #8 should have her mouth rinsed with</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 22</p> <p>water after use of the Symbicort inhaler to prevent bacteria growth and thrush. -She had no been notified by the facility staff of Resident #8 complaining of soreness of her mouth.</p> <p>Interview with the Memory Care Manager (MCM) on 02/01/23 at 2:10pm revealed: -The MA should not document on the eMAR a medication was administered if it was not administered. -The MAs should read the PCP's order and administer the medication as ordered. -The MAs should compare each medication on the medication cart with the medications on the eMAR to ensure all medications were administered as ordered.</p> <p>Interview with the Clinical Supervisor on 02/01/23 at 2:43pm revealed: -The MAs should compare the resident's medication to the eMAR three times prior to administering the medication. -She expected the MAs to administer medication as ordered.</p> <p>Interview with the Administrator on 02/01/23 at 3:05pm revealed: -The MAs should be comparing each medication administered with the eMAR. -She expected the MAs to administered medications as ordered.</p> <p>Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.</p> <p>2. Review of Resident #4's current FL-2 dated 12/14/22 revealed diagnoses of type 2 diabetes,</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 23</p> <p>hypertension, and developmental disorder.</p> <p>a. Review of Resident #4's signed physician's order dated 11/27/22 revealed: -There was an order for Novolog (rapid-acting insulin used to lower blood sugar) U-100 insulin, administer 5 units before meals plus sliding scale. Call Primary Care Provider (PCP) for finger stick blood sugar (FSBS) greater than 500. Administer orange juice for FSBS less than 70 and recheck in 30 minutes and call PCP if FSBS less than 100. -Sliding scale insulin as follows: FSBS result 151-200=10 units, 201-250=15 units, 251-300=20 units, 301-350=25 units, 351-500=30 units.</p> <p>Review of Resident #4's signed physician's order dated 12/14/22 revealed: -There was an order for Novolog U-100 insulin, administer 5 units before meals plus sliding scale. Call Primary Care Provider (PCP) for finger stick blood sugar (FSBS) greater than 500. Administer orange juice for FSBS less than 70 and recheck in 30 minutes and call PCP if FSBS less than 100. -Sliding scale insulin as follows: FSBS result 151-200=10 units, 201-250=15 units, 251-300=20 units, 301-350=25 units, 351-500=30 units.</p> <p>Review of Resident #4's lab results dated 08/18/23 revealed: -Resident #4's A1C was 8.3. (A1C is a simple blood test that measures a person's average blood sugar levels over the past 3 months). -An A1C of 8.3 was considered to be out of range. -For someone with known diabetes, a value of less than 7% would indicate the diabetes was well controlled and a value greater than 7% would indicate suboptimal control.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 24</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2022 revealed:</p> <ul style="list-style-type: none"> -There was an entry for FSBS checks scheduled at 7:00am, 11:00am and 4:00pm; there was a space designated to document the FSBS results, route, site, and units. -Resident #4's documented FSBS ranges were from 110-404 at 7:00am, 230-488 at 11:00am, and 118-350 at 4:00pm. -There was documentation 41 out of 90 opportunities where the wrong amount of insulin was administered. -For example: There was documentation on 12/01/22 at 7:00am, Resident #4's FSBS was 238, and 15 units of Novolog were administered. Twenty units should have been administered. -There was documentation on 12/04/22 at 7:00am, Resident #4's FSBS was 259, and 5 units of Novolog were administered. Twenty-five units should have been administered. -There was documentation on 12/20/22 at 7:00am, Resident #4's FSBS was 296, and 15 units of Novolog were administered. Twenty-five units should have been administered. <p>Review of Resident #4's eMAR for January 2023 revealed:</p> <ul style="list-style-type: none"> -There was an entry for FSBS checks scheduled at 7:00am, 11:00am and 4:00pm; there was a space designated to document the FSBS results, route, site, and units. -Resident #4's documented FSBS ranges were from 193-465 at 7:00am, 254-500 at 11:00am, and 178-497 at 4:00pm. -There was documentation 36 out of 89 opportunities where the wrong amount of insulin was administered. -For example: There was documentation on 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 25</p> <p>01/01/22 at 7:00am, Resident #4's FSBS was 238, and 15 units of Novolog were administered. Twenty units should have been administered.</p> <p>-There was documentation on 01/21/22 at 11:00am, Resident #4's FSBS was 398, and 25 units of Novolog were administered. Thirty-five units should have been administered.</p> <p>-There was documentation on 01/27/22 at 4:00pm, Resident #4's FSBS was 249, and 15 units of Novolog were administered. Twenty units should have been administered.</p> <p>Review of Resident #4's eMAR for February 2023 for 02/01/23 revealed:</p> <p>-There was an entry for FSBS checks scheduled at 7:00am, 11:00am and 4:00pm; there was a space designated to document the FSBS results, route, site, and units.</p> <p>-Resident #4's documented FSBS range was 216 at 7:00am, 511 at 11:00am, and 328 at 4:00pm.</p> <p>-There was documentation 1 out of 3 opportunities where the wrong amount of insulin was administered.</p> <p>-There was documentation on 02/01/23 at 7:00am, Resident #4's FSBS was 216, and 15 units of Novolog were administered. Twenty units should have been administered.</p> <p>Observation of Resident #4's medication on hand on 02/01/23 at 10:24am revealed:</p> <p>-There was a plastic container that contained Resident #4's Novolog insulin pen, glucometer, and glucometer supplies.</p> <p>-There was a handwritten note attached to the inside cover of the container with the directions to inject 5 units subcutaneously before meals plus sliding scale 151-200=10 units, 201-250=15 units, 251-300=20 units, 301-350=25 units.</p> <p>Observation of a medication aide (MA) on</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 26</p> <p>02/01/23 at 10:58am revealed: -The MA took the plastic container into Resident #4's room. -She checked Resident #4's FSBS and the results were 511. -She contacted Resident #4's PCP and obtained an order to administer 40 units of Novolog. -She documented the FSBS result as 511 and units administered as 40.</p> <p>Interview with the MA on 02/01/23 at 11:05am revealed: -In the eMAR, she documented the FSBS results and the total amount of Novolog administered. -Resident #4's sliding scale was to administer 5 units plus the amount needed based on the resident's FSBS. -Because Resident #4's FSBS was greater than 500 today, 02/01/23, she had to call the PCP for further instruction per the order.</p> <p>Interview with another MA on 02/01/23 at 11:05am revealed: -She always documented on the eMAR Resident #4's FSBS results and the total amount of Novolog administered. -Resident #4's sliding scale was to administer 5 units plus the amount needed based on the resident's FSBS. -Resident #4's FSBS was 328 today, 01/01/23, so she administered 5 units plus the sliding scale which was 25 units for a total of 30 units. -MAs were supposed to document the FSBS results and the total number of units administered in the eMAR.</p> <p>Interview with a third MA on 02/02/23 at 7:32am revealed: -She administered Resident #4's insulin when she worked.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 27</p> <ul style="list-style-type: none"> -She read Resident #4's insulin order on the computer and responded to the amount of insulin she would administer based on the FSBS obtained. -If Resident #4's FSBS was 275 she would administer 20 units of insulin. -The amount she entered into the eMAR was the total amount of insulin she administered. -Sometimes Resident #4 would get extra insulin. -She read the order again and stated if Resident #4's FSBS was over 500, she would administer 5 units and call the PCP. -She could not recall if she had to administer the 5 units to Resident #4. <p>Interview with Resident #4 on 02/01/23 at 11:10am revealed:</p> <ul style="list-style-type: none"> -His FSBS was checked before meals and at bedtime. -He did not know what his order was for insulin. -He thought his FSBS ran high a lot. <p>Telephone interview with Resident #4's PCP on 02/02/23 at 8:29am revealed:</p> <ul style="list-style-type: none"> -She did not manage Resident #4's diabetes medication because the resident had such a high resistance and was hyperglycemic. -She was familiar with Resident #4's insulin order. -Resident #4 was administered a short-acting insulin at meals to lower his FSBS. -Resident #4 was to be administered 5 units plus the sliding scale. -She recalled in December 2022, there were questions if Resident #4's insulin was being administered correctly, and she educated the staff. -If Resident #4 was not getting the base (5 units) the Endocrinologist would be getting a false reading and would overcorrect the dosage thinking the resident had received the full dosage 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 28</p> <p>of 5 units plus the sliding scale.</p> <p>-Long-term complications would be Resident #4's FSBS being elevated, which could cause organ damage, diabetic ketoacidosis, and hospital admission.</p> <p>Telephone interview Resident #4's Clinical Pharmacist Practitioner on 02/02/23 at 10:27am revealed:</p> <p>-She and Resident #4's Endocrinologist worked together on the management of his diabetes and medication; they would alternate seeing Resident #4 during clinic visits.</p> <p>-Resident #4 was first seen at the Endocrinology clinic on 08/25/22 and was last seen on 09/27/22.</p> <p>-Resident #4 presented at the clinic on 09/27/22 without any FSBS record and no staff.</p> <p>-Resident #4 was a poor historian of his FSBS.</p> <p>-She could not adjust Resident #4's diabetic medication without knowing his FSBS history.</p> <p>-Resident #4 was a fragile diabetic.</p> <p>-Since the facility did not offer a diabetic diet, they were trying to control Resident #4's glucose levels through medication.</p> <p>-Resident #4 was supposed to get 5 units plus the sliding scale before meals.</p> <p>-If Resident #4 was not administered the correct amount of insulin, he would not be getting enough insulin to cover his FSBS and what he was consuming, and he would be hyperglycemic.</p> <p>-She was more concerned about the long-term implications for diabetes-related issues including, blindness, kidney problems, neuropathy, cardiovascular problems, and stroke.</p> <p>-The goal was to minimize long-term damage and Resident #4 not being administered the correct amount of insulin could cause damage to those vessels.</p> <p>Interview with the Resident Care Coordinator on</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 29</p> <p>02/02/23 at 9:09am revealed:</p> <ul style="list-style-type: none"> -On the eMAR Resident #4's FSBS should be documented, and the number of units documented should be the total amount of insulin administered. -She read Resident #4's order and responded to the amount of insulin that should be administered. -If Resident #4's FSBS was 326 he should be administered 25 units. -If Resident #4's FSBS was 275 he should be administered 20 units. -She read the order a second time and said she would have administered the 5 units plus the sliding scale. -She and Resident #4's PCP talked to the MAs in December 2022 to make sure Resident #4 was being administered the correct amount of insulin. -They specifically talked about administering 5 units plus the sliding scale. -The reason they discussed Resident #4's FSBS and insulin was that the resident's FSBS was running in the 400s and even as high as 500. -She thought the MAs were administering the 5 units plus the sliding scale and did not include the 5 units in the total when entered into the eMAR. -She thought it was a documentation error because when she asked the MAs verbally, they always told her 5 units plus the amount of sliding scale. -She had not audited Resident #4's eMAR to have seen the discrepancy in the amount of insulin documented as administered versus what should have been administered. <p>Interview with the Clinical Supervisor on 02/02/23 at 3:24pm revealed:</p> <ul style="list-style-type: none"> -She was familiar with Resident #4's FSBS and insulin order. -If Resident #4's FSBS was 275 he would be administered 20 units of insulin and that number 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 30</p> <p>would be recorded in the eMAR.</p> <ul style="list-style-type: none"> -She would administer 5 units of insulin to Resident #4 before meals per the order. -She would then check Resident #4's FSBS and administer any additional insulin if needed based on the sliding scale and document that amount on the eMAR. -The pharmacy had entered the order together when it should have been two separate orders. -She had called the pharmacy this morning, 02/02/23, to have the order changed to two orders so there would be no confusion. -She did not recall who, but someone had brought to her attention the confusion with the order. -She was concerned the MAs were not looking at the orders carefully enough. <p>Interview with the Administrator on 02/02/23 at 9:48am revealed:</p> <ul style="list-style-type: none"> -She expected MAs to administer medications as ordered. -She did not know why Resident #4 was not being administered 5 units plus the sliding scale when needed. -She was concerned Resident #4 was not being administered the correct dosage per the PCP's orders. <p>b. Review of Resident #4's signed physician's order dated 12/14/22 revealed an order for Ketoconazole (an antifungal medication) 2% shampoo please wash hair twice weekly. Leave shampoo in place for 5 minutes then rinse hair and scalp with warm water.</p> <p>Review of Resident #4's Primary Care Provider (PCP) after-visit summary dated 12/14/22 revealed:</p> <ul style="list-style-type: none"> -Resident #4 had seborrheic dermatitis. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 31</p> <ul style="list-style-type: none"> -Resident #4 was noted to have seborrheic capitis and dry flaking skin on the scalp. -Resident #4 complained to staff that his scalp was "itchy." -She would begin Ketoconazole 2% shampoo twice weekly and follow up for improvement. <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2022 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Ketoconazole (2% shampoo please wash hair twice weekly. Let rest for 5 minutes then rinse out; frequency was Monday and Friday. -There was documentation Resident #4's Ketoconazole was used on 12/19/22, 12/23/22, 12/26/22, and 12/30/22. -There were no exceptions documented. <p>Review of Resident #4's eMAR for January 2023 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Ketoconazole (2% shampoo please wash hair twice weekly. Let rest for 5 minutes then rinse out; frequency was Monday and Friday. -There was documentation Resident #4's Ketoconazole was used on 01/02/23, 01/06/23, 01/09/23, 01/13/23, 01/16/23, and 01/20/23. -There were exceptions documented for 01/23/23, 01/28/31, and 01/31/23 as not administered, not on correct shower day. <p>Observation of Resident #4's medications on hand on 02/02/23 at 7:01am revealed:</p> <ul style="list-style-type: none"> -The bottle of Ketoconazole was in the bottom drawer of the medication cart in a zippered plastic bag. -The bottle was dispensed on 12/14/22 and had a handwritten note as opened 12/19/22. -The bottle felt full based on the weight of the 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 32</p> <p>bottle when held.</p> <p>-When the cap was removed, there was a white foil-type covering with multiple tabs folded down that had not been removed or altered indicating the bottle had not been opened.</p> <p>Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 02/02/23 at 8:05am revealed:</p> <p>-Resident #4's Ketoconazole shampoo was dispensed on 12/14/22.</p> <p>-The order was written for one bottle and no other bottles of Ketoconazole had been dispensed.</p> <p>Observation of Resident #4 on 02/02/23 at 7:43am revealed Resident #4 was sitting in his recliner in his room rubbing his head.</p> <p>Interview with Resident #4 on 02/02/23 at 7:43am revealed:</p> <p>-His his head was itching.</p> <p>-His head itched "all the time" but especially at night when he laid down.</p> <p>-He took a shower by himself, "no one needed to help him."</p> <p>-He used the shampoo that was in his bathroom.</p> <p>-He did not recall anyone putting a medicated shampoo on his hair and leaving it for 5 minutes before washing it out.</p> <p>Observation of Resident #4's bathroom on 02/02/23 at 7:42am revealed various types of shampoos and body washes; there was no Ketoconazole shampoo in the resident's bathroom.</p> <p>Interview with Resident #4's PCP on 02/02/23 at 8:29am revealed:</p> <p>-She had ordered Ketoconazole for Resident #4 because he had complained about a flaky scalp</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 33</p> <p>and itching.</p> <ul style="list-style-type: none"> -Resident #4 had seborrheic dermatitis and it would not resolve if the Ketoconazole shampoo was not used as ordered and Resident #4's scalp would continue to itch. -She expected Resident #4's Ketoconazole shampoo to be used as ordered. <p>Interview with a medication aide (MA) on 02/02/23 at 2:43pm revealed:</p> <ul style="list-style-type: none"> -Resident #4's Ketoconazole was on the eMAR on the wrong shift. -Resident #4 got his shower on 2nd shift, but the order popped up on her shift, 1st shift. -She had told the Resident Care Coordinator (RCC) (she did not recall when) but it still "popped" on the wrong shift. -She usually documented an exception. -If she did not document an exception, it was an error, as she had not given the Ketoconazole to anyone when she was working to be used. -The personal care aides (PCA) would be the ones to ask the MA for the Ketoconazole and then when it was returned, the MA would document it had been completed. <p>Telephone interview with a PCA on 02/02/23 at 3:05pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 did most of his shower on his own. -She had to help him with the bottom of his legs and feet and his back. -She also helped him wash his hair. -Resident #4 had a special shampoo that was kept on the medication cart. -She could not recall the last time she had washed Resident #4's hair, but it was in January 2023. -She could not answer why Resident #4's shampoo had not been opened. -She had used regular shampoo when washing 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/02/2023
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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	<p>Continued From page 34</p> <p>Resident #4's hair. -She knew Resident #4 had a special shampoo because someone told her.</p> <p>Interview with the Clinical Supervisor on 02/02/23 at 3:24pm revealed: -Resident #4's Ketoconazole was kept on the medication cart. -The PCA was responsible for using the Ketoconazole during Resident #4's showers. -The MA was responsible for giving the Ketoconazole to the PCA and documenting it had been used. -Resident #4 had "real bad dandruff." -She had just put a bottle of Resident #4's Ketoconazole on the medication cart this week. -She audited the medication cart last week. -She did not open the top of the Ketoconazole bottle to see if it had been used or not. -The day the bottle was opened to be used would be the date written on the outside of the bottle. -She thought Resident #4 may have had more than one bottle of Ketoconazole shampoo.</p> <p>Interview with the RCC on 02/02/23 at 3:57pm revealed: -Resident #4's Ketoconazole was supposed to be on the eMAR for his shower days. -There was a problem with the system because it was not on his shower days. -It was fixed (she did not recall when) and she "just fixed it again." -Another staff member brought it to her attention, today, 02/02/23. -She did not know Resident #4's Ketoconazole shampoo had not been opened. -If the shampoo was not opened, the staff were not using the shampoo as ordered. -Resident #4 really needed the shampoo for his dry scalp.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 35</p> <p>Interview with the Administrator on 02/02/23 at 4:03pm revealed: -The morning MA should have notified someone that Ketoconazole was showing on the computer screen to be administered in the mornings and it needed to be changed to the evening when Resident #4 got his showers. -She expected all medications/treatments to be administered as ordered.</p> <p>c. Review of Resident #4's signed physician's order dated 12/14/22 revealed an order for Fluticasone (a nasal spray used to treat symptoms such as sneezing, runny or stuffy nose) 50mcg/actuation, shake well and instill 2 sprays into each nostril daily.</p> <p>Review of Resident #4's Primary Care Provider (PCP) after-visit summary dated 12/14/22 revealed: -Resident #4 had a diagnosis of nasal congestion. -Resident #4 complained of nasal mucous and congestion, as well as a cough that was worse at night.</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2022 revealed: -There was an entry for Fluticasone 50mcg/actuation instill 2 sprays in each nostril daily with a scheduled administration time of 8:00am. -There was documentation Resident #4's Fluticasone was administered daily. -There were no exceptions documented.</p> <p>Review of Resident #4's eMAR for January 2023 revealed:</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 36</p> <ul style="list-style-type: none"> -There was an entry for Fluticasone 50mcg/actuation instill 2 sprays in each nostril daily with a scheduled administration time of 8:00am. -There was documentation Resident #4's Fluticasone was administered daily. -There were no exceptions documented. <p>Observation of Resident #4's medications on hand on 02/01/23 at 10:23am and 4:15pm revealed:</p> <ul style="list-style-type: none"> -There was a Fluticasone box with a pharmacy lab with a dispensed date of 12/01/22. -There was a handwritten note, opened 12/05/22. -There was a second bottle of Fluticasone labeled for Resident #4 with a dispensed date of 01/13/23. -The bottle had a handwritten note, opened 01/17/23. <p>Observation of another resident's unopened box of Fluticasone on 02/03/23 at 2:42pm revealed:</p> <ul style="list-style-type: none"> -The box had not been opened. -The new bottle of Fluticasone was removed from the box. -Resident #4's two bottles of Fluticasone had the same amount of medication as the new bottle of Fluticasone that was used for comparison. <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/01/23 at 3:10pm revealed:</p> <ul style="list-style-type: none"> -Resident #4's Fluticasone had been filled for a one-month supply on 10/05/22, 12/01/22, and 01/13/23. -Based on the order of 2 sprays in each nostril, which was 4 sprays per day, the medication would only last for one month. -Fluticasone was used for allergies and if the medication was not administered as ordered the 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 37</p> <p>resident would have allergy symptoms such as a stuffy or runny nose.</p> <p>Interview with Resident #4 on 02/02/23 at 7:43am revealed: -He used the nasal spray. -Staff administered the nasal spray. -He thought he got 2 sprays on each side. -He could not recall if he had not been administered his Fluticasone nasal spray. -He recently had a stuffy nose but could not recall the date.</p> <p>Interview with Resident #4's PCP on 02/02/23 at 8:29am revealed: -She had ordered Fluticasone for Resident #4 for allergic rhinitis. -If Resident #4 did not receive his Fluticasone as ordered he would have symptoms of mild allergies. -She expected Resident #4's medication to be administered as ordered.</p> <p>Interview with a medication aide (MA) on 02/02/23 at 2:43pm revealed: -She administered Resident #4's Fluticasone nasal spray when she worked. -She could not explain why Resident #4's Fluticasone which was dispensed and opened in December 2022 was still almost full.</p> <p>Interview with the Resident Care Coordinator (RCC) on 02/02/23 at 9:09am revealed: -It was important for Resident #4 to be administered his Fluticasone as ordered. -She did cart audits and looked at the date the medication was opened to see how much had been used. -She would have expected more to be gone from the Fluticasone bottle dated as opened on</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 38</p> <p>12/05/23 unless the resident had more than one bottle.</p> <p>Interview with the Clinical Supervisor on 02/02/23 at 3:24pm revealed: -She did not know how a Fluticasone bottle dated as opened on 12/05/22 had gotten back on the medication cart. -She thought the Fluticasone had been pulled off the cart because it was over 30 days since it had been opened. -The MAs should have been administering the Fluticasone as ordered and monitoring to make sure the medication had been used correctly.</p> <p>Interview with the Administrator on 02/02/23 at 4:03pm revealed: -She expected Resident #4's Fluticasone to be administered as ordered. -If Resident #4's Fluticasone had not been administered as ordered the MAs were not following the rules and regulations related to administering medications.</p> <p>3. Review of Resident #2's current FL2 dated 04/06/22 revealed: -Diagnoses included Alzheimer's dementia, osteopenia, obesity and chronic obstructive pulmonary disease (COPD). -Resident #2 resided in the Special Care Unit (SCU).</p> <p>a. Review of Resident #2's current FL2 dated 04/06/22 revealed medication orders included an order for budesonide-formoterol (used to manage COPD) 160-4.5mcg inhale two puffs twice daily.</p> <p>Review of Resident #2's December 2022 electronic Medication Administration Record</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 39</p> <p>(eMAR) revealed: -There was an entry for budesonide-formoterol 160-4.5mcg inhale two puffs twice daily scheduled at 8:00am and 8:00pm. -There was documentation budesonide-formoterol 160-4.5mcg was administered 62 of 62 opportunities from 12/01/22 to 12/31/22.</p> <p>Review of Resident #2's January 2023 eMAR revealed: -There was an entry for budesonide-formoterol 160-4.5mcg inhale two puffs twice daily scheduled at 8:00am and 8:00pm. -There was documentation budesonide-formoterol 160-4.5mcg was administered 62 of 62 opportunities from 01/01/23 to 01/31/23.</p> <p>Review of Resident #2's eMAR for 02/01/23 to 02/02/23 at 9:12am revealed: -There was an entry for budesonide-formoterol 160-4.5mcg inhale two puffs twice daily scheduled at 8:00am and 8:00pm. -There was documentation budesonide-formoterol 160-4.5mcg was administered twice on 02/01/23 and once at 8:00am on 02/02/23.</p> <p>Observation of Resident #2's medications on hand on 02/02/23 at 10:27am revealed: -There was an inhaler of budesonide-formoterol 160-4.5mcg dispensed on 01/13/23 available for administration. -There was on open date of 01/17/23 hand written on the box containing the budesonide-formoterol. -The counter on the inhaler indicated 118 puffs remained in the inhaler.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023	
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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	<p>Continued From page 40</p> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/23 at 11:49am revealed:</p> <ul style="list-style-type: none"> -Resident #2 had a current order for budesonide-formoterol 160-4.5mcg inhale two puffs twice daily. -Resident #2's budesonide-formoterol inhaler was not on a cycle fill and had to be requested for refill by the facility. -A thirty-day supply of budesonide-formoterol 160-4.5mcg was dispensed on 09/14/22, 12/01/22, and 01/13/23. -The counter on the inhaler began at 120 and indicated the number of doses remaining in the inhaler after each use. -Each puff was counted down on the indicator. -Budesonide-formoterol 160-4.5mcg inhalers were used for long term maintenance of COPD; it helped with breathing by decreasing inflammation and opening airways in the lungs. -A possible outcome of not administering budesonide-formoterol as ordered would be worsening of COPD including inflammation of the lungs which would increase difficulty when breathing and shortness of breath. <p>Telephone interview with Resident #2's primary care provider (PCP) on 02/02/23 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 was on budesonide-formoterol 160-4.5mcg for her COPD. -Budesonide-formoterol 160-4.5mcg had a steroid that helped with managing Resident #2's COPD. -If Resident #2 was not administered her budesonide-formoterol inhaler as ordered due to her COPD there was a potential for her to experience bronchospasm causing shortness of breath; her oxygen levels could decrease to levels she would need to be transported to the 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 41</p> <p>hospital.</p> <p>-She expected her order for Resident #2's budesonide-formoterol 160-4.5mcg inhaler to be followed by the facility.</p> <p>Interview with a medication aide (MA) on 02/02/23 at 10:27am revealed:</p> <p>-Resident #2 did not refuse her medications.</p> <p>-She did not give the inhaler to Resident #2 to use; she depressed the inhaler for her.</p> <p>-She did not pay attention to the counter on the inhalers.</p> <p>Interview with the Memory Care Manager (MCM) on 02/02/23 at 2:55pm revealed:</p> <p>-She observed the MAs administering medications a couple of times a week to ensure they were administering medications correctly.</p> <p>-She looked at the medications on the carts, but she did not do a cart audit; the Clinical Supervisor did the cart audits.</p> <p>-She looked at expiration dates and open dates on medications; she checked open dates of inhalers but did not look at the counters on the inhalers.</p> <p>-The MAs should depress all inhalers for the residents in the SCU when administering them.</p> <p>-Resident #2 did not have the strength to depress the inhaler herself.</p> <p>-Inhalers were not on a cycle fill and had to be reordered when they were low.</p> <p>-The MAs should look at the counter before and after they administered an inhaler.</p> <p>-It looked like Resident #2 did not get her budesonide-formoterol as ordered because the counter would have been a lot lower than 118.</p> <p>Interview with the Clinical Supervisor on 02/02/23 at 3:15pm revealed:</p> <p>-She looked for opened dates on inhalers, eye</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 42</p> <p>drops and insulin; the opened date was the date the medication was open and first administered.</p> <ul style="list-style-type: none"> -She did not look at the amount of medication available when she looked at opened dates. -She did not look at counters on inhalers or levels of medications in creams, or eye drops. -It appeared Resident #2's budesonide-formoterol was not administered because the counter indicated only a couple of doses had been administered since the open date of 01/17/23. <p>Interview with the Administrator on 02/02/23 at 4:16pm revealed:</p> <ul style="list-style-type: none"> -The MAs wrote the opened date on inhalers on the first day they began to administer it. -Resident #2's budesonide-formoterol looked like it was not administered but a couple of times after the open date was marked on it. -She did not know if the Clinical Supervisor looked at the dosage indicator on inhalers when she did her cart audits. -She expected Resident #2's inhaler to be administered as ordered because the PCP had ordered it for a reason. <p>b. Review of Resident #2's current FL2 dated 04/06/22 revealed medication orders included an order for multivitamin (used to provide vitamins that may not be taken in through the diet) once daily.</p> <p>Review of Resident #2's physician's order dated 11/16/22 revealed a discontinue order for a multivitamin once daily.</p> <p>Review of Resident #2's December 2022 electronic Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for multivitamin once daily scheduled at 8:00am. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 43</p> <p>-There was documentation the multivitamin was administered 31 of 31 opportunities from 12/01/22 to 12/31/22.</p> <p>Review of Resident #2's January 2023 eMAR revealed: -There was an entry for a multivitamin once daily scheduled at 8:00am. -There was documentation a multivitamin was administered 31 of 31 opportunities from 01/01/23 to 01/31/23.</p> <p>Review of Resident #2's eMAR for 02/01/23 to 02/02/23 at 9:12am revealed: -There was an entry for multivitamin once daily scheduled at 8:00am. -There was documentation a multivitamin was administered on 02/01/23 and 02/02/23 at 8:00am.</p> <p>Observation of Resident #2's medications on hand on 02/02/23 at 10:27am revealed: -Resident #2's scheduled medication tablets were dispensed in a multidose package. -The label for the multidose package included a multivitamin scheduled daily at 8:00am. -There was a multivitamin in the multidose bubble labeled for the 8:00am administration.</p> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/23 at 11:49am revealed: -Resident #2 had a current order date 05/4/22 for a multivitamin scheduled once daily. -Resident #2's multivitamin was dispensed in a multidose package and was on cycle fill. -A seven-day supply of Resident #2's multivitamin was dispensed on 01/12/23, 01/19/23 and 01/26/23. -Discontinue orders were sent to the pharmacy by</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 44</p> <p>the facility electronically or faxed or electronically by the physician. -The pharmacy did not have a discontinued order for Resident #2's multivitamin.</p> <p>Telephone interview with Resident #2's primary care provider (PCP) on 02/02/23 at 2:10pm revealed: -She had discontinued Resident #2's multivitamin when she saw her on 11/16/22. -She did not feel Resident #2 needed a multivitamin and did not want her to have the calcium and extra iron because they counter each other, and some vitamins interfere with other medications. -It was also an increased tablet burden when a resident had multiple tablets to take every day and a multivitamin was not needed. -She expected the order to discontinue the multivitamin to be followed when she wrote the order.</p> <p>Interview with a medication aide (MA) on 02/02/23 at 10:27am revealed: -She did not know about the discontinue order for Resident #2's multivitamin. -When a discontinue order was sent to the pharmacy and the multidose package was already on the medication cart the Memory Care Manager (MCM) would place a discontinue sticker on the multidose package so the MAs would know to not administer the tablet and to waste it. -She did not recall ever seeing the order to discontinue the multivitamin or see a sticker on the multidose package.</p> <p>Interview with the Memory Care Manager (MCM) on 02/02/23 at 2:55pm revealed: -When a PCP discontinued a medication, the</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 45</p> <p>order would be sent to the pharmacy by the facility or electronically by the PCP.</p> <ul style="list-style-type: none"> -She could also discontinue orders on the eMAR system herself. -She also placed a sticker on the multidose package so the MAs would take the medication out of the package, not administer it and dispose of the tablet. -If the multivitamin order had not gone through and had continued on the eMAR the MA would not have known to not administer the medication because the sticker would have not been placed on subsequent packages. -She checked on discontinue orders on the eMAR to ensure they were completed; she called the pharmacy if the order did not go through. -The physicians' order dated 11/16/22 was an electronic order; it was her responsibility to make sure the order had been discontinued. -The discontinue order for Resident #2's multivitamin had been missed and should have been caught. <p>Interview with the Clinical Supervisor on 02/02/23 at 3:15pm revealed:</p> <ul style="list-style-type: none"> -Discontinued orders were sent to the pharmacy by facility staff and removed from the eMAR by the pharmacy. -The MAs removed discontinued medications from the cart or put a discontinued sticker on the medication label if it was in a multidose package. -She looked for discontinued medication when she did her weekly cart audits. -There was not a process to ensure the orders were received at the pharmacy once they were discontinued. -Discontinued orders were sent to the pharmacy via fax at the facility or electronically by the physician. -Once an order was discontinued at the 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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	<p>Continued From page 46</p> <p>pharmacy the MAs would have to approve the order in the eMAR.</p> <p>-Once the pharmacy discontinued a medication, they stopped dispensing it.</p> <p>-It was up to the MAs, the MCM and herself to look for errors on the medication carts or with medication orders.</p> <p>-A discontinued order for medication should not have been missed; it should not have continued to be administered after it was discontinued.</p> <p>Interview with the Administrator on 02/02/23 at 4:16pm revealed:</p> <p>-Discontinued medication orders were sent to the pharmacy by the facility via fax or electronic communication and the MCM could also remove an order from the eMAR.</p> <p>-The Clinical Supervisor, the MCM, the MAs and the Administrator were responsible for medication discontinue orders.</p> <p>-There was no way to determine which staff processed the discontinue orders for Resident #2's multivitamin.</p> <p>-Resident #2's multivitamin should have been discontinued at the pharmacy and the facility staff should have caught when it was not.</p> <p>-She did not know what happened to Resident #2's discontinue order for the multivitamin and why it was never caught.</p> <p>Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.</p> <p>_____</p> <p>The facility failed to ensure a resident, who had a history of diabetes and elevated FSBS ranging from 110-511, received the correct amount of Novolog insulin on 78 occasions from 12/01/22-02/01/23. The facility's failure was detrimental to the health and welfare of the</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 47 resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 02/02/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2023	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the Medication Aide (MA) pre-charted medications administered on the electronic medication administration record (eMAR) prior to the administration of the medications for 4 of 4 residents (#5, #7, #9, and #10) observed during the 8:00am morning medication pass on 02/01/23. The findings are: Review of the facility's medication administration policy dated September 2013 revealed: -The Medication Aide (MA) must document	D 366	Caswell House shall ensure that the recording of medications administered shall be by the staff member that administered the medication immediately after administration, after watching the Resident actually take the medication, and not precharting. ACD in-serviced the Med Techs on 2/3/23 the importance of following the 6 Rights of medication administration, especially Right Documentation to ensure all Residents are getting their medications as ordered. RCC/Special Care Coordinator (SCC)/ 3/19/23 ED will complete random observations during med pass to ensure Med Techs are following proper procedures regarding medication administration and documentation. ED will provide disciplinary action to 3/19/23 Med staff found to be precharting, as this is an unsafe process and violates the 6 Rights of Medication Administration.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 48</p> <p>medications immediately on the eMAR after each resident's medications are administered and prior to administering another resident's medications. -The MA is not to document medication before the resident actually takes the medication; this is called pre-charting.</p> <p>1. Observation of the 8:00am medication pass on 02/01/23 revealed: -The Medication Aide (MA) clicked on Resident #9's picture on the electronic medication administration record (eMAR). -Resident #9's medications for the 8:00am medication pass appeared on the eMAR. -The MA opened the second drawer of the medication cart and removed Resident #9's weekly multi-dose pack (MDP) and one bubble pack. -The MA removed two individual MDP's from Resident #9's weekly MDP stamped Wednesday morning 02/01/23. -The first MDP contained 1 Tylenol 650mg (used to treat pain) tablet and 2 vitamin D3 400units (used as a supplement) tablets. -The second MDP contained 1 presersivion (used as a supplement) tablet. -The MA clicked "prep" on the eMAR. -She opened both MDP packs and placed the pills in the medication cup. -She popped meloxicam 7.5mg (used to relieve arthritis pain) from the bubble pack into the same medication cup and clicked "complete" on the eMAR. -She administered the medications to Resident #9 with a cup of water at 7:20am. -She returned to the eMAR and selected another resident to administer medications.</p> <p>Review of Resident #9's current FL-2 dated 07/20/22 revealed diagnoses included</p>	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 49</p> <p>Alzheimer's dementia, hyperlipidemia hypothyroidism, depression, and iron deficiency anemia.</p> <p>Review of Resident #9's signed physician order dated 08/03/22 revealed an order for Tylenol 650mg every 12hours.</p> <p>Review of Resident #9's signed physician order dated 11/02/22 revealed an order for vitamin D3 400units 2 tablets daily.</p> <p>Review of Resident #9's signed physician order dated 01/13/23 revealed an order for presersion twice a day with meals.</p> <p>Review of Resident #9's signed physician order dated 01/25/23 revealed an order for meloxicam 7.5mg daily.</p> <p>Interview with MA on 02/01/23 at 7:38am revealed: -She pulled Resident #9's medications from the medication cart and clicked "prep" on the eMAR. -After she popped the pills in the medication cup she clicked "complete" on the eMAR. -When "complete" is clicked it automatically signs your initials on the eMAR. -She knew she signed the eMAR before administering the medications to Resident #9. -She knew which residents would take their medications and which ones would not. -If it was a resident who would not take their medications, she would not have signed the eMAR prior to medication administration.</p> <p>Refer to interview the with the Memory Care Manager on 02/01/23 at 2:10pm.</p> <p>Refer to the interview with the Clinical Supervisor</p>	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 50 on 02/01/23 at 2:43pm.</p> <p>Refer to the interview with the Administrator on 02/01/23 at 3:05pm.</p> <p>2. Observation of the 8:00am medication pass on 02/01/23 revealed:</p> <ul style="list-style-type: none"> -The MA clicked on Resident #5's picture on the electronic medication administration record (eMAR). -Resident #5's medications for the 8:00am medication pass appeared on the eMAR. -The MA opened the second drawer of the medication cart and removed Resident #5's weekly multi-dose pack (MDP). -The MA removed two individual MDP's from Resident #5's weekly MDP stamped Wednesday morning 02/01/23. -The first MDP contained 1 vitamin D3 1000units (used as a supplement), 1 escitalopram 10mg (used to treat depression), 1 lisinopril 100mg (used to treat high blood pressure) and docusate sodium 100mg (used as a stool softener). -The second MDP contained 1 metformin 500mg (used to lower blood sugar). -The MA clicked "prep" on the eMAR. -She opened both MDP packs and placed the pills in the medication cup and clicked "complete" on the eMAR. -She administered the medications to Resident #5 with a cup of water at 7:26am. -She returned to the eMAR and selected another resident to administer medications. <p>Review of Resident #5's current FL-2 dated 08/22/22 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included dementia, type 2 diabetes, hyperlipidemia, and hypertension. -There was an order for vitamin D3 1000units daily. 	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/02/2023
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 51</p> <ul style="list-style-type: none"> -There was an order for escitalopram 10mg daily. -There was an order for lisinopril 100mg daily. -There was an order for docusate sodium 100mg daily. -There was an order for metformin 500mg daily. <p>Interview with MA on 02/01/23 at 7:38am revealed:</p> <ul style="list-style-type: none"> -She pulled Resident #5's medications from the medication cart and clicked "prep" on the eMAR. -After she popped the pills in the medication cup she clicked "complete" on the eMAR. -When "complete" is clicked it automatically signs your initials on the eMAR. -She knew she signed the eMAR before administering the medications to Resident #9. -She knew which residents would take their medications and which ones would not. -If it was a resident who would not take their medications, she would not have signed the eMAR prior to medication administration. <p>Refer to interview the with the Memory Care Manager on 02/01/23 at 2:10pm.</p> <p>Refer to the interview with the Clinical Supervisor on 02/01/23 at 2:43pm.</p> <p>Refer to the interview with the Administrator on 02/01/23 at 3:05pm.</p> <p>3. Observation of the 8:00am medication pass on 02/01/22 revealed:</p> <ul style="list-style-type: none"> -The second Medication Aide (MA) clicked on Resident #'s 7's picture on the electronic medication administration record (eMAR). -Resident #7's medications for the 8:00am medication pass appeared on the eMAR. -The MA opened the second drawer of the medication cart and removed Resident #7's 	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 52</p> <p>weekly multi-dose pack (MDP).</p> <ul style="list-style-type: none"> -The MA removed two individual MDP's from Resident #7's weekly MDP stamped Wednesday morning 02/01/23. -The first MDP contained 1 acetaminophen 500mg (used to treat pain), bupropion 150mg (used to treat depression), carvedilol 6.25mg (used to treat high blood pressure), escitalopram 10mg (used to treat depression), and hydralazine 25mg (used to treat high blood pressure). -The second MDP contained presersivision (used as a supplement). -The MA opened the top drawer of the medication cart and removed one bottle of eye drops for Resident #7. -The MA clicked "prep" on the eMAR. -She opened both MDP packs and placed the pills in the medication cup and clicked "complete" on the eMAR. -She administered the medications to Resident #7 at 7:57am. -She returned to the eMAR and selected another resident to administer medications. <p>Review of Resident #7's current FL-2 dated 11/29/22 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included dementia, type 2 diabetes, chronic kidney disease stage V, end-stage renal disease, unspecified atrial fibrillation, thoracic aortic aneurysm, and pulmonary embolism. -There was an order for acetaminophen 500 mg twice daily. -There was an order for bupropion 150mg every morning. -There was an order for carvedilol 6.25mg twice daily. -There was an order for escitalopram 10mg daily. -There was an order for hydralazine 25mg ½ tablet twice daily. 	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 53</p> <p>Review of Resident #7's signed physician order dated 11/07/22 revealed an order for artificial tears one drop in each eye every 4 hours while awake.</p> <p>Review of Resident #7's signed physician order dated 01/13/23 revealed an order for preservative AREDS-2 one capsule twice daily.</p> <p>Interview with a MA on 02/01/23 at 1:33pm revealed: -She clicked "complete" on the eMAR prior to administration of Resident #7's medications. -She always signed the eMAR prior to administration of medications to the residents unless it was a resident who would refuse their medications. -If she knew a resident refused their medications, she would not sign the eMAR until after the administration of the medications to ensure the resident took the medications. -If she had signed the eMAR that the medications were administered and the resident refused to take the medications she would document in the progress notes the resident refused the medications.</p> <p>Refer to interview the with the Memory Care Manager on 02/01/23 at 2:10pm.</p> <p>Refer to the interview with the Clinical Supervisor on 02/01/23 at 2:43pm.</p> <p>Refer to the interview with the Administrator on 02/01/23 at 3:05pm.</p> <p>4. Observation of the 8:00am medication pass on 02/01/22 revealed: -The second Medication Aide (MA) clicked on</p>	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 54</p> <p>Resident # 8's picture on the electronic medication administration record (eMAR). -Resident #8's medications for the 8:00am medication pass appeared on the eMAR. -The MA opened the second drawer of the medication cart and removed Resident #8's weekly multi-dose pack (MDP). -The MA removed one individual MDP from Resident #8's weekly MDP stamped Wednesday morning 02/01/23. -The MDP contained 1 amlodipine 10mg (used to treat high blood pressure), 1 aspirin 81mg (used to decrease the risk of heart attacks and strokes), escitalopram 10mg (used for depression) 1 potassium chloride 20 mEq (used as a supplement) -The MA opened the top drawer of the medication cart and removed one bottle of eye drops and one inhaler for Resident #8. -The MA clicked "prep" on the eMAR. -She opened the MDP packs and placed the pills in the medication cup and clicked "complete" on the eMAR -She administered the medications to Resident #8 at 8:04am. -She returned to the eMAR and selected another resident to administer medications.</p> <p>Review of Resident #8's current FL-2 dated 06/15/22 revealed diagnoses included dementia, diabetes, paranoia, asthma, and hypertension.</p> <p>Review of Resident #8's signed six-month physician orders dated 12/24/22. -There was an order for escitalopram 10mg every morning. -There was an order for amlodipine 10mg daily. -There was an order for aspirin 81mg daily. -There was an order for potassium chloride 20 mEq twice daily.</p>	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 55</p> <p>-There was an order for Symbicort inhaler 2 puffs twice a day rinse mouth with water and expectorate after each use.</p> <p>Review of Resident #8's signed physician order dated 01/13/23 revealed an order for brimonidine eye drops one drop in each eye twice daily.</p> <p>Review of Resident #10's signed physician order dated 01/13/23 revealed an order for brimonidine 0.2% ophthalmic solution one drop in each eye twice daily.</p> <p>Interview with a MA on 02/01/23 at 1:33pm revealed:</p> <ul style="list-style-type: none"> -She clicked "complete" on the eMAR prior to administration of Resident #7's medications. -She always signed the eMAR prior to administration of medications to the residents unless it was a resident who would refuse their medications. -If she knew a resident refused their medications, she would not sign the eMAR until after the administration of the medications to ensure the resident took the medications. -If she had signed the eMAR that the medications were administered and the resident refused to take the medications she would document in the progress notes the resident refused the medications. <p>Refer to interview the with the Memory Care Manager on 02/01/23 at 2:10pm.</p> <p>Refer to the interview with the Clinical Supervisor on 02/01/23 at 2:43pm.</p> <p>Refer to the interview with the Administrator on 02/01/23 at 3:05pm.</p>	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	<p>Continued From page 56</p> <p>Interview with the Memory Care Manager on 02/01/23 at 2:10pm revealed: -The MAs should prepare the medications and click "prep" on the eMAR. -The MAs should administer the medications to the residents and then click "complete" on the eMAR. -The eMAR should not be signed by the MA that the medication was administered prior to the resident taking the medications. -If the resident's refused the medication, then the documentation on the eMAR would be incorrect.</p> <p>Interview with the Lead SIC on 02/01/23 at 2:43pm revealed: -The MAs should administer the medications prior to signing the eMAR. -She expected the medications to be administered prior to the MA signing the eMAR.</p> <p>Interview with the Administrator on 02/01/23 at 3:05pm revealed: -The MAs should prepare the medications and click "prep" on the eMAR. -The MAs should administer the medications to the residents. -The MA should return to the medication cart and click "complete" on the eMAR. -The MAs should not be documenting medications were administered before they were administered. -She expected the MAs to document on the eMAR that medications were administered after the residents had taken their medications.</p>	D 366		
D 371	<p>10A NCAC 13F .1004(n) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration</p>	D 371	<p>Caswell House shall ensure that medications are administered according to infection control measures that help prevent the development and transmission of disease or infection, prevent cross-contamination and provide a</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	--

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 371	<p>Continued From page 57</p> <p>(n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who popped a pill into her bare hand prior to administration; and failed to don gloves when administering an eye drop and an inhaler.</p> <p>Review of the facility's policy for administration of eye drops and inhalers revealed: -The policy was dated September 2021. -The MA should wash her hands and don gloves prior to the administration of eye drops and inhaler. -The MA should remove gloves and wash her hands after the administration of eye drops and inhaler.</p> <p>Observation of a medication aide MA administering medications during the morning medication pass on 02/01/23 at 7:20am revealed: -The MA initiated preparing medications for administration to a resident. -The MA prepared 5 pills for administration for a resident. -The MA punched 4 pills from the multi-dose pack into a medication cup. -The MA punch one pill from a bubble pack into her ungloved, bare hand and placed the pill in the medication cup.</p> <p>Interview with a medication aide on 02/01/23 at 7:22am revealed:</p>	D 371	<p>safe and sanitary environment for staff and Residents.</p> <p>ACD re-inserviced Med Techs on medication administration related to infection control and hand hygiene, to ensure Residents receive medications in a sanitary manner.</p> <p>ACD will complete random med pass observations at a minimum of 3 per month for the next quarter, to ensure staff is following proper sanitary technique when administering medications.</p> <p>RCC/SCC will complete random observations during med passes to ensure med techs are following the infection control policy. Any concerns will be voiced to the ED and ACD for follow-up education as appropriate.</p>	<p>2/3/23</p> <p>3/19/23</p> <p>3/19/23</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 371	<p>Continued From page 58</p> <ul style="list-style-type: none"> -She popped one pill in her hand. -She should have donned a glove if she was going to pop a pill in her hand. -She could have popped the pill in a cup. -She was use to popping pills that were in bubble packs in her hand. <p>Observation of the second MA administering medications during the morning medication pass on 02/01/23 at 8:00am revealed:</p> <ul style="list-style-type: none"> -The MA gathered the resident's eye drops and from the top drawer of the medication cart. -The MA approached the resident, gave her a tissue, and administered eye drops to both eyes. -The MA returned to the medication cart and placed the eye drops in the top drawer of the medication cart. -The MA did not don gloves or wash her hands with soap and water prior to the administration of the eye drops. <p>Interview with the second medication aide (MA) on 02/01/23 at 1:33pm revealed:</p> <ul style="list-style-type: none"> -She did not don glove or wash her hands before and after administering eye drops. -She did not have any gloves on the medication cart. -She knew she should wear gloves when administering eye drops. -She should have stopped and gotten gloves before continuing with the medication pass. <p>Observation of the second MA administering medications during the morning medication pass on 02/01/23 at 8:04am revealed:</p> <ul style="list-style-type: none"> -The MA gathered the resident's inhaler and from the top drawer of the medication cart. -The MA approached the resident, gave her the inhaler, and instructed the resident how to use the inhaler. 	D 371		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 371	<p>Continued From page 59</p> <ul style="list-style-type: none"> -The MA returned to the medication cart and placed the inhaler in the top drawer of the medication cart. -The MA did not don gloves or wash her hands with soap and water prior to the administration of the inhaler. <p>Interview with the second medication aide (MA) on 02/01/23 at 1:33pm revealed:</p> <ul style="list-style-type: none"> -She did not don glove or wash her hands before and after administering the inhaler. -She did not know she needed to wear gloves and wash her hands before and after administering an inhaler. -She did not recall being told she need to wear gloves and wash her hands each time she administered an inhaler. <p>Interview with the Memory Care Manager on 02/01/23 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -The MAs should pop pills into the medication cup. -The MAs need to ensure the medication cart is stocked with gloves to use when administering medications. -The MAs should wash their hands and don gloves when administering eye drops and inhalers. <p>Interview with the Clinical Supervisor on 02/01/23 at 2:43pm revealed:</p> <ul style="list-style-type: none"> -The MAs need to don gloves if they pop a pill in their hand. -The MAs were to wash their hands and wear gloves before and after administration of eye drops and inhalers. -There was an increase chance of infection if the MAs did not wear gloves or wash their hands. -She expected the MA to follow infection control procedures when administering medications. 	D 371		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 371	Continued From page 60 Interview with the Administrator on 02/01/23 at 3:05pm revealed: -The MAs should pop pills in the medication cups and not in their hands. -Gloves should be worn when eye drops and inhalers were administered. -The MAs should wash their hands after administering eye drops and inhalers. -She expected the MAs to follow infection control policies.	D 371		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours of knowledge of a resident (#10) who verbalized an incident in her room involving other residents. The findings are: Review of the facility's policy on resident abuse, neglect, and exploitation dated September 2021 revealed: -In the event of physical and or verbal abuse, neglect, fraud, or exploitation of the resident or resident property or allegations of physical or	D 438	Caswell House shall comply with G.S. 131E-256 and supporting rules related to HCPR reporting. ED completed 24Hr/5day report on 2/1/23 Resident #10 and submitted to HCPR regarding Resident allegation. ED completed Resident Rights 3/7/23 in-service for all staff. Regional Director of Operations (RDO) in-serviced ED on the importance of 2/3/23 completing required reporting to HCPR on all allegations of abuse, neglect, exploitation even if Resident has cognitive impairment. Also in-serviced staff on the importance of immediately reporting any concerns of abuse/ neglect/ exploitation anytime there is a suspicion, as well as anytime a resident reports an allegation so that appropriate follow-up can occur. ED will ensure accurate and timely 3/19/23 completion of reporting to HCPR	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 438	<p>Continued From page 61</p> <p>verbal abuse, neglect, fraud, or exploitation of the resident or community property by community staff, the community would complete the Health Care Personnel Registry (HCPR) 24-hour report now referred to as the Initial Report.</p> <p>-Upon notification of any of the above allegations the community would begin an investigation and document findings on the HCPR 5-day report now referred to as the Investigation Report and submit it to the HCPR.</p> <p>-In the event of any accusation of abuse; of a resident by staff, visitors, or other resident(s), management would direct staff to assure the immediate safety of the resident.</p> <p>-If resident on resident altercation/abuse, the residents would be separated or relocated to another room as needed.</p> <p>-The physician would be notified for any additional orders which may include referral to outside resources for further medical evaluation, and the family, responsible party, and or guardian will be notified and advised of their right to request notification of local authorities.</p> <p>-If there was any physical harm or injury present the resident(s) would be sent out to the hospital for further evaluation unless the resident or responsible party declines further evaluation.</p> <p>-All required reporting would be completed as required not limited to local law enforcement and the Department of Social Services (DSS).</p> <p>-The community would complete the HCPR 24-hour report and begin an immediate investigation.</p> <p>-Immediate suspension of the accused individual (staff) if named or suspected parties pending investigation.</p> <p>-Complete the HCPR 24-hour report within 24 hours of discovery or knowledge of alleged abuse.</p> <p>-Community Management would begin the</p>	D 438	<p>regarding allegations of abuse.</p> <p>ED will ensure that any staff member accused of abuse is suspended pending completion of the investigation to ensure Resident safety, and will complete a thorough investigation of the allegation.</p>	3/19/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 438	<p>Continued From page 62</p> <p>investigation to substantiate or unsubstantiate the allegations for reporting on the HCPR 5-day working report.</p> <ul style="list-style-type: none"> -Interview all staff present or any individuals present during the allegation. -Interview any providers or ancillary support services that may have details regarding the alleged abuse. -Complete and submit the 5-day working report either substantiated or unsubstantiated <p>Review of Resident #10's current FL-2 dated 06/08/22 revealed diagnoses included dementia, Schizo affective disorder, bipolar affective disorder, and chronic kidney disease.</p> <p>Review of Resident #10's care plan dated 10/27/22 revealed the resident was sometimes disoriented.</p> <p>Review of Resident #10's progress notes from 11/01/22-02/02/23 revealed there was no documentation related to the resident verbalizing there had been an incident in her room involving other residents.</p> <p>Review of Resident #10's primary care provider (PCP) after visit summary dated 12/21/22 revealed:</p> <ul style="list-style-type: none"> -Resident #10 was being seen for an acute visit at the request of the facility. -Resident #10 was alert and oriented x 2. -Resident #10 stated she had been attacked in her room at night by a man. -Resident #10 endorsed fearful delusions and paranoia and wanted to lock her door. -Resident #10 recounted a history of childhood abuse. -The PCP requested 15-minute checks from the facility for 3 days to rule out possible intruders. 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 438	<p>Continued From page 63</p> <p>-The PCP was going to reach out to the geriatric psychiatric provider.</p> <p>Review of Resident #10's Increased Supervision and Accountability Checklist dated 12/21/22-12/23/22 revealed there was documentation that Resident #10 was checked every 15 minutes.</p> <p>Interview with Resident #10 on 01/31/23 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -When she first moved to the facility, "been a while" more than one man came into her room and stood around her bed. -She thought the men were taking turns. -She did not know what the men did, but she was sore the next morning. -Her arms were sore, and her insides were sore. -She knew the men had sex with her even though she did not recall having sex. -She did not remember anything about what happened other than men standing around her bed. -She tried to tell people about it, and it was "pushed under the rug." -She could not describe the men because she did not see them; she just knew they were there. -It only happened one time and no men had come into her room since then. <p>Interview with a representative of the local Department of Social Services (DSS) on 02/01/23 at 9:00am revealed:</p> <ul style="list-style-type: none"> -She met with Resident #10 on 12/16/22 after being notified of the resident's allegation. -Resident #10 told her she had been at the facility for two years and her family member "put her there." -Resident #10 told her men were coming into her room at night. 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 438	<p>Continued From page 64</p> <ul style="list-style-type: none"> -Resident #10 could not tell her anything about the men or when this occurred. -Resident #10 reported she was too sleepy to scream because she was asleep when it happened. -Resident #10 started talking about a male family member and could not be redirected back to the incident. -Resident #10 talked about being watched by people at the facility and the people thought she had money. -Resident #10 was concerned her door could not be locked. -The representative of the local DSS demonstrated to Resident #10 the door was locked from the outside, but because the resident could open it from the inside, she did not believe her door was locked so others could not enter her room. -She interviewed other residents, and no one reported having any issues with others coming into their rooms. -She interviewed the Administrator on 12/16/22 who was aware of the incident and had investigated the incident and reported the resident was not able to tell her anything about the incident or the people involved and who also had a hard time keeping the resident on topic. <p>Interview with Resident #10's PCP on 02/01/23 at 1:25pm revealed:</p> <ul style="list-style-type: none"> -She had been made aware of the incident with Resident #10. -She met with Resident #10, and it was hard to get any information about what had happened. -She asked the facility to do 15-minute checks for 3 days to monitor the resident. -She had reviewed the 15-minute checks that were completed. -She could not ask the facility to do 15-minute 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/02/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379
--	---

(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 438	<p>Continued From page 65</p> <p>checks long-term.</p> <ul style="list-style-type: none"> -The resident had not talked about the incident anymore after that day. -Resident #10's family member contacted her last week (the week of 01/23/23) to discuss the incident. -She had made an appointment for Resident #10 to be seen by a gynecologist on 02/07/23. <p>Interview with the Administrator on 02/01/23 at 1:33pm revealed:</p> <ul style="list-style-type: none"> -She overheard Resident #10 talking about men coming into her room. -She did not recall when Resident #10 was overheard but it was before Christmas. -She asked Resident #10 about men coming into her room and the resident's story was intertwined with other stories and she could not get any clarity on what happened. -The resident could not tell her anything about the man, his race, or how he looked. -She would ask the resident what the man looked like, and she would talk about wanting to go home and about her family member "putting her" at the facility. -She talked to staff on third shift, and no one had observed anyone going into Resident #10's room; staff stated Resident #10 kept her door locked. -The day Resident #10 was talking about the incident, she stayed overnight in a room so she could observe for herself if any residents were going into other resident rooms. -She observed several residents going outside to smoke; residents who smoked were always accompanied by a staff member. -She did not observe any residents going into any other resident rooms. -She talked to Resident #10 on multiple occasions about the incident and Resident #10 could never describe the person who came into 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/02/2023
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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 438	<p>Continued From page 66</p> <p>her room.</p> <ul style="list-style-type: none"> -She did not recall the dates/times of anything related to her investigation and she did not document what she had done. -She talked to Resident #10 multiple times, and she would never stay on the topic of the incident and would start talking about things in the past with her family. -There had only been one male staff who worked at night, and he worked in the special care unit (SCU). -She talked to Resident #10's PCP about the resident's allegation. -She talked to Resident #10's mental health provider about the resident's allegation. -She talked to other residents to see if anyone had any similar concerns, and no one did. -She talked to staff, and no one had been told of any concerns. -She did not do a 24-hour or 5-day report to the HCPR report because she did not have enough information to say anything happened to do a report. <p>_____</p> <p>The facility failed to ensure an allegation of abuse reported by a resident was reported to the HCPR. This failure resulted in putting the resident at risk of physical harm which was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 02/01/23.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2023</p>	D 438		