PRINTED: 03/18/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		DATE SURVEY COMPLETED
						С
		345449	B. WING _			02/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/KING			115 WHITE ROAD		
				KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000		
F 000	investigation survey v 2/8/19. The facility wa		F(	000		
		certification and complaint was conducted on 2/4/19 to				
	Immediate Jeopardy	was identified at:				
	(J) CFR 483.25 at tag F6 (J)	580 at a scope and severity 584 at a scope and severity 760 at a scope and severity				
	The tags F684 and F Quality of Care.	760 constituted Substandard				
	removed on 02/08/19 conducted.	began on 01/25/19 and was  An extended survey was				212112
F 580 SS=J	Notity of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) ·)(i)-(iv)(15)	F 5	580		2/8/19
	consult with the resid consistent with his or representative(s) who (A) An accident involve	rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Electronically Signed 03/04/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345449	B. WING _			C 02/08/2019
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021	<b>'</b>	32/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	mental, or psychosod deterioration in healistatus in either life-tl clinical complication (C) A need to alter the aneed to discontinual treatment due to advormence a new for (D) A decision to train resident from the fact §483.15(c)(1)(ii).  (ii) When making no (14)(i) of this section all pertinent informatis available and proving physician.  (iii) The facility must resident and the resident and	nge in the resident's physical, cial status (that is, a th, mental, or psychosocial preatening conditions or s); reatment significantly (that is, e an existing form of verse consequences, or to rm of treatment); or ensfer or discharge the cility as specified in tification under paragraph (g) to the facility must ensure that the facility of the facility in the facility of the	F	580		

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		IDENTIFICATION NITIMBED:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345449	B. WING			C 2/08/2019	
NAME OF PE	ROVIDER OR SUPPLIER	0.01.0		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	2/06/2019	
	10 115211 011 001 1 21211			115 WHITE ROAD			
UNIVERSA	AL HEALTH CARE/KING			KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	2	F 58	0			
	by:	is not met as evidenced iews, record review, and		The creation of this Letter of Cre	edible		
	Physician interview th	ne facility failed to notify the  f a meal refusal prior to		allegation constitutes a written al of compliance. Preparation and			
		that was ordered by the		submission of this letter does not	t		
	physician to be given			constitute an admission or agree			
	. ,	lents reviewed for insulin		the provider of the truth of the fac	-		
		ilure of the facility to notify		alleged or the correctness of the			
	the physician of the re	esident's refusal to eat and		conclusions set forth by the surve	еу		
	administering the insu	ılin without a meal as		agency. This letter is solely prepa	ared		
	ordered resulted in th	e resident becoming		because of requirement under st	ate and		
	unresponsive and ser	nt to the Emergency		federal law, and to demonstrate t	the good		
	Department. She req	uired a central line and		faith attempts by the provider to i	improve		
	intubation on admissi			the quality of life of each resident			
	T	were acute respiratory		Date: 2/08/2019			
		I status, hypothermia (low		Corrective action accomplished f	or those		
		nd hypoglycemia (low blood		residents found to have been affe			
		also failed to notify the		the deficient practice.	2010 27		
		ended weight loss for 1 of 4		Resident #192 was admitted on	1/23/2019		
		ed residents reviewed for		for short term rehabilitation service			
	nutrition.			Resident #192 received skilled n			
				and rehabilitation services from 1	•		
	Immediate jeopardy b	egan on 1/25/19 when the		up to 1/25/2019. Review of facilit	v most		
		nsure Resident #192's		recent minimum data set, with	,		
		the resident, who was		Assessment reference date 1/25	/2018		
		tes Mellitus (DM) and was		section I (active diagnosis) indica			
	•	d not eaten her breakfast		resident #192 had a diagnosis of			
	-	tering to the resident 58		diabetes mellitus with diabetic ne	• •		
	-	0, a combination of short		Review of physician orders revea			
	_	g insulin, which was ordered		resident #192 had an order for N			
		s. The immediate jeopardy		Mix 70-30 to be given subcutane	•		
	•	19 when the facility provided		twice daily with meals.	•		
	and implemented an	• •		On 1/25/2019 resident #192 rece	eived		
		te Jeopardy removal. The		Novolog 70-30 at 10:24am. Inter-			
	_	of compliance at a lower		nurse aide #1 who was caring for			
		level "D" (no actual harm		#192, on 1/25/2019 morning shift			

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		345449	B. WING			C 02/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE I	02/00/2010	
				115 WHITE ROAD			
UNIVERSA	AL HEALTH CARE/KING			KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From page	÷ 3	F 58	30			
	with the potential for i	minimal than harm that is not		indicated resident #192 refus	sed her		
	immediate Jeopardy)			breakfast in the morning of 1			
	, ,,	·		Interview with nurse assistar			
	Findings included:			conducted by the facility □s D	Director of		
				Nursing indicates resident #			
		admitted to the facility on		snacks during the night of 1/2	24/2019 to		
		noses that included Diabetes		the morning of 1/25/2019.			
		thyroidism (underactive ension (HTN - high blood		On 1/25/2018, at 12:15pm le hours after resident #192 red			
		is (inflammation in the gut		Novolog 70-30, 58 units; lice			
		intestine and colon) related		#1 indicated; she went to res			
		(C-diff), an infection in the		room and observed resident			
	colon that is caused b			unresponsive. She immediat	tely obtained		
	clostridium difficile.			vital signs as well as blood g	lucose. Blood		
				glucose result was noted to l	•		
		an orders for Resident #192		normal limits 70-110). Licens			
	-	ed on 1/23/19 for Finger		contacted emergency medic			
		SBS) checks before meals &		who then transferred residen	it #192 to the		
	at bedtime. There was administer 58 units su			hospital. On 2/8/2019; the facility Med	lical Director		
		ayer between the skin and		had an extensive discussion			
		ith meals of Novolog 70/30.		State surveyors on site to ex			
		ufacturer, Novolog 70/30 is		medical rationale for the repo	-		
		ade fast-acting insulin to		hypoglycemic episode for res			
	help control mealtime	spikes in blood sugar and		documented by both EMS ar	nd emergency		
		at works up to 24 hours to		room Physician on 1/25/2019	-		
	· ·	gar between meals. The		Medical Director explained th			
		nes stated that people with		#192 hypoglycemic episode	-		
		d have the injection within		related to resident #192□s c	•		
	15 minutes before or	after starting their meal.		condition that was not diagno			
	Resident #192's Janu	ary 2019 medication		resident #192 was admitted on 1/23/2019, two days befo	•		
		(MAR) revealed Resident		episode of hypoglycemia. Th			
		A scheduled FSBS check on		medical director added; on 1			
	1/25/19 at 6:37 AM a			ordered thyroid stimulating h			
		ng/dl). The Novolog 70/30		(TSH) laboratory test following			
		eduled for 9:00 AM was		from facility licensed staff that	•		
	documented as admir	nistered on 1/25/19 at 10:24		#192 was lethargic. The facil	lity obtained		
	AM by Nurse #2.			the laboratory test on 1/24/19	9 as ordered		

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		345449	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	0-10-1-10		STREET ADDRESS, CITY, STATE, ZIP CODE	02/08/2019	
NAME OF T	TOVIDER OR SOLT LIER					
UNIVERSA	AL HEALTH CARE/KING			115 WHITE ROAD KING, NC 27021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 580	Continued From page	<del>2</del> 4	F 580			
	According to the meal percentage sheet, Resident #192 did not eat anything for breakfast or lunch on 1/25/19.			and received the result on 1/25/2019. TSH result from 1/24/2019 indicated		
				resident #192 had a condition called Hypothyroidism. The facility Medical		
	During an interview w	rith Nurse Aide (NA) #6 on		Director expressed to the state survey on site that resident #192□s fluctuation		
	2/6/19 at 4:46 PM abo	` ,		blood sugar was related to her untreat		
		take on 1/25/19, she stated		and undiagnosed thyroid condition and		
		on the bedpan several times		not due to the administration of the ins		
	When asked if she no	t she had refused breakfast.		that was given less than two hours befine she was observed been unresponsive		
		at breakfast, she stated		Facility Medical Director ordered Synth		
	Nurse#2 was made a			100mcg, medication used to treat		
				hypothyroidism but medication was no		
	_	rith Nurse #2 on 2/7/19 at		started as resident #192 was transferr	ed	
	1:17 PM she stated to AM she went into Res	nat at approximately 10:00		to the hospital on the same day it was ordered (1/25/2019). Resident #192 is	no	
		ns and she was at baseline		longer in the facility, no further actions		
		ll status. Nurse #2 stated		warranted at this time.		
	she knew she did not	eat her breakfast and had		On 2/08/19; State agency surveyors		
	tried to get her to eat	something at that time, but		indicated that the root cause of this		
	the resident refused a	any food. When asked if she		alleged noncompliance is the action by	/	
		of Novolog 70/30 insulin		licensed nurse #1 to administer Novolo	og	
	when she knew the re			70-30 at 10:24am while resident #192		
		that she did. She stated		refused her breakfast meal without		
		sident #192's room at		notifying physician before that action.		
		PM to check her blood sugar		Address how corrective action will be		
		onsive. Nurse #2 stated she nt #192 up and checked her		accomplished for those residents having the potential to be affected by the same	•	
		sult of 189 mg/dl. She		deficient practice.	<b>c</b>	
	_	ygen, checked vital signs,		Audits of 100% of residents medicati	on	
		I EMS was called to transfer		orders were completed by the Director		
		spital. She stated that she		Nursing, Assistant director of Nursing		
		s pupils and they were fixed		and/or Unit Manager on 2/7/2019, and		
	and dilated.	•		2/8/19 to identify any other resident wi	th	
				any insulin order that need to be given		
		d 1/25/19 at 6:43 PM written		with meals. The audit concluded there		
	_	ne entered Resident #192's		were eight other residents identified w		
	TOOTH at 12:15 PW and	d found Resident #192		orders for insulin medication to be give	<del>;</del> 11	

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			A. BOILDII	_			С	
		345449	B. WING _			۱ ،	2/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	_ <b>I</b>	1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	2/00/2013	
					15 WHITE ROAD			
UNIVERSA	AL HEALTH CARE/KING	G .			KING, NC 27021			
				-	, T			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 580	Continued From pag	ne 5	F!	580				
		resident's SpO2 (blood	' `	500	with meals. Audit of Insulin administra	tion		
		vel) was 98%, blood pressure			records for the last 7 days indicated al			
		Hg, Pulse 54 beats per			other eight identified residents receive			
	minute (bpm), and F				their insulin as ordered with meals.	u		
		ary 2019 MAR revealed that			100% audit of all current residents□			
		ner 11:30 AM FSBS checked			clinical documentation within the last 7	,		
	on 1/25/19 at 1:07 F	M of 189 mg/dl.			days completed by the Director of			
					Nursing, Assistant Director of Nursing,			
		with the Director of Nursing			Staff development Coordinator and/or			
	, ,	5:02 PM she stated she was			Nurse Manager to determine any identified need for notification of change			
	her being unrespons	oom after she was notified of			that was completed in a timely manner	•		
		ar was 189 mg/dl and that			The audit revealed no other			
	_	ion to be concerned about			missing/delayed notification of change	s to		
		ninistered or blood sugar			both physician and/or responsible part			
	level.				This audit was completed on 2/08/19.	,		
					Findings of this audit are documented	on		
	Review of Resident	#192's EMS report from			clinical records audit tool located in the	Э		
	1/25/19 revealed the	e resident was found at the			facility compliance binder.			
		onsive. The chief complaint						
	documented that the				On 2/8/2019, 100% audit was complet	ed		
		ff and it was reported to EMS			by the Director of Nursing, Assistant			
		s last seen normal at 11:00			Director of Nursing, Staff development			
		vere all normal, and her blood			Coordinator and/or Nurse Manager of			
		g/dL. The first blood glucose			incidents reports completed within the			
		y EMS at 1:05 PM was 23 Dextrose 50% (D50 - a			7 days to ensure notifications were do in a timely manner. The audit revealed			
	•	of dextrose, simple sugar			other missing/delayed notification of	110		
	1	to glucose) 25 grams was			changes to both physician and/or			
	1	13 PM the resident's blood			responsible party. This audit was			
		g/dL. At 1:30 PM her blood			completed on 2/08/19. Findings of this			
		g/dL. At 1:30 PM her blood			audit are documented on incident repo			
	, ,	g/dL. Resident #192 was			audit tool located in the facility complia			
	, ,	oital ED staff at 1:45 PM.			binder.			
	Review of the ED R							
	I .	ident was found unresponsive S and EMS obtained a blood			Measures will be put into place or what systematic changes will be made to	t		

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		345449	B. WING			C 2/08/2019	
NAME OF PE	ROVIDER OR SUPPLIER	0.0.1.0	<del>                                     </del>	STREET ADDRESS, CITY, STATE, ZIP CODI		2/06/2019	
TVAINE OF T	COVIDENCE ON OUT LIEN				_		
UNIVERSA	AL HEALTH CARE/KING			115 WHITE ROAD			
				KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	∍ 6	F 58	0			
F 580	glucose of 23 mg/dL. admission on 1/25/19 26 mg/dL. The reside catheter placed into a medications or draw legistration 2:52 PM for acute reserceived D50 for hypo (IVF) for hypotension Care Unit (ICU). Her admission on 1/25/19 failure, altered mental hypoglycemia.  Review of hospital readmission on 1/25/19 failure, altered mental hypoglycemia.  Review of hospital readmission on 1/25/19 failure, altered mental hypoglycemia.  Review of hospital readmission admission diabetes mellitus (IDI insulin dose and not expense of the property of the	Triage Lab results from ED at 2:48 PM were Glucose ent required a central line (a large vein to give lab work) and intubation at spiratory failure, she oglycemia, intravenous fluids, and admission to Intensive final diagnoses for hospital were acute respiratory. I status, hypothermia, and cords from 1/27/19 at 9:22 at Care Progress Note by PA) #1 and Hospital ted problems addressed for ing her insulin dependent DM) were "likely related to eating."  In 2/7/19 at 3:35 PM the Staff nator stated NAs are the nurse when a resident tation and as needed. To look at each resident indually during each ation and were educated to als were not consumed. The resident does not eat a	F 58	ensure that the deficient pract occur.  Effective 2/8/2019 and moving the facility Licensed nurse and administer insulin for any resident refused his/her meal/fresident refused his/her meal/Facility Licensed nurse on Durphysician when a resident with insulin refuse their meal/food adocument physician decision resident smedical records be insulin is administered. Licens will add any new recommendate Physician in a 24 hour report of effective 2/8/2019  Effective 2/8/2019  Effective 2/8/2019 and moving facility sclinical team, which Director of nursing, Assistant Nursing, and/or Nurse supervinitiated a process for reviewir documentation create for the last 24 Physician orders written in the hours to ensure any needed in changes to the physician, and responsible party was done in manner. This systemic process place daily (Monday through F	g forward, d will not dent with an ood when a food. ty will notify h ordered and in each efore the sed nurses ation from form as well g forward the includes Director of isors ng clinical last 24 hours at sheets, hours and e last 24 ootification of l/or a timely ss will take Friday). Any		
	provider for further or administered.  During an interview w 2/7/19 at 5:11 PM she expected the nurse to if a meal wasn't consi	that the nurse call the ders before insulin is with the facility Pharmacist on a stated she would have be hold all short acting insulinumed. She stated if the r was 109 at 6:27 AM, and		identified issues will be address promptly and appropriate action implemented by the DON, AD and/or Registered Nurse superprocess will be incorporated in clinical meeting any negative be documented on the daily command maintained in the dameeting binder.	ons will be ON, SDC ervisor. This n a daily findings will linical report		

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						l c	;	
		345449	B. WING _				8/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	1 02/0	.5.2010	
				115 WHITE	ROAD			
UNIVERSA	AL HEALTH CARE/KING	3		KING, NC				
(V4) ID	SLIMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE	
F 580	Continued From pag	ge 7	F 5	580				
	she didn't eat or hav	e glucagon administered, the		Effectiv	ive 2/08/2019, week end Regist	ered		
	blood sugar going up				supervisor and/or designated			
	approximately 12:15	PM seemed inconsistent.		license	ed nurse will review clinical			
	She stated Novolog	70/30 is used to regulate and		docum	nentation created for the last 24			
	_	vels for residents with		hours	for all residents, 24 hour report			
	· ·	nset of action within 10-20			s, incident reports for the last 24			
		t acting and the medication		I	and Physician orders written in	the		
	peaks within 1-4 hou	urs of administration.		I	4 hours to ensure any needed			
		" " N I I I I I			ation of changes to the physicia			
		with the Medical Director on			r responsible party was done in			
		ne stated she was not aware			manner. This systemic process			
	-	dent with Resident #192's low nsfer to the ED and her		1	lace every Saturday & Sunday. ïed issues will be addressed	Ally		
	_	likely contacted for transfer		I	otly and appropriate actions will	he		
		d if she expected the nurse to		1 '	mented by the DON, ADON, SD			
		lent did not eat, she stated			r Registered Nurse supervisor.			
		e nursing home don't eat all			of this systemic process will be			
		ed if she expected the nurse			nented on the weekend supervi			
	to check another blo	od sugar prior to		report	form maintained in the Daily St	and		
	administering insulin	after a 4-hour time period		up me	eting binder. Findings from this			
	and no food was cor	nsumed, she stated yes but			mic changes will be discussed ir			
		nurse for administering the			∃stand up meeting Monday thro	ough		
		She stated most likely the			effective 2/8/2019. Week end			
		eceiving this ordered insulin		1 -	visor #1  will be educated o			
		od of time and for whatever			ement before their next schedul	ed		
		cular day she had an adverse		1 -	work by the facility Director of			
		n, but she had probably had		Nursin	ıg.			
	in the past without th	ered at that dose without food						
	in the past without the	le same ellect.		The Fa	acility Director of Nursing (DON	1)		
	On 2/7/18 at 6:37 PM	M, the administrator was			ant Director of Nursing and/or s			
		ediate jeopardy. The facility			opment coordinator will complet			
		allegation of Immediate			education for all licensed nurse			
		n 2/8/19. The allegation of		I	e full time, part time and as nee			
	Immediate Jeopardy				The emphasis of this education			
					importance of notifying Physic			
	Credible Allegation of	of Immediate Jeopardy			ne responsible party in a timely			
	removal:				er for any incident/accidents,			
	Date: 2/08/2019			resider	nt□s change of condition, chan	ge of		

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CLIVILIN	3 FOR WEDICARE &	MEDICAID SERVICES				CIVID IVC	<u>, 0930-039 i</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(	
		345449	B. WING _			02/	08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
LININGERO	AL LIEALTH CAREWING			11	5 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KING			K	ING, NC 27021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
E 500	Continued Frame none	- 0	-	.00			
F 580	Continued From page		F 5	80			
	Corrective action acc	•			treatment/intervention an injury of	.,	
		ve been affected by the			unknown source and/or Medication err		
	deficient practice.	1 :11 1 1/00/0040.5			any. The education also emphasized the	ne	
		dmitted on 1/23/2019 for			responsibility of the licensed nurse on		
		on services. Resident #192			Duty to notify physician when a resider		
	received skilled nursi	ng and renabilitation 019 up to 1/25/2019. Review			with ordered insulin refuse their meal/fo		
		t minimum data set, with			and document physician decision in earesident ☐s medical records before the	CII	
		e date 1/25/2018 section I			insulin is administered. Licensed nurse	c	
		were also educated to document any n					
	, · · · · · · · · · · · · · · · · · · ·	iabetes mellitus with diabetic			physician recommendation on the 24 h		
	, ,	of physician orders reveals			report sheets effective 2/8/19. This	Oui	
		order for Novolog Mix 70-30			education will be completed by 2/8/201	9	
		eously twice daily with			Any Licensed Nurse not educated by	· .	
	meals.	,			2/8/2019 will not be allowed to work un	til	
	On 1/25/2019 resider	nt #192 received Novolog			educated. This education will also be		
		terview with nurse aide #1			added on new hires orientation process	3	
	who was caring for re	esident #192, on 1/25/2019			for all new licensed nurses and will also	)	
	morning shift, indicate	ed resident #192 refused her			be provided annually effective 2/8/20	19.	
	breakfast in the morn	ing of 1/25/2019. Interview			The facility plans to monitor its		
	with nurse assistant #	#2 conducted by the facilitys			performance to make sure that solution	ıs	
	Director of Nursing in	dicates resident #192 ate			are sustained.		
		ht of 1/24/2019 to the			Effective 2/8/2019, Assistant Director of	f	
	morning of 1/25/2019				Nursing, and/or Staff Development		
		15pm less than two hours			Coordinator, will monitor compliance w		
		eceived the Novolog 70-30,			notification of changes to Physician an		
		rse #1 indicated; she went to			responsible party to include notification	το	
		and observed resident #192			physician for any resident with insulin		
	-	She immediately obtained			order who refuse their meal. This	v d	
	vital signs as well as				monitoring process will be accomplished	:u	
	_	oted to be 189 (adult normal sed nurse #1 contacted			by reviewing the daily clinical meeting reports to ensure completion and property	ar	
	emergency medical s				follow through. Any issues identified	51	
	transferred resident #				during this monitoring process will be		
		ency surveyors indicated			addressed promptly. Findings from this		
		f this alleged noncompliance			monitoring process will be documented		
		sed nurse #1 to administer			a daily clinical report form and filed in	311	
	-	24am while resident #192			clinical meeting binder after proper		
		t meal without notifying			follow-ups are completed. This monitor	ina	
		1 - J - J	1	- 1	h	_	

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OLIVILIV	O I OIT MEDIO/ IITE A	WEDIO/ ND OEI WIOLO				O 1110	<del>3. 0000 000 1</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	\ -/	SURVEY PLETED
			7 BOILES!	_			С
		345449	B. WING			l	/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	700/2010
				11	15 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KING				ING, NC 27021		
0(4) ID	CHMMADV CT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 9	F!	580			
	physician before that				process will take place daily for 2 week	'e	
	Address how correcti				weekly x 2 more weeks, then monthly x		
		se residents having the			months or until the pattern of compliance		
	1	ed by the same deficient			is maintained.		
	'	sident - medication orders			Director of Nursing will review the		
	were completed by th	ne Director of Nursing,			completion of daily clinical report, and		
		Nursing and/or Unit Manager			proper follow through and ensure		
	on 2/7/2019, and 2/8/	/19 to identify any other			notification of changes is rendered as		
	1	ulin order that need to be			appropriate. Director of nursing docum		
	1 ~	e audit concluded there were			findings from this monitoring process d	-	
	_	identified with orders for			clinical checklist form and filed in clinic		
		be given with meals. Audit of			meeting binder after proper follow-ups		
		records for the last 7 days			completed. This monitoring process will take place daily Manday through Friday		
	_	tht identified residents as ordered with meals.			take place daily Monday through Friday for 2 weeks, weekly x 2 more weeks, the		
	100% audit of all curr				monthly x 3 months or until the pattern		
		the last 7 days completed			compliance is maintained.	O.	
	I .	rsing, Assistant Director of			- Compilarios is maintaines.		
	1 -	pment Coordinator and/or					
	Nurse Manager to de	termine any identified need			Facility Quality Assurance & Performar	nce	
	for notification of cha	nges that was completed in			Improvement Committee was notified of	of	
	a timely manner. The	audit revealed no other			this plan of action on 2/8/2019. Effective		
		fication of changes to both			2/08/19, Facility Director of Nursing and		
	' '	oonsible party. This audit was			Assistant Director of Nursing will report		
	1	9. Findings of this audit are			findings of this monitoring process to the	ne	
		cal records audit toollocated			facility Quality Assurance and	for	
	in the facility complia	nce binder.			Performance Improvement Committee any additional monitoring or modification		
	On 2/8/2010 100% a	audit was completed by the			of this plan monthly for three months,		
		Assistant Director of Nursing,			until the pattern of compliance is	<b>.</b>	
		oordinator and/or Nurse			maintained. The QAPI committee can		
	I	nts reports completed within			modify this plan to ensure the facility		
		sure notifications were done			remains in substantial compliance.		
	_	he audit revealed no other			·		
		fication of changes to both			The title of the person responsible for		
	1	oonsible party. This audit was			implementing the acceptable plan of		
		9. Findings of this audit are			correction		
	documented on incid	ent reports audit toollocated			Effective 2/8/2019 the facility		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		، ا	C
		345449	B. WING				08/2019
NAME OF P	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				11	15 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KING			K	ING, NC 27021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From page	e 10	F	580			
	in the facility complian				Administrator and the Director of Nursi	na	
	Measures will be put				will be ultimately responsible for the	'9	
	1	will be made to ensure that			implementation of this plan of correctio	n	
	the deficient practice				to ensure the facility attains and mainta		
		d moving forward, the facility			substantial compliance.		
		vill not administer insulin for			·		
	any resident with an	order to be given with			Compliance Date 2/8/2019		
	meals/food when a re	esident refused his/her					
	1	censed nurse on Duty will			Tag 580 Part 2		
		a resident with ordered			Root Cause Analysis		
		eal/food and document			Based on the root cause analysis by th	е	
	' '	each residents medical			facility□s administrative staff, it was		
	records before the ins				determined the facility failed to provide		
	Licensed nurses will a	n Physician in a 24 hour			notification to the physician for resident 65 concerning a significant weight loss		
	report form as well ef				03 concerning a significant weight loss	•	
	1 -	d moving forward the			Immediate Action		
	I .	which includes Director of			Resident # 65 was discharged from the	ا	
	_	ector of Nursing, and/or			facility on 2-16-19. No further action is		
	Nurse supervisors ini	<del>-</del>			warranted at this time.		
	1	umentation create for the					
		esidents, 24 hour report			Identification of Others		
	sheets, incident repor	rts for the last 24 hours and			On 2-8-19, a 100% audit was complete	<del>:</del> d	
	_	ten in the last 24 hours to			by the Director of Nursing and Assistar		
		otification of changes to the			Director of Nursing of all incident repor		
		ponsible party was done in a			completed within the last 7 days to ens	ure	
		systemic process will take			notifications were done in a timely		
	place daily (Monday t				manner. The audit revealed no missing		
	I .	be addressed promptly and			delayed notifications of changes to both		
	I .	vill be implemented by the			physicians and/ or responsible party. Taudit was completed on 2-8-19. Finding		
		nd/or Registered Nurse ess will be incorporated in a			of this audit are documented and can be	-	
	1	any negative findings will be			found in the facility compliance binder.	,	
		aily clinical report formand			loand in the idenity compilation billider.		
		ly clinical meeting binder.			Systemic Changes		
	I .	week end Registered Nurse			Effective 2-8-19, the Director of Nursing	a/	
	I .	signated licensed nurse will			Assistant Director of Nursing or	,	
	1 '	entation created for the last			Designated Licensed Nurse will review		
		ents 24 hour report sheets			clinical documentation created for the I		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILD	_	<del></del>	، ا	С
		345449	B. WING				08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	00/2013
					15 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KING				ING, NC 27021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From page	e 11	F	580			
	incident reports for th	e last 24 hours and			24 hours for all residents, 24 hour repo	rt	
		ten in the last 24 hours to			sheets, incident reports for the last 24		
	1 -	otification of changes to the			hours and physician orders written in the	ne	
	physician, and/or resp	oonsible party was done in a			last 24 hours to ensure any needed		
	timely manner. This s	ystemic process will take			notification of changes to the physician		
	place every Saturday	& Sunday. Any identified			and/ or responsible part was done in a		
	issues will be address				timely manner. This systemic process		
		ill be implemented by the			will take place Monday through Friday.		
		nd/or Registered Nurse			Any identified issues will be addressed		
		t of this systemic process			promptly and appropriate actions will b	<del>2</del>	
		n the weekend supervisor			implemented by the DON and ADON.	اعاد	
	1 -	d in the Daily Stand up			This process will be incorporated in a c	-	
		ngs from this systemic ssed in the daily stand up			clinical meeting and negative findings was be documented on the daily clinical rep		
	meetingMonday throu				form and maintained in the daily clinical rep		
		supervisor #1  will be			meeting binder. The weekend nurse	•	
	I .	irement before their next			supervisor or designated licensed nurs	е	
	1	k by the facility Director of			will review clinical documentation for th		
	Nursing.	,			last 24 hours for all residents, 24 hour		
					report sheets, incident reports for the la	ast	
	_	of Nursing (DON), Assistant			24 hours and physician orders written i		
	_	nd/or staff development			the last 24 hours to ensure any needed		
		lete 100% education for all			notification of changes to the physician		
		clude full time, part time and			and/ or responsible party was done in a		
		emphasis of this education			timely manner. This systemic process		
	· •	e of notifying Physician and			take place every Saturday and Sunday		
		in a timely manner for any			Any identified issues will be addressed		
		sidents change of condition, ntervention an injury of			promptly and appropriate actions will b implemented by the DON or ADON. The		
	_	or Medication error if any.			result of this process will be documented		
		mphasized the responsibility			on the weekend supervisor report form		
		on Duty to notify physician			Findings of this process will be reviewe		
		ordered insulin refuse their			by the DON or ADON and will be	-	
		nent physician decision in			discussed in the daily stand up meeting	<b>]</b> .	
		al records before the insulin				-	
	is administered. Licer	nsed nurses were also			Monitoring		
	educated to documer	nt any new physician			Effective 2-8-19, the DON and/ or ADC	N	
	recommendation on t	he 24 hour report sheets			will monitor compliance with notification		
	effective 2/8/19. This	education will be completed			changes to physicians and/ or respons	ible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345449	B. WING _			02/08/2019	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				115 WHITE ROAD			
UNIVERS	AL HEALTH CARE/KING	G		KING, NC 27021			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE HE APPROPRIATE	COMPLETION DATE	
F 580	Continued From pag	ge 12	F 5	80			
	by 2/8/2019. Any Lic	censed Nurse not educated by		party. This monitoring will b	e		
	•	allowed to work until		accomplished by reviewing			
	educated. This educ	cation will also be added on		clinical meeting reports to e	-		
	new hires orientation	n process for all new licensed		completion and proper follow			
		be provided annually		Any issues identified during			
	effective 2/8/2019.			monitoring process will be a	ddressed		
	The facility plans to	monitor its performance to		promptly. Findings of this m	onitoring		
	make sure that solut	tions are sustained.		process will be documented	on the daily		
	i i	Assistant Director of Nursing,		clinical report form and filed	in the clinical		
		oment Coordinator, will		meeting binder after proper	•		
		with notification of changes		complete. This monitoring p			
	_	responsible party to include		take place daily for 2 weeks	•		
	1	cian for any resident with		more weeks, then monthly x			
	insulin order who ref			until the pattern of complian	ce is		
		will be accomplished by		maintained.			
		clinical meeting reports to					
	-	and proper follow through. Any ring this monitoring process					
		romptly. Findings from this					
		will be documented on a daily					
		and filed in clinical meeting					
		follow-ups are completed.					
	1 1	cess will take place daily for 2					
		nore weeks, then monthly x 3					
	-	pattern of compliance is					
	maintained.	·					
	Director of Nursing v	will review the completion of					
	daily clinical report,	and proper follow through and					
	ensure notification of	of changes is rendered as					
	appropriate. Directo	r of nursing document					
		onitoring process daily clinical					
		lled in clinical meeting binder					
		ips are completed. This					
		will take place daily Monday					
		weeks, weekly x 2 more					
		y x 3 months or until the					
	pattern of compliance						
		rance & Performance					
	Improvement Comm	nittee was notified of this plan					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345449	B. WING			C <b>02/08/2019</b>
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021	·	02/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	Director of Nursing a Nursing will report fin process to the facility Performance Improve additional monitoring monthly for three mocompliance is maintal can modify this plant in substantial complia. The title of the perso implementing the acc Effective 2/8/2019 the the Director of Nursin responsible for the incorrection to ensure maintains substantia. Date of immediate je.  The credible allegation removal was verified evidenced by:  Review of facility's rewere completed with 2/7/19 through 2/8/19 and nursing supervisiall education regarding insulin administration physician notification before they were able by phone or in-person Review of facility aud revealed that they we orders were changed order verbiage for all or other types of diabates.	nd/or Assistant Director of dings of this monitoring Quality Assurance and ement Committee for any or modification of this plan onths, or until the pattern of dined. The QAPI committee to ensure the facility remains ance.  In responsible for expetable plan of correction e facility Administrator and ang will be ultimately explementation of this plan of the facility attains and a compliance.  In or of Immediate Jeopardy 2/8/19  In of Immediate Jeopardy 2/8/19 at 8:02 PM as  Cords revealed in-services all active facility staff on the DON, ADON, SDC, ors were trained to provide any abuse/neglect policy, and documentation, and dorders to every employee to to work at the facility either	F 58	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(X3)	(X3) DATE SURVEY COMPLETED		
		345449	B. WING _			C <b>02/08/2019</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021		02/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 580	were reviewed for co  During an interview w PM revealed that she Abuse and Neglect P would report any con DON. She also receiv resident did not eat s and/or report the refu document the meal in charting.  An interview with NA revealed that educati facility Abuse and Ne all concerns or suspi the DON or administr received education th refuses their meal, of they don't want anyth meal percentage, and During an interview w PM she stated that if abuse she was to rep DON and/or the adm education that stated was supposed to offe more times, but that t refuse. If the residen would notify the nurse percentage.  During an interview w 7:55 PM she stated ti ensure a snack or for giving insulin. If the re-	ne clinical meeting binder impletion.  with NA #3 on 2/8/19 at 7:41 was educated on the facility folicy and stated that she cerns or suspicions to the wed education that stated if a he would offer alternates is all to the nurse and intake percentage in her  #4 on 2/8/19 at 7:41 PM on was provided on the glect Policy. She stated that cions would be reported to rator. She stated she also nat stated if a resident iffer alternatives to ensure ining, always document their	F 5	80			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345449	B. WING			C 02/08/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021		02/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 580		e 15 document changes on the cation on the facility Abuse	F 58	30		
	and Neglect Policy st	ated that any and all should be reported to the				
	8:00 PM she stated the ensure a snack or foo giving insulin. If the ranything she was supand follow orders give	with Nurse #3 on 2/8/19 at hat she was educated to od was consumed before resident refused to eat oposed to notify the provider, en for insulin administration. ment changes on the eron-coming nurses.				
	1/5/19 with diagnoses fracture, right wrist fra	dmitted from hospital. She				
	revealed on 1/5/19 ar weekly weights and s regular, no added sal	cord revealed on 1/6/19,				
	and Assessment date Resident #65 had a f 50-75% of most meal months per family me	led a Nutritional Screening ed 1/10/19 which indicated air appetite, consuming ls. Weight stable over last 6 ember's report, usual body 158 pounds, and ideal body				
	-	n note dated 1/10/19 written aled Resident #65's weight e registered dietician				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345449	B. WING _			C <b>02/08/2019</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021		02/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	e 16	F 5	80			
	day with medication president was at risk for use of therapeutic disabove average body plan.	protein supplement twice a pass. The note specified the provent changes related to et, dementia, and weight weight. Will proceed to care on dated 1/10/19 revealed					
	Resident #65 was at related to use of there dementia and weight A handwritten addition was added with no daincluded resident will through next review whandwritten goal of nethrough next review handwritten goal of nethrough next review of an Admis Set assessment date	risk for weight changes apeutic diet, diagnosis of above average body weight. In of significant weight loss ate entry. The care plan goal eat at least 75% of all meals with an additional o significant weight changes andwritten. Interventions rrent listing of likes and tamins as ordered, obtain s needed, encourage dining etary recommendation add ein supplement max twice a pass for nutritional support.					
	assessed as being in set-up, having no swatherapeutic diet, weig inches tall.  An observation on 2/Resident #65 revealed in the main dining root.	raired cognition. She was dependent with meals after allowing disorder, was on a hed 157 pounds and was 66  7/19 at 12:47 PM of d she was sitting at a table of with lunch tray in front of d only consumed bites of her					
	beans. A follow-up of approximately 1:00 P	oservation on 2/7/19 at M revealed the activity esident #65 to eat. Resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345449	B. WING _			C 02/08/2019	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP ( 115 WHITE ROAD KING, NC 27021	CODE	02/05/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	-	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	her meal.  On 2/7/19 at 1:13 PM revealed Resident #6 but did need assistar had good days and be friend would visit free resident to eat. She serident to eat in the in to visit, but sometimely documented which we percent significant we resident's previous we obtained on 1/6/19.  Lab results of a Liver 1/7/19 revealed an all protein of 4.8. Normal 6.0-8.7, respectively.  Review of Resident # revealed there were physician orders writt significant weight loss Additionally, review of record revealed the Frecommendation for daily protein supplements.	In an interview with NA #2 So was able to feed herself, ince at times. She stated she had days. The family or family quently and assist the stated she encouraged the dining room if no one came mes she refused to go.  #65's weight record revealed weight of 146.8 pounds was ras a 10.2 pounds or 6.5 eight loss since the reight of 157 pounds  #Function Panel collected on all lab values are 3.5-5.2 and fe65's medical record no nutritional interventions or ten to address the resident's seriom 1/5/19 to 1/12/19. If the resident's medical RD's 1/10/19 the resident to receive a ment was not implemented.	F	580			
	dietary manager (DM of the weight that wa on 1/12/19 which refl loss from 1/6/19. She	I, an interview with the I) revealed she was unaware s obtained for Resident #65 ected a significant weight e stated she tried to keep up hts. She stated she pulled					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345449	B. WING _			1	C 08/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, 115 WHITE ROAD KING, NC 27021		1 02	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B -REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	the report weekly and weight, she requester resident. If there was notify the dietician by recommendation for the resident's weight loss interventions were im Resident #65's weight 1/6/19 to 1/12/19.  On 2/6/19 at 11:20 Al Nursing (ADON) was weights were done or 2019, the facility initial admission. Nursing a residents' weights an on the hall to enter in if there was a 3 poundobtained. If the weight physician was notified interventions could be Review of Resident # on 1/19/19 a weekly we	If there was a concerning dinursing to reweigh the still a concern, she would phone and get a he physician to stop the The DM confirmed no plemented to address to loss experienced from  If the Assistant Director of interviewed. She stated in admission. In January sted weekly weights x 4 after sesistants were to obtain the digive the result to the nurse to the computer. She stated divariance, a reweight was it was still concerning, the dias well as dietary so that it put into place.  If there was a concerning the dias well as dietary so that weight was not documented.	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345449	B. WING			C 02/08/2019
	ROVIDER OR SUPPLIER AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP COL 115 WHITE ROAD KING, NC 27021		32/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	1/26/19 for Resident between 50-75% of homotopy of homotopy or Resident between 50-75% of homotopy of	centages from 1/6/19 to #65 revealed she consumed ler meals.  I, the dietician was ed she didn't recall Resident sh't sure if the resident was he stated she would get the ided monthly and the Dietary wher of any significant eekly weights. She stated cility's risk committee why formation regarding Resident entified on 1/12/19 and why is obtained for Resident #65 confirmed no approaches address the resident's gan on 1/12/19 until 1/30/19 supplement was ordered.  I, an interview with the DM she rounded with the sident #65. She stated she int's family member who had hat she did not want the to her bowel trouble. The dent's tray card. The DM also intions were implemented to 5's weight loss which began 19 when a house shake was esident's physician. She	F 5	80		
	front of her but wasn' experienced weight lo					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345449	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343449	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		02/08/2019	
NAIVIE OF F	ROVIDER OR SUFFLIER			115 WHITE ROAD	•		
UNIVERS	AL HEALTH CARE/KING			KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	e 20	F 58	00			
	expected to be notifie	d of a weight loss.					
F 684 SS=J	Quality of Care CFR(s): 483.25		F 68	4		2/8/19	
	applies to all treatment facility residents. Bas assessment of a resident residents received accordance with profes practice, the compreheare plan, and the resident	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure is treatment and care in essional standards of inensive person-centered sidents' choices. It is not met as evidenced liews, emergency medical innel interviews, emergency isician interview, and record ed to follow physician orders with meals for 1 of 4 lents reviewed for insulin allure of the facility to in meals as ordered by the the resident becoming int to the Emergency juired a central line and		The creation of this Letter of Callegation constitutes a written of compliance. Preparation an submission of this letter does a constitute an admission or agrithe provider of the truth of the alleged or the correctness of the conclusions set forth by the su agency. This letter is solely probecause of requirement under federal law, and to demonstrat faith attempts by the provider of the quality of life of each resident the quality of life of each residents found to have been at the deficient practice.  Resident #192 was admitted of for short term rehabilitation services from up to 1/25/2019. Review of factors.	a allegation d not reement by facts he urvey repared restate and te the good to improve rent.  In allegation d not reement by facts he urvey repared restate and te the good to improve rent.  In allegation d not reement by restate and		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_	<del></del>	, ا	2	
		345449	B. WING				08/2019	
NAME OF P	ROVIDER OR SUPPLIER		,	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LININGERO	AL LIEALTH CAREWING			1	15 WHITE ROAD			
UNIVERSA	AL HEALTH CARE/KING			K	ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page		F	684				
	short acting and long immediate jeopardy with the facility provided a allegation of Immedia facility will remain our and severity of D to estaff have been in-serving included:	was removed on 2/8/19 when an acceptable credible ate Jeopardy removal. The tof compliance at a scope ensure monitoring and that all			recent minimum data set, with Assessment reference date 1/25/2018 section I (active diagnosis) indicated resident #192 had a diagnosis of type 2 diabetes mellitus with diabetic neuropa Review of physician orders reveals resident #192 had an order for Novolog Mix 70-30 to be given subcutaneously twice daily with meals. On 1/25/2019 resident #192 received Novolog 70-30 at 10:24am. Interview w nurse aide #1 who was caring for resident	thy.		
	Mellitus Type 2, hypor thyroid gland), hyperi pressure), enterocolii that effects the small	noses that included Diabetes of thyroidism (underactive tension (HTN - high blood tis (inflammation in the gut intestine and colon) related (C-diff), an infection in the by the bacteria called			#192, on 1/25/2019 morning shift, indicated resident #192 refused her breakfast in the morning of 1/25/2019. Interview with nurse assistant #2 conducted by the facility Director of Nursing indicates resident #192 ate snacks during the night of 1/24/2019 to the morning of 1/25/2019. On 1/25/2018, at 12:15pm less than tw			
	revealed orders place Stick Blood Sugar (F at bedtime. There wa administer 58 units s injection into the fat la muscle) twice daily w According to the mar a mixture of a man-m help control mealtime long-acting insulin the help control blood su manufacturer guidelin type 2 diabetes shou 15 minutes before or				hours after resident #192 received the Novolog 70-30, 58 units; licensed nurs #1 indicated; she went to resident #192 room and observed resident #192 beer unresponsive. She immediately obtains vital signs as well as blood glucose. Bleglucose result was noted to be 189 (ad normal limits 70-110). Licensed nurses contacted emergency medical services who then transferred resident to the hospital.  On 2/8/2019; the facility Medical Direct had an extensive discussion with the State surveyors on site to explain the medical rationale for the reported hypoglycemic episode for resident #19 documented by both EMS and emerge	e 2 n ed pod ult #1 or		
		Jary 2019 medication (MAR) revealed Resident			documented by both EMS and emerge	псу		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED	
		345449	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	3-33	1 2:	STREET ADDRESS, CITY, STATE, ZIP CODE		2/08/2019	
NAME OF FI	NOVIDER OR SUFFLIER						
UNIVERSA	AL HEALTH CARE/KING			115 WHITE ROAD			
				KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From page 22		F 68	4			
F 684	#192 had her 6:00 AN 1/25/19 at 6:37 AM at milligrams/deciliter (m 58 units of insulin sch documented as admin AM by Nurse #2.  According to the mea Resident #192 did no or lunch on 1/25/19.  During an interview w 2/6/19 at 4:46 PM abocondition and meal in that the resident was that morning, and that When asked if she no resident's refusal to e Nurse#2 was made at During an interview w 1:17 PM she stated the AM she went into Residentiater medication with no altered mental she knew she did not tried to get her to eat the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused a gave her the full dose when she knew the resident refused and found her unrespective full dose when she knew the resident refused and found her unrespective full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when she knew the resident refused and full dose when	All scheduled FSBS check on and the result was 109 ag/dl). The Novolog 70/30 all duled for 9:00 AM was nistered on 1/25/19 at 10:24  Il percentage sheet, at eat anything for breakfast with Nurse Aide (NA) #6 on but Resident #192's at take on 1/25/19, she stated on the bedpan several times at she had refused breakfast. Stiffied the nurse of the lat breakfast, she stated ware.  With Nurse #2 on 2/7/19 at lat at a approximately 10:00 sident #192's room to las and she was at baseline all status. Nurse #2 stated leat her breakfast and had something at that time, but lany food. When asked if she et of Novolog 70/30 insuling esident had not eaten that she did. She stated sident #192's room at PM to check her blood sugar onsive. Nurse #2 stated she	F 68	Medical Director explained that #192 hypoglycemic episode is related to resident #192 s chr condition that was not diagnos resident #192 was admitted to on 1/23/2019, two days before episode of hypoglycemia. The medical director added; on 1/2 ordered thyroid stimulating hor (TSH) laboratory test following from facility licensed staff that #192 was lethargic. The facility the laboratory test on 1/24/19 and received the result on 1/25 TSH result from 1/24/2019 indiresident #192 had a condition Hypothyroidism. The facility Mc Director expressed to the state on site that resident #192 s flublood sugar was related to her and undiagnosed thyroid cond not due to the administration of that was given less than two his he was observed been unrespected in the same day ordered (1/25/2019). Resident longer in the facility, no further warranted at this time.  On 2/08/19; State agency survindicated that the root cause of	medically onic thyroid ed before the facility the facility 4/2019, she mone the report resident obtained as ordered 5/2019. cated called edical e surveyors actuation on untreated fition and of the insulin ours before consive. ed Synthroid eat was not ransferred y it was #192 is no actions		
	blood sugar with a restated she applied ox notified the DON, and	nt #192 up and checked her sult of 189 mg/dl. She ygen, checked vital signs, I EMS was called to transfer spital. She stated that she		alleged noncompliance is the a licensed nurse #1 to administe 70-30 at 10:24am while reside refused her breakfast meal. Sil action by licensed nurse #1 did	r Novolog nt #192 nce the		

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			С	
		345449	B. WING			02/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
				115 WHITE ROAD			
UNIVERS	AL HEALTH CARE/KING			KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	e 23	F 684	4			
F 084	checked the resident and dilated. A progress note date by Nurse #2 stated stroom at 12:15 PM and unresponsive. The recoxygen saturation lever (BP) was 98/68 mml-minute (bpm), and FS.  Review of the Januar Resident #192 had hon 1/25/19 at 1:07 PM.  During an interview wrear (DON) on 2/6/19 at 5 in Resident #192's rother being unresponsive sident's blood sugathere was no indicated the insulin being admilevel.  Review of Resident #1/25/19 revealed the facility to be unresponded unresponsive by staff that the resident was AM, her vital signs we glucose was 129 mg/dL. At 1:09 PM Entry the product of the company in the product of the	d 1/25/19 at 6:43 PM written the entered Resident #192's d found Resident #192 esident's SpO2 (blood vel) was 98%, blood pressure the system of the system o	F 684	physician order for resident #19 the state survey agency alleged resident #192 did not receive tr and care in accordance with pre standards of practice. Also the notification to physician is alleg contrary to the efforts by the face provide quality care for all resid including resident #192 in order each resident physical, ment psychosocial needs. Address how corrective action of accomplished for those resident the potential to be affected by the deficient practice. Audits of 100% of residents or orders were completed by the I Nursing, Assistant director of N and/or Unit Manager on 2/7/20 2/8/19 to identify any other residenty any insulin order that need to b with meals. The audit conclude were eight other residents ident orders for insulin medication to with meals. Attending physician identified residents contacted a approve all orders to be given of food to include a meal or snack meals. Those insulin orders we to be given with food as of 2/8/2 of Insulin administration records last 7 days indicated all other e identified residents received the as ordered with meals.  Audits of 100% of residents or orders were completed by the I Nursing, Assistant director of N Nursing, Assistant director of N	d that reatment ofessional lack of red to be cility to dents r to meet tal, and will be nts having he same nedication Director of lursing 19, and dent with re given re dithere tified with be given of there tified with se given of the given		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
				_		(		
		345449	B. WING			02/	08/2019	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
				11	15 WHITE ROAD			
UNIVERSA	AL HEALTH CARE/KING			K	ING, NC 27021			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 684	Continued From page	e 24	F	684				
	· -	ital ED staff at 1:45 PM.			2/8/19 to identify any other resident wit	h		
	,				any non-insulin medication order that			
	During an interview w	vith EMT #1 on 2/11/19 at			need to be given with meals. The audit			
	_	d he arrived at the facility at			concluded there were six other residen			
		PM and found Resident			identified with orders for non-insulin			
		He stated facility staff had			medication to be given with meals.			
		92's blood sugar was 129			Attending physician for identified reside	ents		
	mg/dl but he was not	sure when that was taken.			contacted and approve all orders to be			
	EMT #1 reported he	and EMT #2 obtained the			given with any food to include a meal o	r		
	resident's vital signs while she was lying in the				snack between meals.			
	facility bed except for	the blood sugar since they						
	had been given the reading of 129 mg/dl. The				100% audit of all current residents□			
	-	he cardiac monitor and pulse			clinical documentation within the last 7			
	-	nutes they had transported			days completed by the Director of			
		nbulance. When they got her			Nursing, Assistant Director of Nursing,			
		cked the resident's blood			Staff development Coordinator and/or			
		roximately 27 mg/dl but			Nurse Manager to determine any			
		e exact result. EMT #1			identified need for notification of chang			
	_	e diabetes protocol and			that was completed in a timely manner			
	transferred her to the	ED.			The audit revealed no other			
	During on interview w	with EMT #2 on 2/12/10 of			missing/delayed notification of changes			
	_	vith EMT #2 on 2/12/19 at d when they arrived and			both physician and/or responsible party This audit was completed on 2/08/19.	/-		
		d when they arrived and dent #192's room, they asked			Findings of this audit are documented	n l		
		blood sugar and was told it			clinical records audit tool located in the			
		and it was approximately 135			facility compliance binder.			
		t Resident #192 in the			lucinty compilance binder.			
		necked her blood sugar and			On 2/8/2019, 100% audit was complete	<del>-</del> d		
		35 mg/dl, but he couldn't			by the Director of Nursing, Assistant	,		
		result. He stated they			Director of Nursing, Staff development			
		grams of D50 with a small			Coordinator and/or Nurse Manager of a			
		minutes from the ED.			incidents reports completed within the			
	,				7 days to ensure notifications were dor			
	Review of the ED Re	port from 1/25/19			in a timely manner. The audit revealed			
		dent was found unresponsive			other missing/delayed notification of	ĺ		
		and EMS obtained a blood			changes to both physician and/or	ĺ		
		Triage Lab results from ED			responsible party. This audit was			
		at 2:48 PM were Glucose			completed on 2/08/19. Findings of this	ĺ		
	26 mg/dL. The reside	ent required a central line (a			audit are documented on incident repo	rts		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345449	B. WING _			1	08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2013
				11	15 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KING			K	KING, NC 27021		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page		F 6	F 684			
	catheter placed into a large vein to give medications or draw lab work) and intubation at 2:52 PM for acute respiratory failure, she received D50 for hypoglycemia, intravenous fluids				audit tool located in the facility complia binder.	nce	
	1 7 7	, and admission to Intensive			Measures will be put into place or what	:	
		final diagnoses for hospital			systematic changes will be made to		
	I .	were acute respiratory			ensure that the deficient practice will no	ot	
	failure, altered mental status, hypothermia, and				occur.  Effective 2/8/2019 and moving forward		
	hypoglycemia.				the facility Licensed nurse and will not	,	
	Review of hospital red	cords from 1/27/19 at 9:22			administer insulin for any resident with	an	
	AM revealed a Critical Care Progress Note by				order to be given with meals/food wher		
		1 and Hospital Physician #1			resident refused his/her meal/food.		
		addressed for Resident			Facility Licensed nurse on Duty will not	ify	
	#192 involving her ins	sulin dependent diabetes			physician when a resident with ordered	1	
	mellitus (IDDM) were	"likely related to insulin			insulin refuse their meal/food and		
	dose and not eating."				document physician decision in each		
					resident□s medical records before the		
		n 2/7/19 at 3:35 PM the Staff			insulin is administered.		
	Development Coordin				Effective 2/8/2019 and moving forward	the	
		the nurse when a resident			facility□s clinical team, which includes		
	does not eat on orien				Director of nursing, Assistant Director		
		to look at each resident			Nursing, and/or Nurse supervisors add	ea	
	receiving insulin indiv	ation and were educated to			the review of insulin orders for all new admits and new insulin orders for		
		als were not consumed.			residents in the facility, to an existing		
		the resident does not eat a			process of reviewing new admits for the	_	
		that the nurse call the			last 24 hours. By adding the review of	,	
	provider for further or				residents insulin orders during daily		
	administered.				clinical meeting, it will ensure that each	1	
					resident with an order for insulin has a		
	During an interview w	rith the facility Pharmacist on			indication of whether it need to be give	n	
	2/7/19 at 5:11 PM she	e stated she would have			with food or not, and ensure that licens	ed	
	1 -	hold all short acting insulin			nurses administer those orders as		
	I .	umed. She stated if the			specified by the physician. The result of		
	_	r was 109 at 6:27 AM, and			this systemic process will be document		
	I .	glucagon administered, the			on the daily clinical report form maintai	ned	
	blood sugar going up				in the Daily clinical meeting binder.		
	approximately 12:15 I	PM seemed inconsistent.			Findings from this systemic changes w	ill '	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 50.25			Ι,	c l
		345449	B. WING				08/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	00/2019
NAME OF T	NOVIDER OR OUT FIER				5 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KIN	IG					
				KI	NG, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From pa	age 26	F 6	684			
	·	g 70/30 is used to regulate and			be discussed in the daily □clinical mee	tina	
		evels for residents with			Monday through Friday effective 2/8/20		
	_	onset of action within 10-20			Effective 2/8/2019 and moving forward		
	l '	ort acting and the medication			weekend Registered Nurse supervisor		
		ours of administration.			and/or designated licensed nurse will		
					review any new insulin orders for the la	ast	
	During an interview	on 2/7/19 at 3:42 PM with the			24 hours to ensure that each resident		
	Medical Records Coordinator she stated the				an order for insulin has an indication of	i	
	Resident #192's glu	ucometer was thrown away			whether it need to be given with food of	r	
	after her return was	s not anticipated and no			not, and validate that licensed nurses		
recordings saved from the glucometer for		om the glucometer for review.			administer those orders as specified by	/	
					the physician. The result of this system	iic	
	_	with the Medical Director on			process will be documented on the		
		she stated she was not aware			weekend supervisor report form		
		ident with Resident #192's low			maintained in the Daily Stand up meet	ng	
	_	ansfer to the ED and her			binder. Findings from this systemic		
		t likely contacted for transfer			changes will be discussed in the daily		
		ed if she expected the nurse to			□ stand up meeting Monday through		
		ident did not eat, she stated			Friday effective 2/8/2019. Week end	thio	
		ne nursing home don't eat all			supervisor #1  will be educated on		
	to check another bl	ked if she expected the nurse			requirement before their next schedule day to work by the facility Director of	u	
		in after a 4-hour time period			Nursing		
	_	onsumed, she stated yes but			The Facility Director of Nursing (DON)		
		e nurse for administering the			Assistant Director of Nursing and/or st		
		I. She stated most likely the			development coordinator will complete		
		receiving this ordered insulin			100% education for all licensed nurses		
		iod of time and for whatever			include full time, part time and as need		
		icular day she had an adverse			staff. The emphasis of this education		
	1	lin, but she had probably had			be on the importance of administering		
	the insulin administ	tered at that dose without food			medication as ordered by physician an	d in	
	in the past without	the same effect.			a timely manner for any medication		
					specifically insulin. The education also		
	During an interview	with the ED Physician on			emphasized the responsibility of the		
		she stated when the resident			licensed nurse on Duty to notify physic	ian	
		ED she was informed by			when a resident with ordered insulin		
		I sugars were in the 20s, 25			refuse their meal/food and document		
		administered during transport,			physician decision in each resident□s		
	and her blood gluce	ose improved into the 100s,			medical records before the insulin is		1

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CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	<del>7. 0936-0391</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	2
		345449	B. WING _		<del></del>	1	08/2019
NAME OF P	ROVIDER OR SUPPLIER		·	S1	FREET ADDRESS, CITY, STATE, ZIP CODE	·	
LININGERO	AL LIEALTH CAREWING			11	5 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KING			K	ING, NC 27021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 27	F 6	884			
		ping again. The resident			administered. This education will be		
		ratory failure and required			completed by 2/8/2019. Any Licensed		
	-	ral line. Her blood sugar at			Nurse not educated by 2/8/2019 will no	ot	
		26 mg/dL and D50 was			be allowed to work until educated. This		
		Labs were drawn and tests			education will also be added on new hi	res	
		sepsis and other processes,			orientation process for all new licensed		
		l level of 2.6 and her history			nurses and will also be provided annua	ılly	
	of C-Diff. She stated			effective 2/8/2019.			
		ucose level kept dropping			The facility plans to monitor its		
		istered. When asked if this			performance to make sure that solution	IS	
	-	e to the resident receiving			are sustained.		
	1	ut a meal, she stated that it			Effective 2/8/2019, Director of Nursing, Assistant Director of Nursing, and/or S		
		anation considering the ose kept dropping and that			Development Coordinator, will monitor		
	_	indicate a diagnosis of			compliance with timely, and accurate		
	-	conditions such as a deep			insulin administration by randomly		
	-	T - blood clot), or pulmonary			observing five residents□ insulin		
	-	air bubble, piece of fatty			administration to verify that it is given v	vith	
	deposit, or other obje	ect which has been carried in			meals/food as ordered by physician.		
	the bloodstream and	can lodge into lung vessels)			Findings from this monitoring process	will	
	that could possibly ca	ause the low glucose levels.			be documented on a daily clinical repo form and filed in clinical meeting binder		
	On 2/7/18 at 6:37 PM	1, the administrator was			after proper follow-ups are completed.	ĺ	
		ediate jeopardy. The facility			This monitoring process will take place	ĺ	
	provided a credible a	llegation of Immediate			daily for 2 weeks, weekly x 2 more week	⊧ks,	
		2/8/19. The allegation of			then monthly x 3 months or until the		
	Immediate Jeopardy	removal indicated:			pattern of compliance is maintained.		
					Effective 2/8/2019: Director of Nursing	will	
	_	f Immediate Jeopardy			review the completion of daily clinical		
	removal:				report, and proper follow through and	rod	
	Date: 2/08/2019				ensure notification of changes is rende as appropriate. Director of nursing	ieu	
	Corrective action acc	complished for those			document ffindings from this monitoring	ן ו	
		ive been affected by the			process daily clinical checklist form an		
	deficient practice.	To book and the by the			filed in clinical meeting binder after pro		
		dmitted on 1/23/2019 for			follow-ups are completed. This monitor		
		ion services. Resident #192			process will take place daily Monday	5	
	received skilled nursi	ng and rehabilitation			through Friday for 2 weeks, weekly x 2		
		019 up to 1/25/2019. Review			more weeks, then monthly x 3 months		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345449	B. WING _			02/	08/2019
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		00.20.0
				115	5 WHITE ROAD		
UNIVERS	AL HEALTH CARE/KING	6		KI	NG, NC 27021		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From pag	e 28	F 6	684			
		t minimum data set, with			until the pattern of compliance is		
		ce date 1/25/2018 section I			maintained.		
	, .	dicated resident #192 had a liabetes mellitus with diabetic			Effective 2/8/2019, Director of Nursing,		
	, ,	of physician orders reveals			Assistant Director of Nursing, and/or S		
		n order for Novolog Mix 70-30			Development Coordinator, will monitor		
		neously twice daily with			compliance with timely, and accurate		
	meals.				insulin administration by reviewing insu	ılin	
		nt #192 received Novolog			administration records from previous da		
		nterview with nurse aide #1			to ensure timely administration, correct	:	
		esident #192, on 1/25/2019			administration and documentation as		
	_	ted resident #192 refused her			ordered by physician, this will include		
		ning of 1/25/2019. Interview #2 conducted by the facility			verifying any resident with orders to be given with food or meals is given as		
	1	ndicates resident #192 ate			ordered. Findings from this monitoring		
	_	ght of 1/24/2019 to the			process will be documented on a daily		
	morning of 1/25/2019				clinical report form and filed in clinical		
	_	15pm less than two hours			meeting binder after proper follow-ups	are	
	after resident #192 re	eceived the Novolog 70-30,			completed. This monitoring process will	l l	
	58 units; licensed nu	rse #1 indicated; she went to			take place daily for 2 weeks, weekly x 2		
		and observed resident #192			more weeks, then monthly x 3 months	or	
	I -	She immediately obtained			until the pattern of compliance is		
		blood glucose. Blood			maintained.		
	1 ~	oted to be 189 (adult normal			Effective 2/8/2019, Assistant Director of	<b>т</b>	
	emergency medical	sed nurse #1 contacted			Nursing, and/or Staff Development Coordinator, will monitor compliance w	ith	
	transferred resident				notification of changes to Physician and		
		gency surveyors indicated			responsible party by to include notifical		
		of this alleged noncompliance			to physician for any resident with insuli		
		sed nurse #1 to administer			order who refuse their meal. This		
		:24am while resident #192			monitoring process will be accomplished	ed	
		t meal. Since the action by			by reviewing the daily clinical meeting	ĺ	
	1	d not follow physician order			reports to ensure completion and prope	er	
		ence the state survey agency			follow through. Any issues identified		
		#192 did not receive			during this monitoring process will be		
	treatment and care in				addressed promptly. Findings from this		
	·	ds of practice. Also the lack			monitoring process will be documented	on	
		sician is alleged to be			a daily clinical report form and filed in	ĺ	
	contrary to the effort	s by the facility to provide			clinical meeting binder after proper		

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OE. TIEIT	O T OIT MEDIONATE OF	MEDIO/ (ID OLI (VIOLO				<u> </u>	. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(	C
		345449	B. WING			02/	08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/KING				15 WHITE ROAD		
				K	ING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page quality care for all res #192 in order to meet mental, and psychoso Address how correcti accomplished for those potential to be affected practice.  Audits of 100% of residents of 100% of resident with any insugiven with meals. The eight other residents insulin medication to Attending physician for contacted and approximately appro	sidents including resident teach residents physical, ocial needs. The action will be see residents having the ed by the same deficient sident- medication orders are Director of Nursing, Nursing and/or Unit Manager (19 to identify any other ulin order that need to be a audit concluded there were identified with orders for be given with meals. For identified residents were clarified to be 2/8/2019. Audit of Insulin sor the last 7 days that identified residents as ordered with meals.  Sidents medication orders are Director of Nursing, Nursing and/or Unit Manager (19 to identify any other anisulin medication order with meals. The audit as six other residents for non-insulin medication to Attending physician for ontacted and approve all the any food to include a meal		684		of t ne for on or	
	100% audit of all curr	rent residents clinical the last 7 days completed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	(X3	) DATE SURVEY COMPLETED
		345449	B. WING			C
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING	0,01,0		STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021	I	02/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Nursing, Staff develor Nurse Manager to defor notification of character at timely manner. The missing/delayed notification and/or responded on 2/08/18 documented on clinic in the facility compliant on 2/8/2019, 100% and Director of Nursing, And Staff development Completed on 2/08/18 documented on incide the last 7 days to ensing a timely manner. The missing/delayed notification in the facility compliant of the facility compliant of the facility compliant of the deficient practice. The deficient practice of the deficient practice of the deficient practice of the deficient practice. The deficient with an meals/food when a remeal/food. Facility Linotify physician where insulin refuse their meals of the deficient practice. The deficient practice of the deficient with an meals/food when a remeal/food. Facility Linotify physician decision in records before the in Effective 2/8/2019 and facilitys clinical team, nursing, Assistant Directors of the deficient practical team, nursing, Ass	rsing, Assistant Director of pment Coordinator and/or etermine any identified need nges that was completed in a audit revealed no other fication of changes to both consible party. This audit was 2. Findings of this audit are cal records audit toollocated nce binder.  Budit was completed by the Assistant Director of Nursing, coordinator and/or Nurse nts reports completed within sure notifications were done the audit revealed no other fication of changes to both consible party. This audit was 2. Findings of this audit are ent reports audit toollocated nce binder.  Into place or what will be made to ensure that	F 6	84		

' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345449	B. WING _			C 2/08/2019	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP COD 115 WHITE ROAD KING, NC 27021		210012013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 684	for residents in the far of reviewing new admadding the review of during daily clinical meach resident with an indication of whether or not, and ensure the administer those order physician. The result be documented on the maintained in the Dair Findings from this system discussed in the daily through Friday effective 2/8/2019 and weekend Registered designated licensed minsulin orders for the each resident with an indication of whether or not, and validate the administer those order physician. The result be documented on the form maintained in the binder. Findings from the discussed in the discu	nits and new insulin orders cility, to an existing process nits for the last 24 hours. By residents insulin orders leeting, it will ensure that order for insulin has an it need to be given with food at licensed nurses ers as specified by the of this systemic process will be daily clinical report form ly clinical meeting binder. Stemic changes will be clinical meeting Monday ve 2/8/2019. It moving forward the Nurse supervisor and/or nurse will review any new last 24 hours to ensure that order for insulin has an it need to be given with food nat licensed nurses ers as specified by the of this systemic process will e weekend supervisor report to Daily Stand up meeting this systemic changes will aily stand up	F 6	84			
		emphasis of this education					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
							C
		345449	B. WING			1	08/2019
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
LIMIN/EDG	AL LIEALTH CARE/KING			115	WHITE ROAD		
UNIVERS	AL HEALTH CARE/KING	1		KIN	NG, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	timely manner for an insulin. The education responsibility of the inotify physician whe insulin refuse their manual physician decision in records before the ineducation will be conficensed Nurse not be allowed to work unwill also be added or process for all new libe provided annually. The facility plans to make sure that solut Effective 2/8/2019, Director of Nursing, Coordinator, will more and accurate insuling observing five residiverify that it is given by physician. Finding process will be docure port form and filed after proper follow-unmonitoring process weeks, weekly x 2 months or until the pmaintained. Effective 2/8/2019: It the completion of dafollow through and exis rendered as approdocument ffindings of daily clinical checklis meeting binder after completed. This more	ed by physician and in a py medication specifically on also emphasized the dicensed nurse on Duty to a resident with ordered meal/food and document a each residents medical asulin is administered. This ampleted by 2/8/2019. Any educated by 2/8/2019 will not until educated. This education a new hires orientation densed nurses and will also by effective 2/8/2019.	F	584			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		(X3	B) DATE SURVEY COMPLETED
	345449	B. WING _			C <b>02/08/2019</b>
			STREET ADDRESS, CITY, STATE, ZIP  115 WHITE ROAD  KING, NC 27021	CODE	GE133/2313
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFII TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
weekly x 2 more wee or until the pattern of Effective 2/8/2019, Di Director of Nursing, a Coordinator, will mon and accurate insulin a insulin administration to ensure timely admi administration and do physician, this will individe with orders to be give given as ordered. Fir process will be docur report form and filed i after proper follow-up monitoring process weeks, weekly x 2 months or until the paramintained. Effective 2/8/2019, As and/or Staff Developmentor compliance we to Physician and/or reinclude notification to with insulin order who monitoring process we reviewing the daily cliensure completion an issues identified durin will be addressed promonitoring process we clinical report form an binder after proper for Facility QAPI was not 2/8/2019. Effective 2/8/2019. Effective 2/8/2019.	ks, then monthly x 3 months compliance is maintained.  irector of Nursing, Assistant ind/or Staff Development itor compliance with timely, administration by reviewing records from previous day inistration, correct ocumentation as ordered by clude verifying any resident in with food or meals is administration and the clinical meeting binder is are completed. This will take place daily for 2 ore weeks, then monthly x 3 attern of compliance is a sistant Director of Nursing, ment Coordinator, will with notification of changes apponsible party by to physician for any resident or refuse their meal. This will be accomplished by an inical meeting reports to and proper follow through. Any ment this monitoring process imptly. Findings from this will be documented on a daily and filed in clinical meeting llow-ups	F	684		
	Continued From page weekly x 2 more wee or until the pattern of Effective 2/8/2019, Director of Nursing, a Coordinator, will mon and accurate insulin a insulin administration to ensure timely administration and dophysician, this will incuit orders to be given as ordered. Fir process will be docur report form and filed after proper follow-up monitoring process with weeks, weekly x 2 months or until the paramintained. Effective 2/8/2019, As and/or Staff Developmentor compliance with insulin order whomonitoring process with insulin order whomonitoring process were viewing the daily cliensure completion ar issues identified durin will be addressed promonitoring process wellinical report form and binder after proper formal process willing and/or Assisting and/or Ass	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 33 weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.  Effective 2/8/2019, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with timely, and accurate insulin administration by reviewing insulin administration records from previous day to ensure timely administration, correct administration and documentation as ordered by physician, this will include verifying any resident with orders to be given with food or meals is given as ordered. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow-ups are completed. This monitoring process will take place daily for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 33  Weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.  Effective 2/8/2019, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with timely, and accurate insulin administration by reviewing insulin administration records from previous day to ensure timely administration, correct administration and documentation as ordered by physician, this will include verifying any resident with orders to be given with food or meals is given as ordered. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow-ups are completed. This monitoring process will take place daily for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.  Effective 2/8/2019, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with notification of changes to Physician and/or responsible party by to include notification to physician for any resident with insulin order who refuse their meal. This monitoring process will be accomplished by reviewing the daily clinical meeting reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow-ups  Facility QAPI was notified of this Plan of action on 2/8/2019. Effective 2/08/19, Facility Director of Nursing and/or Assistant Director of Nursing will	ROUDER OR SUPPLIER AL HEALTH CARE/KING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 33 weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance with timely, and accurate insulin administration by reviewing insulin administration process will be documented on a daily clinical report form and filed in clinical meeting process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a daily clinical meeting binder after proper follow-ups  Facility QAPI was notified of this Plan of action on 2/8/2019. Effective 2/08/19, Facility Director of Nursing will	A BUILDING  345449  345449  STREET ADDRESS, CITY, STATE, ZIP CODE 11s WHITE ROAD KING, NC 27021  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY)  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY)  COntinued From page 33  weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.  Effective 2/8/2019, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with timely, and accurate insulin administration by reviewing insulin administration and documentation as ordered by physician, this will include verifying any resident with orders to be given with food or meals is given as ordered. Findings from this monitoring process will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow-ups are completed. This monitoring process will be accomplished by reviewing inaulin and/or exposure their mean. This monitoring process will be accomplished by reviewing insulin and/or responsible party by to include notification to physician for any resident with insulin order whor refuse their meal. This monitoring process will be accomplished by reviewing the daily clinical meeting pinder after proper follow-ups are completed on a daily clinical report for whor feuse their meal. This monitoring process will be accomplished by reviewing the daily clinical meeting process will be accomplished by reviewing the daily clinical meeting binder after proper follow-ups  Facility QAPI was notified of this Plan of action on 2/8/2019. Effective 2/08/19, Facility Director of Nursing will

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345449	B. WING		C 02/08/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING		1	TREET ADDRESS, CITY, STATE, ZIP CODE  15 WHITE ROAD  KING, NC 27021	02/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 684	facility Quality Assura Improvement Commitmonitoring or modification three months, or use compliance is maintal can modify this plan to in substantial compliance is maintal can modify this plan to in substantial compliance is maintal compliance. Effective 2/8/2019 the the Director of Nursin responsible for the improvement of the impro	nce and Performance tee for any additional ation of this plan monthly ntil the pattern of ned. The QAPI committee of ensure the facility remains nce.  I responsible for eptable plan of correction of acility Administrator and of will be ultimately plementation of this plan of the facility attains and compliance.  The moval date 2/8/2019  In of Immediate Jeopardy 2/8/19 at 8:02 PM as  Cords revealed in-services all active facility staff on The DON, ADON, SDC, ors were trained to provide of abuse/neglect policy, and documentation, and orders to every employee of to work at the facility either	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345449	B. WING _			C 02/08/2019	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021	•	02/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	PM revealed that she Abuse and Neglect F would report any con DON. She also receives resident did not eat sand/or report the refudocument the meal in charting.  An interview with NA revealed that educatifacility Abuse and Ne all concerns or suspict the DON or administraceived education the refuses their meal, of they don't want anythe meal percentage, and During an interview of PM she stated that if abuse she was to republy and/or the admeducation that stated was supposed to offer more times, but that refuse. If the resident would notify the nurspercentage.  During an interview of 7:55 PM she stated the ensure a snack or for giving insulin. If the interview of the provider and follows.	with NA #3 on 2/8/19 at 7:41 was educated on the facility Policy and stated that she cerns or suspicions to the wed education that stated if a he would offer alternates usal to the nurse and ntake percentage in her  #4 on 2/8/19 at 7:41 PM on was provided on the eglect Policy. She stated that coins would be reported to rator. She stated she also nat stated if a resident effer alternatives to ensure using, always document their	F	584			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345449	B. WING		C <b>02/08/2019</b>
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021	02/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 689 SS=D	and Neglect Policy st suspicions of abuse s DON and/or administ During an interview w 8:00 PM she stated the ensure a snack or foo giving insulin. If the ranything she was supand follow orders give She would then docu 24-hour report for the Free of Accident Haz CFR(s): 483.25(d)(1)  §483.25(d) Accidents The facility must ensus \$483.25(d)(1) The reas free of accident has \$483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by:  Based on record revifacility failed to provict two people as care plof the bed to the floor his right forearm and residents (Resident #Findings include:  Resident #62 was ad	ration on the facility Abuse rated that any and all should be reported to the rator.  Fifth Nurse #3 on 2/8/19 at reported to the rator.  Fifth Nurse #3 on 2/8/19 at reported to the rator.  Fifth Nurse #3 on 2/8/19 at reported to do was consumed before resident refused to eat reposed to notify the provider, reported to remark that the resident changes on the reported to remark that the resident environment remains remains remains reported to the receives adequate retained devices to prevent remained as a six possible; and received abrasions to right side of head. One of 5 right side of head and received quadriplegia remained to the facility on resident included quadriplegia.	F 684		2

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE : COMPI	SURVEY LETED
		345449	B. WING _			C <b>02/08/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2019
	10 115211 011 001 1 21211				15 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KING			KING, NC 27021			
(X4) ID		ATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECT		_	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	× 	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 689	Continued From page	<del>2</del> 37	F 6	89			
					with incontinent care.		
	A review of Resident	#62's 10/16/18 quarterly			On 2/26/2019 Certified Nursing Assista	nt	
		vealed the resident was			#5 was re-educated on reviewing and		
		Resident #62 was coded			following the resident □s care guide		
	under functions as tot				regarding the amount of assistance		
	•	required for bed mobility,			needed for activities of daily living care	(	
	_	iting, and bathing. Active			incontinent care).		
	diagnoses included no	•			Identification of Others:		
		of brain, and aphasia.			All residents are at risk for the deficient		
		#62's care plan dated			practice therefore effective 2/25/2019 at 100% audit was conducted by the MDS		
		nned for staff assistance for			Nurses to identify residents in need of		
	•	iving related to his limited			person assist while providing incontine		
		s on Resident #62's care			care.	.it	
	_	resident to have 2-person			49 residents were identified for requiring	ıa 2	
	-	ng and incontinence care.			assist with incontinent care. For each	9 -	
	acciotante mai batini	ig and moonanonoe care.			resident identified, care guides were		
	A review of the facility	's incident report dated			updated as of 2/25/19 to indicate two		
	_	IA (Nursing Assistant) was			person assist with incontinence care.		
		in bed for perineal care and			Systemic Changes:		
	the resident slid out o	f the bed and rubbed his			Effective 2/27/19, 100% of nursing staf	f	
	shoulder and forearm	on the wall. It was reported			was re-educated by the Director of		
	Resident #62 receive	d an abrasion to the right			Nursing and Assistant Director of Nursi	ng	
	-	ght forearm. The resident			on following the residents□ care guide		
		it back in bed with 2-person			regarding the number of persons need	ed	
		#62's responsible party and			to provide assist with incontinent care.		
		otified. A review of Resident			Care guides were updated for resident		
		revealed a physician's order			identified as needing two person assist		
	dated 1/1/19 that orde	-			with incontinent care. The nurses are t		
		ent's right shoulder and right			include on the 24 hour report if there is	а	
	side of head due to fa	III.			change in a resident □s need for		
	Posidont #62's v rav	of the right mandible with			assistance with incontinence care.		
		of the right mandible with of tracture or dislocation			Monitoring: The Director of Nursing/ Assistant		
		ts were viewed and signed			Director of Nursing will monitor the 24		
	by the physician on 1				hour report daily during clinical meeting	15	
	ay the physician on h				days per week (Monday □Friday) for a		
	A telephone interview	was conducted with NA #5			residents with a change in assistance v	-	
	-	n 2/8/19 at 3:50pm. She			incontinence care. Monitoring will conti		
ORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: 42C911		Fa	cility ID: 923159 If continu	ation sheet	t Page 38 of 60

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG	(×	(X3) DATE SURVEY COMPLETED	
		345449	B. WING _			C <b>02/08/2019</b>	
	VIDER OR SUPPLIER  . HEALTH CARE/KING		STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021			02/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
rition is solved as the second	o Resident #62 on 1/She reported she had eft side and was was area. NA #5 reported esident moved his he eported she tried to a was still wet, and her he bed. She reported approximately 3 feet. Was supposed to have Resident #62 but because thought she could move his hoften provided care to assistance prior to the An interview was conditioned it was her exassistants follow the construction of Nursing) of the eported it was her exassistants follow the construction of Nursing assist Nutrition/Hydration St. CFR(s): 483.25(g) (1)-3483.25(g) Assisted in Includes naso-gastric poth percutaneous endoscenteral fluids). Based comprehensive assessensure that a resident (\$483.25(g)(1) Maintai of nutritional status, so	providing incontinence care 1/19 early in the morning. the resident turned on his hing his buttocks and rectal her gloves were wet and the ead and started sliding. She eatch him but because he gloves were wet, he slid off the bed was elevated She reported she knew she es someone help her with ause he was "tiny and little," I manage. She reported he ead. NA #5 reported she e Resident #62 without e fall.  ducted with the DON on 2/8/19 at 5:50pm. She pectation that the nursing eare plans of the residents. er expectation that the d the unit manager make etants follow the care plans. eatus Maintenance (3)  nutrition and hydration. e and gastrostomy tubes, doscopic gastrostomy and on a resident's sment, the facility must	F6	on Saturday and Sund nurse. This monitoring daily x2 weeks, then w monthly x3 months. Fir reported to the monthly for recommendations of until a pattern of complete the compl	will be conducted eekly x2, and then ndings will be y QAPI committee or modifications		

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER:  A. BUILDIN		IPLE CONSTRUCTION  IG	(X3)	(X3) DATE SURVEY COMPLETED	
		345449	B. WING _			C <b>02/08/2019</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP COE 115 WHITE ROAD KING, NC 27021	DE	02/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 692	F 692 Continued From page 39 balance, unless the resident's clinical condition		F 6	92			
	preferences indicate						
	maintain proper hydra						
	there is a nutritional provider orders a the						
	This REQUIREMENT is not met as evidenced by:  Based on observations, record review and staff and physician interviews, the facility failed to identify and implement measures to address an unintended weight loss for 1 of 4 (Resident #65)			F692 Root Cause Analysis Based on the root cause ana facility Administrative staff an	d the facility		
	sampled residents re Findings included:	viewed for nathtion.		Executive Director, the facility follow policy and procedure be put interventions in place for having been identified with si	y failing to a resident		
	1/5/19 with diagnoses fracture, right wrist fra dementia. She was a was not in facility price	dmitted from hospital. She		weight loss. Immediate Action On 2/16/2019 resident #65 w discharged from the facility Identification of Others All residents are at risk for the			
	revealed on 1/5/19 ar weekly weights and s regular, no added sal	nd order was written for the was admitted on a t diet. Review of the cord revealed on 1/6/19,		practice therefore on Februar 100% audit was completed b manager and the Registered residents on monthly and we to identify any residents with	ry 27, 2019 a y the Dietary Dietitian on ekly weights		
	and Assessment date Resident #65 had a fa 50-75% of most meal months per family me	ed a Nutritional Screening ed 1/10/19 which indicated air appetite, consuming ls. Weight stable over last 6 ember's report, usual body 158 pounds, and ideal body		weight loss. If any resident w with significant weight loss th was notified, and an intervent in place.  Systemic Changes Effective March 1, 2019 The Manager will review weekly a weights to identify any reside	e physician tion was put Dietary and monthly		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
			7 55.125			С	
		345449	B. WING		o	2/08/2019	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODI	•		
				115 WHITE ROAD			
UNIVERSA	AL HEALTH CARE/KING			KING, NC 27021			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION DATE	
F 692	Continued From page	<del>2</del> 40	F 69	92			
				significant weight loss. The di	etary		
	A nutritional care plan	note dated 1/10/19 written		manager will place those resid	dents		
	by the dietician revea	led Resident #65's weight		identified on the weekly stand	ards of care		
	was 157 pounds. The	registered dietician		list to be reviewed by the IDT	•		
	_	protein supplement twice a		weekly standards of care mee	•		
		pass. The note specified the		discuss interventions to put in	•		
		or weight changes related to		residents will be placed on the			
		t, dementia, and weight		list to review during her next v			
	above average body weight. Will proceed to care			management will notified the I	•		
	plan.			Nurse Practitioner to inform of	-		
	A care plan for putritic	on dated 1/10/19 revealed		and approve interventions sug Effective February 27, 2019 th			
		risk for weight changes		Manager was in-serviced by the	-		
		apeutic diet, diagnosis of		Director to report any resident			
		above average body weight.		with significant loss to the Die			
	_	n of significant weight loss		Executive Director, and Nurse			
		ate entry. The care plan goal		management weekly/monthly			
	included resident will	eat at least 75% of all meals		interventions are put in place	to prevent		
	through next review v	vith an additional		future weight loss or to mainta	ain weight.		
	_	o significant weight changes		Each resident identified must	•		
	_	andwritten. Interventions		on the weekly standards of ca	•		
		rrent listing of likes and		list and the Dietitian list for rev			
		tamins as ordered, obtain		Effective March 1, 2019 100%	_		
		s needed, encourage dining		staff was in-serviced to report			
		etary recommendation add		residents intake or the ability			
		ein supplement max twice a pass for nutritional support.		or any weight changes to nurs administration as soon as idea	-		
	daily with medication	pass for flutifilorial support.		Licensed staff to place on 24			
	A review of an Admiss	sion/5 day Minimum Data		sheet. Nursing administration			
		d 1/11/19 revealed Resident		24 hour report sheet daily dur			
		aired cognition. She was		rounds. This education was pr	-		
		dependent with meals after		the Director of Nursing/ Assist			
	_	allowing disorder, was on a		of Nursing, any staff not educa			
		hed 157 pounds and was 66		be allowed to work until educa			
	inches tall.			education will also be added t	o the new		
				hire process.			
	An observation on 2/7			Monitoring			
		d she was sitting at a table		Effective March 1, 2019 the D			
	in the main dining roo	m with lunch tray in front of		Nursing/ Assistant Director of	Nursing /		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345449	B. WING			C <b>02/08/2019</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	02/06/2019	
UNIVERSA	AL HEALTH CARE/KING			115 WHITE ROAD KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 692	Continued From page	e 41	F 69	92			
F 092	her. Resident #65 had beans. A follow-up ob approximately 1:00 Pl assistant assisting Ref #65 had consumed at her meal.  On 2/7/19 at 1:13 PM revealed Resident #6 but did need assistant had good days and be friend would visit frequesident to eat. She seresident to eat in the finition in to visit, but sometime Review of Resident #6 on 1/12/19 a weekly we documented which we percent significant we resident's previous we obtained on 1/6/19.  Lab results of a Liver 1/7/19 revealed an all protein of 4.8. Normal 6.0-8.7, respectively.  Review of Resident #7 revealed there were rephysician orders writt significant weight loss Additionally, review or record revealed the Recommendation for the daily protein supplements.	d only consumed bites of her eservation on 2/7/19 at M revealed the activity esident #65 to eat. Resident approximately 75 percent of , an interview with NA #2 5 was able to feed herself, ce at times. She stated she ad days. The family or family uently and assist the tated she encouraged the dining room if no one came nes she refused to go.  65's weight record revealed weight of 146.8 pounds was as a 10.2 pounds or 6.5 eight loss since the eight of 157 pounds  Function Panel collected on bumin of 2.5 and a total I lab values are 3.5-5.2 and  65's medical record no nutritional interventions or en to address the resident's from 1/5/19 to 1/12/19. If the resident's medical	F 69	Unit Manager will review the 2 report to identify any residents intake, decrease in the ability and weight changes during dameeting 5 days per week (Mc Friday). This Monitoring will be by the Charge nurses on Satu Sundays.  The Dietary manager will more /monthly weights to identify resignificant weight loss and ves intervention is put in place. The monitoring will be conducted weeks, then weekly x2 weeks monthly x3. Findings will be recommendations or modificate pattern of compliance is achieved.	s with poor to feed self aily clinical anday  be continued ardays and anitor weekly esidents with arify an anis daily x2 s, then deported dee for attions until a		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(×	(X3) DATE SURVEY COMPLETED			
		345449	B. WING _			C <b>02/08/2019</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP  115 WHITE ROAD  KING, NC 27021	CODE	02/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 692	of the weight that was on 1/12/19 which reflet loss from 1/6/19. She with the weekly weight the report weekly and weight, she requested resident. If there was notify the dietician by recommendation for the resident's weight loss interventions were im Resident #65's weigh 1/6/19 to 1/12/19.  On 2/6/19 at 11:20 Al Nursing (ADON) was weights were done or 2019, the facility initial admission. Nursing arresidents' weights and on the hall to enter infif there was a 3 pound obtained. If the weigh physician was notified interventions could be Review of Resident # on 1/19/19 a weekly weights and 1/19/19 a weekly weight at 12:40 Pl interviewed. Nurse #1 the E/F halls on 1/19/19 resided. She stated in the resident weights a or the supervisor to e system.	s obtained for Resident #65 ected a significant weight stated she tried to keep up hts. She stated she pulled If there was a concerning d nursing to reweigh the still a concern, she would phone and get a he physician to stop the The DM confirmed no plemented to address t loss experienced from  If the Assistant Director of interviewed. She stated he admission. In January hted weekly weights x 4 after esistants were to obtain the d give the result to the nurse to the computer. She stated d variance, a reweight was t was still concerning, the d as well as dietary so that e put into place.  65's weight record revealed weight was not documented.	F	692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		CTION	(X3) DATE SURVEY COMPLETED		
		345449	B. WING _				C ( <b>08/2019</b>
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING		1	STREET ADD 115 WHITE F KING, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	e 43	F	692			
	on 1/26/19 a docume which equates into a weight loss since 1/6/ A review of meal pero 1/26/19 for Resident between 50-75% of home of the control of the cont	centages from 1/6/19 to #65 revealed she consumed er meals.  I, the dietician was ed she didn't recall Resident control was he stated she would get the ded monthly and the Dietary of her of any significant eekly weights. She stated collity's risk committee why remation regarding Resident continued for Resident #65 confirmed no approaches address the resident's gan on 1/12/19 until 1/30/19 supplement was ordered.  I, an interview with the DM she rounded with the sident #65. She stated she nt's family member who had					
	On 2/7/19 at 3:48 PM	, an interview was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSIDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED
		345449	B. WING		C 02/08/2019
	OVIDER OR SUPPLIER  L HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021	1 02/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	stated she didn't have front of her but wasn't experienced weight to expected to be notifie	sident's physician. She Resident #65's chart in aware she had ss. She stated she	F 692		2/8/19
SS=J	CFR(s): 483.45(f)(2) The facility must ensuge 483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on record reviewergency medical sinterviews, and emergency for 1 of 4 (Resident #reviewed for insulin a administering 58 units which was ordered to did not make sure Rebreakfast meal. As a became unresponsive hospital. She required intubation. Resident hospital admission or respiratory failure, alto hypothermia (low both hypoglycemia (low bloth limmediate jeopardy befailed to ensure Resident failed failed to ensure Resident failed to ensure Resident failed faile	are that its- its are free of any significant  is not met as evidenced  ew, staff interviews, ervice (EMS) personnel gency department (ED) ine facility failed to prevent a error by not following dminister insulin with meals 192) sampled residents dministration. Prior to s of Novolog 70/30 Insulin, be given with meals, staff sident #192 had eaten her result, Resident #192 e and was admitted to the d a central line and e192's final diagnoses for a 1/25/19 were acute ered mental status, by temperature), and bod glucose).  regan on 1/25/19 when staff lent #192, who had diabetes er breakfast prior to s of Novolog Insulin which		The creation of this Letter of Credible allegation constitutes a written allegat of compliance. Preparation and submission of this letter does not constitute an admission or agreement the provider of the truth of the facts alleged or the correctness of the conclusions set forth by the survey agency. This letter is solely prepared because of requirement under state a federal law, and to demonstrate the graith attempts by the provider to improve the quality of life of each resident.  Date: 2/08/2019  Corrective action accomplished for the residents found to have been affected the deficient practice.  Resident #192 was admitted on 1/23/2 for short term rehabilitation services. Resident #192 received skilled nursing and rehabilitation services from 1/23/2 up to 1/25/2019. Review of facility morecent minimum data set, with Assessment reference date 1/25/2018	ion by  nd bood ve  Dise by  2019 g 2019 g 2019 st

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			، ا	С	
		345449	B. WING				08/2019	
NAME OF PI	ROVIDER OR SUPPLIER	I	_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2010	
				1.	15 WHITE ROAD			
UNIVERSA	AL HEALTH CARE/KING				(ING, NC 27021			
(V4) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 760	Continued From page	e 45	F	760				
		vas removed on 2/8/19 when			section I (active diagnosis) indicated			
	the facility provided a				resident #192 had a diagnosis of type 2	2		
		te Jeopardy removal. The			diabetes mellitus with diabetic neuropa			
		compliance at a lower			Review of physician orders reveals	,		
	-	"D" (no actual harm with the			resident #192 had an order for Novolog	1		
		than minimal harm that is			Mix 70-30 to be given subcutaneously			
	not immediate jeopar	dy) to ensure monitoring and			twice daily with meals.			
	all staff have been in-	serviced.			On 1/25/2019 resident #192 received			
					Novolog 70-30 at 10:24am. Interview w	/ith		
	Findings included:				nurse aide #1 who was caring for resid	ent		
					#192, on 1/25/2019 morning shift,			
	Resident #192 was a	dmitted to the facility on			indicated resident #192 refused her			
		noses that included Diabetes			breakfast in the morning of 1/25/2019.			
		thyroidism (underactive			Interview with nurse assistant #2			
		ension (HTN - high blood			conducted by the facility Director of			
	1 *	is (inflammation in the gut			Nursing indicates resident #192 ate			
		intestine and colon) related			snacks during the night of 1/24/2019 to	)		
		(C-diff), an infection in the			the morning of 1/25/2019.			
	colon that is caused b	by the bacteria called			On 1/25/2018, at 12:15pm less than tw	0		
	clostridium difficile.				hours after resident #192 received the			
		L 6 D :1 1//400			Novolog 70-30, 58 units; licensed nurs			
		an orders for Resident #192			#1 indicated; she went to resident #192			
		ed on 1/23/19 for Finger			room and observed resident #192 been			
	at bedtime. There wa	SBS) checks before meals &			unresponsive. She immediately obtaine			
					vital signs as well as blood glucose. Blo			
	administer 58 units su	ayer between the skin and			glucose result was noted to be 189 (ad normal limits 70-110). Licensed nurse			
		ith meals of Novolog 70/30.			contacted emergency medical services			
		ufacturer, Novolog 70/30 is			who then transferred resident to the			
		ade fast-acting insulin to			hospital.			
		spikes in blood sugar and			On 2/8/2019; the facility Medical Direct	or		
		at works up to 24 hours to			had an extensive discussion with the			
		gar between meals. The			State surveyors on site to explain the			
		nes stated that people with			medical rationale for the reported			
	_	d have the injection within			hypoglycemic episode for resident #19	2		
		after starting their meal.			documented by both EMS and emerge			
					room Physician on 1/25/2019. Facility	- ,		
	Resident #192's Janu	ary 2019 medication			Medical Director explained that resider	ıt		
		(MAR) revealed Resident			#192 hypoglycemic episode is medical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345449	B. WING _			02/	08/2019	
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
LININ/EDO/				11:	5 WHITE ROAD			
UNIVERSA	AL HEALTH CARE/KING			KI	NG, NC 27021			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	•	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
F 760	Continued From page		F 7	760				
	#192 had her 6:00 AN	M scheduled FSBS check on			related to resident #192 □s chronic thyr			
	1/25/19 at 6:37 AM ar	nd the result was 109			condition that was not diagnosed before	е		
		ng/dl). The Novolog 70/30			resident #192 was admitted to the facil	ity		
		neduled for 9:00 AM was			on 1/23/2019, two days before the			
		nistered on 1/25/19 at 10:24			episode of hypoglycemia. The facility			
	AM by Nurse #2.				medical director added; on 1/24/2019,	she		
					ordered thyroid stimulating hormone			
	According to the mea				(TSH) laboratory test			
		t eat anything for breakfast						
	or lunch on 1/25/19.				following the report from facility license			
	<b>.</b>	::I N			staff that resident #192 was lethargic.	Ihe		
	_	vith Nurse Aide (NA) #6 on			facility obtained the laboratory test on			
	2/6/19 at 4:46 PM abo				1/24/19 as ordered and received the			
		take on 1/25/19, she stated			result on 1/25/2019. TSH result from	_		
		on the bedpan several times			1/24/2019 indicated resident #192 had	а		
		t she had refused breakfast.  otified the nurse of the			condition called Hypothyroidism. The facility Medical Director expressed to the			
		eat breakfast, she stated			state surveyors on site that resident	ie.		
	Nurse#2 was made a				#192 s fluctuation on blood sugar was			
	Nuisc#2 was made a	ware.			related to her untreated and undiagnos			
	During an interview w	vith Nurse #2 on 2/7/19 at			thyroid condition and not due to the	Cu		
		nat at approximately 10:00			administration of the insulin that was gi	ven		
	AM she went into Res				less than two hours before she was	•••		
		ns and she was at baseline			observed been unresponsive. Facility			
		al status. Nurse #2 stated			Medical Director ordered Synthroid			
	she knew she did not	eat her breakfast and had			100mcg, medication used to treat			
		something at that time, but			hypothyroidism but medication was not	t		
		any food. When asked if she			started as resident #192 was transferre			
		of Novolog 70/30 insulin			to the hospital on the same day it was			
	when she knew the re	esident had not eaten			ordered (1/25/2019). Resident #192 is	no		
	breakfast, she stated	that she did. She stated			longer in the facility, no further actions			
	she had gone into Re	sident #192's room at			warranted at this time.			
	approximately 12:00 l	PM to check her blood sugar			On 2/08/19; State agency surveyors			
		onsive. Nurse #2 stated she			indicated that the root cause of this			
		nt #192 up and checked her			alleged noncompliance is the action by			
		sult of 189 mg/dl. She			licensed nurse #1 to administer Novolo	g		
		ygen, checked vital signs,			70-30 at 10:24am while resident #192			
		d EMS was called to transfer			refused her breakfast meal.			
	the resident to the ho	spital. She stated that she			Address how corrective action will be			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345449	B. WING			C <b>02/08/2019</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021		02/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	Continued From pag	e 47	F 76	60			
	and dilated.  A progress note date by Nurse #2 stated s room at 12:15 PM an unresponsive. The roxygen saturation lev (BP) was 98/68 mm-minute (bpm), and F3  Review of the Januar Resident #192 had h on 1/25/19 at 1:07 Pl  During an interview w (DON) on 2/6/19 at 5 in Resident #192's roher being unrespons resident's blood sugathere was no indication.	ry 2019 MAR revealed that er 11:30 AM FSBS checked M of 189 mg/dl. with the Director of Nursing 0:02 PM she stated she was soom after she was notified of		accomplished for those reside the potential to be affected by deficient practice.  Audits of 100% of residents orders were completed by the Nursing, Assistant director of Nand/or Unit Manager on 2/7/20 2/8/19 to identify any other residents in the audit conclude were eight other residents iderorders for insulin medication to with meals. Attending physicial identified residents contacted approve all orders to be given food to include a meal or snac meals. Those insulin orders were beginned to be given with food as of 2/8.  Audits of 100% of residents orders were completed by the Nursing, Assistant director of Nand/or Unit Manager on 2/7/20	medication Director of Nursing D19, and sident with be given ed there ntified with o be given an for and with any k between ere clarified //2019. medication Director of Nursing		
	1/25/19 revealed the facility to be unrespondocumented that the unresponsive by staff that the resident was AM, her vital signs wiglucose was 129 mg. level documented by mg/dL. At 1:09 PM Enhypertonic solution of chemically identical tradministered. At 1:1 glucose was 273 mg.	#192's EMS report from resident was found at the nsive. The chief complaint resident was found f and it was reported to EMS last seen normal at 11:00 ere all normal, and her blood /dL. The first blood glucose EMS at 1:05 PM was 23 Dextrose 50% (D50 - a f dextrose, simple sugar o glucose) 25 grams was 3 PM the resident's blood /dL. At 1:30 PM her blood /dL. At 1:30 PM her blood		2/8/19 to identify any other resany non-insulin medication ordined to be given with meals. To concluded there were six othe identified with orders for non-inmedication to be given with meals attending physician for identificant and approve all orders given with any food to include snack between meals.  Measures will be put into place systematic changes will be material ensure that the deficient practical occur.  Effective 2/8/2019 and moving	der that The audit r residents nsulin eals. ed residents ers to be a meal or e or what ade to ice will not	S	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		E SURVEY IPLETED
		245440	D WING			С
		345449	B. WING _			2/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
UNIVERS	AL HEALTH CARE/KING	<b>.</b>		115 WHITE ROAD		
ON ENO	AL HEALIN OAKE/KING	•		KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 760	Continued From pag	je 48	F 7	60		
	glucose was 110 mg	/dL. Resident #192 was		the facility Licensed nur	rse and will not	
	received by the hosp	oital ED staff at 1:45 PM.		administer insulin for ar	ny resident with an	
				order to be given with m	neals/food when a	
	Review of the ED Re	eport from 1/25/19		resident refused his/her	meal/food.	
	documented the resi	ident was found unresponsive		Facility Licensed nurse	on Duty will notify	
		S and EMS obtained a blood		physician when a reside		
		. Triage Lab results from ED		insulin refuse their mea		
		9 at 2:48 PM were Glucose		document physician de		
	_	dent required a central line (a		resident□s medical reco	ords before the	
	catheter placed into			insulin is administered.		
		lab work) and intubation at		Effective 2/8/2019 and	_	
	2:52 PM for acute respiratory failure, she received D50 for hypoglycemia, intravenous fluids			facility □s clinical team,		
		n, and admission to Intensive		Director of nursing, Ass Nursing, and/or Nurse s		
		final diagnoses for hospital		the review of insulin ord	•	
		9 were acute respiratory		admits and new insulin		
		al status, hypothermia, and		residents in the facility,		
	hypoglycemia.			process of reviewing ne	_	
	7,1-3,1-1			last 24 hours. By adding		
	Review of hospital re	ecords from 1/27/19 at 9:22		residents□ insulin ordei		
	AM revealed a Critic	al Care Progress Note by		clinical meeting, it will e	nsure that each	
	Physician Assistant	(PA) #1 and Hospital		resident with an order for	or insulin has an	
		ated problems addressed for		indication of whether it	need to be given	
		ving her insulin dependent		with food or not, and en	sure that licensed	
		DM) were "likely related to		nurses administer those		
	insulin dose and not	eating."		specified by the physici		
		0/5/40 + 0.05 514 # 04 #		this systemic process w		
		on 2/7/19 at 3:35 PM the Staff		on the daily clinical repo		
	•	inator stated NAs are		in the Daily clinical mee Findings from this syste		
	-	g the nurse when a resident ntation and as needed.			•	
		ntation and as needed. If to look at each resident		be discussed in the dail Monday through Friday		
	receiving insulin indi			Effective 2/8/2019 and		
	_	ration and were educated to		weekend Registered Nu	•	
		eals were not consumed.		and/or designated licen		
		the resident does not eat a		review any new insulin		
	· ·	d that the nurse call the		24 hours to ensure that		
		orders before insulin is		an order for insulin has		
	administered.	<del>-</del>		whether it need to be gi		

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		345449	B. WING			C
NAME OF D	DOVIDED OD CUIDDUED	343449	15: 11:10	CTREET ADDRESS CITY STATE ZID CODE		2/08/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ	
UNIVERSA	AL HEALTH CARE/KING			115 WHITE ROAD		
				KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	<u>.</u> 49	F 70	60		
	During an interview w 2/7/19 at 5:11 PM she expected the nurse to if a meal wasn't constresident's blood sugar she didn't eat or have blood sugar going up approximately 12:15 She stated Novolog 7 lower blood sugar lev diabetes, it has an on minutes for the short peaks within 1-4 hour During an interview w 2/7/19 at 3:55 PM she of the particular incide blood sugar and trans associate was most li orders. When asked hold insulin if a reside most residents in the the time. When asked to check another blood administering insulin and no food was consishe did not fault the rinsulin without food. resident had been red dose for a long period reason on that particular in the past without the	with the facility Pharmacist on a stated she would have of hold all short acting insulingumed. She stated if the rowas 109 at 6:27 AM, and a glucagon administered, the to 189 mg/dl at PM seemed inconsistent. 10/30 is used to regulate and els for residents with set of action within 10-20 acting and the medication is of administration.  With the Medical Director on a stated she was not aware ent with Resident #192's low in the second the nurse to ent did not eat, she stated nursing home don't eat all dif she expected the nurse and sugar prior to after a 4-hour time period sumed, she stated yes but nurse for administering the She stated most likely the second for whatever allar day she had an adverse, but she had probably had ed at that dose without food		not, and validate that licensed administer those orders as spothe physician. The result of this process will be documented on weekend supervisor report for maintained in the Daily Stand binder. Findings from this systemages will be discussed in the stand up meeting Monday the Friday effective 2/8/2019. We supervisor #1  will be educated to work by the facility Director of Nursing The Facility Director of Nursing Assistant Director of Nursing adevelopment coordinator will consider for all licenses include full time, part time and staff. The emphasis of this education as ordered by phy a timely manner for any medication as ordered by phy a timely manner for any medicated the responsibility licensed nurse on Duty to noti when a resident with ordered refuse their meal/food and doc physician decision in each resmedical records before the insadministered. This education completed by 2/8/2019. Any L Nurse not educated by 2/8/20 be allowed to work until education will also be added corientation process for all new nurses and will also be provided.	ecified by is systemic in the important prough each of the each of	
	informed of the imme	, the administrator was diate jeopardy. The facility legation of Immediate		effective 2/8/2019.  The facility plans to monitor its	-	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345449	B. WING		C 02/08/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021	, 32:33:23:3
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 760	Continued From page	e 50	F 76	60	
	Immediate Jeopardy Credible Allegation of			performance to make sure that so are sustained. Effective 2/8/2019, Director of Nur Assistant Director of Nursing, and	rsing, /or Staff
	removal: Date: 2/08/2019			Development Coordinator, will mo compliance with timely, and accurinsulin administration by reviewing administration records from previous	ate g insulin pus day
	Date: 2/08/2019 Corrective action accoresidents found to har deficient practice.	omplished for those ve been affected by the		to ensure timely administration, co administration and documentation ordered by physician, this will inclu verifying any resident with orders	as ude
	short term rehabilitation	dmitted on 1/23/2019 for on services. Resident #192 ong and rehabilitation on 1/25/2019. Review		given with food or meals is given a ordered. Effective 2/8/2019,Directon Nursing, and/or Staff Developmen Coordinator, will monitor complian	or of t
	of facility most recent Assessment referenc (active diagnosis) ind	minimum data set, with e date 1/25/2018 section I icated resident #192 had a		timely, and accurate insulin admin by randomly observing five resider insulin administration to verify that	istration nts' : it is
	neuropathy. Review or resident #192 had an	abetes mellitus with diabetic of physician orders reveals order for Novolog Mix 70-30 eously twice daily with		given with meals/food as ordered physician. Findings from this moni process will be documented on a clinical report form and filed in clin	toring daily
	70-30 at 10:24am. Int	at #192 received Novolog erview with nurse aide #1 sident #192, on 1/25/2019		meeting binder after proper follow- completed. This monitoring proces take place daily for 2 weeks, week more weeks, then monthly x 3 money	ss will kly x 2
	morning shift, indicate breakfast in the morn	ed resident #192, on 1723/2019 ed resident #192 refused her ing of 1/25/2019. Interview £2 conducted by the facility		until the pattern of compliance is maintained.  Facility QAPI was notified of this F	
	snacks during the nig morning of 1/25/2019			action on 2/8/2019. Effective 2/08/ Facility Director of Nursing and/or Assistant Director of Nursing will re findings of this monitoring process	eport
	after resident #192 re 58 units; licensed nur resident #192 room a been unresponsive. S	ceived the Novolog 70-30, se #1 indicated; she went to nd observed resident #192 She immediately obtained		facility Quality Assurance and Performance Improvement Comm any additional monitoring or modif of this plan monthly for three mon	ittee for ication
	vital signs as well as	blood glucose. Blood		until the pattern of compliance is	

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		345449	B. WING_			С	
		345449	B. WING _			02/08/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE		
UNIVERSA	AL HEALTH CARE/KING			115 WHITE ROAD			
ONIVERO	ALTIERETTI OAKEMINO			KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760		ted to be 189 (adult normal	F 7	maintained. The QAPI con			
	emergency medical stransferred resident to	the hospital.		modify this plan to ensure remains in substantial com	npliance.		
	that the root cause of is the action by licens Novolog 70-30 at 10:2 refused her breakfast Address how correction	ve action will be		The title of the person respinglementing the acceptable correction  Effective 2/8/2019 the facil Administrator and the Direwill be ultimately responsible to the person of	ole plan of lity ctor of Nursing ble for the		
	potential to be affecte practice. Audits of 100% of res	se residents having the d by the same deficient dents medication orders		implementation of this plar to ensure the facility attains substantial compliance.	s and maintains		
	on 2/7/2019, and 2/8/ resident with any insur- given with meals. The eight other residents in insulin medication to be Attending physician for contacted and approv- any food to include a meals. Those insuling given with food as of 2	Jursing and/or Unit Manager 19 to identify any other lin order that need to be a audit concluded there were dentified with orders for be given with meals. or identified residents re all orders to be given with meal or snack between orders were clarified to be 2/8/2019.		Compliance Date 2/8/2019			
	were completed by th Assistant director of N on 2/7/2019, and 2/8/ resident with any non- that need to be given concluded there were identified with orders be given with meals. A identified residents co-	Jursing and/or Unit Manager 19 to identify any other -insulin medication order with meals. The audit six other residents for non-insulin medication to Attending physician for ontacted and approve all h any food to include a meal					

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		345449	B. WING			C 02/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	12/06/2019
UNIVERSA	AL HEALTH CARE/KING			KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 760	Continued From page	e 52	F 70	60		
	the deficient practice Effective 2/8/2019 and Licensed nurse and wany resident with an emeals/food when a remeal/food. Facility Licenotify physician where insulin refuse their may physician decision in records before the insulin refuse their may physician decision in records before the insulin records before the insuling. Assistant Dir Nurse supervisors and orders for all new address for exidents in the factor of the each resident with an indication of whether or not, and ensure the administer those orders for the each resident with an indication of whether or not, and ensure the administer those orders for the each resident with an weekend Registered designated licensed in insulin orders for the each resident with an each res	will be made to ensure that will not occur.  d moving forward, the facility will not administer insulin for order to be given with esident refused his/her censed nurse on Duty will a resident with ordered eal/food and document each residents medical sulin is administered.  d moving forward the which includes Director of ector of Nursing, and/or ided the review of insulin mits and new insulin orders cility, to an existing process nits for the last 24 hours. By residents insulin orders insulin order for insulin has an it need to be given with food at licensed nurses ers as specified by the of this systemic process will be of this systemic process will be of clinical meeting binder. Instemic changes will be of clinical meeting Monday (ve 2/8/2019).  d moving forward the Nurse supervisor and/or nurse will review any new last 24 hours to ensure that a order for insulin has an it need to be given with food				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3)	(X3) DATE SURVEY COMPLETED	
		345449	B. WING			C	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021	<u> </u>	02/08/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 760	physician. The result be documented on the form maintained in the binder. Findings from be discussed in the comeeting Monday throe 2/8/2019. Week end educated on this requischeduled day to wo Nursing. The Facility Director Director of Nursing a coordinator will complicensed nurses to interest as needed staff. The will be on the important medication as orderest timely manner for an insulin. The education responsibility of the linotify physician where insulin refuse their machina physician decision in records before the interest of the education will be confucensed Nurse not be allowed to work unwill also be added on process for all new liebe provided annually. The facility plans to make sure that solution the sure that solution of the sure that sure that solution of the sure that solution of the sure that sure that solution of the sure that su	ers as specified by the of this systemic process will be weekend supervisor report to Daily Stand up meeting a this systemic changes will laily stand up ugh Friday effective supervisor #1  will be uirement before their next rk by the facility Director of of Nursing (DON), Assistant and/or staff development bette 100% education for all clude full time, part time and emphasis of this education ance of administering and by physician and in a sy medication specifically a laso emphasized the censed nurse on Duty to a resident with ordered eal/food and document each residents medical sulin is administered. This appleted by 2/8/2019. Any educated by 2/8/2019 will not not new hires orientation censed nurses and will also effective 2/8/2019. Inonitor its performance to ons are sustained. Iriector of Nursing, Assistant and/or Staff Development and or	F 76	60			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345449	B. WING			02/	08/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE  15 WHITE ROAD  KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	physician, this will incomit with orders to be give given as ordered. Efform Nursing, and/or Staff will monitor compliance insulin administration residents' insulin admigiven with meals/food physician. Findings from will be documented on and filed in clinical meals follow-ups are comples process will take place 2 more weeks, then in the pattern of compliance is facility QAPI was not 2/8/2019. Effective 2/8/2019. Effective 2/8/2019 this facility Quality Assural mprovement Committee months, or uncompliance is maintain can modify this plant in substantial compliance. The title of the person implementing the accent of the person in the person in the person in the person in	decumentation as ordered by clude verifying any resident in with food or meals is ective 2/8/2019, Director of Development Coordinator, with timely, and accurate by randomly observing five sinistration to verify that it is as ordered by the om this monitoring process in a daily clinical report form eeting binder after proper eted. This monitoring e daily for 2 weeks, weekly x monthly x 3 months or until since is maintained. Eified of this Plan of action on 08/19, Facility Director of ant Director of Nursing will monitoring process to the ince and Performance etee for any additional action of this plan monthly intil the pattern of ined. The QAPI committee in ensure the facility remains ance.  In responsible for eptable plan of correction efacility Administrator and g will be ultimately eplementation of this plan of the facility attains and compliance.	F	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345449	B. WING _				C /08/2019
	ROVIDER OR SUPPLIER	3		STREET AD  115 WHITE  KING, NC		1 02/	00/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	removal was verified evidenced by:  Review of facility's rewere completed with 2/7/19 through 2/8/1 and nursing supervisall education regard insulin administration physician notification before they were ab by phone or in-personal revealed that they worders were change order verbiage for all or other types of dia records audit tool, In 24-hour report, and were reviewed for company to the property of the propert	ion of Immediate Jeopardy d 2/8/19 at 8:02 PM as ecords revealed in-services an all active facility staff on 9. The DON, ADON, SDC, sors were trained to provide ing abuse/neglect policy, an and documentation, and anyorders to every employee le to work at the facility either on.  dits from 2/7/19 to 2/8/19 rere completed and that d to reflect the new insulin Il resident's receiving insulin betic medications. Clinical acident reports audit tool, the clinical meeting binder	F 7	60			
	revealed that educa facility Abuse and Nall concerns or susp	A #4 on 2/8/19 at 7:41 PM tion was provided on the eglect Policy. She stated that icions would be reported to trator. She stated she also					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG		(X3) DATE COMP	LETED
		345449	B. WING _			02/	08/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING	I		STREET ADDRESS, CITY, STATE, ZIP CODE 115 WHITE ROAD KING, NC 27021		OZI.	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 760	refuses their meal, of they don't want anyth meal percentage, and During an interview w PM she stated that if abuse she was to rep DON and/or the admi education that stated was supposed to offer more times, but that the refuse. If the resident would notify the nurse percentage.  During an interview w 7:55 PM she stated the ensure a snack or for giving insulin. If the resident the provider and follow administration, then of 24-hour report. Educand Neglect Policy states and Neglect P	and stated if a resident ifer alternatives to ensure ing, always document their id notify the nurse.  with NA #1 on 2/8/19 at 7:49 she suspected any type of bort her suspicions to the inistrator. She also received if a resident did not eat she if alternates or offer several the resident had the right to it still refused to eat she is and document the meal  with Nurse #1 on 2/8/19 at that she was educated to bod was consumed before resident refused to eat, notify worders given for insulin document changes on the cation on the facility Abuse ated that any and all should be reported to the rator.  with Nurse #3 on 2/8/19 at that she was educated to bod was consumed before resident refused to eat posed to notify the provider, en for insulin administration. ment changes on the	F 7	60			
F 761 SS=E	Label/Store Drugs an	d Biologicals	F 7	61			3/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		, ,	ATE SURVEY DMPLETED				
		345449	B. WING _			C 02/08/2019	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING			STREET ADDRESS, CITY, STATE, ZIP CODE  115 WHITE ROAD  KING, NC 27021		02/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 761	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable.  §483.45(h) Storage of §483.45(h) Storage of §483.45(h)(1) In according to several laws, the fact biologicals in locked temperature controls personnel to have accessor storage of controlled the Comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed quantity stored is min be readily detected. This REQUIREMENT by:  Based on observation facility failed to date of in 1 of 1 medication storage findings include:  1. An observation was with Nurse #13 of room refrigerator. It was opened vial of tub	of Drugs and Biologicals are used in the facility must be a with currently accepted as, and include the y and cautionary expiration date when  If Drugs and Biologicals ordance with State and ality must store all drugs and compartments under proper and permit only authorized cess to the keys.  It is must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can are is not met as evidenced and staff interviews, the one opened vial of tuberculin storage room. The facility in correct refrigerator medication refrigerator in the room.  If Drugs and Biologicals and staff interviews are under the service and staff interviews, the one opened vial of tuberculing the correct refrigerator in the room.  If any provide separately are subject to the facility are considered as and staff interviews, the one opened vial of tuberculing the correct refrigerator in the correct refrigerator	F 7	Ftag 761 Root Cause Analysis Based on root cause analysis b facility administrative staff it was determined the facility failed to facility policy for medication and labeling. Immediate: On February 8, 2019 the undate vile of tuberculin was removed refrigerator and discarded. The refrigerator temperature was se	s follow the storage ed opened from the		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _		,	_
		345449	B. WING			l	08/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LININ/EDO	AL LIEALTH OADE#/NO			1	15 WHITE ROAD		
UNIVERSA	AL HEALTH CARE/KING			K	ING, NC 27021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 761	Continued From page	e 58	F.	761			
		he reported all medication	•	, , ,	maintain a temperature between 36 to	46	
		be dated and labeled. She			degrees according to facility policy.	+0	
		esponsibility of whoever			Identification of others:		
	opened the vial to da				All residents are at risk for deficient		
		iducted with the DON			practice. On February 18, 2019 a 100%	,	
		on 2/8/19 at 5:55pm. She			audit of the medication refrigerator,		
		xpectation that all opened			medication storage room, and each		
	·	edication storage refrigerator			medication cart was conducted by		
	should be labeled an			pharmacy any medications not dated			
	2. A review of the n			when opened were removed and			
	temperature log for F			discarded. The refrigerator settings we	re		
	refrigerator's tempera			verified to maintain a temperature			
	8:00am. The tempera	ature readings were 2/8/19:			between 36 to 46 degrees according to	)	
	30 degrees F (Fahre	nheit), 2/7/19: 32 degrees F,			policy.		
	2/6/19: 32 degrees F	, 2/5/19: 28 degrees F.			Systemic Changes:		
					Effective March 1, 2019 100% of licens	ed	
	A review of the manu	facturing recommendations			nurses and medication aides were		
	for Trulicity, Risperda	al, Tuberculin, and insulin			re-educated by the Director of nursing	<i>'</i>	
	revealed that the med	dications should be stored			Assistant Director of Nursing and/ or th	е	
	between 35 degrees	and 46 degrees Fahrenheit.			Staff Development Coordinator on the		
		made on 2/8/19 at 9:50 am			facility □s policy on medication storage		
	I .	e medication storage room			and labeling. Nursing staff was educate	ed	
	refrigerator. The med				to document any findings of undated		
		ed to be 30 degrees. It was			opened medications and out of range		
	observed that 3 Truli	•			refrigerator temperatures on the 24 hou	ır	
		.5ml(milliliters) (type 2			report, discard undated opened		
		dication) pens had a frosty			medications, reset refrigerator		
	1	n. The refrigerator was			temperature to maintain a range of 36	to	
	I .	25 insulin pens, 5 insulin			46 degrees and to document in the		
	I .	perdal filled syringes, and 4			maintenance book.		
		was observed on the			Monitoring:		
	Trulicity, Risperdal, T				The Director of nursing and/or Assistan		
		n that the medication should			Director of nursing will review the 24 ho		
	Fahrenheit.	5 degrees and 46 degrees			report and verify refrigerator temperatu during clinical meeting 5 days per weel		
		ducted on 2/8/19 at 9:50 am			(Monday □ Friday). Findings will be	`	
	with Nurse #13. She				documented on the clinical report form.		
	responsible for check	•			Monitoring will continue on Saturday ar		
	temperatures every of				Sunday by the charge nurse. This		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		OATE SURVEY COMPLETED				
		345449	B. WING			C
	ROVIDER OR SUPPLIER  AL HEALTH CARE/KING	010110		STREET ADDRESS, CITY, STATE,  115 WHITE ROAD  KING, NC 27021	ZIP CODE	02/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 761	degrees. She reported temperature that the rebelow. An interview was conditionally and the temperature was but if the medication work concern. She reported found frozen, it would immediately. An interview was conditionally all medication refriger and 41 degrees. She as insulin, Trulicity, and stored at 32 degrees contraindicated and coff the medications. An interview was conditionally all medications. An interview was conditionally are stored at 32 degrees contraindicated and coff the medications. An interview was conditionally are ported it was her examedication refrigerated above 41 degrees or reported she was not	defrigerator should not fall ducted with the ADON Nursing) on 2/8/19 at 10:45 refrigerator temperature egrees. She reported that occasionally below freezing was not frozen there was no diff any medication was be disposed of ducted with the Pharmacy at 12:38pm. She reported rators should be between 34 reported medications such and Risperdal should not be or below as it was ould affect the effectiveness ducted with the DON on 2/8/19 at 5:55pm. She	F 7	monitoring will be cond weeks, then weekly x2 months. The Director of Director of nursing and licensed nurse will aud medication room and nurefrigerator for expired/weekly x 4 weeks and thereafter. The monthly ongoing monitoring probe reported to the mon committee meeting for or modifications until a compliance is maintain	, and monthly for 3 or nursing, Assistant // or designated it medication carts/nedication room // undated items then monthly y audits will be an ocess. Findings will thly QAPI recommendations pattern of	