DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		34G058	B. WING			10/2	23/2019
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RM ROAD			4	09 OLD FARM ROAD		
				F	RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 189	STAFF TRAINING CFR(s): 483.430(e)	(1)	W 1	89			
	initial and continuin	ovide each employee with g training that enables the m his or her duties effectively, petently.					
	Based on observat interviews, the facil	s not met as evidenced by: ions, record review and ity failed to ensure staff were o perform their duties. The					
		hnician (MT) was not o perform required duties administration.					
	8:18am - 9:23am, the room on eight sepa the room, the close	ons of medication e home on 10/23/19 from he MT left the medication rate occasions. As the MT left t containing medications and lication room were unlocked					
	pass observations	9 of the facility's medication sheet (last modified 6/23/16) ation closet should be "locked					
	confirmed staff hav medications are ke	19 with the facility's nurse e been trained to ensure pt locked if the MT needs to					
LABORATORY	I DIRECTORS OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NALUKE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

PRINTED: 10/24/2019

		AND HUMAN SERVICES				FORM	10/24/2019 APPROVED 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		34G058	B. WING			10/:	22/2019
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OLD FARM ROAD					09 OLD FARM ROAD AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 189	leave the area durin b. During observation administration in the and 9:07am, the M ^T medication pill card medication cup and Medication Adminis Afterwards, the clie with water and/or pr	ng medication administration. ons of medication e home on 10/23/19 at 8:51am T obtained the client's ls, punched the pills into a d immediately signed the stration Record (MAR). onts ingested the medications	W 1	89			
	routinely sign the M medications. Addit had been trained to clients their medica Review on 10/23/19 pass observations s revealed the MT "m prior to documentin Interview on 10/23/ confirmed staff hav clients ingest their r signed.	AR before giving clients their ional interview indicated they o sign the MAR and then give ations. 9 of the facility's medication sheet (last modified 6/23/16) nakes sure meds are ingested og on MAR". 19 with the facility's nurse re been trained to ensure medications before the MAR is					
W 240	CFR(s): 483.440(c) The individual prog relevant intervention toward independer This STANDARD is Based on observat interviews, the facili)(6)(i) ram plan must describe ns to support the individual	W 2	240			

If continuation sheet Page 2 of 7

		AND HUMAN SERVICES				FORM	10/24/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G058	B. WING			10/	22/2019
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
OLD FAR	RM ROAD				09 OLD FARM ROAD RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
W 240	Continued From pa	-	W 2	240			
		ort his independence. This t clients. The finding is:					
	Client #6's IPP did regarding the use o	not include information f his eye glasses.					
	program on 10/22/1 client #6 was not ob Throughout the obs	observations at the day 19 from 10:45am - 12:50pm, oserved wearing eye glasses. servations, the client sat at a eos on a small tablet.					
	from 3:15pm - 6:15 glasses for approxi removing them. W the eye glasses, the over the fire place.	s at the home on 10/22/19 pm, client #6 wore eye mately one hour before hen the client was not wearing ey were located on a mantel On 10/23/19, in the home, glasses shortly before leaving					
	#6 wears his eye gl	19 with Staff C revealed client asses "all the time" but will em off when viewing things on					
	7/18/19 revealed, "I time." Additional re had an eye exam o noted, "Hyperopia a Rx provided attemp may help patient wi Further review of th	9 of client #6's IPP dated No order for glasses at this eview of the record revealed he n 4/25/19. The exam report and astigmatismnew glasses of glasses wear. New glasses th near work (like tablet use)." he IPP did not include any regarding the use of client					
		19 with the Qualified ies Professional (QIDP)					

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	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	CO	TE SURVEY
	34G058	B. WING		10	/22/2019
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	22/2010
M ROAD			409 OLD FARM ROAD RAEFORD, NC 28376		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	JLD BE	(X5) COMPLETIO DATE
confirmed there wa	s no information regarding	W 24	0		
DRUG ADMINISTR	RATION	W 36	9		
that all drugs, inclue	ding those that are				
Based on observation interviews, the facili medications were a This affected 4 of 4	tions, record reviews and ity failed to ensure all administered without error. c clients (#1, #3, #4, #5)				
Clients did not rece ordered.	ive their medications as				
administration in th 8:28am, client #1 ir Depakote. The clie	e home on 10/23/19 at ngested Robinol and ent did not receive any other				
orders dated 9/1/19 for Isopt atrop sol 1	9 - 12/1/19 revealed an order %, use as directed				
technician (MT) ind still receives the so	icated they thought the client lution; however, they did not				
	(EACH DEFICIENCY REGULATORY OR L Continued From pa confirmed there wa client #6's eye glas DRUG ADMINISTF CFR(s): 483.460(k) The system for dru that all drugs, inclus self-administered, a This STANDARD i Based on observat interviews, the facil medications were a This affected 4 of 4 observed receiving Clients did not rece ordered. a. During observat administration in th 8:28am, client #1 ir Depakote. The clie medications during Review on 10/23/19 orders dated 9/1/19 for Isopt atrop sol 1 sublingually twice a Interviews the so recall seeing it in hi b. During observat	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 confirmed there was no information regarding client #6's eye glasses in his IPP. DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered without error. This affected 4 of 4 clients (#1, #3, #4, #5) observed receiving medications. Clients did not receive their medications as	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGContinued From page 3 confirmed there was no information regarding client #6's eye glasses in his IPP. DRUG ADMINISTRATION CFR(s): 483.460(k)(2)W 24The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.W 36This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered without error.WClients did not receive their medications as ordered.Clients did not receive their medications as ordered.a. During observations of medication administration in the home on 10/23/19 at 8:28am, client #1 ingested Robinol and Depakote. The client did not receive any other medications during this time.Review on 10/23/19 of client #1's physician's orders dated 9/1/19 - 12/1/19 revealed an order for loopt atrop sol 1%, use as directed sublingually twice a day at 8:00am and 8:00pm.Interview on 10/23/19 with the medication technician (MT) indicated they thought the client still receives the solution; however, they did not recall seeing it in his basket during the med pass.b. During observations of medication	M ROAD RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY) Continued From page 3 confirmed there was no information regarding client #6's eye glasses in his IPP. DRUG ADMINISTRATION CFR(s): 483.460(k)(2) W 240 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. W 369 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered without error. W This affected 4 of 4 clients (#1, #3, #4, #5) observed receiving medications. . Clients did not receive their medication administration in the home on 10/23/19 at 8:28am, client #1 ingested Robinol and Depakote. The client did not receive any other medications during this time. Review on 10/23/19 of Client #1's physician's orders dated 9/1/19 - 12/1/19 revealed an order for lsopt atrop sol 1%, use as directed sublingually twice a day at 8:00am and 8:00pm. Interview on 10/23/19 with the medication technician (MT) indicated they thought the client still receives the solution, however, they did not recall seeing it in his basket during the med pass. b. During observations of medication	M ROAD RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BUT FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX PREVENCED TO THE APPROPRIATE DEFICIENCY MIST BE PRECEDED OF VPLL REGULATORY OR LSC IDENTIFYING INFORMATION) IV 240 Continued From page 3 confirmed there was no information regarding client #0: sey glasses in his IPP. DRUG ADMINISTRATION CFR (s): 483.460(k)(2) W 240 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. W 369 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered without error. This affected 4 of 4 clients (#1, #3, #4, #5) observed receiving medications as ordered. a. During observations of medication administration in the home on 10/23/19 at 8:28am, client #1 ingested Robinol and Depakote. The client did not receive any other medications during this time. Review on 10/23/19 of client #1's physician's orders dated 91/119 - 121/119 revealed an order for lsopt atrop sol 1%, use as directed sublingually twice a day at 8:00am and 8:00pm. Interview on 10/23/19 with the medication technician (MT) indicated they thought the client still receives the solution, however, they did not recall seeing it in his basket during the med pass. b. During observations of medication

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 10/24/2019 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY IPLETED
		34G058	B. WING	i		10/	22/2019
NAME OF F	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
OLD FAR	M ROAD				109 OLD FARM ROAD RAEFORD, NC 28376		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
W 369	 8:40am, client #3 in The client did not reduring this time. Review on 10/23/19 orders dated 9/1/19 Alphagen sol 1%, in a day at 8:00am an powder, dissolve 17 oz of liquid and drin 8:00am and 8:00pm Interview on 10/23/ thought the client's and his Gavilax was c. During observati administration in the 8:51am, client #4 in Cal Cit, Zantac and receive any other m Review on 10/23/19 orders dated 9/1/19 Albuterol Neb .083° one vial) per nebuli 8:00am. The order should receive 8 oz medications daily" a Interview on 10/23/ thought client #4's r discontinued but the interview revealed of at breakfast. d. During observati administration in the 	 angested Abilify and Aspirin. acceive any other medications 9 of client #3's physician's 9 - 12/1/19 revealed orders for nstill 1 drop in each eye twice and 8:00pm and Gavilax 7gm (1 capful to the line) in 8 nk by mouth twice a day at m. (19 with the MT revealed they eye drops were discontinued s only given at night. and the second medication the home on 10/23/19 at the second of the second orders for %, inhale 3ml (the contents of izer by mouth every morning at rs also indicated the client z of prune juice "with at 8:00am. (19 with the MT indicated they nebulizer treatments had been ey were not sure. Additional client #4 gets the prune juice 		369			
	administration in the						

Facility ID: 922329

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		AND HUMAN SERVICES			FORM	10/24/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G058	B. WING	 	10/2	22/2019
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
OLD FA	RM ROAD			09 OLD FARM ROAD RAEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 369	Thermotabs, Docus Carnitor. The clien medications during Review on 10/23/19 orders dated 8/5/19 following: Systane eye drops, three times a day a Flonase spray, insti- daily at 8:00am Lactulose, give 15c 9:00am and 9:00pm Interview on 10/23/ client #5 wears his his eye drops. Add were not sure but th may have been dise Interview on 10/23/ confirmed all medic by the MT during m administration on 1 and #5 remain curre given as ordered. DRUG STORAGE / CFR(s): 483.460(l)()	Oxtellar XR, Vitamin D3, sate Sodium, Coestid and t did not receive any other this time. 9 of client #5's physician's 9 revealed orders for the instill one drop in each eye t 8:00am, 4:00pm and 8:00pm ill two sprays in each nostril c by mouth twice a day at n. 19 with the MT revealed if glasses, he does not receive itional interview indicated they he nasal spray and Lactulose continued. 19 with the facility's nurse cations and treatments omitted iorning medication 0/23/19 for clients #1, #3, #4 ent and should have been AND RECORDKEEPING	W 3			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 10/24/2019 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G058	B. WING _			10/	22/2019
NAME OF	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OLD FARM ROAD					09 OLD FARM ROAD AEFORD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 382	This STANDARD is Based on observat interview, the facility medications remain administered. This in the home. The fi Medications were n During observations in the home on 10/2 the medication tech medication room or As the MT left the n medications and the were unlocked and/ Interview on 10/23/1 had been trained to medication room "w administering medic Review on 10/23/19 pass observations a revealed the medication when unattended". Interview on 10/23/19	is not met as evidenced by: tions, record review and ty failed to ensure all ned locked except when being potentially affected all clients inding is: not kept locked. s of medication administration 23/19 from 8:18am - 9:23am, nnician (MT) left the n eight separate occasions. room, the closet containing te door to the medication room l/or open. (19 with the MT revealed they be ensure the door to the was closed" when ications. 9 of the facility's medication sheet (last modified 6/23/16) cation closet should be "locked	W 38	82			

Facility ID: 922329

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