

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2017
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW HOPE		STREET ADDRESS, CITY, STATE, ZIP CODE 1680 SOUTH NEW HOPE ROAD GASTONIA, NC 28054		
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 29, 30 and 31, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls and floors were clean and in good repair in 9 Resident Bedrooms/Bathrooms and the Hallways and Dining room. The findings are: Observation of resident room #22 on 3/29/17 at 9:45am revealed: -There was small amount of paper debris scattered on the floor. -There were 2 carpet stains dark gray, ranging in approximate size from 6 to 20 inches. -There was one area which appeared to be worn approximately 4 inches in diameter. Observation of the bathroom in resident room #47 on 3/29/17 at 9:50am revealed: -A small amount of paper debris on the floor of the bathroom. -A crescent shaped tear approximately 2 inches in length in the vinyl flooring of the bathroom. Observation of resident room #12 on 3/29/17 at	D 074		

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

TITLE

(X6) DATE

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D 074	Continued From page 1 9:53am revealed: -There was a small amount of paper debris, threads, and food crumbs scattered on the floor. Observation of resident room #19A on 3/29/17 at 10:00am revealed: -There were 2 carpet stains dark brown, ranging in approximate size from 6 to 12 inches. -The shared bathroom in suite #19 had toilet paper and loose red brown debris scattered on the floor. Observation of resident room #24 on 3/29/17 at 10:10am revealed: -There was a small amount of paper and thread debris scattered on the floor. Observation of resident room #20 on 3/29/17 at 10:15am revealed: -A carpet stain gray brown and approximately 12 inches in size. -There was small pieces of paper scattered on the floor. Observation of resident room #44 on 3/29/17 at 10:35am revealed: -A large amount of paper debris on the carpet all around the resident's bed and chair. -A large amount of paper on the floor of the bathroom. -Debris on the bathroom floor included a piece of plastic packaging and an empty cardboard toilet paper roll. Interview with the resident who resided in room #44 on 3/29/17 at 10:40am revealed: -Housekeeping staff usually cleaned his room once a week on Wednesday. -Staff had not cleaned his room today, (3/29/17 was a Wednesday.)	D 074		

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D 074	Continued From page 2 -He believed staff cleaned his bathroom once a week also. Observation on 3/29/17 at 10:45am revealed housekeeping staff were at end of the hall working their way towards room #44. Observation of resident room #44 on 3/29/17 at 3:30pm revealed approximately 90% of the paper debris was gone from the carpeted area of the bedroom and the bathroom floor. Observation of resident room #15 on 3/29/17 at 10:49am revealed: -An area of worn carpet approximately 15 by 20 inches in front of the bathroom door. -There were three stains on the carpet dark gray, ranging in size from 3 to 5 inches. Observation of the facility hallway on 3/29/17 at 11:20am revealed: -The entrance to the laundry room had a dark gray worn carpet area of approximately 3 feet by 3 feet. -The entrance to the medication room had a dark gray worn carpet area of approximately 2 feet by 2 feet. -There were dark and light gray stains throughout the hallway carpets ranging in sizes from 3 inches to 7 inches. Observation of the carpet in resident room #29 on 3/29/17 at 11:30am revealed a dark stain approximately 8 by 10 inches near a resident's recliner. Interview with Resident #4 on 3/29/17 at 11:35am revealed: -He resided in room #29. -The stain in the carpet near the recliner had	D 074		

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D 074	Continued From page 3 been there "quite a while." -His roommate had spilled something on the carpet. -Staff had tried to clean it up. -Staff cleaned his room weekly. -The weekly cleaning consisted of changing sheets, vacuuming, and taking out the trash. -Staff cleaned his bathroom more often, but could not specify how often. Confidential interviews with 10 residents revealed: -The housekeeping could be better. -"The floors get vacuumed once a week." -The trashcan does not get emptied daily, and sometimes was full. -"The stains on my room floor has been there since I moved in." -"I think there needs to be more housekeepers." -"Some residents spill things in the hallway." -"My floors are not dirty, just stained and worn." -They had noticed the Maintenance Man cleaning the carpets. -They had seen an outside company cleaning carpets. -Resident stated they had spilled drinks on their floor and told staff, and the housekeeping would then try to clean it. -Some of the stains on the floor will not come up by cleaning. Observation of the dining room on 3/30/31 at 11:15pm revealed: -There were 3 damaged areas above the chair railing on the walls where the chairs had been pushed back and hit the walls all in length of approximately 3 feet. -There were stains on the floor gray and ranging in sized from 3 inches to 6 inches.	D 074		

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D 074	Continued From page 4 Confidential interviews with 12 residents between 3/29/17 through 3/31/17 revealed none of the residents had complaints about the facility environment or cleanliness of dining room. Confidential interviews with 4 Personal Care Aides revealed: - "Some of the residents spill drinks and food on their floors." - "There are some residents who are incontinent and have had accidents on the carpet." - "There had been some residents and families complain about the carpet being stained in the resident rooms." - "We do clean up spills or let the housekeeper know and they will clean it up." - "There are a lot of rooms that need new carpet." - "There is a company that comes in sometimes and cleans the carpet." - "When a resident moves out of the facility the carpets are cleaned and the room is painted." - "The maintenance man cleans the carpet sometimes." Interview with the Maintenance Man on 3/30/17 at 10:00am revealed: - He would clean the carpets when needed. - He had cleaned some of the carpet in resident rooms. - He had worked in the facility since October 2016. Interview with the Housekeeper on 3/31/17 at 10:45am revealed: - The facility has two housekeepers. - She cleaned the carpets in the rooms when needed, but some of the stains will not come up with a carpet cleaner. - If the carpet is "too bad" to clean [Administrator Name] will get an outside company to come in and clean them.	D 074		

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D 074	Continued From page 5 -The residents eat and drink food in the rooms and hallways and occasionally spill food and drinks on the floor. -She did let the Administrator know when a room had a bad stain on the floor. -When a resident moved out the room carpet is cleaned and the walls are painted. -The Personal Care Aides let her know if there was a room that needed cleaned. -"We vacuum the resident rooms weekly and when needed." -The PCA's had access to the vacuums, so if the rooms need vacuumed in the evenings, they can do it. Review of documentation provided by the Administrator on 3/31/17 of carpet cleaning completed in the facility by an outside carpet cleaning company revealed: -On 6/15/16 the dining room carpet had been cleaned. -On 7/7/16 rooms #46, #47, #49 and the Hallway had been cleaned. -On 8/16/16 rooms #45 and #46 had been cleaned, the common areas had been spot cleaned, hallways and the living room in front of facility had been cleaned. -On 9/26/16 rooms #12, #14, #19B, #24A, #27, #30, #35, #39, #40 and #49 had been cleaned. -On 11/1/16 rooms #18, #28, #51 and 52 had been cleaned. -On 2/8/17 all common areas had been cleaned. -On 2/10/17 the dining room had been cleaned. -On 2/14/17 furniture in the common areas had been spot cleaned. Interview with the Administrator on 3/30/17 at 3:40pm revealed: -"When a resident moves out of the facility the carpet is replaced in the room and the walls are	D 074		

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D 074	Continued From page 6 painted." -He has a carpet cleaning company come into the facility to clean the carpets whenever the floors need cleaning. -The Maintenance Man and the housekeepers have access to carpet cleaners and can spot clean spills as needed. -He will have the Maintenance Man repair the walls in the dining room.	D 074		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hot water temperatures were maintained between a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 8 sinks located in the residents' bathrooms. The findings are: Observation on the initial tour in the facility on 3/29/17 of hot water temperatures revealed: -At 10:05am, the hot water temperature of the sink for resident room #23 bathroom was 120 degrees F.	D 113		

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D 113	Continued From page 7 -At 10:10am, the hot water temperature of the sink for resident room #19 bathroom was 120 degrees F. -At 10:16am, the hot water temperature of the sink for resident room #24 bathroom was 120 degrees F. -At 10:18am, the hot water temperature of the sink for resident room #45 bathroom was 120 degrees F, and a shower hot water temperature of 114 degrees F. -At 10:34am, the hot water temperature of the sink for resident room #16 bathroom was 120 degrees F. -At 10:35am, the hot water temperature of the sink for resident room #44 bathroom was 118 degrees F. -At 10:40am, the hot water temperature of the sink for resident room #18 bathroom was 120 degrees F. -At 11:10am, the hot water temperature of the sink for resident room #47 bathroom was 120 degrees F. Random interviews with 8 residents revealed: -The hot water was not too hot for them. -They liked the water a little warmer. -They had never gotten burned. -They had not noticed the water was too hot. Interview on 3/29/17 at 11:15am with the Maintenance Man revealed: -He checked the water temperatures weekly. -He was notified on 3/29/17 at 10:45am by the Administrator about the elevated water temperatures which had been pointed out by the surveyor he immediately checked the thermostat and it was set at 120 degrees. -He turned the water temperature down to 114 degrees. -He did not know why the thermostat was set that	D 113		

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D 113	Continued From page 8 high. -He normally kept the thermostat set between 114 and 116 degrees. -He was not the only person that had a key to access the hot water thermostat. -He had never noticed the water temperatures being too hot. -The showers were equipped with "Scald valves" (Scald valves are installed in faucets to prevent hot water from leaving the tap and accidentally burning someone) which stops the water from running at 118 degrees. -The "Scald Valve" is preset at the factory for 118 degrees. -No one had reported to him that the water was too hot. -He checks one rooms water temperature per week. Review of the temperature log documentation provided by the facility on 3/29/17 revealed: -The water temperature in room #19 on 2/28/17 was 115 degrees. -The water temperature in room #9 on 3/9/17 was 115 degrees. -The water temperature in room #28 on 3/16/17 was 112 degrees. -The water temperature in room #8 on 3/22/17 was 114 degrees. -The water temperature in room #8 on 3/28/17 was 115 degrees. Random interviews with 3 Personal Care Aides revealed: -They helped most of the residents with showers. -They had never noticed the water being too hot. -No residents had ever complained to them about the water being too hot. -The showers had never cut off because the water was too hot.	D 113		

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D 113	Continued From page 9 -To their knowledge no resident had ever been burned because the water was too hot. Interview on 3/29/17 at 11:20am with the Administrator revealed: -The maintenance man checked the water temperatures once per week. -On the weekends there was a manager on call who was responsible for checking water temperatures. -If the manager noticed the water temperature was too high, they have a key and are expected to adjust the thermostat. Observations in the facility on 3/29/17 of hot water temperatures revealed. -A recheck of the hot water temperature in resident room #44 bathroom sink was 114 degrees F at 4:13pm. -A recheck of the hot water temperature in resident room #45 bathroom sink was 114 degrees F at 4:15pm. -A recheck of the hot water temperature in resident room #47 bathroom sink was 114 degrees F at 4:20pm. -A recheck of the hot water temperature in resident room #23 bathroom sink was 114 degrees F at 4:30pm. -A recheck of the hot water temperature in resident room #19 bathroom sink was 114 degrees F at 4:25pm. -A recheck of the hot water temperature in resident room #24 bathroom sink was 114 degrees F at 4:33pm. Interview on 3/31/17 at 11:15am with the Dietary Manager revealed: -She had been the manager on call the previous weekend. -When she checked the dining room water	D 113		

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D 113	Continued From page 10 temperature it was 118 degrees. -She checked a hot water temperature on a hallway that was 114 degrees. -She rechecked the dining room water temperature 45 minutes later and it was 114 degrees. -If the water temperature had remained high she would have put a sign on it and called the Maintenance Man. -She does not adjust the water temperatures.	D 113		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure Tuberculosis (TB) disease testing had been completed upon admission for 1 of 5 (#5) sampled residents in accordance with the Commission for Public Health. The findings are: Review of Resident #5's current FL2 dated 2/24/17 revealed diagnoses included hyperlipidemia, aortic regurgitation and	D 234		

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D 234	Continued From page 11 osteopenia. Review of Resident #5's Resident Register revealed the date of admission was 2/27/17. Review of Resident #5's record revealed no documentation of a TB test being completed. Interview with Resident #5 on 3/31/17 at 10:15am revealed: -She could not remember when she had a TB test. -She did not recall having one recently. -She had not had one at the facility. Interview on 3/31/17 at 2:15pm with the Resident Care Coordinator (RCC) revealed: -When a resident is admitted to the facility she was responsible for assuring the TB test was completed. -She was unsure of why Resident #5 did not have any documentation of a TB test. -She thought Resident #5 had a TB test at the physician's office before she was admitted to the facility. -She had attempted to make contact with the physician's office about Resident #5's TB test, but they would not return her call. Interview on 3/31/17 at 3:00pm with the Administrator revealed the Health and Wellness Director and the RCC were responsible to assure that TB testing was completed on every resident prior to admission.	D 234		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health	D 280		

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D 280	Continued From page 12 Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the Licensed Health Professional Support (LHPS) evaluations were completed quarterly for 2 of 5 sampled residents (#3 and #4) and included a physical assessment, evaluation of the residents' care being provided, or needed recommendations for changes in the care of the resident. The findings are: A. Review of Resident #3's current FL2 dated 1/16/17 revealed:	D 280		

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D 280	Continued From page 13 -Diagnoses included urinary retention, thrombocytopenia, benign prostate hyperplasia, and vitamin D deficiency. -The resident was semi-ambulatory and used a wheelchair for ambulation. -The resident had an order for Ted Hose (A compression sock used to prevent swelling and maintain blood flow) to be placed on in the morning and removed in the evening. -The resident had an indwelling catheter. Review of Resident #3's Resident Register revealed an admission date of 1/16/16. Review of Resident #3's current care plan, completed on 8/5/16 and signed by the physician indicated the resident required limited assistance for transfers and some assistance with toileting related to his catheter. Review of Resident #3's LHPS evaluations revealed: -An initial LHPS evaluation completed on 2/5/16 with transfers, Ted Hose and catheter care listed as LHPS tasks. -An LHPS evaluation completed on 3/12/16 with identified tasks of transfers, Ted Hose and catheter care. -An LHPS evaluation completed on 8/25/16 with identified tasks of transfers, Ted Hose and catheter care. Interview on 3/31/17 at 11:45am with Resident #3 revealed: -The staff put his Ted hose on in the morning and removed it at night. -"Some staff are better than others at getting it on and off." -He was able to transfer and get into his wheel chair with limited assistance.	D 280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2017
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW HOPE		STREET ADDRESS, CITY, STATE, ZIP CODE 1680 SOUTH NEW HOPE ROAD GASTONIA, NC 28054		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 14 -He has a catheter because of his kidney problems. -The staff check his catheter during the day. Confidential interviews with 3 Personal Care Aides (PCA) revealed: -They had assisted Resident #3 with his catheter care. -They had been trained by the previous LHPS nurse how to do catheter care. -They felt comfortable performing catheter care. -If the urine in the catheter had an odor or was cloudy or bloody they told the HWD or the Resident Care Coordinator (RCC) and they would evaluation the resident. -Resident #3 needed little assistance with transfers. -They would help Resident #3 with his Ted Hose in the mornings. Refer to interview on 3/30/17 at 11:10am with the Health and Wellness Director. Refer to interview on 3/30/17 at 11:30am with the Administrator. B. Review of Resident #4's current FL2 dated 7/15/16 revealed: -Diagnoses included congestive heart failure, hypertension, edema in both lower extremities, and hyponatremia. -A medication order for Novolog subcutaneously (SQ) before each meal. (Novolog is a quick acting insulin used to lower blood sugar levels around meal times.) -A medication order for Lantus SQ at bedtime. (Lantus is a long acting insulin used to lower blood sugar levels around the clock.) -An order to monitor blood sugar levels, (with insulin administration) and call medical doctor if	D 280		

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D 280	Continued From page 15 blood sugar levels are less than 60 or greater than 500. Record review revealed a subsequent order dated 1/30/17 to increase the dose of Lantus at bedtime. Review of Resident #4's Medication Administration Records (MARs) for February and March 2017 revealed: -An additional diagnosis of diabetes due to underlying condition. -An entry for Lantus 30 units SQ at bedtime and an entry for Novolog insulin, 7 units SQ before meals. -An entry for finger stick blood sugars (FSBS) before meals and bedtime. Review of Resident #4's most recent Licensed Health Support (LHPS) assessment revealed: -An assessment date of 8/19/16. -The tasks identified were FSBS and medications by injection. Record review revealed no other LHPS assessments were documented as completed after 8/19/16 for Resident #4. Observation of a Medication Aide (MA) on 3/29/17 at 11:25am revealed she performed a FSBS using approved in accordance with approved infection control standards. Interview with Resident #4 on 3/29/17 at 11:35am revealed he believed he received his insulin injections and FSBS as ordered by his physician. Refer to interview on 3/30/17 at 11:10am with the Health and Wellness Director.	D 280		

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D 280	Continued From page 16 Refer to interview on 3/30/17 at 11:30am with the Administrator. _____ Interview on 3/30/17 at 11:10am with the Health and Wellness Director (HWD) revealed: -She was responsible for completing the LHPS assessments. -She was under the impression that the LHPS evaluations were to be completed upon admission and then annually. -She believed the LHPS assessment had to be completed yearly like care plans. -She had worked at the facility since October 2016. -She was not trained by the previous LHPS nurse. -She would go through all records to assure that the LHPS evaluations are current and up to date. Interview on 3/30/17 at 11:30am with the Administrator revealed: -He had showed the HWD the rule regarding the LHPS evaluations being completed quarterly. -He had instructed the HWD to make sure all residents LHPS evaluations were current. -When the HWD was hired, she trained at a sister facility under another Health and Wellness Director. -He did not know why she was under the impression that the LHPS evaluations were to be completed annually.	D 280		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional	D 310		

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D 310	Continued From page 17 supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 3 sampled Residents (#1) with a physician ordered therapeutic diet was served as ordered. The findings are: Review of Resident #1's current FL2 dated 11/28/16 revealed: -Diagnoses included coronary artery disease, stroke, congestive heart failure, transient ischemic attack, and diabetes. -A diet order for a regular diet. Review of an Addendum to the FL2 dated 12/5/16 revealed: -The FL2 Addendum contained a list of the available diets at the facility with the 2 gram sodium diet checked for Resident #1. -"The 2 gram sodium diet restricts sodium to no more than 2000 mg of sodium per day." -"Since food intake decreases as part of the normal aging process, the 2 gram sodium diet should be used with care with the older adult." Review of Resident #1's record revealed a subsequent order dated 12/19/16 affirmed the dietary order for Resident #1 as a 2 gram sodium diet. Review of the posted therapeutic diet list for the facility revealed Resident #1 was to receive a regular diet.	D 310		

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D 310	Continued From page 18 Observation of the noon meal on 3/29/17 at 12:00pm revealed: -Resident #1 was served a regular diet consisting of a beet salad, tomato juice, cubed pork and gravy, macaroni and cheese, collard greens, a roll and peach cobbler. -She did not use the salt shaker on the table. Observation of the noon meal on 3/30/17 at 12:00pm revealed: -Resident #1 was served a regular diet consisting of tomato and onion salad, Italian roasted chicken, potatoes au gratin, seasoned cauliflower and lemon cake. -She did not use the salt shaker on the table. Interview on 3/30/17 at 9:45am with the Dietary Manager revealed there were no 2 gram sodium diets being served in the facility. Interview with Resident #1 on 3/31/17 at 10:20am revealed: -She was not on a special diet. -She had never been on a special diet while at the facility. -Her doctor had never talked to her about being on a special low sodium diet. Interview with Resident #1's primary care provider on 3/31/17 at 11:58am revealed: -It was not critical that Resident #1 be on a 2 gram sodium diet. -The 2 gram sodium diet may have helped some with her edema (swelling). -She saw Resident #1 today and she had no edema or shortness of breath. -She was going to change Resident #1's dietary order to "no added table salt." Interview on 3/31/17 at 11:35am with the Dietary	D 310		

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D 310	Continued From page 19 Manager revealed: -She was not aware of any resident who was on a 2 gram sodium diet. -A 2 gram sodium diet was "very restrictive". -She serves frozen vegetables which are sodium free. -All stocks and broths used for cooking in the facility are low sodium. -She does not use any salt in cooking. -"With a 2 gram sodium diet canned vegetables are limited." -"Breakfast meats are substituted with a beef patty." -"A typical 2 gram sodium breakfast would be eggs, beef patty, grits, and one slice of toast." -Processed sandwich meats are limited to low sodium. Review on 3/31/17 of the facility "2 gram sodium diet guidelines" revealed: -The 2 gram sodium diet is appropriate for older adults for the management of congestive heart failure, high blood pressure and edema... -"The 2 gram sodium diet is planned as a modification of the Regular Diet. High sodium foods are restricted, medium sodium foods are limited." -"The 2 gram sodium diet allows a limited amount of salt in cooking and no salt is used at the table."	D 310			
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358			

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D 358	Continued From page 20 which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure medications (furosemide, fexofenadine, and Seroquel) were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents observed on a medication pass (Resident #7), and 2 of 5 residents (#1 and #2) sampled. The findings are: A. Review of Resident #7's current FL2 dated 1/31/17 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease, and transient ischemic attacks. -A medication order for fexofenadine 180mg, 1 tablet daily. (Fexofenadine is a non-sedating antihistamine use to treat allergic rhinitis.) Observation of the morning medication pass on 3/30/17 at 8:46am revealed Resident #7 received 6 oral medications, but no fexofenadine. Observation of Resident #7's medications on hand on 3/30/17 at 8:50am revealed: -No fexofenadine 180mg was available to administer. -A partially filled 100 count bottle of diphenhydramine 25mg tablets. (Diphenhydramine is a sedating oral antihistamine used to treat seasonal allergies and	D 358		

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D 358	Continued From page 21 itching. The National Institute of Health cautions against the use of diphenhydramine in the elderly due to a high risk of side effects including dizziness, dry mouth, blurred vision, constipation, and increased confusion.) Observation of Resident #7's bottle of diphenhydramine 25mg on 3/30/17 at 10:54am revealed: -The bottle originally contained 100 tablets of diphenhydramine 25mg with 44 tablets remaining in the bottle. -The expiration date on the bottle was 11/18. -The bottle of diphenhydramine 25mg was obtained from a local chain pharmacy. Record review revealed Resident #7 did not have a physician's order for diphenhydramine 25mg tablets. Confidential interview with a Medication Aide (MA) revealed: -The family brought Resident #7's medications into the facility. -The MAs let the families know when they are running low on medications. -If the families do not bring in the medications, we obtain them from our pharmacy provider. -She has given Resident #7 diphenhydramine in place of the fexofenadine. -She believed Resident #7 has gotten diphenhydramine in place of the fexofenadine "for quite a while." -She believed the two medications were the same or at least a similar product because they were both for allergies. -She believed Resident #7 had fexofenadine in the facility in the past, but could not say when. -When families brought medications into the facility, the MAs or the Health and Wellness	D 358		

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D 358	Continued From page 22 Director would check them to make sure they were the right medications. Review of Resident #7's Medication Administration Records (MARs) for February and March 2017 revealed: -An entry for fexofenadine 180mg tablets, 1 tablet a day for allergy, with a scheduled administration time of 8am. -The fexofenadine was initialed as administered daily from 2/5/17 through 3/28/17 for 52 doses. -An entry on 3/29/17 noted the medication was not administered to the resident because he was out of the facility. Interview with the Resident Care Coordinator on 3/30/17 at 10:30am revealed: -Initially, she or the Health and Wellness Director checked in medications brought in by the families to make sure they are the correct medications. -After that initial check in, the Medication Aides can check the medications brought in by families. Interview with a pharmacist at the pharmacy provider on 3/30/17 at 10:58am revealed: -They did not have an order for fexofenadine 180mg in their system for Resident #7. -They had never sent any fexofenadine 180mg to the facility for Resident #7. An attempt to interview Resident #7 on 3/30/17 at 12:08pm was not successful due to resident sleeping. Interview with the Administrator on 3/31/17 at 10:11am revealed: -Resident #7 had gone out of the facility on the evening of 3/30/17 with a family member. -While they were out of the facility, the family member took Resident #7 to the local emergency	D 358		

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D 358	Continued From page 23 room. -Resident #7 was admitted to the hospital with possible congestive heart failure. Interview with Resident #7's relative on 3/31/17 at 11:07am revealed: -The family provided medications for Resident #7. -Another family member, "took the lead" in obtaining Resident #7's medications. -The other family member "probably thought the two medications (diphenhydramine and fexofenadine) were the same." -The bottle of diphenhydramine in the facility came from the resident's home. -The bottle wasn't full, but he wasn't sure how many tablets were in the bottle. -The family member was not sure if Resident #7 had ever had fexofenadine in the facility. -The family would provide Resident #7 the fexofenadine 180mg tablets as ordered by his physician. Interview with Resident #7's primary care provider on 3/31/17 at 11:58am revealed she did not believe Resident #7 receiving 1 tablet of 25mg diphenhydramine tablet a day instead of 1 tablet of 180mg fexofenadine was a significant medication error. Review of the facility's policy and procedures for pharmacy services for residents not using the preferred pharmacy provider revealed: -"I will be required to provide medications that are packaged in a unit of use packaging system, unless I have been granted an exemption to this requirement." -"I understand there is a service fee of \$200.00 per month associated with using a pharmacy that does not package medications in the same manner as the preferred provider due to the	D 358		

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D 358	Continued From page 24 additional administrative oversight required." -"I understand that I will have the responsibility for reordering medications, but in the event the medications are not delivered within 2 days prior to the depletion of my medication stock, the community will reorder my medications with the preferred pharmacy to insure no disruption takes place. -"I agree to pay for the medications and any associated service charges." B. Review of Resident #1's current FL2 dated 11/28/16 revealed: -Diagnoses included coronary artery disease, stroke, congestive heart failure, transient ischemic attack, and diabetes. -A medication order for furosemide 20mg, 1 tablet twice daily. (Furosemide is a potent diuretic used to remove excess fluid from the body in congestive heart failure.) Interview with Resident #1 on 3/30/17 at 3:45pm revealed: -She ran out of her fluid pill (furosemide) for 4 days about 2 weeks ago. -During those 4 days, she had a small amount of swelling in her lower extremities. -She had some swelling in her abdominal area with some shortness of breath. -She did not see the doctor or need to go to the emergency room at that time for the swelling or shortness of breath. -She brought medications from home including a bottle of Lasix, (brand name for furosemide.) -Facility staff (not specified) told her the Lasix was on order from the pharmacy. Review of Resident #1's Medication Administration Record (MAR) for February 2017 revealed:	D 358		

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D 358	Continued From page 25 -An entry for furosemide 20mg, 1 tablet by mouth one time a day for swelling with a scheduled administration time of 8am. -An entry for furosemide 20mg, 1 tablet by mouth one time a day for swelling with a scheduled administration time of 5pm. -All doses of furosemide 20mg had been initialed as administered twice daily from 2/1/17 through 2/28/17. Review of Resident #1's MAR for March 2017 revealed: -An entry for furosemide 20mg, 1 tablet by mouth one time a day for swelling with an administration time of 8am. -An entry for furosemide 20mg, 1 tablet by mouth one time a day for swelling with a scheduled administration time of 5pm. -Furosemide 20mg had been initialed as administered daily at 8am except for the 18th and the 19th, where a chart code of 09 was noted on those days. -Furosemide 20mg had been initialed as administered daily at 5pm except for the 16th, 17th, 18th, and 19th, where a chart code of 09 was noted on those days. Review of the digital progress notes on the electronic MAR revealed the note text for the 09 chart code simply stated "awaiting pharmacy." Observation of Resident #1's medications on hand on 3/30/17 at 3:40am revealed: -Two bubble packs of furosemide 20mg tablets labeled, 1 tablet twice daily, with a dispense date of 3/18/17. -One of the bubble packs of furosemide 20mg contained 30 tablets, and the other contained 9 tablets.	D 358		

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D 358	Continued From page 26 Interview with a MA on 3/30/17 at 3:43pm revealed: -Resident #1 ran out of her furosemide, but believed it was only for 1 day. -She could not explain the documentation on the March MAR that showed Resident #1 missed 6 doses of furosemide. Interview with a second MA on 3/31/17 at 10:22am revealed: -She remembered Resident #1 had a big bottle of furosemide 20mg she brought from home. -She was not sure how many tablets were in the bottle, but she could not remember a time when Resident #1 ran out of her furosemide. -The MAs do not wait to put medications from the provider pharmacy tote into the med carts for use by the residents. Confidential interview with a third MA revealed: -Medications are ordered when 7 doses, or a 7 day supply, remain in the bubble pack. -Sometimes the ordered medications do not come from the pharmacy and we (MAs) reorder them. -The Health and Wellness Director (HWD) was informed if a medication doesn't come in. -MAs were told by the HWD not to leave gaps on the MARs if residents were out of medications, just document "resident spit out, or resident refused." Interview with a pharmacist at the pharmacy provider on 3/30/17 at 10:58am revealed: -The pharmacy had dispensed a 30 day supply of furosemide 20mg for Resident #1 on 12/2/16 and 3/18/17. -Based on dispensing records, the pharmacist believed Resident #1 had gotten some of her medications from an outside pharmacy.	D 358		

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D 358	Continued From page 27 Interview with a pharmacist at the pharmacy provider on 3/31/17 at 10:40am revealed: -The furosemide 20mg refill for Resident #1 was ordered on 3/18/17 at 9:44pm. -The furosemide 20mg with a dispense date of 3/18/17 went out to the facility for delivery on the evening of 3/19/17 and would have been delivered to the facility on 3/19/17 between 8:30pm and 9:00pm. Interview with Resident #1's primary care provider on 3/31/17 at 11:58am revealed: -She had just examined Resident #1 and she had no complaints today. -The resident had no shortness of breath or edema today. -She saw Resident #1 last week casually in the hall and she had no edema or shortness of breath. -It was not good Resident #1 ran out of her furosemide 20mg, but missing those doses for a short period of time was not critical. C. Review of Resident #2's current FL2 dated 12/1/16 revealed: -Diagnoses included dementia, Alzheimer's type, tremors, depression and sinus tachycardia. -A medication order for Seroquel 25mg, 1 tablet daily and Seroquel 50mg at bedtime (Seroquel is an anti-psychotic medication that is used in the treatment of dementia.) Interview on 3/29/17 at 11:15am with Resident #2's roommate revealed: -She was a family member. -Resident #2 could not hold a conversation due to his dementia. -Resident #2 had been out of his Seroquel for several days.	D 358		

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D 358	Continued From page 28 -He takes the Seroquel for his dementia. -The Seroquel helps him sleep at night. Review of Resident #2's Medication Administration Record (MAR) for March 2017 revealed: -An entry for Seroquel Tablet 25mg, give 1 tablet one time a day related to major depressive disorder, recurrent, unspecified. -The medication had a start date of 12/03/16 with an administration time of 2:00pm. -Entries on 3/26/17 and 3/27/16 noted the medication was not administered to the resident because the medication was not available in the facility. A confidential interview with a MA revealed: -The third shift MA's are responsible for checking all residents narcotic medications to see if a "hard script" is needed and then they let the HWD or the Resident Care Coordinator (RCC) know so they can get the "hard scripts" so the medications can be reordered. -All MA's are responsible for checking the medications on the cart and should reorder when only five days of medications are left. -She did not know why Resident #2 ran out of his 25mg of Seroquel. Interview on 3/30/17 at 10:50am with the Health and Wellness Director (HWD) revealed: -Resident #2 brought a supply of medications with him when he was admitted into the facility. -She did not think the medications that came with the resident was counted. -The Medication Aides (MA) were responsible for assuring residents did not run out of medications. -The MA's should reorder a resident's medications when they get down to 5 days. -She did not know why the resident ran out of his	D 358		

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D 358	Continued From page 29 Seroquel. Based on record review and observations it was determined that Resident #2 was not interviewable. Attempted telephone interview on 3/31/17 at 2:10pm with Resident #2's physician was unsuccessful. _____ The facility failed to assure medications (furosemide, fexofenadine, and Seroquel) were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents observed on a medication pass (Resident #7), and 2 of 5 residents (#1 and #2) sampled. Failure to administer furosemide and Seroquel as ordered exposed Residents #1 and #2 respectively to increased risks of the worsening of the symptoms of hypertension and congestive heart failure, and worsening of behaviors associated with dementia. The use of diphenhydramine in place of fexofenadine exposed Resident #7 to an increased risk of side effects associated with the use of older first generation antihistamines like diphenhydramine which include dizziness, dry mouth, blurred vision, constipation, confusion, and urinary retention. The failure to administer medications as ordered exposed these residents to serious side effects and adverse effects and constitutes a Type B Violation. _____ Review of the Plan of Protection provided by the facility on 3/30/17 revealed: -The Health and Wellness Director and the Resident Care Coordinator will immediately audit all of the medication carts to assure all medications are available for administration.	D 358		

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D 358	Continued From page 30 -The facility is going to be changing to a pharmacy that will offer "cycle refills" for all medications. -Third shift will audit all medication carts nightly for medication accuracy and availability. -Training will be provided to all Medication Aides regarding the timely ordering and reordering of medications. -All medications brought into the facility by family members will be reviewed by the Health and Wellness Director or designee prior to administration. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 15, 2017.	D 358			
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a	D 367			

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D 367	Continued From page 31 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure accurate documentation on 1 of 5 sampled resident's (#7) Medication Administration Records (MARs) by documenting the administration of a medication not available to administer. The findings are: Review of Resident #7's current FL2 dated 1/31/17 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease, and transient ischemic attacks. -A medication order for fexofenadine 180mg, 1 tablet daily. (Fexofenadine is a non-sedating antihistamine use to treat allergic rhinitis.) Observation of the morning medication pass on 3/30/17 at 8:46am revealed Resident #7 received 6 oral medications, but no fexofenadine. Observation of Resident #7's medications on hand on 3/30/17 at 8:50am revealed: -No fexofenadine 180mg available to administer. -A partially filled 100 count bottle of diphenhydramine 25mg tablets. -The manufacturer's label for the diphenhydramine stated the tablets were for allergy symptoms. Observation of Resident #7's bottle of diphenhydramine 25mg on 3/30/17 at 10:54am revealed: -The bottle originally contained 100 tablets of	D 367		

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D 367	Continued From page 32 diphenhydramine 25mg, with 44 tablets still in the bottle. -The bottle of diphenhydramine 25mg was obtained from a local chain pharmacy. Record review revealed Resident #7 did not have an order for diphenhydramine 25mg tablets. Review of Resident #7's Medication Administration Records (MARs) for February and March 2017 revealed: -An entry for fexofenadine 180mg tablets, 1 tablet a day for allergy, with a scheduled administration time of 8am. -The fexofenadine was initialed as administered daily from 2/5/17 through 3/28/17 for a total of 52 doses. -An entry on 3/29/17 noted the medication was not administered to the resident because he was out of the facility. -No documentation of the administration of the diphenhydramine 25mg tablets. Confidential interview with a Medication Aide (MA) revealed: -The family brought Resident #7's medications into the facility. -If the families do not bring in the medications, we obtain them from our pharmacy provider. -She had given Resident #7 diphenhydramine in place of the fexofenadine, and documented giving fexofenadine on the MAR. -She believed Resident #7 has gotten diphenhydramine in place of the fexofenadine "for quite a while." -She believed the two medications were the same or at least a similar product because they were both for allergies. -She believed Resident #7 had fexofenadine in the facility in the past, but could not say when.	D 367		

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D 367	Continued From page 33 Confidential interview with a second MA revealed: -The Health and Wellness Director (HWD) was informed if a medication doesn't come in and was not available to administer. -All the MAs were told by the HWD not to leave gaps on the MARs if residents were out of their medications, but instead to document "resident refused, or resident spit out." Interview with the Resident Care Coordinator on 3/30/17 at 10:30am revealed: -Initially, she or the Health and Wellness Director checked in medications brought in by the families to make sure they are the correct medications. -After that initial check in, the Medication Aides can check the medications brought in by families. Interview with a pharmacist at the pharmacy provider on 3/30/17 at 10:58am revealed: -They did not have an order for fexofenadine 180mg in their system for Resident #7. -They had never sent any fexofenadine 180mg to the facility for Resident #7. An attempt to interview Resident #7 on 3/30/17 at 12:08pm was not successful due to resident sleeping. Interview with the Administrator on 3/31/17 at 10:11am revealed: -Resident #7 had gone out of the facility on the evening of 3/30/17 with a family member. -While they were out of the facility, the family member took Resident #7 to the local emergency room. -Resident #7 was admitted to the hospital with possible congestive heart failure. Interview with Resident #7's relative on 3/31/17 at	D 367		

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D 367	Continued From page 34 11:07am revealed: -The family provided medications for Resident #7. -Another family member, "took the lead" in obtaining Resident #7's medications. -The other family member "probably thought the two medications (diphenhydramine and fexofenadine) were the same." -The bottle of diphenhydramine in the facility came from the resident's home. -The bottle of diphenhydramine wasn't full, but he wasn't sure how many tablets were in the bottle. -The family member was not sure if Resident #7 had ever had fexofenadine in the facility. -The family would provide Resident #7 the fexofenadine 180mg tablets as ordered by his physician. Interview with Resident #7's primary care provider on 3/31/17 at 11:58am revealed she did not believe Resident #7 receiving 1 tablet of 25mg diphenhydramine tablet a day instead of 1 tablet of 180mg fexofenadine was a significant medication error.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure all residents received care and services which were adequate,	D912		

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D912	Continued From page 35 appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration (Residents #1 and #2). The findings are: Based on observations, record reviews, and interviews, the facility failed to assure medications (furosemide, fexofenadine, and Seroquel) were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents observed on a medication pass (Resident #7), and 2 of 5 residents (#1 and #2) sampled. [Refer to Tag 358, 10A NCAC 13F .1004 (a) (Type B Violation)].	D912		