STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINT HILL SENIOR LIVING	10830 LAWYERS ROAD CHARLOTTE, NC 28227

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on May 10-11, 2017.	D 000	Responces to the cited deficiencies ,do not constitute an admission or agreement by the facility of the facts alleged or conculsuons, set forth in the Statement of Deficiencies is perpared soley as a matter of complainance with the law.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to follow up with the durable medical equipment company to ensure portable oxygen was available, to ensure the acute health care needs were met for 1 of 5 sampled residents (Resident #4) with physician orders for oxygen at 3L/M. The findings are: Review of Resident #4's current FL2 dated 11/01/16 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), dementia, pulmonary hypertension, anemia and diabetes mellitus type II. -An order to check every shift to make sure oxygen is on 3 liters per min (L/M) and that the portable tank is on refill schedule daily midnight to 6:59 am, 7:00 am to 2:59 pm, and 3:00 pm to midnight.	D 273	10A NCAC 13F .0902(b) Health Care Facility will assure that referral and follow-up is completed to meet the routine and acute health care needs of the residents. Facility contacted durable medical provider to ensure immediate delievery of portable oxygen tanks. Facility implemented and posted a list of all residents who have physician orders for oxygen. List includes durable medical company name and phone numbe that supply oxygen to individual residents Facility RCC will monitor "Facility Oxygen List" weekly and update as needed. Facility ED/RCC will date and sign "Oxygen List Check" tracking form weekly for one month, then monthly for 3 months than radomly there after to assure list is updated and posted. (Attachment A) Facility ED/RCC have been in-serviced on "Oxygen List Check" tracking forms Facility contacted resident physicians for clarification of oxygen orders.	06/11/17 05/11/17 05/11/17 05/11/17 05/11/17 05/11/17

Reviewed and accepted
6/26/17 LJW

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D 273	Continued From page 1 Review of Resident #4's Physical Therapist (PT) notes revealed: -A start date of 09/08/16 and an end date of 12/02/16. -On 09/13/16 PT spoke with staff and Administration about the need for mobile oxygen. -On 09/13/16 PT spoke with the oxygen delivery company about the need for portable tanks for Resident #4 so the resident could ambulate and go to the dining room with oxygen as ordered continuously. -On 09/20/16 a comment of, "deferred gait today due to oxygen situation still unsettled after calling twice and still no progress and still not having a portable oxygen tank". -On 09/22/16 Resident #4 "continues to await updated oxygen situation to proceed with plan". -On 11/28/16, Resident #4 "is not safe" due to the "need for portable oxygen". Review of Resident #4's oxygen delivery receipts revealed: -On 09/07/16 the following was delivered to Resident #4: 6 E cylinders (E tanks capable of holding 680 liters each of compressed oxygen lasting 3.8 hours at 3L/M), a cart with wheels for E cylinder and regulators, a nasal cannula, a concentrator, a M cylinder (capable of holding 3596 liters of compressed oxygen lasting 58.2 hours on 3L/M), a M regulator, a M cylinder stand, and 3 monthly oxygen supply kits. -A delivery receipt dated 12/29/16 for 4 E cylinders. -A delivery receipt dated 03/31/17 for a concentrator. -A delivery receipt dated 04/06/17 for a concentrator delivered and one picked up. -A delivery receipt dated 04/20/17 for 3 E cylinders.	D 273	Continued from page 1: Facility Staff in-serviced on "Faciltiy Oxygen List" Facility Staff In-serviced on Oxygen Storage and Usage.	05/12/17
			Durable Medical Oxygen Company provided training with all staff	05/19/17
			Training titled "Management of the Resident Using Oxygen" provided to facility staff	06/07/17
		D276	10A NCAC 13F .0902(c)(3-4) Health Care Facility will assure that documentation of the following is in the resident's record: (3) written procedures, treatments or orders from a physician or licensed healthe professional: and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of the rule.	06/11/17

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D 273	Continued From page 2 Observation on 05/10/17 of Resident #4 at 9:43 am revealed: -Resident #4 was in her room. -Resident #4 had oxygen via nasal cannula (NC) coming from a concentrator at 1 ½ L/M. -There were 3 oxygen tanks (2 E tanks capable of holding 680 liters each of compressed oxygen lasting 3.8 hours at 3L/M, and one was a M tank (used only if the power goes out, and capable of holding 3596 liters of compressed oxygen lasting 58.2 hours on 3L/M) in the room, these were all empty. -The small and medium portable tanks were empty and not stored properly. -The large tank, used for power outages was also empty. -Resident #4's walker did not have a carrier for the small portable oxygen tank. Review of a physician's progress note from an Emergency Room (ER) visit dated 02/03/17 revealed: -Resident #4 was taken to the ER on 02/03/17 for respiratory distress. -Documentation of Resident #4's ER respiratory exam showed shortness of breath, cough, chest tightness, wheezing, and noted Resident #4 to be in respiratory distress. -Medications documented as given: albuterol 2.5 mg/0.5 ml nebulizer treatment (used to treat wheezing and shortness of breath caused by breathing problems), Atrovent 5 mg nebulizer treatment (used to prevent bronchospasm in people with bronchitis, emphysema, or COPD), Decadron 10 mg injection, and Solu-medrol 125 mg injection (both meds used to decrease inflammation). -A chest x-ray with no acute abnormality was documented. -Resident #4 was discharged back to the facility	D ~~273~~ D276	Continued from page 2: Facility has reviewed residents charts and EMARs to assure orders, procedures and/or treatments have been implemented as ordered by the physician or licensed health care provider. Facility has notified and/or clarified, when needed, all treatment/vital sign orders which are outside of the prescribed parameters. Facility will assure notification to physicians or licensed health professionals is documented in resident record. Facility has contacted/clarified oxygen orders with residents physician for all residents currently using oxygen. ED/RCC will monitor EMAR system no less than weekly to assure all orders have been implemented correctly. Facility has implemented new tracking form "Implementation of Orders Check" ED/RCC will sign and date weekly for 1 month, then randomly there after, as noted documention of reviewed MARs for implementation of orders. (Attachment B) ED/RCC have been in-serviced on tracking form "Implemention of orders" Facility has made staffing changes in the RCC/SCC positions. Facility ED/RCC have reviewed EMARS for blood pressure, weight,pulse and/or other orders with designated parameters. Facility has notified physicians for any vital signs which were outside of prescrided parameters. Facility has implementjed a new tracking form "Orders with Parameters". (Attachement C) ED/RCC will monitor EMAR weekly for 2 months, than randomly there after to assure documention of contact with physician regarding parameters is documented in the residents notes/record. Facility ED/RCC have been in-serviced on tracking form.	06/11/17 06/11/17 06/11/17 05/19/11 05/19/17 05/12/11 05/12/17 06/11/17 05/12/17 05/12/17

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D 273	Continued From page 3 on 02/03/17 with orders for oxygen 3L/M nasal cannula continuously. Review of a physician's progress note from an emergency room visit dated 03/18/17 revealed: -Resident #4 complained of severe abdominal pain and difficulty breathing. - Medications documented as given: albuterol 2.5 mg/0.5 ml nebulizer treatment, and Atrovent 5 mg nebulizer treatment. -The chest x-ray was documented as unremarkable. -An abnormal Arterial Blood Gas (ABG) a test to measure the acidity (pH) and the levels of oxygen and carbon dioxide in the blood from an artery. -A CT of the abdomen with results of Resident #4 having cholecystitis. -Resident #4 was admitted to the hospital on 03/18/17 for shortness of breath (SOB) and cholecystitis. Review of Resident #4's Hospital Discharge Summary dated 03/22/17 revealed: -A diagnoses of SOB and severe abdominal pain. -After a surgical procedure Resident #4 had difficulty being weaned off of the ventilator. -A physician's order for Oxygen at 3L/M NC continuously. Review of Resident #4's Hospital admission notes dated 03/31/17 - 04/03/17 revealed: -An ER visit dated 03/31/17 at 9:36 pm for shortness of breath, and difficulty breathing. -Documentation of Resident #4's ER respiratory exam showed shortness of breath, cough, chest tightness, wheezing, rales and in respiratory distress. -Chest x-ray with no acute abnormality documented. -Medications documented as given: albuterol 2.5	D 273	Continued from page 3 Facility Med Staff, ED and RCC has been in-serviced on parameter orders, when to contact/notify physicians, when/where to document contact/ notification. Facility Med Staff, RCC,and ED have been in-serviced on measuring vital signs. 10A NCAC 13F .0904(b)(2)) Nutrition and Food (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at a knife, fork,spoon,plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the residents Facility will assure that each place setting consist of a knife, fork, spoon, plate and beverage container. Facility ED/RCC/SCC and/or Dietary Manager will monitor meal place settings weekly for 1 month and then randomly there after to assure that each place setting consist of a knife, fork, spoon, plate and beverage container Facility has ordered additional place setting untensils. Facility Staff have been in-serviced on proper place settings.	D276 D287	06/07/17 06/15/17 06/11/17 ON-GOING 06/11/17 05/20/17

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D 273	Continued From page 4 mg/0.5 ml nebulizer treatment, Atrovent 5 mg nebulizer treatment, Decadron 10 mg injection, and Solu-medrol 125 mg injection. -An abnormal ABG, while Resident #4 was on oxygen at 3L/M documented as follows; a PCO2 of 60 (the partial pressure of carbon dioxide, a measure of the relative concentration of the gas in the blood. The normal range is 35-45.), a PO2 of 136 (the partial pressure of oxygen, and reflects the amount of oxygen gas dissolved in the blood. It primarily measures the effectiveness of the lungs in pulling oxygen into the blood stream from the atmosphere. The normal range is 80-100.), a HCO3 of 35 (blood bicarbonate (plasma bicarbonate) the bicarbonate of the blood plasma, an important parameter of acid-base balance measured in blood gas analysis. The normal range is 24-26.). -On 04/01/17 at 12:07 am documentation of Resident #4 was placed on BiPAP (Bilevel Positive Airway Pressure is a form of non-invasive mechanical pressure support ventilation) for respiratory failure. -On 04/01/17 at 4:59 am documentation of taking Resident #4 off of the BiPAP and not doing well and having to be put back on the BiPAP at 5:01 am. -Resident #4 was admitted on 04/01/17 at 6:17 am for respiratory distress. Review of Resident #4's Discharge Summary dated 04/03/17 revealed: -Resident #4's diagnoses included COPD, chronic respiratory failure with hypoxia, chronic hypercarbia (a condition of abnormally elevated carbon dioxide (CO2) levels in the blood), and obesity hypoventilation syndrome (a condition in which severely overweight people fail to breathe rapidly enough or deeply enough, resulting in low blood oxygen levels and high blood carbon	D 273 D299	10A NCAC 13F.0904(d)(3)(A) Nutrition and Food Service Facility will assure that residents are servered one cup (8oz) of pasteurized milk at least twice a day. Facility ED/RCC/SCC and/or Dietary Manager will monitor no less than 2 meal services daily for 2 weeks, then no less than 2 meal services weekly, then randomly there after to assure residents are servered milk at least twice a day. Facility staff have been in-serviced on servering milk at least twice a day.	05/12/17 05/12/17 05/19/17

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D 273	Continued From page 5 dioxide (CO2) levels). -A physician's order to continue oxygen at 3L/M NC continuously. Review of Resident #4's Care Plan dated 04/12/17 revealed: -An assessment documented, shortness of breath (SOB), the need for continuous oxygen. -Resident #4 needed extensive assistance with Activities of Daily Living (ADL's), such as, bathing, dressing, mobility, toileting due to SOB and the need for continuous oxygen. Review of Resident #4's Licensed Health Professional Support (LHPS) dated 05/04/17 revealed the resident required continuous oxygen at 3L/M NC. Telephone interview on 05/10/17 with an oxygen supply Representative at 5:15 pm revealed: -A new oxygen concentrator was delivered on 03/31/17 for Resident #4. -The last three E cylinders of oxygen were delivered on 04/20/17 would last Resident #4 11.4 hours at 3L/M. Review of Resident #4's March 2017 Electronic Medication Administration Record (eMAR) revealed an entry for oxygen 3L/M and documented as applied via nasal cannula continuously 12:00 am - 6:59 am, 7:00 am - 2:59 pm, and 3:00 pm - 11:59 pm 03/01/17 to 03/31/17. Review of Resident #4's April 2017 eMAR revealed an entry for oxygen 3L/M and documented as applied via nasal cannula continuously 12:00 am - 6:59 am, 7:00 am - 2:59 pm, and 3:00 pm - 11:59 pm 04/01/17 to 04/30/17.	D358	10A NCAC 13F.1004(a) Medication Administration Facility will assure that the administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record: and (2) rules in the Section and the facility's policies and procedures Facility has reviewed resident's Charts and EMARS to assure mediciations, perscription and non-perscriptions, and treatments are being adminstrated as prescrided. Facility ED/RCC/SCC will monitor EMARs no less than weekly to assure all orders including discontinued orders are processed timely and accuary. Facility ED/RCC will sign and date the "Implementation of orders" tracking form weekly for 1 month, then randomly there after, as noted documentation of reviewed EMARS. (Attachement B) Facility has made a staffing change in the RCC/SCC positions. Facility ED/RCC have been in-serviced on trackling form.	Ongoing 06/11/17 05/12/17 05/12/17

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D 273	Continued From page 6 Review of resident #4's May 2017 eMAR revealed an entry for oxygen 3L/M and documented as applied via nasal cannula continuously 12:00 am - 6:59 am, 7:00 am - 2:59 pm, and 3:00 pm - 11:59 pm 05/01/17 to 05/11/17. Interview on 05/10/17 with a Medication Aide (MA) at 4:32 pm revealed: -She had worked at the facility since 2015. -Resident #4 was in and out of the hospital for breathing issues. -Resident #4 only got out of bed to go to the dining room for meals. -"Resident #4 was on oxygen at 2 liters continuously and used a portable tank to go to all meals" per the doctor's order on the eMAR. -When asked she could not tell us where it was. -Resident #4 has a holder attached to her walker for her portable oxygen tank. -All extra oxygen tanks were stored in the oxygen storage room. -Resident #4 gets all of her oxygen tanks refilled by home health and they refill /replace them for her once a week. -The oxygen setting was checked every shift and documented on the eMAR. -She was not aware that Resident #4's oxygen concentrator was set on 1 ½ liters. -"I documented that it was set on 3L/M but I actually did not check the settings" -She was not aware that the portable cylinders in the room were empty. Interview on 05/11/17 with a Personal Care Assistant (PCA) at 9:47 am revealed: -She helped Resident #4 with all of her ADL's. -She put on and removed the nasal cannula, adjusted the oxygen flow rate from 0 to 1 ½ liters per the MA's direction.	~~D273~~ D914	G.S 131D-21(4) Declaration of Residents' Rights Facility will assure that all residents are free of mental and physical abuse, neglect, and exploitation. Facility has implemented 3 new tracking systems to assure all residents prescribed orders/treatments are reviewed on a regular basis. Facility has made changes in the staffing positions that manage, approve, track and implement prescibed orders/treatments. Facility ED/RCC have been trained on all tracking forms Facility Staff have been re-trained on Residents' Rights	06/11/17 ONGOING 06/11/17 05/12/17 05/19/17

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D 273	Continued From page 7 -She switched out the empty tanks on all residents that have oxygen but Resident #4 did not have extra tanks. -She was aware that the oxygen tanks in the room were empty and had notified the MA several times over the past few months. -She was aware that there were 20 portable tanks in a separate oxygen room but Resident #4 did not have extra tank assigned to her in there. -She was aware Resident #4 could not go to meals because there were no portable tanks for the resident to use and she had made the MA aware. -Resident #4 "won't leave her room because she has no way to take the oxygen with her". -Resident #4 had been without full tanks since she came to work at the facility 6 months ago. -She was responsible for checking the oxygen tanks every shift to see if empty or if needing to be switched out. -"There are only 2 residents in the facility that require oxygen and Resident #4 is the only resident that does not have a filling station on top of her concentrator". -She had not been trained on oxygen administration since she had been at the facility. Interview on 05/11/17 with second PCA at 10:05 am revealed: -She checked the oxygen was on correctly, tanks were not empty, and set all of the flow rates per the MA's direction. -She removed the empty tank and replaced it with a full tank from the oxygen room except for Resident #4 because there were no tanks available for her. -She was aware that Resident #4 did not have portable tanks that were full and had informed a MA. -She was aware that there were 20 full portable	D 273		

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D 273	Continued From page 8 tanks in the oxygen room, but none of them were for Resident #4. -She was aware that there were only 2 residents in the facility on oxygen. -Resident #4 needs portable tanks reordered. -She had not been trained on oxygen administration, just putting the nasal cannula on and taking it off, since she was hired at this facility 2 months ago. -Resident #4 was "confined to her room because she does not have a portable tank". Interview on 05/11/17 with the LHPS Nurse at 11:00 am revealed: -She trained and checked off all PCA's on applying and removing the nasal cannula only. -She was not aware the PCA's were adjusting the flow meter on the oxygen or changing out the portable tanks. -The MAs were responsible for applying and removing nasal cannula, replacing empty tanks with full ones and adjusting oxygen flow according to doctor's orders. Interview on 05/10/17 with Resident #4 at 9:43 am revealed: -She had resided at the facility for more than 6 months. -She was supposed to be on Oxygen at 3L/M but they "always put it on 1 ½ liters". -"All of my tanks are empty and have been for a long time" and "I have told the nursing assistants and nurses but nothing changed". -"I have to go to the dining room without oxygen". -She did not have a portable carrier for her walker for the portable oxygen tank. -"I get out of breath walking to the dining room without oxygen." -"I am tired all of the time", and she felt "sluggish".	D 273		

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D 273	Continued From page 9 Observation on 05/10/17 of Resident #4 at 11:16 am revealed: -The oxygen concentrator was set at 1 ½ liters. -There was no portable tank that was full or a holder for her walker for a portable tank. Observation on 05/10/17 of Resident #4 at 12:24 pm revealed: -She was sitting in dining room eating lunch and did not have oxygen on at all. -The oxygen concentrator in her room was in the off position and the dial was set at 0 liters per minute. Observation on 05/10/17 of Resident #4 at 2:44 pm revealed: -Resident #4 was lying in her bed without the nasal cannula on. -"I was told by the MA to not mess with the machine or the dial and they would do it." -"The aide had not come in yet and to put it back on me and turn on the machine." Observation on 05/10/17 of the oxygen storage room at 3:23 pm revealed: -There were 20 full midsize (E) portable oxygen tanks and 2 midsize (E) portable rolling carts. -There were no indications of who the tanks were to be used for. Observation on 05/10/17 of Resident #4 at 3:55 pm revealed: -Resident #4 was lying in bed and was not wearing oxygen NC. -She was breathing rapidly. -She was having difficulty speaking and breathing at the same time. -She was displaying pursed lip breathing (is a breathing technique that consists of exhaling	D 273		

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D 273	Continued From page 10 through tightly pressed (pursed lips) and inhaling through the nose with the mouth closed. Interview on 05/10/17 with Resident #4 at 3:55 pm revealed: -She was "tired a lot and sleepy all of the time". -She could only walk to her door before becoming short of breath from not being on oxygen. -She "takes lots of breaks" before she go to the dining room. -She was short of breath when she got to the dining room. -"There is no holder for a portable tank" and "I do not have a full tank to use". -She had reported the need for the portable tank to go to the dining room to the MA's and the PCA's. -"I told the medication aide this morning that this is not normal for me to be this sleepy and tired". -"I have no energy". -The big tank was for backup if the power goes out and "it is empty" and has been for months, "since the first of the year". -She asked the MA to come in the room, turn on her concentrator and adjust the oxygen flow to the ordered 3L/M. Interview on 05/10/17 with a second MA at 4:50 pm revealed: -Resident #4's concentrator was replaced recently because it didn't work and Resident #4 had to be sent to the ER. -She called the company on the tank and was told that the tanks in Resident #4's room did not belong to the resident. -She did not know whose tanks they were and therefor could not get them refilled. -She was aware of the oxygen storage room containing 20 full portable tanks but thought those tanks belonged to someone else.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING _____ B. WING _____	05/11/2017

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D 273	Continued From page 11 -She checked on all of the tanks in the facility every day to see if they were empty and needed to be replaced. Interview on 05/10/17 with the Resident Care Coordinator (RCC) at 5:11 pm revealed: -She was responsible for ordering all of the oxygen tanks and supplies when the portable tanks for Resident #4 were empty or oxygen concentrator not working correctly. -She was not aware that Resident #4's portable tanks were empty. -The MAs were responsible for checking all of the oxygen tanks in the facility every shift, and if empty and none available in the oxygen storage room, they should call for a delivery and then let the RCC know. -The MAs were trained by the LHPS Nurse on how to use oxygen and change out tanks. Observation on 05/11/17 of Resident #4 at 9:44 am revealed: -She was in her room wearing oxygen at 3L/M via the concentrator. -She has a full E cylinder portable oxygen tank at her bedside. Interview on 05/11/17 with Resident #4 at 9:44 am revealed: -Her oxygen was at 3L/M via nasal cannula. -"It was easier to get to the dining room" on the portable oxygen tanks, "without getting out of breath". -"I feel a lot better this morning". -"I don't feel as tired this morning". Interview on 05/11/17 with Resident #4's physician at 12:00 pm revealed: -It was her expectation that the oxygen was administered continuously at 3 liters by nasal	D 273		

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D 273	Continued From page 12 cannula as ordered because of her respiratory issues, failure to do so could end up in Resident #4 going into respiratory distress and an unnecessary hospital admission. -Her past medical history required her to be on oxygen continuously. Interview on 05/11/17 with the Administrator at 1:00 pm revealed: -MAs were responsible for all oxygen administration and monitoring. -PCAs were responsible for checking oxygen tanks to see if they were empty, putting on and removing the nasal cannula. -The MAs and PCAs are responsible for letting the RCC know of any portable tanks or compressors that need to be ordered. -The oxygen room is where you first go to get full tanks if one is found empty. -She was not aware PCAs were not swapping empty tanks out for full ones and adjusting oxygen flow rates. -The LHPS Nurse was responsible for training the MAs and the PCAs on oxygen administration and monitoring. -She was not aware Resident #4 did not have portable oxygen tanks. -"There are full tanks" for Resident #4 to use in the oxygen room. -She was not aware the portable tanks from the oxygen room were not being used for Resident #4. Telephone interview on 05/11/17 with Resident #4's family member at 3:25 pm revealed: -She told the MAs, PCAs and RCC since January 2017 the portable tanks and the backup tanks were empty. -She was told by the MA and RCC since January 2017 she was to call ambulance to take Resident	D 273		

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D 273	Continued From page 13 #4 to doctor's appointments or any appointment outside the facility because of not having a portable tank for Resident #4 to use. -She visited Resident #4 at least once a week and also extra to take her to any appointments. -She called the oxygen supply company herself on 03/31/17 and had the concentrator replaced due to not working correctly and Resident #4 having to go to the hospital for difficulty breathing and the need for new portable tanks. -A new concentrator was delivered but she never saw any new portable tanks delivered to Resident #4. -Resident #4 was admitted to the hospital many times for difficulty breathing. -Resident #4 could not leave her room because she did not have a portable oxygen tank. -If Resident #4 wanted to go eat in the dining room she must do it without oxygen. The facility failed to provide services necessary to maintain the physical heath of one resident who required portable oxygen to go to the dining room and medical appointments which resulted in substantial risk of serious injury to the resident and constitutes a Type A1 Violation. A Plan of Protection was provided by the facility on 5/11/17 as follows: -Facility has contacted the oxygen provider for immediate delivery of portable oxygen tanks, which were delivered on 5/11/17. -Facility will immediately post list of all resident who have orders for oxygen, "Facility Oxygen List". List will have resident name, room number, provider name and number and current liters ordered. The list will be posted in the medication room and on medication carts. -Facility will be contacting physicians for any resident who has orders for oxygen to clarify	D 273		

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D 273	Continued From page 14 order and correct liters. -Facility will immediately in-service all staff on oxygen storage and use. -Facility will immediately review eMARs, clarify and /or notify physician if needed, for all treatment and vital sign (VS) orders. -Facility will review eMARs for BP, weight, pulse and/or other orders with designated parameters to assure order has been implemented correctly, and facility will notify physician of any vital signs which are out of prescribed parameter. -Ongoing, the facility has contacted the oxygen provider for an in-service scheduled for 5/19/17. -The RCC/SCC will monitor and update facility oxygen list weekly and update as needed. -The RCC/SCC will monitor eMAR system weekly to assure all orders have been implemented correctly. -The ED will monitor facility oxygen list monthly for 3 months then randomly thereafter. -The ED will monitor the eMAR system monthly for 3 months then randomly thereafter to assure implementation of orders. -The facility Licensed Health Professional Support Registered Nurse will in-service all medication staff including the RCC/SCC on obtaining and recording VS. -The RCC/SCC will monitor eMAR no less than weekly to assure physician notification of any VS of prescribed parameters. DATE OF CORRECTION FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 11, 2017.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the	D 276		

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D 276	Continued From page 15 following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 2 of 5 sampled residents with physician orders for oxygen administration (Resident #4) and blood pressure checks to be obtained 3 times a day (Resident #2). The findings are: A. Review of Resident #4's current FL2 dated 11/01/16 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), dementia, pulmonary hypertension, anemia and diabetes mellitus type II. -An physician's order to check every shift to make sure oxygen was on 3 liters per min (3L/M) and that the portable tank was on refill schedule daily midnight to 6:59 am, 7:00 am to 2:59 pm, and 3:00 pm to midnight. Observation on 05/10/17 of Resident #4 at 9:43 am revealed: -Resident #4 was in her room. -Resident #4 had oxygen via nasal cannula (NC) coming from a concentrator and the liter flow was set at 1 ½ L/M.	D 276		

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D 276	Continued From page 16 Review of a physician's progress note from an Emergency Room (ER) visit dated 02/03/17 revealed: -Resident #4 was taken to the ER on 02/03/17 for respiratory distress. -An ER respiratory exam documentation showed shortness of breath, cough, chest tightness, wheezing, and noted Resident #4 to be in respiratory distress. -Medications documented as given: albuterol 2.5 mg/0.5 ml nebulizer treatment (used to treat wheezing and shortness of breath caused by breathing problems), Atrovent 5 mg nebulizer treatment (used to prevent bronchospasm in people with bronchitis, emphysema, or COPD), Decadron 10 mg injection, and Solu-medrol 125 mg injection (both meds used to decrease inflammation). -A chest x-ray with no acute abnormality documented. -Resident #4 was discharged back to the facility with orders for oxygen 3L/M nasal cannula continuously. Review of a physician's progress note from an emergency room visit dated 03/18/17 revealed: -Resident #4 complained of severe abdominal pain and difficulty breathing. - Medications documented as given: albuterol 2.5 mg/0.5 ml nebulizer treatment, and Atrovent 5 mg nebulizer treatment. -The chest x-ray was documented as unremarkable. -An abnormal Arterial Blood Gas (ABG) a test to measure the acidity (pH) and the levels of oxygen and carbon dioxide in the blood from an artery. -A CT of the abdomen with results of Resident #4 having cholecystitis. -Resident #4 was admitted to the hospital on	D 276		

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D 276	Continued From page 17 03/18/17 for shortness of breath (SOB) and cholecystitis. Review of Resident #4's Hospital Discharge Summary dated 03/22/17 revealed: -A diagnoses of SOB and severe abdominal pain. -After a surgical procedure Resident #4 had difficulty being weaned off of the ventilator. -A physician's order for Oxygen at 3L/M NC continuously. Review of Resident #4's Hospital admission notes dated 03/31/17 - 04/03/17 revealed: -An ER visit dated 03/31/17 at 9:36 pm for shortness of breath, and difficulty breathing. -Documentation of Resident #4's ER respiratory exam showing shortness of breath, cough, chest tightness, wheezing, rales and in respiratory distress. -Chest x-ray with no acute abnormality documented. -Medications documented as given: albuterol 2.5 mg/0.5 ml nebulizer treatment, Atrovent 5 mg nebulizer treatment, Decadron 10 mg injection, and Solu-medrol 125 mg injection. -An ABG documented as abnormal. -On 04/01/17 at 12:07 am documentation of Resident #4 was placed on BiPAP (Bilevel Positive Airway Pressure is a form of non-invasive mechanical pressure support ventilation) for respiratory failure. -Documentation dated 04/01/17 at 4:59 am, Resident #4 was taken off of the BiPAP and not doing well and had to be put back on the BiPAP at 5:01 am. -Resident #4 was admitted on 04/01/17 at 6:17 am for respiratory distress. Review of Resident #4's Discharge Summary dated 04/03/17 revealed:	D 276		

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D 276	Continued From page 18 -Resident #4's diagnoses included COPD, chronic respiratory failure with hypoxia, chronic hypercarbia (a condition of abnormally elevated carbon dioxide (CO2) levels in the blood), and obesity hypoventilation syndrome (a condition in which severely overweight people fail to breathe rapidly enough or deeply enough, resulting in low blood oxygen levels and high blood carbon dioxide (CO2) levels). -A physician's order to continue oxygen at 3L/M NC continuously. Review of Resident #4's Care Plan dated 04/12/17 revealed: -An assessment documented, Resident #4 experienced shortness of breath (SOB), the need for continuous oxygen. -Resident #4 needed extensive assistance with Activities of Daily Living (ADL's), such as, bathing, dressing, mobility, toileting due to SOB and the need for continuous oxygen. Review of Resident #4's Licensed Health Professional Support (LHPS) dated 05/04/17 revealed the resident required continuous oxygen at 3L/M NC. Interview on 05/11/17 with a Personal Care Assistant (PCA) at 9:47 am revealed: -She helped Resident #4 with all of her ADL's. -She put on and removed the nasal cannula, adjusted the oxygen flow rate from 0 to 1 ½ liters per the MA's direction. Interview on 05/11/17 with a second PCA at 10:05 am revealed: -She checked the oxygen was on correctly, tanks were not empty, and set all of the flow rates per the MA's direction. -She sets the flow rate at 1 ½ liters for Resident	D 276		

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D 276	Continued From page 19 #4. Interview on 05/11/17 with the LHPS Nurse at 11:00 am revealed: -She trained and checked off all PCA's on applying and removing the nasal cannula only. -She was not aware the PCA's were adjusting the flow meter on the oxygen or changing out the portable tanks. -The MAs were responsible for applying and removing nasal cannula, replacing empty tanks with full ones and adjusting oxygen flow according to doctor's orders. Review of facility oxygen policy revealed any staff member, resident or family member handling oxygen tanks should be properly trained. Interview on 05/10/17 with Resident #4 at 9:43 am revealed: -She had resided at the facility for more than 6 months. -She was supposed to be on Oxygen at 3L/M but they "always put it on 1 ½ liters". Observation on 05/10/17 of Resident #4's oxygen at 11:16 am revealed the oxygen concentrator's liter flow was set at 1 ½ liters. A second interview on 05/10/17 with Resident #4 at 3:55 pm revealed Resident #4 put on her NC, and the concentrator was in the off position and called the MA into Resident #4's room to adjust the oxygen flow to the ordered 3L/M. Review of Resident #4's March 2017 electronic Medication Administration Record (eMAR) revealed an entry for oxygen 3L/M and documented as applied via nasal cannula continuously 12:00 am - 6:59 am, 7:00 am - 2:59	D 276		

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D 276	Continued From page 20 pm, and 3:00 pm - 11:59 pm 03/01/17 to 03/31/17. Review of Resident #4's April 2017 eMAR revealed an entry for oxygen 3L/M and documented as applied via nasal cannula continuously 12:00 am - 6:59 am, 7:00 am - 2:59 pm, and 3:00 pm - 11:59 pm 04/01/17 to 04/30/17. Review of resident #4's May 2017 eMAR revealed an entry for oxygen 3L/M and documented as applied via nasal cannula continuously 12:00 am - 6:59 am, 7:00 am - 2:59 pm, and 3:00 pm - 11:59 pm 05/01/17 to 05/11/17. Interview on 05/10/17 with a Medication Aide (MA) at 4:32 pm revealed: -She had worked at the facility since 2015. -Resident #4 was in and out of the hospital for breathing issues. -"Resident #4 was on oxygen at 2 liters per the doctor's order on the MAR". -She did not consult the MAR for the prescribed liter flow of oxygen and was not aware the liter flow was to be set at 3L/M. -The oxygen setting was checked every shift and documented on the MAR. -She was not aware that Resident #4's oxygen concentrator was set on 1 ½ liters. -"I documented that it was set on 3L/M but I actually did not check the settings". A third interview on 05/11/17 with Resident #4 at 9:44 am revealed: -Her oxygen was at 3L/M via nasal cannula. -"It was easier to get to the dining room without getting out of breath". -"I feel a lot better this morning". -"I don't feel as tired this morning".	D 276		

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D 276	Continued From page 21 Interview on 05/11/17 with Resident #4's physician at 12:00 pm revealed: -She was not aware the oxygen was being set at 1 ½ liters instead of the 3 liters ordered. -She was not aware Resident #4 did not have oxygen on continuously as ordered. -It was her expectation that the oxygen was administered at 3 liters by nasal cannula as ordered because of her respiratory issues, failure to do so could end up in Resident #4 going into respiratory distress and an unnecessary hospital admission. -Her past medical history required her to be on oxygen continuously. Interview on 05/11/17 with the Administrator at 1:00 pm revealed: -MAs were responsible for all oxygen administration and monitoring. -PCAs were responsible for checking oxygen tanks to see if empty, putting on and removing nasal cannula. -She was not aware Resident #4 was on 1 ½ liters of oxygen instead of the 3L/M as ordered by the physician. Telephone interview on 05/11/17 with Resident #4's family member at 3:25 pm revealed she told the MA's since January 2017 about Resident #4's concentrator being on 1 ½ liters instead of 3L/M and no changes were made. B. Review of Resident #2's current FL2 dated 5/02/17 revealed: -Diagnoses included hypertension and end stage renal disease -stage 4. -A physician's order for amlodipine 5 mg daily and clonidine 0.6 mg 3 times a day. Both medications are used to treat high blood pressure.	D 276		

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D 276	Continued From page 22 -A physician's order to check Resident #2's blood pressure (BP) weekly, but no parameters to notify a physician were specified. Review of Resident #2's record revealed a subsequent physician's order dated 5/02/17 to "give second dose of amlodipine today, then discontinue. Start Procardia XL 60 mg daily. BP and pulse check 3 times a day-notify if systolic BP (SBP) is greater than 190 or less than 90." Review of Resident #2's May 2017 electronic Medication Administration Record (eMAR) revealed: -An entry to "check BP every week" and documented weekly from 5/01/17 to 5/10/17. -A weekly BP result was documented on 5/01/17 as 130/58, and on 5/08/17 as 146/80. -There was no entry to check BP and pulse 3 times a day starting 5/02/17 with parameters for physician notification if SBP was greater than 190 or less than 90. -There were 24/24 opportunities that Resident #2's BP and pulse were not documented as checked 3 times a day from 5/02/17 to 5/10/17. -An entry for amlodipine 5 mg daily was documented as administered daily at 9:00 am from 5/01/17 to 5/02/17 with a discontinued date of 5/02/17. -An entry for nifedipine ER (Procardia XL) 60 mg daily was documented as administered daily at 8:00 am from 5/03/17 to 5/10/17. -Resident #2's BP and pulse checks monitoring were not done as ordered by the physician, although new BP medications were administered. Interview on 5/10/17 at 3:30 pm with the previous Executive Director (ED) revealed: -She had been the ED at the facility from 1/16/17 to 3/28/17.	D 276		

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D 276	Continued From page 23 -The Resident Care Coordinator (RCC) or Special Care Coordinator (SCC) entered orders into the eMAR, faxed the orders to the pharmacy, and made sure the orders were keyed in correctly by the pharmacy. -There was a "bucket list system for order processing", where the order travels from one bucket to the next until it was ready to be filed in the resident's record as completed. Interview on 5/10/17 at 4:50 pm with the current ED revealed: -She had worked at the facility as the ED since 3/31/17. -The RCC or the SCC entered orders into the eMAR and worked together to make sure physician's orders were followed. -Resident #2's physician's order dated 5/02/17 for medication and BP check changes were signed "noted and faxed" by the RCC at the bottom of the page. "I'm not sure why the order was not entered into the system." Review of Resident #2's BP check obtained by a Medication Aide (MA) on 5/10/17 at 5:05 pm was 161/81. Interview on 5/11/17 at 11:30 am with a MA revealed: -The pharmacy entered orders into the eMAR system. The RCC "approves" that the orders, including medication, BP, vital signs and weight checks, were entered correctly. -The MAs did not "handle resident orders or order entry". Interview on 5/10/17 at 4:55 pm with the RCC revealed: -She had worked at the facility since the end of January 2017.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING _____ B. WING _____	05/11/2017

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D 276	Continued From page 24 -If orders were from a resident's primary physician, the orders were sent electronically to the pharmacy. The facility was also sent a copy which she faxed to the pharmacy as a "double check" that the pharmacy received the order. -If the orders were from an outside physician, "I fax the orders to the pharmacy." -The pharmacy entered medication orders into the eMAR. -"We use a bucket system to track orders. The first bucket/bin is yellow for the "noted and faxed/ we've seen the order and faxed it to the pharmacy. The order moves from the yellow to the green bucket/bin after everything was approved and the medication was in the building. It is ready to file when it is in the green bucket/bin." -Resident #2's order for BP checks changed to three times a day was in the green bucket/bin and ready to be filed in his record. "Since it was not filed yet, but was in the green folder, it should have all been done". -She was not sure why the BP changes were not entered into the eMAR system. "If the pharmacy did not enter it, we could enter the BP, weights and vital signs orders, or call the pharmacy to enter it." -She was not aware the BP and pulse checks had not been transcribed correctly onto the eMAR, and could not say why she had approved in the eMAR since it was not correct. -Since the order for BP checks three times a day was missed, she would contact the pharmacy to enter the order into the eMAR system, and would notify the physician of the omission. Observation of the facility's "bucket system" revealed: -A set of 5 bins that were each a different color, and labeled for what orders were to be placed in	D 276		

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D 276	Continued From page 25 them. -A yellow bin labeled "Bucket #1-yellow. New physician's orders. Task: faxed new order(s) to [named] pharmacy and waiting for orders(s) to show in [named] MAR." -A blue bin labeled "Bucket #2-blue. New orders in [named] MAR." -A red bin labeled "Bucket #3-red. Meds not delivered". -A green bin labeled "Bucket #4-green. Ready to file. Task: These orders have been processed and medications received or physician orders have been implemented. These should be filed in the appropriate section of the chart..." -An orange bin labeled "Bucket #5-orange. Lab, diet, oxygen, therapy, hospital follow-up and miscellaneous orders..." Review of a facility fax on 5/11/17 at 9:15 am revealed: -A notification sent by the facility on 5/10/17 at 5:26 pm to Resident #2's physician "that resident did not start receiving BP and pulse checks three times daily as ordered on 5/02/17 until 5/10/17." -There was no physician response or orders as of 5/11/17 at 9:15 am. Review of Resident #2's updated May 2017 eMAR revealed: -An entry dated 5/10/17 for "check BP and pulse three times daily and notify [named physician] if SBP greater than 190 or less than 90", and scheduled to be obtained at 10:00 am, 4:00 pm and 10:00 pm. -The printed copy of the eMAR was dated 5/10/17, so no BP results were recorded at this new entry. Interview on 5/11/17 at 11:20 am with Resident #2's physician revealed:	D 276		

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D 276	Continued From page 26 -Resident #2 was a new admission to the physician. -The physician was notified that Resident #2's BP's were uncontrolled, so she wanted to monitor the BP results with the BP medication changes. -She had not been aware Resident #2's BP's were being checked weekly and not three times a day as ordered. -She expected physician orders to be followed. Attempted telephone interview on 5/11/17 at 3:25 pm with Resident #2's Power of Attorney was unsuccessful. Based on observations, interviews and record reviews, it was determined that Resident #2 was not interviewable. _____ The facility failed to maintain the physical health of Resident #4 and administer oxygen with a liter flow of 3 L/M of oxygen as ordered by a physician which resulted in 4 emergency room visits and 3 hospital admissions related to respiratory distress to one resident and this posed a substantial risk of serious injury to a resident and constitutes a Type A1 Violation. _____ A Plan of Protection was provided by the facility on 5/11/17 as follows: -Facility has contacted the oxygen provider for immediate delivery of portable oxygen tanks, which were delivered on 5/11/17. -Facility will immediately post list of all resident who have orders for oxygen, "Facility Oxygen List". List will have resident name, room number, provider name and number and current liters ordered. The list will be posted in the medication room and on medication carts. -Facility will be contacting physicians for any resident who has orders for oxygen to clarify	D 276		

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D 276	Continued From page 27 order and correct liters. -Facility will immediately in-service all staff on oxygen storage and use. -Facility will immediately review eMARs, clarify and /or notify physician if needed, for all treatment and vital sign (VS) orders. -Facility will review eMARs for BP, weight, pulse and/or other orders with designated parameters to assure order has been implemented correctly, and facility will notify physician of any vital signs which are out of prescribed parameter. -Ongoing, the facility has contacted the oxygen provider for an in-service scheduled for 5/19/17. -The RCC/SCC will monitor and update facility oxygen list weekly and update as needed. -The RCC/SCC will monitor eMAR system weekly to assure all orders have been implemented correctly. -The ED will monitor facility oxygen list monthly for 3 months then randomly thereafter. -The ED will monitor the eMAR system monthly for 3 months then randomly thereafter to assure implementation of orders. -The facility Licensed Health Professional Support Registered Nurse will in-service all medication staff including the RCC/SCC on obtaining and recording VS. -The RCC/SCC will monitor eMAR no less than weekly to assure physician notification of any VS of prescribed parameters. DATE OF CORRECTION FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 11, 2017.	D 276		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 287		

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D 287	Continued From page 28 (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a place setting which included a knife, fork and spoon for residents' meals in the Special Care Unit (SCU). The findings are: Interview with the Administrator on 5/10/17 at 8:45 am revealed the current census was 17 residents in the SCU. Observation of the lunch meal served in the SCU on 5/10/17 from 12:15 pm to 12:55 pm revealed: -The 17 residents were served in the SCU dining room by the Personal Care Aides (PCAs) from a food cart that was sent from the kitchen. -Silverware was sent on the food cart from the kitchen, and included forks and spoons, but no knives. -Each of the 17 residents in the dining room were given a place setting which included a fork and a spoon. -No one received a knife. -Residents were served 2 chicken tenders, french fries, mixed vegetables, coleslaw, a roll, a cookie, tea and water. -The chicken was cut up, ground or pureed for residents prior to being served to the residents.	D 287		

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D 287	Continued From page 29 -No resident asked for a knife. Observation of the breakfast meal served in the SCU on 5/11/17 at 8:30 am revealed: -Silverware was sent on the food cart from the kitchen, and included forks and spoons, but no knives. -Each of the 17 residents in the dining room were given a place setting which included a fork and a spoon. -No one received a knife. -Residents were served eggs, grits, sausage patty, a biscuit, juice and water and were offered coffee. -No resident asked for a knife or attempted to butter their biscuit. -The sausage patty was cut up, ground or pureed for residents prior to being served to the residents. Observation on 5/11/17 at 8:30 am of the serving area and dining room of the SCU revealed there were no forks, spoons or knives available in the SCU. Interview on 5/11/17 at 8:35 am with 2 PCAs in the SCU revealed: -One PCA had worked at the facility for 6 months. -One PCA had worked at the facility for 11 months. -The residents were given knives at some meals. -Sometimes the staff asked residents if they wanted butter or jelly on their biscuit or roll, and then the staff would apply it for them. -There was no extra silverware, including knives, in the SCU. If the kitchen did not send it on the food cart, they would have to call for what was needed. -One resident "sometimes gets aggressive, but never with silverware. I have never seen any	D 287		

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D 287	Continued From page 30 resident get aggressive with silverware". Interview on 5/11/17 at 8:55 am with a Cook revealed: -She had worked at the facility for 5 months and was not responsible for preparing the food cart that was sent to the SCU at mealtimes. -A Dining Aide (DA) prepared the food cart that was sent to the SCU. -The Cook prepared the food trays that went on the food cart, and was not aware if a full place setting of silverware was sent to the SCU. -She had not seen knives on the SCU food cart, and was not aware if there was an order or a reason knives were not sent to the SCU. Interview on 5/11/17 at 9:10 am with the Dining Room Manager (DRM) revealed: -She had worked at the facility for 2 years, but had been the DRM for 6 months. -A DA prepared the meal cart that was sent to the SCU at mealtimes. -If something was missing from the meal cart, she would expect the SCU staff to call to request what was needed, and it would be sent. -Knives were sent to the SCU "sometimes, but not often because there have been instances of residents becoming aggressive. She could not describe any instances, dates or name specific residents. -If something needed to be cut up, the kitchen would sent a few knives for staff use. -She was not aware if any resident had a physician's order for no knives. Interview on 5/11/17 at 9:15 am with the DA revealed: -She had worked at the facility for 1 month, and had been instructed by the DRM to send only forks and spoons to the SCU.	D 287		

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D 287	Continued From page 31 -She did not send any knives, even for staff use on the SCU food cart. Interview on 5/11/17 at 9:20 am with the Executive Director (ED) revealed: -Staff were to cut resident's food if needed in the SCU. -Some residents "cannot coordinate using a knife". Record review of the 5 sampled resident's records for the meal observations revealed none had been assessed for the use of knives at meals by the Primary Care Provider. Based on observations and interviews on 5/10/17 and 5/11/17 it was determined the residents were not interviewable.	D 287		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations interviews and record review, the facility failed to serve eight ounces of pasteurized milk at least twice a day to residents	D 299		

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D 299	Continued From page 32 in the Special Care Unit (SCU). The findings are: Interview with the Administrator on 5/10/17 at 8:45 am revealed the current census was 17 residents on the SCU. Review of the week at a glance menu revealed: -Milk (8 ounces) was to be served at breakfast and dinner for all diets on 5/10/17 and 5/11/17. -Milk was not listed for lunch on 5/10/17 and 5/11/17. -A snack menu did not specify a beverage to be served, so it could not be determined if milk should be served with any snack service. Observation on 5/10/17 at 9:30 am revealed snacks of juice, applesauce or cookies were offered and served by the Personal Care Aides (PCA) in the SCU. No milk was served at the snack service. Observation on 5/10/17 at 9:45 am of the kitchen food supply revealed there was more than a 3 day supply of milk, in gallon containers and single-serving cartons, available to be served to the residents. Observation of the lunch meal served in the SCU on 5/10/17 from 12:15 pm to 12:55 pm revealed: -The 17 residents were served in the SCU dining room. -Beverages were served by the PCAs from beverage pitchers from a cart that was sent from the kitchen. -Beverages served included water or tea. -Milk was not offered or served in the SCU dining room at the lunch meal.	D 299		

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D 299	Continued From page 33 Observation of the breakfast meal served in the SCU on 5/11/17 at 8:30 am revealed: -The 17 residents were served in the SCU dining room. -Beverages were served by the PCAs from beverage pitchers from a food cart that was sent from the kitchen, or from a coffee pot on a counter in the dining room. -Beverages served included water, cranberry or orange juice or coffee. -There was no milk available on the food cart or in the SCU dining room mini refrigerator. -Milk was not offered or served in the SCU dining room at the breakfast meal. Interview on 5/11/17 at 8:35 am with 2 PCAs in the SCU revealed: -One PCA had worked at the facility for 6 months. -One PCA had worked at the facility for 11 months. -No milk was served at dinner last night (5/10/17) or at breakfast today since the kitchen had not sent milk to be served. -They had not called the kitchen for milk. -They were not aware it should be served at least twice a day in the SCU. Interview on 5/11/17 at 8:55 am with a Cook revealed: -She had worked at the facility for 5 months and was not responsible for preparing the food cart that was sent to the SCU at mealtimes. -A Dining Aide (DA) prepared the food cart that was sent to the SCU. -The Cook prepared the food trays that went on the food cart, and was not aware if milk was sent to the SCU. Observation on 5/11/17 at 9:10 am revealed the Dining Room Manager (DRM) was returning the	D 299		

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D 299	Continued From page 34 SCU meal cart to the kitchen. In one hand she held a small metal pan that was full with ice and 6 cartons of milk. There was no room for more cartons of milk. Interview on 5/11/17 at 9:10 am with the DRM revealed: -She had worked at the facility for 2 years, but had been the DRM for 6 months. -A DA prepared the meal cart that was sent to the SCU at mealtimes. -The DA today (5/11/17) was new and "must have forgotten" to put milk on the cart. -The milk in the metal pan she had carried to the SCU when she went to get the meal cart, but had brought the milk back since breakfast was over. -The kitchen sent milk and/or shakes in a container of ice. -If something was missing from the meal cart, she would expect the SCU staff to call to request what was needed, and it would be sent. -Some residents would drink milk if it were placed in front of them. -She was aware milk was to be served twice a day. -Milk was on the menu to be served twice a day. Interview on 5/11/17 at 9:15 am with the DA revealed: -She had worked at the facility for 1 month, and was not aware milk was to be served twice a day. -She had not realized she had forgotten to send milk to the SCU with breakfast this morning. Interview on 5/11/17 at 9:20 am with the Executive Director (ED) revealed: -Milk should be served with breakfast and dinner in the SCU. -If milk was served to a resident, she was certain many would drink it.	D 299		

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D 299	Continued From page 35 Based on observations and interviews on 5/10/17 and 5/11/17 it was determined the residents were not interviewable.	D 299		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents sampled residents (#5) including medications for chronic obstructive pulmonary disease. The findings are: Review of Resident #5's current FL2 dated 5/02/17 revealed diagnoses included chronic obstructive pulmonary disease. 1. Review of Resident #5's signed Physician's Visit Summary dated 1/10/17 revealed an order for Advair HFA 115/21 mcg/actuation inhale 2 puffs twice daily (a medication used to treat chronic obstructive pulmonary disease). Review of a physician's order dated 4/18/17	D 358		

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D 358	Continued From page 36 revealed an order to discontinue Advair and to start Breo Ellipta 100/25 mcg one puff daily (a medication used to treat chronic obstructive pulmonary disease). Review of Resident #5's March 2017 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Advair HFA 115/21 mcg/actuation inhale 2 puffs daily and documented as administered at 8:00 am from 3/01/17 through 3/31/17. Review of Resident #5's April 2017 eMAR revealed: -There was an entry for Advair HFA 115/21 mcg/actuation inhale 2 puffs daily and documented as administered at 8:00 am from 4/01/17 through 4/30/17. -There was a second entry for Advair diskus 200-50 mcg disc 1 puff into lungs twice daily and documented as administered at 8:00 am and 8:00 pm 4/14/17 through 4/18/17. -There was an entry for Breo Ellipta 100-25 mcg inhale one puff daily and documented as administered at 8:00 am from 4/20/17 through 4/30/17. Review of Resident #5's May 2017 eMAR revealed: -There was an entry for Advair HFA 115/21 mcg/actuation inhale 2 puffs daily and documented as administered at 8:00 am from 5/01/17 through 5/10/17. -There was an entry for Breo Ellipta 100-25 mcg inhale one puff daily and documented as administered at 8:00 am from 5/01/17 through 5/10/17. Observation of medication on hand 5/10/17 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING _____ B. WING _____	05/11/2017

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D 358	Continued From page 37 3:45 pm revealed: -One purple inhaler labeled as Advair 115/21 mcg dispensed 12/30/16 with a total of 120 doses. -The inhaler had 92 doses left and he inhaler had a hand-written opened date of 1/08/17. -One round container of Breo Ellipta 100-25 mcg dispensed 4/18/17. Interview with a representative from the contracted pharmacy on 5/11/17 at 10:53 am revealed: -Orders are faxed from the facility and a pharmacy employee enters the physician's order into the pharmacy's system. -The physician's order was also entered into the eMAR. -All entries must be approved by someone at the facility before it becomes an active order on the eMAR. -They have no way of knowing if an order has been accepted or denied by the facility. -If there was a mistake with an order entry the facility was expected to call the pharmacy to make the correction. -The facility was expected to have the orders clarified by the prescribing physician. Interview with a Medication Aide on 5/11/17 at 9:45 a revealed: -She administered two inhalers this morning. -The two inhalers had been on the eMAR and she could remember questioning the Resident Care Coordinator (RCC) that Resident #5 had two inhalers but it was never changed on the eMAR. -She continued to give the inhalers as the eMAR instructed. Interview with the RCC on 5/11/17 at 10:19 am revealed: - She was not aware there was an order to	D 358		

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D 358	Continued From page 38 discontinue the Advair and to start the Breo Ellipta. -She was not aware Resident #5 was taking both inhalers. -New physician order's were faxed to the pharmacy or electronically transmitted directly from the physician. -The pharmacy entered the orders into the eMAR and all of the orders had to be approved by either the RCC or the Memory Care Coordinator (MCC). -She was not sure who approved the order to start Breo Ellipta without discontinuing the Advair. Interview with the Administrator on 5/11/17 at 4:15 pm revealed: -She expected facility staff to fax new physician orders to the pharmacy. -The pharmacy staff was to enter all of the orders into the eMAR. -The RCC was responsible for reviewing and approving all of the new orders entered by the pharmacy. -She was not aware of Resident #5 receiving Advair after it was discontinued by the physician. Interview with Resident #5's physician on 5/11/17 11:25 am revealed: -She was not aware the facility was administering both the Breo Ellipta and the Advair. -There was probably no adverse clinical effect from having administered both inhalers but she definitely wanted the facility to discontinue the Advair now because Resident #5 should only be on one of these inhalers. Interview with Resident #5 on 5/10/17 at 3:54 pm revealed: -She was administered two inhalers every morning. -She did not know the names of her inhalers but	D 358		

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D 358	Continued From page 39 described one as "a little round one" and the other as "a purple one". -She did not remember receiving an inhaler in the evening. -She was not aware that one inhaler had been discontinued. 2. Review of Resident #5's current FL2 dated 5/02/17 revealed diagnoses included chronic obstructive pulmonary disease. Review of Resident #5's Physician's Visit Summary dated 1/10/17 revealed an order for .63mg/3ml vial nebulizer treatments every four hours as needed for wheezing or shortness of breath (a medication used to open airways and facilitate airflow through the lungs). Review of Resident #5's physician order dated 4/12/17 to administer albuterol .63mg/3ml via nebulizer twice daily. Review of Resident #5's March 2017 eMAR revealed: -An entry for albuterol sulfate .63mg/3ml vial nebulizer treatments every four hours as needed for wheezing or shortness of breath with no documented administrations. Review of Resident #5's April 2017 eMAR revealed: -An entry for albuterol sulfate .63mg/3ml vial nebulizer treatments every four hours as needed for wheezing or shortness of breath with no documented administrations.. -An entry for albuterol sulfate .63mg/3ml vial nebulizer treatments twice daily and documented as administered at 8:00 am and 8:00 pm on 4/14/17 through 4/30/17.	D 358		

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D 358	Continued From page 40 Review of Resident #5's May 2017 eMAR revealed: -An entry for albuterol sulfate .63mg/3ml vial nebulizer treatments every four hours as needed for wheezing or shortness of breath with no documented administrations. -An entry for albuterol sulfate .63mg/3ml vial nebulizer treatments twice daily and documented as administered at 8:00 am and 8:00 pm on 5/01/17 through 5/09/17 and 8:00 am on 5/10/17. Observation of medication on hand 5/10/17 at 3:45 pm revealed there was no albuterol .63mg/3ml available for administration. Interview with a representative from the contracted pharmacy on 5/11/17 at 10:53 am revealed: -The pharmacy dispensed 75 ml of albuterol on 12/30/16. -The pharmacy dispensed 150 ml of albuterol on 4/14/17, which was a 25 day supply. -The pharmacy dispensed 150ml of albuterol on 5/10/17. Observation of medication on hand 5/11/17 at 12:32 pm revealed there was a box of albuterol .63mg/3ml with a dispense date of 5/10/17 available for administration. Interview with Resident #5 on 5/10/17 at 3:54 pm revealed: -She had not had an albuterol nebulizer treatment yet. -She was aware the physician had ordered the nebulizer treatments to be administered twice daily. -She could not get a nebulizer until her insurance approved the machine. -She received her nebulizer machine "yesterday"	D 358		

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D 358	Continued From page 41 and it was in a box on the floor at the bottom of her bed. Observation of Resident #5's Nebulizer Delivery Box on 5/10/17 at 4:00 pm revealed: -The nebulizer machine had not been unpacked or used. -There was a packing slip inside the box dated 5/08/17. Interview with the MCC on 5/11/17 at 12:27 pm revealed: -Resident #5 recently changed rooms and during this room change her nebulizer was misplaced. -She ordered a new nebulizer machine on 5/05/17. Interview with the Administrator on 5/11/17 at 4:15 pm revealed: -She was not aware Resident #5's nebulizer had been misplaced when Resident #5 changed rooms. -She was not aware of a nebulizer machine the facility had available for resident use. -She expected the MAs to report the missing nebulizer machine to the RCC and the RCC to order a new new nebulizer machine.	D 358		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were free of neglect, abuse and exploitation as	D914		

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D914	Continued From page 42 evidenced by the facilities failure to provide the portable oxygen and administer prescribed liter flow administer oxygen according to physician's orders which resulted in repeat hospitalizations related to respiratory distress (Resident #4). The findings are: A. Based on observations, interviews, and record reviews, the facility failed to follow up with the durable medical equipment company to ensure portable oxygen was available, to ensure the acute health care needs were met for 1 of 5 sampled residents (Resident #4) with physician orders for oxygen at 3L/M. [Refer to tag 0273, 10 A NCAC 13F .0902 (b)]. B. Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 2 of 5 sampled residents with physician orders for oxygen administration (Resident #4) and blood pressure checks to be obtained 3 times a day (Resident #2). [Refer to tag 0273, 10 A NCAC 13F .0902(c3-4)].	D914		