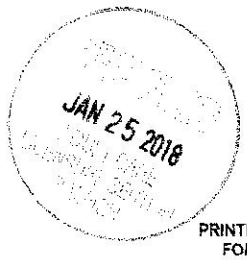

PRINTED: 12/22/2017
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013042	A. BUILDING: _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2906 COUNTRY HOME ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual survey on December 06 and December 07, 2017.	D 000	It is the Policy of The Country Home Assisted Living Dba K&B Adult Care to ensure Facility is full Compliances with NC Rules & Regulations 10A NCAC 13F.0902(b) Health Care 10A NCAC 13F. 0904(e)	
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: Based on record reviews and interviews, the facility failed to obtain the ordered lab value for one of five sampled residents (Resident #5) and follow up with the physician with the results. The findings are: Review of Resident #5's current FL-2 dated 9/6/17 revealed: -Diagnoses included epilepsy, unsteadiness on feet, muscle weakness, malaise, septic pulmonary dysphagia, vascular implants & grafts, schizophrenia and traumatic brain injury. -A physician's order for Depakote (medication used to prevent seizures) 750 mg twice a day. Review of physician's order dated 9/25/17 for Resident #5 revealed: -Resident #5's Depakote level was 104.9 (acceptable range is 50.0-100.0) on 09/25/17. -Depakote was to be decreased from 750 mg twice a day to 500mg twice a day. -Depakote level was to be rechecked in one	D 273		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katherine Thomas Administrator — TITLE: Administrator — (X6) DATE: 1/15/18

STATE FORM 6899 ELMC11 If continuation sheet 1 of 11

Revised & Accepted
Katherine King 2/6/18

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D 273	Continued From page 1 week. Review of Resident #5's record revealed: -There was no documentation the Depakote level was rechecked in accordance with 9/25/17 physician's order. -There was no documentation Resident #5's physician was contacted about the 9/25/17 lab orders. -Resident was seen by a home health nurse on 10/3/17 and 10/5/17 for pneumonia monitoring. -Resident was seen at the emergency room at the local hospital on 10/31/17. Review of Emergency Room (ER) visit report for Resident #5 dated 10/31/17 revealed: -The confirmed diagnosis was a fall and not a seizure. -Resident #5's Depakote level was 66.1 (acceptable range 50.0-100.0). Review of Resident #5's record revealed: -An incident report dated 10/31/17 for a fall, due to unsteadiness on his feet. Interview with Resident #5 at 9:45 am on 12/7/17 revealed: -The Depakote levels were checked but he were unsure of frequency. -The resident did not recall any recent issues with Depakote levels. -He had not experienced any recent seizures. Interview with the Corporate Nurse at 11:30 am on 12/7/17 revealed: -He was unable to locate Depakote level that was to be done per the 9/25/17 order. -He spoke with home health nurse and she was unaware of the 9/25/17 order. -The facility missed the 9/25/17 order and did not	D 273	**Pg 1-5 Tag D273 Health Care Follow Up & Referral** ***Plan:*** *RCD will keep a Lab Log, once Lab Order is given RCD will fax to Home Health Agency. RCD will go Back and int that Lab was completed* *SEE ATTACHMENT* ***Who Will Monitor:*** RCD / Corp RN will follow up behind RCD ***How Often:*** Twice Weekly Correction 1/30/2018	

THE COUNTRY HOME LAB TRACKER

RESIDENTS NAME: _____

DATE LAB ORDERED	ORDER	COLLECTED	RCD INT CONFIRM

PLEASE FILE IN RESIDENT CHART FOR RECORD 1/2018

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D 273	Continued From page 2	D 273		

follow-up for Depakote level labs to be done.
-The facility was responsible for ensuring the labs were completed.
-The Resident Care Coordinator (RCC) reviewed orders and followed up to assure lab orders are completed.
-The facility had a different RCC in September 2017 and the new RCC started in October 2017.

Telephone interview with the home health nurse on 12/7/17 at 11:32 am revealed:
-Resident #5 was seen on 10/3/17 and 10/5/17 to be checked and monitored due to pneumonia.
-The notes did not reflect any order for Depakote levels.
-Resident #5 was a "new patient" for her, she had Resident #5 as a patient for since his admission to the facility on 9/15/17.
-She was not aware of the 9/25/17 lab order for a Depakote level to be checked in a week.
-The order was not noted in her system when she visited the resident on 10/3/17 and 10/5/17.
-The facility did not make her aware of the 9/25/17 order.
-Usually the facility faxed any new orders to the home health agency, but there was no record of this order.
-She was at facility on 10/31/17 to see other residents, and observed Resident #5 to be staggering and unsteady.
-She consulted with the primary care provider and was instructed Resident #5 should be sent out for evaluation.
-The facility sent Resident #5 out to the local hospital for evaluation.

Interview with the Administrator at 11:55 am on 12/7/17 revealed:
-She was not aware of a lab order for Resident #5.

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D 273	Continued From page 3 -The new RCC began on 10/16/17. -The RCC was responsible for reviewing physician orders to assure changes and orders were implemented. -The RCC would fax any physician orders, including orders for labs, to the home health agency for completion of those orders. Telephone interview with Resident #5's Nurse Practitioner on 12/7/17 at 12:00 pm revealed: -She saw a lot of residents taking Depakote and it would be hard to recall a specific order for Resident #5. -The home health nurse or facility RCC would make her aware of lab results. -When at the facility, she reviewed information received from the home health agency and wrote orders as needed based on the information. -She did not recall being notified that Resident #5 missed a lab for a Depakote level that was to be done per the 9/25/17 order. -If she had been notified, she would have looked at the current dosage; inquired about symptoms & overall condition; possibly lowered the dose and asked that level be rechecked in four days. Telephone Interview with Resident #5's Physician at 12:08 pm on 12/7/17 revealed: -The facility would call or fax him or the Nurse Practitioner regarding the residents and their needs. -He thought the facility may have notified him about the 9/25/17 lab order being missed. -If a lab for a Depakote level was missed, he would look at the current dosage and ask how the resident was doing. -If the resident was okay, he may not request the lab to be done at that time to check a Depakote level. -He may advise staff to monitor the resident and	D 273		

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D 273	Continued From page 4 check a level in 3-6 months. Telephone interview with RCC on 12/7/17 at 12:11 pm revealed: -She reviewed all physician orders and filed the orders in the resident records. -She followed up to assure labs were done in accordance with physician orders. -Lab orders were faxed to the appropriate home health agency. -She started on 10/16/17 and did not recall seeing the 9/25/17 order regarding Depakote level for Resident #5. -She reviewed Medication Administration Records when she started at the facility to make notes of all residents receiving Depakote to assure levels were checked. -A notebook was used to document labs and assist with assuring labs were done timely. -The notebook was with the RCC and not in the facility for review on 12/7/17.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure therapeutic diets were served as ordered for 3 of 3 sampled residents (Residents #1, #4, and #6) with physician orders for a Low Concentrated Sweets	D 310	SEE PAGE 6 Tag D310 Nutrition & Food Service	

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D 310	Continued From page 5 (LCS) diet. The findings are: Review of the LCS therapeutic diet menu for lunch on 12/6/17 revealed residents ordered this diet were to be served 3 ounces (oz.) of Salisbury steak, 1/2 cup (c.) of stewed tomatoes, 1/2 c. of garlic mashed potatoes, 1 wheat roll/bread, margarine, ¼ c. of coconut cream pudding, 8 oz. diet beverage of choice, and 8 oz. milk. A. Review of Resident #1's current FL2 dated 5/5/17 revealed a diagnosis of diabetes mellitus. Review of Resident #1's record revealed a diet order dated 6/11/17 for a LCS diet. Review of the facility's diet list revealed Resident #1 was to be served a LCS diet. Observation on 12/6/17 from 11:55 am to 12:30 pm of the lunch meal service revealed: -Resident #1's meal consisted of 3 oz. of Salisbury steak, 1/2 c. of stewed tomatoes, 1/2 c. of mashed potatoes, 1 dinner roll, 1/2 c. of banana pudding, 8 oz. of sweet tea, and 6 oz. of water. -The resident consumed 100% of the meal. Review of Resident #1's Medication Administration Record (MAR) for the month of November and December 2017 revealed blood sugar ranged between 117 to 423 from 11/1/17-11/30/17 and 120 to 298 from 12/1-12/7/17. Interview on 12/7/17 at 10:30 am with Resident #6 revealed: -She was diabetic and unsure of how often her	D 310	**Pg 5-11 Tag D310 Nutrition & Food Service** ***Plan:*** *Dietary Staff will be inservice on Physician Diet Orders. Dietary Staff will be inservice on Menu* ***Who Will Monitor:*** Dietary Cook/RCD/Administrator ***How Often:*** Daily Correction 1/30/2018	

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D 310	Continued From page 6	D 310		

blood sugar was to be checked.
-She thought she was to be following a diabetic diet which included "no sugar".
-She received the same amount of dessert as everyone else and her drink "always tastes like water".

Refer to interview on 12/6/17 at 9:40 am with a fill-in Cook.

Refer to interview on 12/7/17 at 8:45 am with the Dietary Manager (DM).

Refer to interview on 12/7/17 at 9:15 am with the Registered Dietitian (RD).

Refer to interview on 12/7/17 at 10:12 am with the Primary Care Physician (PCP).

Refer to interview on 12/7/17 at 12/7/17 at 10:20 am with the Administrator.

B. Review of Resident #4's current FL2 dated 7/27/17 revealed:
-Diagnoses included diabetes.
-There was a diet order for LCS diet.

Review of the facility's diet list revealed Resident #4 was to be served a LCS diet.

Observation on 12/6/17 from 11:55 am to 12:30 pm of the lunch meal service revealed:
-Resident #1's meal consisted of 3oz. of Salisbury steak, 1/2 c. of stewed tomatoes, 1/2 c. of mashed potatoes, 1 dinner roll, 1/2 c. of banana pudding, 8 oz. of sweet tea, and 6 oz. of water.
-Resident #4 received an additional portion of banana pudding after it was offered by a dietary aide.
-The resident consumed 100% of the meal.

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D 310	Continued From page 7 Review of Resident #4's MAR for November 2017 revealed blood sugars ranged between 129 and 336 from 11/01/17 to 11/30/17 and 115-247 from 12/1/17-12/7/17. Interview on 12/6/17 at 3:20 pm with Resident #4 revealed: -He was diabetic -His blood sugars is checked by staff but, he could not remember how often it was checked. -He was unaware he was ordered a LCS diet. -He was served what everyone else was served for all meals. Refer to interview on 12/6/17 at 9:40 am with a fill-in Cook. Refer to interview on 12/7/17 at 8:45 am with the Dietary Manager (DM). Refer to interview on 12/7/17 at 9:15 am with the Registered Dietitian (RD). Refer to interview on 12/7/17 at 10:12 am with the Primary Care Physician (PCP). Refer to interview on 12/7/17 at 12/7/17 at 10:20 am with the Administrator. C. Review of Resident #6's current FL-2 dated 11/2/17 revealed: -Diagnoses included diabetes. -There was a diet order for LCS diet. Review of the facility's diet list revealed Resident #6 was to be served a LCS diet. Review of Resident #6's record revealed there was no order for blood sugar monitoring.	D 310		

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D 310	Continued From page 8 Observation on 12/6/17 from 11:55 am to 12:30 pm of the lunch meal service revealed: -Resident #6's meal consisted of 3 oz. of Salisbury steak, 1/2 c. of stewed tomatoes, 1/2 c. of mashed potatoes, 1 dinner roll, 1/2 c. of banana pudding, 8 oz. of sweet tea, and 6 oz. of water. -Resident #6 received an additional portion of banana pudding after it was offered by a dietary aide. -The resident consumed 100% of the meal. Interview on 12/6/17 at 3:30 pm with Resident #6 revealed: -She was not aware that she had a diagnosis of diabetes. -She was not served a different diet than any of the other residents. -She received the same amount of dessert as other residents and drinks were never unsweetened. Interview on 12/6/17 at 9:40 am and 12:20 pm with the fill-in Cook revealed: -This was her first day working in the kitchen as the cook because the Dietary Manager (DM) was off work. -She had received training from the current DM for 2 weeks in November 2017. -She was not aware of a therapeutic diet list and all residents received the same meal for lunch. -The dessert for the lunch meal was instant banana pudding. -All residents were served water and tea sweetened with pure sugar. -She was not aware residents ordered LCS diets were to receive a smaller portion of desserts. -She was unaware residents ordered LCS diets were to receive a diet beverage.	D 310		

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D 310	Continued From page 9 Interview on 12/7/17 at 8:45 am with the DM revealed: -He had been the DM for 4 months. -He was aware of the difference in the regular diet and the LCS diet. -When he served the meals, he served residents on the LCS diet a smaller portion. -He served beverages sweetened with sugar because he did not have any sugar substitute. -He had requested sugar substitute packets and sugar free foods from the administrator a while ago but never received them. -The Administrator was responsible for ordering food for the kitchen. Interview on 12/7/17 at 10:12 am with the Registered Dietician (RD) revealed: -She was the RD who reviewed the facility's menus twice per year. -She last reviewed a LCS and Regular menu for the facility in August 2017. -The LCS diet included a smaller portion of dessert and sugar free drinks. -The regular diet menu could not be used in place of the LCS diet. Interview on 12/7/17 at 10:12 am with Primary Care Physician (PCP) revealed: -He was the physician for Residents #1, #4, and # 6. -He expected residents to be served the diets as he ordered them. -If facility could not comply with diet he should have been notified so blood sugars could be reviewed and medications could be adjusted if needed. -If residents received a regular diet instead of a LCS diet, it may cause there blood sugars to elevate.	D 310		

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D 310	Continued From page 10 Interview on 12/7/17 at 10:20 am with the facility Administrator revealed: -She had been the administrator for 9 months. -She was aware Residents #1, #4, and #6 were to receive a LCS, but was not aware of how it differed from a regular diet. -She expected the DM to ensure the residents ordered a LCS diet received their meals according to the menu. -She was responsible for ordering the food, but could not remember if the DM requested she purchase a sugar substitute. -She would purchase sugar substitutes for residents who were to follow a LCS diet.	D 310		