STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(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 New Hanover County Department of Social Services conducted an annual survey and complaint investigation on 09/09/15, 09/10/15 and 09/11/15. Complaint investigations were initiated by the County Department of Social Services on 09/01/15.	D 000		
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 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 B VIOLATION Based on observations, interviews, and record review,s the facility failed to implement orders of for 1 of 6 residents sampled (#3) for a nutritional supplement for a resident who refused meals and had a documented history of weight loss. The findings are: Review of Resident #3's current FL-2 dated 06/15/15 revealed: -Diagnoses included bi-polar disorder, diabetes mellitus, multi-infarct dementia, encephalopathy, and Parkinson's Disease. -Resident #3 required the care and supervision of	D 276	Cedar Cove's Resident Care Coordinator (RCC) will provide additional training to the medication technicians (med techs) responsible for the transcription of orders to ensure medication orders / physician orders are accurately and completely transferred to the Medication Administration Record (MARs). Additionally, the training will also include instruction on ensuring the narrative / instructions on the MARs are implemented. Cedar Cove will centralize the responsibility of physician orders with the RCC. The RCC will be responsible for ensuring all physician orders are properly transcribed and implemented. The Plan of Correction will be implemented on October 26, 2015.	

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D 276	Continued From page 1 special care unit. Review of the Resident Registry revealed Resident #3 was admitted to the facility on 10/06/03. Observation and interview with Resident #3 at 12:05 p.m. on 09/09/15 revealed: -Resident was alert and oriented. -Resident was in a wheelchair. -Resident was neatly groomed. -Resident self-propelled her wheelchair by shuffling her feet down the hall from the dining area of the special care unit to her room. -Resident #3 had not eaten lunch; "I'm not particularly fond of chicken." -Resident skipped meals "sometimes." Review of the Physician Order Sheet signed by the prescribing provider on 0 6/26/15 revealed an order for "Give 4 oz. Med Pass by mouth three times daily." (Med Pass is a nutritional supplement designed to be used when administering medications to supplement calories and protein). Review of Resident #3's July 2015 Medication Administration Records (MARs) revealed no entry for Med Pass nutritional supplement and no documentation Med Pass was administered to Resident #3 in July 2015. Review of Resident #3's August 2015 MARs revealed no entry for Med Pass nutritional supplement and no documentation Med Pass was administered to Resident #3 in August 2015. Review of Resident #3's September 2015 MARs on 09/09/15 revealed no entry for Med Pass nutritional supplement and no documentation	D 276		

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D 276	Continued From page 2 Med Pass was administered to Resident #3 from 09/01/15-09/09/15. Interview with the Resident Care Coordinator (RCC) on 09/09/15 at 4:35 p.m. revealed: -Orders for nutritional supplements come from a licensed prescribing provider. -Orders for nutritional supplements are found on the MARs. -The Medication Aide (MA) on duty is responsible for transcribing provider orders to the MARs. -The MA on duty is responsible for making a copy of the orders for the RCC. -The RCC is responsible for verifying the orders. -Orders for nutritional supplements are faxed to the pharmacy by the RCC or MA on duty. -Upon receipt from the pharmacy, the monthly MARs are checked for accuracy and discrepancy. -The MAs are responsible for checking the monthly MARs. -The MA or RCC notified the pharmacy of MAR discrepancies. -Resident #3 had a history of weight loss. -The RCC did not know why Resident #3 's July, August, or September 2015 MARs did not contain an entry for Med Pass nutritional supplement. -The RCC did not know if Resident #3 had been receiving Med Pass nutritional supplement. -The RCC would check Resident #3's thinned record for provider orders for Med Pass. Interview with Resident #3's Power of Attorney (POA) on 09/10/15 at 8:236 a.m. revealed: -Resident #3 had "lost a lot of weight." -The facility notified the POA that Resident #3 had lost weight. -Resident #3's weight had been "pretty stationary" at "between 104 and 108 (pounds) the last few months." -Resident #3 had told the POA that she did not	D 276		

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D 276	Continued From page 3 eat sometimes. -Resident #3 had told the POA that she did not have a good appetite. -Resident #3 complained to the POA of frequent diarrhea. -Resident #3's physician was aware of her weight loss. -Resident #3 had received nutritional supplements in the past. -Resident #3 was not currently receiving nutritional supplements. Interview with the Executive Director (ED) on 09/10/15 at 9:05 a.m. revealed: -The ED did not know if Resident #3 had been receiving Med Pass nutritional supplement. -The ED would check Resident #3's orders for Med Pass, -Med Pass should be documented on Resident #3's MAR if she had been receiving the supplement. Interview with a Medication Aide (MA) on 09/10/15 at 9:16 a.m. revealed: -It was facility procedure for orders for nutritional supplements to be included on the MARs. -Provider orders are faxed to the pharmacy, transcribed to the MARs, and copied for the RCC. -MAs are responsible for transcribing orders to the MARs. -The MA did not know if Resident #3 received Med Pass nutritional supplement. Interview with a Resident Care Assistant/Nurse Aide (RCA/NA) on 09/10/15 at 11:00 a.m. revealed: -Orders for Med Pass supplement were written on the MARs. -MAs administered Med Pass and documented on the MARs.	D 276		

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D 276	Continued From page 4 -The RCA/NA was not sure if Resident #3 received Med Pass nutritional supplement. -The RCA/NA was not sure if Resident #3 had lost weight. Interview with another MA on 09/10/15 at 11:07 a.m. revealed: -Resident #3 ate "in spurts." -Resident #3 "sometimes" would not eat her meals but would eat snacks. -The MA was not aware of Resident #3 having weight loss. -Orders for nutritional supplements are found on the MARs. -The MA referred to Resident #3's September 2015 MARs which included a handwritten entry for Med Pass three times a day with scheduled administration times of 8:00 a.m., 12:00 p.m., and 8:00 p.m. beginning on 09/10/15. Additional interview with Resident #3 on 09/11/15 at 08:55 a.m. revealed: -Resident #3 had lost weight. -"I remember my clothes were large but I cannot tell you the time frame." -Resident #3's POA had to bring her more clothes "that fit." -Resident #3 had not eaten breakfast that morning. -Resident #3 received a nutritional supplement the previous night and earlier that day. -Resident #3 did not recall receiving the supplement prior to that. Interview with the Memory Care Coordinator (MCC) on 09/11/15 at 9:07 a.m. revealed: -On occasion, Resident #3 refused to eat and complained of diarrhea. -Resident #3 didn't eat when she had complaints about her stomach.	D 276		

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D 276	Continued From page 5 -Resident #3 did not have a recent history of weight loss. -The MCC was aware Resident #3 had not eaten breakfast that morning and was going to get her a sandwich from the kitchen. -Resident #3 started receiving Med Pass nutritional supplement three times daily on the previous day (09/10/15). Review of the 2015 Monthly Weight Record for Resident #3 on 09/09/15 revealed: -January 2015: Weight documented as 116 lbs. (pounds). -February 2015: Weight documented as 115.2 lbs. -March 2015: Weight documented as 113.8 lbs. -April 2015: Weight documented as 115 lbs. -May 2015: Weight documented as 104.9 lbs. -June 2015: Weight documented as 105.8 lbs. -July 2015: Weight document as 105 lbs. -August 2015: Weight documented as 107 lbs. -September 2015: Weight documented as 105 lbs. Interview with the RCC on 09/09/15 at 4:35 p.m. revealed: -It was facility procedure to weigh each resident monthly or per provider orders. -It was facility policy to notify the provider any time a resident lost 5 pounds or more during a one month time frame. Interview with the Executive Director (ED) on 09/10/15 at 9:05 a.m. revealed: -Resident #3 had a history of weight loss. -Resident #3's brother had passed away in "April or May" of 2015 and the facility had monitored her weight loss more closely during that time. Review of Resident #3's record on 09/11/15	D 276		

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D 276	Continued From page 6 revealed: -A "Resident Weight Loss/Gain MD Notification" form dated 10/23/14 documenting that Resident #3 had lost 25 pounds in 6 months. -Documentation by the contracted hospice provider dated 03/29/15 that Resident #3's brother had passed away on 03/29/15. -No additional documentation that Resident #3's weight had been measured or monitored more than once monthly. Review of Resident #3's thinned record on 09/11/15 revealed: -A second "Resident Weight Loss/Gain MD Notification" form dated 11/06/14 documenting Resident #3 had lost 25 pounds in 6 months. -No additional documentation that Resident #3's weight loss had been measured or monitored more than once monthly. Review of Resident #3's annual Assessment and Plans of Care dated 07/14/15 and 08/21/14 revealed no documentation about Resident #3's weight loss. Review of the "Resident Profile/Care Plan 90-Day Review" form revealed: -Documentation stating "I certify that at this time the residents Profile/Care Plan is current and accurate, reflecting the status of the Care Plan dated 08/21/14." -The RCC signed the 90-Day Review form on 09/3014, 12/31/14, 03/31/15, and 06/30/15 documenting no change in Resident #3's profile or plan of care. Observation of Resident #3, the RCC, and the MCC on 09/11/15 at 4:05 p.m. revealed: -Resident #3 was weighed by the MCC and RCC, at the request of the surveyor.	D 276		

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D 276	Continued From page 7 -Resident #3 was weighed using a wheel chair scale. -Resident #3's weight measured 101.8 lbs. while sitting in her wheelchair. -Resident #3 was then assisted by the MCC to stand on the scale for weight measurement. -Resident #3's standing weight was 101.8 lbs. Interview with the RCC on 09/11/15 at 4:07 p.m. revealed: -Resident #3 had been weighed earlier in September between the dates of 09/01/15 and 09/09/15. -It was facility procedure to measure and document each resident's weight by the 10th day of each month. -The RCC did not know the exact date between 09/01/15 and 09/09/15 that Resident #3 was weighed. -The RCC did not know which staff member weighed Resident #3 between 09/01/15 and 09/09/15. -The RCC did not know which staff member documented the weight of Resident #3 on to the "Monthly Weight Record"form between 09/01/15 and 09/09/15. -The RCC acknowledged Resident #3 had lost weight from the time she was weighed earlier in September 2015 and the time she was re-weighed on 09/11/15. Interview with the ED on 09/10/15 revealed: -No additional provider orders were found in Resident #3's thinned record which discontinued Resident #3's Med Pass nutritional supplement. -The physician's order sheet signed by the provider and dated 06/26/15 for Med Pass had not been transcribed on to Resident #3's MARs. -The ED provided a typed written plan of correction dated 09/10/15 and signed by the ED	D 276		

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D 276	Continued From page 8 and RCC to document the steps for correction of the "medication error." -The facility had contacted the MA responsible for order transcription by telephone because she was not scheduled to work on 09/10/15. -The MA responsible would receive additional training immediately. -The nutritional supplement would be implemented for Resident #3 immediately. Telephone interview with a Pharmacist from the facility's contracted outside pharmacy on 09/11/15 at 2:20 p.m. revealed: -Resident #3 had an order on the Physician's Order Sheet signed by a licensed provider and dated 06/26/15 for Med Pass 3 times daily. -Resident #3 had a provider order dated 01/05/15 for Med Pass 3 times daily which originated the order for Med Pass 3 times daily which printed on the Physician Order Sheet in June 2015 for renewal. -The original Med Pass order dated 01/05/15 was not available for electronic download by the pharmacist during the time of the telephone interview on 09/11/15. -The original Med Pass order dated 01/05/15 was stored in the pharmacy "attic" and could be located for review but it would not be possible for the pharmacy to complete the task on 09/11/15. Interview with the facility Administrator on 09/11/15 at 3:50 p.m. revealed: -Resident #3 had a history of weight loss, but her weight had stabilized over the last several months. -Resident #3's brother had passed away earlier in the year which could have been contributory to her weight loss. -The provider orders for Med Pass for Resident #3 had been "missed."	D 276		

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D 276	Continued From page 9 Telephone interview with Resident #3's primary physician on 09/10/15 at 10:25 a.m. revealed: -The physician was aware of Resident #3's weight loss. -The physician was not aware that Resident #3 was not getting Med Pass nutritional supplement. -The physician recalled being notified previously by the facility when Resident #3 had refused her medications. -The physician expected to be notified by the facility if Med Pass was not being given or Resident #3 had refused Med Pass. -The physician did not recall ever being notified by the facility regarding Resident #3's refusal of Med Pass nutritional supplement. Review of the Plan of Protection dated 09/11/15 revealed the facility will: -Provide additional training to the Medication Aide responsible for transcription of orders to ensure medication orders from the allocated Medication Administration Record (MARS) blocks and the narrative section of the MARS are implemented. -The dietary supplement was implemented for Resident #3 on 09/10/15. -The facility will centralize responsibility of physician orders to the Resident Care Coordinator (RCC). -The RCC will be responsible for ensuring all physician orders are transcribed and implemented. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2015.	D 276		

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D 310	Continued From page 10	D 310		
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: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure mechanical soft diet was prepared as ordered for 1 of 1 Residents (#5) with an order for mechanical soft diet. The findings are: Review of Resident #5's FL-2 dated 07/01/15 revealed: - Diagnoses of Parkinson's disease, dementia (stable), and gastroesophageal reflux disease (GERD). -The resident's diet order diet order was mechanical soft and no added salt diet. Review of Resident Register revealed Resident #5 was admitted to the facility (on the memory care unit) on 07/01/15. Review of Resident #5's "Admission Assessment" completed on 07/01/15 revealed the type/consistency of diet was no added salt /mechanical soft.	D 310	Cedar Cove's RCC and Dietary Manager will supervise and inspect meal preparation and service. The RCC will create a schedule of all special diet orders. A copy of the special diet schedule will be provided to the Dietary Manager. The RCC will create individual diet cards for each resident. All dietary staff will be trained on special diet orders and card system. The Plan of Correction will be implemented on October 26, 2015.	

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D 310	Continued From page 11 Review of the facility's current list of residents who were on therapeutic diets revealed Resident #5 was not listed on the list. Observation of lunch meal on the memory care unit on 9/10/15 at 12:00 noon revealed: - Resident #5 was served a slice of ham, peas and carrots, cornbread dressing, pineapple chunks, a roll, tea and water. - The resident ate about ½ of the slice of ham without coughing or choking. Review of the facility's mechanical soft menu, dated 9/10/15, (lunch menu)revealed ground ham, peas and carrots, sliced beets, wheat roll/bread, margerine, forest pears, milk and beverage of choice. Interview with Resident #5 on 9/10/15 at 12:25pm revealed: - The facility has never served meals with ground or chopped meats or other foods. - The resident has never choked or coughed while eating. - The resident was not aware of her ordered diet. Staff interview with a 1st shift nursing assistant on 9/10/15 at 12:40pm revealed: - Resident #5 usually eats well and feeds herself. - The resident has never choked or coughed while eating. - The resident's food (including meats) has never been served ground or chopped. Interview with the facility's Dietary Manager on 9/11/15 at 10:05am revealed: - There was not a therapeutic diet spreadsheet (menu) available in the kitchen.	D 310		

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D 310	Continued From page 12 - A copy of all resident's current diet orders were kept in a notebook in the kitchen. - The Dietary Manager "thought" Resident #5 was ordered a regular diet. - Resident #5 was ordered a mechanical soft diet (after reviewing a copy of a current diet order in the notebook in the kitchen). - Resident #5 has always been served meats which were not grounded or chopped. - The resident has never complained about her diet/food. - The resident will be served a mechanical soft diet from now on. - The therapeutic spread sheet was "probably" in the Administrator's office. Interview with the facility's Administrator on 9/11/15 at 10:20am revealed: - The Administrator was not aware Resident #5's meals were not being prepared according to the ordered diet (mechanical soft). - The current Dietary Manager has worked in food service for many years and "knows everything about preparing diets" for residents. - The therapeutic diet spreadsheets were available in the facility but not kept in the kitchen. - The Administrator will assure all residents' diet cards in the kitchen will be updated with the current ordered diet. - The therapeutic menus will be available in a notebook and kept in the kitchen for use by the dietary staff. _____ According to the facility's Plan of Protection dated 9/24/15: - The Administrator and Executive Director verbally communicated to dietary staff the protocol for each type of special diet on 9/24/15.	D 310		

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D 310	Continued From page 13 - RCC [Resident Care Coordinator] and Dietary Manager will supervise and inspect meal preparation and service. - RCC will create a schedule of all special diet orders. - RCC will provide a copy of the schedule to the Dietary Manager. - RCC will create individual diet cards for each resident. - All dietary staff will be trained on special diet orders and card system. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2015.	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 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 assure medications (Divalproex Sodium and Miralax) were administered as ordered for 3 of 7 residents (Residents #9, #10, and #11) observed. The findings are: The medication pass error rate was 8% as evidenced by 3 errors out of 34 opportunities observed during the 4:00pm medication pass on	D 358	Cedar Cove will provide training to med techs on how to ensure proper administration of medications in accordance with the written narrative on the MARs. The RCC will randomly supervise the administration of medications by the med techs to gauge compliance. The Plan of Correction will be implemented on October 26, 2015.	

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	HAL065035	A. BUILDING: _____ B. WING _____	09/11/2015

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D 358	Continued From page 14 09/09/2015 and the 8:00am medication pass on 09/10/2015. 1. Observation of the medication pass on 09/09/2015 at 4:15pm revealed: -The Medication Aide (MA) administered Resident #9 Divalproex Sodium (used to treat seizures and the manic phase of bipolar disorder) 125mg two tablets at 4:15pm with water. -The MA did not offer Resident #9 any food with the medication. Interview with the MA on 09/09/2015 at 4:15pm revealed supper would be served at 5:30pm. Interview with Resident #9 on 09/09/2015 at 4:20pm revealed: -Resident #9 was not ever given food when her medications were administered. -Resident #9 ate supper at 6:00pm. Review of Resident #9's current FL-2 dated 07/06/2015 revealed: -Diagnoses included personality changes, mild mental retardation, and cannibas dependence. -A physician's order for Divalproex Sodium 125mg take two capsules (250mg) everyday with supper. Review of September 2015 Medication Administration Records (MARs) for Resident #9 revealed: -Printed instructions for Divalproex cap 125mg take 2 capsules (=250mg) once daily with supper ** may open and sprinkle on small amount of food **. -The scheduled time of administration for the Divalproex Sodium was 5pm. Interview with the MA on 09/09/2015 at 5:00pm	D 358		

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D 358	Continued From page 15 revealed: -The MA usually administered medications scheduled to be administered with food 30 minutes before the resident went to the dining room for a meal. -If an order states to sprinkle the medication over food, the MA would sprinkle the medication over the resident's food before the plate was delivered to the resident. -The MA was not aware of the order for Resident #9 to be administered the Divalproex Sodium with food. -The MA had always been administering the Divalproex Sodium at 5:00pm. Observation of Resident #9 on 09/09/2015 at 5:15pm revealed Resident #9 was outside smoking. Interview with Resident #9 on 09/09/2015 at 5:15pm revealed Resident #9 had not eaten supper yet because it was not time. Observation of the facility dining room on 09/09/2015 at 5:30pm revealed: -The entrance door to the dining room was closed. -The lights were off in the dining room. -Resident #9 was not in the dining room eating her supper meal. Interview with the Administrator on 09/10/2015 at 2:30pm revealed: -The Administrator had contacted the Physician and the Pharmacist. -The Divalproex Sodium did not need to be given with food and Resident #9 had no digestive issues. -The intent of the physician's order for the Divalproex Sodium was to ensure Resident #9	D 358		

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D 358	Continued From page 16 took her medications. -Resident #9 had a personality disorder. Review of a clarification order dated 09/11/2015 for Resident #9 revealed the facility sent a clarification order to the physician on 09/10/2015 as follows: "Resident order has Depakote 125mg sprinkle cap take 2 caps = 250mg by mouth once daily with supper may open and sprinkle on small amount of food. May the order say Depakote 125mg take 2 caps to equal 250mg by mouth at 5pm." The physician returned a response of "yes" on 09/11/2015. The physician was not available for interview on 09/11/2015 at 10:45am. No return call was received from the physician. 2. Observation of the medication pass on 09/10/2015 at 8:24am in the Special Care Unit of the facility revealed: -The Medication Aide (MA) administered to Resident #10 a total of 9 pills with a cup of water. -The MA did not prepare and administer to Resident #10 any Miralax Powder mixed in water or a beverage of any kind. Review of Resident #10's current FL-2 dated 04/23/2015 revealed: -Diagnoses included Multi-infarct dementia, vascular dementia with delirium, and dermatophytosis of scalp and beard. -A physician's order for Miralax (used to treat constipation) Powder one capful with 8 ounces of water every day. Review of physician orders for Resident #10 revealed: -A Physician's Order sheet for Resident #10 dated 06/01/2015 with an order for Miralax	D 358		

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D 358	Continued From page 17 Powder mix one capful (17 grams) with 8 ounces of water and drink by mouth once a day. -No additional subsequent orders. Review of September 2015 Medication Administration Records (MARs) for Resident #10 revealed: -Printed instructions for Polyeth Glyc Pow 3350 NF (for Miralax) mix one capful (=17 grams) with 8 ounces of water and drink by mouth once a day. -The Miralax was scheduled for administration at 9:00am. Interview with the MA on 09/10/2015 at 9:55am revealed: -The MA had not administered the Miralax to Resident #10 on 09/10/2015. -The Miralax used to be ordered on an as needed basis for Resident #10 and asked if the Miralax was a "prn" (as needed) for Resident #10. -The MA was going to go back and administer the Miralax to Resident #10 but forgot until she (MA) was reminded by the surveyor. -The MA had signed the MAR, but had not prepared the Miralax until reminded by the surveyor. -The MA was going to administer the Miralax when shen went down the hall with the medication cart. Observation of the MA on 09/10/2015 at 10:05am revealed the MA administered the Miralax mixed in 8 ounces of water to Resident #10 in the dayroom. 3. Observation of the medication pass on 09/10/2015 at 8:35am in the Special Care Unit of the facility revealed: -The Medication Aide (MA) administered to	D 358		

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D 358	Continued From page 18 Resident #11 a total of 13 pills with a cup of water. -The MA did not prepare and administer to Resident #11 any Miralax Powder mixed in water or a beverage of any kind. Review of Resident #11's current FL-2 dated 02/10/2015 revealed diagnoses included alzheimer ' s, seizure, bladder retention, cholesterol, high blood pressure, hemorrhoids, and history of rectal prolapse. Review of physician orders for Resident #11 revealed: -A Physician's Order sheet for Resident #11 dated 06/01/2015 with an order for Miralax Powder mix one capful (17 grams) with 8 ounces of water and drink by mouth once a day. -No additional subsequent orders. Review of September 2015 Medication Administration Records (MARs) for Resident #11 revealed: -Printed instructions for Polyeth Glyc Pow 3350 NF (for Miralax) mix one capful (=17 grams) with 8 ounces of water and drink by mouth once a day. -The Miralax was scheduled for administration at 9:00am. Interview with the MA on 09/10/2015 at 9:35am revealed: -The MA had not administered the Miralax to Resident #11 on 09/10/2015. -The MA was going to go back and administer the Miralax to Resident #11 but forgot until she (MA) was reminded by the surveyor. -The MA had signed the MAR, but had not prepared the Miralax until reminded by the surveyor.	D 358		

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D 358	Continued From page 19 -The MA was going to administer the Miralax when shen went down the hall with the medication cart. Observation of the MA on 09/10/2015 at 10:15am revealed the MA administered the Miralax mixed in 8 ounces of water to Resident #11 in the dayroom.	D 358		
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 observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to implementation of orders of prescribing provider for nutrtional supplement. The findings are: 1. Based on observations, interviews, and record review,s the facility failed to implement orders of for 1 of 6 residents sampled (#3) for a nutritional supplement for a resident who refused meals and had a documented history of weight loss. [Tag 276, 10A NCAC 13F .0902(c)(3)(4) Health Care (Type B Violation)]. 2. Based on observation, interview and record	D912	The Plans of Correction previously listed in the document are intended to ensure Cedar Cove is compliant with the Declaration of Resident Rights by October 26, 2015.	

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D912	Continued From page 20 review, the facility failed to assure mechanical soft diet was prepared as ordered for 1 of 1 Residents (#5) with an order for mechanical soft diet. [Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)].	D912		