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	HAL013042	A. BUILDING: _____ B. WING _____	12/07/2017

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THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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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		
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		

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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

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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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-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

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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		

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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		

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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		