STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 conducted an annual and follow-up survey on March 7 - 9, 2018 with an exit conference via telephone on March 12, 2018.	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: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 2 of 5 sampled residents (#1, and #2) by failing to coordinate a urologist physician visit referral for a resident (#1) with a documented history of urinary infections, urinary retention with an indwelling foley catheter and for failing to coordinate a follow-up appointment with the Infectious Disease physician for Resident #1 in regard to antibiotic treatment; by failing to coordinate a gastroenterologist referral appointment for a resident (#2) with a documented history of dysphagia and gastroesophageal reflux disease (GERD), and failing to coordinate a basic metabolic panel (BMP) to evaluate his potassium level and kidney function as recommended by several quarterly pharmacist reviews. The findings are:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

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OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 1	D 273		

1. a. Observation on 3/7/18 during the initial tour between 9:15am and 10:30am revealed:
-Resident #1 was sitting in a wheelchair; he used both hands to maneuver the wheelchair down the hall.
-Under the wheelchair a foley catheter tubing was dangling across the bottom of the wheelchair between the wheels.
-The foley catheter tubing was dragging on the floor and had a whitish thick substance in the catheter tubing.

Review of Resident #1's current FL-2 dated 5/12/17 revealed:
-Diagnoses included benign prostatic hyperplasia (BPH), mental retardation, alcohol abuse, schizoaffective disorder and anxiety.
-Resident #1 was intermittently disoriented.
-Resident #1 was semi-ambulatory and used a wheelchair.
-Extensive personal care documented included bathing, feeding, and dressing.

Review of Resident #1's care plan dated 5/19/17 revealed:
-Resident #1 required total assistance with bathing, grooming and toileting.
-Resident #1 required extensive assistance with ambulation, dressing, grooming, and transfers.

Review of a discharge summary from a local hospital for Resident #1 dated 11/27/17 revealed:
-Resident #1 was admitted to the hospital on 11/22/17.
-Resident #1 was admitted through the emergency room with a diagnosis of complicated urinary tract infection (UTI).
-Resident #1 had a urine culture obtained which was positive for Escherichia coli (a bacterial infection) and Morganella (a gram negative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 2	D 273		

bacterial infection).
-There was documentation the complicated UTI was due to Resident #1's indwelling foley catheter.
-Resident #1 received intravenous antibiotic Rocephin (an antibiotic used to treat UTI) during the hospital stay.
-There was documentation a laboratory study was completed with an elevated white blood count of 17.1 (normal range 4.3-10.8) on admission.
-There was an order for Resident #1 to follow-up with the Urologist on 12/20/17.
-There was an order for home health services to provide foley catheter care monthly.
-Resident #1 was discharged back to the facility on 11/27/17.

Review of Resident #1's record revealed:
-There was a signed physician order dated 12/20/17 with documentation a new foley catheter had been placed by the Urologist.
-The ordered included a follow-up for a "recheck" with the Urologist in one month.

Review of the facility appointment calendar for January 2018 revealed:
-There was a physician appointment scheduled for Resident #1 for 1/17/18 at 11:00 am with the Urologist.
-There was an "X" mark made through the appointment on 1/17/18.
-There was a comment written on 1/17/18 "Rescheduled resident sick and not feeling well."
-There was no other documentation in January 2018 for Resident #1 on the appointment calendar.

Review of a second discharge summary from the local hospital for Resident #1 dated 1/31/18 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 3	D 273		

-Resident #1 was admitted to the hospital on 1/25/18 with diagnoses that included UTI and sepsis.
-Resident #1 was seen by the Urologist.
-There was documentation Resident #1 had been diagnosed with Escherichia coli and Extended Spectrum Beta Lactamases (a bacteria that is resistant to many antibiotics) UTI infection.
-There was documentation Resident #1 had an ultrasound of the left kidney which was abnormal.
-There was an order for a follow up appointment; Resident #1 required further testing and a MRI study was to be performed, contact the Urologist office to schedule.
-There was documentation the facility was to contact and set up an appointment for Resident #1 to have the MRI study in 1 or 2 days after discharged back to the facility.
-The discharge summary was electronically signed and dated by the physician on 1/31/18.

Review of the facility appointment calendar for February 2018 revealed:
-There was a physician appointment with the Urologist scheduled for Resident #1 on 2/6/18.
-There was an "X" documented through the appointment for 2/6/18.
-There was documentation on 2/6/18 "Canceled tried to contact office but office closed."

Telephone interview on 3/8/18 at 8:30am with Resident #1's Urologist office revealed:
-Resident #1 was seen in the Urologist office on 12/20/17 for a foley catheter change.
-Resident #1 was to be seen by the Urologist for foley catheter care monthly as well as the MRI order dated 1/31/18.
-Resident #1 missed three appointments; on 1/24/18, on 2/6/18 and another on 3/12/18 (the facility had already called the office and canceled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 4	D 273		

this appointment).
-Each time the facility contacted the Urologist office to cancel the appointment for Resident #1 the reason given was "due to transportation."
-The Urologist wanted to see Resident #1 monthly to change the foley catheter and to schedule an MRI for Resident #1.
-The Urologist office informed the facility they needed a "face to face" with the facility staff and Resident #1, due to Resident #1 was unable to lie still during the MRI and would need sedation.
-The facility canceled the appointment in January 2018 and in March 2018.
-Because the facility had not kept Resident #1 appointment the Urologist had to fax orders to the facility for the home health nurse to change the foley catheter on two occasions.
-Orders were faxed to the facility on 1/25/18 and on 3/5/18 for the home health agency to change Resident #1's foley catheter.
-"It is very important the facility provide transportation for [Resident #1] to the physician office".
-"The physician cannot treat and care for [Resident #1] if he does not come into the office."

Review on 3/8/18 of Resident #1's record revealed there were no orders dated 1/25/18 or 3/5/18 in the record from the Urologist.

Review of faxed documents for Resident #1 from the Urologist office revealed:
-An order dated 1/25/18, Resident #1 needed to have foley catheter changed, collect a urinalysis for culture, and send results to office.
-An order dated 3/5/18, Resident #1 needed to have foley catheter changed, collect a urinalysis for culture, and send results to office.
-A urinalysis completed on 3/7/18 with the results as follows: The color was documented as red, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 5	D 273		

clarity was documented as cloudy, there was documented large amount of blood, there was documented the white blood count was high 762 (normal range 0-5), there was documented the red blood count was high 4268 (normal range 0-5).
-The culture was not available for review.

Telephone interview on 3/8/18 at 9:44am with Resident #1's home health (HH) nurse revealed:
-She had started care for Resident #1 about 2 months ago.
-She knew Resident #1 had a foley catheter.
-She was aware Resident #1 had appointments with the Urologist.
-Resident #1 was in the hospital in January 2018 with UTI and sepsis.
-She had informed the facility Resident #1 was to follow-up with the Urologist office for an MRI ordered on 1/31/18 on the discharge instructions from the hospital.
-The staff person she had spoken to was the medication aide (MA) who was in charge of scheduling appointments for the residents.
-The HH nurse contacted the Urologist office on 2/14/18 to inform them Resident #1 had an order for an MRI and to please schedule.
-The office was to contact the facility when the appointment had been made.
-The office contacted her requiring a "face to face" with a facility representative and Resident #1 in reference to performing the MRI using sedation for Resident #.
-She had informed the facility again on 2/28/18 the Urologist needed to see the facility staff and Resident #1 in the office.
-The HH nurse was aware Resident #1 had missed three appointments, 2 with the Urologist and one with the infectious disease physician.
-She was not aware the facility had canceled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 6	D 273		

Resident #1's Urologist appointment for 3/12/18.
-On 2/28/18, she had instructed the facility on the importance of Resident #1 keeping the physician appointments.
-The facility contacted her on 3/7/18 with an order from the Urologist to change Resident #1's foley catheter, obtain a urinalysis for culture; and fax results to the Urologist office.
-She had completed the order and changed the foley catheter on 3/7/18.
-"There was a lot of thick whitish sediment in the foley bag and the tubing."
-She was not aware of the order in January 2018 to change Resident #1's foley catheter.

Review of home health notes for February 2018 revealed:
-A Skilled Nurse (SN) visit documented on 2/14/18 as follows; the SN spoke to the Urologist office, notified of the residents' need for the MRI post discharge order from hospital; the Urologist office staff stated she would schedule the MRI and would notify staff at ALF.
-Another SN visit documentation on 2/28/18 as follows; SN spoke to MA regarding Resident #1's appointments with the Urologist. An appointment was made for March 12, 2018 with the Urologist. The facility canceled 3 appointments for the resident in February 2018. Two appointments were for the Urologist and one with the Infectious Disease physician. All were canceled "due to unable to arrange transportation." The SN spoke with the Urologist office regarding the importance of caregiver's instructions "on importance of making appointments." The resident and caregivers (staff) verbalized understanding.

Review of Resident #1's results from the urine culture dated 3/7/18 revealed:
-Resident #1's urine culture grew 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 7	D 273		

Staphylococcus aureus and gram negative rod organisms 2. Staphylococcus aureus and morganella morganii organisms.
-Panic results were documented, "staph aureus is a multi-resistant organism; infection control precautions must be taken."
-The Urologist had written on the culture, "Cipro 500 mg 2 times daily for 7 days, Bactrim DS take one tablet for 14 days; then change catheter and re-culture.

b. Review of the discharge summary from the local hospital for Resident #1 dated 1/31/18 revealed:
-Resident #1 was admitted to the hospital on 1/25/18 with diagnoses that included UTI and sepsis.
-Resident #1 was seen by the Infectious Disease physician.
-There was documentation Resident #1 had been diagnosed with Escherichia coli and Extended Spectrum Beta Lactamases (a bacteria that is resistant to many antibiotics) UTI infection.
-The discharge summary was electronically signed and dated by the physician on 1/31/18.

Telephone interview on 3/13/18 at 9:15am with the Infectious Disease physician's staff revealed:
-Resident #1 had an appointment on 2/12/18 for a follow-up appointment from the hospital discharge on 1/3/18.
-The follow-up appointment was related to continued antibiotic treatment for the UTI and sepsis.
-The resident was a no call no show.
-"It is very important the facility brings [Resident #1] to the appointment; the Infectious Disease physician is in-charge of his antibiotic treatment."
-The facility contacted the office on 2/28/18 to reschedule the appointment for Resident #1, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 8	D 273		

"they refused to bring [Resident #1] in sooner that 3/26/18."
-There were staff available at the physician's office to assist a resident in a wheelchair out of the car and into the office, if they required help.
-"When a patient missed an appointment, we rescheduled the appointment on the following week, that's how important the continued antibiotic treatments are."
-Resident #1 had a "bad bacterial infection" in the hospital in January 2018, and was administered antibiotic during his hospitalization.
-Resident #1 was discharged to back to the facility on IM antibiotics.
-"Without keeping his [Resident #1] appointment, we do not have a laboratory finding to determine if the infection is improved or not."

Review of the facility appointment calendar for February 2018 revealed:
-There was a physician appointment with the Infectious Disease physician scheduled for Resident #1 on 2/12/18.
-There was an "X" documented through the appointment for 2/12/18.
-There was documentation on 2/12/18 "Canceled by office."

Review of home health notes for February 2018 revealed:
-A SN visit documentation on 2/28/18 the SN spoke to MA regarding Resident #1's appointment with the Infectious disease physician The SN documented the appointment was canceled "due to unable to arrange transportation. The SN documented she had spoken with the staff on the importance of keeping the appointments with the physician.

Interview on 3/8/18 at 10:10am with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 9	D 273		

medication aide (MA) revealed:
-Resident #1 had missed 2 physician appointments because "He was sick."
-One of the missed appointments was for the Infectious Disease physician.
-There were two vehicles available for transportation to use for transporting residents to the physician offices.
-Resident #1 was a two person assist, "we have only one person to transport the residents."

Interview on 3/8/18 at 11:00am with the facility transportation staff revealed:
-She was the only staff that transported residents to appointments.
-She had never transported Resident #1 to any physician visit.
-"The MA never ask me transport [Resident #1]."
-She was not aware Resident #1 had missed physician appointments, "It was not because of transportation he missed visits."

Interview on 3/8/18 at 11:50pm with Resident #1 revealed:
-"I know I had appointments, but they won't take me."
-He was not sure why the facility would not take him to the appointments, "I have never refused."

Interview on 3/8/18 at 12:10pm with the facility Director revealed:
-The MA was responsible for reviewing orders and making appointments for resident to be transported to physician office.
-She was aware Resident #1 had a follow-up appointments the Infectious Disease physician in February 2018.
-"He [Resident #1] refused to go; then ended up in the hospital a few days later."
-The facility van used for transportation did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 10	D 273		

have a lift for wheelchairs.
-The other private vehicle did not have a lift, but could be used for transportation Resident #1 to the physician office.

Interview on 3/8/18 at 12:10pm with the Administrator revealed:
-She relied on the Director to oversee the staff and the day to day operations in the facility.
-She knew Resident #1 had been in the hospital, but was not aware of the missed follow-up appointments.
-She relied on the Director to manage the facility, the staff, and provide the appropriate care in scheduling appointment with physician for the residents.

Review of the facility "Home policies & residents rights" documentation form in Resident #1's record revealed, "The Administrator or supervisor in charge will provide or arrange transportation to necessary medical appointments without charge."

2. a. Review of Resident #2's current FL-2 dated 7/7/17 revealed:
-Diagnoses included prostate cancer, gastroesophageal reflux disease (GERD), hyperlipidemia, anxiety, depression, and bipolar disorder.
-Resident #2 was intermittently disoriented.
-Resident #2 was semi-ambulatory and used a wheelchair.

Review of a physician order dated 1/20/18 revealed a gastroenterology (GI) referral appointment dated 1/25/18.

Review of the facility appointment calendar for the month of January 2018 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 11	D 273		

-There was a physician appointment scheduled for Resident #2 on 1/25/18 at 11:00am with the gastroenterologist.
-There was an "X" mark made through the appointment on 1/25/18.
-No explanation was documented in the appointment calendar.

Review of Resident #2's progress notes revealed there was no documented explanation as to why the GI referral was canceled.

Telephone interview on 3/08/18 at 4:30pm with the facility's nurse practitioner (NP) revealed:
-He referred Resident #2 to the gastroenterologist for dysphagia, GERD and swallowing difficulty as expressed by the resident.
-The facility scheduled the appointment for 1/25/18.
-He did not remember if the facility informed him Resident #2 did not go to the appointment.
-He did not know if the facility attempted to re-schedule the appointment.
-He believed the appointment was necessary.

Interview on 3/9/18 at 9:10am with the medication aide (MA) revealed:
-Resident #2 frequently refused appointments.
-He refused to go to the appointment on 1/25/18 because "he was much better."
-The appointment was for a sore throat-"he was spitting stuff up."
-She made a follow up appointment on 2/13/18 and he refused again.
-She was sure she contacted the physician's office at some point and canceled the appointment.
-She notified the NP of the canceled appointment. There was no documentation of the notification.
-The NP did not request the MA to schedule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 12 another appointment. Interview on 3/9/18 at 10:05am with the Executive Director (ED) revealed: -Resident #2 frequently refused appointments. -The MA scheduled all appointments. -She did not know if the NP was notified of the cancelation. It was the responsibility of the MA to inform the NP. -If a resident refused their appointments or treatments, the MA was responsible to notify the prescribing physician. -It was a resident's right to cancel appointments. Interview on 3/9/18 at 10:55 am with Resident #2 revealed: -His primary care provider was the NP who comes to the facility. -He had not seen a doctor in a long time. He was concerned because he had been diagnosed with atrial fibrillation. -He did have difficulty swallowing his food and medications, and had heartburn and bloating. -He told the MA he was feeling better but he never refused to go to any appointments. -The MA made the appointments. She informed the residents the morning of their appointments. -He was never told of an appointment to the GI physician and did not refuse to go. Interview on 3/9/18 at 11:20am with scheduler at the GI office revealed: -Resident #2 had not arrived for his appointment on 1/25/2018. -The facility had not called the office to give a reason for the missed appointment. -The facility had not rescheduled his appointment. Interview on 3/8/18 at 11:15am with the facility transportation staff revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 273	Continued From page 13 -She worked third shift as a personal care aide and was also responsible for transportation during the first shift. -There were two vehicles used for transportation one was a facility van and the other was a private vehicle, both were in running condition. -"The van is not wheelchair accessible, but if the resident can stand and turn we can get them in the van." -The private vehicle used for transportation did not have a lift, but would be used if residents could stand. -She was the only staff that transported residents to appointments. -She was not in charge of scheduling appointments; "The MA tells me who and where to go." b. Review of Resident #2's Consultant Pharmacist recommendations revealed: -A recommendation dated 2/3/17 to obtain a K+ level was unsigned by the NP. -A recommendations dated 9/8/17 to obtain a K+ level was unsigned by the NP. -A recommendations dated 12/15/17 to obtain a K+ level was unsigned by the NP. -A recommendation from the pharmacist during her quarterly review on 2/28/18 included a note recognizing a basic metabolic panel (BMP) which would identify the potassium level and kidney function for Resident #2 had not been performed to date. Interview on 3/9/18 at 9:10am with the MA revealed: -The NP had given a verbal order to the MA on 1/12/18 to make an appointment for Resident #2 to have a K+ level drawn. -There was no record of this order. -The MA had the responsibility to transcribe	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

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D 273	Continued From page 14	D 273		

verbal orders she received.
-The phlebotomist was scheduled to be at the facility on 1/15/18.
-The MA filled out the requisition slip and left it in the laboratory binder in the medication room.
-The phlebotomist reported she approached the resident and Resident #2 refused.
-The phlebotomist wrote refused at the top of the requisition slip.
-The NP was informed of the refusal and no further orders were given.

Review of Resident #2's laboratory blood work revealed the potassium levels were last drawn on 7/24/15 and were 3.8 mmol/L(therapeutic range is 3.6-5.0).

Review Resident #2's laboratory requisition on 3/9/18 revealed:
-A potassium blood level was requested to be drawn by the phlebotomist at the facility on 1/15/18.
-There was handwritten documentation, on the top of the requisition form, Resident #2 "refused".

Interview on 3/9/18 at 10:40am with the manager at the laboratory contracted by the facility revealed:
-There was no record at the laboratory for technicians to state the reason an order for a blood test was not completed.
-There was no documentation that Resident #2 had a K+ levels obtained at any time.
-If the resident refused or was not at the facility when the phlebotomist arrived, documentation would be at the top of the requisition form.

Telephone interview on 3/9/18 at 11:05am with the office manager of the laboratory facility contracted prior to December 2017 revealed, they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 15 had no record of Resident #2 having received any laboratory services from them. Telephone interview on 3/9/18 at 11:15am with home health office manager revealed: -The home health agency usually received all the referrals for services for the residents at this facility. -They had not received any orders from the facility for Resident #2. Interview on 3/9/18 at 10:35am with Resident #2 revealed: -He had not refused laboratory work from the phlebotomist. -He was not told that his NP had requested a blood test (basic metabolic panel) to review his potassium level and kidney function. -He does not remember any technician coming to his room for blood work. Interview on 3/8/18 at 4:40pm with the NP revealed: -He had given a verbal order to the MA on 1/12/18 to make an appointment for Resident #2 to have a K+ level drawn. -He did not remember if the facility notified him Resident #2 refused to have his blood drawn. -He ordered K+ levels to be drawn on residents prescribed lasix, a diuretic. (Frequent urination can result in an excessive loss of potassium causing hypokalemia.) -Resident #2 received lasix 20 milligrams (mg) every morning. -He believed the resident had the right to refuse treatment. The failure of the facility to meet the health care	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 16 needs for Resident #1 who missed follow-up appointments with the Urologist for foley catheter care, an MRI, and a follow-up appointment with the Infectious Disease physician in regards to a bacterial infection and the need for continued antibiotic treatment, and Resident #2 who had multiple reminders from the pharmacy consultant to obtain potassium levels through laboratory draws every 6 to 12 months, to determine if the resident was at risk for hypokalemia or hyperkalemia; the facility failed to meet the health care needs for Resident #2 by missing the gastroenterologist appointment recommended by his primary care physician regarding his swallowing difficulties and GERD, and failing to coordinate a basic metabolic panel (BMP) to evaluate his potassium level and kidney function as recommended by several quarterly pharmacist reviews. These failures by the facility placed multiple residents at substantial risk for serious medical harm or death, and constitutes a Type A2 Violation. _____ Review of the facility's Plan of Protection dated 3/8/18 revealed: -The Administrator shall assure referral and follow-up to meet the routine and acute health care needs of residents. -The MA called the Urologist office on 3/8/18 but the office was closed, the MA will call the Urologist office on Monday 3/12/18 and schedule the MRI for Resident #1. -The Administrator conducted a staff meeting 3/8/18 with the MA and the Director to discuss the importance of keeping scheduled appointments. -All rescheduled appointments will be approved by the Director before rescheduled. -If appointments are scheduled for after transportation hours, another staff member will be	D 273		

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D 273	Continued From page 17 utilized to transport. -The Administrator will monitor appointments to ensure all appointments are kept, weekly times 3 weeks, biweekly for 3 weeks, monthly for 3 months then quarterly thereafter to ensure compliance. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 11, 2017.	D 273		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (Resident #1, and #2) were provided transportation to scheduled physician's appointments in regard to Resident #1's Urologist appointment with a documented history of urinary	D 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 321	Continued From page 18	D 321		

infections, urinary retention, and an indwelling foley catheter, and the facility failed to provide transportation for Resident #1 to the Infectious Disease physician related to continued antibiotic treatments for a diagnoses that included bacterial urine infection and sepsis; the facility failed to provide transportation for Resident #2 to the Gastroenterologist physician with a documented history of dysphagia and gastroesophageal reflux disease.

The findings are:

1. Review of Resident #1's current FL2 dated 5/12/17 revealed:
-Diagnoses included benign prostatic hyperplasia (BPH), mental retardation, alcohol abuse, schizoaffective disorder and anxiety.
-Resident #1 was intermittently disoriented.
-The resident was semi-ambulatory and had a wheelchair.
-He required extensive personal care included bathing, feeding, and dressing.

Review of Resident #1's care plan dated 5/19/17 revealed:
-Resident #1 required total assistance with bathing, grooming and toileting.
-Resident #1 required extensive assistance with ambulation, dressing, grooming, and transfers.

Review of a discharge summary from a local hospital for Resident #1 dated 11/27/17 revealed:
-Resident #1 was admitted to the hospital on 11/22/17 and discharged back to the facility on 11/27/17.
-Resident #1 was admitted through the emergency room with a diagnosis of complicated urinary tract infection (UTI).
-There was an order for Resident #1 to follow-up

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D 321	Continued From page 19 with the Urologist on 12/20/17. Review of Resident #1's record revealed: -There was a signed physicians order dated 12/20/17 with documentation a new foley catheter had been placed by the Urologist. -The ordered included a follow-up for a "recheck" with the Urologist in one month. Review of the facility appointment book calendar for January 2018 revealed: -There was an appointment scheduled for Resident #1 for 1/17/18 at 11:00am with the Urologist. -There was an "X" made through the appointment on 1/17/18. -There was a comment written on 1/17/18 "Rescheduled Resident sick and not feeling well". -There was no other documentation in January 2018 for Resident #1 in the appointment book. Review of a second discharge summary from a local hospital for Resident #1 dated 1/31/18 revealed: -Resident #1 was admitted to the hospital on 1/25/18 with diagnoses that included UTI and sepsis. -Resident #1 was seen by the Infectious Disease physician and the Urologist. -An order for a follow up appointment with the Urologist in regard to further testing for a MRI study. -There was documentation the facility was to contact the Urologist office and set up an appointment time for Resident #1 to have the MRI study. -The discharge summary was electronically signed by the physician on 1/31/18. Review of the facility appointment calendar for	D 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 321	Continued From page 20	D 321		

February 2018 revealed:
-There were appointments scheduled for Resident #1 on 2/6/18 and 2/12/18.
-There was an "X" documented through the appointments for both days.
-There was documentation on 2/6/18 "Canceled tried to contact office but office closed".
-There was documentation on 2/12/18 "Canceled by office".
-There was no other documentation in February 2018 for Resident #1.

Telephone interview on 3/8/18 at 8:30am with Resident #1's Urologist's office revealed:
-Resident #1 was being followed by the Urologist for foley catheter care as well as the MRI ordered on 1/31/18.
-Resident #1 had missed three appointments; one on 1/24/18, two on 2/6/18 and 2/26/18, another 3/12/18 (the facility had already called the office and canceled this appointment).
-Each time the facility contacted the Urologist office to cancel the appointment the reason was "due to transportation".
-"It is very important the facility provide transportation to the physician office".
-"The physician cannot treat and care for the resident if does not come into the office."

Telephone interview on 3/8/18 at 9:44am with Resident #1's home health nurse revealed:
-She started service for Resident #1 in February 2018.
-She was aware Resident #1 had appointments with the Urologist and the Infectious Disease physician.
-She had informed the facility Resident #1 was to follow-up with the Urologist office for an MRI ordered on 1/31/18.
-She had spoken to the medication aide (MA)

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D 321	Continued From page 21	D 321		

who was in charge of scheduling appointments for the residents.
-She contacted the Urologist office on 2/14/18 informing them Resident #1 had an order for an MRI and to please schedule.
-She had informed the facility the Urologist needed to see a facility representative and Resident #1 in the office.
-She knew Resident #1 had missed three appointments, 2 with the Urologist and one with the Infectious Disease physician.
-She was not aware the facility had already called the Urologist office and canceled the appointment for Resident #1 on 3/12/18.
-The facility was responsible for providing transportation to the physician office for Resident #1.

Telephone interview on 3/13/18 at 9:15am with the Infectious Disease physician office revealed:
-Resident #1 had an appointment on 2/12/18 to see the infectious disease physician for a follow-up appointment from the hospital discharge on 1/3/18.
-The follow-up appointment was related to continued antibiotic treatment for the UTI and sepsis.
-The resident was a no call no show.
-"It is very important the facility brings the resident to the appointment, the infectious disease physician is in-charge of his antibiotic treatment."
-The facility contacted the office on 2/28/18 to reschedule the appointment for Resident #1, "they refused to bring [Resident #1] in sooner that 3/26/18."
-"When a resident missed an appointment we rescheduled the appointment on the following week, that's how important the continued antibiotic treatments are."
-Resident #1 had a "bad bacterial infection" in the

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OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D 321	Continued From page 22	D 321		

hospital in January 2018, and was administered antibiotic during his hospitalization.
-Resident #1 was discharged on 1/31/18 back to the facility on an intra-muscular injection of an antibiotics.
-"Without keeping his [Resident #1] appointment we do not have lab findings to determine if the infection is improved or not."

Interview on 3/8/18 at 10:10am with the medication aide (MA) revealed:
-She was responsible for scheduling appointments for the residents.
-She was responsible for reviewing new orders for residents and reviewing discharge summaries from the hospital.
-She knew Resident #1 had appointments with the Urologist and the Infectious Disease physician.
-Resident #1 had missed two physician's appointments because "He was sick."
-The two missed appointments were for the Urologist and the Infectious Disease physician.
-There were two vehicles available for transportation to use for transporting residents to the physician offices.
-Both the vehicles did not have a wheelchair lift, but if a resident could stand they could be transported.
-Resident #1 was a two person assist, we have only one person to transport the residents.
-The transportation staff did not keep a log of what residents were to be transported to the physician's office.

Interview on 3/8/18 at 11:00am with the facility transportation staff revealed:
-She worked third shift as a personal care aide and was also responsible for transportation during the first shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 321	Continued From page 23 -There were two vehicles used for transportation one was a facility van and the other was a private vehicle, both were in running condition. -"The van is not wheelchair accessible, but if the resident can stand and turn we can get them in the van." -The private vehicle used for transportation did not have a lift, but would be used if residents could stand. -She was the only staff that transported residents to appointments. -She had never transported Resident #1 to any physician visit. -She was not in charge of scheduling appointments; "The MA tells me who and where to go." -"The MA never ask me transport [Resident #1]." -She was not aware Resident #1 had missed physician appointments, "It was not because of transportation he missed visits." Interview on 3/8/18 at 3:10pm with a personal care aide (PCA) revealed: -She assisted Resident #1 to bed at night, the resident required two staff for transfer. -She had never assisted with transportation for Resident #1 to the physician office. Interview on 3/8/18 at 11:50pm with Resident #1 revealed: -"It's been awhile since I saw the doctor who takes care of my catheter." -"I know I had appointments, but they won't take me." -He was not sure why the facility would not take him to the appointments, "I have never refused." -"I know they have a van." -"I am not sure when the appointments were, but they [facility] should know."	D 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 321	Continued From page 24 Interview on 3/8/18 at 12:10pm with the facility Director revealed: -The MAs was responsible for reviewing orders and making appointments for residents to be transported to physician's office. -She was aware Resident #1 had follow-up appointments with the Urologist and the Infectious Disease physician in January 2018, February 2018 and March 2018. -"He [Resident #1] refused to go; then ended up in the hospital a few days later." -She did not know Resident #1 had an order on the discharge instructions dated 1/31/18 to schedule an MRI with the Urologist until 3/7/18 after the survey team had informed her of the MRI order. -She relied on the MAs to review the orders and make appointment for the residents. -There was no system in place to review the orders once the MA had reviewed the new orders. -The facility van used for transportation did not have a lift for wheelchairs. -The other private vehicle did not have a lift, but could be used for transportation for Resident #1 to go the physician's office. Interview on 3/8/18 at 12:10pm with the Administrator revealed: -She relied on the Director to oversee the staff and the day to day operations in the facility. -She was aware there was only 1 MA in the facility who was responsible for administering medications, scheduling appointments and providing treatment to residents in the facility. -She knew Resident #1 had been in the hospital, but was not aware of the missed follow-up appointments. -She knew the facility had two vehicles available for transportation for staff to use when transporting a resident to physician appointments.	D 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 321	Continued From page 25 -She knew neither facility transportation vehicles had a lift for wheelchair accessibility. -She relied on the Director manage the facility, the staff, and provide the appropriate care in scheduling appointments with physician's for the residents. Refer to review of the facility's Home Policies & Residents Rights documentation form. 2. Review of Resident #2's current FL2 dated 7/7/17 revealed: -Diagnoses included prostate cancer, gastroesophageal reflux disease (GERD), hyperlipidemia, anxiety, depression, and bipolar disorder. -Resident #2 was intermittently disoriented. -Resident #2 was semi-ambulatory and used a wheelchair. Review of a physician order dated 1/20/18 revealed a gastroenterology (GI) referral appointment dated 1/25/18. Review of the facility appointment book calendar for the month of January 2018 revealed: -There was a physician appointment scheduled for Resident #2 on 1/25/18 at 11:00am with the gastroenterologist. -There was an "X" mark made through the appointment on 1/25/18. -No explanation was documented in the appointment book. Review of Resident #2's progress notes revealed there was no documented explanation as to why the GI referral was canceled. Telephone interview on 3/08/18 at 4:30pm with	D 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

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D 321	Continued From page 26	D 321		

the facility's nurse practitioner (NP) revealed:
-He referred Resident #2 to the gastroenterologist for dysphagia, GERD and swallowing difficulty as expressed by the resident.
-The facility scheduled the appointment for 1/25/18.
-He did not remember if the facility informed him Resident #2 did not go to the appointment.
-He did not know if the facility attempted to re-schedule the appointment.

Interview on 3/9/18 at 9:10am with the medication aide (MA) revealed:
-Resident #2 frequently refused appointments.
-He refused to go to the appointment on 1/25/18 because "he was much better."
-The appointment was for a sore throat-"he was spitting stuff up."
-She made a follow up appointment on 2/13/18 and he refused again.
-She was sure she contacted the physician's office at some point and canceled the appointment.
-She notified the NP of the canceled appointment. There was no documentation of the notification.
-The NP did not request the MA to schedule another appointment.

Interview on 3/9/18 at 10:05am with the Executive Director (ED) revealed:
-Resident #2 frequently refused appointments.
-The MA scheduled all appointments.
-She did not know if the NP was notified of the cancelation. It was the responsibility of the MA to inform the NP.
-If a resident refused their appointments or treatments, the MA was responsible to notify the prescribing physician.
-It was a resident's right to cancel appointments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 321	Continued From page 27 Interview on 3/9/18 at 10:55 am with Resident #2 revealed: -His primary care provider was the NP who visits the facility. -He had not seen a doctor in a long time. He was concerned because he had been diagnosed with atrial fibrillation (an irregular heart beat). -He did have difficulty swallowing his food and medications, and had heartburn and bloating. -He told the MA he was feeling better, but he never refused to go to any appointments. -The MA made the appointments. She informed the residents the morning of their appointments. -He was never told of a GI appointment and he did not refuse to go. Interview on 3/9/18 at 11:20am with the scheduler at the GI office revealed: -Resident #2 did not arrive for his appointment on 1/25/2018. -The facility did not call to give a reason for the missed appointment. -The facility did not reschedule his appointment. Interview on 3/8/18 at 11:15am with the facility transportation staff revealed: -She worked third shift as a personal care aide and was also responsible for transportation during the first shift. -There were two vehicles used for transportation; one was a facility van and the other was a private vehicle. Both vehicles were in running condition. -"The van is not wheelchair accessible, but if the resident can stand and turn we can get them in the van." -The private vehicle used for transportation did not have a lift, but would be used if residents could stand. -She was the only staff person that transported residents to appointments.	D 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 321	Continued From page 28 -She was not in charge of scheduling appointments. "The MA tells me who I am to take and where to go." Refer to review of the facility's Home Policies & Residents Rights documentation form. Review of the facility "Home policies & residents rights" documentation form in Resident #1's record revealed, "The Administrator or supervisor in charge will provide or arrange transportation to necessary medical appointments without charge." Based on interviews and record reviews, the facility failed to ensure Resident #1, and #2 were provided transportation to scheduled physician's appointments in regard to Resident #1 Urologist appointment with a documented history of urinary infections, urinary retention, and a indwelling foley catheter, and the facility failed to provide transportation for Resident #1 to the Infectious Disease physician related to continued antibiotic treatments for diagnoses that included bacterial urine infection and sepsis; the facility failed to provide transportation for Resident #2 to the Gastrointestinal physician with a documented history of dysphagia and gastroesophageal reflux disease. These failures by the facility were detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 4/5/18 revealed: -The Administrator conducted a meeting with the Director and the MA to discuss Resident Rights to include transportation to and from doctor office	D 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 321	Continued From page 29 for appointments. -The Administrator and the Director will ensure that the rights of all residents are guaranteed. -The Administrator and the Director will monitor for compliance weekly times 3 weeks, biweekly for 3 weeks, monthly for 3 months then quarterly thereafter to ensure compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 26, 2018.	D 321		
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, record reviews and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 8 residents observed during a medication pass (#6 and #7) and 1 of 5 sampled residents (#2) regarding medications. The findings are: 1. Observation of the medication pass on 3/7/18	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 358	Continued From page 30 at 11:05am and on 3/8/18 at 7:30am revealed the medication error rate was 6% as evidenced by 2 errors out of 31 opportunities. a. Review of Resident #6's current FL2 dated 1/23/18 revealed: -Diagnoses included diabetes mellitus. -There was an order for Novolg insulin per sliding scale (a short acting injection to lower blood sugar.) -Sliding Scale parameters were not documented on the FL2. Review of Resident #6's subsequent physician orders dated 2/8/18 revealed: -Sliding scale parameters were: 100-149 = 2 units; 150-199 = 3 units; 200-249 = 4 units; 250-299 = 5 units; 300-349 = 6 units; 350-399 = 7 units; and greater than 400 units, notify the physician. -Fingerstick blood sugars were obtained 3 times a day at 7:30am,11:30am and 5:30pm. Observation of the medication pass on 3/7/18 at 11:00am revealed: -The blood sugar reading for Resident #6 was 205. -The medication aide (MA) removed a NovoFlex pen, containing Novolog insulin, from a box labeled with Resident 6's name, and administered 4 units of insulin. -The MA did not prime the NovoFlex pen for 2 units. Interview with MA on 3/7/18 at 11:15am revealed: -She did not know she had to prime the insulin pen before each injection. -She received diabetic training in May of 2017, the first week she began her job. -She did not recall the Registered Nurse (RN),	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 358	Continued From page 31	D 358		

who taught the diabetic training class, had mentioned priming the insulin pen.
-She did not know the pen was primed by expelling 2 units of insulin from the pen prior to the injection of insulin, removing air from the needle and cartridge of the pen.

Interview with the pharmacist on 3/9/18 at 11:30am revealed:
-The representative for the company manufacturing the NovoFlex pen instructed the pharmacists, at a recent in service, to prime the insulin pen with 2 units of insulin before insulin is administered. This ensures there is no air in the pen.
-The correct dosage of insulin would not be administered to the resident if there was air in the cartridge or needle of the pen.

Interview with the Director on 3/12/18 at 10:30am revealed:
-She did not know the MA was not priming the insulin pens before the insulin was administered.
-The Director was not sure she herself had been instructed regarding best practice for administering insulin with a NovoFlex pen.
-She was "in negotiations..." with the pharmacy to provide additional training to MAs.

b. Review of Resident #7's current FL2 dated 12/15/17 revealed:
-A physician's order for Novolin 70/30 (a medication used to decrease blood sugar), to be administered twice a day.
-There was no diagnosis of diabetes on the FL2.
-There was no time interval or dosage on the FL2.

Review of Resident #7's physician's order dated 2/28/18 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 358	Continued From page 32	D 358		

-Novolin 70/30, inject 25 units twice a day before meals.
-Blood sugars were to be obtained 4 times a day at 7:30am, 11:30am, 5:30pm and 8:00pm.

Observation of the medication pass on 3/7/18 at 11:30am revealed the MA prepared the Novolin 70/30 in the insulin syringe for 25 units and did not roll the insulin in the palm of her hands prior to drawing insulin into the syringe.

Telephone interview with the pharmacist on 3/9/18 at 12:00pm revealed:
-Novolin 70/30 is one of the insulin combinations required to be rolled gently between the palm of the hands before drawing up into the syringe.
-If not rolled, the heavier particles of insulin settle out and fall to the bottom of the vial, resulting in the resident not receiving the correct concentration of insulin.
-If insulin vial was shaken, air bubbles would be created and drawn in to the syringe, resulting in inaccurate dosing of insulin.

Interview with the MA on 3/7/18 at 11:45am revealed:
-The MA would usually "shake" the Novolin 70/30 before drawing the insulin from the vial to the syringe.
-She did not shake the insulin vial this time because she was nervous.
-She was not aware the insulin needed to be "rolled gently" in the palm of her hands.
-She was not aware shaking the Novolin was contraindicated.

Telephone interview with the Nurse Practitioner (NP) on 3/9/18 at 12:10pm revealed:
-The NP did not know the MA was not practicing proper technique in administering insulin to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 358	Continued From page 33	D 358		

Resident #7.
-He had not had any reports from the facility of Resident #7 having any health concerns.
-He indicated hyperglycemia could be a possible outcome of improper administration of this insulin.
-He expected the MAs to administer medications as prescribed.

Telephone interview with the Director on 3/12/18 at 12:40pm revealed:
-She did not know the MA was not rolling the insulin vial before drawing the insulin into the syringe.
-She did not know the MA verbalized she "shook" the vial before drawing insulin into the syringe.

2. Review of Resident #2's current FL2 dated 7/7/17 revealed diagnoses included gastroesophageal reflux disease (GERD) and dysphagia.

Review of Resident #2's subsequent physician orders dated 1/20/18 revealed:
There was an order for Protonix 40 mg delayed release tablets (DR), take one tablet twice daily for GERD.
There was an order for NuIron 150 mg capsules, take 1 capsule by mouth daily for iron deficiency anemia.

3. Review of Resident #2's electronic medication administration record (eMAR) from 1/20/18 to 3/7/18 revealed:
a. Protonix 40 mg DR tablets, take 1 tablet twice daily was not entered on the eMAR.
b. NuIron 150 mg capsules, take 1 capsule by mouth daily was not entered on the eMAR.

Interview with the MA on 3/9/18 at 9:30am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 358	Continued From page 34	D 358		

-The MA was responsible for reviewing orders from the physician for the residents.
-She was responsible for faxing those orders to the pharmacy.
-She was responsible for filing the physician visit notes with the signed medication list into the resident's record.
-She did not know how she missed those orders "for so long."

Interview with the Director on 3/9/18 at 10:30am revealed:
-The MA was responsible for "following up" with the medication orders, labs and treatments for the residents, and filing them in the record.
-The Director did not know Resident #6 had orders for Protonix and NuIron and were not entered onto the MAR.
-There was no oversight of the MA for the processing and transcription of orders.

Interview with the facility's pharmacist on 3/8/18 at 3:45pm revealed:
-The pharmacist had not received orders from the facility for Protonix DR 40 mg tablets.
-The pharmacist had not received orders from the facility for NuIron 150 mg capsules.
-Orders received by the pharmacist were faxed from the facility to the pharmacy.
-Computer generated medication administration records (MARS) were delivered monthly to the facility.
-Orders received between the first of one month and the first of the following month were handwritten on the MAR by the MA.

Interview with Resident #2's NP on 3/8/18 at 4:20pm revealed:
-He was concerned the Protonix DR 40 mg tablet was not being administered due to the diagnosis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 358	Continued From page 35 of GERD. -He was less concerned since the facility did not report any complaints from the resident regarding acid reflux or heartburn. -He did not remember writing a prescription for NuIron 150mg capsule. -He was not sure if the resident had a diagnosis of anemia. -He expected the facility to transcribe his orders and administer medications as ordered.	D 358		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (Resident #5) was treated with respect and dignity as evidenced by his head had been shaved due to hearsay in the facility that Resident #5 had head lice. The findings are: 1. Review of Resident #5's current FL2 dated 11/30/17 revealed: -Diagnoses included dementia and altered mental status. -There was documentation Resident #5 was intermittently disoriented. -There was documentation Resident #5 was ambulatory.	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D911	Continued From page 36	D911		

Review of Resident #5's Resident Register revealed he had a guardian.

Interview on 3/7/18 at 10:06am with Resident #5 revealed.
-He was upset the facility said he had lice in his hair.
-He said the facility staff made him get his hair cut.
-He said he did not have lice and had never itched or scratched his head.
-He had never seen lice on him or in his hair.
-He had never seen a physician about lice or had any treatment for lice.

Interview on 3/8/18 at 8:48am with another facility resident revealed:
-She was previously a hair dresser and had cut Resident #5's hair last week, "I think last Tuesday or Wednesday."
-The Director had told her to cut Resident #5's hair because "he had lice in his hair."
-She had trimmed Resident #5's hair due to Resident #5 had attempted to cut his own hair several weeks ago and he had "a gap in the back".
-She had not seen lice in Resident #5's hair.
-When she had finished trimming Resident #5's hair, the Director told her she wanted Resident #5's head shaved due to "he had lice".
-She had told the Director she had not seen any head lice on Resident #5's head or in his hair.
-She was told to shave Resident #5's head.
-Resident #5 had told her he did not have any bugs or lice on him.
-She shaved Resident #5's head using the clippers she had stored in a re-closable plastic bag and secured in her locked closet in her room.
-A nurse came into the room and took a sample of Resident #5's hair to send off to see if Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D911	Continued From page 37	D911		

#5 had "lice eggs".
-She was not paid by Resident #5 or the facility to cut his hair or to shave his head.
-Sometimes residents ask "me to cut their hair and they pay me $3.00 or buy me sodas."
-"Sometimes I just cut hair for free because I know the residents do not have money."

Telephone interview on 3/8/18 at 9:00am with the facility nurse practitioner (NP) revealed:
-The facility had not made him aware Resident #5 had head lice.
-He was not aware the facility shaved Resident #5's head.
-"There are treatments you can use for shampooing hair if lice are present."

Telephone interview on 3/8/18 at 9:44am with the home health nurse revealed she was not aware Resident #5 had head lice and she had not obtained a hair specimen for laboratory studies; Resident #5 was not seen by HH services.

Telephone interview on 3/8/18 at 4:15pm with the county health department nurse revealed:
-The facility had not contacted her or the local county health department regarding Resident #5 and head lice.
-The facility should report to the health department if they had multiple residents in the facility (outbreak) who had been diagnosed with head lice.

Interview on 3/7/18 at 5:15pm with a personal care aide (PCA) revealed:
-She had been off work for a week and when she returned to work Resident #5's head had been shaved.
-Resident #5 had told her the facility made him shave his head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D911	Continued From page 38 -Resident #5 told me he did not have lice. -"I never saw lice on him." Interview on 3/7/18 at 5:22pm with another PCA revealed: -Resident #5 had told her the facility made him shave his head because they said he had lice in his hair. -She had never seen lice on Resident #5. Interview on 3/7/18 at 5:30pm with the medication aide (MA) revealed: -Another resident in the facility shaved Resident #5's head. -She was unsure if Resident #5 had shaved his head due to lice, "I've not heard that." -Resident #5 had paid the other resident for cutting his hair. Interview on 3/8/18 at 12:10pm with the Director revealed: -She knew Resident #5 had his head shaved by another resident in the facility. -The staff reported "they saw something in his [Resident #5] hair." -"I told the staff to look at Resident #5's hair and to wash his head." -Resident #5 had refused to have staff look at his head or to wash it, "He said just cut it off." -Resident #5 had ask the other resident to cut his hair. -"I never saw anything in his hair." -"I never ask the other resident to cut [Resident #5's] hair or to shave his head." -Resident #5 had come into the office and told me to cut his hair. -The two housekeepers were present when Resident #5 had come into the office. -The facility nurse retired last week, "No one took samples of Resident #5's hair."	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D911	Continued From page 39 -Resident #5 never complained to me about his head being shaved." -The resident who cuts hair for other resident in the facility was a beautician before coming here. -"I leave it up to the resident who cuts their hair." -"We do not have a policy on lice or what treatments to use. -Resident #5 had never been seen by the facility physician for a diagnosis of head lice. Interview on 3/8/18 at 3:00pm with the housekeepers revealed: -They both had gone into the Director's office last week and informed the Director they had "seen things" on Resident #5's pillow case. -"It looked like flakes of something." -"We never said lice." -The Director called Resident #5 into the office and told him to wash his head and to take a shower. -Resident #5 could take a shower by himself. -The housekeepers never heard the Director tell Resident #5 to get his head shaved. Attempted telephone interview with Resident #5's guardian on 3/8/18 at 2:00pm was unsuccessful.	D911		
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:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D912	Continued From page 40 Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding Health Care, Other Resident Care and Services, and Adult Care Home Infection Prevention Requirements. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 2 of 5 sampled residents (#1, and #2) by failing to coordinate a urologist physician visit referral for a resident (#1) with a documented history of urinary infections, urinary retention with an indwelling foley catheter; by failing to coordinate a gastroenterologist referral appointment for a resident (#2) with a documented history of dysphagia and gastroesophageal reflux disease (GERD), and failing to coordinate a basic metabolic panel (BMP) to evaluate his potassium level and kidney function as recommended by several quarterly pharmacist reviews. [Refer to Tag 273,10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 5 of 5 diabetic residents sampled (#3, #4, #6, #7 and #8) with orders for finger stick blood sugar monitoring, resulting in the shared use of glucometers. [Refer to Tag 932, G.S. 131D-4.4A(b), ACH Infection Prevention Requirements (Type B Violation)].	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D912	Continued From page 41 3. Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (Resident #1, and #2) were provided transportation to scheduled physician's appointments in regard to Resident #1 Urologist appointment with a documented history of urinary infections, urinary retention, and a indwelling foley catheter, and the facility failed to provide transportation for Resident #1 to the Infectious Disease physician related to continued antibiotic treatments for a diagnoses that included bacterial urine infection and sepsis; the facility failed to provide transportation for Resident #2 to the Gastrointestinal physician with a documented history of dysphagia and gastroesophageal reflux disease. [Refer to Tag 321, 10A NCAC 13F .0906(a) Other Resident Care And Services (Type B Violation)].	D912		
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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (Resident #1, and #2) were free of neglect as evidenced by the facility failed to transport Resident #1 to a Urologist appointment with a documented history of urinary infections, urinary retention, and a indwelling foley catheter, and the facility failed to provide transportation for Resident #1 to the Infectious Disease physician	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D914	Continued From page 42	D914		

related to continued antibiotic treatments for a diagnoses that included bacterial urine infection and sepsis; the facility failed to provide transportation for Resident #2 to the Gastroenterologist with a documented history of dysphagia and gastroesophageal reflux disease.

The findings are:

1. Review of Resident #1's current FL2 dated 5/12/17 revealed:
-Diagnoses included benign prostatic hyperplasia (BPH), mental retardation, alcohol abuse, schizoaffective disorder and anxiety.
-Resident #1 was intermittently disoriented.
-The resident was semi-ambulatory and had a wheelchair.
-He required extensive personal care included bathing, feeding, and dressing.

Review of Resident #1's care plan dated 5/19/17 revealed:
-Resident #1 required total assistance with bathing, grooming and toileting.
-Resident #1 required extensive assistance with ambulation, dressing, grooming, and transfers.

Review of a discharge summary from a local hospital for Resident #1 dated 11/27/17 revealed:
-Resident #1 was admitted to the hospital on 11/22/17 and discharged back to the facility on 11/27/17.
-Resident #1 was admitted through the emergency room with a diagnosis of complicated urinary tract infection (UTI).
-There was an order for Resident #1 to follow-up with the Urologist on 12/20/17.

Review of Resident #1's record revealed:
-There was a signed physicians order dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D914	Continued From page 43 12/20/17 with documentation a new foley catheter had been placed by the Urologist. -The ordered included a follow-up for a "recheck" with the Urologist in one month. Review of the facility appointment book calendar for January 2018 revealed: -There was an appointment scheduled for Resident #1 for 1/17/18 at 11:00am with the Urologist. -There was an "X" made through the appointment on 1/17/18. -There was a comment written on 1/17/18 "Rescheduled Resident sick and not feeling well". -There was no other documentation in January 2018 for Resident #1 in the appointment book. Review of a second discharge summary from a local hospital for Resident #1 dated 1/31/18 revealed: -Resident #1 was admitted to the hospital on 1/25/18 with diagnoses that included UTI and sepsis. -Resident #1 was seen by the Infectious Disease physician and the Urologist. -An order for a follow up appointment with the Urologist in regard to further testing for a MRI study. -There was documentation the facility was to contact the Urologist office and set up an appointment time for Resident #1 to have the MRI study. -The discharge summary was electronically signed by the physician on 1/31/18. Review of the facility appointment calendar for February 2018 revealed: -There was an appointment scheduled for Resident #1 on 2/6/18 and 2/12/18. -There was an "X" documented through the	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D914	Continued From page 44	D914		

appointments for both days.
-There was documentation on 2/6/18 "Canceled tried to contact office but office closed".
-There was documentation on 2/12/18 "Canceled by office".
-There was no other documentation in February 2018 for Resident #1.

Telephone interview on 3/8/18 at 8:30am with Resident #1's Urologist's office revealed:
-Resident #1 was being followed by the Urologist for foley catheter care as well as the MRI ordered on 1/31/18.
-Resident #1 had missed three appointments; one on 1/24/18, two on 2/6/18 and 2/26/18, another 3/12/18 (the facility had already called the office and canceled this appointment).
-Each time the facility contacted the Urologist office to cancel the appointment the reason was "due to transportation".
-"It is very important the facility provide transportation to the physician office".
-"The physician cannot treat and care for the resident if does not come into the office."

Telephone interview on 3/8/18 at 9:44am with Resident #1's home health nurse revealed:
-She started service for Resident #1 in February 2018.
-She was aware Resident #1 had appointments with the Urologist and the Infectious Disease physician.
-She had informed the facility Resident #1 was to follow-up with the Urologist office for an MRI ordered on 1/31/18.
-She had spoken to the medication aide (MA) who was in charge of scheduling appointments for the residents.
-She contacted the Urologist office on 2/14/18 informing them Resident #1 had an order for an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D914	Continued From page 45	D914		

MRI and to please schedule.
-She had informed the facility the Urologist needed to see a facility representative and Resident #1 in the office.
-She knew Resident #1 had missed three appointments, 2 with the Urologist and one with the Infectious Disease physician.
-She was not aware the facility had already called the Urologist office and canceled the appointment for Resident #1 on 3/12/18.
-The facility was responsible for providing transportation to the physician office for Resident #1.

Telephone interview on 3/13/18 at 9:15am with the Infectious Disease physician office revealed:
-Resident #1 had an appointment on 2/12/18 to see the infectious disease physician for a follow-up appointment from the hospital discharge on 1/3/18.
-The follow-up appointment was related to continued antibiotic treatment for the UTI and sepsis.
-The resident was a no call no show.
-"It is very important the facility brings the resident to the appointment, the infectious disease physician is in-charge of his antibiotic treatment."
-The facility contacted the office on 2/28/18 to reschedule the appointment for Resident #1, "they refused to bring [Resident #1] in sooner that 3/26/18."
-"When a resident missed an appointment we rescheduled the appointment on the following week, that's how important the continued antibiotic treatments are."
-Resident #1 had a "bad bacterial infection" in the hospital in January 2018, and was administered antibiotic during his hospitalization.
-Resident #1 was discharged on 1/31/18 back to the facility on an intra-muscular injection of an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D914	Continued From page 46	D914		

antibiotics.
-"Without keeping his [Resident #1] appointment we do not have lab findings to determine if the infection is improved or not."

Interview on 3/8/18 at 10:10am with the medication aide (MA) revealed:
-She was responsible for scheduling appointments for the residents.
-She was responsible for reviewing new orders for residents and reviewing discharge summaries from the hospital.
-She knew Resident #1 had appointments with the Urologist and the Infectious Disease physician.
-Resident #1 had missed two physician's appointments in January 2018 because "He was sick."
-The two missed appointments were for the Urologist and the Infectious Disease physician.
-There were two vehicles available for transportation to use for transporting residents to the physician offices.
-Both the vehicles did not have a wheelchair lift, but if a resident could stand they could be transported.
-Resident #1 was a two person assist, we have only one person to transport the residents.
-The transportation staff did not keep a log of what residents were to be transported to the physician's office.

Interview on 3/8/18 at 11:00am with the facility transportation staff revealed:
-She worked third shift as a personal care aide and was also responsible for transportation during the first shift.
-There were two vehicles used for transportation one was a facility van and the other was a private vehicle, both were in running condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D914	Continued From page 47	D914		

-"The van is not wheelchair accessible, but if the resident can stand and turn we can get them in the van."
-The private vehicle used for transportation did not have a lift, but would be used if residents could stand.
-She was the only staff that transported residents to appointments.
-She had never transported Resident #1 to any physician visit.
-She was not in charge of scheduling appointments; "The MA tells me who and where to go."
-"The MA never ask me transport [Resident #1]."
-She was not aware Resident #1 had missed physician appointments, "It was not because of transportation he missed visits."

Interview on 3/8/18 at 3:10pm with a personal care aide (PCA) revealed:
-She assisted Resident #1 to bed at night, the resident required two staff for transfer.
-She had never assisted with transportation for Resident #1 to the physician office.

Interview on 3/8/18 at 11:50pm with Resident #1 revealed:
-"It's been awhile since I saw the doctor who takes care of my catheter."
-"I know I had appointments, but they won't take me."
-He was not sure why the facility would not take him to the appointments, "I have never refused."
-"I know they have a van."
-"I am not sure when the appointments were, but they [facility] should know."

Interview on 3/8/18 at 12:10pm with the facility Director revealed:
-The MAs was responsible for reviewing orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D914	Continued From page 48	D914		

and making appointments for residents to be transported to physician's office.
-She was aware Resident #1 had follow-up appointments with the Urologist and the Infectious Disease physician in January 2018, February 2018 and March 2018.
-"He [Resident #1] refused to go; then ended up in the hospital a few days later."
-She did not know Resident #1 had an order on the discharge instructions dated 1/31/18 to schedule an MRI with the Urologist until 3/7/18 after the survey team had informed her of the MRI order.
-She relied on the MAs to review the orders and make appointment for the residents.
-There was no system in place to review the orders once the MA had reviewed the new orders.
-The facility van used for transportation did not have a lift for wheelchairs.
-The other private vehicle did not have a lift, but could be used for transportation for Resident #1 to go the physician's office.

Interview on 3/8/18 at 12:10pm with the Administrator revealed:
-She relied on the Director to oversee the staff and the day to day operations in the facility.
-She was aware there was only 1 MA in the facility who was responsible for administering medications, scheduling appointments and providing treatment to residents in the facility.
-She knew Resident #1 had been in the hospital, but was not aware of the missed follow-up appointments.
-She knew the facility had two vehicles available for transportation for staff to use when transporting a resident to physician appointments.
-She knew neither facility transportation vehicles had a lift for wheelchair accessibility.
-She relied on the Director manage the facility,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D914	Continued From page 49 the staff, and provide the appropriate care in scheduling appointments with physician's for the residents. Refer to review of the facility's Home Policies & Residents Rights documentation form. 2. Review of Resident #2's current FL2 dated 7/7/17 revealed: -Diagnoses included prostate cancer, gastroesophageal reflux disease (GERD), hyperlipidemia, anxiety, depression, and bipolar disorder. -Resident #2 was intermittently disoriented. -Resident #2 was semi-ambulatory and used a wheelchair. Review of Resident #2's physician order dated 1/20/18 revealed a gastroenterology (GI) referral appointment dated 1/25/18 . Review of the facility appointment book calendar for the month of January 2018 revealed: -There was a physician appointment scheduled for Resident #2 on 1/25/18 at 11:00am with the GI physician. -There was an "X" mark made through the appointment on 1/25/18. -No explanation was documented in the appointment book. Review of Resident #2's progress notes revealed there was no documented explanation the GI referral was canceled. Telephone interview on 3/8/18 at 4:30pm with the nurse practitioner (NP) revealed: -He referred Resident #2 to the gastroenterologist (GI physician) for dysphagia, GERD and	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D914	Continued From page 50	D914		

swallowing difficulty as expressed by the resident.
-The facility scheduled the appointment for 1/25/18.
-He did not remember if the facility informed him Resident #2 did not go to the appointment.
-He did not know if the facility attempted to re-schedule the appointment.

Interview on 3/9/18 at 9:10am with the medication aide (MA) revealed:
-Resident #2 frequently refused appointments.
-Resident #2 refused to go to the appointment on 1/25/18 because " he was much better."
-The appointment was for a sore throat-"he was spitting stuff up."
-She made a follow up appointment on 2/13/18 and he refused again.
-She was sure she contacted the physician's office at some point and canceled the appointment.
-She notified the NP of the canceled appointment.

Interview on 3/9/18 at 10:05am with the Director revealed:
-Resident #2 frequently refused appointments.
-The MA scheduled all appointments.
-She did not know if the NP was notified of the cancellation. It was the responsibility of the MA to inform the NP.
-It was a resident's right to cancel appointments.

Interview on 3/9/18 at 10:55am with Resident #2 revealed:
-His primary care provider was the NP who visits the facility.
-He had not seen a doctor in a long time.
-He was concerned because he had been diagnosed with atrial fibrillation.
-He did have trouble with swallowing and digestion, but he felt better.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D914	Continued From page 51 -He told the MA he was feeling better but he never refused to go to any appointments. -The MA makes the appointments and informed the residents the morning of their appointments. -He was never told of a GI appointment and did not refuse to go. Interview on 3/9/18 at 11:20am with the scheduler at the GI office revealed: -Resident #2 did not arrive for his appointment on 1/25/18. -The facility did not call to give a reason for the missed appointment. -The facility did not reschedule his appointment. Interview on 3/8/18 at 11:15am with the facility transportation staff revealed: -She worked third shift as a personal care aide and was also responsible for transportation during the first shift. -There were two vehicles used for transportation; one was a facility van and the other was a private vehicle. Both were in running condition. -"The van is not wheelchair accessible, but if the resident can stand and turn we can get them in the van." -The private vehicle used for transportation did not have a lift, but would be used if residents could stand. -She was the only staff that transported residents to appointments. -She was not in charge of scheduling appointments. "The MA tells me who I take and where to go." Refer to review of the facility's Home Policies & Residents Rights documentation form. _____ Review of the facility's Home Policies &	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D914	Continued From page 52 Residents Rights documentation form revealed "The Administrator or supervisor in charge will provide or arrange transportation to necessary medical appointments without charge." _____ Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (Resident #1 and #2) were free of neglect as evidence by the facility failed to transport Resident #1 to a Urologist appointment with a documented history of urinary infections, urinary retention, and a indwelling foley catheter, and the facility failed to provide transportation for Resident #1 to the Infectious Disease physician related to continued antibiotic treatments for a diagnoses that included bacterial urine infection and Sepsis; The facility failed to provide transportation for Resident #2 to the Gastrointestinal physician with a documented history of dysphagia and gastroesophageal reflux disease. These failures of the facility to ensure Resident #1 and #2 were transported to their medical physician appointments, were detrimental to the health and welfare of the residents, which constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 3/8/18 revealed: -The Administrator conducted a meeting on 3/8/18 with the Director and the MA to discuss Resident Rights to include transportation to and from doctor office for appointments. -The Administrator and the Director will ensure that the rights of all residents are guaranteed. -The Administrator and the Director will monitor for compliance weekly times 3 weeks, biweekly for 3 weeks, monthly for 3 months then quarterly thereafter to ensure compliance.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D914	Continued From page 53 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 26, 2017.	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D932	Continued From page 54 dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 5 of 5 diabetic residents sampled (#3, #4, #6, #7 and #8) with orders for finger stick blood sugar monitoring, resulting in the shared use of glucometers. The findings are: Observation on 3/7/18 at 11:03am during the 11:00am medication pass revealed: -The facility stored the diabetic residents' glucometers in vinyl zippered cases, placed in individual plastic reclosable bags. -The plastic reclosable bags were dirty and ripped	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 55	D932		

in places, and were kept in an open plastic basket.
-Some of the bags contained glucose strips, lancing devices and alcohol swabs.
-Each plastic reclosable bag was labeled with a resident's name on the outside of the bag.
-The vinyl glucometer cases in the plastic reclosable bags were labeled with the resident's name.
-The glucometers, lancing devices and test strips were not labeled with the residents' names.

Observation on 3/7/18 at 11:33am revealed the MA did not wipe glucometers with alcohol pad after usage.

Review of the Centers for Disease Control and Prevention (CDC) guidelines for blood glucose (blood sugar) monitoring revealed the following infection control requirements:
-Fingerstick devices should never be used for more than one person
-Whenever possible, blood glucose meters should not be shared.
-If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions.
-If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared.

Review of the manufacturer's guidelines for the brand A glucometer revealed:
-The glucometer was single person use only.
-It should be cleaned by wiping the outside with a soft cloth dampened with water and mild detergent.
-Alcohol or other solvents should not be used.
-Healthcare professionals performing blood tests with this system on multiple patients must always

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 56	D932		

wear gloves and should follow the infection control policies and procedures approved by their facility.

Review of the manufacturer's guidelines for the brand B glucometer revealed:
-Healthcare professionals performing blood tests with this system on multiple patients must always wear gloves and should follow the infection control policies and procedures approved by their facility.
-Acceptable cleaning solutions include: 70% isopropyl alcohol, a mixture of 1 part ammonia, 9 parts water, or a mixture of 1 part household bleach, 9 parts water.
-Do not try to clean the strip port.
-Do not pour liquid into the strip port or onto the buttons.
-Do not immerse the meter in water or any other liquid.

Interview on 3/7/18 at 4:31pm with the medication aide (MA) revealed:
-She cleaned all glucometers with an alcohol wipe after each usage.
-She was trained to wipe glucometers with an alcohol pad after each use by the previous MA who trained her.
-There were 14 residents with physician orders for FSBS checks.

Record Review on 3/7/18 at 5:30pm revealed there was no known diagnosis of a blood borne pathogen for any of the 14 residents with orders for FSBS checks.

1. Observation on 3/7/18 at 11:14am with the MA in the medication room revealed:
-The plastic reclosable bag for Resident #6 had the name of another resident on the outside of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 57	D932		

the bag.
-The vinyl zippered case which contained the glucometer, was labeled with Resident #6's name on the outside of the case.
-Neither the Brand B glucometer or the lancing device in the vinyl case were labeled with Resident #6's name.
-The lancet needles in the plastic reclosable bag were not the correct needles for the lancing device.

A second interview on 3/7/18 at 11:45am with the MA revealed:
-The Brand B glucometer, in the plastic reclosable bag labeled with another resident's name, was Resident #6's glucometer and lancing device.
-She did not have another plastic reclosable bag available to store Resident #6's glucometer and lancing device.
-She had re-used a bag, with another resident's name, that had been discharged from the facility.

Review of the glucometer's history in Resident #6's glucometer on 3/7/18 at 11:57am revealed there were no readings prior to 3/2/2018.

Review of Resident #6's current FL2 dated 1/23/18 revealed he was admitted to the facility on 2/7/18.

Review of Resident #6's medication administration record (MAR) and facility FSBS log revealed FSBS were scheduled 3 times a day at 7:30am, 11:30am and 5:30pm.

Review of the brand B glucometer contained in the vinyl zippered case labeled for Resident #6 revealed:
-The time was not set correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 58 -The date shown was 3/7/18 and the time for the 11:15am FSBS was shown as 1:30pm. Review of Resident #6's glucometer history on 3/7/18 at 11:57am compared to the FSBS log revealed: -The glucometer's history had FSBS readings that did not match the readings on Resident #6's FSBS log. -There were missed readings. Examples of inconsistencies were as follows: -On 3/2/18 at 7:30am, there was no reading on the glucometer. The FSBS log revealed a reading of 260, that was found on Resident #8's glucometer history on 3/2/18 at 5:12am. -On 3/2/18 at 11:30am, there was no reading on the glucometer, but the FSBS log revealed a reading of 343. -On 3/2/18 at 5:30pm, the FSBS reading on the glucometer was 263, but the FSBS log revealed a reading of 239. -On 3/1/18 there were no readings on Resident #6's glucometer. The FSBS log revealed readings on 3/1/18 of 361 at 7:30am, 222 at 11:30am, and 336 at 5:30pm. -The readings for 3/1/18 of 361 and 222 were found on Resident #8's glucometer history on 3/1/18 at 4:53am and 9:22am respectively. -There were no additional readings on the glucometer. Interview on 3/7/18 at 1:00pm with the Administrator revealed she did not know why there were no entries on the glucometer for Resident #6 from 2/21/2018 to 3/2/2018. Interview on 3/8/18 at 2:50pm with Resident #6 revealed: -He had FSBS checked 2-3 times a day.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 59 -He was unable to identify what type of glucometer the MAs used to check his blood sugar. Refer to interview on 3/7/18 at 1:00pm with the Administrator. Refer to telephone interview on 3/8/18 at 4:20pm with the Nurse Practitioner (NP). Refer to telephone interview on 3/12/18 at 10:36am with the medication aide. Refer to telephone interview on 3/12/18 at 12:16pm with the NP. 2. Review of Resident #7's MAR revealed FSBS were scheduled 4 times a day at 6:30am, 11:30am, 4:30pm and 8:00pm. Observation on 3/7/18 at 12:00pm with the MA in the medication room revealed: -Resident #7's glucometer was stored in a dirty plastic reclosable bag, torn across the middle of the bag. -The vinyl zippered case which stored the glucometer was labeled with Resident #7's name on the outside of the case. -Neither the Brand B glucometer or the lancing device in the soft case were labeled with Resident #7's name. Review of the brand B glucometer for Resident #7 revealed: -The time was not set correctly. -The date shown was 3/7/2018 and the time for the 11:15am FSBS was shown as 1:30pm. Review of Resident #7's glucometer history on 3/7/18 at 11:35am compared to the FSBS log	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 60	D932		

revealed:
-The glucometer's history had blood sugar readings that did not match the readings on Resident #7's FSBS log.
Examples of inconsistencies were as follows:
-On 3/2/18, the FSBS reading on the glucometer at 9:00am was 201. The FSBS log revealed a reading of 138.
-On 3/2/18, the FSBS reading on the glucometer at 8:00pm was 139 The FSBS log revealed a reading of 157.
-On 3/3/18 at 5:30pm, the FSBS reading was 102. The FSBS log revealed a reading of 109.
-On 3/5/18 at 11:30am, the FSBS reading was 124. The FSBS log revealed a reading of 128.
-On 3/5/18 at 8:00pm, the FSBS reading was 103. The FSBS log revealed a reading of 152.

Interview on 3/8/18 at 2:45pm with Resident #7 revealed:
-She had her FSBS checked 3-4 times daily.
-She would receive insulin if her readings were 'high.'
-She was able to identify what type of glucometer was used to check her blood sugar.

Interview with the MA on 3/8/18 at 3:12pm revealed:
-The FSBS readings were entered on a separate sheet, the FSBS Record.
-The FSBS record was kept in the medication room labeled with each resident's name, the time of the FSBS and the results.
-She entered some of the FSBS readings on the MAR if the computer generated copy of the MARS, provided monthly by the pharmacy, had entered an FSBS order for that resident.

Interview on 3/8/18 at 5:04pm with the Administrator revealed she did not know of any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 61	D932		

diabetic residents in her facility with a communicable disease.

Record review on 3/9/18 at 8:30am revealed:
-FL2's were reviewed for the 14 residents that had glucometers in plastic reclosable bags in the medication room.
-There were no diagnoses of communicable diseases listed for any of the residents who used Brand A or Brand B glucometers.

Refer to interview on 3/7/18 at 1:00pm with the Administrator.

Refer to telephone interview on 3/8/18 at 4:20pm with the Nurse Practitioner (NP).

Refer to telephone interview on 3/12/18 at 10:36am with the medication aide.

Refer to telephone interview on 3/12/18 at 12:16pm with the NP.

3. Review of Resident #3's current FL2 dated 11/27/17 revealed there was no diagnosis of diabetes documented.

Review of Resident #3's physician orders revealed there was an order dated 2/1/18 to check finger stick blood sugar (FSBS) 3 times daily before meals.

Review of Resident #3's March 2018 MAR revealed an entry to check FSBS 3 times daily before meals at 8:00am, 11:00pm, and 5:00pm daily.

Observation on 3/7/18 at 3:45pm of Resident #3's glucometer revealed:
-There were 2 Brand A glucometers, a soft

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 62 zippered case, and 1 lancing device in Resident #3's labeled plastic reclosable bag. -The soft case, both glucometers, and the lancet device were not labeled with Resident #3's name. Review of Resident #3's glucometer's history compared to values documented on Resident #3's March 2018 MAR from 3/1/18 to 3/7/18 revealed: -The FSBS values recorded in the glucometer's history were inconsistent for values documented on the MAR. -There was no current date or time on the glucometer. Examples of inconsistencies were as follows: -On 3/2/18 at 4:28am, a FSBS reading of 259 matched the MAR on 3/2/18 at 7:00am and at 2:07pm a reading of 348 matched the MAR on 3/2/18 at 5:00pm. -On 3/2/18, there was no reading in the glucometer's history for a FSBS of 170 at 11:00am documented on the MAR. -On 3/3/18 at 4:01am, a FSBS reading of 474 matched the MAR on 3/3/18 at 7:00am and at 8:10am, a reading of 107 matched the MAR on 3/3/18 at 11:00am. -On 3/3/18, there was no reading in the glucometer's history for a FSBS of 207 at 5:00pm documented on the MAR. -On 3/3/18 there was an additional FSBS reading recorded in the glucometer's history on 3/3/18 at 10:16am of 214, that was not documented on the MAR. -There was an additional FSBS reading recorded in the glucometer's history at 11:01am of 309 that was not documented on the MAR. -On 3/5/18, there was no reading in the glucometer's history, for a FSBS of 342 at 5:00pm that was documented on the MAR.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 63 -On 3/6/18 at 6:44am, there was a FSBS reading recorded in the glucometer's history of 62 that was not documented on the MAR. Interview on 3/7/18 at 4:31pm with the medication aide (MA) revealed: -The extra glucometer in Resident #3's plastic reclosable bag did not belong to Resident #3, but to another resident. -She stated she would look to see which residents' plastic reclosable bag was missing a glucometer. Observation on 3/7/18 at 4:32pm of the stored glucometers in the medication room revealed: -The MA looked at the other stored glucometers to see which residents' plastic reclosable bag was missing a glucometer. -The MA placed the glucometer into another resident's (Resident #8's) plastic reclosable bag. -The MA did not clean the glucometer or verify that it belonged to the other resident (Resident #8). Interview on 3/8/18 at 2:55 with Resident #3 revealed: -She had her FSBS checked 4 times a day. -"We got our own machine...they use my machine." -She was able to identify what type of glucometer used. Refer to interview on 3/7/18 at 1:00pm with the Administrator. Refer to telephone interview on 3/8/18 at 4:20pm with the Nurse Practitioner (NP). Refer to telephone interview on 3/12/18 at 10:36am with the medication aide.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 64 Refer to telephone interview on 3/12/18 at 12:16pm with the NP. 4. Review of Resident #8's current FL2 dated 11/27/17 revealed: -A diagnosis of diabetes mellitus. -An order to check finger stick blood sugars monthly. Review of Resident #8's March 2018 Medication Administration Record (MAR) revealed: -There was an entry to check FSBS on the first Sunday of each month. -There was a FSBS reading of 300 documented on 3/4/18. Observation on 3/7/18 at 3:55pm of Resident #8's glucometer revealed: -Resident #8's Brand A glucometer was in another resident's (Resident #3) labeled plastic reclosable bag. -The Brand A glucometer was not labeled with Resident #8's name. Review of Resident #8's glucometer history compared to values documented on Resident #8's March 2018 MAR from 3/1/18 to 3/4/18 revealed: -The FSBS values recorded in the glucometer's history were inconsistent for values documented on the MAR. -There were no additional FSBS values documented in the glucometer's history. -There was no current date or time on the glucometer. Examples of inconsistencies were as follows: -On 3/1/18, there were additional FSBS readings recorded in the glucometer's history at 4:53am of	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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
D932	Continued From page 65	D932		

361 and at 9:22am of 222, that were not documented on the MAR.
-On 3/2/18 there was an additional FSBS reading recorded in the glucometer's history at 5:12am of 260 that was not documented on the MAR.
-On 3/4/18 at 6:43am a FSBS reading of 300 matched the MAR on 3/4/18.

Interview on 3/7/18 at 4:31pm with the medication aide (MA) revealed Resident #8's glucometer had been placed in another resident's plastic reclosable bag (Resident #3).

Observation on 3/7/18 at 4:32pm of the stored glucometers in the medication room revealed:
-The MA placed Resident #8's glucometer into his labeled plastic reclosable bag.
-She did not clean the glucometer or verify that it belonged to Resident #8.

Interview on 3/8/18 at 9:40am with Resident #8 revealed:
-He only had FSBS checked once a month.
-He was not on any type of insulin, only oral medications.
-FSBS were checked at the door of the medication room.
-He was able to identify the type of glucometer used to check his blood sugar.

Refer to interview on 3/7/18 at 1:00pm with the Administrator.

Refer to telephone interview on 3/8/18 at 4:20pm with the Nurse Practitioner (NP).

Refer to telephone interview on 3/12/18 at 10:36am with the medication aide.

Refer to telephone interview on 3/12/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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D932	Continued From page 66 12:16pm with the NP. 5. Review of Resident #4's current FL2 dated 5/12/17 revealed: -A diagnosis of uncontrolled diabetes mellitus. -An order to check finger stick blood sugars 3 times daily. Review of Resident #4's March 2018 MAR revealed: -There was an entry to check FSBS 3 times daily before meals at 8:00am, 11:00pm, and 5:00pm daily. -There was an entry for Novolog insulin inject 25 units SQ 3 times daily before meals. Observation on 3/7/18 at 3:50pm of Resident #4's glucometer revealed: -There was a Brand A glucometer and 1 lancing device in Resident #4's labeled plastic reclosable bag. -The black glucometer bag, glucometer, and the lancing device were not labeled with Resident #4's name. Review of Resident #4's glucometer history on 3/7/18 at 3:50pm compared to values documented on Resident #4's March 2018 MAR from 3/1/18 to 3/7/18 revealed: -FSBS values recorded in the glucometer history were inconsistent for values documented on the MAR. -There was no current date or time on the glucometer. Examples of inconsistencies were as follows: -On 3/1/18, at 5:17am a FSBS reading of 202 matched the MAR on 3/1/18 at 7:00am, and at 8:21am, a FSBS reading of 493 matched the FSBS documented on the MAR on 3/2/18 at	D932		

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	HAL049016	A. BUILDING: _____ B. WING _____	R 03/12/2018

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D932	Continued From page 67 11:00am. -On 3/1/18, no readings were recorded in the glucometer's history for a FSBS of 289 at 5:00pm as documented on the MAR. -On 3/2/18, at 8:34am a FSBS reading of 231 matched the MAR on 3/2/18 at 11:00am. -On 3/2/18 no readings were recorded in the glucometer's history for a FSBS of 201 at 7:00am, and 239 at 5:00pm, as documented on the MAR. -There was an additional FSBS reading recorded in the glucometer's history on 3/2/18 at 5:20am of 138, that was not documented on the MAR. -On 3/5/18, there was a reading recorded in the glucometer's history at 8:34am of 310 that was not documented on the MAR. Interview on 3/8/18 at 2:40pm with Resident #4 revealed: -He had FSBS checked 2-3 times daily. -He was not able to identify the type of glucometer used by the MAs to check his blood sugar. Refer to interview on 3/7/18 at 1:00pm with the Administrator. Refer to telephone interview on 3/8/18 at 4:20pm with the Nurse Practitioner (NP). Refer to telephone interview on 3/12/18 at 10:36am with the medication aide. Refer to telephone interview on 3/12/18 at 12:16pm with the NP. --- Interview on 3/7/18 at 1:00pm with the Administrator revealed: -The glucometers currently used, for the	D932		

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D932	Continued From page 68	D932		

residents with orders for FSBS, were purchased on 2/21/2018.
-She did not know the glucometers and lancing devices were not labeled.
-There were enough plastic reclosable bag in the kitchen to be used for glucometers.

Interview on 3/8/18 at 4:20pm with the Nurse Practitioner revealed:
-He provided care for all 5 residents.
-He did not know there were inconsistencies in the glucometer's history, the MARs and FSBS logs for all 5 residents.
-He would be concerned if there was sharing of glucometers.
-He was not aware of any infection control issues related to glucometers and FSBS testing.

Telephone interview on 3/12/18 at 10:36am with the MA revealed:
-All residents with orders for FSBS were to have their own glucometer.
-On 3/7/18 the residents' glucometers were stored in plastic reclosable bag.
-There were no labels on the glucometers or lancing devices.
-The MAs were not to share glucometers between residents.
-The plastic reclosable bag, glucometers and lancing devices should have been labeled.

Telephone interview on 3/12/18 at 12:16pm with the same NP revealed:
-He expected the facility to not share glucometers.
-He expected the facility to follow manufacturer guidelines and facility policy related to the use of glucometers.
-He was not aware that glucometers had been shared between residents.

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D932	Continued From page 69 The facility's failure to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines placed residents receiving finger stick blood sugar checks with glucometers at risk due to possible exposure of blood borne pathogens by the sharing of glucometers for Residents #3, #4, #6, #7 and #8. These failures were detrimental to the health, safety and welfare of the residents receiving FSBS checks with glucometers and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 3/7/18 revealed: -Facility will contact pharmacy to obtain new glucometers for all residents who require FSBS checks. -Glucometers and lancing devices will be placed in new storage bags, and will be labeled to ensure accuracy and infection prevention. -Inservice provided to MA on glucometers, infection prevention and accuracy. -Inservice provided immediately by Administrator and Director. -Monitoring of glucometers will be done by Administrator/Director to ensure accurate labeling, accurate use, and infection prevention. -Monitoring will be done weekly x 3, biweekly x 3, monthly x 3, then quarterly thereafter. -New admissions who require FSBS monitoring will be monitored and reviewed on admission to ensure accurate labeling, accurate use, and infection prevention. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 26, 2018.	D932		

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