STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 05/22/18-05/23/18.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 5 sampled residents (#1) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #1's current FL2 dated 01/12/18 revealed diagnoses included depression, pulmonary emboli and pneumonia. Review of Resident #1's Resident Register revealed an admission date of 01/27/17 and he was his own responsible person. Review of Resident #1's record revealed there	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

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JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 234	Continued From page 1	D 234		

was no documentation testing for tuberculosis disease was completed upon admission to the facility.

Review of Resident #1's faxed document from an out of state facility revealed a TB skin test had been administered on 08/27/15, but the results were too light to read.

Interview with the Resident Care Director (RCD) on 05/23/18 at 11:15am revealed:
-She knew all the residents were required to have a TB tested upon admission to the facility.
-She had completed a chart audit in January 2018 for Resident #1, and recalled reviewing documentation of Resident #1's two-step TB skin test.
-She had completed another chart audit for Resident #1 in May 2018 and could not find the documentation Resident #1 had a TB test.
-She was unsure where or what happened to Resident #1's documentation for the TB skin test was.
-She contacted the facility contract nurse on 05/18/18 to administer a two-step TB to Resident #1.
-The RCD was informed by the nurse she was unavailable until 5/28/18 to administer the TB skin test to Resident #1.
-The RCD had not contacted Resident #1's physician for further guidance.

Interview with the Administrator on 05/23/18 at 11:55am revealed:
-He was aware all the residents were required to have a two-step TB test upon admission to the facility.
-He was not aware Resident #1 had not received a TB test upon admission to the facility.
-He had not seen documentation in Resident #1's

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	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 234	Continued From page 2 record that a TB skin test had been completed. -He relied on the RCD to audit the resident's records and to ensure the records were complete. Interview with Resident #1 on 05/23/18 at 10:42am was unsuccessful.	D 234		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for 4 of 5 sampled residents as evidenced by no No Concentrated Sweets (NCS) menu for Residents #1, #3 and #4 and no Puree menu for Resident #2. The findings are: Review of the facility menus on 05/22/18 revealed: -There were no Week at a Glance menus. -Each meal's menu was on a separate sheet of paper and contained only the foods available with no beverage choices or serving sizes listed. -All menus available were for a regular diet. -There were no therapeutic menus available for guidance of food service staff. Interview with the Dietary Manager (DM) on	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 296	Continued From page 3	D 296		

05/22/18 at 9:31am revealed:
-The facility's food distributor provided Week at a Glance menus.
-Because the residents had complained of disliking the food at times, she utilized the Week at a Glance menus to create her own daily menus.
-The daily menus were the only menus used by the food service staff to prepare and serve food to the residents.
-The facility offered 2 therapeutic diets including NCS and Puree.

1. Review of Resident #1's current FL2 dated 01/12/18 revealed:
-Diagnoses included diabetes.
-A physician's order for a NCS diet.

Review of the color coded seating chart posted in the kitchen revealed Resident #1 was to be served a NCS diet.

Review of the lunch menu for 05/22/18 revealed residents on a regular diet were to be served a salmon patty, stewed potatoes, sweet snap peas, rolls and "Kay's treat."

Observation of the lunch meal service on 05/22/18 from 12:00pm to 12:40pm revealed:
-Resident #1 was served a salmon patty, a roll with margarine, mashed potatoes, sweet snap peas, a 3x3 inch square of sugar-free cherry pie, unsweetened tea with artificial sweetener and water.
-Resident #1 consumed 50% of the salmon patty, 50% of the roll with margarine, 50% of the mashed potatoes, 50% of the sweet snap peas, 100% of the sugar-free cherry pie, and 100% of both the unsweetened tea and water.
-Without a therapeutic diet menu, it could not be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 296	Continued From page 4	D 296		

determined if Resident #1 was served the NCS diet as ordered by the physician.

Review of the breakfast menu for 05/23/18 revealed residents on a regular diet were to be served cold cereal, scrambled eggs, grits/oatmeal and sausage biscuit.

Observation of the breakfast meal service on 05/23/18 from 8:15am to 9:00am revealed:
-Resident #1 was served cold cereal with milk, a sausage biscuit, orange juice, water and black coffee.
-Resident #1 consumed 100% of all food items.
-Without a therapeutic diet menu, it was unable to be determined if Resident #1 was served the NCS diet as ordered by the physician.

Refer to interview with the DM on 05/23/18 at 9:00am.

Refer to interview with the Administrator on 05/22/28 at 4:55pm.

Refer to interview with the Administrator on 05/23/18 at 11:30am.

2. Review of Resident #2's current FL2 dated 09/26/17 revealed:
-Diagnoses included unspecified protein-calorie malnutrition and abnormal weight loss.
-A physician's order for a Puree diet.

Review of the tray cards located in the kitchen revealed Resident #2 was to be served a Puree diet.

Review of the lunch menu for 05/22/18 revealed residents on a regular diet were to be served a salmon patty, stewed potatoes, sweet snap peas,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 296	Continued From page 5 rolls and "Kay's treat." Observation of the lunch meal service on 05/22/18 from 12:00pm to 12:40pm revealed: -Resident #2 was served a pureed brown food, a pureed green food, a pureed white food, chocolate pudding, water and sweetened tea. -Resident #2 was fed by a Personal Care Assistant (PCA). -Resident #2 consumed 75% of the pureed brown food, 75% of the pureed green food, 100% of the pureed white food, 100% of the chocolate pudding, 100% of the sweetened tea and none of the water without difficulty. -Without a therapeutic diet menu, it could not be determined if Resident #2 was served the Puree diet as ordered by the physician. Interview with the DM on 05/22/18 at 12:40pm revealed the pureed brown food was stewed beef, the pureed green food was sweet snap peas, and the pureed white food was potatoes. Review of the breakfast menu for 05/23/18 revealed residents on a regular diet were to be served cold cereal, scrambled eggs, grits/oatmeal and sausage biscuit. Observation of the breakfast meal service on 05/23/18 from 8:15am to 9:00am revealed: -Resident #2 was served scrambled eggs, oatmeal, orange juice and water. -Resident #2 was fed by a PCA. -Resident #2 consumed 100% of all food items without difficulty. -Without a therapeutic diet menu, it could not be determined if Resident #2 was served the Puree diet as ordered by the physician. Refer to interview with the DM on 05/23/18 at	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 296	Continued From page 6 9:00am. Refer to interview with the Administrator on 05/22/28 at 4:55pm. Refer to interview with the Administrator on 05/23/18 at 11:30am. 3. Review of Resident #3's current FL2 dated 10/18/17 revealed: -Diagnoses included Type 2 diabetes without complications, hypertension, and chronic kidney disease stage 3. -A physician's order for a NCS diet. Review of a physician's diet order sheet dated 01/18/18 revealed an order for a NCS diet with the words "low carbs" written in. Review of the color coded seating chart posted in the kitchen revealed Resident #1 was to be served a NCS diet. Review of the lunch menu for 05/22/18 revealed residents on a regular diet were to be served a salmon patty, stewed potatoes, sweet snap peas, rolls and "Kay's treat." Observation of the lunch meal service on 05/22/18 from 12:00pm to 12:40pm revealed Resident #3 did not eat lunch. Review of the breakfast menu for 05/23/18 revealed residents on a regular diet were to be served cold cereal, scrambled eggs, grits/oatmeal and sausage biscuit. Observation of the breakfast meal service on 05/23/18 from 8:15am to 9:00am revealed: -Resident #3 was served grits, scrambled eggs, a	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 296	Continued From page 7	D 296		

sausage biscuit, orange juice and water.
-Resident #3 consumed 100% of all food items.
-Without a therapeutic diet menu, it was unable to be determined if Resident #3 was served the NCS diet as ordered by the physician.

Refer to interview with the DM on 05/23/18 at 9:00am.

Refer to interview with the Administrator on 05/22/28 at 4:55pm.

Refer to interview with the Administrator on 05/23/18 at 11:30am.

4. Review of Resident #4's current FL2 dated 06/30/17 revealed:
-Diagnoses included Type 2 diabetes, dementia and confusion.
-A physician's order for a NCS diet.

Review of the tray cards located in the kitchen revealed Resident #4 was to be served a NCS diet.

Review of the lunch menu for 05/22/18 revealed residents on a regular diet were to be served a salmon patty, stewed potatoes, sweet snap peas, rolls and "Kay's treat."

Observation of the lunch meal service on 05/22/18 from 12:00pm to 12:40pm revealed:
-Resident #4 was served a cut up salmon patty, a roll, mashed potatoes, sweet snap peas, a 3X3 inch square of sugar-free cherry pie, water and unsweetened tea.
-Resident #4 was fed by a Personal Care Assistant (PCA).
-Resident #4 consumed 50% of the salmon patty, none of the roll, 50% of the mashed potatoes,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 296	Continued From page 8	D 296		

50% of the sweet snap peas, 100% of the sugar-free cherry pie, 100% of both the unsweetened tea and the water.
-Without a therapeutic diet menu, it could not be determined if Resident #4 was served the NCS diet as ordered by the physician.

Review of the breakfast menu for 05/23/18 revealed residents on a regular diet were to be served cold cereal, scrambled eggs, grits/oatmeal and sausage biscuit.

Observation of the breakfast meal service on 05/23/18 from 8:15am to 9:00am revealed:
-Resident #4 was served grits, a sausage patty, a biscuit, scrambled eggs, orange juice and water.
-Resident #4 was fed by a PCA.
-Resident #4 consumed 50% of the grits, 50% of the sausage patty, none of the biscuit, 50% of the scrambled eggs, 100% of the orange juice and none of the water.
-Without a therapeutic diet menu, it could not be determined if Resident #4 was served the NCS diet as ordered by the physician.

Refer to interview with the DM on 05/23/18 at 9:00am.

Refer to interview with the Administrator on 05/22/28 at 4:55pm.

Refer to interview with the Administrator on 05/23/18 at 11:30am.

Interview with the DM on 05/23/18 at 9:00am revealed:
-She had been the DM at this facility for 1 ½ years.
-She had always used regular diet menus for all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 296	Continued From page 9 residents. -No one had ever told her she needed a menu for every therapeutic diet offered to residents. -For residents on a Puree diet, she pureed all foods on the regular diet menu. -For residents on a NCS diet, she made adjustments to what she served them based on her personal knowledge of family members who had diabetes which usually consisted of not adding sugar to any foods during preparation. -She could not recall taking the required Food Service Orientation training. Interview with the Administrator on 05/22/18 at 4:55pm revealed: -He provided oversight to the DM. -He was aware the facility was required to have a menu for every therapeutic diet offered. -He thought the DM was using therapeutic menus to prepare meals for residents on a NCS diet and Puree diet. A second interview with the Administrator on 05/23/18 at 11:30am revealed: -He had located therapeutic diet menus provided by the facility's food distributor. -The menus were located in a notebook in the DM's office. -He did not know why she had not been using the therapeutic diet menus, but he would ensure the menus would be used in the future for the guidance of food service staff.	D 296		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 367	Continued From page 10 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure accurate documentation on the electronic Medication Administration Record (eMAR) for 1 of 5 sampled residents (Resident #4) regarding Lasix (a medication used to treat fluid retention and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions). The findings are: Review of Resident #4's current FL2 dated 06/30/17 revealed: -Diagnoses included Type 2 diabetes, dementia, confusion and edema (swelling caused by excess fluid trapped in the body's tissues.) -A physician's order for Lasix 20mg 1 tablet to be	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 367	Continued From page 11 administered every other day. Review of Resident #4's medical record revealed: -There was no order for Lasix on the subsequent signed physician's order sheet dated 12/04/17. -There was documentation dated 03/26/18 facility staff sent a fax to Resident #4's physician indicating Resident #4's left lower extremity was swollen with what appeared to be 3+ edema and she was not currently taking any diuretics. -There was a physician's order dated 03/28/18 for Lasix 20mg 1 tablet daily for 3 days, then stop and an order to have a Doppler ultrasound of the left leg. Review of Resident #4's March 2018 eMAR revealed: -An entry for Lasix 20mg 1 tablet daily for 3 days with a start date of 03/29/18 and a stop date of 04/05/28. -Lasix 20mg 1 tablet daily was documented as being administered at 8:00am on 03/30/18 and 03/31/18. Review of Resident #4's April 2018 and May 2018 eMARs revealed: -An entry for Lasix 20mg 1 tablet daily for 3 days with a start date of 03/29/18 and a stop date of 04/05/28. -Lasix 20mg 1 tablet daily was documented as being administered at 8:00am on 04/01/18 and then again from 04/06/18 to 04/30/18. -There was no documentation for Lasix 20mg from 04/02/18 to 04/05/18. -Lasix 20mg 1 tablet daily was documented as being administered at 8:00am from 05/01/18 to 05/22/18. Observation of Resident #4's medications available for administration on 05/23/18 at	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 367	Continued From page 12 12:12pm revealed there was no Lasix available for administration. Attempted telephone interview with Resident #4's responsible party on 05/23/18 at 10:30am was unsuccessful. Telephone interview with a representative from the facility's contracted pharmacy on 05/23/18 at 1:11pm revealed: -The last order the pharmacy had for Resident #4's Lasix was dated 03/28/18 for Lasix 20mg 1 tablet daily for 3 days then stop. -The previous order for Lasix 20mg 1 tablet every other day had been discontinued in August 2017. -The pharmacy had last dispensed Lasix 20mg for Resident #4 on 03/28/18 and had dispensed only 3 tablets at that time. Interview on 05/23/18 at 1:35pm with the medication aide (MA) responsible for Resident #4's morning medication pass on 05/23/18 revealed: -She realized during the 05/23/18 morning medication pass there was no Lasix 20mg available for administration to Resident #4. -She attempted to reorder the Lasix for Resident #4 on 05/23/18 but the computer system would not allow her to do so. -Upon further investigation, she realized she was unable to order more Lasix for Resident #4 because the order was written for only 3 days of administration. -Typically the facility only received enough medications from the pharmacy to fulfill the current order. -In the case of Resident #4's Lasix, the facility would have only received 3 tablets. -She could not explain why she had documented 40 times since 04/06/18, including the morning of	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 367	Continued From page 13	D 367		

05/23/18, Resident #4 had been administered Lasix 20mg 1 tablet daily even though there was no Lasix available for administration.
-MAs could document the administration of medications on the eMAR either by scanning the barcode on the medication punch card or by manually clicking a box on the computer screen.
-She was unable to produce the empty punch card for Lasix 20mg.

Interview on 05/23/18 at 1:40pm with the MA responsible for Resident #4's morning medication pass on 05/22/18 revealed:
-Her first day of administering medications at this facility was 05/22/18.
-She could not recall if she had administered Lasix to Resident #4 on 05/22/18 or if there was any Lasix available for administration to Resident #4.
-She was unable to produce the empty punch card for Lasix 20mg.

Telephone interview with the Director of Clinical Services from the facility's contracted pharmacy on 05/23/18 at 2:10pm revealed:
-She was the facility's primary point of contact for questions on the eMAR system.
-She provided monthly training sessions to facility staff.
-The pharmacy entered all orders into the eMAR system.
-Facility staff could edit orders in the eMAR system if necessary.
-If any facility staff had edited Resident #4's order for Lasix 20mg 1 tablet daily for 3 days and did not reenter the original stop date of 04/02/18, the stop date would have reverted back to the default date of 2028.
-Any order with a stop date of 2028 would still appear on the MA's computer screen for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 367	Continued From page 14	D 367		

administration to the resident.
-Without a medication available for administration and a barcode to scan, the only way the MAs could document a medication as administered would be to manually check the administration box.

Interview with the Resident Care Director (RCD) on 05/23/18 at 2:20pm revealed:
-She was responsible for the oversight of the MAs.
-She did not know MAs were documenting they had administered Lasix to Resident #4 even though there was no Lasix available for administration.
-She could not explain why the MAs would document the administration of medications not available.
-She and the Assistant RCD (A-RCD) were responsible for auditing eMARs for accuracy.
-Around the 25th of each month, the contracted pharmacy would send the upcoming month's eMARs to the facility.
-She or the A-RCD would compare the upcoming month's eMARs to the current month's eMAR to ensure they were accurate.
-They must have missed the order for Lasix 20mg was for 3 days only and the MAs were continuing to document it as being administered.

A second interview with the RCD on 05/23/18 at 3:00pm revealed:
-The facility trained all MAs on a 3 check system for administering medications.
-The MAs were to verify they had the correct medication by looking at the label on the medication punch card, compare the label to the orders in the eMAR and then scan the barcode on the label.
-When the MAs scanned the barcode on the

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D 367	Continued From page 15	D 367		

medication punch card, a check mark would appear in the medication box on their computer screen.
-Once the medications were administered to the resident, the MAs were to click the button for "administered."
-The only time the MAs should be manually clicking the medication box instead of scanning the barcode would be if the medication was over the counter (OTC), a standing order medication or if the medication did not have a scannable barcode.
-All medications dispensed from the facility's contracted pharmacy came with a barcode on the label.

Interview with the A-RCD on 05/23/18 at 3:22pm revealed:
-She was currently working in the roles of A-RCD, a MA, and Activities staff.
-She had audited Resident #4's April e-MAR prior to the order being received for Lasix 20mg 1 tablet daily for 3 days on 03/28/18.
-She had audited Resident #4's May e-MAR but had not noticed the order for Lasix 20mg 1 tablet daily was only for 3 days and the MAs were continuing to document it as being administered.
-While working as an MA, she had documented Resident #4 had been administered Lasix 20mg 1 tablet daily for a total of 5 times since 04/06/18, even though there was no Lasix available for administration.
-Most MAs, including herself, would manually enter a medication as being administered rather than scan the barcode.
-The scanners often did not work and they would receive an "error" when trying to scan a medication so it was easier to manually enter it as administered.
-It was likely the MAs had quickly clicked through

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D 367	Continued From page 16 Resident #4's medication list and manually documented the Lasix was administered when it was not "just to get done by 9:00am." Interview with the Administrator on 05/23/18 at 3:17pm revealed: -MAs were trained by staff from the facility's contracted pharmacy. -The RCD was responsible for ensuring the MAs were following the facility's policies for administering medication. -It was his expectation that MAs would only document a medication as being administered if it were actually administered to the resident. Based on observations and record review, it was determined Resident #4 was not interviewable.	D 367		