Rcd via email 9.11.2018

PRINTED: 08/13/2018
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted an annual, follow-up survey, and complaint investigations on 07/24/18-07/26/18. The complaint investigations were initiated by the Surry County Department of Social Services on 07/09/18, 07/11/18, and 07/18/18.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and documentation review the facility failed to keep the carpet floor coverings clean and in good repair and the showers clean and free of mold. The findings are: 1. Observation on 07/24/18 between 9:30 am and 11:30 am during the initial tour revealed all carpets in the hallways had dark black stains, and were worn toward the center of the hallways. Observations of the carpeted floors between rooms 102 and 118 on the west hallway on 07/24/18 at 9:45 am revealed: -The nap on the carpeted floors in multiple areas was worn slick.	D 074	Wendy A. Hayes 8/28/18 See attached	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Reviewed and Accepted
HNR 9-11-2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 074	Continued From page 1 -The carpet had an approximate 4 foot wide black stained strip the length of the hallway. -The entrance way to the west hallway from the front alcove had carpet seam which was coming apart and the threads were separating. Observations of the carpeted floors between rooms 115 and 134 on the east hallway on 07/24/18 at 10:15 am revealed: -The nap on the carpeted floors in multiple areas was worn slick. -The carpet had an approximate 4 foot wide black stained strip the length of the hallway. -The entrance way to the east hallway from the front alcove had the seam which was coming apart and separating. Observations of the carpeted floors on the west hallway on 07/25/18 at 10:40 am revealed: -The nap on the carpet in front of the utility room was worn slick and pulling up from the floor. -The carpet on the floor had separated from the floor and was loose. -The carpet in front of the door to the utility room had a black stain approximately 24 inches is diameter. -The carpet had an approximate 4 foot wide black stained strip the length of the hallway. Observations of the carpeted floors on the short hallway on 07/24/18 at 11:15 am revealed: -The nap on the carpeted floors in multiple areas was worn slick. -The carpet had an approximate 4 foot wide black strip the length of the hallway. -The lounge area leading to the smoking area was heavily stained with a black ground in substance on the carpet floor. -The corridor adjacent to the lounge entrance had heavily stained carpeted floors.	D 074	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 074	Continued From page 2 Interviews with six residents on 07/24/18 between 9:30 am and 4:00 pm at various intervals revealed: -The residents bedroom carpet had not been shampooed "in over a year" since they had lived at the facility. -The stains on the carpets were caused by some residents had spilled drinks on the floors. -Occasionally the floors get vacuumed, but they had never seen the carpets shampooed. -The carpet was dirty and needed to be replaced. -Another 2 residents had never seen the carpets shampooed. -They felt that the housekeeper did an "ok" job at keeping the carpets picked up. -The floors had not been vacuumed in a while [unsure of specific timeframe]. Interviews with staff between 07/24/18 at 9:30 am and 07/26/18 at 5:00 pm revealed: -There had been some family members that had commented to them about the carpets being stained and needing replaced. -The staff were embarrassed about the condition of the carpet. -They had told the previous administration about the family comments about the carpet, but nothing had been done. -The residents would "drag in" dirt and cigarette ashes on their wheelchairs from the smoking area when they came in which would stain the carpets. -Some residents spill drinks on the floor. -There are "a few" residents who were incontinent and urinated on the floors. Interview with the Resident Care Coordinator on 07/25/18 at 9:40 am revealed: -She had told the previous administration about	D 074	Wendy A Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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
O 074	Continued From page 3 the dirty carpets, but nothing was done. -She wished the carpets were clean and in better condition. -She had worked at the facility for several years. -The carpets had been stained and worn for "many years". -She could not remember the carpets ever being cleaned by a professional company. Interview with the Housekeeper on 7/26/18 at 10:45 am revealed: -She had not been able to do housekeeping full time because she was pulled to cook because the kitchen was short staffed. -A family member would fill in as housekeeper at the facility when needed. -She had previously been the dietary manager and then transferred to housekeeping. -She had worked at the facility for 3 years. -There was a carpet cleaner, but it had not worked for about a month or so. -The residents track up the carpet with cigarette ashes and dirt from the smoking area. -There are some residents in the facility who are incontinent and also spill food and drinks on the floor. -The carpets had been dirty and worn since she had worked at the facility. -The vacuum had been broken for over a month. -"You could not tell, after using the carpet cleaner, that the carpet had ever been cleaned. -"The maintenance man told me the carpet cleaner did not work because it was losing suction". -She would try to use a broom and sweep the carpet when needed. -She had told the previous Administrator about the vacuum being broke and did not get a response.	O 074	Wendy O'Hyde 3/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 074	Continued From page 4 Review of the facility sanitation report dated 06/14/18 revealed: -The sanitation score was 91.5. -'Carpet in the hallways need cleaning'. -' ...was told vacuum is broken and are using a ...' -'Clean moldy showers on both wings'. Interview with the Chief Operating Officer and Interim Executive Director on 07/26/18 at 3:45 pm revealed: -They did not know the vacuum cleaner was not working. -There was a carpet cleaner in the facility and they did not know it did not work. -They thought the carpets could be cleaned. -To their knowledge there were no plans to replace the carpet in the facility. 2. Observation on 07/24/18 at 9:45 am during the initial tour revealed: -The shower stall in the common spa on the back side of Hall 100 (west wing) had a build up of a black substance on the shower tiles on both sides of the portable shower stool. -There was a build-up of a black substance on the bottom of nine wall tiles on the right side of the stool, on the caulking seam next to the floor, as well as the grout seam above the tiles. -There was a black substance on several bottom wall tiles on the left side of the stool, on the caulking seam next to the floor and the grout seam above the 3rd through 8th tiles. Interview with the Maintenance Director on 07/24/18 at 11:50 am revealed: -He was not responsible for cleaning the bathrooms. -The housekeepers were responsible for cleaning the facility including the bathrooms.	D 074	Wendy A Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 074	Continued From page 5 -He did not know what days the bathrooms and spa rooms were scheduled to be cleaned. Interview with the housekeeper on 7/26/18 at 2:30 pm revealed: -She had worked at the facility for 3 years. -She had previously been the dietary manager and then transferred to housekeeping. -She was currently assigned to assisting dietary with the morning and lunch meals due to staffing shortages. -She had not been able to do housekeeping full time because she was pulled to cook in the kitchen because of the kitchen being short staffed. -She was responsible for keeping the bathrooms and spa areas clean. -Her family member would fill in as housekeeper at the facility when needed, but her family member was not full time. -She knew the spa areas needed a deep cleaning. Review of the building Environmental Health Inspection Report dated 06/14/18 revealed: -Total score of 91.5. - "Clean moldy showers on both wings" and "observed mold and mildew on shower and potty chair in both spas" was listed in the comments section of the report. (One demerit was assigned for the cleanliness)	D 074	Wendy A. Hayd 8/28/18 See attached	
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 079	Continued From page 6 orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to maintain a hazard free environment related to raised thresholds in all doors. The findings are: Observation on 07/24/18 between 9:30 am and 11:30 am during the initial tour revealed all doorways had a ceramic threshold of approximately 2 inches in width and 1/4 of an inch in height. Observation on 07/24/18 at 10:00 am of a resident in a wheelchair revealed: -The resident had to back into his room with the wheelchair. -The resident made two attempts to maneuver his wheelchair over the threshold Interview on 07/24/18 at 10:00 am with the same resident revealed: -The only way to get in his room with his wheelchair was to back over the "bump" in the doorway. -It sometimes took him 2 tries to get in his room. -There were some people in wheelchairs that had trouble getting in and out of the doors. Observation on 07/24/18 at 11:45 am of several residents entering the dining room revealed: -One resident rolled his wheelchair up to the	D 079	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 079	Continued From page 7 doorway threshold and placed his hands on both sides of the door and with several attempts pulled himself in the dining room. -A second resident made 2 attempts to roll his wheelchair over the threshold going into the dining room when a staff member came and assisted by pushing him into the dining room by slightly tilting the front wheels of the wheelchair back enough to get over the threshold. Interview on 07/24/18 at 12:20 pm with the two previous residents revealed: -They had trouble getting into the dining room every day because of the elevated area in the doorways. -One of the residents said he was thrown out of his wheel chair when going over the threshold in his room about 6 months ago, but was not hurt. Interviews with 4 residents between 07/24/18 at 9:30 am and 07/26/18 3:00 pm at various intervals revealed: -The residents who use wheelchairs had difficulty with the raised thresholds. -They had seen other residents stumble and trip over the thresholds. -The staff help the residents in wheelchairs to get over the thresholds. -They encourage residents to turn their wheelchairs around and back into their rooms. Interviews with staff between 9:30 am on 07/24/18 and 5:00 pm on 07/26/18 revealed: -Some of the residents in wheelchairs had difficulty getting over the thresholds. -They had not known of any resident who had fallen because of the thresholds. -One of the staff members said that it would be easy for the residents to trip going into their rooms.	D 079	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 079	Continued From page 8 -They helped the residents in wheelchairs to get over the thresholds. Interview with the Resident Care Coordinator on 07/25/18 at 9:45 am revealed: -The staff assisted residents in wheelchairs get over the thresholds. -She could see how they would be a trip hazard for the residents. -They had broken several medication carts going over the thresholds. -She does remember a previous discussion about removing the thresholds and were told that the thresholds were a part of the original fire code. Interview with the Chief Operating Officer and Interim Executive Director on 07/26/18 at 3:45 pm revealed: -They were unaware of any problems caused by the thresholds. -They would mention it to corporate and see if anything could be done.	D 079	Wendy A. Hagh 8/28/18 See attached	
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by:	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 113	Continued From page 9 Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 4 of 10 sampled fixtures (2 sinks,1 shower and 1 tub). The findings are: Observations during the initial facility tour of 100 Hall (West Hall) on 07/24/18 between 11:00 am to 11:45 am revealed: -At 11:04 am, the hot water temperature in the 100 Hall Common Shower Room #1 at the shower was 116 degrees F. -At 11:04 am, the hot water temperature in the 100 Hall Common Shower Room #2 at the sink was 120 degrees F. -At 11:06 am, the hot water temperature in the 100 Hall Common Shower Room #1 at the sink was 120 degrees F. -At 11:10 am, the hot water temperature in the 100 Hall Common Shower Room #2 at the tub was 120 degrees F. -At 11:35 am, the hot water temperature in room #115 at the bathroom sink was 120 degrees F. -At 11:40 am, the hot water temperature in room #120 at the bathroom sink was 120 degrees F. -There were no signs posted to caution residents at any of the fixtures with high temperatures. Interview on 07/24/18 at 11:55 am with the Interim Executive Director revealed: -She would immediately post signs warning residents in the affected rooms where hot water temperature were elevated and to request staff to assist residents with using the hot water until the water was adjusted. Observation on 07/24/18 at 12:20 pm revealed signs had been posted at the sinks, tub and	D 113	Wendy A. Hayd 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 113	Continued From page 10 shower of the affected rooms. Interview on 07/24/18 at 11:50 am with the Maintenance Director revealed: -He had been working at the facility since December 2017. -He had not been monitoring hot water temperatures in the building. -He did not know hot water temperature should be maintained between 100 to 116 degrees F. -He was unable to locate a thermometer for checking hot water temperatures. -He had never seen a hot water temperature log since he had been working at the facility. -There were 4 hot water heaters controlling the hot water temperature for the facility. -He would locate the hot water heater for the affected spas and areas of the 100 Hall and adjust the hot water temperature to be within 100 to 116 degrees F. Interview on 07/24/18 at 11:55 am with the Interim Executive Director revealed: -She had been assigned to the building for 2 to 3 weeks. -She did not know the Maintenance Director was not checking hot water temperatures. -She did not know if the facility had hot water temperature logs for documentation of hot water temperature checks. Interview on 07/24/18 at 12:10 pm with the Resident Care Coordinator (RCC) revealed: -No residents had complained to her about elevated hot water temperatures in the 2 spas or the residents' rooms on the front end of 100 Hall. -No resident or staff had reported burns from elevated hot water temperatures on the 100 Hall. -She did not know if the facility monitored hot water temperatures or maintained a hot water	D 113	Wendy A. Hayes 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 113	Continued From page 11 temperature log or not. -She nor her staff had ever been asked to monitor hot water temperatures in the building except for the kitchen for dish washing. -She thought the Maintenance Director would be responsible for monitoring hot water temperatures. A calibration of the surveyor's thermometer was performed using an ice water slurry on 07/24/18 at 3:40 pm. The temperature registered 32 degrees F. Observations on 07/24/18 from 4:15 pm to 4:25 pm of recheck for hot water temperatures on 100 Hall (West Hall) revealed: -At 4:15 pm, the hot water temperature in the 100 Hall Common Shower Room #1 at the shower was 104 degrees F. -At 4:16 pm, the hot water temperature in the 100 Hall Common Shower Room #1 at the sink was 106 degrees F. -At 4:17 pm, the hot water temperature in the 100 Hall Common Shower Room #2 at the tub was 104 degrees F. -At 4:18 pm, the hot water temperature in the 100 Hall Common Shower Room #2 at the sink was 104 degrees F. -At 4:20 pm am, the hot water temperature in the bathroom in room #115 at the sink was 104 degrees F. -At 4:23 pm am, the hot water temperature in the bathroom in room #120 at the sink was 108 degrees F. Interview on 07/25/18 at 3:25 pm with a personal care aide (PCA) revealed she had not had a resident complain about the hot water temperature being elevated on the 100 Hall.	D 113	Wendy Hyde 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 113	Continued From page 12 Interviews on 07/25/18 from 3:30 pm to 3:35 pm with 3 residents on the 100 Hall in the area with elevated hot water temperatures on 07/24/18 revealed: -One resident stated she adjusted the hot water to a temperature that was comfortable. The water had never been hot enough to burn the resident. -Two residents stated staff always adjusted the hot water at the shower for the resident, and helped to adjust the temperature of the the sink water also.	D 113	Wendy A. Hayes 8/28/18 see attached	
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 staff sampled (B) was tested for tuberculosis (TB) disease upon hire. The findings are: Review of Staff B, medication aide/supervisor's personnel record revealed: -Staff B was hired on 01/16/18. -Staff B had a tuberculosis (TB) skin test placed	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 131	Continued From page 13 on 03/16/17 and read as negative on 03/18/17. -Staff B had a TB skin test placed on 03/31/17 and read as negative on 04/03/17. -There was no documentation of any TB skin tests for Staff B after the 01/16/18 hire date. Interview with Staff B on 07/25/18 at 9:10 am revealed: -She had worked for the facility since January 2018. -The Business Office Manager would have the information for TB skin tests. -She was not sure if she had a TB skin test when she was hired. Interview with the Interim Executive Director (IED) on 07/26/18 at 3:00 pm revealed: -The business office manager (BOM) was responsible for the personnel files. -The current BOM had only been in her position for a couple of months. -The TB skin test information was kept on file at the corporate office. -She was unable to locate information for a TB skin test other than the two TB skin tests in March 2017 for Staff B. -The IED would assure Staff B had TB skin tests scheduled as quickly as possible. Interview with the BOM on 07/26/18 at 3:10 pm revealed: -She was very new to her current position of BOM. -She was responsible for the personnel records. -She was not the BOM when Staff B was hired. -She was unable to locate documentation for a TB skin test since January 2018 for Staff B in any of the facility's personnel records.	D 131	Wendy A Hayes 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 161	Continued From page 14	D 161		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) were competency validated by a registered nurse with return demonstration prior to performing Licensed Health Professional Support (LHPS) tasks, related to transferring a non-ambulatory resident from a wheelchair to a bed with a Hoyer lift. The findings are: Review of Resident #3's current FL2 dated 07/02/18 revealed: -Diagnoses included diabetes, hypertension, hyperlipidemia, hypothyroidism and possible transient ischemic attack (TIA). -Resident #3 was non-ambulatory. Review of Resident #3's physician's order dated 04/19/18 revealed an order for a Hoyer lift related	D 161	Wendy Q. & K.C 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 161	Continued From page 15 to a diagnosis of general weakness and gait instability. Review of Resident #3's LHPS evaluation dated 03/15/18 and 06/12/18 revealed documentation for staff to assist the resident with transferring with a 1 to 2 person assist, but did not mention staff was trained to use a Hoyer lift. 1. Review of Staff A's personnel file on 07/26/18 revealed: -Staff A was hired on 02/14/17 as a medication aide (MA) and supervisor. -There was no documentation of the LHPS competency validation documenting competency in using a Hoyer lift. Review of Resident #3's July 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for a Hoyer lift to use Hoyer lift each shift when transferring the resident. -The Hoyer lift was documented as being used each shift from 07/15/18 to 07/24/18. -Staff A had documented that she had transferred the resident with the Hoyer lift six times during third shift from 11:00pm to 7:00am. Refer to interview with the Resident Care Coordinator (RCC) at on 07/25/18 at 12:52pm and 4:08pm and on 07/26/18 at 4:08pm. Refer to interview with Resident #3 on 07/25/18 at 12:44pm and 4:35pm. Refer to interview with Resident #3's power of attorney (POA) on 07/26/18 at 5:56pm. Refer to interview with the primary care physician	D 161	Wendy A. HSC 3/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 161	Continued From page 16 (PCP) on 07/26/18 at 9:52am. Refer to interview with the Interim Executive Director (ED) and the Chief Operating Officer (COO) on 07/26/18 at 5:00pm. 2. Review of Staff B's personnel file revealed: -Staff B was hired 01/16/18 as a MA and supervisor. -There was no documentation of the LHPS competency validation documenting competency in using a Hoyer lift. Review of Resident #3's July 2018 eMAR revealed: -There was a computer generated entry for a Hoyer lift to use Hoyer lift each shift when transferring the resident. -The Hoyer lift was documented as being used each shift from 07/15/18 to 07/24/18. -Staff B had documented that she had transferred the resident with the Hoyer lift eight times during first shift from 7:00am to 3:00pm and five times during second shift from 3:00pm to 11:00pm. Interview with Staff B on 07/25/18 at 8:15am revealed if she needed to transfer Resident #3, she would get another staff member to assist in a 2 person transfer without using the Hoyer lift. Refer to interview with the RCC at on 07/25/18 at 12:52pm and 4:08pm and on 07/26/18 at 4:08pm. Refer to interview with Resident #3 on 07/25/18 at 12:44pm and 4:35pm. Refer to interview with Resident #3's power of attorney (POA) on 07/26/18 at 5:56pm. Refer to interview with the primary care physician	D 161	Dandy A. Hayes 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 161	Continued From page 17 (PCP) on 07/26/18 at 9:52am. Refer to interview with the ED and COO on 07/26/18 at 5:00pm. --- Interview with the RCC on 07/25/18 at 12:52pm and 4:08pm and on 07/26/18 at 4:08pm revealed: -The Hoyer lift had been in the facility for several weeks before the staff was able to obtain training. -The facility had to find an external agency that would provide a licensed health professional that was willing to come in the facility to provide the training for the Hoyer lift. -A physical therapist had trained staff on 06/21/18 but only 3 staff who were initially trained were still employed by the facility. -The physical therapist had explained how to use the Hoyer lift then each staff member had to show a return demonstration of how to operate the lift. -Since the initial training, the RCC was training additional staff by explaining how to use the Hoyer lift and then observing the staff member using the lift with Resident #3 in the lift. -The RCC was not a registered nurse. -She had no documentation clearly showing which staff members had been trained and what was covered in the training. -Each staff member "should be using the lift with every transfer but we are only documenting it once per shift." -She was leaving it up to each individual staff member if they felt comfortable transferring Resident #3 without the Hoyer lift. Interview with Resident #3 on 07/25/18 at 12:44pm and 4:35pm revealed: -Staff does not always use a Hoyer lift when transferring her.	D 161	Wendy A. Hoyle 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 161	Continued From page 18 -When transferring her from the wheelchair to the bed without the lift, 2 staff members will pull her up from the wheelchair and let her fall back onto her bed. -She has never fallen to the floor while being transferred. -She is not sure that all the staff has been trained in how to use the lift. -She had been having some back pain. Interview with Resident #3's power of attorney (POA) on 07/26/18 at 5:56pm revealed: -He was aware that the facility should be using the Hoyer lift to transfer his family member. -He was upset that it took the facility several weeks to start using the lift once it was in the building. -He had called the facility and had requested they start using the lift and stop dropping his family member during transfers. Interview with the primary care physician (PCP) on 07/26/18 at 9:52am revealed: -The PCP had written the order for the Hoyer lift at the request of the staff because they were having difficulty with transferring Resident #3. -The expectation of the PCP was that the "Hoyer lift should be used with every transfer" involving Resident #3. -The PCP was not aware that it took 2 months after the order was written for any of the staff to be trained on how to use the lift. Interview with Interim Executive Director (ED) and Chief Operating Officer (COO) on 07/26/18 at 5:00pm revealed that staff should be trained before using the Hoyer lift with any resident.	D 161	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 19	D 273		
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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow up to meet the acute health care needs of 1 of 3 sampled residents (Resident #3) related to a referral for wound care. The findings are: Review of Resident's #3 current FL-2 dated 07/02/18 revealed: -Diagnoses included diabetes, hypertension, hyperlipidemia, hypothyroidism and possible transient ischemic attack (TIA). -The resident was non-ambulatory and incontinent of bowel and bladder. -The skin of the peri-area and buttocks region had some excoriations. Review of Resident #3's Care Plan dated 05/07/18 revealed that the resident required extensive assistance with toileting, dressing, grooming and ambulation and complete assistance with bathing. Review of Resident #3's Care Notes dated 06/15/18 revealed she had an open sore on her left bottom buttocks and the wound was dressed	D 273	Wendy A. Hayden 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 20 with petroleum jelly and antibiotic cream. Review of Resident #3's physician order signed and dated 06/28/18 revealed an order for a wound care evaluation from a skilled nurse for the lower buttocks area. Interview with a home health nurse on 07/25/18 at 10:07am revealed -Resident #3's had a diagnosis of dementia. -She had to get permission from the resident's power of attorney (POA) or responsible guardian to enroll the resident in home health services. -When she contacted the resident's relative, he refused care because he wanted to move his family member to skilled care. -She wrote a note to the primary care provider (PCP) and faxed the notification to her office that the service could not be provided. -When she talked with the Interim Executive Director (ED) about the status of the referral, the ED took some notes and said she would "look into it." Interview with the Resident Care Coordinator (RCC) on 07/25/18 at 10:13am revealed: -The home health agency should have contacted the doctor when the wound referral was declined by the resident's POA. -The wound was red and looked like a "diaper rash." Interview with Resident #3's POA on 07/26/18 at 5:56pm revealed: -He had not been contacted by home health or the facility about his family member having a wound referral. -The facility "very rarely" contacted him about anything related to the care of his family member. -She sat in her wheelchair all day and was not	D 273	Wendy A. Hayes 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 21 cleaned properly. -During her recent hospitalization, she was treated for a yeast infection in her groin area. Interview with a Personal Care Aid (PCA) on 07/26/18 at 4:32pm revealed: -The buttocks region of Resident #3 was red with no open wounds. -She applied a barrier cream to area after toileting. -The wound would changed "daily with some days looking better than others." Observation of Resident #3's wound on 07/26/18 at 4:08pm with staff present and resident permission revealed: -The wound covered approximately 75% of Resident #3's peri and groin area. -The wound was a dark red to purple color and it appeared to have blisters approximately 12 inches in length forming in the center of the wound. -The wound appeared to have no weeping or drainage. Interview with Resident #3 on 07/26/18 at 4:40pm revealed: -The area where the wound was located burned, itched and was uncomfortable. -The staff applied the barrier cream daily to her buttocks area. Interview with Resident #3's PCP on 07/26/18 at 9:52am revealed: -She "did not know that the wound evaluation was never followed through with." -"The wound may progress if wound care was not provided in a timely manner." -Resident #3 was a diabetic and had uncontrolled blood sugars.	D 273	Wendy C. Hayden 8/28/18 see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING: _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 22 Interview with Interim Executive Director (ED) and Chief Operating Officer (COO) on 07/26/18 at 5:00pm revealed that it was the "responsibility of the RCC to make sure that all orders were successfully followed through." The failure of the facility to follow up with Resident #3's provider, who ordered a home health wound care referral, related to the resident's POA refusing to provide consent for treatment, was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2018.	D 273	Wendy A. Hayes 8/28/18 See attached	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 23 clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician following a hospitalization for clarification of medication orders for 1 of 5 sampled residents (Resident #3) regarding orders for Novolog Flexpen, Baza Protective cream, loratadine, potassium chloride, and fish oil. The findings are: Review of Resident's #3 current FL2 dated 07/02/18 revealed: -Diagnoses included diabetes, hypertension, hyperlipidemia, hypothyroidism and possible transient ischemic attack (TIA). -The medications listed included Novolog Flexpen (used to treat diabetes) 3 times daily with meals per sliding scale, potassium chloride 10meq (used as a supplement to maintain potassium levels) once daily, and fish oil 1000mg (a supplement used to treat cholesterol) once daily. -There were no medication orders for loratadine (used to treat allergies) or Baza Protective cream (barrier cream used to protect the skin from irritation) listed on the FL2. -The directions for the sliding scale insulin was not included on the FL2. Review of Resident #3's discharge summary from the hospital dated 07/02/18 revealed: -The admission date was 06/29/18. -The medications listed included Novolog inject 1 unit subcutaneous 3 times daily, potassium chloride 20meq daily, and fish oil 3000mg once	D 344	Wendy A. Hoyle 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 24 daily. -There were no medication orders for loratadine or Baza Protective cream listed on the discharge summary. 1. Review of Resident #3's physician order's dated 06/14/18 revealed a medication order for Novolog Flexpen check fingerstick blood sugar (FSBS) three time daily; inject subcutaneously 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U; notify MD if less than 70 or greater than 400. Review of Resident #3's June 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for Novolog Flexpen check fingerstick blood sugar (FSBS) three time daily; inject subcutaneously 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U; notify MD if less than 70 or greater than 400. -Novolog Flexpen was documented as administered a total of 81 times from 06/01/18 to 06/29/18. -The resident was out of the facility at the hospital prior to 5:00pm medication pass on 06/29/18 through 06/30/18. Review of Resident #3's July 2018 eMAR revealed: -There was a computer generated entry for Novolog Flexpen check fingerstick blood sugar (FSBS) three time daily; inject subcutaneously 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U; notify MD if less than 70 or greater than 400. -Novolog Flexpen was documented as administered a total of 53 times from 07/02/18 to 07/24/18.	D 344	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 25 -The resident was out of the facility at the hospital on 07/01/18 and returned before the 8:00pm medication pass on 07/02/18. Observations of Resident #3's medications on hand on 07/26/18 at 12:46pm revealed the resident had 1 Novolog Flexpen available for administration. Telephone interview with the facility contracted pharmacy on 07/26/18 at 12:33pm revealed Novolog Flexpen (5 pens each containing 3 ml of medication) was last dispensed on 07/18/18 with the directions check FSBS 3 times daily; 200-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units; contact doctor if FSBS<70 or >400. Interview with the medication aide (MA) on 07/25/18 at 1:08pm revealed: -She was administering sliding scale insulin to Resident #3 based on a signed physician's order dated prior to the 07/02/18 hospital discharge summary or FL2. -The medication orders were faxed to the pharmacy by the MA or the supervisor. -Once the pharmacy entered the order, the order was "pended" until the MA verified the order. -The MA made sure the order from the pharmacy matched the written order. -The new order appeared on the eMAR starting at midnight of the day it was entered. Refer to interview with the Resident Care Coordinator (RCC) on 07/25/18 at 1:27pm. Refer to interview with Resident #3 on 07/25/18 at 12:44pm. Refer to interview with Resident #3's Primary	D 344	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 26 Care Physician (PCP) on 07/26/18 at 9:52am. Refer to interview with the Interim Executive Director (ED) on 07/26/18 at 5:00pm. 2. Review of Resident #3's physician order dated 06/28/18 revealed a medication order for Baza Protective Cream apply to buttocks with each toileting every 2 hours. Review of Resident's #3 current FL2 dated 07/02/18 revealed no order for Baza Protective Cream. Review of Resident #3's June 2018 electronic Treatment Administration Record (eTAR) revealed: -There was a computer generated entry for Baza Protective cream, apply to buttocks after toileting every 2 hours. -Baza Protective Cream should be administered at 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am, 4:00am and 6:00am. -The cream was applied six times during the month of June prior to Resident's hospital admission on 06/29/18. Review of Resident #3's July 2018 eTAR revealed: -There was a computer generated entry for Baza Protective cream, apply to buttocks after toileting every 2 hours. -Baza Protective Cream should be administered at 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am, 4:00am and 6:00am. -Baza Protective cream was documented as administered every 2 hours from the resident's readmission from the hospital on 07/02/18 to	D 344	Wendy A. Hyde 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 27 07/24/18. Observation of medications on hand for Resident #3 on 07/26/18 at 12:46pm revealed that Baza Protective cream was not available for application. Interview with the Resident Care Coordinator (RCC) on 07/25/18 at 10:40am and 07/26/18 at 12:46pm revealed: -The staff kept the Baza cream at the bedside of Resident #3 because they applied it so often. -The order for the barrier cream was dated prior to the last FL2 but the facility still considered it an active order. Interview with Resident #3 on 07/26/18 at 12:52pm revealed that the staff applied the Baza Protective cream on her and she knew it was on the nightstand by her bed. Telephone interview with the facility contracted pharmacy on 07/26/18 at 12:33pm revealed: -Baza Protective cream (142 gram tube) was dispensed on 07/13/18 and 07/17/18 each for a 7 day supply with the directions apply to buttocks after every toileting every 2 hours. -The medication order for Baza Protective Cream was dated 06/28/18. Refer to interview with the medication aide (MA) on 07/25/18 at 1:08pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/25/18 at 1:27pm. Refer to interview with Resident #3 on 07/25/18 at 12:44pm. Refer to interview with Resident #3's Primary	D 344	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 28 Care Physician (PCP) on 07/26/18 at 9:52am. Refer to interview with the Interim Executive Director (ED) on 07/26/18 at 5:00pm. 3. Review of Resident #3's physician order dated 06/14/18 revealed a medication order for loratadine 10mg once daily. Review of Resident's #3 current FL2 dated 07/02/18 revealed no order for loratadine. Review of Resident #3's June 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for loratadine 10mg once daily at 8:00am. -Loratadine had been documented as administered daily from 06/01/18 to 06/29/18 except for 06/23/18 and 06/26/18 when the medication was on order from the pharmacy. Review of Resident #3's July 2018 eMAR revealed: -There was a computer generated entry for loratadine 10mg once daily at 8:00am. -Loratadine had been documented as administered daily from 07/01/18 to 07/24/18 except for 07/01/18, 07/02/18 and 07/14/18 when the resident was out of the facility at the hospital. Observation of medications on hand for Resident #3 on 07/26/18 at 12:46pm revealed a medication card of loratadine 10mg containing 27 tablets. Telephone interview with the facility contracted pharmacy on 07/26/18 at 12:33pm revealed loratadine 10 mg was last dispensed on 07/17/18 for 28 days' supply with the directions once daily and was a monthly cycle fill medication that was	D 344	Wendy A. Hayd 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 29 dispensed every 28 days. Refer to interview with the medication aide (MA) on 07/25/18 at 1:08pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/25/18 at 1:27pm. Refer to interview with Resident #3 on 07/25/18 at 12:44pm. Refer to interview with Resident #3's Primary Care Physician (PCP) on 07/26/18 at 9:52am. Refer to interview with the Interim Executive Director (ED) on 07/26/18 at 5:00pm. 4. Review of Resident #3's physician order dated 06/14/18 revealed a medication order for potassium chloride 20mEq once daily. Review of Resident #3's June 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for potassium chloride 10mEq take 2 capsules (20mEq) once daily (do not crush) at 8:00am. -Potassium chloride had been documented as administered daily from 06/01/18 to 06/29/18. Review of Resident #3's July 2018 eMAR revealed: -There was a computer generated entry for potassium chloride 10mEq take 2 capsules (20mEq) once daily (do not crush) at 8:00am. -Potassium chloride had been documented as administered daily from 07/01/18 to 07/24/18 except for 07/01/18, 07/02/18 and 07/14/18 when the resident was out of the facility at the hospital.	D 344	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 30 Observation of medication on hand for Resident #3 on 07/25/18 at 8:15am revealed a medication card of potassium chloride 10mEq containing 22 capsules. Interview with the pharmacy consultant on 07/25/18 at 1:18pm revealed the pharmacy enters medication orders based on the discharge summary and they do not go by the FL2. Telephone interview with the facility contracted pharmacy on 07/26/18 at 12:33pm revealed: -Potassium chloride was cycled filled at the pharmacy and was last filled on 07/17/18 for a 28 day supply. -Potassium chloride was last filled with the directions 20mEq daily. Refer to interview with the medication aide (MA) on 07/25/18 at 1:08pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/25/18 at 1:27pm. Refer to interview with Resident #3 on 07/25/18 at 12:44pm. Refer to interview with Resident #3's Primary Care Physician (PCP) on 07/26/18 at 9:52am. Refer to interview with the Interim Executive Director (ED) on 07/26/18 at 5:00pm. 5. Review of Resident #3's physician order dated 06/14/18 revealed a medication order for fish oil 3 capsules (3000mg) once daily. Review of Resident #3's June 2018 eMAR revealed: -There was a computer generated entry for fish	D 344	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 31 oil 3 capsules (3000mg) once daily at 11:00am. -Fish oil had been documented as administered daily from 06/01/18 to 06/29/18. Review of Resident #3's July 2018 eMAR revealed: -There was a computer generated entry for fish oil 3 capsules (3000mg) once daily at 11:00am. -Fish oil had been documented as administered daily from 07/01/18 to 07/24/18 except for 07/01/18, 07/02/18 and 07/14/18 when the resident was out of the facility at the hospital. Interview with the pharmacy consultant on 07/25/18 at 1:18pm revealed that the pharmacy enters medication orders based on the discharge summary and they do not go by the FL2. Telephone interview with the facility contracted pharmacy on 07/26/18 at 12:33pm revealed fish oil was last filled on 07/17/18 with the directions 3000mg daily and was cycled filled every 28 days. Refer to interview with the medication aide (MA) on 07/25/18 at 1:08pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/25/18 at 1:27pm. Refer to interview with Resident #3 on 07/25/18 at 12:44pm. Refer to interview with Primary Care Physician (PCP) on 07/26/18 at 9:52am. Refer to interview with the Interim Executive Director (ED) on 07/26/18 at 5:00pm. Interview with the medication aide (MA) on	D 344	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 32 07/25/18 at 1:08pm revealed: -The medication orders were faxed to the pharmacy by the MA or the supervisor. -Once the pharmacy entered the order, the order was "pended" until the MA verified the order. -The MA made sure the order from the pharmacy matched the written order. -The new order appeared on the eMAR starting at midnight of the day it was entered. Interview with the Resident Care Coordinator (RCC) on 07/25/18 at 1:27pm revealed: -It was the responsibility of her or the Supervisor to contact the doctor who wrote the order, if a order needed clarification. -She was responsible for follow up to make sure orders were clarified, including any discrepancies between FL2s and discharge summaries. -All FL2 documents should be faxed to the pharmacy immediately and then placed on her desk for her review and processing. Interview with Resident #3's Primary Care Physician (PCP) on 07/26/18 at 9:52am revealed: -She did not know that Resident #3 had been admitted to the hospital from 06/29/18 to 07/02/18. -She came to the facility every 2 weeks to evaluate the residents. -She was sometimes not notified about changes in health of the residents. -If the facility had contacted her to clarify orders, then she would have instructed facility to follow all medication orders on the discharge summary from the hospital. -The facility should have called her to get a clarification on the sliding scale insulin order. -She would have instructed the facility to continue the sliding scale insulin dosing that was being followed prior to hospital admission.	D 344	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 344	Continued From page 33 -The RCC was her primary contact at the facility and was usually the only person she has contact with from the facility. -She will make sure all orders are clarified and orders are updated in Resident #3's record. Interview with the Interim Executive Director (ED) and Chief Operation Officer (COO) on 07/26/18 at 5:00pm revealed: -All orders should be faxed to the pharmacy once they are received. -The RCC or supervisor should approve all orders once they are entered into the computer by the pharmacy. -The RCC had the responsibility to decide which supervisors could approve orders. -The RCC should check MARs to orders monthly and do referral and follow up. -The RCC should be comparing FL-2 documents with discharge summaries and performing random monthly audits of medications.	D 344	Wendy A. Hyde 8/28/18 See attached	
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: TYPE B VIOLATION	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING: _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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		

Based on observations, record reviews, and interviews, the facility failed to administer medications as prescribed by a licensed prescribing practitioner for 3 of 3 residents observed during the medication pass with errors related to polyethylene glycol powder (#7), Advair 250/50 inhaler (#8) and loratadine 10 mg and Citracal 200/500 international units (#3), administration of a mouthwash (#9), and 2 of 5 sampled residents related to administration of Novolog Flexpen sliding scale insulin (#4 and #3), and finger stick blood sugar (FSBS) checks (#3).

The findings are:

1. The medication pass error rate was 10 % as evidenced by the observation of 4 errors out of 38 opportunities during the 8:00 am medication pass on 07/25/18.

a. Review of Resident #7's current FL-2 dated 10/05/17 revealed:
-Diagnoses included hypertension, diabetes mellitus 2 and hyperlipidemia.
-There was an order for Miralax 17 grams mix in 8 ounces of water and drink daily. (Miralax is used to treat constipation.)

Review of Resident #7 physician's order dated 06/18/18 revealed an order for polyethylene glycol 3350 powder (generic Miralax) mix one capful (17 grams) with 8 ounces of water and drink once daily.

Observation of the 8:00 am medication pass on 07/25/18 at 7:40 am revealed:
-The dayshift medication aide (MA) prepared 8 medications for administration to Resident #7, including 7 oral medications and 17 grams

Wendy A. Hayes
8/28/18
See attached

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 (measured in the medication's cap) of polyethylene glycol 3350 powder mixed in 8 ounces of water. -At 7:45 am, the MA carried the medications to the dining room where Resident #7 was seated for breakfast. -Resident #7 took the 7 oral medications using 2 sips of the polyethylene glycol 3350 powder mixed in 8 ounces of water. -The MA turned and walked out of the dining room, leaving Resident #7 with 6 ounces of polyethylene glycol 3350 powder mixed in water. -Resident #7 sat the partial cup (six ounces) of polyethylene glycol 3350 powder mixed in 8 ounces of water down on the table and started to eat breakfast. Observation on 07/25/18 at 7:40 am revealed a partial bottle of polyethylene glycol 3350 powder labeled for Resident #7. Observation on 07/25/18 at 8:40 am of the dining room table where Resident #7 had been sitting revealed the Styrofoam cup used for polyethylene glycol 3350 powder mixed in 8 ounces of water was sitting on the table with 6 ounces of the mixture remaining in the cup. Review of Resident #7's July 2018 electronic medication administration record (eMAR) revealed: -There was an entry for Polyethylene glycol 3350 powder mix one capful (17 grams) with 8 ounces of water and drink once daily and scheduled for administration at 8:00 am. -The medication was documented as administered on 07/25/18 at 8:00 am. Interview on 07/25/18 at 10:50 am with Resident #7 revealed:	D 358	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 36 -He routinely drank all his laxative medication (polyethylene glycol 3350 powder mixed in 8 ounces) with his medications in the dining room. -He did not finish the medication this morning because he forgot to drink the rest. -Some staff watched him drink all the medication and some staff left it for him to drink. Interview on 07/25/18 at 1:13 pm with the medication aide (MA) observed administering Resident #7's medications revealed: -She prepared Resident #7's polyethylene glycol 3350 powder mixed in 8 ounces of water as ordered. -She took the medication to the dining room and did not wait for the resident to consume all of the medication. -She knew she was supposed to watch the resident swallow all medications before documenting administration on the eMAR. -She left the medication with the resident because she needed to pass more medications to other residents and did not want to get behind on her medication pass. Interview on 07/25/18 at 3:30 pm with the Resident Care Coordinator (RCC) revealed: -The MAs were trained to document administration of medications only after they observed the resident swallow the medications. -The MA should have encouraged the resident to drink the polyethylene glycol 3350 mixture or documented the refusal if the resident did not consume the medication. Interview on 07/25/18 at 5:00 pm with the Interim Executive Director and Chief Operating Officer (COO) revealed the MAs should have administered medications as ordered and watched the resident consume the medication	D 358	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 37 prior to documenting on the eMAR. Review of the facility's "Medication Administration policy revealed "Staff will provide documentation on the MAR after observing the residents taking the medications and before administration to another resident". b. Review of Resident #8's current FL-2 dated 03/16/18 revealed: -Diagnoses included dementia and chronic obstructive pulmonary disease. -There was an order for Advair 250-50 disk (used to improve breathing) inhale one puff orally twice a day. Review of Resident #8's signed physician's orders dated 06/14/18 revealed an order for Advair 250-50 disk inhale one puff orally twice daily. Observation of the 8:00 am medication pass on 07/25/18 at 8:00 am revealed: -The dayshift medication aide/supervisor (MA) prepared 11 oral medications in a plastic souffle cup for Resident #8. -The MA asked to step away from the medication cart, carefully placed the plastic souffle cup in the top drawer of the medication cart, locked the cart, went down the hall, and returned in 1-2 minutes. The MA did not give a reason for leaving the cart. -The MA did not identify any additional medications to be administered for Resident #8 at 8:00 am. -At 8:05 am, the MA administered the oral medications to Resident #8 in the resident's room. -The MA documented administration of the medications on the electronic medication administration record (eMAR).	D 358	Wendy A Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 38 Review of Resident #8's July 2018 eMAR revealed: -There were 11 oral medications entered on the eMAR scheduled for administration on 07/25/18 at 8:00 am and documented as administered to Resident #8. -There was an entry for Advair 250-50 inhale one puff orally twice daily and scheduled for administration at 8:00 am with documentation "patient unable to take medication" on 07/25/18 under the exceptions. Observation on 07/25/18 at 10:00 am revealed no Advair 250-50 disk inhaler for Resident #8 was available for administration on the medication cart or in the back-up stock. Interview on 07/25/18 at 11:00 am with the MA during the medication pass revealed: -She did not administer Resident #8's Advair 250-50 because the resident did not have the medication in the medication cart. -She checked the resident's back-up stock when she asked to leave the medication cart. -Resident #8's Advair was added to the list of medications requested from the contracted pharmacy today (07/25/18) and it should be delivered to the facility with the medication orders from the contracted pharmacy today. -She did not consider ordering the Advair 250-50 from the back-up pharmacy because the medication was documented as administered the night before (07/24/18 at 8:00 pm). -She mainly just ordered antibiotics or medications that might run out on the weekend from the back-up pharmacy. -She documented "patient unable to take medication" for the reason not administered because the resident could not take the	D 358	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING: _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 39 medication if there was none on hand to administer; there was not an option for medication not available in the drop down selections on the eMAR. -She was instructed when she trained on the medication cart to use that code, but she was not sure by whom. -Most medications were sent from the contracted pharmacy on a monthly cycle fill. -Advair 250-50 inhalers were not routinely sent on a cycle fill and should be reordered when the indicator showed about 10 doses remaining. -She could not explain why Resident #8's Advair had not been reordered before it ran out. Interview on 07/25/18 at 3:30 pm with the Resident Care Coordinator (RCC) revealed: -The residents should not be running out of medication. -The MAs were responsible to look through the medication carts for residents needing medication during each shift they worked. -She did not have a system in place to routinely audit the medication carts for non-cycle filled medications. -MAs could order medications from the back-up pharmacy and have the medication within an hour for most medications, but they should not need to order routine medications from the back-up pharmacy if proper reordering was done. -MAs documented "patient unable to take medication" when a medication was not available from the pharmacy because there was not an option for "medication not available from pharmacy." -She was going to discuss adding the out of stock option for MA documentation of medications not administered. Interview on 07/26/18 at 4:20 pm with Resident	D 358	Wendy A. Hoyle 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING: _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 40 #8 revealed: -She knew she did not receive Advair 250-50 inhaler on the morning of 07/25/18. -She did not experience any difference in her breathing during the day (07/25/18). -She used the medication to help her breathing. c. Review of Resident's #3 current hospital FL-2 and hospital discharge summary dated 07/02/18 revealed: -Diagnoses included diabetes, hypertension, hyperlipidemia, hypothyroidism and possible transient ischemic attack (TIA). -Loratadine 10 mg one tablet daily was not ordered on the FL2 or discharge summary. -There was an order for Citracal calcium 200-500 tablet one tablet 3 times a day (no order for citrus calcium/vitamin D 200-250 tablet). Observation of the medication pass on 07/25/18 at from 8:10 am to 8:32 am revealed: -The dayshift medication aide (MA) prepared 17 oral medications for administration to Resident #3, including one loratadine 10 mg tablet (used to treat allergies) and one citrus calcium/vitamin D 200-250 tablet (a supplement used to treat low calcium). -Resident #3 was administered the 17 oral medications on 07/25/18 at 8:30 am. Review of Resident #3's physician's order dated 06/14/18 revealed an order for loratadine 10mg once daily. Review of Resident #3's July 2018 electronic medication administration record (eMAR) revealed: -There was an entry for loratadine 10 mg one tablet daily scheduled for administration at 8:00 am daily and documented as administered on	D 358	Wendy A. Hyde 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 41 07/25/18 at 8:00 am. -There was an entry for Citrus calcium/vitamin D 200-250 tablet scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily and documented as administered on 07/25/18 at 8:00 am. Observation on 07/25/18 at 8:32 am of medication on hand for administration for Resident #3 revealed: -There were 23 tablets remaining on a bingo card of 28 tablets dispensed on 7/17/18 for citrus calcium/vitamin D 200-250 -There were 27 tablets remaining on a bingo card of 28 tablets dispensed on 7/17/18 for loratadine 10 mg. Interview on 07/25/18 at 11:04 am with the dayshift medication aide (MA) revealed: -She administered medications according to the eMAR. -She did not know Resident #3 loratadine 10 mg was left off the FL2 dated 07/02/18 and the hospital discharge dated 07/02/18, and should not have been administered until clarified. -She did not know Resident #3 had an order for citrus calcium/vitamin D 200-250 (Citracal calcium 200-500 tablet was ordered on the FL2 and discharge summary). -The residents' medication orders (discharge summary, FL2, or written orders) were supposed to be faxed to the pharmacy by the MA on duty when the orders were received. -The contracted pharmacy was responsible to enter all medication orders and place the order in pending status for the facility staff to review. -The facility staff released the orders for the pending status when approved and the medications appeared on the eMAR screen for administration.	D 358	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 42 -The Resident Care Coordinator (RCC) or supervisor were responsible to check the residents' orders against the current FL2 or discharge summary for accuracy. Interview with Resident #3 on 07/25/18 at 12:44 pm revealed she was not able to keep track of all the medications she received; she depended on the MAs to give medications as ordered by the physician. Interview on 07/25/18 at 1:13 pm with a pharmacist representative for the contracted pharmacy revealed: -The pharmacy should have discontinued the lorstadine from the eMAR based on the medication not appearing on the FL2 and discharge summary for Resident #3 dated 07/02/18. (The pharmacy would make the correction on the eMAR on 07/25/18.) (It was ordered on 06/14/18 before the FL2 and D/C summary) -The pharmacy made a substitution for the citrus calcium/vitamin D 200-250 (Citracal calcium 200-500 tablet was ordered one the FL2 and discharge summary). They did not document contact with the provider for the substitution. (The pharmacy would clarify the switch with the provider). -The pharmacy routinely used the discharge summary for filling orders if both the FL2 and discharge summary were dated the same day because the FL2 may have been generated on admission and not corrected at discharge. -The facility staff were responsible to verify or clarify any orders compared to the eMAR if the orders were different on the FL2 or discharge summary. Interview with the RCC on 07/25/18 at 3:30 pm	D 358	Wendy O. Hyde 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 43	D 358		

revealed:
-She randomly "spot checks" the MARs monthly at random.
-She tried to check the orders for the residents she knew who had a lot of order changes.
-She had no specific system for ensuring that medications were being administered correctly.
-She had not seen the FL2 or discharge summary dated 07/02/18 because they were filed in the resident's record without her checking.

2. Review of Resident #9's current FL2 dated 01/12/18 revealed diagnoses included hypertension, and bipolar disorder.

Observation on 07/25/18 at 7:52 am of the medication pass in the dining room revealed Resident #9 was seated at the dining room table and there was a plastic souffle cup containing 15 ml of pale blue thin liquid sitting on the table in front of her plate.

Review of Resident #9's current FL2 dated 01/12/18 and physician's orders dated 06/14/18 revealed orders for chlorhexidine gluconate 0.12% solution swish 15 ml in mouth for 1 to 2 minutes twice a day and expectorate every morning and every evening after brushing. (Chlorhexidine gluconate 0.12% solution is a pale blue thin liquid, used to treat gum irritations.)

Review of Resident #9's July 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for chlorhexidine gluconate 0.12% solution with directions to swish 15 ml in mouth for 1 to 2 minutes twice a day and expectorate every morning and every evening after brushing and scheduled at 8:00 am and 8:00 pm daily.

Wendy A. Hyde
8/28/18
See attached

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING: _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 44 -Chlorhexidine gluconate 0.12% solution was documented as administered at 8:00 am on 07/25/18. Interview on 07/25/18 at 7:52 am with Resident #9 revealed: -The medication aide (MA) routinely poured her mouthwash in "a little cup" and sat it on the table when she received her morning medications in the dining room. -Resident #9 left it sitting beside her beverage cups until she finished her meal, then she took the mouth rinse with her to her room. -She swished her mouth with the rinse for a minute or two and then spit the rinse in her sink. -She preferred to receive the mouth rinse like that and knew not to swallow. Interview on 07/25/18 at 1:13 pm with the dayshift MA revealed: -She did not think about she had to watch Resident #9 use the chlorhexidine gluconate 0.12% solution mouth rinse before she documented administration. -She knew she was supposed to watch administration before documenting on the eMAR. -She prepared the rinse and sat it on the table when she gave Resident #9 her morning medications. -Resident #9 knew how to use the mouth rinse and requested the mouth rinse in the past when she was getting her other medications. Interview on 07/25/18 at 3:30 pm with the Resident Care Coordinator (RCC) revealed the MAs were trained to document administration of medications only after they observed the resident swallow the medication. Interview on 07/25/18 at 5:00 pm with the Interim	D 358	Wendy A. Hyd 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 45 Executive Director and Chief Operating Officer (COO) revealed the MAs should administered medications as ordered and watch the resident consume the medication prior to documenting on the eMAR. 3. Review of Resident #4's current FL-2 dated 12/12/17 revealed: -Diagnoses included history of atrial fibrillation and type 2 diabetes. -There was an order for finger stick blood sugar checks (FSBS) four times a day before meals and at bedtime and as needed. -There was an order for Novolog Flexpen 100 units/milliter subcutaneously as needed per sliding scale (high dose sliding scale). (Novolog is a rapid acting insulin whose manufacturer recommends eating a meal within 5 to 10 minutes after taking the insulin. Flexpen is a delivery system for administering insulin by dialing the dose from an insulin pen). Review of Resident #4's record revealed an admission orders clarification dated 12/12/17 as follows: -There was an order for FSBS 4 times a day before meals and at bedtime and as needed (prn). -There was an order to discontinue high dose sliding scale. -There was an order for Novolog per sliding scale insulin (SSI) 3 times a day with FSBS. -The sliding scale (SS) parameters for FSBS results were: 201-250= 2 units, 251-300= 4 units, 301-350=6 units, 351-400= 8 units, 401-450= 10 units and notify MD (physician). Review of Resident #4's physician's order dated 06/14/18 revealed an order for Novolog Flexpen 100 units/milliter subcutaneously per SSI 3 times	D 358	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 46 a day with meals. SS parameters for FSBS results were: 201-250= 2 units, 251-300= 4 units, 301-350=6 units, 351-400= 8 units, 401-450= 10 units and notify MD (physician). Observation of the medication pass on 07/25/18 from 7:30 am to 8:32 am revealed: -No resident was administered sliding scale insulin during the 8:00 am medication pass. -Residents were observed receiving breakfast beginning at 7:35 am. Review of Resident #4's May 2018 electronic medication administration record (eMAR) revealed: -There was an entry for check FSBS before meals and at bedtime and scheduled for 6:00 am, 11:00 am, 5:00 pm and 9:00 pm daily. There were documented FSBS results for 31 times out of 31 opportunities at each time (except at 11:00 am on 05/22/18). -There was an entry for Novolog Flexpen subcutaneously per SSI 3 times a day with meals: 201-250= 2 units, 251-300= 4 units, 301-350=6 units, 351-400= 8 units, 401-450= 10 units and notify MD (physician). -The times for administration listed were 6:30 am, 11:00 am, and 5:00 pm. -At 6:30 am, there were 31 FSBS results documented and SSI was documented as administered 22 times for 22 opportunities according to the SSI parameters. (FSBS results ranged from 144 to 315). (FSBS results at the next schedule time of 11:00 am ranged from 104 to 389). -Documentation by staff of FSBS results and SSI administration on the eMAR at 6:30 am were different than staff who documented medication administration at 11:00 am on the eMAR.	D 358	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 47 Review of Resident #4's June 2018 eMAR revealed: -There was an entry for check FSBS before meals and at bedtime and scheduled for 6:00 am, 11:00 am, 5:00 pm and 9:00 pm daily. There were documented FSBS results for 30 times out of 30 opportunities at each time (except at 9:00 pm on 06/10/18 and at 5:00 pm 06/22/18). -There was an entry for Novolog Flexpen subcutaneously per SSI 3 times a day with meals: 201-250= 2 units, 251-300= 4 units, 301-350=6 units, 351-400= 8 units, 401-450= 10 units and notify MD (physician) -The times for administration listed were 6:30 am, 11:00 am, and 5:00 pm. -At 6:30 am, there were 30 FSBS results documented and SSI was documented as administered 2 times for 2 opportunities according to the SSI parameters. (FSBS results ranged from 72 to 234). (FSBS results at the next schedule time of 11:00 am were 206 and 154). -Documentation by staff of FSBS results and SSI administration on the eMAR at 6:30 am were different than staff who documented medication administration at 11:00 am on the eMAR. Review of Resident #4's July 2018 eMAR revealed: -There was an entry for check FSBS before meals and at bedtime and scheduled for 6:00 am, 11:00 am, 5:00 pm and 9:00 pm daily. There were documented FSBS results for 23 times out of 23 opportunities at each time from 07/01/18 to 07/23/18 (except at 9:00 pm on 07/13/18). -There was an entry for Novolog Flexpen subcutaneously per SSI 3 times a day with meals: 201-250= 2 units, 251-300= 4 units, 301-350=6 units, 351-400= 8 units, 401-450= 10 units and notify MD (physician). -The times for administration listed were 6:30 am,	D 358	Wendy A. Harper 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING: _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 48 11:00 am, and 5:00 pm. -At 6:30 am, there were 23 FSBS results documented and SSI was documented as administered 0 times for 0 opportunities according to the SSI parameters. (FSBS results ranged from 70 to 161). -Documentation by staff of FSBS results and SSI administration on the eMAR at 6:30 am were different than staff who documented medication administration at 11:00 am on the eMAR. Interview with the medication aide/supervisor (MA) on 07/25/18 at 12:55 pm revealed: -She gave the 11:00 am dose of Novolog SSI but the third shift MA gave the morning dose of SSI. -She worked third shift occasionally and would give the residents' SSI before leaving at 7:00 am. -The third shift MA checked the blood sugars at 6:00 am then give a dose of Novolog Flexpen if indicated by SSI orders. -The residents routinely started eating breakfast at 7:30 am. -She was trained by another MA when she started on the medication cart to administer the morning SSI with the FSBS checks starting at 5:30 am. Interviews with the Resident Care Coordinator (RCC) on 07/25/18 at 3:30 pm and on 07/26/18 at 11:50 am revealed: -Staff were trained to start FSBS checks at 5:30 am and finish around 6:30 am administering the sliding scale insulin at the time of FSBS. -The night shift (3rd shift) did the FSBS checks and administered SSI to residents before the dayshift (7:00 am to 3:00 pm) started in order to get the FSBS checks on an empty stomach and completed before breakfast. -She knew the SSI order for Resident #4's was Novolog 3 times a day with meals, however staff had been giving the morning SSI the same way	D 358	Wendy A. Hyde 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 49 for a couple of years -The residents were routinely served breakfast at 7:30 am. -She did not know of any resident having blood sugar drops that required a visit to the local emergency room for low blood sugars after receiving their SSI one hour or more before breakfast. -She randomly "spot checks" the MARs monthly at random. -She tried to check the orders for the residents she knew who had a lot of order changes. -She had no specific system for ensuring that medications were being administered correctly. Interview on 07/26/18 at 9:55 am with the Nurse Practitioner (NP) at Resident #4's primary care physician's office revealed: -She would expect the facility to administer rapid acting insulins according to the manufacturer's recommendation for consuming meals within 10 to 15 minutes of receiving Novolog insulin injections. -She did not know residents receiving Novolog SSI in the morning were getting insulin injections more than one hour before eating a meal instead of with a meal as ordered or at 5:30 am to 6:30 am for the morning SSI doses. -She reviewed residents' eMARs during routine check-up visits with the diabetic residents, however she did not focus on the time of administration of SS.I but on the FSBS results for adjusting long acting insulin to help control the diabetes. Interview with the Interim Executive Director (ED) and Chief Operation Officer (COO) on 07/25/18 at 5:00 pm revealed: -The RCC was responsible to assure medications were administered as ordered.	D 358	Wendy A. Taylor 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 50 -Rapid acting insulin like Novolog should be administered according to the directions of with meals or within 10 to 15 minutes of a resident eating a meal. -The MAs would have received training on administering insulin at least annually for the administration of insulin and the various types of insulin along with which were long acting and which were rapid acting. 4. Review of Resident's #3 current FL2 dated 07/02/18 revealed: -Diagnoses included diabetes, hypertension, hyperlipidemia, hypothyroidism and possible transient ischemic attack (TIA). -There was an order for Novolog Flexpen 3 times daily with meals per sliding scale. a. Review of Resident #3's signed physician order's dated 06/14/18 revealed Novolog Flexpen check FSBS three time daily; inject subcutaneously 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U; notify MD if less than 70 or greater than 400. Review of Resident #3's May 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for Novolog Flexpen check FSBS three time daily; inject subcutaneously 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U; notify MD if less than 70 or greater than 400. -FSBS was checked 3 times daily at 6:00am, 11:00am and 5:00pm from 05/01/18 to 05/31/18. -Novolog Flexpen was documented as administered a total of 66 times from 05/01/18 to 05/31/18. -At 6:00am, there were 31 FSBS values documented and SSI was administered 30 times	D 358	Wendy A.T kept 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 51 out of 31 opportunities according to SSI parameters (FSBS values ranged from 163 to 457). -The FSBS checks and the 6:00am dose of Novolog Flexpen for sliding scale insulin (SSI) were administered by the third shift medication aide (MA). -Resident #3 was documented as administered the wrong SSI dose per SSI parameters on 05/09/18 at 6:00am (FSBS was 361 and 6 units of Novolog were documented as administered). Review of Resident #3's June 2018 eMAR revealed: -There was a computer generated entry for Novolog Flexpen 100units/ml check FSBS three time daily; inject subcutaneously 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U; notify MD if less than 70 or greater than 400. -FSBS was checked 3 times daily at 6:00am, 11:00am and 5:00pm from 06/01/18 to 06/29/18. -Novolog Flexpen was documented as administered a total of 81 times from 06/01/18 to 06/29/18. -The resident was at the hospital prior to 5:00pm medication pass on 06/29/18 through 06/30/18. -At 6:00am, there were 29 FSBS values documented and SSI was documented as administered 28 times out of 29 opportunities according to SSI parameters (FSBS values ranged from 136 to 359). -The FSBS checks and the 6:00am dose of Novolog Flexpen for sliding scale insulin (SSI) was documneted as administered by the third shift medication aide (MA). -The resident #3 was administered the wrong SSI dose per SSI parameters on 06/20/18 and 06/24/18 at 5:00pm (FSBS was 300 and 4 units of Novolog were documented as administered and FSBS was 320 and 8 units were documented	D 358	Wendy A Hyde 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 52 as administered). Review of Resident #3's July 2018 eMAR revealed: -There was a computer generated entry for Novolog Flexpen 100units/ml check fingerstick blood sugar (FSBS) three time daily; inject subcutaneously 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U, notify MD if less than 70 or greater than 400. -FSBS was checked 3 times daily at 6:00am, 11:00am and 5:00pm from 06/01/18 to 06/29/18. -Novolog Flexpen was documented as administered a total of 53 times from 07/02/18 to 07/24/18. -The resident was out of the facility in the hospital on 07/01/18 and returned prior to the 5:00pm FSBS check. -At 6:00am, there were 22 FSBS values documented and SSI was administered 19 out of 29 opportunities according to SSI parameters (FSBS values ranged from 92 to 334). -Resident #3 was administered the wrong SSI dose per SSI parameters on 07/11/18 at 11:00am and 07/14/18 at 5:00pm (FSBS was 298 and 8 units of Novolog were documented as administered and FSBS was 337 and 8 units were administered). Observation of the medication pass on 07/25/18 from 7:30am to 8:32am revealed: -No resident was administered sliding scale insulin during the 8:00am medication pass. -Residents were observed receiving breakfast beginning at 7:35am. Observations of medications on hand for Resident #3 on 07/26/18 at 12:46pm revealed resident had 1 Novolog Flexpen available for administration.	D 358	Wendy A. Hyde 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 53 Telephone interview with contracted facility pharmacy on 07/26/18 at 12:33pm revealed the Novolog Flexpen was last dispensed to Resident #3 on 07/18/18 with the directions check FSBS three times daily and inject subcutaneously 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U, notify MD if less than 70 or greater than 400. Interview with the medication aide/Supervisor (MA) revealed on 07/25/18 at 12:55 pm revealed -She gave the 11:00am dose of Novolog but the third shift MA administered the morning dose. -She worked third shift occasionally and would give the residents' SSI before leaving at 7:00 am. -The third shift MA checked the blood sugar at 6:00 am then would administer a dose of Novolog Flexpen if indicated by sliding scale. -The residents routinely started eating breakfast at 7:30 am. -She was trained by another MA to administer the morning SSI with the FSBS checks starting at 5:30 am. Interviews with the Resident Care Coordinator (RCC) on 07/25/18 at 3:30 pm and on 07/26/18 at 11:50 am revealed: -Staff were trained to start FSBS checks at 5:30 am and finish around 6:30 am administering the sliding scale insulin at the time of FSBS. -The night shift (3rd shift) did the FSBS checks and administered SSI to residents before the dayshift (7:00 am to 3:00 pm) started in order to get the FSBS checks on an empty stomach and completed before breakfast. -The residents were routinely served breakfast at 7:30 am. -She did not know of any resident having blood sugar drops that required a visit to the local	D 358	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 54	D 358	Wendy A. Hayden 8/28/18 See attached	

emergency room for low blood sugars after receiving their SSI one hour or more before breakfast.
-She "spot checks" the MARs monthly at random.
-She tries to check the orders for the residents she knows have had a lot of changes.
-She has no specific system for ensuring that medications are being administered correctly.

Interview on 07/26/18 at 9:55 am with Resident #4's primary care Nurse Practitioner (NP) revealed:
-She would expect the facility to administer rapid acting insulins according to the manufacturer's recommendation for consuming meal within 10 to 15 minutes of receiving Novolog insulin injections.
-She did not know residents receiving Novolog SSI in the morning were getting insulin injections more than one hour before eating a meal instead of with a meal as ordered or at 6:30 am to 6:30 am for the morning SSI doses.
-She reviewed residents' eMARs when she had routine check-up visits with the diabetic residents, however she did not focus on the time of administration of SSI or the amount of insulin given.
-She would focus on the FSBS values for adjusting long acting insulin to help control the diabetes.

Interview with the Interim Executive Director (ED) and Chief Operation Officer (COO) on 07/25/18 at 5:00 pm revealed:
-The RCC was responsible to assure medications were administered as ordered.
-Rapid acting insulin, like Novolog, should be administered according to the directions of with meals or within 10 to 15 minutes of a resident eating a meal.
-The medication aides would have received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 55 training on administering insulin at least annually for the administration of insulin and the various types of insulin along with which were log acting and which were rapid acting. b. Review of Resident's #3 current FL2 dated 07/02/18 revealed an order to check finger stick blood sugars (FSBS) before each meal and at bedtime (four times daily). Review of Resident #3's July 2018 eMAR revealed FSBS was checked 3 times daily at 6:00am, 11:00am and 5:00pm only with no bedtime readings. Interview with Resident #3 on 07/25/18 at 12:44pm revealed that she did not remember getting her blood sugar checked at bedtime. Interview with the RCC on 07/25/18 at 12:52pm and on 07/26/18 at 11:50am revealed: -The facility did not check Resident #3's FSBS at bedtime because she did not have a current order stating to check it at this time. -The RCC did not have the most recent order for Resident #3's FSBS and was implementing an order from May 2018. -She "spot checks" the MARs monthly at random. -She tried to check the orders for the residents she knows have had a lot of changes. -She had no specific system for ensuring that medications are being administered correctly. Interview with Resident #3's primary care physician (PCP) on 07/26/18 at 5:00pm revealed: -She did not know that Resident #3 had been to the hospital and had updated orders for FSBS. -She would clarify the order for the facility to start checking Resident's FSBS with every meal and at bedtime.	D 358	Wendy A. Hyde 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 56 Interview with the Interim Executive Director (ED) and Chief Operation Officer (COO) on 07/26/18 at 5:00pm revealed: -The RCC was responsible to assure medications were administered as ordered. -The RCC or supervisor should approve all orders once they are entered into the computer by the pharmacy. -The RCC should check MARs to orders monthly and do referral and follow up. -The RCC should be comparing FL-2 documents with discharge summaries and performing random monthly audits of medications. --- The failure of the facility to administer medications as ordered related to polyethylene glycol powder (#7) increasing the risk for pain and discomfort from constipation, Advair 250/50 inhaler (#8) increasing the risk for difficulty breathing, and 2 of 5 sampled residents related to administration of Novolog Flexpen sliding scale insulin (#4 and #3) which placed the residents at risk for dizziness, falls, and loss of consciousness, and finger stick blood sugar (FSBS) check (#3) which reduced the monitoring provided to the resident was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. --- The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2018.	D 358	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 371	Continued From page 57	D 371		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to assure medications were administered to 2 of 5 residents (Resident #3, and #8) observed during a medication pass in accordance with infection control measures. The findings are: 1. Observation of the 8:00 am medication pass on 07/25/18 at 8:00 am revealed: -The dayshift medication aide/supervisor (MA/S) prepared 11 oral medications in a plastic souffle cup for Resident #8. -At 8:05 am, the MA administered the oral medications to Resident #3's in the resident's room. -The MA returned to the medication cart and documented administration of the medications in the electronic medication administration record (eMAR). -The MA did not use a hand sanitizer or wash her hands after administration of Resident #3's medications. 2. Observation of the medication pass on 07/25/18 at from 8:10 am to 8:32 am revealed: -There was a box of gloves on the medication	D 371	Wendy Atkinson 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 371	Continued From page 58 cart. -The dayshift MA prepared 17 oral medications for administration to Resident #3. -The MA removed a Levemir Flexpen (an insulin pen used to supplement insulin in diabetic individuals) from top drawer of the medication cart, applied an unopened needle cap and dialed the insulin pen to 57 units. -The MA retrieved a bottle of olopatadine 0.2% eye drops (used to treat itchy eyes) from the top drawer of the medication cart. -The MA gathered an alcohol swab, the insulin pen, the eye drops, and the cup of medication in her hands, and stated she was ready to administer Resident #3's medication, and turned toward the resident's room. -At 8:25 am, the surveyor intervened, asking the MA if she was going to use gloves to administer the eye drops or the Levemir insulin. Interview on 07/25/18 at 8:26 am with the dayshift MA revealed: -She did not routinely use gloves when she administered insulin to a resident because she did not see blood when she gave the insulin. -The MA did use gloves when she obtained residents' finger stick blood sugar checks because there was blood present during the procedure. -The MA did not routinely use gloves when she administered eye drops because she was not coming into contact with body fluids. -The MA periodically used hand sanitizer but not between each resident. Observation on 07/25/18 at 8:32 am revealed the MA applied gloves and administered the oral medications, one drop of olopatadine 0.2% eye drops in each eye, and the Levemir insulin in the resident's room.	D 371	Wendy A. Hayden 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 371	Continued From page 59 Interview on 07/25/18 at 3:30 pm with the Resident Care Coordinator (RCC) revealed: -The facility's policy was to wear gloves when doing FSBS checks -The facility policy was staff did not have to apply gloves for eye drops unless the staff was helping with opening the eye (If the resident could keep eye open for drops then staff did not need gloves.) -Staff did not always wear gloves for administering insulin with pens. -MAs should use hand sanitizer after administering each residents' medications. Review of the facility's medication administration policy revealed "Facility staff will administer medications in accordance with infection control measures".	D 371	Wendy A. Hayes 8/28/18 See attached	
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to report allegations of neglect toward a resident, regarding one staff, Staff D,	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 438	Continued From page 60 personal care aide (PCA) obtaining illegal drugs for a resident, to the Health Care Personnel Registry (HCPR) within 24 hours of the Interim Executive Director's notification and failed to complete the HCPR 5 day report. The findings are: Review of Staff D, PCA's, personnel record revealed: -Staff D was hired on 5/31/18. -Staff D had no substantiated findings on the HCPR when completed on 05/30/18. Review of the complaint information received by the local Department of Social Services revealed allegations of an employee selling marijuana to a resident at the facility. Interview with the Business Office Manager on 7/09/18 at 12:45 pm revealed: -She did not know of the allegation of resident neglect on 7/03/18. -She did not know if the allegation of resident neglect had been reported to the Resident Care Coordinator or other supervisors. -The staff member (Staff D) identified in the complaint was not working today. Interview on 07/11/18 at 2:30 pm with the named resident revealed: -The resident used to "smoke pot a long time ago, but I don't anymore". -"I don't know what you are talking about. Somebody is lying." -Further interview was declined. Interview with the Interim Executive Director on 7/11/18 at 4:30 pm revealed: -She did not know of an allegation of resident	D 438	Wendy Cif Kupka 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 438	Continued From page 61 neglect on 7/03/18. -She would know if the allegation of resident neglect had been reported. -She talked with Human Resources Chief Operating Officer by phone (on 07/11/18 at 4:30 pm) who verified there were no reports of an allegation of resident neglect. -She would begin an in-house investigation immediately. -Staff D would be suspended immediately until after the in-house investigation was closed. -An in-house investigation would include interviewing the resident specified in the allegation. -The investigation would then involve interviewing staff. Interview with Business Office Manager on 7/18/18 at 1:35 pm revealed: -The last day of work for the Staff D was 7/07/18. -The Staff D had called on 7/13/18 and resigned without giving a notice. -She had mailed a termination letter to Staff D on 7/16/18. Telephone interview with the Interim Executive Director on 7/18/18 at 3:50 pm revealed: -The in-house investigation started on 7/11/18 when she became aware of the alleged incident. -The Staff D was suspended as soon as she became aware of the alleged incident. -The last thing she heard was Corporate Human Resources have not been able to get in touch with Staff D. -Staff D had not worked since 7/07/18. -She did not file a 24-hour report with HCPR and did not file a 5 day report regarding the in-house investigation of the allegation on 7/03/18. -She would talk with Chief Operating Officer at Corporate Human Resources for further	D 438	Wendy A. Hyde 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 438	Continued From page 62 information. Telephone interview with the Interim Executive Director on 7/18/18 at 4:45 pm revealed: -She had talked with Chief Operating Officer at Corporate Human Resources. -Staff D had called the Business Office Manager on 7/16/18 and resigned. -She did not submit a 24-hour report to HCPR. -She had looked at the "new form" for the initial allegation report and based on the definitions, the alleged incident did not "fall under one of those categories". -She would submit a 24-hour report for alleged neglect to HCPR today. Interview with the Resident Care Coordinator on 7/24/18 at 10:00 am revealed: -She had been working third shift for the last couple of weeks. -She was not made aware of an allegation against Staff D on 7/3/18. -If she had known about any complaint between a staff member and a resident, she would immediately report the information to the Interim Executive Director. Review of the HCPR 24- hour report dated 7/18/18 completed by the Interim Executive Director and faxed on 7/18/18 revealed: -The report alleged resident neglect by Staff D on an unknown date. -Staff D was hired on 5/31/18 as a Personal Care Aide. -The report did not identify a "reasonable suspicion of a crime." -The incident was not reported to Law Enforcement. -In the "Allegation Information" section, the date reported was 7/11/18 at 4:30 pm, and contained	D 438	Wendy A. Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 438	Continued From page 83 the statement, "DSS came to the facility on 7/11/18 to look into a complaint they received. Adult Home Specialist reported an allegation of an employee selling marijuana at facility." Review of the HCPR 5-day report dated 7/25/18 completed by the Interim Executive Director revealed: -The in-house investigation was conducted by a Corporate employee between the dates of 7/18/18 to 7/25/18. -The results of the investigation was, "allegation against Staff D was not substantiated due to the inability to prove that employee sold marijuana to a resident or that marijuana was brought into the facility". Telephone interview with a representative for HCPR on 7/26/18 at 3:00 pm revealed: -The 24- hour HCPR report was received by fax on 7/18/18 from the facility. -The 5-day HCPR investigation was received by fax on 7/25/18 from the facility. The facility failed to report allegations to HCPR within 24 hours of becoming aware of allegations that Staff D was providing illegal drugs to a resident. The facility's failure to report the allegation was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/13/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2018	D 438	Wendy Hayes 8/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 64	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to health care, medication administration, and reporting to the Health Care Personnel Registry (HCPR). The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow up to meet the health care needs of 1 of 3 sampled residents (Resident #3) related to a wound referral. [Refer to Tag D0273, 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to administer medications as prescribed by a licensed prescribing practitioner for 3 of 3 sampled residents observed during the medication pass with errors related to polyethylene glycol powder (#7), Advair 250/50 inhaler (#8) and loratadine 10 mg and Citracal 200/500 international units (#3).	D912	Wendy A. Hayes 2/28/18 See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 65 administration of a mouthwash (#9), and 2 of 5 sampled residents related to administration of Novolog Flexpen sliding scale insulin (#4 and #3), and finger stick blood sugar (FSBS) check (#3). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)] 3. Based on record reviews and interviews, the facility failed to report allegations of neglect toward a resident, regarding Staff D obtaining illegal drugs for a resident, to the Health Care Personnel Registry (HCPR) within 24 hours of the Interim Executive Director's notification and failed to complete the HCPR 5 day report. (Type B Violation).]	D912	Wendy A. Hayden 8/28/18 See attached	

Elkin Assisted Living
HAL-086-013
Plan of Correction
DHSR Survey/Complaint

10A NCAC 13F.0306(a) Housekeeping and Furnishings

Plan of Correction

- Carpeting to be cleaned 8/2/18
- Mold in the shower to be cleaned 8/2/18

Monitoring System

- Hallway carpets to be cleaned weekly x8 weeks or until new carpet is installed 8/27/18 and ongoing)
- Residents rooms to be cleaned on a rotating basis in order to be cleaned quarterly and as needed. 8/27/18 and ongoing
- Carpets to be vacuumed in common areas 3x weekly and as needed. 8/27/18 and ongoing
- Residents rooms to be vacuumed weekly and as needed. 8/27/18 and ongoing
- Shower/spa to be cleaned daily by housekeeping to remain free from mold and mildew. 8/27/18 and ongoing.
- Executive Director/Designee will check the hallway, common areas, resident room and bathrooms 1x week for 4 weeks then monthly x3 months then randomly thereafter. 8/27/18 and ongoing.

10A NCAC 13F.0306(a)(5) Housekeeping and Furnishings

Plan of Correction

- The thresholds will be replaced. 8/27/18 and ongoing

10A NCAC 13F.0311(d) Other Requirements

Plan of Correction

- Hot water temps to be adjusted immediately. 7/24/18
- Signs to be posted immediately to alert residents and staff of high water temps. 7/24/18
- Staff to assist residents with adjusting water temps. 7/24/18

Monitoring System

- Maintenance will check water temps weekly x4 weeks then on a biweekly basis. 8/27/18 and ongoing
- Maintenance will maintain a log of water temps. 8/27/18 and ongoing
- Maintenance will report any raised water temps(above 116 degrees) immediately to the Executive Director. 8/27/18 and ongoing
- Executive Director will monitor log of water temps on biweekly x2 months then randomly thereafter. 8/27/18 and ongoing

10A NCAC 13F.0406(a) Test for Tuberculosis

Plan of Correction

- Staff B received 2 step TB 7/30/18

Monitoring System

- All new hires will have 1st step TB prior to hire date. 7/30/18 and ongoing
- Executive Director will randomly review TB tests of new hires . 8/23/18 and ongoing

10A NCAC 13F.0504 Competency Validation for LHPS Tasks

Plan of Correction

- All PCA staff to be trained using the Hoyer Lift. 9/5/18
- Hoyer lift will be used for all transfers for ordered resident. 9/5/18 and ongoing

Monitoring System

- RCC will check that all PCA staff have Competency Validation for LHPS tasks by the RN to include using the Hoyer Lift. 9/5/18 and ongoing
- RCC will review MAR 1x week for 4 weeks and then monthly to assure Hoyer Lift is being used of all transfers for ordered resident. 8/27/18 and ongoing

Elkin Assisted Living
HAL-086-013
Plan of Correction
DHSR Survey/Complaint

10A NCAC 13F.0902(b) Health Care
G.S 131D-21(2) Declaration of Residents' Rights

Plan of Correction

- RCC to review all recent (w/in last 60 days) discharge summaries and orders to ensure any orders needing referral to outside agencies or providers are completed. 7/26/18 to 7/28/18
- RCC will follow up on all referrals immediately to ensure accuracy and correct documentation 7/28/18 to 7/31/18
- Staff to be retrained on Resident Rights. 8/30/18

Monitoring System

- RCC will follow up with outside service providers to ensure ordered service is being provided. 8/27/18 and ongoing
- Executive Director will randomly speak to residents regarding any resident rights concerns they may have. 8/16/18 and ongoing

10A NCAC 13F.1002(a) Medication Orders

Plan of Correction

- RCC to review discharge orders/current FL-2 as it relates to current MAR's on all residents returning to the facility from the hospital/rehab with in the last 60 days to ensure all orders match. 7/28/18 to 7/30/18

Monitoring System

- RCC to review all returning resident discharge orders/FL-2 and current MARs to ensure they match 8/27/18 and ongoing
- RCC will contact physician for order clarification on all current returning residents on any non-matching and/or unclear orders 8/27/18 and ongoing

10A NCAC 13F.1004(a) Medication Administration
G.S. 131D-21(2) Declaration of Residents' Rights

Plan of Correction

- MA staff retrained on medication administration. 8/22/18
- MA staff retrained on medication errors. 8/22/18
- MA staff retrained on caring for diabetic residents. 8/24/18
- Staff retrained on Residents Rights. 8/30/18

Monitoring System

- RCC to watch medication pass 1x week for 4 weeks then monthly. 7/25/18 and ongoing
- RCC/Designee will review medication orders to ensure medications are ordered/refilled timely. 8/24/18 and ongoing
- RCC to check MAR's monthly to ensure the upcoming month's MAR is correct. 8/24/18 and ongoing
- Executive Director will randomly speak to residents regarding any resident rights concerns they may have. 8/16/18 and ongoing

10A NCAC 13F.1004(n) Medication Administration

Plan of Correction

- Staff retrained in proper infection control measures. 8/31/18

Monitoring System

- RCC to observe medication pass 1x week for 4 weeks then monthly thereafter to ensure proper infection control measures are used. 8/27/18
- RCC to observe PCA staff 1x for 4 weeks then randomly thereafter to ensure proper infection control measures are used. 8/27/18

Elkin Assisted Living
HAL-086-013
Plan of Correction
DHSR Survey/Complaint

10A NCAC 13F.1205 Health Care Personnel Registry
G.S. 131D-21(2) Declaration of Residents Rights

Plan of Correction

- 24- hour report to be completed and submitted to HCPR. 7/18/18
- 5- day report completed and submitted to HCPR. 7/25/18

Monitoring System

- Facility will submit all allegation to the HCPR with in 24 hours. 7/18/18 and ongoing
- Facility will submit 5- day report to the HCPR. 7/25/18 and ongoing
- Executive Director/Designee will ensure the investigative reports are completed and submitted to the HCPR in 24 hours and the 5 day investigation.

Wendy A. Hayden
Executive Director

8/28/18
Date

Peedin, Ray

From: Karen Shaver <Karen.Shaver@myvschome.com>
Sent: Tuesday, September 11, 2018 4:17 PM
To: Peedin, Ray
Subject: [External] Plan of Correction
Attachments: scanner@mytahome.com_20180911_151713.pdf

CAUTION: External email. Do not click links or open attachments unless verified. Send all suspicious email as an attachment to Report Spam.<mailto:report.spam@nc.gov>

Ray—

Was able to get the corrections you requested. Please let me know if I can be of further assistance.

Thanks
Karen Shaver
VSC Compliance Director
Karen.Shaver@myvschome.com