STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl035032	A. BUILDING: _____ B. WING _____	11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE AT HILLSBORO STREET	502 HILLSBORO STREET YOUNGSVILLE, NC 27596

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C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on November 20, 2018.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to implement a physician's order for 1 of 1 sampled residents (#1) with an order for blood pressures weekly. Review of Resident #1's current FL-2 dated 10/04/18 revealed diagnoses included Alzheimer's dementia, hyperlipidemia, depression, anxiety, and osteoporosis. Review of Resident #1's physician orders revealed there was an order dated 10/26/18 for blood pressure checks once a week and no other orders for blood pressure checks were in the record. Review of Resident #1's October 2018 and November 2018 medication administration records (MARs) revealed -There was a handwritten entry dated 10/26/18 to check blood pressure monthly call physician if systolic blood pressure was more than 200 or	C 249		

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C 249	Continued From page 1	C 249		

less than 90 and diastolic blood pressure was more than 110 or less than 50.
-There were no entries for blood pressure readings on the October 2018 MAR.
-There was a handwritten entry on the November 2018 MAR for a blood pressure reading on 11/15/18 of 114/71.

Interview with the contract pharmacy on 11/20/18 at 12:15 pm revealed:
-Physician orders were sent to the pharmacy via fax, electronic prescription or the healthcare provider may call in a prescription.
-The pharmacy placed orders on the MARs for the facility, unless the orders were written and received after monthly MARs were delivered or right after the monthly MARs were printed.
-Also, any orders received mid-month were not placed on the MAR until the next month's MARs were printed.
The facility was responsible for placing orders written and received between MARs delivery dates and mid-month on the current months MARs.

Interview with the Supervisor in Charge (SIC) on 11/20/18 at 1:05 pm revealed:
-She was responsible for ensuring the physician's orders were sent to the pharmacy and placed on the MARs.
-The Administrator was supposed to "double check" the MARs to ensure the MARs were accurate.
-The orders were faxed over to the contract pharmacy with a cover letter.
-The contract pharmacy placed blood pressure orders on the MARs if the order was received prior to the delivery date of the new MARs.
-If the physician's order was received after the 15th of the month, she wrote the order on the

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C 249	Continued From page 2	C 249		

MAR.
-She wrote the entry on the October 2018 and November 2018 MAR to check Resident #1's blood pressure once a month.
-Resident#1's blood pressure check order was monthly and the facility's policy was to check weights and blood pressures on the 15th of every month.
-She did not know Resident #1's physician's order was for once a week and she was wrong about Resident #1's blood pressure order being monthly.
-She needed to change the entry on the November 2018 MAR.
-The last time she took Resident #1's blood pressure was 11/15/18 and the blood pressure was 114/71.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Attempted interview with Resident #1's health care provider on 11/20/18 at 11:38 am was unsuccessful.

Interview with the Administrator on 11/20/18 at 1:16 pm revealed:
-Resident #1 was seen by the facility's healthcare provider in October 2018.
-The SIC was responsible for processing the orders for residents.
-The SIC was responsible for placing orders on the MAR.
-He was responsible for "double checking" the MAR for accuracy and he usually did the check once a week.
-He had only "browsed" over Resident #1's MARs on the previous week.
-He did not know Resident #1's blood pressure

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C 249	Continued From page 3 was ordered to be checked weekly. -He did not notice the blood pressure was documented wrong on the MAR. -He expected the LHPS nurse to catch the error as well because she checked over the physician's orders and MARs.	C 249		
C 256	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to keep the upright freezer clean and protected from contamination. Observation of the upright freezer on 11/20/18 at 9:53 am revealed: -The temperature of the freezer was 18 degrees Fahrenheit. -There were three of four shelves with a heavy coating of frost. -The top of the freezer had a thick layer of frost. -There was four rust spots on the lower front portion of the freezer. -There was a black stain to the right side of the lower wire drawer of the freezer. -There were rust spots along the left side of the freezer where the door met the wall of the freezer.	C 256		

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C 256	Continued From page 4 -There were several rust spots along the left wall of the freezer. -The top portion of the door gasket had brownish stains along the portion that met the freezer wall. -The right lower portion of the door gasket had brownish stains. -The left side door gasket where the freezer door was hinged was twisted and not aligned with the door. -The left side door gasket was twisted when the freezer door was opened and closed. Review of the monthly freezer defrost and cleaning sign off sheet revealed there was documentation that the freezer was defrosted and cleaned on 10/25/18 and 11/01/18. Interview with the Supervisor in Charge (SIC) on 11/20/18 at 10:00 am and 12:50 pm revealed: -She was responsible for the cleanliness of the kitchen. -She had defrosted the freezer twice since the facility admitted the resident on 10/25/18 and 11/01/18. -She did notice the freezer built up with frost quickly but did not report it to the Administrator. -She thought the temperature was too low in the freezer and caused the frost build up. -She did not know the door gasket was twisted. -She did attempt to remove the rusted areas in the freezer but was unsuccessful on 10/25/18 and 11/01/18. Interview with the Administrator on 11/20/18 at 1:16 pm revealed: -The SIC was responsible for cleaning the kitchen and appliances. -He expected the freezer to be cleaned weekly and for the SIC to report any problems with the freezer to him.	C 256		

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C 256	Continued From page 5 -He had placed the appliances in the facility October 2018 and he had not looked at the appliances since that time. -He did not know the freezer was built up with frost. -He did not know the door gasket was twisted. -He thought the temperature was turned down too low and causing the frost build up. -He did not know about the rusted areas inside of the freezer. -He planned to call the company whom he purchased the appliance from and request the freezer to be repaired. -He planned to adjust the temperature on the freezer to assist with the decrease of frost production.	C 256		