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	hal045127	A. BUILDING: _____ B. WING _____	11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4145 HAYWOOD ROAD MILLS RIVER, NC 28759

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an initial survey and complaint investigation completed on 11/19/18 and 11/20/18.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the physician was notified of medication refusals for 1 of 3 sampled residents (#3) related to tamsulosin. The findings are: Review of Resident #3's current FL2 dated 08/02/18 revealed: -Diagnoses included dementia and hypertension. -There was a physician order for tamsulosin (medication used to improve urinary retention) 0.4mg daily. Review of Resident #3's August 2018 eletronic Medication Administration Record (eMAR) revealed: -There was an entry for tamsulosin 0.4mg daily with an administration time of 8:00am. -There was documentation the tamsulosin had been administered 5 out of 23 opportunities. -The documented reason the tamsulosin had not	D 273		

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been administered was family refused.

Review of Resident #3's September 2018 eMAR revealed:
-There was an entry for tamsulosin 0.4mg daily with an administration time of 8:00am.
-There was documentation the tamsulosin had been administered 1 out of 30 opportunities.
-The documented reason the tamsulosin had not been administered was family refused.

Review of Resident #3's October 2018 eMAR revealed:
-There was an entry for tamsulosin 0.4mg daily with an administration time of 8:00am.
-There was documentation the tamsulosin had not been administered from 10/01/18 through 10/14/18.
-The documented reason the tamsulosin had not been administered was family refused, wife will call the doctor for a d/c order, waiting for a d/c order per wife.
-There was documentation on 10/15/18 that Resident #3 was on hospital leave.

Interview on 11/20/18 at 10:25am with a Medication Aide (MA) revealed:
-The MA had informed the new Resident Care Coordinator (RCC) when Resident #3's POA had refused the medication.
-The MA had informed the RCC that a discontinue order was needed for the medication.
-The MA did not know when she had informed the RCC.
-The policy was to inform the physician when a resident refused medications three times.
-The MA did not know if the physician had been notified.

Interview on 11/20/18 at 1:20pm with a second

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MA revealed:
-The physician should be notified after a medication is refused three times.
-The MA did not know if the physician had been notified.
-The MA or the RCC could notify the physician.

Interview on 11/20/18 at 10:00am with the RCC revealed:
-The RCC knew the physician was called but "I would bet there is no documentation on it."
-The physician should be called after the third refusal.
-The staff needed more education on when to call the physician.
-The RCC had been hired after the refusals had started.
-Resident #3 had been discharged to the hospital on 10/14/18.

Interview on 11/20/18 at 10:13am with the Administrator revealed:
-The Administrator did not know the tamsulosin had been refused by Resident #3's Power of Attorney (POA).
-The policy was the physician should be notified after the medication was refused three times.
-She did not know why the physician was not notified of the refusals.

Review of the facility's Medication Administration Policy and Procedure revealed that if more than two doses in a row are refused, report it to the Nurse or Administrator for follow up with the physician and/or responsible party.

Based on interviews and record reviews it was determined Resident #3 was not interviewable.

Attempted telephone interview on 11/19/18 at

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D 273	Continued From page 3 6:17pm and 11/20/18 at 1:00pm with Resident #3's POA was unsuccessful. Attempted telephone interview on 11/20/18 at 10:34am with Resident #3's physician was unsuccessful.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure food and beverages being stored by the facility were protected from contamination. The findings are: Review of the facility kitchen sanitation report dated 08/27/18 revealed: -A score of 98. -A demerit was received for date marking and disposition of food. -A package of deli turkey, ham, and cheese were not date marked during the inspection. Observations of the dry goods pantry on 11/19/18 at 9:05am revealed: -A 5 pound(lb) bag of pasta shells had been opened, tied closed but not dated. -A 5 lb bag of egg noodles opened tied closed but not dated.	D 283		

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D 283	Continued From page 4 -A 160 ounce bag of spaghetti noodles had been opened, wrapped in a clear plastic wrap and was not dated. -A 16 ounce (oz). bag of powdered sugar was half full, opened but not dated. -A 16 oz. bag of round cereal was half full, had been opened but was not dated. -A half bag of pancake mix had been opened and was not dated. Observation of the refrigerator at the back of the kitchen on 11/19/18 at 9:12am revealed: -A 1/2 of a pound cake wrapped in plastic wrap and was not dated. -A bag of small marshmallows had been opened, wrapped in plastic wrap and was not dated. -A bag of whipped topping was opened and lying on the second shelf of the refrigerator and was not dated. Observation of the freezer inside the refrigerator on 11/19/18 at 9:24am revealed: -A 32 oz. bag of frozen carrots had been opened, tied closed and was not dated. -A 5 lb bag of frozen chicken nuggets, half full, had been opened, tied closed and not dated. -There were 10 hot dogs wrapped in plastic wrap not dated. -On the top shelf of the freezer was a half bag of cheese tortellini tied closed and not dated. -There was a bag with approximately 12 rib meat pieces (for sandwiches) in a clear plastic bag, tied closed and not dated. Interview with the Cook/Dietary Manager (DM) on 11/19/18 at 9:30am revealed: -Everything was supposed to be dated when it was opened. -She was still training her staff to kitchen processes.	D 283		

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D 283	Continued From page 5 -"I have to keep reminding them." Interview with the Administrator on 11/19/18 at 1:05pm revealed: -She was not aware items in the kitchen were not being dated when they were opened. -The DM was responsible for training staff to date items when they were opened. -The items should have been dated after they were opened. -She would start spot checking the items in the kitchen to make sure they were being dated.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 3 sampled residents (Resident #4) with a physician's order for ground meat and pureed vegetables therapeutic diet. The findings are:	D 310		

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Review of the current FL2 for Resident #4 dated 09/05/18 revealed:
-Diagnoses included dysphagia, dementia, gastro-esophageal reflux disease (GERD) and pneumonia.
-Diet order included mechanical soft diet with chopped meats and pureed vegetables.

Review of a subsequent physician's order dated 11/04/18 for Resident #4 revealed a mechanical soft diet with ground meats, pureed vegetables and a full range of liquids.

Observation of the therapeutic diet list provided by the dietary manager (DM) on 11/19/18 at 9:05am revealed:
-It was posted on the serving table in the main part of the kitchen.

Review of the diet list posted in the kitchen on 11/19/18 at 9:05am revealed Resident #4's diet order included mechanical soft diet with chopped meats and pureed vegetables.

Based on record review, observation and interview with Resident #4 on 11/19/18 at 10:30am revealed he was not interviewable.

Observation on 11/19/18 at 12:57pm of the noon meal for Resident #4 revealed:
-His meal was plated in the dining room by the DM.
-The personal care assistant (PCA) preceptor delivered Resident #4 his plate.
-He received a plate with two (whole) pieces of bread with a (whole) piece of sliced ham (sliced like regular deli meat), a bowl of cucumber (cut in cubes), cherry tomatoes (cut in half) with pieces of onion, a bowl of cooked carrots with chunks of carrots and 2 oatmeal raisin cookies.

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-After resident began eating a staff member assisted Resident #4 by cutting his sandwich into smaller pieces.

Interview with the DM on 11/19/18 at 12:43pm revealed:
-She was aware Resident #4 was supposed to have ground meat and pureed vegetables.
-She gave Resident #4 carrots because they were well cooked and soft.
-"I didn't think about the cucumber salad, I shouldn't have given it to him."
-The staff cut up his sandwich into small bite size pieces and she thought that was ok.

Interview with the cook on 11/19/18 at 12:50pm revealed:
-"We don't have anyone on anything pureed."
-The menu called for ground ham moistened with mayonnaise or mustard, pureed carrots.
-He did not know what Resident #4 had received as the DM served the food from the steam table in the main dining room.
-He had not prepared any pureed food for the noon meal for Resident #4.
-He was not aware of what therapeutic diet Resident #4 had been ordered.

Observation of Resident #4's breakfast plate on 11/20/18 7:20am revealed:
-He received scrambled eggs, sausage links cut up into pieces, fried potatoes, biscuit and a small bowl of peaches.
-Resident #4 did not have any issues with his meal during this meal observation.
-He ate 100% of his breakfast.

Interview with the Medication Aide (MA) on 11/20/19 at 11:15am revealed:
-Resident #4 required "more care than most".

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-Resident #4 had trouble eating, "you have to make sure he doesn't choke when he eats".
-"He didn't have any trouble with his breakfast this am."

Interview with the PCA preceptor on 11/20/18 at 1:20pm revealed:
-She had a list of everyone's diet orders in a notebook in the dining room.
-The Resident Care Coordinator (RCC) would let her know if a diet order was different and would give her a daily list of the diet orders.
-She was aware Resident #4 had swallowing issues and "we have to watch him real good."
-If they notice anything wrong with the residents' meals they are to let the DM know and get them another plate.
-She just "didn't pay attention" to what he had been served.
-She thought Resident #4 should have received a soft diet with ground meats and pureed vegetables.

Interview with the Administrator 11/20/18 at 1:05pm revealed:
-She could not explain why Resident #4 was not receiving the diet which had been ordered by his physician.
-She expected the dietary staff to follow the diet order the residents physician had ordered.

Telephone interview with the staff member from Resident #4's primary physicians office on 11/21/18 at 8:12am revealed:
-Resident #4 had a diagnosis of dysphagia.
-Resident #4 was supposed to be on a ground meats and pureed vegetables diet.
-Resident # 4 was at risk for aspiration if he was not receiving this diet.

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D 358	Continued From page 9	D 358		
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 Based on interviews and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, #3) related to Lovenox (Resident #1), glipizide (Resident #2), and donepezil and Haldol (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 11/07/18 revealed diagnoses included multiple cerebral vascular accidents, left foot diabetic ulcer, and left arterial insufficiency. Review of the Resident Register revealed an admission date of 11/08/18.	D 358		

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D 358	Continued From page 10 Review Resident #1's hospital discharge summary dated 11/08/18 revealed a physician order for Lovenox (blood thinner used to prevent deep vein thrombosis) 30mg subcutaneously daily. Review of Resident #1's November 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lovenox inject 30mg subcutaneously daily with the administration time of 8:00am. -There was documentation that the Lovenox had not been administered 11/09/18 through 11/15/18. -The Lovenox was discontinued on 11/15/18. -The documented reasons the Lovenox had not been administered were, "do not give injections, unable to administer", and "waiting on clarification". Interview on 11/19/18 at 11:45am with Resident #1 revealed: -The resident had recently been in the hospital. -The resident had difficulty walking due to a wound on the left foot. -The resident had not received any Lovenox injections at the facility. Interview on 11/19/18 at 12:30pm with the Resident Care Coordinator (RCC) revealed: -She did not know the medication aides (MA) could not administer Lovenox injections to Resident #1 until a MA informed her on 11/11/18. -She notified the Home Health Agency on 11/12/18 the Lovenox injections needed to be administered. -The Home Health Nurse was not able to administer the injections daily. -Per corporate policy only the Home Health Nurse	D 358		

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or a physician could administer Lovenox injections.
-The RCC informed the Nurse Practitioner (NP) on 11/14/18 that the Lovenox injections had not been administered.
-She had not notified the NP before 11/14/18 because the NP had not seen Resident #1 yet.

Telephone interview on 11/19/18 at 12:55pm with the Home Health Nurse revealed:
-She had been notified on 11/12/18 that Resident #1 required Lovenox injections.
-The Home Health Agency attempted to clarify with the physician the Lovenox orders.
-The Home Health Agency had been unable to get clarification from a physician regarding the injections.

Telephone interview on 11/19/18 at 1:10pm with the corporate Nurse revealed:
-The policy regarding Lovenox injections was only a home health nurse or a physician could administer Lovenox injections due to the need for frequent monitoring.
-"If the Home Health Nurse was unable or willing to give the injections, the facility should have contacted the physician that discharged the Resident from the hospital to have the Lovenox discontinued or to have the Resident transferred to a different level of care."

Interview on 11/19/18 at 2:15pm with a first shift MA revealed:
-The only injections MAs can give are insulin injections.
-She had informed the RCC on 11/08/18 about the order for Lovenox injections.
-She did not know why a physician was not notified.

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D 358	Continued From page 12 Interview on 11/19/18 at 2:22pm with a second first shift MA revealed: -The MA had informed the RCC of the order for Lovenox injections. -The MA did not remember when she notified the RCC of the Lovenox injections. -The MA could not give Lovenox injections. Telephone interview on 11/19/18 at 2:27pm with the NP revealed: -Resident #1 was admitted to the facility from the hospital on 11/08/18 and was not registered with the facility's contracted physician as a patient until 11/14/18. -The facility notified the NP during her visit to assess the Resident on 11/14/18. -The Lovenox had been ordered for Resident #1 to prevent blood clots due to being non ambulatory in the hospital and immediately after. -Not receiving the Lovenox as ordered put the resident at risk of a blood clot. Interview on 11/19/18 at 2:50pm with the Administrator revealed: -Resident #1 did not have a physician when admitted to the facility. -The facility sends registration paperwork to the physician's office upon admission and the NP would see the residents on the next scheduled facility day. -She had not had this issue before. -She expected staff to notify the RCC and physician when there are issues with medications. 2. Review of Resident #2's current FL2 dated 06/13/18 revealed diagnoses included brittle type II diabetes, hypertension, Parkinson's Disease and dementia.	D 358		

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D 358	Continued From page 13 Review of the Resident Register revealed an admission date of 07/31/18. Review of Resident #2's October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Glipizide 10 mg one tablet twice daily with the administration times of 7:30am and 5:30pm. -There was documentation that the glipizide had not been administered 10/14/18 through the 7:30 am dose on 10/20/18. -The documented reasons the glipizide had not been administered were; "unavailable, waiting on medication to come from the Veterans Administration (VA)". Interview on 11/20/18 at 9:55am with the Resident Care Coordinator (RCC) revealed: -Resident #2's medications came from the VA. -We should have called the VA and reordered the glipizide before it ran out. -"I don't know about a backup pharmacy for the VA" residents. -"They just come in the mail." -"We should not have run out there is no reason for us to run out of a medication." -Resident #2's family brings in medication from the VA and does not always do so in a timely manner. -There was a "lack of staff education". Interview on 11/20/18 at 10:30am with the Administrator revealed: -She had learned today that the facilities pharmacy or their back up pharmacy could have sent the glipizide so Resident #2 should not have been out of his medication. -"It is our responsibility to get the medications here from our back-up pharmacy if we do not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	11/20/2018

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D 358	Continued From page 14	D 358		

have them here."

Interview on 11/19/18 at 10:58am with a first shift MA revealed:
-She thought Resident #2's family brought his medications.
-She did not remember Resident #2 being out of any medication.
-She would tell the RCC if a resident was out of medication.

Interview on 11/20/18 at 11:05am with a second first shift MA revealed:
-If a resident was out of a medication she would call the pharmacy and get the medication refilled.
-If there pharmacy did not have a medication she could call the local back up pharmacy.

Based on interviews and record reviews it was determined Resident #2 was not interviewable.

Attempted telephone interview with Resident #2's physician at the VA on 11/20/18 at 7:45am was unsuccessful.

Attempted telephone interview on 11/20/18 at 12:57pm with Resident #2's family was unsuccessful.

3. Review of Resident #3's current FL2 dated 08/02/18 revealed:
-Diagnoses included dementia and hypertension.
-There was an admission date of 08/07/18.
-There were physician orders for donepezil (medication used to improve cognition and behavior) 10mg at bedtime and Haldol (antipsychotic medication) 0.5mg two times daily.

Review of Resident #3's August 2018 electronic Medication Administration Record (eMAR)

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D 358	Continued From page 15 revealed: -There was an entry for Haldol 0.5mg one tablet two times daily with administration times of 8:00am and 8:00pm. -The Haldol was documented as administered 25 out of 43 opportunities. -The Haldol was documented not administered on 08/11/18 at 8:00pm, 08/12/18 at 8:00pm, 08/14/18 at 8:00pm, 08/15/18 at 8:00am, 08/16/18 at 8:00am, 08/17/18 at 8:00am and 8:00pm, 08/18/18 at 8:00am and 8:00pm, 08/19/18 at 8:00am and 8:00pm, 08/20/18 at 8:00am and 8:00pm, 08/21/18 at 8:00am and 8:00pm, 08/22/18 at 8:00am and 8:00pm, and 08/23/18 at 8:00pm. -The documented reason the Haldol had not been administered was drug not available. Review of Resident #3's September 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for donepezil 10mg every night at bedtime with administration time of 8:00pm. -The donepezil was documented as administered 23 out of 30 opportunities. -The donepezil was documented as not administered on 09/14/18 through 09/20/18. -The documented reason the donepezil had not been administered was drug not available. Review of Resident #3's October 2018 electronic Medication Administration Record (eMAR) revealed: -The Haldol and donepezil was administered correctly from 10/01/18 through 10/13/18. -There was documentation the Haldol and donepezil was not administered 10/14/18 due to Resident #3's hospitalization.	D 358		

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D 358	Continued From page 16 Interview on 11/20/18 at 10:00am with the Resident Care Coordinator (RCC) revealed: -Staff were not aware of how to get medications from a back up pharmacy. -"If we call in a timely manner we get the meds before they run out." -Resident #3's medications were mailed from a hospital pharmacy. -The RCC did not know who the back up pharmacy was in the event medications did not arrive in the mail. -Resident #3 had been discharged to the hospital in October 14, 2018. Interview on 11/20/18 at 10:13am with the Administrator revealed: -The Administrator did not know the back up procedure for refilling medications when they did not arrive in the mail. -The Administrator had not had this issue before and needed to check on the procedure. Interview on 11/20/18 at 10:25am with a first shift MA revealed: -The MA knew to call the facility's contracted pharmacy for back up medications. -The MAs were to call the family of Resident #3 when medications were late coming in the mail. Interview on 11/20/18 at 1:20pm with a second first shift MA revealed: -When residents were down to a 3 day supply of medications the facility's contracted pharmacy was to be called for a refill. -The facility should not run out of medications. -The MA did not know why the pharmacy was not contacted for refills. -Resident #3 did not have any adverse behaviors other than wandering.	D 358		

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D 358	Continued From page 17 Based on interviews and record reviews it was determined Resident #3 was not interviewable. Attempted telephone interview on 11/19/18 at 6:17pm and 11/20/18 at 1:00pm with Resident #3's Power of Attorney was unsuccessful. Attempted telephone interview on 11/20/18 at 10:34am with Resident #3's physician was unsuccessful. Attempted telephone interview on 11/20/18 at 10:35am with the hospital pharmacy was unsuccessful. The facility failed to administer medications as ordered, including a blood thinner to Resident #1, a medication to improve blood glucose levels to Resident #2, and medications to improve behaviors and cognition to Resident #3. This failure increased the risk of a blood clot to Resident #1, elevated blood glucose levels in Resident #2, and a decline in cognition level and increased adverse behaviors to Resident #3. The facility's failure to administer medications as ordered 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 11/19/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 4, 2019	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

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D912	Continued From page 18 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 upon observation, staff interview and record review, the facility failed to ensure that each resident received care and services which were in compliance with relevant state rules and regulations. The findings are: Based on interviews and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, #3) related to Lovenox (Resident #1), glyburide (Resident #2), and donepezil and Haldol (Resident #3).[Refer to Tag 0358, 10A NCAC 13F .1004(a) Type B Violation].	D912		