STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 Transylvania County DSS conducted a Follow-up survey on 12/18/18 and 12/19/18.	{D 000}		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure medication aides observed residents take their medications after administration for 1 of 5 sampled residents (Resident #1). The findings are: Observation on 12/18/18 at 8:39am during the initial tour revealed: -Resident #1 was walking in the hall toward her room pushing a rolling walker. -There was a medication cup on top of the walker seat. -There were ten medication pills inside the cup. -There were no staff in the hall.	D 366		

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D 366	Continued From page 1	D 366		

Interview on 12/18/18 at 8:40am with Resident #1 revealed:
-The resident was going to take the medications to her room and then take them.
-Sometimes she took her medications to her room to take but "not always".

Review of Resident #1's current FL2 dated 08/31/18 revealed:
-Diagnoses included mild dementia, depression and anxiety, asthma, esophageal strictures, and hypertension.
-There were physician orders for loratadine (treats allergies) 10mg daily, duloxetine (antidepressant) 30mg daily, ferrous sulfate (iron supplement) 325mg daily, folic acid (vitamin supplement) 400mcg daily,
metoprolol (treats high blood pressure) 50mg daily, olanzapine (antipsychotic) 5mg daily, and omeprazole (reduces gastric acid) 40mg twice daily.

Review of a physician order dated 09/19/18 revealed clonazepam (treats anxiety) 1mg every 12 hours.

Review of a physician order dated 09/28/18 revealed memantine (treats confusion related to dementia) 5mg twice daily for 30 days then increase to 10mg twice daily.

Review of a physician order dated 11/01/18 revealed pantoprazole (treats gastric acid) 40mg twice daily.

Review of Resident #1's electronic Medication Administration Record (eMAR) for December 18, 2018 revealed:
-There were entries for duloxetine 30mg daily, ferrous sulfate 325mg daily, folic acid 400mcg

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D 366	Continued From page 2	D 366		

daily, loratadine 10mg daily, memantine 10mg twice daily, metoprolol 50mg daily, olanzapine 5mg daily, omeprazole 40mg twice daily, pantoprazole 40mg twice daily, and clonazepam 1mg every 12 hours with the morning administration time of 9:00am.
-There was documentation the duloxetine, ferrous sulfate, folic acid, loratadine, memantine, metoprolol, olanzapine, omeprazole, pantoprazole, and clonazepam had been administered at 9:00am.

Interview with the Resident Care Coordinator (RCC) on 12/18/18 at 8:45am and 12/19/18 at 9:15am revealed:
-The medication aides (MA) should always observe the residents taking their medications.
-Resident #1 had "pretended" to take her medications and then went to her room with the cup.
-Resident #1 had taken her medications in her room because the empty medication cup was in her trash can.

Interview with the first shift MA on 12/18/18 at 11:02am revealed:
-Resident #1 was asked to take her scheduled 9:00am medications at 8:30am.
-She "pretended" to take the medications by placing the medication cup to her mouth and then covering the cup with a napkin.
-He should have watched Resident #1 take her medications more carefully.
-He knew he was to observe residents taking their medications before documenting they were administered.

Interview with the Administrator on 12/18/18 at 2:00pm revealed:
-The MAs are supposed to watch the residents

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D 366	Continued From page 3 take their medications. -The MA had not informed the Administrator why he did not observe Resident #1 take her medication.	D 366		