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
	HAL036019	A. BUILDING: _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF GASTONIA	2755 UNION ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on November 14 to November 16, 2018.	D 000	Licensed plumbing service vendor replaced mixing valve on 11/15/18 to better control water temperatures. Hot water was turned off to affected rooms until repairs made. The Maintenance Director/ Supervisor-in-Charge/ designee recorded water temperatures in 10 resident rooms for 48 hours. After the initial 48 hours, water temperatures were checked daily in 10 resident rooms for 7 days. After seven days, water temperatures will be checked weekly. The Executive Director (ED) monitored the checks daily until the weekly checks resumed. The ED will monitor the water temperatures weekly thereafter.	12/31/18
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: TYPE B VIOLATION 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 15 of 15 water fixtures (sinks) in residents' rooms (#101, #113, #117, #123, #124, #138, #208, #215, #222, and #224, #228, #238, #239, #241, and the Specialty Care Unit (SCU) Dining Room sink). The findings are: Observations of water temperatures on 11/14/18 from 9:40am to 10:05am revealed: -At 9:30am, the hot water temperature at the sink in the bathroom of Room #101 was 117 degrees F.	D 113		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula D Withers | TITLE: Executive Director | (X6) DATE: 12-28-18

Karen M. Polce, RN 12/28/2018 Received and acknowledged

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D 113	Continued From page 1 -At 9:40am, the hot water temperature at the sink in the bathroom of Room #113 was 118 degrees F. -At 9:40am, the hot water temperature at the sink in the bathroom of Room #222 was 118 degrees F. -At 9:44am, the hot water temperature at the sink in the bathroom of Room #241 was 124 degrees F and there was visible steam when the water was running. -At 9:55am, the hot water temperature at the sink in the bathroom of Room #123 was 124 degrees F and there was visible steam when the water was running. -At 10:04am, the hot water temperature at the sink in the bathroom of Room #124 was 118 degrees F. Observations of water temperatures on 11/14/18 between 10:35am to 12:00pm revealed: -At 10:35am, the hot water temperature at the sink in the bathroom of Room #117 was 120 degrees F and there was visible steam when the water was running. -At 10:40am, the hot water temperature at the sink in the bathroom of Room #123 was 124 degrees F and there was visible steam when the water was running. -At 10:45am, the hot water temperature at the sink in the bathroom of Room #124 was 120 degrees F and there was visible steam when the water was running. -At 10:48am, the hot water temperature at the sink in the bathroom of Room #138 was 120 degrees F and there was visible steam when the water was running. -At 11:15am, the hot water temperature at the sink in the bathroom of Room #208 was 118 degrees F. -At 11:20am, the hot water temperature at the	D 113		

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D 113	Continued From page 2 sink in the bathroom of Room #215 was 122 degrees F and there was visible steam when the water was running. -At 11:22am, the hot water temperature at the sink in the bathroom of Room #239 was 118 degrees F. -At 11:30am, the hot water temperature at the sink in the bathroom of Room #238 was 118 degrees F. -At 11:36am, the hot water temperature at the sink in the bathroom of Room #228 was 117 degrees F. -At 11:40am, the hot water temperature at the sink in the bathroom of Room #241 was 122 degrees F and there was visible steam when the water was running. -At 11:45am, the hot water temperature at the sink in the bathroom of Room #222 was 122 degrees F and there was visible steam when the water was running. -At 11:48am, the hot water temperature at the sink in the bathroom of Room #224 was 122 degrees F and there was visible steam when the water was running. -At 11:58am, the hot water temperature at the sink in the Specialty Care Unit (SCU) Dining Room was 120 degrees F and there was visible steam when the water was running. Observation of water temperatures on 11/14/18 between 2:40pm and 3:15pm revealed: -At 2:40pm, the hot water temperature at the sink in the bathroom of Room #138 was 120 degrees F and there was visible steam when the water was running. -At 2:44pm, the hot water temperature at the sink in the bathroom of Room #117 was 120 degrees F and there was visible steam when the water was running. -At 2:50pm, the hot water temperature at the sink	D 113		

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D 113	Continued From page 3 in the bathroom of Room #228 was 119 degrees F and there was visible steam when the water was running. -At 2:55pm, the hot water temperature at the sink in the SCU dining room was 128 degrees F and there was visible steam when the water was running. -At 2:59pm, the hot water temperature at the sink in the bathroom of Room #241 was 120 degrees F and there was visible steam when the water was running. -At 3:00pm, the hot water temperature at the sink in the bathroom of Room #239 was 120 degrees F and there was visible steam when the water was running. -At 3:07pm, the hot water temperature at the sink in the bathroom of Room #238 was 128 degrees F and there was visible steam when the water was running. -At 3:10pm, the hot water temperature at the sink in the bathroom of Room #208 was 120 degrees F and there was visible steam when the water was running. -At 3:13pm, the hot water temperature at the sink in the bathroom of Room #215 was 122 degrees F and there was visible steam when the water was running. Observation of the water temperatures in the SCU on 11/15/18 between 9:00am, and 9:05am (one hour after the water was turned back on) revealed: -At 9:00am, the hot water temperature at the sink in the bathroom of Room #241 was 120 degrees F and there was visible steam when the water was running. -At 9:05am, the hot water temperature at the sink in the bathroom of Room #239 was 120 degrees F and there was visible steam when the water was running.	D 113		

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D 113	Continued From page 4 -At 9:05am the water to the sinks was turned off in the SCU until the plumber arrived. Review of a health inspection report dated 06/04/18 revealed 1 point was deducted for hot water temperatures greater than 116 degrees F. Review of the facility log temperature book revealed: -At 8:30am on 09/01/18 a sink temperature was documented as 127 degrees for room #115, 134 degrees F for room #120 and 125 degrees F for room #103. -At 5:20am on 09/18/18 a sink temperature was documented as 118 degrees F for room #202, and 117 degrees F for room #211. -At 11:30am on 09/29/18 a sink temperature was documented as 121 degrees F for room #125, 119 degrees F for room #137 and 118 degrees F for room #108. -At 6:45am on 10/16/18 a sink temperature was documented as 120 degrees F for room #210. -At 6:15am on 11/09/18 a sink temperature was documented as 120 degrees F for room #216, and 118 degrees F for room #242. -There was no weekly checks documented from 06/12/18 to 09/01/18. Review of the facility's water temperature policy revealed: -Daily monitoring of the hot water temperatures at the beginning of the 7:00am-3:00pm shift. -A daily log included the date, location, temperature measured at the source, initials of the person monitoring, did the temperature fall within the acceptable range (yes or no), and if no, measures taken to correct and follow-up temperature. -Devices used to measure water temperature should be appropriate for this purpose and should	D 113		

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D 113	Continued From page 5 be calibrated by following the manufacturer's suggested guidelines. Interview with a resident who resided in Room #123 on 11/14/18 at 10:40am revealed: -The water from the sink in the bathroom had always been too hot for at least 6 months. -The hot water heated up slowly, so he added cold water to make the water temperature cooler. -He had not been burned by the hot water because he knew to adjust the hot water temperature by adding cold water. -He could not recall if he had ever complained to the facility staff about the hot water being too hot. Interview with a resident who resided in Room #215 on 11/14/18 at 11:20am revealed: -He had not been burned by the hot water because he knew to adjust the hot water temperature by adding cold water. -He could not recall if he had ever complained to the facility staff about the hot water being too hot. Interview with the Resident Service Director (RSD) on 11/14/18 at 11:53am revealed: -She did not monitor hot water temperatures; as far as she knew the facility Maintenance Director (MD) monitored hot water temperatures on a weekly basis. -The facility's MD had worked on adjusting the hot water temperatures since September 2018. -She did not know the hot water temperatures were elevated in the SCU. -No resident had complained to her about the hot water temperature being too hot. -No resident had reported to her about being burned by the hot water. -The staff had not complained about the water being too hot.	D 113		

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D 113	Continued From page 6 Interview with the MD on 11/14/18 at 11:53am revealed: -He was hired as the MD in August 2018. -He was responsible and performed weekly hot water temperatures on 3 random rooms along with the boiler, laundry and kitchen temperatures. -During his weekly checks if there were any temperatures greater than 116 degrees F, then he would lower the temperature on the boiler. -He kept weekly logs for the temperature checks since September 2018. -There were issues with the hot water back in June 2018 but there have not been any since then. Interview with a personal care aide (PCA) in the SCU on 11/14/18 at 11:58am revealed: -She was hired as a PCA 14 years ago. -She knew the water in the sink of the SCU dining room was hot and had been for over 6 months. -The water in the resident's room was also hot but she always used more cold than hot to adjust for the hot temperatures. -The SCU residents received their showers in their rooms. -The resident "could get burned" because they did not know how to adjust the water and use more cold than hot. -She had not reported the excessive hot water temperatures before because she would adjust the temperature herself. -She was supposed to let the MD know if there were issues with water temperatures that were really hot. -She did not know how to check the actual temperature of the water. -There had not been any signs posted about "caution hot water". Most of the residents in the SCU would not understand the sign. -The only way to fix the hot water temperatures	D 113		

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D 113	Continued From page 7 was to "self-adjust" the water. Interview with the SCU Coordinator on 11/14/18 at 12:00pm revealed: -The water in the SCU dining room sink was very hot. -She was not sure of the actual temperature and did not check it with a thermometer but saw steam every time. -She would use more cold to adjust for the really hot water. -The residents had used the sink before and could get burned because the water comes out hot fast and the residents could not react quickly enough. -She did not know the hot water temperatures in the resident's rooms were greater than 116 degrees F. -The staff were to inform the MD if the temperatures were too hot or cold. -There were no thermometers in the SCU to check the temperatures but if they felt too hot or too cold then the staff was to report that to the MD. -The MD was responsible for adjusting the boiler. -She did not let the MD know about the SCU dining room sink was too hot. -Interview with an Assisted Living (AL) Medication Aide (MA) on 11/14/18 at 2:40pm revealed: -The hot water temperatures was too high all the time and she adjusts the cold water to make it safer for the residents that asked for help with their showers. -The resident in the SCU or AL that have dementia could get burned because they lack the cognitive ability to adjust the water temperatures. A calibration of the surveyor's thermometer was performed on 11/15/18 at 7:00am using an	D 113		

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D 113	Continued From page 8 ice-water slurry and the thermometer was determined to be reading accurately at 32 degrees F. The MD's thermometer and the surveyor's thermometers were used on 11/07/18 at 7:00am to check a water temperature in SCU Room #241, and both thermometers read the same at 95 degrees F. Interview with a SCU PCA on 11/15/18 at 9:47am revealed: -She did not know the water temperature caused any burns on residents or staff. -If the temperature was hot for her then she considered it twice as hot for the residents. -It was easier to burn the residents because of their "thin skin". -She tested the water temperature on her "upper arm, near the elbow". -She was trained in PCA class to check water temperatures before a bath or shower was given. -She did not know the regulation temperature ranges. -She was to notify the MD if the water temperatures were not right. -When the previous water temperatures were too hot she did not report them to the MD, she adjusted the temperature herself by adding cold water. -Some of the residents in the SCU could get burned if the water was too hot because they "cannot comprehend" the difference in water temperatures until it was too late. Interview with a SCU MA on 11/15/18 at 9:55am revealed: -There were issues with the hot water temperature regulation all year. -She would "adjust" the water temperature by	D 113		

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D 113	Continued From page 9 turning down the hot and turning up the cold. -She would test the water on her arm to make sure the temperature was correct for the residents. -She did not report the increased hot water temperature to the MD because she would just adjust the water temperature herself by turning up the cold water. -She did not know the water temperature caused any burns. -She did not know what the water temperature range should be. -If the water was hot to her then it was much hotter for the residents because of their "thin skin". Interview with the MD on 11/15/18 at 10:20am revealed: -The regulation called for the hot water temperature to be between 110 degrees and 115 degrees F. -He did now know the elevated water temperatures could cause a first or second degree burn. -He was responsible for adjusting the temperature of the water by adjusting the boiler. -The mixing valves were cleaned every other week and he did not keep documentation of the cleanings. -The re-circulating loop pump was checked only by the health inspector yearly and there was no documentation for those checks available. -The policy was to turn down the boiler if the water temperatures were greater than 116 degrees F. -He did not have any issues with the water temperature being too high until 11/14/18. -He notified a plumber to come out and fix the issue with the hot water temperatures. -A plumber was not called out to the facility since	D 113		

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D 113	Continued From page 10 June 2018. -June 2018 was the last time the hot water was an issue. -He used a digital measuring device and did not calibrate it at all. Interview with a local plumber on 11/15/18 at 10:30am revealed: -This was the first time he was called to the facility. -After inspecting the hot water mixing valves it was determined the mixing valves had a buildup of calcium on them making it almost impossible to function properly by "getting stuck" allowing the hot water temperature to increase. -The mixing valves must be checked yearly but weekly to monthly when having an increase in hot water temperatures. -The re-circulating loop pump was to be checked yearly. -His recommendation was to rebuild the mixing valve and keep the water off in the SCU until that was complete. -He also recommended checking more rooms on each hall instead of three throughout the facility. Interview with the Executive Director (ED) on 11/15/18 at 10:47am revealed: -She did not know the staff were manually adjusting the water temperatures without notifying the MD about the water being too hot. -She did not know if the elevated water temperatures had caused any burns. -The MD was responsible for adjusting the boiler to maintain the regulation water temperature between 100 degrees and 116 degrees F. -The policy was to notify the MD and the adjustment was to be done immediately. -The water temperatures were to be monitored weekly and a temperature log was to be kept.	D 113		

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D 113	Continued From page 11 -If the water temperatures were high on a routine basis (2 weeks in a row) then a plumber was to be called. -Devices used to monitor the water temperatures were to be calibrated monthly. -She did not know the devices were not calibrated at all. -She considered the residents in the SCU and some of the residents in the Assisted Living area to be at a greater risk for burns because of their dementia. The facility failed to assure the hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 15 of 15 water fixtures (sinks) in residents' rooms (#101, #113, #117, #123, #124, #138, #208, #215, #222, and #224, #228, #238, #239, #241, and the Specialty Care Dining Room sink) with hot water temperatures above 116 degrees F, ranging from 117 degrees F to 128 degrees F. The elevated hot water temperatures were detrimental to the health and safety of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D 113		
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,	D 358		

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D 358	Continued From page 12 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: Based on observations, interviews, and record reviews the facility failed to assure medications were administered as ordered for 1 of 7 sampled residents (Resident #5) related to Remeron, used in depression complicated by anxiety or trouble sleeping. The findings are: Review of Resident #5's FL2 dated 04/25/18 revealed: -Diagnoses included dementia and hypertension. -The recommended level of care was a special care unit (SCU). -Medications included Remeron 45mg, 1 tablet at bedtime. Review of Resident #5's Resident Register revealed she was admitted to the SCU on 12/17/15. Review of Resident #5's November 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Remeron 45mg in the	D 358	The Resident Services Director (RSD)/Assistant Resident Services Director (ARSD)/Bridge to Rediscovery Director (BTR Dir) will train all Med Techs on proper re-ordering of medications and notification of their supervisor when medications have not arrived within 24 hours. MARs will be reviewed twice a week for 4 weeks by the RSD/ARSD/BTR Dir to monitor medication administration. MARS will be reviewed weekly thereafter on an ongoing basis. Medication carts will be audited weekly for 4 weeks by the RSD/ASRD/ BTR Dir/designee to monitor medications and twice monthly thereafter. Documentation of the MAR reviews and the cart audits will be reviewed and maintained by the Executive Director.	1/31/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 evening with the administration time of 8:00pm. -There was documentation the Remeron had not been administered from 11/10/18 through 11/16/18. -On 11/10/18 the documented reason the Remeron had not been administered was "waiting from the pharmacy." -There were no documented reasons on the eMAR from 11/11/18 through 11/16/18 for not administering the medication to Resident #5. Observation of medications on hand in the SCU medication cart on 11/27/18 at 3:45pm revealed there were no Remeron tablets on the medication cart or in the medication overstock closet. Interview with the first shift medication aide (MA) on 11/15/18 at 9:35am revealed: -It was the responsibility of the MA to re-order a medication when it was "getting low". -She had not been told an exact amount, but she re-ordered medications when there were 5 pills left. -There was a re-order sticker on the label which was to be removed from the bubble pack and attached to a medication re-order sheet. -The re-order sheet was to be faxed to the pharmacy. -If the pharmacy was notified before 3:00pm, the medication was delivered the same evening. -If she had not received the medication the next day, she called the pharmacy to follow up. -If the medication had not been delivered by day 2, she would contact her supervisor. Interview with the second shift MA on 11/15/18 at 3:45pm revealed: -She faxed the re-order sheet requesting a refill for Remeron 45mg medication on 11/10/18. -She did not follow up with the pharmacy when	D 358		

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D 358	Continued From page 14 the Remeron did not arrive in the tote. -She did not contact her supervisor to let her know the medication had not arrived. -"I guess I should have told my Supervisor or called the pharmacy." -She remembered being instructed to follow up on medications not in the building during her training as a MA. Interview with the pharmacist at the facility's contracted pharmacy on 11/15/18 at 3:25pm revealed: -A request for a refill of Remeron 45mg for Resident #5 had been received on 11/08/18. -The medication was out of stock. -The billing department discontinued the request for a refill order in error. -There had been no follow up request from the facility regarding this order since 11/08/18. -Remeron was an antidepressant, which if stopped abruptly, the resident could manifest "discontinuation syndrome". -Discontinuation syndrome demonstrates as anxiety, tinnitus, panic attack, vertigo, flu like symptoms, nausea and diarrhea. -A gradual slow reduction of the medication was advised to avoid these symptoms. Interview with the SCU Coordinator on 11/16/18 at 9:55am revealed: -It was the responsibility of the MAs to re-order medications when they "were low". -She expected the MAs to re-order a medication when there were 3 pills left in the bubble pack. -The MAs were to remove the sticker from the medication bubble pack and attach it to a re-order form. -The re-order form was to be faxed to the pharmacy. -The medication should arrive the same night on	D 358		

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D 358	Continued From page 15 the tote. -The MAs should call the pharmacy if a medication did not arrive within 24 hours. -The MAs should contact their supervisor if the medication had not arrived by day 2. -She did not know Resident #5 had not received Remeron in 8 days. -The MAs knew the process and she did not know why the MA did not follow up with her or the pharmacy. -Cart audits were not routinely performed on the medication carts. Interview with the Resident Care Director (RCD) on 11/16/18 at 10:20am revealed: -The MAs were responsible for re-ordering medications when they were low. -She would expect them to re-order medications when there were 5 pills left in the bubble pack. -The MAs were to remove the sticker on the medication bubble pack and attach it to a reorder form. -The re-order form was to be faxed to the pharmacy. -The medication should arrive the same night on the tote. -The MAs should follow up with the pharmacy if a medication did not arrive within 24 hours. -She expected the MAs to notify their supervisor if medications were not arriving in a timely manner. -She did not know Resident #8 had not received her Remeron medication for 8 evenings. -She did not know why the MA did not follow up with the pharmacy. "She may need more training." Interview with the Executive Director on 11/16/18 at 11:05am revealed: -She did not know Resident #5 had missed 8 doses of her antidepressant medication because	D 358		

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D 358	Continued From page 16 it was not in the building. -She did not know the medication was re-ordered and the MA had not followed up with the pharmacy when it had not been delivered. -She left the clinical aspects of the facility to the RCD. Attempted phone interview with the primary care physician on 11/16/18 at 9:10am was unsuccessful. Attempted phone interview with the guardian on 11/16/18 at 9:00am was unsuccessful.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure 2 of 3	D 375		

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D 375	Continued From page 17 sampled residents permitted to self-administer their medications met requirements to do so related to Resident #4 who did not have a physician's order to self-administer and Resident #7 who did not have specific instructions for administration printed on the medication label. The findings are: Review of the facility's Resident Self-Administration of Medications policy dated 11/14/05 revealed: -If a resident wished to self-administer his/her medications, the Resident Services Director (RSD) or designee would assess the resident's ability to participate, by completing a Self-Administration of Medication Assessment. The assessment must be completed upon move-in or resident request. -The RSD would interview the resident to determine their ability to identify, prepare and administer medications/treatments. -Based on the assessment, a decision was made as to whether or not the resident was a candidate for self-administration. This would be recorded on the assessment tool. -A valid written physician's order must be obtained for each resident conducting self-administration of medications/treatments. -The RSD would assess accuracy and compliance of self-administration by periodic observation and counting of doses. 1. Review of Resident #7's current FL-2 dated 03/28/18 revealed: -Diagnoses included hypertension (HTN), congestive heart failure (CHF) and macular degeneration (an eye disease that causes vision loss). -Medication orders included acetaminophen	D 375	Medications were removed from Resident #7's apartment. Med Techs became responsible for administering medications. At the time of the survey, the Resident Services Director (RSD)/Assistant Resident Services Director (ARSD) monitored other residents who self-administered medications for safe administration. In the future, any residents wishing to self-administer medications will be assessed the by the RSD/ ARSD for safe medication administration. The resident's primary care physician must provide an order allowing the resident to self-medicate. The resident must maintain the medications in their container labeled with the doctor's instructions and in a locked space. On a quarterly basis, the RSD/ ASRD will re-assess the	12/31/18

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D 375	Continued From page 18 500mg two tablets twice daily as needed (used to treat pain), amoxicillin 500mg four capsules prior to dental procedures (used to treat infections), azelastine HCL 0.1% two sprays in each nostril twice daily (used to treat allergic itching of the eyes), CoQ10 one daily (an antioxidant), Vitamin D3 2000 units two daily, Lomotil 2.5-0.025mg one daily as needed (used to treat diarrhea), Allegra 180mg ½ tablet daily as needed (used to treat hay fever symptoms), fish oil 1000mg daily (a dietary supplement), furosemide 40mg twice daily (used to treat fluid retention), latanoprost 0.005% one drop in both eyes daily (used to treat glaucoma), metoprolol tartrate 100mg twice daily (used to treat high blood pressure), multivitamin one daily, Preparation H rectal cream apply twice daily as needed (used to treat hemorrhoids), spironolactone 25mg one daily (used to treat high blood pressure), temazepam 15mg daily as needed (used to treat insomnia), Vision Formula one daily (a dietary supplement used for good eye health), Vitamin C 500mg daily, Warfarin 2mg on Sundays, Tuesdays, Thursdays and Saturdays and 3mg on Mondays, Wednesdays and Fridays (a blood thinner). -A physician's order the resident could self-administer medications. Review of Resident #7's electronic administration records (eMARs) for September, October and November 2018 revealed documentation she had self-administered all her medications. Observation on 11/16/18 at 10:00am of medications available for administration kept in Resident #7's room revealed: -Resident #7 did not have a roommate. -The resident had two unlocked metal boxes containing bottled medications. -One of the metal boxes contained two plastic pill	D 375	resident's ability to safely self-medicate. Any resident not meeting the requirements will not be permitted to self-medicate. The Executive Director will review the assessment and re-assessments as they are completed.	12/31/18

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D 375	Continued From page 19 organizers labeled with the days of the week containing multiple pills mixed together. -The resident removed two unlabeled medication bottles with tablets inside from a plastic bag located in a compartment in her walker. -One unlabeled bottle contained a piece of tape with "Oxy??" handwritten on it. The bottle contained twelve light blue tablets imprinted with A 44 and one white tablet of the same size imprinted with 54 583. -The second unlabeled bottle contained a piece of tape with "Lasix??" handwritten on it with white tablets imprinted with 54 583. -A medication bottle located on the resident's dining table had a pharmacy label for Furosemide (lasix) 40mg and contained intact white tablets imprinted with 54 583. The bottle also contained one white tablet cut in half and one light blue tablet cut in half. -A medication bottle located on the resident's dining table had a pharmacy label for oxybutynin 5mg and contained light blue tablets imprinted with A 44. Interview with Resident #7 on 11/16/18 at 10:00am revealed: -She did not recall facility staff ever looking at her medications in her room or asking her questions about them to assess her ability to self-administer medications. -She was "legally blind." -She could read the labels on her medication bottles if she wore her eye glasses and used a lighted magnifying glass. However, it was difficult for her to differentiate between the different colors of the tablets. -A family member would remove her medications from the pharmacy labeled bottles and put them in her pill organizers every two weeks. -She had recently been prescribed oxybutynin,	D 375		

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D 375	Continued From page 20 but because of its side effects, had decided to no longer take it. -The oxybutynin tablets looked like the lasix tablets so she had attempted to remove both tablets that looked the same from her pill organizers and separate them into the unlabeled bottles. -She planned to have her family member look at the bottles and tell her which one contained the oxybutynin so she could discard them and keep the lasix tablets. Interview with the morning shift medication aide (MA) on 11/16/18 at 12:00pm revealed: -Assessments were done on residents who self-administered their medications every three months to assure they had the ability to continue self-administration. -She had completed an assessment for Resident #7 on 07/31/18. -During assessments for self-administration she looked at the residents' medications in their room, compared the dose and frequency on the label to the resident's eMAR and also checked the expiration dates on the medications. -At times, she would have residents demonstrate their ability to read the labels and sometimes "I just ask them if they are able to read the labels." -She did not ask Resident #7 to read the medication labels or to identify the color of the pills. -She did not find unlabeled pill bottles or pill organizers in Resident #7's room. -Resident #7 had never told her she had difficulty with her vision. -She had documented on the Self Administration of Medications Assessment form, Resident #7 could safely self-administer medications. Telephone interview with a second MA on	D 375		

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D 375	Continued From page 21 11/16/18 at 12:32pm revealed: -Assessments were done on residents who self-administered their medications every three months to assure they had the ability to continue self-administration. -She had completed Resident #7's most recent assessment on 10/03/18. -She looked at Resident #7's medications in her room and compared them to her eMAR. -She had Resident #7 tell her what each medication was used for, how many she took each time and how often. -She had Resident #7 demonstrate the ability to read the labels on her medication bottles and she had done so successfully. -She had asked Resident #7 to identify the colors of each pill and was "a little concerned" because she had incorrectly identified some of the colors. -She did not discuss her concerns with any other staff because by the end of the session, Resident #7 was able to identify the colors through the "process of elimination." -She did not find unlabeled pill bottles, but she knew Resident #7 used unlabeled pill organizers. -She did not report to any other staff Resident #7 was using unlabeled pill organizers because she thought it was acceptable for her to do so since she thought Resident #7 was removing the pills from the pill bottles, herself, and doing it daily. -She did not ask Resident #7 to identify the pills mixed together in the pill organizer. -She had documented on the Self Administration of Medications Assessment form, Resident #7 was fully able to self-administer her medications. Interview with the Resident Services Director (RSD) on 11/16/18 at 12:50pm revealed: -MAs were typically the ones who completed the Self Administration of Medications assessments. -She would sign off behind the MAs indicating	D 375		

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D 375	Continued From page 22 they had completed the assessments. -She expected MAs to have the resident demonstrate their ability to read the medication labels as well as identify the colors of each pill. -She did not know Resident #7 was having difficulty differentiating between the colors of her pills. -She did not know Resident #7 had unlabeled pill bottles and unlabeled pill organizers in her room. -She expected MAs to assure residents were not using pill organizers and only removing pills from medication bottles at the time of administration. -The MA should have reported to her when she found unlabeled pill bottles and organizers in Resident #7's room and when she had concerns about Resident #7's vision. Interview with the Administrator on 11/16/18 at 1:20pm revealed: -It was the RSD's responsibility to assure MAs were completing the Self Administration of Medications assessments correctly. -She expected MAs to have the residents demonstrate the ability to read the medication bottles and identify the color of each pill. -It was against the facility's policy for residents to use a pill organizer. -Medications were to remain in their original, pharmacy labeled bottles so they could be easily identifiable. -If unlabeled bottles or pill organizers were found in a resident's room, she expected staff to remove the unlabeled bottles and pill organizers from the room and report it to either the RSD or herself so they could follow up with the resident's responsible party. -She knew Resident #7 had a diagnosis of macular degeneration, but did not know she was having difficulty with her vision.	D 375		

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D 375	Continued From page 23 Telephone interview with a representative from Resident #7's Primary Care Provider's (PCP) office on 11/16/18 at 2:19pm revealed: -Resident #7 was prescribed lasix because she had a diagnosis of CHF. -Oxybutnin was a new medication for Resident #7. It had been prescribed on 10/30/18 due to the resident's complaints of urinary incontinence. -If Resident #7 were to confuse lasix and oxybutynin and stop taking the lasix because she thought it was the oxybutynin, she would have continued fluid buildup around her heart, making it more difficult for her heart to function. -If Resident #7 stopped taking the lasix, it could result in hospitalization and the risk of death. -If Resident #7 were to take more lasix than what was prescribed, she could become dehydrated. -The PCP's office was aware Resident #7's responsible party was organizing her pills into a pill organizer and felt this was a good idea because Resident #7 was easily confused. 2. Review of Resident #4's current FL-2 dated 10/02/18 revealed diagnoses included coronary artery disease (CAD), hypertension (HTN), hyperlipidemia (HLD), cardiovascular disease (CVD), benign prostatic hyperplasia (BPH), chronic kidney disease (CKD) Stage 3 and chronic dizziness. Review of Resident #4's admission FL-2 dated 09/13/18 revealed: -Diagnoses included CAD, HTN, HLD, CVD, BPH, CKD Stage 3 and chronic dizziness. -Medication orders included nitroglycerin 0.4mg sublingual as needed (a medication used to treat chest pain), lisinopril 20mg daily (used to treat HTN), atorvastatin 40mg daily (used to treat HLD), finasteride 5mg daily (used to treat BPH), aspirin 81mg daily (a blood thinner), Lumigan	D 375		

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D 375	Continued From page 24 0.03% solution one drop daily (used to treat glaucoma), dorzolamide ophthalmic 2% solution one drop in both eyes twice daily (used to treat glaucoma), sertraline 25mg daily (used to treat depression), Miralax powder daily as needed (used to treat constipation), and iron 65mg every week (a dietary supplement used to treat low blood levels of iron). -There were no orders Resident #4 could self-administer medications. Review of Resident #4's record revealed: -There was no physician's order for Resident #4 to self-administer medications. -There was no assessment completed by the facility to assess Resident #4's ability to self-administer medications. -A note documented by a medication aide (MA) on 09/27/18 at 11:00pm "New resident moved into room 123. He is verbal of needs, self-administers own medication." -A physician's order dated 10/02/18 Resident #4 could not safely administer his own medications and they were to be administered by staff. -A nurse's note dated 10/03/18 at 11:00am documented "New orders received on 10/02/18. Resident will no longer self-administer medications. All medications removed from resident's room. Nursing staff will administer medications." Review of Resident #4's electronic administration record (eMAR) for September 2018 revealed documentation Resident #4 had self-administered the following medications from 09/27/18 through 09/30/18: nitroglycerin 0.4mg sublingual as needed, Lisinopril 20mg daily, atorvastatin 40mg daily, finasteride 5mg daily, aspirin 81mg daily, Lumigan 0.03% solution, dorzolamide ophthalmic 2% solution one drop in both eyes twice daily,	D 375		

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D 375	Continued From page 25 sertraline 25mg daily, and iron 65mg weekly. Review of Resident #4's eMAR for October 2018 revealed: -No documentation staff had administered any medications to Resident #4 from 10/01/18 through 10/02/18. -A line was drawn through the dates of 10/01/18, 10/02/18 and 10/03/18 for the following medications: nitroglycerin 0.4mg sublingual as needed, Lisinopril 20mg daily, atorvastatin 40mg daily, finasteride 5mg daily, aspirin 81mg daily, dorzolamide ophthalmic 2% solution one drop in both eyes twice daily, sertraline 25mg daily, and iron 65mg weekly. -Lumigan 0.03% solution one drop in both eyes at bedtime was first documented as administered by staff on 10/03/18 at 8:00pm. -There was documentation staff began administering all ordered medications on 10/04/18. Observation of Resident #4's room on 11/14/18 at 9:55am revealed he did not have medications in his room. Interview with Resident #4 on 11/15/18 at 2:15pm revealed: -He was admitted to this facility on 09/27/18 from another facility. -He was allowed to administer his own medications at the previous facility. -He was allowed to administer his own medications at this facility "for a while." -He could not recall any facility staff assessing his ability to self-administer his medications. -He did recall his physician visiting the facility and asking him to identify his medications and what he used them for. "I thought I did okay, but they (the staff) came and took them (the medications)	D 375		

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MORNINGSIDE OF GASTONIA	2755 UNION ROAD GASTONIA, NC 28054

(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 375	Continued From page 26 out of my room." -"I am blind in my left eye." Interview with the facility's Licensed Practical Nurse (LPN) on 11/15/18 at 9:06am revealed: -She could not locate a physician's order for Resident #4 to self-administer medications and did not recall completing an assessment to determine Resident #4's ability to self-administer medications. -She removed Resident #4's medications from his room on 10/03/18 after receiving a physician's order Resident #4 could no longer self-administer his own medications due to poor vision. Interview with the RSD on 11/15/18 at 9:06am revealed: -Typically a resident would visit the facility or she would visit the resident at home prior to admission. -During this visit, she would assess the resident for cognition and desire to self-administer medications. -If the resident desired to self-administer medications, she would ask the resident or resident's responsible party to obtain a completed FL-2 from the resident's physician with orders the resident could self-administer medications. -When the resident's FL-2 was returned to the facility, if it had a physician's order the resident could self-administer medications, either she, the LPN or a MA would assess the resident's ability to self-administer medications and would complete the facility's Self-Administration of Medication Assessment form. -When the resident's FL-2 was returned to the facility, it was her responsibility to review the FL-2 and if it did not have a physician's order the resident could self-administer medications, she would contact the physician and request the	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 375	Continued From page 27 order. -Once a physician's order was obtained and the resident was assessed to be capable of self-administering medications, she would visualize the resident's medications, compare them to the physician's orders, complete the eMAR with the resident's list of ordered medications, document "resident to self-administer" on the eMAR and allow the resident to keep the medications in their room. -Resident #4 had been admitted from another facility in a different area of the state so there was no pre-admission visit done. -Resident #4 had been admitted to the facility late in the evening on 09/27/18. -The Administrator had a pre-admission conference call with Resident #4's responsible party and they had indicated Resident #4 desired to self-administer his medications. -The RSD did not realize Resident #4's FL-2 did not have physician's orders to self-administer medications so she did not follow up with Resident #4's physician. -No facility staff had completed an assessment to determine Resident #4's ability to self-administer his medications. -The RSD completed Resident #4's eMAR using the physician's orders for medications on Resident #4's FL-2 and had written "SA" on the eMAR indicating to the MAs they were not to administer Resident #4's medications because he would self-administer his own medications. -Resident #4's physician had assessed him on 10/02/18 and determined he was not capable of self-administering medications. -Resident #4 had self-administered his own medications from 09/27/18 to 10/03/18 at 8:00pm (the first medication pass after Resident #4's medications were removed from his room).	D 375		

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D 375	Continued From page 28 Interview with an evening shift MA on 11/15/18 at 3:27pm revealed: -She had documented upon Resident #4's admission on 09/27/18 at 11:00pm, Resident #4 would self-administer his own medications. -She was aware a physician's order was required before a resident could be allowed to self-administer medications. -She did not know if Resident #4 had a physician's order to self-administer medications, but because "SA" was documented on his eMAR, she assumed the RSD had verified Resident #4 had a physician's order to do so. Attempted telephone interview with Resident #4's Primary Care Provider on 11/16/18 at 8:49am was unsuccessful. Interview with the Administrator on 11/16/18 at 9:30am revealed: -It was the RSD's responsibility to assure a resident had a physician's order to self-administer medications prior to allowing the resident to do so. -It was the RSD's responsibility to assure the resident was assessed and determined to be a good candidate to self-administer medications. -She did not know the facility's policy on allowing a resident to self-administer medications had not been followed for Resident #4 and did not know why. -The facility should have administered Resident #4's medications until a physician's order could be obtained and an assessment completed. The facility failed to assure residents permitted to self-administer their medications met requirements to do so for 2 of 3 sampled residents. Allowing Resident #7, with a diagnosis of macular degeneration and self-reporting of	D 375		

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D 375	Continued From page 29 vision problems, to use pill bottles and organizers not labeled with specific instructions for administration put Resident #7 at risk for taking more lasix than ordered which could have resulted in hospitalization or death. This failure was detrimental to the health and safety of the resident and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/16/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D 375		
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, record reviews and interviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to other requirements and self-administration of medications The findings are:	D912	Residents' rights will be addressed through the plans of correction for the three rules indicated in this report.	12/31/18 + 1/31/19

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D912	Continued From page 30 1. Based on observations, record reviews and interviews, the Administrator failed to assure the management and overall operations of the facility by failing to meet and monitor rules related to water temperatures and self administration of medications.[Refer to Tag 980 G.S. 131D-25 Implementation (Type B Violation).] 2. Based on observations, record reviews and interviews, the facility failed to assure the hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 15 of 15 water fixtures (sinks) in residents' rooms (#101, #113, #117, #123, #124, #138, #208, #215, #222, and #224, #228, #238, #239, #241, and the Specialty Care Unit (SCU) Dining Room sink). [Refer to Tag 113, 10A NCAC 13F .0311(d) Other Requirements (Type B Violation).] 3. Based on observations, record reviews and interviews, the facility failed to assure 2 of 3 sampled residents permitted to self-administer their medications met requirements to do so related to Resident #4 who did not have a physician's order to self-administer and Resident #7 who did not have specific instructions for administration printed on the medication label. [Refer to Tag 375, 10A NCAC 13F .1005(a) Self-Administration of Medications (Type B Violation).]	D912		