STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078096	A. BUILDING: _____ B. WING _____	01/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

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C 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services conducted an annual survey on January 4 and 7, 2019.	C 000		
C 066	10A NCAC 13G .0312(d) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance And Exits (d) All exit door locks shall be easily operable, by a single hand motion, from the inside at all times without keys. Existing deadbolts or turn buttons on the inside of exit doors shall be removed or disabled. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to assure that 3 of 3 exit doors would open when locked with a single movement. The findings are: Observations during initial tour on 01/04/19 between 9:30am and 10:07am revealed: -Three exit doors equipped with both knob locks and deadbolt locks. -The knob locks opened when locked by turning the doorknob. -The deadbolt locks required engaging a thumb-turn in addition to turning the doorknob. Review of a Division of Health Service Regulation Construction Section survey report dated 08/18/18 revealed: -Deficiencies cited included deadbolt locks were present on the 3 exit doors. -The facility was instructed to remove or disable the deadbolt locks.	C 066		

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C 066	Continued From page 1 Interview with a medication aide (MA)/live-in on 01/07/19 at 10:43am revealed she engaged the deadbolt locks on the 3 exit doors at night. Interview with the Administrator on 01/07/19 at 10:55am revealed: -She thought the deadbolts had been disabled. -She would have the deadbolts removed or disabled as soon as possible. -She would immediately instruct the live-in staff not to engage the deadbolt.	C 066		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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 observations, interviews and record reviews, the facility failed to assure blood pressure checks were completed and documented as ordered for 1 of 3 sampled residents (Resident #3) with an order for weekly blood pressure checks. The findings are: Review of Resident #3's current FL2 dated 07/16/18 revealed: -Diagnoses included paranoid schizophrenia, hypertension, hyperlipidemia, and diabetes. -Resident was ambulatory. -There was an order for weekly blood pressure checks.	C 246		

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C 246	Continued From page 2 Review of Resident #3's November 2018 medication administration record (MAR) revealed there was no documentation of weekly blood pressure checks. Review of Resident #3's December 2018 MAR revealed there was no documentation of weekly blood pressure checks. Review of Resident #3's January 2019 MAR revealed there was no documentation of weekly blood pressure checks. Review of the facilities "blood pressure protocol" revealed: -Facility staff were to check blood pressure per physician's order. -Facility staff to notify the supervisor in charge (SIC) or Administrator. if top number (systolic) was higher than 160 or if bottom number (diastolic) was higher than 100. - The SIC or Administrator was to notify physician if blood pressure readings were greater than the above perimeter for 2 consecutive readings. -Facility staff were to call 911 with any resident distress and facility staff should notify next of kin. SIC to notify physician if during business hours or on the next business day. Review of Resident #3's physician note dated 08/20/18 revealed: -Resident #3 was seen by the facility physician to establish new patient care. -Resident #3's blood pressure was 108/62. Review of Resident #3's physician note dated 10/25/18 revealed: -Resident #3 was seen for a follow up visit. -Resident #3's blood pressure was 102/70.	C 246		

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C 246	Continued From page 3 Interview with the Resident Care Coordinator (RCC) on 01/04/19 at 4:30pm revealed: -The RCC was responsible for reviewing the FL2 and setting up a log if blood pressures were ordered. -She had overlooked the order for weekly blood pressure checks for Resident #3. -She would contact the primary care physician for guidance and to make her aware the blood pressure checks had not been completed as ordered. Interview with the Administrator on 01/04/19 at 4:40pm revealed: -The RCC was responsible for reviewing resident orders on the FL2. -She was not aware Resident #3 had an order for weekly blood pressure checks. -She would have the personal care aide (PCA) check Resident #3's blood pressure today. -Resident #3's blood pressure would be checked daily and the diabetic protocol followed until further guidance was received from the primary care physician. Observation on 01/04/19 at 4:50pm revealed resident #3's blood pressure was checked and was 160/92. Interview with the Administrator on 01/07/19 at 10:15am revealed: -Resident #3's blood pressure had been checked daily from 01/04/19 - 01/7/19. -Documentation of the daily checks and request for clarification was faxed to the physician this morning (01/07/19). Interview with Resident #3 on 01/07/19 at 11:30am revealed: -Her blood pressure was checked at the facility	C 246		

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C 246	Continued From page 4 on 01/04/19, and had been checked daily since then. -Her blood pressure had not been checked by staff prior to 01/04/19. -She was not aware of having an order for daily blood pressure checks. Review of a note written by the Administrator and faxed to Resident #3's physician on 01/07/19 revealed: -"Resident was ordered weekly blood pressure checks on the admission FL2, but was not done". -"Please advise if this is order to continue or discontinue". -Resident #3's blood pressure on 01/04/19 was 160/92. -Resident #3's blood pressure on 01/05/19 was 147/61. -Resident #3's blood pressure on 01/06/19 was 138/56. -Resident #3's blood pressure on 01/07/19 was 131/63. Attempted interview with Resident #3's physician on 01/07/19 at 12:45pm was unsuccessful.	C 246		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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.	C 330		

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C 330	Continued From page 5 This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to administer medication as ordered for 1 of 3 (Resident #1) sampled residents for an iron supplement. The findings are: Review of Resident #1's current hospital generated FL-2 from dated 01/02/19 revealed: -Diagnoses included blood loss anemia, gastrointestinal bleed, chronic congestive heart failure, hyperparathyroidism and diabetes mellitus Type 2. -There was a medication order for Ferrous Sulfate (iron supplement) 325mg EC every day. Review of Resident #1's medication administration record (MAR) dated January 2019 on 01/04/19 revealed there was no entry for Ferrous Sulfate or documentation of administration. Review of medications on hand for Resident #1 on 01/04/19 at 4:40pm revealed there was no Ferrous Sulfate available for administration. Interview with the supervisor in charge (SIC) on 01/04/19 at 4:15pm revealed: -The SIC reviewed the MARs each month. -She transcribed new medication orders onto the MARs as needed. -She "just overlooked" Resident #1's Ferrous Sulfate order on the January 2019 MAR. Interview with the Administration on 01/04/19 at 4:00pm revealed: -She did not know the order for Resident #1's Ferrous Sulfate was not transcribed onto the January 2019 MAR.	C 330		

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C 330	Continued From page 6 -She did not know the pharmacy had not filled the order Ferrous Sulfate. -She would notify Resident #1's primary care provider (PCP) of the missed dosages. Interview with a pharmacy technician from the facility's providing pharmacy on 01/07/19 at 11:00am revealed the pharmacy had not received Resident #1's discharge medications from 01/02/19 until 01/07/19. Attempted telephone interview with Resident #1's PCP on 1/7/19 at 12:45pm was unsuccessful.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	C 342		

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C 342	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain accurate and complete medication administration records (MARs) for 1 of 3 sampled residents (Resident # 1) for an insulin.. The findings are: Review of Resident #1's current FL-2 from a hospitalization discharge dated 01/01/19 revealed: -Diagnoses included blood loss anemia, gastrointestinal bleed, chronic congestive heart failure, hyperparathyroidism and diabetes mellitus Type 2. -Levemir insulin was not included in the discharge medications. Review of Resident #1's medication administration record (MAR) dated January 2019 on 01/04/19 revealed: -There a computer generated entry for Levemir injection 0.4ml subcutaneously once daily. -There was documentation Levemir was administered on 01/03/19 and 01/04/19. Interview with a medication aide (MA) on 01/04/19 at 3:07pm revealed she had administered Levemir to Resident #1 on 01/03/19 and 01/04/19 and had documented the administration of the Levemir on Resident #1's January 2019 MAR. Interview with Resident #1 on 01/04/19 at 3:15pm revealed that she had not received an insulin injection since discharge from the hospital on 01/02/19. Interview with a pharmacy technician from the	C 342		

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C 342	Continued From page 8	C 342		

facility's providing pharmacy on 01/07/19 at 11:00am revealed the pharmacy had not received Resident #1's discharge medications from 01/02/19 until 01/07/19.

Interview with the facility's supervisor in charge (SIC) on 01/04/19 at 4:15pm revealed:
-She had faxed Resident #1's discharge medications to the providing pharmacy on 01/02/19.
-The facility's fax machine did not print a confirmation of sent faxes unless requested.
-The SIC did not routinely print a confirmation of sent faxes.
-She would refax the prescriptions immediately.

Interview with the Administrator on 01/04/19 at 4:00pm revealed:
-Levemir had been prescribed upon admission (11/01/18) for Resident #1.
-The Administrator had removed Resident #1's Levemir syringe from the facility while the resident was hospitalized from 12/17/18 until 01/02/19.
-The Administrator knew Levemir insulin had not been reordered for Resident #1 upon discharge from the hospital on 01/02/19.
-The Administrator did not know the MA had documented administration of Levemir that was no longer ordered or on hand.

Observation of Resident #4's medications on hand on 01/04/19 at 4:20pm revealed there was no Levemir insulin syringe available for administration.

A second interview with the MA on 01/04/19 at 4:25pm revealed:
-She did not administer Levemir to Resident #1 on 01/03/19 and 01/04/19.
-She must have "made a mistake when I read it."

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C 342	Continued From page 9 -She "could not have administered the Levemir if it was not here." Attempted telephone interview with Resident #1's primary care provider on 1/07/19 at 12:45pm was unsuccessful.	C 342		