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
	HAL086013	A. BUILDING: _____ B. WING _____	R 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 Surry County Department of Social Services conducted a follow-up survey on November 28, 2018 to November 30, 2018 with an exit via telephone on December 3, 2018.	{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: Follow-up to Type B Violation Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to notify health care providers for 3 of 5 sampled residents (Residents #2, #3, and #4) regarding referral to pulmonologist, shortness of breath with oxygen saturation level less than 83%, and blood pressure outside of parameters (low and high) (#4); blood sugars greater than 300 and refusal to wear oxygen (#3); refusals of scheduled insulin and blood pressures outside of ordered parameters (#2). The findings are:	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sherry Chappell — TITLE: Administrator — (X6) DATE: 1/17/2019

Reviewed and accepted 01/30/19

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{D 273}	Continued From page 1 1. Review of Resident #4's current FL2 dated 08/02/18 revealed: -Diagnoses included chronic obstructive pulmonary disorder/asthma, hypertension, osteoarthritis, gastroesophageal reflux disease, hyperlipidemia, depression, and pacemaker. -Resident #4 was semi-ambulatory and used a rollator walker as an assistive device. -Resident #4 was incontinent of bowel and bladder. a. Review of Resident #4's Physician Encounter Sheets revealed: -On 09/20/18, the plan was a pulmonology referral as the physician was unsure of the last time the resident was seen. -On 08/23/18, the assessment for chronic obstructive pulmonary disease (COPD) revealed the disease was stable and resident was scheduled for an appointment with pulmonology "next week". Observation of Resident #4 on 11/28/18 at 10:30am revealed: -Taking deep breath and coughing as she exhaled each breath. -She had a bad cough and was having a hard time talking. -After several coughs the resident was able to communicate. Interview with Resident #4 on 11/28/18 at 10:32am revealed: -She had COPD and was always short of breath. -She thought that she had an appointment with the pulmonologist about her lungs but had not been to an appoint. -Facility staff were responsible for making her appointments. -She was waiting for facility staff to tell her about	{D 273}	Sherry Chappell, Administrator 1/17/2019 Please see attached	

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{D 273}	Continued From page 2 the appointment. Interview with transportation staff member on 11/29/18 at 3:25 pm revealed: -She had worked at the facility for a couple of months. -She was responsible for making sure residents went to appointments scheduled on the calendar. -Staff made her aware when a resident had an appointment and hand wrote the appointment on the calendar -She had transported Resident #4 to several doctor's appointments in the past two months. -She reviewed her calendar and stated she transported Resident #4 to the pulmonologist on 11/21/18. Second interview with transportation staff member on 11/29/18 at 4:25 pm revealed she had not taken Resident #4 to the pulmonologist on 11/21/18 but had rescheduled it for 11/30/18 at 9:00 am. Telephone interview with a nurse from the pulmonologist's office on 11/29/18 at 4:30 pm revealed: -Resident #4 had an appointment with the pulmonary doctor on 12/20/17 and was a no show. -Resident #4 had an appointment with the pulmonary doctor on 08/28/18 and the assisted living facility rescheduled the appointment for 11/21/18. -The doctor's office had to reschedule the appointment for 11/21/18. -The facility called today and scheduled appointment for 11/30/18 at 9:00 am. -The last time Resident # 4 was seen was on 10/26/15.	{D 273}	Sherry Chappell, Administrator 1/17/2019 Please see attached	

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{D 273}	Continued From page 3 Telephone interview with Resident #4's primary care provider (PCP) on 11/30/18 at 12:40 pm revealed: -She did not know Resident #4 had not been to an appointment with the pulmonary doctor. -On 07/11/18, she had discontinued Resident #4's CPAP (continuous positive airway pressure) machine because she was not using it, with the understanding that Resident # 4 would be seeing the pulmonologist in August 2018 to determine lung capacity. Interview on 11/30/18 at 5:15 pm with the Resident Care Coordinator (RCC) revealed: -She did not know Resident # 4 had been referred to a pulmonary doctor. -She had not been able to monitor resident records or physician encounter sheets due to staffing issues. b. Review of Resident #4's current FL2 dated 08/02/18 revealed an order to check oxygen saturation levels (02 sats) daily with no parameters listed. Review of Resident #4's September 2018 electronic Treatment Administration Record (eTAR) revealed: -There was a computer generated entry for 02 sats daily scheduled for 10:00 am. -In September 2018 Resident #4's 02 sats were checked twice. -On 09/29/18, 02 sat was 94. -On 09/30/18, 02 sat was 97. -There were no more 02 sats documented for September 2018. Review of Resident #4's October 2018 eTAR revealed: -There was a computer generated entry for 02	{D 273}	Sherry Chappell, Administrator 1/17/2019 Please see attached	

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{D 273}	Continued From page 4 sats daily scheduled for 10:00am. -Resident #4's 02 sats were documented from 10/01/18 through 10/31/18. -The 02 sats ranged from 77 to 100. Review of Resident #4's November 2018 eTAR revealed: -There was a computer generated entry for 02 sats daily scheduled for 10:00am. -Resident #4's 02 sats were documented from 11/01/18 through 11/28/18. -The 02 sats ranged from 68 to 99. -Resident # 4's 02 sats were 77 on 11/03/18, 68 on 11/05/18, and 73 on 11/16/18. Interview with Resident #4 on 11/28/18 at 10:32am revealed: -She had COPD and was always short of breath. -At times she had increased shortness of breath, so she turned her oxygen level up. -The MA checked her 02 sats daily. -Some times the MA told her what the levels were. -She did not recall the MA telling her that her 02 sats were low. -When she was in the hospital her oxygen was 4L/M when she had pneumonia. -She thought the PCP at the facility had changed the order oxygen to 2L/M because facility staff set her machine at 2L/M. -The 2L/M was not enough because she was still short of breath, so she increased the oxygen level to 3L/M. -She had increased her oxygen for at least a month or longer. Interview with Resident #4's primary care physician (PCP) on 11/30/18 at 12:40 pm revealed: -She knew there were no parameters on the	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 5 order to check 02 sats daily. -Even without parameters, staff should contact her and report when 02 sats were below 90. -Staff did not notify her when Resident #4 02 sats were lower than 90. -She would clarify the order for 02 sats to include parameters. Interview with the Resident Care Coordinator (RCC) on 11/30/18 at 5:15 pm revealed: -She was not notified by the medication aide of Resident # 4's pulse ox value being below 80. -If Resident #4's pulse ox value was in the 80's or lower, she would think that staff would exercise common sense and report the information to her so that the PCP could be notified. c. Review of Resident #4's FL2 dated 08/02/18 revealed an order to check blood pressure (BP) every morning and to notify the PCP if it was greater than 150/90. Review of a subsequent physician's order dated 09/20/18 revealed an order to check BP daily between 7:00 am and 3:00 pm and to notify PCP if it was greater than 150/90. Review of Resident #4's September 2018 electronic Treatment Administration Record (eTAR) revealed: -There was a computer generated entry for BP to be checked daily and to notify PCP if greater than 150/90. -BPs were only taken twice in September 2018. -On 09/29/18 BP was 142/88. -On 09/30/18 BP was 122/70. Review of Resident # 4's October 2018 eTAR revealed: -There was a computer generated entry for BP to	{D 273}	Sherry Chappell, Administrator Please see attached 1/17/2019	

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{D 273}	Continued From page 6 be checked daily and to notify PCP if greater than 150/90. -BP values were documented daily from 10/01/18 to 10/31/18. -BP values ranged from 87/52 to 158/97. -There were 2 occasions with BP values were greater than 150/90 (on 10/3/18, BP was 158/97, and on 10/18/18, BP was 156/91). -There was no documentation the physician was notified of BP values were outside the parameters of 150/90. Review of Resident # 4's November 2018 eTAR revealed: -There was a computer generated entry for BP to be checked daily and to notify PCP if BP was greater than 150/90. -BP values were documented daily from 11/01/18 to 11/30/18. -BP values ranged from 62/30 to 169/102. -There were 3 occasions with BP values were greater than 150/90 as follows: -On 11/01/18, BP was 169/102, on 11/16/18, BP was 152/97 and on 11/18/18, BP was 179/93. -There was no documentation the physician was notified of BP values were outside the parameters of 150/90.. -There were 4 occasions with low BP values, although there was no physician order for low BP parameters as follows: -On 11/22/18, BP was 86/48, on 11/23/18, BP was 89/48, on 11/25/18, BP was 62/30, and on 11/26/18, BP was 92/57. Interview with Resident #4 on 11/29/18 at 4:40pm revealed: -The MA checked her BP daily. -Her BP was usually normal. -She did not feel any different when her BP was high.	{D 273}	Shirley Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 7 -She felt sleepy and tired when her BP was low, so she got up and moved around. Interview with Resident #4's PCP on 11/30/18 at 12:40 pm revealed: -She did not remember being notified by staff of Resident #4's BP being higher than the ordered parameters. -She did not write a low blood pressure parameter, but she wanted to be contacted by the staff for lower BP, "especially for low BP's 2 days in a row". Interview with the RCC on 11/30/18 at 5:15 pm revealed: -She did not know Resident #4's blood pressures were outside the physician ordered parameters and were not being reported to the PCP. -She knew there was not a parameter for low blood pressure. -She did not know Resident #4's BP had dropped 4 days in November 2018. -If Resident #4's BP was "that low", the medication aide should have "exercised common sense, because it was taught in medication aide class". -She expected staff to report the information to her so that the PCP could be notified. -She was supposed to monitor electronic medication or treatment administration records, but had not been able to do the monitoring of records due to staffing issues. 2. Review of Resident #3's current FL2 dated 11/26/18 revealed diagnoses included diabetes. a. Review of Resident #3's current FL2 dated 11/26/18 revealed physician orders for fingerstick blood sugars (FSBS) "AC & HS" (before meals and at bedtime).	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 8 Review of Resident #3's previous FL2 dated 10/02/18 revealed physician orders for FSBS before meals, at bedtime and as needed (PRN). Review of Resident #3's physician's order dated 08/01/18 revealed FSBS three times daily, "if BS over 300 or less than 70 notify MD." Review of Resident #3's September 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for FSBS three times daily at 7:00am, 12:00pm and 5:00pm. -An entry to notify the physician when Resident #3's FSBS was greater than 300 or less than 70. -Documentation Resident #3's FSBS was checked three times daily at 7:00am, 12:00pm and 5:00pm with results. -Resident #3 had two documented FSBS results greater than 300 as follows: -On 09/13/18 at 5:00pm, FSBS= 317. -On 09/20/18 at 12:00pm, FSBS= 334. -The current FSBS order was not entered on the eMAR. Review of Resident #3's record revealed no documentation the physician was notified regarding the two FSBS greater than 300 in September 2018. Review of Resident #3's October 2018 eMAR revealed: -An entry for FSBS three times daily at 7:00am, 12:00pm and 5:00pm. -An entry to notify the physician when Resident #3's FSBS was greater than 300 or less than 70. -Documentation Resident #3's FSBS was checked three times daily at 7:00am, 12:00pm and 5:00pm with results.	{D 273}	Sherry Chappell, Administrator Please see attached 1/17/2019	

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{D 273}	Continued From page 9 -Resident #3 had seventeen FSBS greater than 300 with examples as follows: -On 10/07/18 at 12:00pm, FSBS= 392. -On 10/17/18 at 12:00pm, FSBS=410. -On 10/21/18 at 7:00am, FSBS=386. -On 10/23/18 at 12:00pm, FSBS= 400. -On 10/25/18 at 5:00pm, FSBS-368. -On 10/26/18 at 12:00pm, FSBS= 426. -On 10/28/18 at 12:00pm, FSBS=432. -On 10/29/18 at 5:00pm, FSBS=355. -On 10/30/18 at 12:00pm, FSBS=369. -On 10/30/18 at 5:00pm, FSBS=334. -On 10/31/18 at 12:00pm, FSBS 416. -On 10/31/18 at 5:00pm, FSBS=327. Review of the Nurse's Notes in Resident #3's record revealed: -Documentation the Nurse Practitioner (NP) was notified three times in October 2018 regarding blood sugars greater than 300. -On 10/23/18 staff documented the NP was notified via fax, no response noted in the record. -On 10/26/18 staff documented the NP was notified at 12:00pm regarding the 426 FSBS, instructions to give more insulin and re-check the resident FSBS in one hour. There was no documentation a re-check was done. -On 10/27/18 staff documented the NP was notified regarding the 323 FSBS, instructions were given to give insulin and recheck. -There was documentation Resident #3's FSBS was re-checked at 8:00pm, but the result was not documented. Review of Resident #3's November 2018 eMAR revealed: -An entry for FSBS three times daily at 7:00am, 12:00pm and 5:00pm. -An entry to notify the physician when Resident #3's FSBS was greater than 300 or less than 70.	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 10 -Documentation Resident #3's FSBS was checked three times daily at 7:00am, 12:00pm and 5:00pm with results. -Resident #3 had sixteen FSBS greater than 300 with examples as follows: -On 11/02/18 at 7:00am, FSBS= 390. -On 11/02/18 at 12:00pm, FSBS= 348. -On 11/03/18 at 12:00pm, FSBS= 350. -On 11/05/18 at 7:00pm, FSBS= 331. -On 11/08/18 at 12:00pm, FSBS=337. -On 11/08/18 at 5:00pm, FSBS=324. -On 11/09/18 at 12:00pm, FSBS=328. -On 11/13/18 at 12:00pm, FSBS=315. -On 11/15/18 at 12:00pm, FSBS=354. -On 11/16/18 at 12:00pm BS= 406. -On 11/16/18 at 5:00pm BS=328. Review of the Nurse's Notes in Resident #3's record revealed documentation the NP was notified one time in November 2018 on 11/16/18 for the FSBS result of 406. There was no documentation the NP responded. Interview with Resident #3 on 11/29/18 at 3:12pm revealed: -Facility staff checked her FSBS before each meal. -Staff did not tell her the FSBS readings. -She did not know when her blood sugar was high. Interview with Resident #3's primary care provider (PCP) on 11/20/18 at 12:05pm revealed: -She wanted Resident #3's FSBS checked before meals and at bedtime, four times daily. -She wanted facility staff to notify her or the on-call PCP by phone, not by fax with FSBS greater than 300. -It did not matter if the Resident's blood sugar was 301, she still wanted to be notified.	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 11 -She was able to recall once, maybe twice in October 2018, she received notification regarding Resident #3's blood sugars greater than 300. -She did not remember if the notification was by phone or fax. -She did not know Resident #3 had seventeen FSBS greater than 300 in October 2018. -She did not recall being notified in November 2018 that Resident #3 had sixteen FSBS greater than 300. Interview with the medication aide (MA) on 11/30/18 revealed: -Resident #3's FSBS was checked three times daily. -The resident sometimes had FSBS over 300. -She knew to notify the PCP when Resident #3's FSBS were greater than 300. -When Resident #3's FSBS was 350 or greater she called the PCP, if less than 350 she faxed the PCP the results. -There should be documentation in the "care notes" section of Resident #3's record that showed the PCP was notified when FSBS was greater than 300. -She also documented the PCP notification in the "comment" section of the eMARs -If there was no documentation in the resident's care notes or on the eMARs, then the PCP was not notified. Interview with the Resident Care Coordinator (RCC) on 11/30/18 at 1:20 pm revealed: -She was the supervisor over the medication aides. -She had instructed the MA supervisors to review the eMARs and orders to ensure medications and treatments were as ordered by the physician. -If the MAs had notified Resident #3's PCP there should be documentation in the resident's record.	{D 273}	Sherry Chappell, Administrator Please see attached 1/17/2019	

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{D 273}	Continued From page 12 -If there was no documentation in the record, she could not verify the PCP had been notified. -She did not know the MAs did not contact Resident #3's PCP with FSBS greater than 300. -The facility did not have a system to check and ensure the MAs contacted the PCP regarding Resident #3's FSBS greater than 300. b. Review of Resident #3's current FL2 dated 11/26/18 revealed diagnoses included hypoxic respiratory failure. -Physician orders for oxygen (O2) continuous and as needed "keep sat greater than 88." Review of a facility order clarification form dated 11/26/18 revealed the PCP ordered oxygen 2 liters per minute via nasal cannula continuous. Review of Resident #3's November 2018 eMAR revealed oxygen and 02 saturation levels were not documented on the MARs. Observation of Resident #3 on 11/29/10 from 2:30pm to 5:03pm of Resident #3 revealed: -At 3:00pm Resident #3 was in her room, lying with the upper part of the body on the bed with her legs hanging off the bed and her feet were on the floor. -The oxygen concentrator was in the room, but there was no noise coming from the concentrator and the black switch was in the off position. -The liters per minute set on the concentrator could not be determined because the concentrator was off. -The nasal cannula was on the bed beside Resident #3. -At 3:40pm Resident #3 was in the same position and the oxygen machine was off. -At 4:00pm the same as above. -At 5:03pm the same as above.	{D 273}	Sherry Chappell, Administrator Please see attached 1/17/2019	

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	HAL086013	A. BUILDING: _____ B. WING _____	R 12/03/2018

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{D 273}	Continued From page 13 Interview with Resident #3 on 11/29/18 at 3:00pm revealed: -She had "breathing problems" and was often tired, short of breath with some light headedness. -She only had to wear the oxygen at bedtime. -Currently, she was "a little short of breath," but had not considered wearing the oxygen. -She had not mentioned to staff that she was short of breath because staff had not come to her room. -She was able to put the cannula on, but staff turned the machine on for her. -She was waiting for staff to come and help her get in the bed. Interview with two personal care aides (PCA) on 11/29/18 at 4:05pm revealed: -Resident #3 was only to wear her oxygen at bedtime. -At nighttime they assisted the resident with putting the oxygen on. -Resident #3 sometimes took the oxygen off and they had to verbally remind her to put the oxygen back on. -The PCAs had reported to the MA Resident #3 took her oxygen off, and was unable to recall the exact times or dates. Interview with the second shift MA on 11/29/18 at 5:10pm revealed: -She did not know Resident #3 returned from the hospital on 11/26/18 with orders for oxygen continuous. -She did not know the resident was refusing to wear the oxygen. -When Resident #2 returned from the hospital the RCC handled the paperwork. -The facility's process was the MA on duty faxed the orders to the pharmacy and the pharmacy	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 14 entered the orders into the eMAR system. -A note popped up in the eMAR system to let the MA know there was an order she needed to accept or reject. -The MA compared the pharmacy entry of the order with paper order to ensure it was entered correctly. -If the order was entered correctly, the MA accepted the order; if the order was not correct, the MA rejected the order and sent a note back to the pharmacy as to why the order was not correct. -If the order was not in the eMAR system she had no way of knowing about the order. Interview with a second MA on 11/29/18 at 5:40pm revealed: -She did not know Resident #3's had an order for oxygen continuous. -She knew Resident #3 returned from the hospital with oxygen. -She thought the oxygen was for night use only. -She knew Resident #3 sometimes refused to wear her oxygen. -She did not notify the PCP Resident #3 was refusing to wear the oxygen. -She sometimes had to talk to Resident #3 to get the resident to put the oxygen on. -She did not check the resident's oxygen saturation level, because she did not know the order existed. -She knew of new orders because they would pop-up in the eMAR system for the resident. -If the resident refused three times in a row she notified the RCC or one of the MA supervisors, and they contacted the resident's physician. Interview with the RCC on 11/29/18 at 5:05pm revealed: -She knew Resident #3 had an order to wear	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 15 oxygen continuous. -She had not been told Resident #3 sometimes refused to wear oxygen. -The MAs should have made Resident #3's physician aware the resident refused to wear the oxygen. Review of the facility's medication and treatment policy revealed after three refusals the PCP would be contacted, the RCC would be made aware and documentation would be made in the resident record. 3. Review of Resident #2 current FL2 dated 08/03/18 revealed diagnoses included diabetes type 2, hypertension, and coronary artery disease. a. Review of Resident #2's current FL2 dated 08/03/18 revealed an order for fingerstick blood sugar (FSBS) checks before meals and at bedtime, and Humulin Kwikpen 70/30 (a combination of a short acting insulin and intermediate acting insulin for lowering blood sugar) inject 8 units subcutaneously with breakfast and dinner. Review of Resident #2's November 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS before meals and at bedtime scheduled at 7:00 am, 12:00 pm, 5:00 pm, and 8:00 pm. -There was an entry for Humulin Kwikpen 70/30 inject 8 units subcutaneously with breakfast and dinner scheduled for administration at 7:00 am and 5:00 pm. -FSBS values documented on the eMAR for 7:00 am were, on 11/14/18 - FSBS=87, on 11/15/18 - FSBS=94, on 11/16/18 - FSBS=118 and on	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 16 11/18/18 - FSBS=78. -Humulin 70/30 was documented as refused at 7:00 am on 11/14/18, 11/15/18, 11/16/18 and 11/18/18. -FSBS values documented on the eMAR for 12:00 pm were on 11/14/18 - FSBS=222, on 11/15/18 - FSBS=168, on 11/16/18 - FSBS=131 and on 11/18/18 - FSBS=158. -FSBS values at 7:00 am ranged between 78 to 414 from 11/01/18 to 11/28/18. -FSBS values at 12:00 pm ranged between 118 to 347 from 11/01/18 to 11/28/18. Review of the facility's policy on "Medication Administration" revealed "following three medication refusals, the MD will be contacted and the RCC made aware and documentation will be made in the resident chart". Review of Resident #2's record revealed no documentation the resident's physician was notified for refusing Humulin Kwikpen for 3 doses from 11/14/18 to 11/16/18. Interview on 11/29/18 at 4:25 pm with Resident #2 revealed: -Staff informed her of blood sugar values each time it was checked. -She refused to take Humulin Kwikpen 70/30 if her blood sugar was less than 120 because she did not want her blood sugar to go too low (hypoglycemia). -She had not told her primary care provider that she was refusing to take insulin when her blood sugar was low. Interview on 11/29/18 at 3:15 pm with the Resident Care Coordinator (RCC) revealed: -There was no documentation for notifying Resident #2's provider regarding refusing 7:00	{D 273}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 17 am Humulin Kwikpen 70/30 insulin from 11/14/18 to 11/16/18. -She knew Resident #2 refused her 7:00 am insulin when her FSBS was low (less than 120) because she had passed medications on 11/14/18 and 11/18/18. -She was responsible to assure medication aides (MA) were contacting providers for refusals per the facility policy. -The MA staff were responsible to fill out a fax notification and fax to the provider when a resident refused medications or treatments 3 times in a row. -She did not know Resident #2 had refused insulin 3 times in a row at 7:00 am. Telephone interview on 11/30/18 at 9:45 am with an office representative at Resident #2's primary care provider revealed: -There was no documentation regarding the facility notifying the provider for Resident #2 refusing her insulin injection. -It was the provider's expectation that the facility would notify the provider because changes to the insulin dose may need to be considered. Interview with the RCC on 11/30/18 at 1:20pm revealed: -She was the supervisor over the MAs. -She had instructed the MA supervisors to review the eMARs and orders to ensure medications and treatments were as ordered by the physician. -If the MAs had notified a resident's PCP there should be documentation in the resident's record. -If there was no documentation in the record, she could not verify the PCP had been notified. -The facility did not have a system to check and ensure the MAs contacted the PCP regarding refusals.	{D 273}	Shuny Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 18 b. Review of Resident #2's current FL2 dated 08/03/18 revealed an order to check blood pressure every morning and notify the physician (MD) if blood pressure greater than (>) 150/90. Review of Resident #2's September 2018 electronic Medication Administration Record (eMAR) revealed: -Blood pressure values were documented daily for except on 09/20/18 and 09/21/18 when the resident refused blood pressure check. -Resident #2's blood pressure values ranged from 106-187/51-97. -There were 6 occasions when Resident #2 had a blood pressure value greater than 150/90 documented on the eMAR. (Examples included: on 09/07=187/67, on 09/17/18=168/85, on 09/22/18=176/87, and on 09/27/18=155/97. Review of Resident #2's October 2018 eMAR revealed: -Blood pressure values were documented daily for 31 of 31 opportunities. -Resident #2's blood pressure values ranged from 100-198/53-107. -There were 12 occasions when Resident #2 had a blood pressure value greater than 150/90 documented on the eMAR. Examples included: on 10/02/18=155/84, on 10/09/18=167/85, on 10/12/18=187/91, on 10/27/18=167/88, and on 10/31/18=198/107. Review of Resident #2's November 2018 eMAR revealed: -Blood pressure values were documented daily from 11/01/18 to 11/28/18 except on 11/21/18 when the resident was sent to the hospital emergency room for a urinary tract infection. -Resident #2's blood pressure values ranged from 96-184/65-105.	{D 273}	Shirley Chappell, Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 19 -There were 10 occasions when Resident #2 had a blood pressure value greater than 150/90 documented on the eMAR. Examples included: on 11/01/18=184/105, on 11/04/18=156/82, on 11/14/18=158/95, and on 11/26/18=166/95. Review of Resident #2's record revealed no documentation the resident's physician was notified for blood pressure values above 150/90 for September 2018, October 2018 or November 2018. Interview on 11/29/18 at 3:15 pm with the RCC revealed: -She interpreted the parameters for Resident #2's blood pressure to notify the provider if the systolic(higher) pressure was greater than 150 or the dystolic(lower) pressure was over 90. -There was no documentation available for notifying Resident #2's provider regarding Resident #2's blood pressure values greater than 150/90. -The eMAR did not have an area for noting provider notification for blood pressure values outside the ordered parameters. -She did not know Resident #2 had blood pressure values greater than the parameters of 150/90. -She was responsible to assure MAs were contacting providers for medication or treatment parameters per the facility policy. -The MA staff were responsible to fill out a fax notification and fax to the provider when a resident had medications or treatment that exceeded parameters. -MAs could also document notes regarding provider notification in the residents' records in the care notes. -Since there was no documentation in the care notes and no copies of fax notification available	{D 273}	Shirley Chappell Administrator Please see attached	1/17/2019

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{D 273}	Continued From page 20 for review, she did not know if Resident #2's provider was notified for blood pressures greater than 150/90. Telephone interview on 11/30/18 at 9:45 am with an office representative at Resident #2's primary care provider revealed: -There was no documentation regarding the facility notifying the provider for Resident #2 blood pressure reading above the 150/90 parameters. -It was the provider's expectation that the facility would notify the provider because changes to the blood pressure medications may need to be considered. Interview on 11/29/18 at 4:25 pm with Resident #2 revealed: -Staff informed her of blood pressure value most of the time it was checked. -She could not tell when her blood pressure was elevated because she did not feel any differently. -She had not told the Nurse Practitioner (NP) her blood pressure was elevated some times and did not know if the facility had contacted the NP. The facility failed to assure provider notification and follow-up for residents regarding a referral appointment to the pulmonologist for Resident #4, who was experiencing difficulty breathing with oxygen saturation levels less than 85% causing the resident to gasp and pant for air, and not notifying the PCP when the resident's blood pressures were outside of ordered parameters (low and high); not notifying Resident #3's PCP when the resident blood sugar parameters to notify the PCP for values greater than 300, and the resident's refusal to wear oxygen; not notifying the PCP for Resident #2's blood pressures outside of parameters (placing the resident at increased risk for organ damage or	{D 273}	Shery Chappell, Administrator Please see attached 1/17/2019	

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{D 273}	Continued From page 21 stroke), and for refusal of the morning doses of Humulin insulin (placing the resident at risk for uncontrolled diabetes). These failures were detrimental to the health, safety and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 11/29/18.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician orders were implemented for 1 of 5 sampled residents (Resident #3) with orders for fingerstick blood sugars (FSBS) four times daily, oxygen saturation level monitoring and weekly weights. The findings are:	D 276	Sherry Chappell, Administrator Please see attached 1/17/2019	

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D 276	Continued From page 22 Review of Resident #3's current FL2 dated 11/26/18 revealed diagnoses included diabetes. a. Review of the current FL2 dated 11/26/18 revealed physician orders for fingerstick blood sugars (FSBS) "AC & HS" (before meals and at bedtime, four times daily). Review of a previous FL2 dated 10/02/18 revealed physician orders for fingerstick blood sugar (FSBS) before meals, at bedtime and as needed (PRN). Review of Resident #3's September, October and November 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for FSBS three times daily at 7:00am, 12:00pm and 5:00pm. -Documentation Resident #3's FSBS was checked three times daily at 7:00am, 12:00pm and 5:00pm with results. -There was no entry a fourth FSBS reading was obtained at bedtime on the eMARs. Interview with Resident #3 on 11/29/18 at 3:12pm revealed: -Facility staff checked her FSBS before each meal. -She did not know her FSBS were to be checked four times daily. Interview with Resident #3's primary care provider (PCP) on 11/20/18 at 12:05pm revealed: -She wanted Resident #3's FSBS checked before meals and at bedtime, four times daily. -She did not know facility staff were not checking Resident #3's FSBS four times daily. Interview with the medication aide (MA) on 11/30/18 revealed:	D 276	Sheny Chappell, Administrator Please see attached	1/17/2019

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D 276	Continued From page 23 -Resident #3's FSBS was checked three times daily. -She did not know the resident had current orders for FSBS four times daily. -When orders were received they were faxed to the pharmacy and the supervisors entered the orders into the eMAR system. -She had not seen the FL2 from 10/02/18 and 11/26/18 and did not know Resident #3's FSBS was to be checked four times daily. Interview with the Resident Care Coordinator (RCC) on 11/30/18 at 1:20pm revealed: -The facility's protocol when orders were received was for the MA on duty to fax the order to the pharmacy. -The pharmacy entered the order into the eMAR system and sent a notification for the MA to accept the entry. -The MA was to verify the entry with the order and if it was okay she accepted the entry, which appeared on the resident's eMAR. -The FL2s were considered orders and should have followed the facility's protocol for processing orders. -She did not know why Resident #3's FSBS were not check four times daily. b. Review of Resident #3's current FL2 dated 11/26/18 revealed diagnoses included hypoxic respiratory failure. -There was a physician's order to "keep sat greater than 88." Review of a facility order clarification form dated 11/26/18 revealed the PCP ordered "check 02 sat [oxygen saturation] once per shift. Notify MD if less than 88%." Review of Resident #3's November 2018 eMAR	D 276	Shirley Chappell, Administrator Please see attached 1/17/2019	

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D 276	Continued From page 24 revealed no entry on the eMAR to check O2 sats once per shift and no documentation 02 sats were checked. Interview with Resident #3 on 11/29/18 at 3:00pm revealed: -She had chronic obstructive pulmonary disease (COPD) and was ordered oxygen. -Facility staff did not check oxygen saturation levels. Interview with a personal care aide (PCA) on 11/29/18 at 5:09pm revealed: -The facility had a "pulse ox" (measure oxygen level in the blood) to check oxygen saturation level. -The MA's sometimes told the PCA's to check 02 sats on residents. -The had never been told to check Resident #3's 02 sat's. Interview with a second shift MA on 11/29/18 at 5:10pm revealed: -She did not know Resident #3 had an order to check her 02 sats. -If the resident had an order it should be on the eMAR to alert the MA and to document the 02 level. -When Resident #3 returned from the hospital the RCC had the paperwork. -The RCC would have been the one to enter the 02 sats on the eMAR. Interview with the RCC on 11/29/18 at 5:45pm revealed: -When Resident #3 returned from the hospital she clarified the FL2 with Resident #3's PCP, but had not faxed the order to the pharmacy. -She had authority to enter orders into the eMAR system, but had not entered Resident #3's order	D 276	Shuny Chappell, Administrator Please see attached 1/17/2019	

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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 276	Continued From page 25 for 02 sat's into the eMAR system. -She had a lot of papers on her desk and Resident #3's orders got lost in the paperwork. -The MAs did not check Resident #3's oxygen saturation level each shift because the order was not on the eMAR. c. Review of Resident #3's current FL2 dated 11/26/18 revealed diagnoses included diabetes, hypertension and sleep apnea. Review of a medication clarification order sheet in Resident #3's record revealed: -On 09/06/18 the PCP was notified by facility staff that Resident #3 had a 10% increase in weight over the past six months and asked the PCP to advise. -The PCP wrote orders for weekly weights. Review of Resident #3's September, October and November 2018 eMARs revealed: -There was no entry on the eMAR for weekly weights. -There was no documented weekly weights. Review of the facility's vital sign book revealed: -Monthly weights were documented for Resident #3 as follows: -On 09/12/18 Resident #3 weighed 220 pounds. -On 10/03/18 there was no entry for Resident #3's weight. -On 11/09/18 Resident #3 weighed 220 pounds. -There were no weekly weights documented for Resident #3. Interview with Resident #3 on 11/29/18 at 3:12pm revealed: -Facility staff did not weigh her weekly. -She did not remember if she was weighed at the facility.	D 276	Sherry Chappell, Administrator Please see attached 1/17/2019	

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	HAL086013	A. BUILDING: _____ B. WING _____	R 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

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D 276	Continued From page 26 Interview with Resident #3's PCP on 11/20/18 at 12:05pm revealed: -In September 2018, Resident #3 had an increased weight gain and she ordered weekly weights. -Facility staff should document the weight after it was obtained. -It had been a month since she had seen Resident #3 and did not know facility staff were not obtaining the resident's weights. Interview with a MA on 11/30/18 revealed: -The facility had a scale for weighing residents. -She did not know Resident #3 had an order for weekly weights. -The MA receiving the order should have faxed the order to the pharmacy so it could be put on the eMAR. -The MA usually had the PCA weigh the resident. -The PCA told the MA the resident's weight and the MA recorded the weight on the eMAR. -She was sure Resident #3 was not being weighed weekly. Interview with the RCC on 11/30/18 at 1:20pm revealed: -The facility's protocol when orders were received was for the MA on duty to fax the order to the pharmacy. -The MA supervisors and her were also able to enter orders into the eMAR system. -She was not sure what happened, but Resident #3's order for weekly weights was never implemented.	D 276		
{D 344}	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders	{D 344}	Sherry Chappell, Administrator Please see attached	1/17/2019

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{D 344}	Continued From page 27 (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to obtain clarification of medication orders from the primary care provider (PCP) for 1 of 5 sampled residents (Resident #4) regarding medication orders for meloxicam and trazodone. The findings are: Review of Resident #4's current FL2 dated 08/02/18 revealed: -Diagnoses included chronic obstructive pulmonary disorder/asthma, hypertension, osteoarthritis, gastroesophageal reflux disease, hyperlipidemia, depression, and pacemaker. -There was a physician's order for trazodone (used to treat depression), 100mg every night and trazodone 50mg every night. -The treatments listed included CPAP on every	{D 344}	Sherry Chappell, Administrator Please see attached 1/17/2019	

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{D 344}	Continued From page 28 night and off every morning. a. Review of a physician's order dated 10/08/18 and 10/18/18 revealed there was a discontinue order for trazodone 100mg (1 tablet) with 50mg equal to 150mg. Review of Resident # 4's October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for trazodone 100mg and trazodone 50mg every night scheduled for administration at 8:00pm. -Trazodone 100mg tablet and the trazodone 50mg tablet were administered from 10/01/18 to 10/08/18. -Trazodone 50mg tablet was administered on 10/10/18, 10/12/18, and 10/17/18 through 10/31/18. Review of Resident #4's November 2018 eMAR revealed; -There was an entry for trazodone 50mg every night scheduled for administration at 8:00pm. -Trazodone 50mg was administered from 11/01/18 to 11/27/18. Interview with Resident #4 on 11/29/18 at 4:40pm revealed: -She did not know her medications ordered. -She did not recall anyone at the facility discussing with her new, changed or discontinued medication orders. -She did not know she was administered trazodone daily. Telephone interview with a representative from the facility contracted pharmacy on 11/30/18 at 12:45pm revealed: -They received the order dated 10/09/18 to	{D 344}	Sherry Chappell, Administrator Please see attached 1/17/2019	

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{D 344}	Continued From page 29 discontinue the trazodone 100mg with the trazadone 50mg to equal 150mg. -The pharmacy faxed the facility and asked if Resident #4 was to continue to take the 100mg and 50mg of trazodone, as the order was confusing. -The facility did not respond back to the fax regarding clarifying the trazodone. -The pharmacy did not contact Resident #4's primary care provider (PCP). -The pharmacy had no record of speaking to anyone at the facility or any written documentation of clarification, so they continued to send the trazodone 50mg. -Trazodone 50mg was delivered on 10/16/18 and again on 11/01/18. Telephone interview on 11/30/18 at 12:40pm with Resident #4's PCP revealed: -Both the trazodone 100mg and trazodone 50mg should have been discontinued as of 10/09/18. -The Resident Care Coordinator (RCC) or a medication aide should have contacted her to clarify the order for trazodone. Interview on 11/30/18 at 5:15 pm with the RCC revealed: -She did not know what happened with the 50mg trazodone. -There should have been a clarification with the primary care provider regarding trazadone. b. Review of Resident #4's current FL2 dated 08/02/18 revealed the FL2 did not include an order for meloxicam (Mobic) (used to treat anti-inflammation) 15mg daily. Review of a physician's order sheet signed on 07/26/18 by PCP revealed Mobic 15mg daily.	{D 344}	Sherry Chappell, Administrator Please see attached 1/17/2019	

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{D 344}	Continued From page 30 Review of Resident #4's September, October and November 2018 electronic Medication Administration Records (eMARs) revealed: -There was an entry for meloxicam 15mg daily scheduled for administration at 8:00am. -Meloxicam (Mobic), 15mg was documented as administered daily at 8:00am from 09/01/18 to 09/30/18; 10/01/18 to 10/31/18, and 11/01/18 to 11/30/18. Interview with Resident #4 on 11/29/18 at 4:40pm revealed: -She did not know her medications ordered. -She did not know she was administered meloxicam daily. Telephone interview with a representative from the contracted pharmacy on 11/30/18 at 12:45pm revealed: -The order for meloxicam 15mg daily was faxed to the pharmacy on 06/28/18 by the facility staff. -The pharmacy filled and dispensed the medication on 06/30/18 for a quantity of 28 tablets. -The pharmacy filled and dispensed the medication for the same quantity in July, August, September, October and November 2018. Telephone interview on 11/30/18 at 12:40 pm with Resident #4's PCP revealed: -Resident #4 should not be taking Mobic. -The RCC or a MA should have clarified the order for meloxicam 15mg. Interview on 11/30/18 at 5:15pm with the RCC revealed: -The MA supervisor on duty when the order was received was responsible for ensuring the order for meloxicam was discontinued. -The order for meloxicam 15mg was before her	{D 344}	Shuy Chappell, Administrator Please see attached 1/17/2019	

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{D 344}	Continued From page 31 time and she was not sure why the medication was still on the eMAR. -There should have been a clarification with the primary care provider regarding the meloxicam.	{D 344}		
{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: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observation, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed practicing practitioner for 2 of 6 residents sampled (#1, and #2) related to a non-steroidal pain medication ordered as needed (#1), and a medication for anxiety (#2).	{D 358}	Shirley Chappell, Administrator Please see attached 1/17/2019	

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{D 358}	Continued From page 32 The findings are: 1. Review of Resident #2's current FL2 dated 08/03/18 revealed diagnoses included diabetes type 2, hypertension, and coronary artery disease. Review of Resident #2's current FL2 dated 08/03/18 revealed an order for alprazolam 0.25 mg take one-half tablet at bedtime (Alprazolam is used to treat anxiety and to induce sleep. Review of Resident #2 physician's order dated 10/05/18 revealed an order for alprazolam 0.25 mg one tablet every day as needed for increased anxiety/agitation. Review of Resident #2's November 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for alprazolam 0.25 mg take one-half tablet at bedtime. -Alprazolam 0.25 mg one-half tablet was documented as administered at 8:00 pm each night from 11/01/18 to 11/21/18. -Alprazolam 0.25 mg one-half tablet was not documented as administered on 11/22/18, 11/23/18, 11/24/18, 11/25/18, 11/26/18, and 11/27/18 with the reason documented on the eMAR as both waiting on the pharmacy and patient unable to take (because waiting on pharmacy). -There was an entry for alprazolam 0.25 mg take one tablet every day as needed for increased anxiety/agitation. -Alprazolam 0.25 mg one tablet every day as needed was documented as administered on 11/21/18, 11/22/18, 11/24/18, 11/25/18, and 11/26/18.	{D 358}	Sheryl Chappell, Administrator Please see attached 1/17/2019	

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{D 358}	Continued From page 33 Review of Resident #2's controlled substance count sheets (CSCS) for alprazolam 0.25 mg one-half tablet at bedtime revealed: There was a CSCS dated 10/16/18 for 28 of one-half alprazolam 0.25 mg tablets. -There were 28 one-half tablets signed out as administered from 10/26/18 to 11/21/18 (one additional tablet wasted on 10/31/18) at 8:00 pm. -There was no subsequent CSCS sheets for alprazolam 0.25 mg tablets one-half tablet at bedtime. Review of Resident #2's CSCS for alprazolam 0.25 mg one tablet every day as needed dispensed on 10/05/18 for 30 tablets revealed: -There were 8 tablets signed out as administered from 10/30/18 to 11/21/18. -There were 5 tablets signed out as administered from 11/21/18 to 11/26/18 (11/21/18, 11/22/18, 11/24/18, 11/25/18, and 11/26/18). Observation of medications on hand for administration to Resident #2 on 11/28/18 at 4:00 pm revealed: -There was no alprazolam 0.25 mg one-half tablet at bedtime available for administration. -There were 17 tablets remaining for alprazolam 0.25 mg one tablet daily as needed for increased anxiety/agitation dispensed on 10/05/18 for 30 tablets. Interview on 11/28/18 at 3:00 pm with an evening shift medication aide (MA) revealed: -She routinely worked the evening shift most days. -She knew Resident #2 was out of alprazolam 0.25 mg one-half tablet at bedtime. -The pharmacy had not sent the alprazolam 0.25 mg one-half tablets because the resident needed	{D 358}	Shirley Chappell, Administrator Please see attached 1/17/2019	

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{D 358}	Continued From page 34 a new prescription. -The day shift Supervisor told the MA she called Resident #2's primary care physician (PCP) on 11/27/18, but the PCP did not refill medications ordered by the mental health provider. -She did not know if the mental health provider had been notified Resident #2 was out of alprazolam 0.25 mg one-half tablet at bedtime. -Resident #2 had an order for alprazolam 0.25 mg, one tablet every day as needed, the resident had requested on at least 2 of the days the MA had been working, while she was waiting for the renewal of the alprazolam one-half tablet at bedtime order. -She had not notified Resident #2's mental health provider for Resident #2 not receiving alprazolam 0.25 mg one-half tablet at bedtime as ordered. Interview on 11/29/18 at 4:25 pm with Resident #2 revealed: -She knew she did not have alprazolam 0.25 mg one-half tablet at bedtime available because the pharmacy was waiting on a refill from her physician. -She knew she had another order for alprazolam one tablet she could request as needed however, she did not routinely take a whole tablet to help her sleep; the half tablet usually helped her fall asleep. -If she did not take the alprazolam she would still be awake at 2:00 am. -She had not seen her mental health provider since she ran out of one-half alprazolam tablets. Telephone interview on 11/30/18 at 8:30 am with a pharmacist for the contract pharmacy revealed: -Resident #2's alprazolam 0.25 mg one-half tablet at bedtime was dispensed for 28 doses on 08/14/18, 9/11/18, 10/09/18 (sent out on 10/16/18 but no reason given).	{D 358}	Penny Chappell, Administrator Please see attached	1/17/2019

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{D 358}	Continued From page 35 -Resident #2's mental health provider had been faxed a refill request by the pharmacy on 11/05/18, but the pharmacy had no documentation for a provider's response. -The facility should have received a note Resident #2 needed a refill for alprazolam 0.25 mg in the medication delivery tote on 11/05/18 or maybe 11/06/18. -The facility was responsible to contact the provider to assure a refill had been received. Telephone interview on 11/30/18 at 3:30 pm with Resident #2's mental health provider revealed: -She did not know Resident #2 needed a refill on her alprazolam 0.25 mg one-half tablet at bedtime. -She came to the facility every 2 weeks and signed medication requests for her residents. -She would refill Resident #2's alprazolam 0.25mg one-half tablet at bedtime if the pharmacy or facility sent her the refill request. -Resident #2 also had an order for alprazolam 0.25 mg one tablet daily as need if the resident needed to use that medication while she was being contacted for refills. 2. Review of Resident #1's current FL2 dated 08/25/18 revealed: -Diagnoses included Type 2 diabetes mellitus, and chronic pain. -There was an order for ibuprofen 800 mg every 12 hours as needed (Ibuprofen is used to treat mild pain.) Interview during the initial tour on 11/28/18 at 10:15 am with Resident #1 revealed: -He requested ibuprofen 800 mg in the evening on 10/27/18 and early on 11/28/18. -The medication aide (MA) told Resident #1 he had no ibuprofen 800 mg on the cart for	{D 358}	Shirley Chappell, Administrator Please see attached 1/17/2019	

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{D 358}	Continued From page 36 administration. -He was told the facility staff were waiting on the pharmacy to send ibuprofen 800 mg. -He took ibuprofen for breakthrough pain. Review of Resident #1's November 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for ibuprofen 800 mg one tablet every 12 hours as needed for pain. -Ibuprofen 800 mg had been documented as administered for 23 doses from 11/03/18 to 11/27/18. -Ibuprofen 800 mg was documented as administered at 5:40 am on 11/27/18. Observation of Resident #1's medication on hand for administration on 11/30/18 at 4:25 pm revealed there was no ibuprofen 800 mg was on the medication cart for administration. Interview on 11/29/18 at 6:35 pm with Resident #1 revealed: -He had scheduled pain medication that was administered routinely. -He took the ibuprofen to help with breakthrough pain in his legs and feet. -He requested his prn (as needed) ibuprofen 800 mg yesterday (11/28/18). -He requested ibuprofen 800 mg today (11/29/18) from the evening shift medication aide (MA). -He was told there was no ibuprofen 800 mg available on the medication cart again today. -He had been out of his ibuprofen for 2 days counting today. Interview on 11/29/18 at 6:45 pm with the evening MA revealed: -Resident #1 did not have ibuprofen 800 mg available to administer when he requested the	{D 358}	Shirley Chappell, Administrator Please see attached	1/17/2019

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{D 358}	Continued From page 37 prn. -She checked the facility back-up stock for Resident #1, but was not able to locate any back-up ibuprofen 800 mg. -She had not called the contract pharmacy regarding the ibuprofen not being available for Resident #1. -She thought ibuprofen had been requested from the pharmacy today (11/29/18) and it may show up in the pharmacy order received tonight. -She would let the resident know if the medication came in today's delivery. Interview on 11/29/18 at 6:50 pm with the Resident Care Coordinator (RCC) revealed: -Resident #1 was administered the last ibuprofen 800 mg from his bubble pack on 11/27/18 at 5:40 am. -Resident #1's ibuprofen was reordered electronically on 11/27/18 and should have come in the pharmacy order on 11/27/18 or 11/28/18. -She did not know why the contract pharmacy had not sent Resident #1's ibuprofen unless he was out of refills and the primary care provider had to be contacted. -She would call the pharmacy for information in the morning if the order did not arrive in the pharmacy delivery this evening (11/29/18). Telephone interview on 11/30/18 at 8:50 am with a pharmacist at the contract pharmacy revealed: -Resident #1's ibuprofen 800 mg was dispensed for 30 tablets on 11/04/18 (should be 15 days supply). -Resident #1's ibuprofen 800 mg was dispensed for 30 tablets on 11/16/18 (should be 15 days supply). -The facility requested a refill on Resident #1's ibuprofen on 11/27/18. -The prescription refill request was too early for	{D 358}	Johny Chappell, Administrator Please see attached	1/17/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	R 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

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{D 358}	Continued From page 38 insurance to pay on 11/27/18. -He would refill ibuprofen 800 mg today (11/30/18) but the resident should not be out of ibuprofen 800 mg this early. Interview on 11/30/18 at 9:50 am with the RCC revealed: -She checked all the facility overstock locations. -She was not able to locate any ibuprofen 800 mg for Resident #1 in the overstock. -"She did not know where the medication could be". -She could not explain why Resident #2 was out of ibuprofen based on the amount sent from the pharmacy (30 tablets on 11/04/18 and 30 tablets on 11/16/18) and the amount documented as administered on the resident's eMAR. -She would have staff inform the resident as soon as the order came in tonight. Telephone interview on 11/30/18 at 12:00 pm with the Nurse Practitioner (NP) from Resident #1's primary care provider's office revealed: -The facility should administer medications as ordered. -The facility should assure residents had medication available to administer as ordered. -She did not know Resident #1 had not received ibuprofen 800 mg as needed. Review of the facility's pharmacy packing slips for medications received from the contract pharmacy revealed facility staff signed for receipt of 30 ibuprofen 800 mg for Resident #1 on 11/06/18 and 30 tablets on 11/17/18. Based on review of Resident #1's November 2018 eMAR review documenting 23 doses of ibuprofen 800 mg documented as administered for 11/01/18 to 11/27/18 and 60 ibuprofen 800 mg	{D 358}	Jane Church, Administrator Please see attached 1/17/2019	

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{D 358}	Continued From page 39 tablets dispensed by the contract pharmacy in November 2018, Resident #1 should have at least 30 ibuprofen tablets available for administration.	{D 358}		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times on 11/29/18 for 5 of 33 residents (#5, #7, #8, #9, and #10) resulting in several medications ordered multiple times a day and medications being administered too close to the next scheduled administration times. The findings are: Review of the facility's resident census roster dated 11/28/18 - 11/29/18 revealed there were 33 residents residing at the facility. Interview with two residents on 11/28/18 at 10:30 am revealed: -Medications were administered late in the facility. -Medications administered late to the residents depended on the medication aide (MA)	D 364	Shirley Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 40 administering medications. -One newer MA was late to administer medications all the time. -There was one MA working the morning medication pass for the whole building most mornings. -A resident was supposed to receive medications at 9:00 am, but did not receive them until 11:00 am on 11/27/18. -A second resident was supposed to receive medications at 9:00 am but did not receive medications until 10:45 am on 11/27/18. -Both residents stated evening medications scheduled for 8:00 pm were not administered until 10:00 pm or later on some days. Interview with the day shift MA on 11/29/18 at 10:15 am revealed: -She trained on the medication cart and started administering medications in July 2018. -She was still learning all the residents' medications. -The day shift was 7:00 am to 3:00 pm daily. -She arrived at 7:00 am and began administering medications on the opposite side of the building. -She was the only MA for two medication carts in the facility. -The facility used to have two MAs working to pass the morning medications, but due to staffing shortages only one MA was currently passing morning medications. -She was unable to do much resident care because she was so busy passing medications. -Medications were scheduled for 8:00 am on the West hall and started appearing on the electronic Medication Administration Record (eMAR) screen at 7:00 am. She routinely started administering medications on the West hall and worked her way to the East hall. -Most mornings she did not complete the West	D 364	Jenny Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 41 hall (opposite side) until close to 9:00 am. -Medications were scheduled for 9:00 am on the East hall and started appearing on the eMAR screen at 8:00 am. She did not have the 2 hour window for the East hall because she did not finish West hall until close to 9:00 am. -She focused on completing the medications pass accurately, but was unable to complete the medication pass scheduled for 9:00 am until after 10:30 am most mornings she worked. -She had completed most of the East hall medication pass, but she had 5 residents remaining to receive routine medications scheduled at 9:00 am; the eMAR computer was displaying the medications as missed medications. Interview with the facility's contracted primary care provider (PCP) on 11/30/18 at 12:00 pm revealed: -She had not been contacted by the facility about the morning medications being administered late. -This was the first time anyone had made her aware of any problems with medications being administered late. -Staff should administer medications within the one hour before or after scheduled times. -She was concerned about the medications being administered late especially medications given multiple times a day. -There was potential for side effects if the doses of medications were administered too close together. -She would need to assess each resident to determine if the next scheduled dose of medication would need to be adjusted. Interview on 11/29/18 at 4:00 pm with the Resident Care Coordinator (RCC) revealed: -She knew medications were late today	D 364	Shirley Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 42 (11/29/18) because she observed the MA completing the 9:00 am medication pass after 10:30 am. -The RCC had administered medications during the 8:00 am and 9:00 am medication passes on some days and was always able to complete the medication passes within the one hour after scheduled times for administration. -The MA on the medication cart during the morning medication pass had been at the facility for more than 3 months. -She did not know why the MA could not complete the medication pass within the one hour before or after scheduled time parameters. -She trained MA staff to administer medications within the time parameters. -She would talk with the MA to determine what adjustments must be made in order to assure medications were administered to residents as scheduled. Review of the November 2018 eMARs on the West hall revealed: -All 5 of the residents observed after 10:20 am, during the 9:00 am medication pass on 11/29/18, had medications ordered more than once a day, some with multiple administration times. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.] -One of the 5 residents had medications that were scheduled 3 to 4 times a day in which doses were administered too close together due to the 9:00 am medication pass being late on 11/29/18. a. Review of Resident #9's current FL2 dated 11/14/17 revealed diagnoses included atrial fibrillation, hypertension, heart failure, chronic obstructive pulmonary disease (COPD), and hypothyroidism.	D 364	Shirley Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 43 Observation of medication administration on 11/29/18 at 10:35 am revealed: -The MA prepared 11 solid dose medication, one inhalant, and one eye drop for Resident #9. -The medications prepared included one drop of Refresh eye drops instilled in each eye (used to treat dry, itchy or irritated eyes), two acetaminophen 325 mg (used to treat pain and inflammation), one alprazolam 0.5 mg (used to treat anxiety and nervousness), and one inhalation of Symbicort 160-4.5 (used to improve breathing in COPD treatment). -Resident #9 was administered medications at 10:45 am. Review of Resident #9's November 2018 electronic medication administration record (eMAR) revealed: -There were at 13 medications scheduled to be administered at 9:00 am and one medication scheduled at 8:00 am. -There was an entry for Refresh eye drops one drop in each eye 4 times a day, and scheduled for administration at 8:00 am, 12:00 pm, 4:00 pm, and 9:00 pm; the 8:00 am dose of Refresh eye drops observed administered at 10:45 am was documented as administered at 8:00 am; the next dose scheduled for 12:00 pm was documented as administered at 12:00 pm by a different MA. (one hour and 15 minutes after the previous dose). -There was an entry for acetaminophen 325 mg two tablets 3 times a day, and scheduled for administration at 9:00 am, 3:00 pm, and 9:00 pm; the 9:00 am dose of acetaminophen 650 mg observed administered at 10:45 am was documented as administered at 9:00 am with the next dose scheduled for 3:00 pm documented as administered at 3:00 pm (4 hours and 15 minutes	D 364	Jenny Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 44 after the previous dose). -There was an entry for alprazolam 0.5 mg tablet one tablet twice a day and Symbicort 160-4.5 inhaler one puff inhaled twice a day and both scheduled for administration at 9:00 am and 9:00 pm. -The 9:00 am doses of alprazolam 0.5 mg and Symbicort 160-4.5 observed administered at 10:45 am were documented as administered at 9:00 am; the next scheduled dose for 9:00 pm was documented as administered at 9:00 pm. Interview with Resident #9 on 11/29/18 at 11:10 am revealed: -She was supposed to get her medicines at 9:00 am but her medicines were "usually late." -"When she received her medications depended on who was working when the medications were being given". 2. Review of Resident #5's current FL2 dated 10/5/18 revealed diagnoses included diabetes mellitus type 2, major depression, osteoarthritis, and chronic obstructive pulmonary disease (COPD), and gastroesophageal reflux disease (GERD). Observation of medication administration on 11/29/18 at 10:35 am revealed: -The MA prepared 10 solid dose medication and 2 inhalation medications for Resident #5. -The medications prepared included one and one-half buspirone 15 mg (used to treat anxiety disorders), one rantidine 150 mg (used to treat GERD), one carvedilol 6.5 mg (used to treat high blood pressure), two inhalations of Symbicort 80-4.5 (used to improve breathing in COPD treatment), and Incruse Ellipta 62.5 mg (used to improve breathing in COPD treatment). -Resident #5 was administered medications at	D 364	Amy Chappell, Administrator Please see attached	1/17/2019

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D 364	Continued From page 45 10:40 am. Review of Resident #5's November 2018 electronic medication administration record (eMAR) revealed: -There were at least 12 medications scheduled to be administered at 9:00 am. -There was an entry for buspirone 15 mg one and one-half tablets twice a day, carvedilol 6.5 mg twice a day, and Symbicort 80-4.5 inhaler two puffs inhaled twice a day and all 3 were scheduled for administration at 9:00 am and 9:00 pm. -The 9:00 am doses of buspirone 15 mg, carvedilol 6.5 mg, and Symbicort 80-4.5 observed administered at 10:35 am were documented as administered at 9:00 am; the next scheduled dose for 9:00 pm was documented as administered at 9:00 pm (the doses were administered 10 hours and 25 minutes apart instead of 12 hours.) Interview with Resident #5 on 11/29/18 at 11:25 am revealed: -She was supposed to get her medicines at 9:00 am but she never got her medication before 10:00 am." -The facility used to have two medication aides (MAs) giving out medications in the morning, and medications were received on time; now there was only one medication aide and medications were given late depending on which MA worked. -Her breathing medications helped to ease her breathing in the morning, so it was important to her that she got them on time so she could start her day breathing better. -She "would like to get her medications on time". 3. Review of Resident #7's current FL2 dated 09/23/18 revealed diagnoses included	D 364	Amy Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 46 hypertension, and hypothyroidism and recurrent deep vein thrombosis (DVT). Observation of medication administration on 11/29/18 at 10:30 am revealed: -The MA prepared 5 solid dose medications for Resident #7. -The medications prepared included Eliquis 5 mg (used to treat or prevent DVT). -Resident #7 was administered medications at 10:30 am. Review of Resident #7's November 2018 eMAR revealed: -There were at least 5 medications scheduled to be administered at 9:00 am. -There was an entry for Eliquis 5mg one twice daily and it was scheduled for 9:00 am and 9:00 pm. -The 9:00 am dose of Eliquis 5 mg observed administered at 10:35 am were documented as administered at 9:00 am; the next scheduled dose for 9:00 pm was documented as administered at 9:00 pm (the doses were administered 10 hours and 30 minutes apart instead of 12 hours). Interview with Resident #7 on 11/29/18 at 11:00 am revealed: -His medications were late in the mornings when the newer MA was working the medication carts. -He expected the MA to be careful to administer medications correctly and the newer MA took longer. -He always received his medications scheduled for 9:00 am by 11:00 am. -He only had one medication scheduled for a second dose and he had not experienced any problems because of the late morning medications.	D 364	Jenny Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 47 4. Review of Resident #8's current FL2 dated 12/12/17 revealed diagnoses included type 2 diabetes mellitus, history of atrial fibrillation, and history of pulmonary embolism. Review of Resident #8's record revealed previous diagnoses included chronic obstructive pulmonary disease (COPD),auditory hallucinations, schizophrenia, asthma and depression. Observation of medication administration on 11/29/18 at 10:20 am revealed: -The MA prepared 8 solid dose medications, and one inhalant for Resident #8. -The medications prepared included one lorazepam 1 mg (used to treat anxiety and nervousness), one magnesium oxide 400 mg (used to treat heartburn and indigestion), one-half tablet of metoprolol 25 mg (used to treat high blood pressure and rapid heart rate), one potassium chloride 10 meq (used to supplement potassium), one clozapine 200 mg (used to treat schizophrenia), one divalproex delayed release 250 mg (used to treat mental disorders like bipolar), and one inhalation medication Breo-Ellipta 100-25 (used to improve breathing in COPD treatment). -Resident #8 was administered medications at 10:25 am. Review of Resident #8's November 2018 eMAR revealed: -There were at least 9 medications scheduled to be administered at 9:00 am. -There was an entry for lorazepam 1 mg one tablet 3 times a day, and scheduled for administration at 9:00 am, 3:00 pm, and 9:00 pm; the 9:00 am dose of lorazepam 1.0 mg observed	D 364	Shery Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 48 administered at 10:25 am was documented as administered at 9:00 am; the next dose scheduled for 3:00 pm was documented as administered at 3:00 pm by a different MA. (Four hour and 35 minutes after the previous dose, instead of 6 hours). -There was an entry for divalproex delayed release 250 mg one tablet twice a day, and scheduled for administration at 9:00 am and 3:00 pm; the 9:00 am dose of divalproex delayed release 250 mg observed administered at 10:25 am was documented as administered at 9:00 am: the next dose scheduled for 3:00 pm was documented as administered at 3:00 pm (Four hours and 35 minutes after the previous dose, instead of 6 hours as scheduled). -There was an entry for magnesium oxide 400 mg, potassium chloride 10 meq, clozapine 200 mg, one tablet of each medication twice a day, and both were scheduled for administration at 9:00 am and 9:00 pm. -There was an entry for metoprolol 25 mg one-half tablet twice a day, and scheduled for administration at 9:00 am and 9:00 pm. -There was an entry for Breo-Ellipta 100-25 one puff inhaled twice a day and scheduled for administration at 9:00 am and 9:00 pm. -The 9:00 am doses of magnesium oxide 400 mg, potassium chloride 10 meq, clozapine 200 mg, metoprolol 12.5 mg and Breo-Ellipta 100-25 observed administered at 10:25 am were documented as administered at 9:00 am; the next scheduled doses for 9:00 pm were documented as administered at 9:00 pm (10 hours and 35 minutes after the first dose instead of 12 hours apart). Interview with Resident #8 on 11/29/18 at 11:25 am revealed: -She was supposed to get her medicines at 9:00	D 364	Shirley Chappell, Administrator Please see attached 1/17/2019	

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D 364	Continued From page 49	D 364		

am, but her medicines were "usually late."
-She was fine with receiving the morning medications at whatever time they were administered.
-She did not have any problems with breathing from getting her Breo-Ellipta late.
-She could not tell if she was sleepy from receiving lorazepam 1.0 mg tablets closer than 6 hours scheduled.

5. Review of Resident #10's current FL2 dated 12/08/17 revealed diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), depressive disorder, and atrial fibrillation.

Observation of medication administration on 11/29/18 at 10:15 am revealed:
-The MA prepared 9 solid dose medications, one eye drop, and one inhalant for Resident #10.
-The medications prepared included one buspirone 5 mg (used to treat anxiety disorders), one potassium chloride extended release 20 meq (used to supplement potassium), and Refresh eye drops (used to treat dry, itchy or irritated eyes).
-Resident #10 was administered medications at 10:17 am.

Review of Resident #10's November 2018 eMAR revealed:
-There was an entry for Refresh eye drops one drop in each eye 4 times a day, and scheduled for administration at 9:00 am, 12:00 pm, 6:00 pm, and 12:00 am; the 9:00 am dose of Refresh eye drops observed administered at 10:17 am was documented as administered at 9:00 am; the next dose scheduled for 12:00 pm was documented as administered at 12:00 pm by a different MA. (one hour and 43 minutes after the previous dose

Shery Chappell, Administrator
Please see attached 1/17/2019

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 364	Continued From page 50 instead of 3 hours apart). -There were entries for buspirone 5 mg and potassium chloride extended release 20 meq one tablet of twice a day, and both were scheduled at 9:00 am and 9:00 pm; the 9:00 am doses of buspirone 5 mg and potassium chloride extended release 20 meq observed administered at 10:17am were documented as administered at 9:00 am; the next scheduled doses for 9:00 pm were documented as administered at 9:00 pm (10 hours and 43 minutes after the first dose instead of 12 hours apart). Interview with Resident #10 on 11/29/18 at 4:45 pm revealed: -He received his medication scheduled for 9:00 am late every day. -He had not experienced any known side effects (itchy eyes, or increased agitation) due to not receiving his medications as scheduled. -He just would like to receive his medications at the scheduled time. The facility failed to assure scheduled medications were administered timely, within one hour before or one hour after the scheduled administration times, during the morning medication pass on 11/29/18 for 5 residents. The facility's failure to administer medications at scheduled intervals increased residents' risk of experiencing adverse side effects or therapeutic failure including anxiety medication, inhalers with multiple scheduled administration times and administered too close together, which 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 for this violation	D 364	Shery Chappell, Administrator Please see attached 1/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	R 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

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D 364	Continued From page 51 on 11/29/18. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 17, 2018.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document the administration of	D 367	Jenny Chappell, Administrator Please see attached 1/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	R 12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

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D 367	Continued From page 52 oxygen (O2) on the electronic Medication Administration Record (eMAR) for 1 of 5 sampled residents (Resident #4). The findings are: Review of Resident #4's current FL2 dated 8/2/18 revealed: -Diagnoses included chronic obstructive pulmonary disorder/asthma, hypertension, osteoarthritis, gastroesophageal reflux disease, hyperlipidemia, depression, and pacemaker. -The treatments listed included oxygen at 4 liters per minute (L/M) via nasal cannula; check oxygen concentrator and tanks per shift for 4L/M oxygen flow. Observation of Resident #4's oxygen concentrator on 11/29/18 at 4:40 pm revealed the oxygen was set on 2L/M. Review of September, October, and November 2018 electronic Treatment Administration Record (eTAR) revealed: -There was a computer generated entry for staff to make sure oxygen was set on 4L/M every shift. -The September eTAR was initialed for first and second shifts on 09/29/18 and all three shifts on 09/30/18. -Staff documented O2 was set on 4L/M on 09/29/18 and 09/30/18. -From 10/01/18 through 10/31/18, all three shifts were initialed by a medication aide (MA) that O2 was set on 4L/M. -From 11/01/18 through 11/28/18, all three shifts were initialed by a MA that the O2 was set on 4L/M. Interview on 11/29/18 at 4:40 pm with Resident #4 revealed:	D 367	Amy Chappell Administrator Please see attached 1/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	R 12/03/2018

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ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

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D 367	Continued From page 53 -She used her O2 concentrator in her room and she changed it to the portable oxygen tank herself when she left the room. -When she needed more portable O2, she would roll in her wheelchair up to the front area and have a MA switch out the O2 tank. - When she was in the hospital, her O2 was on 4L/M because she had pneumonia. - The physician had changed her oxygen to 2L/M "a while back", but she needed more, so she had set it on 3L/M. - Staff checked "every now and then" to see what her O2 was set on. -Staff did set the flow of O2 on the concentrator. Interview with a MA on 11/29/18 at 6:00 pm revealed: -She had been a MA there for almost a month. -She thought Resident #4's O2 was supposed to be set on 2L/M, but was not sure. Interview on 11/30/18 at 5:15 pm with the Resident Care Coordinator (RCC) revealed: -Resident #4's O2 was supposed to be set on 4L/M. -She did not know MAs were setting Resident #4's O2 at 2L/M. -She did not know Resident #4 was changing the O2 concentration to 3L/M. -The MAs were initialing the eMAR incorrectly. -The RCC was supposed to be monitoring the residents' care and accuracy of the eMARs, but she had not had time to put her monitoring in place due to staff shortages.	D 367		
{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:	{D912}	Shirley Chappell, Administrator Please see attached 1/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086013	A. BUILDING: _____ B. WING _____	R 12/03/2018

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ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

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{D912}	Continued From page 54 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 and interviews, the facility failed to ensure that residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as it relates to health care and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to notify health care providers for 3 of 5 sampled residents (Residents #2, #3, and #4) regarding referral to pulmonologist, shortness of breath with oxygen saturation level less than 83%, and blood pressure outside of parameters (low and high) (#4); blood sugars greater than 300 and refusal to wear oxygen (#3); refusals of scheduled insulin and blood pressures outside of ordered parameters (#2). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Unabated Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered within one hour before or after the prescribed or scheduled times on 11/29/18 resulting in several medications ordered multiple times a day for 5 of the 33 residents (#5, #7, #8, #9, and #10) and medications being administered too close to the next scheduled administration	{D912}	Sherry Chappell, Administrator Please see attached 1/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	Continued From page 55 time. [Refer to Tag. 364, 10A NCAC 13F .1004(g) Medication Administration (Type B Violation)].	{D912}	Shirley Chappell, Administrator Please see attached 1/17/2019	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL086013 Y1	A. Building B. Wing Y2	12/3/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKIN ASSISTED LIVING	500 JOHNSON RIDGE ROAD ELKIN, NC 28621

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0074	Correction	ID Prefix D0079	Correction	ID Prefix D0131	Correction
Reg. # 10A NCAC 13F .0306(a) (1)	Completed	Reg. # 10A NCAC 13F .0306(a) (5)	Completed	Reg. # 10A NCAC 13F .0406(a)	Completed
LSC	11/30/2018	LSC	11/30/2018	LSC	11/30/2018
ID Prefix D0438	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 10A NCAC 13F .1205	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/30/2018	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Keturah H. Hawkins, PhD	DATE 12/18/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/26/2018	☐ YES ☐ NO

Elkin Assisted Living
HAL-086-013
Plan of Correction
DHSR Survey/Follow-up

10A NCAC 13F.0902(b) Health Care
G.S. 131D-21(2) Declaration of Residents' Rights
Plan of Correction

- RCC/Designee will review all physician orders to ensure they are followed up on timely. 1/11/19 and ongoing.
- RCC/Designee will audit charts for referral and follow-up. 1/11/19 and ongoing
- Staff retrained on the Daily Orders Notebook. 1/11/19 and ongoing
- Staff retrained on residents' rights. 1/11/19 and ongoing

Monitoring System

- Executive Director/RCC shall check orders Monday through Friday to ensure orders are followed up on and on the MAR's as ordered by the physician. 1/11/19 and ongoing

10A NCAC 13F.0902(c)(3)(4) Health Care
Plan of Correction

- RCC/SIC/Med Aides retrained on procedures for documentation and implementation of written procedures, treatments and orders form physician or other licensed health professionals. 1/8/19 and ongoing

Monitoring System

- Executive Director/Designee will monitor health care documentation and implementation through record review weekly x6 and then monthly thereafter. 1/8/19 and ongoing

Elkin Assisted Living
HAL-086-013
Plan of Correction
DHSR Survey/Follow-Up

10A NCAC 13F.1002(a) Medication Orders

Plan of Correction

- SIC/Med Aides retrained on using Daily Orders notebook. 1/8/19 and ongoing
- SIC/Med Aides retrained on procedures and documentation for clarification of orders. 1/8/19 and ongoing

Monitoring System

- RCC will review Daily Orders Notebook daily x 30 days and then weekly thereafter to assure clarification and accuracy of orders. 1/8/19 and ongoing

10A NCAC 13F.1004(a) Medication Administration

Plan of Correction

- SIC/Med Aides retrained on medication administration. 1/8/19 and ongoing
- SIC/Med Aides retrained on medication errors. 1/8/19 and ongoing

Monitoring System

- RCC/Designee will review medication orders to ensure all medications are ordered/refilled timely. 1/8/19 and ongoing
- RCC to check MAR's monthly to ensure accuracy of upcoming month's MAR.
- RCC will observe a medication pass on first and second shift 1x week for 4 weeks then monthly therafter. 1/8/19 and ongoing

Elkin Assisted Living
HAL-086-013
Plan of Correction
DHSR Survey/Follow-Up

10A NCAC 13F.1004(g) Medication Administration
G.S. 131D-21(2) Declaration of Residents' Rights
Plan of Correction

- SIC/Med Aides retrained on medication administration including the importance of getting medications on time-the one hour before to the one hour after prescribed time. 1/11/19 and ongoing
- Staff to be retrained on resident's rights. 1/11/19 and ongoing

Monitoring System

- Executive Director/Designee will observe a medication pass on first and second shift weekly x 4 week, then monthly x3 months and randomly thereafter to ensure medications are being given on time. 1/11/19 and ongoing

10A NCAC 13F.1004(j) Medication Administration
Plan of Correction

- SIC/Med Aides will verify every shift the medication or treatment the resident is to receive to see that it shows on the eMAR. 1/8/19 and ongoing
- SIC/Med Aides will only initial a medication or treatment has been received by a resident when staff directly observe the administration of the medication or treatment. 1/8/19 and ongoing
- SIC/Med Aides to complete medication administration retraining. 1/8/19 and ongoing

Monitoring System

- Executive Director/Designee to monitor a medication pass on first and second shift weekly x4 weeks, monthly x 3 months then randomly thereafter. 1/8/19 and ongoing
- Executive Director/Designee to monitor eMAR's weekly x6, then monthly thereafter to ensure medications/treatments are documented correctly on the eMAR's. 1/8/19 and ongoing

Sherry Chappell, Administrator 1/17/2019
Executive Director Date