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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/30/19 through 05/02/19.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents related to a rescheduled physician's appointment resulting in an anti-psychotic medication and anti-anxiety medication being stopped abruptly (Resident #4). The findings are: Review of Resident #4's current FL2 dated 02/12/19 revealed diagnoses included hypertension, dementia, and anxiety. Review of Resident #4's hospital discharge summary dated 03/29/19 revealed: -Resident #4 was hospitalized on 03/23/19 for altered mental status. -Resident #4 was discharged on 03/29/19 with medications for urinary tract infection and agitation/anxiety. -Resident #4 was scheduled for a follow-up	D 273		

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appointment with neurology on 04/30/19.

1. Review of Resident #4's hospital discharge orders revealed a physician's order dated 03/29/19 for gabapentin 100 mg 3 times daily for 30 days. (Gabapentin is used to treat seizure, pain, and mental health disorders, like anxiety).

Review of Resident #4's record revealed nophysician's order to discontinue gabapentin 100 mg.

Review of Resident #4's March 2019 and April 2019 electronic medication administration records (eMARs) revealed:
-There was an entry for Gabapentin 100mg and scheduled for administration at 8:00am, 2:00pm, and 8:00pm daily.
-Gabapentin 100 mg was documented as administered from 03/29/19 at 8:00pm to 04/28/19 at 2:00pm (30 days).
-Gabapentin 100 mg was not documented as administered from 04/28/19 at 8:00pm to 04/30/19 at 8:00pm.

Review of Resident #5's May 2019 eMARs) revealed there was no entry for gabapentin 100 mg on the May 2019 eMAR.

Interview with a representative from Resident #4's neurology clinic on 05/02/19 at 4:50 pm revealed:
-The neurology clinic rescheduled Resident #4's appointment on 05/13/19.
-There was no documentation for a facility request to refill or discontinue Resident #4's gabapentin 100 mg.
-The clinic did not have documentation the facility notified the clinic regarding Resident #4'c lack of medication to last until the rescheduled appointment.

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D 273	Continued From page 2 Interview with the facility's transportation staff on 05/02/19 at 9:15am revealed: -She was responsible for scheduling appointments and assuring residents were transported to scheduled appointments. -She also worked as a medication aide. -She routinely called to verify scheduled appointments the day of the appointment to avoid transporting residents to find out an appointment had been changed. -She called the neurology clinic on 04/30/19 prior to transporting Resident #4 to the appointment. -She was informed by the clinic Resident #4's appointment needed to be rescheduled due to a change in neurologist. -Resident #4 was not transported to the appointment on 04/30/19 as previously arranged upon discharge from the local hospital on 03/29/19. -The transportation staff informed the neurology clinic appointment scheduler that Resident #4 did not have gabapentin 100 mg for longer than 30 days and would need a physician's order for more gabapentin 100 mg to last until the appointment. -The transportation staff did not document the request for additional gabapentin 100 mg. -The facility's Health and Wellness Director (HWD) would be responsible to assure residents' medication orders were updated. -She told the HWD Resident #4 had medications that needed to be refilled but Resident #4's appointment was rescheduled on 04/30/19. -She had not followed-up with the HWD regarding Resident #4's gabapentin because she thought the neurology clinic would sent an order to the facility. Interview with the HWD on 05/02/19 at 12:15 pm revealed:	D 273		

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-Resident #4's order for Gabapentin 100 mg was entered into the eMAR system by the medication aide (MA) receiving the order.
-Gabapentin 100 mg was entered into the eMAR system with a 30 day stop date according to the order written on discharge.
-Resident #4 had enough gabapentin 100 mg to last until his appointment on 04/30/19.
-The transportation staff was responsible to coordinate appointments and keep track of the appointments using her appointment calendar.
-The transportation staff was a also MA, which was supposed to help assure any medications issues affected by appointments were addressed.
-Resident #4 should have a request for additional medication in the facility "New Medication Order Tracking" book documenting physician notification of the need for additional medication since the appointment was rescheduled.
-She was responsible to assure physician request were followed up when orders were filed in the "New Medication Order Tracking" book.
-Resident #4 was not receiving gabapentin 100 mg because the original order dated 03/29/19 was for 30 days; the 30 days ended 04/28/19 and the appointment scheduled for 04/30/19 was rescheduled by the provider.
-Staff had not informed her Resident #4 was not administered gabapentin 100mg from 04/29/19 until today (05/02/19).

Interview with first shift MA Supervisor on 05/02/19 at 12:20 pm revealed:
-She recognized Resident #4's gabapentin 100 mg supply was getting low and called the provider ordering Resident #4's gabapentin 100 mg on 04/23/19 to request a refill.
-She did not document the phone call.
-She did not work from 04/23/19 to 04/29/19.
-She did not follow-up on Resident #4's

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gabapentin 100 mg status when she came back to work.

Telephone interview with a representative from the contracted pharmacy on 05/02/19 at 12:58pm revealed:
-The pharmacy dispensed a 30 day supply (90 capsules) of gabapentin 100 mg on 03/29/19 per a physician's order dated 03/29/19.
-The facility was responsible to request a refill from the pharmacy since the order specifically stated for 30 days.
-There was no documentation the facility had requested a refill for Resident #4's gabapentin.

Telephone interview with Resident #4's primary care provider's physician assistant on 05/02/19 at 1:50pm revealed:
-She would expect the facility to contact the neurology clinic for refills for the gabapentin 100 mg.
-She had not be notified Resident #4 was out of gabapentin 100 mg and his appointment was rescheduled for 05/13/19.

Interview with a representative from Resident #4's neurology clinic on 05/02/19 at 4:50 pm revealed:
-The neurology clinic rescheduled Resident #4's appointment for 05/13/19.
-There was no documentation for a facility request to refill or discontinue Resident #4's gabapentin 100 mg.
-The clinic did not have documentation the facility notified the clinic regarding Resident #4 lack of medication to last until the rescheduled appoint.

Based on observation, interview, and record reviews it was determined Resident #4 was not interviewable.

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Attempted telephone interview with Resident #4's Power of Attorney (POA) on 05/02/19 at 10:15 am was unsuccessful.

2. Review of Resident #4's hospital discharge orders revealed a physician's order dated 03/29/19 for perphenazine 2 mg 3 times daily for 30 days. (Perphenazine is used to mental health disorders, like agitation).

Review of Resident #4's record revealed no physician's order to discontinue perphenazine 2mg.

Review of Resident #4's March 2019 and April 2019 electronic medication administration records (eMARs) revealed:
-There was an entry for Perphenazine 2 mg and scheduled for administration at 8:00am, 2:00pm, and 8:00pm daily.
-Perphenazine 2 mg was documented as administered from 03/29/19 at 8:00pm to 04/28/19 at 2:00pm (30 days).
-Perphenazine 2 mg was not documented as administered from 04/28/19 at 8:00pm to 04/30/19 at 8:00pm.

Review of Resident #5's May 2019 eMARs) revealed there was no entry for perphenazine 2 mg on the May 2019 eMAR.

Interview with the facility's transportation staff on 05/02/19 at 9:15am revealed:
-She was responsible for scheduling appointments and assuring residents were transported to scheduled appointments.
-She also worked as a medication aide.
-She routinely called to verify scheduled appointments the day of the appointment to avoid transporting residents to find out an appointment

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had been changed.
-She called the neurology clinic on 04/30/19 prior to transporting Resident #4 to the appointment.
-She was informed by the clinic Resident #4's appointment needed to be rescheduled due to a change in neurologist.
-Resident #4 was not transported to the appointment on 04/30/19 as previously arranged upon discharge from the local hospital on 03/29/19.
-The transportation staff revealed she informed the neurology clinic appointment scheduler that Resident #4 did not have perphenazine 2 mg for longer than 30 days and would need a physician's order for more perphenazine 2 mg to last until the appointment.
-The transportation staff did not document the request for additional perphenazine 2 mg.
-The facility's Health and Wellness Director (HWD) would be responsible to assure residents' medication orders were updated.
-She told the HWD Resident #4 had medications that needed to be refilled but Resident #4's appointment was rescheduled on 04/30/19.
-She had not followed-up with the HWD regarding Resident #4's perphenazine 2 mg because she thought the neurology clinic would sent an order to the facility.

Interview with the HWD on 05/02/19 at 12:15 pm revealed:
-Resident #4's order for perphenazine 2 mg was entered into the eMAR system by the medication aide (MA) receiving the order.
-Gabapentin 100 mg was entered into the eMAR system with a 30 day stop date according to the order written on discharge.
-Resident #4 had enough perphenazine 2 mg to last until his appointment on 04/30/19.
-The transportation staff was responsible to

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coordinate appointments and keep track of the appointments using her appointment calendar.
-The transportation staff was also a MA, which was supposed to help assure any medications issues affected by appointments were addressed.
-Resident #4 should have a request for additional medication in the facility "New Medication Order Tracking" book documenting physician notification of the need for additional medication since the appointment was rescheduled.
-She was responsible to assure physician requests were followed up when orders were filed in the "New Medication Order Tracking" book.
-Resident #4 was not receiving perphenazine 2 mg because the original order dated 03/29/19 was for 30 days; the 30 days ended 04/28/19 and the appointment scheduled for 04/30/19 was rescheduled by the provider.
-Staff had not informed her Resident #4 was not administered perphenazine 2 mg from 04/29/19 until today (05/02/19).

Interview with first shift MA Supervisor on 05/02/19 at 12:20 pm revealed:
-She recognized Resident #4's perphenazine 2 mg supply was getting low and called the provider ordering Resident #4's perphenazine 2 mg on 04/23/19 to request a refill.
-She did not document the phone call.
-She did not work from 04/23/19 to 04/29/19.
-She did not follow-up on Resident #4's perphenazine 2 mg status when she came back to work.

Telephone interview with the facility's contracted pharmacy on 05/02/19 at 12:58pm revealed:
-The pharmacy dispensed a 30 day supply (90 capsules) of perphenazine 2 mg on 03/29/19 per a physician's order dated 03/29/19.
-The facility was responsible to request a refill

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D 273	Continued From page 8 from the pharmacy since the order specifically stated for 30 days. -There was no documentation the facility had requested a refill for Resident #4's perphenazine. Telephone interview with Resident #4's primary care provider's physician assistant on 05/02/19 at 1:50pm revealed: -She would expect the facility to contact the neurology clinic for refills for perphenazine 2 mg. -She had not be notified Resident #4 was out of perphenazine 2 mg and his appointment was rescheduled for 05/13/19. Interview with a representative from Resident #4's neurology clinic on 05/02/19 at 4:50 pm revealed: -The neurology clinic rescheduled Resident #4's appointment for 05/13/19. -There was no documentation for a facility request to refill or discontinue Resident #4's perphenazine 2 mg. -The clinic did not have documentation the facility notified the clinic regarding Resident #4's lack of medication to last until the rescheduled appointment. Based on observation, interview, and record reviews it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident #4's Power of Attorney (POA) on 05/02/19 at 10:15 am was unsuccessful.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:	D 310		

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D 310	Continued From page 9 (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 4 sampled residents (Resident #2)with diet orders for a texture modified diet and nectar thickened liquids. The findings are: Review of Resident #2's current FL2 dated 03/26/ 03/26/19 revealed included diagnoses included dysphagia. a. Review of the current FL2 dated 03/26/19 revealed a physician's order for a mechanical soft diet. Review of Resident #2's record revealed a subsequent physician's order dated 03/28/19 for a texture modified diet. Review of the therapeutic diet list dated 04/29/19 revealed Resident #2 was to be served a texture modified diet. Review of the therapeutic diet menu for lunch on 04/30/19 revealed residents on a texture modified meats diet were to be served Italian salad with	D 310		

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shredded lettuce, ground chicken, wild rice blend, soft steamed green beans, and soft dinner roll with butter.
-Dessert was chocolate ice cream.

Observation of the lunch meal service on 04/30/19 from 12:00pm to 1:15pm revealed:
-Resident #2 was served lettuce with vinaigrette dressing, a whole chicken breast, wild rice, green beans, a slice of bread, and nectar thick water.
-The dessert was vanilla ice cream in a waffle cone with a hard chocolate covering and nuts.
-The lettuce was not shredded, it was in squares that were one inch to one and one-half inch pieces and a small amount of thin vinaigrette dressing.
-Resident #2 used her knife to cut up the chicken breast.
-The resident ate half of the chicken breast without difficulty.
-Resident #2 ate 30% of the of the salad, then started to cough.
-The resident coughed three times and then pushed the salad away.
-The resident later took two more bites of the salad and did not cough.

Interview with the Dining Services Manager (DSM) on 04/30/19 at 12:56pm revealed:
-He cut up the lettuce in small pieces for residents that were ordered a texture modified diet.
-The staff serving the meal must had given Resident #2 the wrong salad.
-He knew Resident #2 was ordered a texture modified diet and the chicken should have been grounded.
-Staff took residents' orders for the meal.
-When the staff came to the kitchen to get the meal, they did not tell him the plate was for

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Resident #2.
-Diets were posted in the kitchen for all staff to view to ensure residents were served the correct meal.
-He did not know why staff gave Resident #2 a whole chicken breast.

Interview with the medication aide on 04/30/19 at 1:08pm revealed:
-She checked the food list that was posted in the kitchen.
-She knew that Resident #2 was ordered a texture modified diet.
-She asked the resident if she wanted her to cut up the chicken breast, which was what she usually did.
-The resident said she did not want her to cut up the chicken breast.
-She did not know that texture modified diet required grounded meat.
-Resident #2 was never served grounded meat.

Interview with Resident #2 on 05/01/19 at 9:10am revealed:
-She had swallowing difficulties and recently had her throat stretched.
-She was ordered cut up meats.
-When she first came to the facility on 03/29/19, staff used to cut up her meat, but had not done so in "a while."
-She thought maybe the order to cut up meats was discontinued, because it had been two to three weeks since her meats were cut up for meals.
-She had to cut her own meats and did not ask staff to cut her meat.
-Some foods caused her to cough during meals, but she could not say specifically which foods caused her to cough.

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Interview with the primary care physician (PCP) for Resident #2 on 05/02/19 at 10:24am revealed:
-The resident was ordered ground meats diet due to her diagnosis of dysphagia.
-Resident #2 had a speech evaluation and was ordered a texture modified diet, which was ground meats.
-The physician expected the facility to serve Resident #2 ground meat to make the meat easier to swallow.

Interview with the Executive Director on 04/30/19 at 1:40pm revealed:
-The personal care aides, medication aides, Resident Care Coordinator and Health and Wellness Director all helped serve residents meals.
-The staff should view the diet list posted in the kitchen to make sure residents were served the correct meal.
-She did not know if all staff were aware that a texture modified diet required the meat to be ground.
-She did not know if all staff had food service training to help identify the texture consistency of diets.

Interview with a speech therapist on 05/01/19 at 11:10am revealed:
-She had seen Resident #2 for the first time this week.
-She did not observe Resident #2 during her meal, but knew the resident was ordered a texture modified diet, which required meats to be grounded.
-The resident had dysphagia and needed soft meat.
-The ground meat should have a liquid over it like gravy to make the meat soft and easy to swallow.
-The resident's meat should not be cut up, but

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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
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grounded to prevent coughing and difficulty swallowing.

b. Review of the current FL2 dated 03/26/19 revealed a physician's order for nectar thick liquids.

Observation of the facility's food storage area on 04/30/19 at 9:40am revealed a variety of nectar pre-thickened liquids (i.e., water, milk, orange juice and tea).

Review of the therapeutic diet list dated 04/29/19 revealed Resident #2 was to be served nectar thickened liquids.

Review of the therapeutic menu guidelines for residents ordered thickened liquids revealed:
-Ice cream was a "Thin liquid."
-Ice cream should be excluded from the list of foods served residents ordered nectar, honey or spoon-thick liquids.

Observation of the lunch meal service on 04/30/19 from 12:00pm to 1:15pm revealed:
-The Resident Care Coordinator (RCC) gave Resident #2 vanilla ice cream in a waffle cone topped with a hard chocolate covering and nuts.
-The resident used her spoon to remove the chocolate and nuts.
-She proceeded to use her spoon to eat the ice cream out of the cone.
-The resident ate all the ice cream without difficulty or coughing.

Interview with the RCC on 04/30/19 at 1:20pm revealed:
-Resident #2 had not resided at the facility long.
-She knew the resident was ordered nectar thick liquids.

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	HAL041030	A. BUILDING: _____ B. WING _____	R 05/02/2019

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D 310	Continued From page 14 -She did not know the resident was not allowed ice cream when ordered nectar thickened liquids. Interview with the Dining Services Manager (DSM) on 04/30/19 at 12:56pm revealed: -He knew that Resident #2 was ordered nectar thickened liquids. -He ordered nectar pre-thickened liquids for Resident #2. -He did not know the facility had menu guidelines for residents ordered thickened liquids until today. -He also did not know Resident #2 should not be served ice cream. Interview with Resident #2 on 05/01/19 at 9:10am revealed: -She had swallowing difficulties and was ordered thickened liquids. -She was always served ice cream. -Some foods caused her to cough at different times. -She may cough from certain foods today, but the next time she did not cough. -When she started coughing she stopped the food that caused her to cough. -She could not say that ice cream specifically caused her to cough because she did not cough today. Interview with the Executive Director on 04/30/19 at 1:40pm revealed: -The personal care aides, medication aides, RCC and Health and Wellness Director all helped serve residents meals. -The management staff in the dining room should ensure meals were served as ordered. -She did not know if the RCC knew ice cream was not allowed when a resident was ordered thickened liquids.	D 310		

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D 358	Continued From page 15	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #5) including errors with medications used to control high blood pressure. The finding are: Review of Resident #5's current FL-2 dated 03/12/19 revealed: -Diagnoses included diastolic congestive heart failure and hypertension. -There was a physician's order with instruction to administer clonidine (used to reduce high blood pressure) 0.1mg as needed for systolic blood pressure (BP) greater than 150 or diastolic blood	D 358		

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pressure greater than 95.

Review of Resident #5's February 2019 electronic medication record (eMAR) revealed:
-There was a computer generated entry for clonidine 0.1mg as needed for systolic blood pressure greater than 150 or diastolic blood pressure greater than 95.
-There was a computer generated entry for blood pressure checks scheduled for 8:00am.
-There was documentation in February 2019 Resident#5 had three BP results with systolic BP greater 150 as follows:
-On 02/17/19 systolic BP was 165.
-On 02/21/19 systolic BP was 166.
-On 02/28/19 systolic BP was 154.
-There was documentation clonidine was administered on 02/21/19 at 8:00am.
-There was no documentation clonidine was administered on 02/21/19 and 02/28/19.
-Systolic BPs ranged between 130 to 166 from 02/01/19 through 02/28/19.

Review of Resident #5's March 2019 eMAR revealed:
-There was a computer generated entry for clonidine 0.1mg as needed for systolic blood pressure greater than 150 or diastolic blood pressure greater than 95.
-There was a computer generated entry for blood pressure checks scheduled for 8:00am.
-There was documentation in March 2019 Resident#5 had four BP results with systolic BP greater 150 as follows:
-On 03/08/19 systolic BP was 159.
-On 03/12/19 systolic BP was 161.
-On 03/18/19 systolic BP was 176.
-On 03/23/19 systolic BP was 156.
-There was no documentation clonidine was administered from 03/01/19 through 03/31/19.

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-Resident #5 had no diastolic BPs greater than 95.
-Systolic BPs ranged between 115 to 176 from 03/01/19 through 03/31/19.

Review of Resident #5's April 2019 eMAR revealed:
-There was a computer generated entry for clonidine 0.1mg as needed for systolic blood pressure greater than 150 or diastolic blood pressure greater than 95.
-There was a computer generated entry for blood pressure checks scheduled for 8:00am.
-There was documentation in April 2019 Resident#5 had 5 BP results with systolic BP greater 150 as follows:
-On 04/01/19 systolic BP was 152.
-On 04/05/19 systolic BP was 159.
-On 04/13/19 systolic BP was 151.
-On 04/14/19 systolic BP was 155.
-On 04/18/19 systolic BP was 152.
-There was no documentation clonidine was administered from 04/01/19 through 04/30/19.
-Resident #5 had no diastolic BPs greater than 95.
-Systolic BPs ranged between 111 to 159 from 04/01/19 through 04/30/19.

Observation of Resident #5's medications on hand at the facility on 05/02/19 at 9:00am revealed:
-Clonidine was available for administration.
-There were eight clonidine tablets left in the bubble packed card.
-There were 30 tablets of clonidine dispensed on 11/18/18 with 8 tablets remaining.

Interview with Resident #5 on 05/01/19 at 4:40pm revealed:
-Her BP was checked by facility staff.

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-When her BP was "high" facility staff told her when her BP was high, but did not tell her the BP results.
-She did not feel different, she felt the same always.
-Facility staff gave her medications every morning, but she did not know if they gave a medication to bring her BP down.

Interview with the medication aide (MA) on 05/02/19 at 10:21am revealed:
-She did not see physician's order to administer clonidine to Resident #5 as two sets of instructions.
-She thought the order required the systolic to be 150 and diastolic to 95 at the same time.
-She did not contact the resident's physician to clarify the order.
-She was responsible for contacting the physician if she did not understand an order.
-She did not contact Resident #5's physician.
-She was the staff that mostly checked Resident #5's BP.
-She further checked the eMARs and realized she had one entry when she administered clonidine on 02/21/19, when the resident's systolic was 166 and diastolic was 93.
-She was thinking that maybe she had administered the medication and forgot to document she administered the medication.

Interview with the Health and Wellness Director (HWD) on 05/02/19 at 9:27am revealed:
-Sometimes the system did not show the administration of as needed medications.
-Several months ago she noticed there was a problem and she had to add an additional entry so staff could document the administration of as needed medications.
-She may have missed Resident #5's clonidine.

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D 358	Continued From page 19 -Because there was documentation clonidine was administered on 02/21/19, the problem was not the system. -If the MA did not understand the order for clonidine she should have contacted the physician instead of not administering the medication. Interview with the Executive director on 05/02/19 at 9:00am revealed: -She did not do medication cart audits, but thought the HWD did weekly audits. -The MAs should follow instructions on medications orders and if the order is not clear they should contact the Primary Care Physician (PCP) to clarify the order. Interview with Resident #5's physician on 05/02/19 at 10:19am revealed: -Resident #5 was ordered a routine medication to control high blood pressure (Lisinopril). -The resident sometimes had elevated BPs so clonidine 0.1mg was ordered. -The order was specific with instructions to administer clonidine 0.1mg when the systolic was greater than 150 or the diastolic greater than 95. -The instructions were not inclusive, but were two separate sets of instructions. -If the facility staff were not clear on the instructions they should have contacted the physician.	D 358		