

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL083018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/10/2019
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NAME OF PROVIDER OR SUPPLIER PRESTWICK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 JOHNS ROAD LAURINBURG, NC 28352
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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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D 000 Initial Comments

The Adult Care Licensure Section and the Scotland County Department of Social Services conducted an annual survey and complaint investigation on 04/09/19-04/10/19.

D 161 10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks

10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task
(a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff E) was competency validated by a registered nurse with return demonstration prior to performing Licensed Health Professional Support (LHPS) tasks, related to transferring a non-ambulatory resident from a wheelchair.

The findings are:

Review of Staff E's personnel file revealed:
-Staff E was hired on 12/10/18 as a Maintenance

D 000

D 161

*See Attached
5-24-2019*

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

0609

MOXZ11

05/24/2019

If continuation sheet 1 of 41

Reviewed and Accepted with Revisions 06/03/19 Mary Agena/ma

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D 161	Continued From page 1 Director. -There was no documentation of the LHPS competency validation documenting competency with transferring residents. Interview with Staff E on 04/10/19 at 3:08pm revealed: -He had been asked by the staff to assist Resident #4 with transfers, because Resident #4 required 1-2 people to assist him with transferring. -The facility had an external agency that would provide a licensed health professional that came to the facility to provide the training on LHPS tasks. -He had not received the LHPS training and skills validation required to perform transfers for Resident #4. Review of Resident #4's current FL2 dated 02/07/19 revealed: -Diagnoses included chronic pain, anxiety, depressive disorder, alcohol induced mood disorder, prostate cancer, colitis, eczema, gastro-esophageal reflux disease, hypertension, hyperlipidemia, mood disorder, coronary artery disease, and urinary retention. -Resident #4 was semi-ambulatory. Review of Resident #4's Resident Register dated 02/07/19 revealed: -He was admitted to the facility on 02/07/19. -He was his own responsible party. Review of Resident #4's LHPS evaluation dated 02/21/19 revealed resident required assistance with ambulation and transfers. Interview with the PCA on 04/10/19 at 10:14am revealed:	D 161			

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PRINTED: 04/30/2019
FORM APPROVED

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D 161	Continued From page 2 -Resident #4 was not able to transfer on his own. -Resident #4 had frequent falls and would fall every time he attempted to transfer himself from his wheelchair to his recliner. -She requested Staff E transfer Resident #4 when he requested to be moved to his recliner because she was unable to do it without assistance. -Staff E had independently transferred Resident #4 from his wheelchair to the recliner when he entered his room at 9:42am. A second interview with the PCA on 04/10/19 at 10:51am revealed: -Resident #4 had required extensive assistance with all tasks and had been confused for the past two months. -The facility staff relied on Staff E to transfer Resident #4 because he was too heavy for the PCAs to transfer. -If Resident #4 fell, it took "four to five women" to get him up, but Staff E could do it on his own. Review of a video recording with the Administrator on 04/10/19 at 1:06pm revealed: -Resident #4 had been recorded on 04/09/19 at 11:07am in a common living room. -Resident #4 attempted to stand from his wheelchair and slipped down onto his knees on the floor. -Two PCAs entered the common living room and attempted to transfer Resident #4 back to his wheelchair and were unable to do so. -Resident #4 had a foley catheter bag attached to his wheelchair and the tubing was pulled taught. -One PCA used her radio to call for help. -After the PCA called for help, two female staff and Staff E entered the common living area. -Staff E exited the common living area while the two PCAs and two other female staff remained with Resident #4.	D 161			

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D 161	Continued From page 3 -Staff E returned to the common living area and independently transferred Resident #4 from the floor back into his wheelchair. Interview with the Administrator on 04/10/19 at 1:06pm revealed: -Resident #4 was heavy and would not assist with his own transfers. -Resident #4 was a three to four person assist for transfers. -The facility did not use hoier lifts. -They relied on Staff E to assist with lifting and transferring Resident #4. -If Staff E was not at the facility and Resident #4 fell, they had to call Emergency Medical Services (EMS) to get him out of the floor. -She did not know Staff E was not validated to perform transfers of residents by a Registered Nurse to perform LHPS tasks such as transfers. Interview with the LHPS nurse on 04/10/19 at 4:10pm revealed: -Resident #4 required assistance with transfers. -She had provided skills validation for LHPS tasks to the facility monthly. -She had not validated Staff E for LHPS tasks. -LHPS tasks for Resident #4 required validation to ensure safe transfers and prevent injury to the resident.	D 161			
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270			

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D 270	Continued From page 5 Interview with a personal care assistant (PCA) on 04/09/19 at 8:50am revealed: -Resident #4 had become more confused and unable to express his needs. -Resident #4 had a fall within the last month on another shift when she was not working. -Resident #4 required extensive assistance with transfers from his wheelchair. -Resident #4 had a call bell and was able to use it when needed. -She was checking on him every thirty minutes. Observation of Resident #4's room on 04/10/19 at 9:30am revealed: -Resident #4's room was the second to the last room at the end of a hallway and not within sight of the nurse's station. -Resident #4 was sitting in his private room in a wheelchair. -Resident #4's wheelchair was parked approximately two feet away from his bed and recliner. -A call bell was wrapped around the railing of Resident #4's bed and not within Resident #4's reach. -Resident #4's door to the entrance of his room was open approximately forty-five degrees. Observation of Resident #4's room on 04/10/19 from 9:46am to 10:14am revealed: -At 9:46am, the Maintenance Director exited Resident #4's room. -Resident #4's door to the entrance of his room was open approximately two inches, and Resident #4 was not visible from the hall. -Resident #4 was sitting in a recliner in his room with his feet elevated. -No facility staff checked on Resident #4 from 9:46am to 10:14am.	D 270			

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D 270	Continued From page 6 -At 10:14am, a PCA opened Resident #4's door and offered him a snack. Interview with Resident #4 on 04/10/19 at 9:30am revealed he was confused and tearful. Interview with a second PCA on 04/10/19 at 10:51am revealed: -Resident #4 had frequent falls and would fall every time he attempted to transfer on his own. -She would often find Resident #4 on his knees on the floor where he had slipped out of his chair. -Resident #4's past injuries from falls consisted mainly of abrasions. -Resident #4 had required extensive assistance with all tasks and had been confused for the past two months. -She checked on Resident #4 every hour, but did not document the checks. -She had not been told to check on Resident #4 any more frequently than every hour. Review of Resident #4's incident reports revealed: -On 02/25/19 at 6:15pm, Resident #4 had an unwitnessed fall in his room and stated he was trying to transfer from his wheelchair to his recliner and complained of right hip pain; he was sent to the Emergency Department (ED). -On 03/05/19 at 7:45pm, Resident #4 was found on the floor of his room on his knees and complained of back pain; he was sent to the ED. -On 03/23/19 at 1:50am, Resident #4 was found on the floor of his room and stated he fell out of his wheelchair. Staff encouraged Resident #4 to sleep in his recliner or bed in the future and sent him to the ED for further observation. -On 03/25/19 at 9:30am, Resident #4 was found on the floor of his room; no injuries were noted. It was documented Resident #4 was not sent to the	D 270			

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D 270	Continued From page 7 hospital. -On 03/27/19 at 1:00am, Resident #4 was found on the floor in his room and stated he was asleep and fell out of his chair, no injuries were noted. -On 03/28/19 at 1:50pm, Resident #4 was found face down on the floor of his room and was unable to explain what happened. There was documentation he was groggy and disoriented at times, the facility had completed a new FL-2 for a higher level of care and was awaiting the Primary Care Provider's (PCP) signature. -On 03/28/19 at 11:20pm, Resident #4 was found on the floor in the right wing living room and was unable to explain what happened; no injuries were noted. -On 03/29/19 at 7:30 (in the evening), Resident #4 was trying to get out of his chair and fell to the floor in his room; no injuries were noted. Staff encouraged him to use his call light for transfer assistance. -On 04/01/19 at 6:30 (am or pm was not documented), Resident #4 was found on the floor (location was not documented) and stated squirrels pushed him to the floor; no injuries were noted. -On 04/07/19 at 5:00am, Resident #4 was found on the floor (location was not documented) and he stated he did not know how he fell; no injuries were noted. -On 04/08/19 at 5:30 (in the evening), Resident #4 was trying to get out of his wheelchair and fell on the floor in the living room; no injuries were noted. There was documentation staff would continue every thirty minute checks and the facility was still awaiting skilled nursing facility placement. -On 04/09/19 at 11:05am, Resident #4 was found on the floor in the living room; no injuries were noted.	D 270			

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D 270	Continued From page 8 Review of Resident #4's ED after visit summary reports revealed: -On 02/25/19, Resident #4 was seen in the ED and diagnosed with a fall and pain of the right hip joint. -On 03/05/19, Resident #4 was seen in the ED and diagnosed with contusions of both elbows, contusions of both knees and lumbosacral strain. -On 03/23/19, Resident #4 was seen in the ED and diagnosed with acute pain of the left shoulder, acute pain of both knees and multiple abrasions. -On 03/25/19, Resident #4 was seen in the ED and diagnosed with fall, back pain and rib pain on the right side. Review of Resident #4's nursing assistant notes revealed: -On 03/26/19 during the 11:00pm-7:00am shift, Resident #4 was found on the floor in his room and stated he fell asleep and woke up on the floor; no injuries were noted. -On 03/29/19 during the 11:00pm-7:00am shift, Resident #4 was found on the floor in the left wing living room and could not explain how he fell; no injuries were noted. -On 04/03/19 during the 3:00pm-11:00pm shift, Resident #4 was found on the floor "in living room (foyer) also in his room, resident talking out of his mind (altered mental status)" and had a skin tear on his left knee. -There was documentation dated 04/08/19 Resident #4 had been falling "almost every day" as he tried to get out of his wheelchair. Review of Resident #4's Physician Notification of Resident Fall forms revealed: -Resident #4 had a fall on 03/17/19 (no time or location was documented), and he was advised to use his call light for all transfers.	D 270			

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D 270	Continued From page 9 -Resident #4 was advised to use his call light for all transfers after his fall on 03/23/19. -Resident #4 was advised to use his call light for assistance after his fall on 03/27/19. -Resident #4 was advised to use his call light for all transfers after his fall on 03/28/19. -Resident #4 was advised to use his call light for all transfers after his fall on 04/01/19. Review of Resident #4's physician's orders dated 02/14/19 revealed an order for physical therapy (PT) to evaluate and treat Resident #4 due to unsteady gait, generalized weakness and patient reported multiple falls in room, since arrival, without injury. Review of Resident #4's physician's orders dated 03/21/19 revealed: -There was an order to start every fifteen minute checks on Resident #4 due to repeated falls from his wheelchair. -There was no stop date documented for the fifteen minute checks. Telephone interview with Resident #4's physical therapist on 04/10/19 at 10:02am revealed: -The start of care date for Resident #4's PT was 02/18/19. -He had worked with Resident #4 to improve his balance and strengthening. -Resident #4 had been declining both physically and cognitively since approximately his second PT session. -Staff reported to him Resident #4 was having multiple falls every week. -Resident #4 had been discharged from PT on 04/04/19 because Resident #4 was not making any improvements with his PT. -He had spoken with Resident #4's PCP on 04/04/19 regarding Resident #4's need for a	D 270		

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D 270	Continued From page 10 higher level of care than assisted living. -He thought Resident #4 would benefit from a chair alarm and a room located closer to the nurse's station because most of his falls were occurring when he tried to transfer from his wheelchair to another chair in his room. -He had educated facility staff on Resident #4 being at a high risk for falls due to pain and weakness in his back and legs. -Resident #4 required extensive assistance with all activities of daily living (ADL). Telephone interview with Resident #4's PCP on 04/10/19 at 10:30am revealed: -She had first seen Resident #4 on 02/14/19. -Her last visit with Resident #4 was on 04/04/19. -Resident #4 had frequent falls in which many were unwitnessed. -She had ordered every fifteen minute checks for Resident #4 on 03/21/19 and had not discontinued the order. -She expected the staff to continue checking on Resident #4 every fifteen minutes. -Resident #4 had abrasions and complaints of pain after some of his falls, but all X-rays had been negative. -Resident #4 needed a higher level of care than assisted living, and it was her understanding the facility had been seeking skilled nursing facility placement for Resident #4. -If Resident #4 continued to have falls, he was at risk for fracture of the hip or leg and worsening of his neck condition because he had "hardware" in it. Interview with the medication aide/Supervisor (MA/Supervisor) on 04/10/19 at 11:59am revealed: -Resident #4 had frequent falls due to him attempting to transfer himself from his wheelchair	D 270			

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D 270	Continued From page 11 to his recliner or due to him bending over to pick up something off the floor. -Resident #4 would go on more frequent checks, every one hour, for seventy-two hours after each fall. -The PCAs were responsible for performing the checks and documenting them on a check log. -The check logs were given to the Resident Care Coordinator (RCC) after completion. -Resident #4 had "scrapes" from his falls. -Resident #4 was "very confused a lot." -She thought Resident #4 was cognitive enough to use his call bell if he needed assistance. -Most of the time when Resident #4 was in his room, staff would place him in his recliner with his call bell at the recliner. -She thought Resident #4 was sometimes laying down in the floor and not actually falling in order to get attention. Interview with the RCC on 04/10/19 at 12:29pm revealed: -Resident #4 required total assistance with ADLs. -Resident #4 had been declining physically and cognitively over the past couple of weeks. -Resident #4 had been falling at least daily if not multiple times a day. -Resident #4 was too confused to use his call bell. -She worked passing medications on 04/09/19 and even though Resident #4 had his call bell in his recliner with him, he began yelling for help rather than press his call bell. -She did not like that Resident #4's room was located so far from the nurse's station because if she had not been on his hall passing medications the previous night when he began yelling for help, no one would have heard him. -Facility staff had considered moving his room, but there were no vacant rooms available located	D 270			

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D 270	Continued From page 12 closer to the nurse's station. -Resident #4 was on every thirty minute checks. -The PCAs were responsible for completing the thirty minute checks. -If a resident required specific checks, the PCAs and MAs would communicate that to each other during their shift change. -PCAs were responsible for documenting checks on a check log. -Interventions the facility had implemented to prevent Resident #4 from falling in the future included reminding him to use his call bell for assistance, every thirty minute checks, and placing him in his recliner to discourage him from standing. -The facility had been working on locating a skilled nursing facility for Resident #4 for approximately two weeks. -She thought Resident #4 had had some true falls, but she thought he would also deliberately lay himself on the floor to get attention from the staff. Interview with the Administrator on 04/10/19 at 1:06pm revealed: -She did not know if the facility had a policy on falls. -Resident #4 had frequent falls and would fall at least once every other day. -Resident #4 had sustained abrasions in the past from falls. -Because Resident #4 was confused and could not explain why he fell, anytime a fall was unwitnessed, Resident #4 should be sent to the ED. -Resident #4 was too confused to know to use his call bell for assistance. -PCAs were responsible for checking on all residents every two hours and had been told to check on Resident #4 every hour due to his	D 270			

This is what I said!

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D 270	Continued From page 13 frequent falls. -PCAs should be documenting the checks "somewhere." -She did not know the PCP had ordered Resident #4 to be checked every fifteen minutes. -The RCC and the MA/SIC were responsible for reviewing PCP orders and ensuring their implementation. -She had considered moving the resident closer to the nurse's station, but did not have a vacant room available. -Resident #4's PCP had signed a new FL-2 on 04/04/19 recommending a skilled nursing facility so she had begun seeking a higher level of care for him. -Resident #4 was observed on camera on 04/09/19 sliding from his wheelchair down to his knees onto the floor, and because he remembered to lock his wheelchair before he slid, she felt he slid to the floor deliberately. -"That's not the first time (Resident #4 had deliberately slid to the floor). Other staff had witnessed him stand up, fix his chair and get back in it." Telephone interview with Resident #4's psychiatric Family Nurse Practitioner (FNP) on 04/10/19 at 2:12pm revealed: -She routinely provided psychiatric care to Resident #4 for severe depression and explosive anger episodes. -Resident #4 had frequent falls. -Staff had never discussed with her they thought Resident #4 was falling deliberately. -She had observed abrasions on his knees and elbows as a result of past falls and did not think he would want to deliberately fall and reinjure those areas. -Resident #4 needed a higher level of care than what the current staff could provide for him.	D 270			

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D 270	Continued From page 14 -Resident #4's falls were due to his declining physical health and not attention seeking behaviors. A second interview with the MA/Supervisor on 04/10/19 at 2:43pm revealed: -Resident #4's PCP visited the facility every Thursday. -When the PCP was at the facility, the PCP would give verbal orders and then fax written orders to the facility at the end of her visit. -She did not document the PCP's verbal orders, but was responsible for reviewing the written orders once they were received and ensuring their implementation. -When she received an order for more frequent checks on a resident, she would create a check log to reflect the more frequent checks and give it to the PCAs to use for documentation. -She had created a check log documenting Resident #4 was to have fifteen minute checks for one week starting 03/21/19 because she thought she had received it as a verbal order from the PCP. -She did not notice the PCP's written order did not have a stop date on it, and she did not realize the PCP wanted the fifteen minutes checks to be continued indefinitely for Resident #4. A second interview with the RCC on 04/10/19 at 2:58pm revealed: -She provided a check log used by the PCAs with documentation Resident #4 was to be checked every fifteen minutes for one week beginning 03/21/19. -The PCAs had documented checks were completed for Resident #4 every thirty minutes not every fifteen minutes from 03/21/19 at 3:00pm through 03/29/19 at 3:30pm because the check log did not have space to document every	D 270			

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D 270	Continued From page 15 fifteen minute checks. -Check logs for all other days had documentation Resident #4 was checked every two hours. -She did not know why there was documentation on the check log to stop the every fifteen minute checks after one week for Resident #4. -The MA/Supervisor was responsible for reviewing PCP orders and ensuring their correct implementation. The facility failed to assure staff provided supervision for Resident #4, who had a history of falls and a decline in both physical and cognitive abilities, resulting in him having sixteen documented falls from 02/25/19 to 04/09/19 with four of the falls requiring a visit to the Emergency Department. This failure was detrimental to the health and safety of the resident and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 04/10/19. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 25, 2019.	D 270			
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids,	D 307			

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D 307	Continued From page 16 unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure diet orders were clarified for 1 of 5 sampled residents (Resident #6). The findings are: 1. Review of Resident #6's current FL2 dated 04/13/18 revealed: -Diagnoses included hypertension, depression, congestive heart failure, and cerebral vascular accident. -An order for a regular diet. Review of Resident #6's record revealed: -There was a diet order dated 01/31/19 for a no concentrated sweets (NCS). Review of the Dietary Manager's (DM) diet order binder located in her office revealed there was a diet order for Resident #6 dated 01/31/19 for a mechanical soft diet /NCS diet. Review of the facility's most recent diet list posted in the kitchen dated 03/15/19 revealed Resident #6 was to be served a mechanical soft/NCS diet. Observation of the kitchen on 04/09/19 at 10:10am revealed there were therapeutic diet menus available for regular/no added salt (NAS), house renal, mechanical soft, pureed, and NCS to be used for staff guidance when preparing meals.	D 307			

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D 307	Continued From page 17 Observation of the lunch meal on 04/09/19 from 11:45am-1:25pm revealed: -Resident #6 was served chopped turkey with gravy, rice and gravy, mixed vegetables, peach cobbler, water, and unsweetened tea. -Resident #6 consumed her meal without difficulty. Observation of the lunch meal on 04/10/19 from 12:00pm-1:00pm revealed: -Resident #6 was served chicken, zucchini, potatoes, red velvet cake, water, and tea. -Resident #6 consumed her meal without difficulty. Review of therapeutic diet menus available revealed there was an extension spreadsheet for each individual diet, there were no instructions or menus for residents with orders for two or more therapeutic diets. Interview with the cook on 04/09/19 at 1:20pm revealed: -She assisted with preparing meals for the residents. -She prepared the lunch meal on 04/09/19. -Resident #6 had a diet order for mechanical soft/NCS. -She referred to the mechanical soft menu to prepare Resident #6's food and followed the instructions for NCS menu when preparing the beverage and dessert. -There was no menu to follow when preparing resident who had more than one diet order. -It was "tricky" when preparing meals for residents with more than one diet order. -She did the best she could with preparing meals for residents with two diet orders. -She was trained on by the Dietary Manager when she was employed 8 years ago.	D 307			

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D 307	Continued From page 18 Interview with the Dietary Manager (DM) on 04/09/19 at 10:15am revealed: -She reviewed diet orders for each resident at the end of the month. -Resident #6 was to be served a mechanical soft/NCS diet as list on the diet list. -She realized Resident #6 had two diets ordered dated the same date. -The Resident Care Coordinator (RCC) was responsible for ensuring each resident had an updated diet order. -The RCC was responsible for ensuring residents' diets orders were clarified. -She thought residents could have two diets ordered and both menus could be referenced to serve both diets. -She had not informed the RCC that she did not have a menu to reference for mechanical soft/NCS. -The previous Administrator allowed physicians to choose more than one diet even though there was no menu to reference. Interview with the primary care provider (PCP) on 04/10/19 at 10:54am revealed: -She wanted Resident #6 to be served a mechanical soft/NCS diet. -The facility provided a list of diets and allowed her to check which diets she wanted the resident to be served. -There were no instructions to choose only one diet. -She thought residents could be ordered a combination of diets. -She did not know only one diet could be ordered at a time. -She would have ordered Resident #6 a mechanical soft diet with sugar free drinks and desserts.	D 307			

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D 307	Continued From page 19 Interview with the RCC on 04/09/19 at 3:39pm revealed: -She was responsible for obtaining diet orders for the residents. -Once a diet order was received she would give the order to the DM. -She did not realize Resident #6 had two diet orders dated on the same date. -She thought physician could choose more than one diet option on the diet list. -She did not know there was not a menu for two or more therapeutic diets combined. -"I've only been working here since the beginning of March 2019". -"I did not think about the menus the kitchen had available". Interview with the Administrator on 04/09/19 at 4:04pm revealed: -She had been the Administrator for two months. -She did not know Resident #6 had two diets orders dated 01/31/19. -She expected the RCC to get the diet orders clarified. -She did not know physicians were choosing more than one diet order on the list. -She did not know the dietary staff did not have instructions or menus when two or more diets were selected. -She thought the kitchen had all the menus and instructions they needed to reference.	D 307			
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes; (3) The facility shall maintain an accurate and	D 309			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PRESTWICK VILLAGE

1000 JOHNS ROAD
LAURINBURG, NC 28352

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D 309 Continued From page 20

current listing of residents with physician-ordered
therapeutic diets for guidance of food service
staff.

This Rule is not met as evidenced by:
Based on observations, interviews, and record
reviews, the facility failed to ensure an accurate
and current listing of residents was available for
guidance of food service staff for 1 of 5 sampled
residents (Resident #7).

The findings are:

Review of Resident #7's current FL2 dated
11/09/18 revealed diagnoses included
hypertension, chronic kidney disease stage 4,
hyperlipidemia, and dementia.

Review of a physician's diet order dated 01/24/19
for Resident #7 revealed an order for a regular
diet.

Review of the therapeutic diet list posted in the
kitchen on 04/09/19 revealed:

-The therapeutic diet list was last updated on
03/15/19.

-Resident #7 was listed as having a house renal,
no concentrated sweets diet (NCS).

Review of the Dietary Manager's (DM) diet order
binder located in her office revealed there was a
diet order for Resident #7 dated 01/24/19 for
regular/no added salt (NAS) diet.

Observation of the lunch meal service on
04/09/19 from 11:45-1:25pm revealed:

-Resident #7 was served a turkey, rice with gray,

D 309

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D 309	Continued From page 21 mixed vegetables, a roll, peach cobbler, cranberry juice, and water. -Resident #7 consumed her meal without difficulty. Observation of the lunch meal service on 04/10/19 from 12:00pm-1:00pm revealed: -Resident #7 was served chicken, zucchini, potatoes, a roll, red velvet cake, water, and cranberry juice. -Resident #7 consumed her meal without difficulty. Interview with a Medication Aide (MA) on 04/10/19 at 11:16am revealed: -She assisted in the kitchen with serving meals. -The Resident Care Coordinator (RCC) was responsible for obtaining diet orders and given them to the Dietary Manager (DM). -The DM was responsible for updating the therapeutic diet list. -She thought the therapeutic diet list was updated when a new resident was admitted or there was a change in the diet order. Interview with a dietary staff 04/09/19 at 1:20pm revealed: -The DM was responsible for updating the therapeutic diet list. -Resident #7 was to be served a house renal/NCS diet as listed on the therapeutic spreadsheet. -Resident #7 had been ordered that diet since she was admitted. -The therapeutic diet list was updated when there was a change in a resident's diet order and when a new resident was admitted to the facility. Interview with the Dietary Manager (DM) on 04/09/19 at 3:25pm revealed:	D 309			

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D 309	Continued From page 22 -The RCC was responsible for providing her with updated diet orders. -The diet list was updated monthly, when a resident's diet order changed or when new residents were admitted to the facility. -She knew the diet order in her binder was for a regular diet. -She thought the diet order dated 01/24/19 was wrong because Resident #7 had been ordered a renal diet since being admitted due to her health condition. -She did not update the diet list to include Resident #7 with a regular diet, because she thought the order was wrong. -She thought she checked with the previous RCC about the order. -She was sure Resident #7 was to be served a renal/NCS diet. Interview with the nurse for Resident #7's primary care provider (PCP) on 04/10/19 at 1:15pm revealed: -The PCP wanted Resident #7 to receive a regular diet as ordered on 01/24/19. -Due to Resident #7's health condition, a regular diet was appropriate. Interview with the RCC on 04/09/19 at 3:39pm revealed: -The DM was responsible for updating the diet list. -Resident #7 was ordered a regular diet on 01/24/19. -The DM had been given a copy of the new order. -She did not know why Resident #7's diet was not updated on the diet list. Interview with the Administrator on 04/09/19 at 4:04pm revealed: -The DM was responsible for updating the	D 309			

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D 309	Continued From page 23 therapeutic diet list. -The diet list was updated when new residents were admitted or there was a change in a resident's diet order. -She did not know Resident #7's diet was listed incorrectly. -She expected the DM to follow the orders as written and update the diet list accordingly. Based on observations, interview, and record review Resident #7 was not interviewable.	D 309			
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (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 contact the physician	D 344			

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D 344	Continued From page 24 to clarify medication orders for 1 of 8 residents observed during a medication pass (Resident #8) as related to potassium chloride and Vitron-C, an iron pill with vitamin c. Observation of the medication pass on 04/09/19 at 8:55am revealed: -The medication aide (MA) administered 13 tablets to Resident #8 during the morning medication pass. -Potassium chloride 20 mEq extended release, one tablet, was administered to Resident #8. Review of Resident #8's current FL2 dated 03/19/19 revealed diagnoses included atrial fibrillation, cardiomyopathy and chronic kidney disease (CKD) stage 3. a. Review of Resident #8's current FL2 dated 03/19/19 revealed: -There was an order for lasix 40mg twice a day. -There was no order for potassium chloride on the FL2. Review of Resident #8's hospital discharge summary, electronically signed, on 03/19/19 revealed: -Resident #8 was admitted to the hospital on 03/14/19 for shortness of breath and bilateral lower leg edema. -Diagnoses included bilateral pulmonary edema. -There was an order for lasix 40 mg one tablet twice a day. -There was no order for potassium chloride on the discharge summary. Review of Resident #8's Medication Clarification form dated 03/20/19 revealed: -There was an order for lasix 40 mg one tablet twice a day.	D 344			

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D 344	Continued From page 25 -There was no order for potassium chloride on the clarification form. Review of Resident #8's April 2019 electronic medication administration record (eMAR), from 04/01/19-04/10/19 revealed; -There was an entry for lasix 40 mg one tablet twice a day. -There was an entry for potassium chloride 20 mEq ER (extended release) once a day at 8:00am. -There was documentation potassium chloride was administered from 04/02/19 through 04/09/19. Telephone interview with Resident #8's primary care physician (PCP) on 04/10/19 at 9:20am revealed: -She had reviewed the discharge orders for Resident #8 on 03/20/19. -Resident #8's lasix and potassium chloride medications were being managed by the cardiologist. -Before Resident #8's hospitalization, she had requested the facility clarify any lasix and potassium chloride orders with the cardiologist. -Potassium chloride 20 mEq ER was previously on Resident #8's medication profile. Review of Resident #8's record revealed no documentation the cardiologist had been contacted regarding clarification of the lasix and potassium chloride medication orders. Interview with the Resident Care Coordinator (RCC) on 04/09/19 at 10:20am revealed: -The process reviewing discharge orders from the hospital was as follows: -The MA received the discharge summary and compared the medications to the current	D 344			

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D 344	Continued From page 26 medication profile for the resident. -The MA completed the Medication Clarification form, including the medications listed from the hospital discharge and any medications the resident was on prior to hospitalization not included with the discharge medication list. -The MA sent the Medication Clarification form to the PCP. -When the Medication Clarification form returned with the physician's signature it was sent to the pharmacy. -A second MA reviewed the signed clarification form with the eMAR to verify the medications were entered correctly. -The staff person completing the second step of verification entered "Accept" on the eMAR which activated the orders. -The clarification form should be placed in the RCC box, and the third check for medication accuracy was completed by the RCC. -She did not receive a copy of the Medication Clarification form for Resident #8 and did not verify the resident's medications. -The MA who wrote the Medication Clarification form should have entered potassium chloride for clarification from the PCP. -The MA who "accepted" the order should have compared the clarification form to the current eMAR and requested a clarification of the potassium chloride order. -The MAs did not follow the process for clarifying orders with the physician. -She did not know Resident #8 was receiving potassium chloride without a clarification of the order. Interview with the first shift MA on 04/10/19 at 10:10am revealed: -When a resident returned from a hospital admission, she reviewed the discharge	D 344			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL083018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/10/2019
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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 344	Continued From page 27 medication orders and compared them to the current eMAR. -She would send the discharge medication list with any medications that had changed or were not included, on a Medication Clarification form, to the PCP. -The Medication Clarification form would be signed by the PCP and returned. -She would send the clarification form to the pharmacy. -The MA on the next shift would verify the orders on the resident's eMAR had matched the orders on the signed Medication Clarification form. -To activate the orders, the MA entered "Accept" on the eMAR after completing the verification of orders. -The Medication Clarification form was placed in the RCC box to be reviewed by the RCC. -She did not process the discharge orders for Resident #8. -She did not know the potassium chloride order for Resident #8 was not clarified with the physician. Interview with the Administrator on 04/10/19 at 11:40am revealed: -The RCC supervised the MAs and her responsibilities included oversight of the medications and the medication orders. -The MAs were responsible for clarifying orders when a resident returned from a hospital admission. -The MAs were responsible for sending a Medication Clarification form to the PCP to ensure resident's had the appropriate medications on their profile. -The MAs were to inform the PCP if any medications prior to admission to the hospital were discontinued or changed. -She did not know the MAs did not inform the	D 344			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL083018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/10/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PRESTWICK VILLAGE

1000 JOHNS ROAD

LAURINBURG, NC 28352

(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 344	Continued From page 28 PCP potassium chloride 20 mEq was not on the discharge medications from the hospital. -She did not know the MAs were not following the facility process for medication clarification. Interview with the facility's contracted pharmacist on 04/10/19 at 3:44pm revealed: -The FL2 dated 03/19/19, and signed by the PCP, was received from the facility and did not include potassium chloride. -There was an order clarification form dated 03/20/19 received from the facility and did not include potassium chloride. -When the pharmacist received a new FL2 or discharge summary from another facility, it would be compared to the previous orders. -If there was an existing order for a medication, not included on the current orders, an Omission Form is sent back to the facility requesting clarification. -If a medication does not have a specific discontinued order from the physician, the medication continued to be an active order and remained on the eMAR. -There was no discontinue order received for potassium chloride 20 mEq ER. -The facility was on a "cycle fill" for medications-active orders that are not narcotics, insulin or treatments receive monthly refills to the facility. -Since the potassium chloride continued as an active order, it was re-entered on the April 2019 eMAR and sent with the cycle medications in April. -The pharmacy staff should have sent an Omission Form to the facility requesting clarification of the status of the potassium chloride. -There was no documentation the Omission Form was sent to the facility.	D 344		

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D 344	Continued From page 29 Telephone interview with Resident #8's nurse at the cardiologist office on 04/11/19 at 9:10am revealed: -There was no record of the facility staff contacting the physician regarding clarification of the lasix and potassium chloride orders. -Resident #8 was last seen on 03/09/19. -The physician did not know Resident #8 had been hospitalized on 03/14/19. -The physician had not seen her discharge medications. -The cardiologist referred medication clarification of potassium chloride and lasix orders to the PCP. Attempted telephone interview with the second shift MA on 04/10/19 at 2:05pm was unsuccessful. b. Observation of the medication pass on 04/09/19 at 8:55am revealed: -The medication aide (MA) administered 13 tablets to Resident #8 during the morning medication pass. -Vitron-C 65-125, one tablet, was administered to Resident #8. Review of Resident #8's current FL2 dated 03/19/19 revealed there was not an order for Vitron-C 65-125 one tablet once a day. Review of Resident #8's record revealed: -There was a hospital discharge summary dated 03/19/19. -The discharge medications did not include Vitron-C 65-125. -Resident #8's medication profile as of 03/19/19 included Vitron-C tablet to be administered daily. -There was a Medication Clarification form dated	D 344			

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D 344	Continued From page 30 03/20/19 sent from the facility staff to the primary care physician (PCP). -The Medication Clarification form did not include Vitron-C. Review of Resident #8's April 2019 electronic medication administration record (eMAR), from 04/01/19-04/10/19 revealed there was an entry for Vitron-C 65-125 to be administered daily at 8:00am. Telephone interview with Resident #8's primary care physician (PCP) on 04/10/19 at 9:20am revealed: -She had reviewed the discharge orders, and the Medication Clarification form, for Resident #8 on 03/20/19. -She did not remember the Vitron-C being on the eMAR prior to Resident #8's hospital admission. -She did not think she had originally prescribed the Vitron-C. -She would expect the facility staff to clarify all orders that were changed due to a hospitalization. Review of Resident #8's record revealed no documentation the PCP had been contacted regarding clarification of the Vitron-C orders. Interview with the facility's contracted pharmacist on 04/10/19 at 3:44pm revealed: -The FL2 dated 03/19/19, and signed by the PCP, was received from the facility and did not include Vitron-C. -There was an order clarification form dated 03/20/19 received from the facility and did not include Vitron-C. -If a medication does not have a specific discontinued order from the physician, the medication continued to be an active order and remained on the eMAR.	D 344			

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D 344	Continued From page 31 -There was no discontinue order received for Vitron-C. -The pharmacy staff should have sent an Omission Form to the facility requesting clarification of the status of the Vitron-C. -There was no documentation the Omission Form was sent to the facility. Attempted telephone interview with the second shift MA on 04/10/19 at 2:05pm was unsuccessful. Attempted interview with Resident #8 on 04/10/19 at 2:25 was unsuccessful.	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: Based on observations, interviews, and record	D 358		

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D 358	Continued From page 32 reviews, the facility failed to administer medications as ordered and in accordance with the facility's policy for 2 of 8 residents (#8 and #9) observed during the medication pass, including errors with electrolyte and vitamin supplements administered without an order, and a medication used for gastroesophageal reflux (GERD) not administered as scheduled (Resident #8), and fingerstick blood sugar (FSBS) to be administered before breakfast, not administered until after breakfast (Resident #9). The findings are: The medication error rate was 13% as evidenced by the observation of 4 errors out of 31 opportunities during the 8:00 am through 9:30 am medication pass on 04/09/19. Review of Resident #8's current FL2 dated 03/19/19 revealed diagnoses included atrial fibrillation, cardiomyopathy and chronic kidney disease (CKD) stage 3. a. Observation of the medication pass on 04/09/19 at 8:55am revealed: -The medication aide (MA) administered 13 tablets to Resident #8 during the morning medication pass. -Potassium chloride 20 mEq extended release, one tablet, was administered to Resident #8. Review of Resident #8's current FL2 dated 03/19/19 revealed there was no physician's order for potassium chloride on the FL2. Review of Resident #8's April 2019 electronic medication administration record (eMAR), from 04/01/19-04/10/19 revealed; -There was an entry for potassium chloride 20	D 358			

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D 358	Continued From page 33 mEq ER (extended release) once a day at 8:00am. -There was documentation potassium chloride was administered from 04/02/19 through 04/09/19. Interview with the Resident Care Coordinator (RCC) on 04/09/19 at 10:20am revealed: -She did not know Resident #8 had been administered medications without a physician's order from 04/01/19-04/09/19. -The facility process for verifying a new FL2 was to compare the FL2 to the current medication orders on the eMAR. -The MAs would send a Medication Clarification to the physician to be reviewed and signed. -The signed Medication Clarification would be placed in her box and she would complete the final review. -She had not received the Medication Clarification form for Resident #8 and did not know there were medications on the eMAR that were not on the current FL2. Telephone interview with Resident #8's primary care physician (PCP) on 04/10/19 at 9:20am revealed: -She had reviewed the hospital discharge orders (03/19/19) for Resident #8 on 03/20/19. -Resident #8's potassium chloride medication was being managed by the cardiologist. -Potassium chloride 20 mEq ER was previously on Resident #8's medication profile. -She requested the facility clarify the potassium chloride orders with the cardiologist. -She expected the facility to follow the most current physician's orders in the administration of medications. -The current orders were on the hospital discharge FL2 of 03/19/19, verified by the PCP.	D 358			

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D 358	Continued From page 34 Interview with the Administrator on 04/10/19 at 11:40am revealed: -The RCC supervised the MAs and her responsibilities included oversight of the medications and the medication orders. -The MAs were responsible for clarifying orders when a resident returned from a hospital admission. -The MAs were responsible for sending a Medication Clarification form to the PCP to ensure resident's had the appropriate medications on their profile. -The MAs were to inform the PCP if any medications prior to admission to the hospital were discontinued or changed. -She did not know the MAs were not following the facility process for medication clarification. -She did not know Resident #8 was receiving medications that were not on her current FL2. Interview with the pharmacist from the facility's contracted pharmacy on 04/10/19 at 3:44pm revealed: -The FL2 dated 03/19/19, and signed by the PCP, was received from the facility and did not include potassium chloride. -There was an order clarification form dated 03/20/19 received from the facility and did not include potassium chloride. -The pharmacy policy was to remove orders from the eMAR when a signed order discontinuing the medication was received from the physician. -There was no documentation of a signed physician's order to discontinue potassium chloride 20 mEq. Attempted interview with Resident #8 on 04/10/19 at 2:25 in her room was unsuccessful due to her napping.	D 358			

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D 358	Continued From page 35 b. Observation of the medication pass on 04/09/19 at 8:55am revealed: -The medication aide (MA) administered 13 tablets to Resident #8 during the morning medication pass. -Vitron-C 65-125, one tablet, was administered to Resident #8. Review of Resident #8's current FL2 dated 03/19/19 revealed there was no physician's order for Vitron- C 65-125. Review of Resident #8's April 2019 electronic medication administration record (eMAR), from 04/01/19-04/10/19 revealed; -There was an entry for Vitron-C once a day at 8:00am. -There was documentation Vitron-C was administered from 04/02/19 through 04/09/19. Interview with the Resident Care Coordinator (RCC) on 04/09/19 at 10:20am revealed: -She did not know Resident #8 had been administered medications without a physician's order from 04/01/19-04/09/19. -The facility process for verifying a new FL2 was to compare the FL2 to the current medication orders on the eMAR. -The MAs would send a Medication Clarification to the physician to be reviewed and signed. -The signed Medication Clarification would be placed in her box and she would complete the final review. -She had not received the Medication Clarification form for Resident #8 and did not know there were medications on the eMAR that were not on the current FL2. Telephone interview with Resident #8's primary	D 358			

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D 358	Continued From page 36 care physician (PCP) on 04/10/19 at 9:20am revealed: -She had reviewed the discharge orders for Resident #8 on 03/20/19. -Vitron-C was not on the FL2 dated and signed on 03/19/19. -She had not prescribed the Vitron-C for Resident #8. -She did not know why she was on the medication, and would have to review the order. -She expected the facility to follow the most current physician's orders in the administration of medications. Interview with the Administrator on 04/10/19 at 11:40am revealed she did not know Resident #8 was receiving a medication without an order Interview with the facility's contracted pharmacist on 04/10/19 at 3:44pm revealed: -The FL2 dated 03/19/19, and signed by the PCP, was received from the facility and did not include Vitron-C 65-125. -There was an order clarification form dated 03/20/19 received from the facility and did not include Vitron-C. -The pharmacy policy was to remove orders from the eMAR when a signed order discontinuing the medication was received from the physician. -There was no documentation of a signed physician's order to discontinue Vitron-C 65-125. Interview with the Administrator on 04/10/19 at 11:40am revealed she did not know Resident #8 was receiving a medication without an order. c. Observation of the medication pass on 04/09/19 at 8:55am revealed: -The medication aide (MA) administered 13 tablets to Resident #8, including Pantoprazole	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL083018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/10/2019
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D 358	Continued From page 37 40mg, during the morning medication pass. -Pantoprazole was administered at 9:03am in the resident's room. Review of Resident #8's current FL2 dated 03/19/19 revealed there was a physician's order for Pantoprazole 40 mg every morning before breakfast. Review of the April 2019 electronic medication administration record (eMAR) revealed an entry for Pantoprazole 40mg to be administered before breakfast, scheduled at 7:30am daily. Interview with the resident on 04/09/19 at 9:05am revealed the resident had already eaten breakfast. Interview with the MA on 04/09/19 at 9:30am revealed: -The personal care assistant (PCA) had wheeled Resident #8 into the dining room before she could administer her medications. -She knew Resident #8 should take her Pantoprazole before breakfast to aid in her digestion. -She usually was able to "catch her" before breakfast. Review of the Medication Administration Policy was unsuccessful. The facility was unable to produce the policy. 2. Review of Resident #9's current FL2 dated 03/21/19 revealed diagnoses included type 2 diabetes. Observation of the morning medication pass on 04/09/19 at 8:55am revealed: -Resident #9 was directed to the medication	D 358			

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PRINTED: 04/30/2019
FORM APPROVED

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D 358	Continued From page 38 room. -The MA checked his fingerstick blood sugar (FSBS) on the left hand, pointer finger. -The FSBS was 141 and no insulin was administered. Review of Resident #9's current FL2 dated 03/21/19 revealed: -There was an order for FSBS three times a day before meals. -There was an order for Novolog Flexpen insulin with the following sliding scale parameters: FSBS at 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-450 = 12 units, greater than 450 = 12 units. Interview with the MA on 04/09/19 at 9:30am revealed: -Resident #9 ate breakfast at approximately 7:45am. -The MA knew Resident #9's FSBS should be checked before breakfast. -She knew the FSBS indicated the need for insulin before Resident #9 ate to control his blood sugar. -The resident "just got away from me" this morning. Review of the Medication Policy was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 04/09/19 at 10:20am revealed: -Residents on a sliding scale insulin should have their FSBS checked before meals. -The sliding scale insulin dose was based on the blood sugar levels before meals. -She did not know the MA was not adhering strictly to the FSBS orders for Resident #9.	D 358			

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D 358	Continued From page 39 Telephone interview with Resident #8's primary care physician (PCP) on 04/10/19 at 9:20am revealed: -It was very important for residents on a sliding scale insulin to have their FSBS checked before meals. -The sliding scale parameters, based on the readings of the FSBS, keeps the blood sugar at optimal levels. -Her expectation was the orders would be followed as written. -It was important to regulate the blood sugar levels of diabetic residents to prevent hypoglycemia or hyperglycemia with complications. -She did not know Resident #9 received his FSBS after eating breakfast. Interview with the Administrator on 04/10/19 at 11:40am revealed: -She did not know the MAs were not following the physicians orders regarding the timing of medications. -She did not know Resident #9 did not receive his FSBS prior to breakfast as ordered. -She expected the MAs to follow the physician orders as written.	D 358			
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912			

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D912	Continued From page 40 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 1 of 2 sampled residents with a history of falls (Resident #4). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912			

Plan of Correction for Statement of Deficiencies received 05/03/2019

Prestwick Village Assisted Living
Scotland County
HAL-083-018

10A NCAC 13F .0504(a) Competency Validation for LHPS Tasks

On 04/10/2012 and 04/11/2019 the Administrator has instructed all staff not to assist a resident unless you have a competency validation for Licensed Health Professional Support Task on file at the facility. Any staff that aids in assistance of any resident must have proper validation as required by the state. If an invalidated staff sees a resident needs assistance he or she will notify care staff of that need. The Administrative Assistant and the Administrator will monitor once a month that all LHPS's have been completed and signed off by an RN.

10 A NCAC 13F .0901 (b) Personal Care and Supervision

The RCD will implement documented 30 minute checks for any resident that has two or more repeated falls within 30 days. The RCD will report to PCP for any resident with multiple falls. Staff will provide 30 minute checks and the RCD will audit once a week and the Administrator will monitor. All falls will be discussed during standup meeting each morning by the RCD and the Administrator.

10A NCAC 13F .0904 (e) (1) Nutrition and Food Services

On 04/11/2019 the Administrator and RCD, will review all diet orders and clarified with resident's physician if needed. Diet orders no longer have orders for two or more therapeutic diets. The Dietary Manager will also be responsible for making sure the diet lists are accurate and available for dietary staff, and this will be monitored by the Administrator monthly.

10A NCAC 13F .0904 (e) (3) Nutrition and Food Services

The RCD and Administrator will ensure an accurate and current listing of residents is available for dietary. Anytime there is a change in a diet order the RCD will give a corrected order to the dietary department. The Administrator will monitor all diet orders monthly.

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

On 04/15/2019 RCD audited all medication and treatment orders. The RCD will monitor all medication and treatment orders to make sure they are correct. The RCD will clarify any orders that are needed to be clarified. The Administrator will monitor monthly.

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

On 04/15/2019 the RCD had an in-service for all Med-Techs concerning medication orders. The RCD will monitor all medications orders when a resident returns from a hospital admission to ensure all medications given have a physician's order. The facility has an updated Medication Administration Policy on site. RCD will monitor Med-Tech's to be sure that any resident requiring a finger stick blood sugar

check before meals will be followed. All Med-tech's will go back through FEL's 15 hour med training to be completed by 06/21/2019.

G.S. 131 D-21 (2) Declarations of Residents Rights

On 06/17/2019 the Ombudsman will conduct Resident Rights training for all staff. The Administrator will assure all resident's receive care and services which are adequate and in compliance with federal and state laws and rules and regulations. The Administrator and RCD will routinely monitor all staff that all residents assessed needs and care plans are followed.

Signature  Date 5-24-2019

Reviewed and accepted on 06/03/19 by Mary Agena/ma