

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted a follow-up survey and complaint investigation on 03/14/19 through 03/15/19 and 03/18/19. The complaint investigation was initiated by the Surry County Department of Social Services on 03/05/19.	{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: Follow-up to Unabated Type B Violation Based on these findings, the previous Unabated Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to notify the primary care providers for 2 of 3 sampled residents (Residents #2 and #3) regarding fingerstick blood sugars (FSBS) greater than 350 and antifungal medication and blood pressure (BP) results outside the ordered parameters(#2), an eye drop not available for administration and blood pressure results outside of ordered parameters (#3).	{D 273}		

See attached
Karen Shaver
5-6-19

Division of Health Service Regulation

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

TITLE

(X6) DATE

FORM

0699

VX5P13

If continuation sheet 1 of 88

Reviewed and Accepted

Keisha Banks

05/10/19

Division of Health Service Regulation

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{D 273}	Continued From page 1 The findings are: 1. Review of Resident #2's current FL2 dated 12/06/18 revealed diagnoses included diabetes and hypertension. a. Review of Resident #2's current FL2 dated 12/06/18 revealed physician orders for fingerstick blood sugars (FSBS) before meals and at bedtime. Review of Resident #2's subsequent physician's order dated 12/20/18 revealed an order to notify the physician if blood sugar was less than 70 or greater than 350. Review of Resident #2's January 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for FSBS before meals and at bedtime scheduled 7:00 am, 12:00 pm, 5:00 pm and 9:00 pm and notify the physician if blood sugar less was than 70 or greater than 350. -Resident #2 had three documented FSBS results greater than 350 as follows: -On 01/10/19 at 9:00pm, the FSBS result was 388. -On 01/16/19 at 5:00pm, the FSBS result was 378. -On 01/27/19 at 12:00pm, the FSBS result was 375. -There was no documentation of physician notification for FSBS results greater than 350 in January 2019. Review of Resident #2's February 2019 eMAR revealed: -There was an entry for FSBS before meals and at bedtime scheduled 7:00 am, 12:00 pm, 5:00 pm and 9:00 pm and notify the physician if blood	{D 273}	See attached Karen Shaver 5-6-19	

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{D 273}	Continued From page 2 sugar less was than 70 or greater than 350. -Resident #2 had ten documented FSBS results greater than 350 as follows: -On 02/06/19 at 9:00pm, the FSBS result was 353. -On 02/12/19 at 12:00pm, the FSBS result was 391. -On 02/12/19 at 9:00pm, the FSBS result was 400. -On 02/13/19 at 9:00pm, the FSBS result was 363. -On 02/14/19 at 12:00pm, the FSBS result was 397. -On 02/19/19 at 9:00pm, the FSBS result was 393. -On 02/22/19 at 12:00pm, the FSBS result was 442. -On 02/23/19 at 9:00pm, the FSBS result was 447. -On 02/25/19 at 9:00pm, the FSBS result was 394. -On 02/27/19 at 12:00pm, the FSBS result was 397. -There was no documentation of physician notification for FSBS results greater than 350 in February 2019. Review of Resident #2's March 2019 eMAR revealed: -There was an entry for FSBS before meals and at bedtime and scheduled for 7:00 am, 12:00 pm, 5:00 pm and 9:00 pm and notify the physician if blood sugar less was less than 70 or greater than 350. -Resident #2 had six documented FSBS results greater than 350 as follows: -On 03/06/19 at 9:00 pm, the FSBS result was 395. -On 03/07/19 at 5:00 pm, the FSBS result was 393.	{D 273}		

*See attached
Karen Shaver
5-6-19*

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{D 273}	Continued From page 3 -On 03/07/19 at 9:00 pm, the FSBS result was 384. -On 03/09/19 at 12:00 pm, the FSBS result was 371. -On 03/10/19 at 12:00 pm, the FSBS result was 470. -On 03/11/19 at 9:00 pm, the FSBS result was 416. -There was no documentation of physician notification for FSBS greater than 350 in March 2019. Review of Resident #2's care notes revealed: -On 01/16/19 at 4:53pm, staff notified the physician of Resident #2's FSBS of 378. -There was no documentation the physician was notified regarding the additional 18 FSBS results greater than 350 between 01/10/19 to 03/11/19. Interview with Resident #2 on 03/15/19 at 3:55pm revealed: -Facility staff checked her FSBS four times a day. -She did not know her FSBS results. -She did not know when she had any symptoms of hypoglycemia or hyperglycemia. Interview with the medication aide (MA) on 03/15/19 at 3:00pm revealed: -The Supervisor or Resident Care Coordinator (RCC) were responsible for physician notification of FSBS when outside the ordered parameters. -Resident #2's FSBS was checked before meals and at bedtime. -She knew the PCP was to be notified for FSBS results less than 70 and greater than 350. -She did not know the FSBS was greater than 350 in January 2019, in February 2019, and in March 2019. -Physician notification of FSBS results outside of ordered parameters should be documented in the	{D 273}	See attached Karen Shaver 5-6-19		

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{D 273}	Continued From page 4 care notes. -She had notified the PCP of FSBS results outside of ordered parameters, but not in the recent months. -The PCP could have been notified and the Supervisor or RCC did not document the notification in the care notes. -Without documentation in the resident care notes there was no way to show the physician was notified. Interview with the RCC on 03/15/19 at 10:26am revealed: -The MA/Supervisors were responsible for obtaining FSBS. -The MA, Supervisor or RCC were responsible for physician notification. -She did not know there were FSBS results greater than 350 in January 2019 through March 2019. -If the PCP was notified regarding Resident #2's FSBS results there should be documentation in the care notes. -The facility did not have a system to check and ensure the MAs contacted the PCP regarding Resident #2's FSBS results less than 70 or greater than 350. Interview with the Executive Director on 03/15/19 at 6:30pm revealed: -The MA or Supervisor were responsible for obtaining FSBS. -She expected staff to notify the physician with FSBS outside the ordered parameters. -Staff were expected to document physician notification in the care notes. -She did not know the physician was not notified of the FSBS outside of the parameters. Interview with the Administrator on 03/18/19 at	{D 273}	See attached Karen Shaver 5-6-19		

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STATE FORM

6890

VX5P13

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{D 273}	Continued From page 5 1:55pm revealed: -The MA or RCC were responsible for obtaining FSBS and documenting on the eMAR. -If the FSBS was outside of parameters the MA or RCC were responsible for physician notification. -He did not know about Resident #2's FSBS outside the parameters from January 2019 through March 2019. Interview with Resident #2's primary care provider (PCP) on 03/18/19 at 5:55pm revealed: -She expected the staff to call her with FSBS below 70 and greater than 350. -She had been notified of FSBS outside ordered parameters in the past. -She did not remember being notified in January, February, or March 2019 of FSBS outside of ordered parameters. -She visited the facility every other week. -She reviewed FSBS results when she visited the facility. -If the facility had notified she could have adjusted her diabetic medication. -Resident #2 was last seen by the PCP two weeks ago. b. Review of Resident #2's current FL2 dated 12/06/18 revealed no order for blood pressure (BP). Review of Resident #2's subsequent physician's order dated 12/20/18 revealed there was a physician's order to obtain BP daily and notify the physician if BP greater than 140/85 or less than 100/50. Review of Resident #2's January 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check BP daily on first	{D 273}	See attached Karen Shaver 5-6-19	

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STATE FORM

6699

VX5P13

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{D 273}	Continued From page 6 shift and notify the physician if BP greater than 140/85 or less than 100/50. -Resident #2 had three documented BPs outside the ordered parameters as follows: -On 01/24/19 the BP reading was 98/56. -On 01/26/19 the BP reading was 129/99. -On 01/27/19 the BP reading was 129/86. -On 01/28/19 the BP reading was 134/95. Review of Resident #2's February 2019 eMAR revealed: -There was an entry to check BP daily on first shift and notify the physician if BP greater than 140/85 or less than 100/50. -Resident #2 had eleven documented BPs outside the ordered parameters as follows: -On 02/04/19 the BP reading was 142/78. -On 02/10/19 the BP reading was 138/88. -On 02/11/19 the BP reading was 142/76. -On 02/14/19 the BP reading was 140/86. -On 02/15/19 the BP reading was 146/88. -On 02/16/19 the BP reading was 142/88. -On 02/20/19 the BP reading was 95/58. -On 02/22/19 the BP reading was 99/67. -On 02/25/19 the BP reading was 152/85. -On 02/26/19 the BP reading was 124/86. -On 02/26/19 the BP reading was 142/78. Review of Resident #2's March 2019 eMAR revealed: -There was an entry to check BP daily on first shift and notify the physician if BP greater than 140/85 or less than 100/50. -Resident #2 had seven documented BP's outside the ordered parameters. -On 03/05/19 the BP reading was 144/88. -On 03/07/19 the BP reading was 142/86. -On 03/08/19 the BP reading was 142/88. -On 03/10/19 the BP reading was 144/84. -On 03/11/19 the BP reading was 142/88.	{D 273}	See attached Karen Shaver 5-6-19	

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{D 273}	Continued From page 7 -On 03/14/19 the BP reading was 142/78. -On 03/15/19 the BP reading was 142/80. Review of Resident #2's care notes revealed no physician notification for the 21 BPs outside the ordered parameters from 01/24/19 through 03/15/19. Interview with Resident #2 on 03/15/19 at 3:55pm revealed: -Facility staff checked her BP daily. -She did not remember her BP results. Interview with the medication aide (MA) on 03/15/19 at 3:00pm revealed: -The Supervisor or Resident Care Coordinator (RCC) were responsible for physician notification of Resident #2's BP when results were outside of the ordered parameters. -Resident #2's BP was checked daily. -MAs were responsible for obtaining BPs. -She did not know about the ordered BP parameters for Resident #2. -She did not know there were several BPs requiring physician notification from January 2019 through March 2019. -The MA/RCC was responsible for physician notification via telephone of BPs outside of ordered parameters. -Physician telephone notification for Resident #2's BP should be documented in the care notes. -She never notified the physician for Resident #2's BPs. She must have overlooked the instructions on the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/15/19 at 10:26am revealed: -The MA or Supervisor were responsible for obtaining Resident #2's BP. -The MA, Supervisor or RCC were responsible for	{D 273}	See attached Karen Shaw 5-6-19		

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{D 273}	Continued From page 8 physician notification regarding Resident #2's BPs outside of ordered parameters. -She did not know there was BPs that required physician notification from January 2019 through March 2019. -If the PCP was notified regarding Resident #2's BP results, there should be documentation in the care notes. -The facility did not have a system to check and ensure the MAs contacted the PCP regarding Resident #2's BP results outside of ordered parameters. -The facility was not conducting MAR audits. Interview with the Executive Director on 03/15/19 at 6:30pm revealed: -The MA or Supervisor were responsible for obtaining Resident #2's BP daily. -She expected staff to notify Resident #2's physician for BPs outside the ordered parameters. -Staff were expected to document physician notification for Resident #2's BPs in the care notes. -If there was no documentation the physician was notified there was no way to know if the physician was notified. -She did not know Resident #2 had BP results requiring physician notification. -The facility was not conducting MAR audits. Interview with the Administrator on 03/18/19 at 1:55pm revealed: -The MA or RCC were responsible for obtaining Resident #2's BP and documenting on the eMAR. -If Resident #2's BP was outside of parameters the MA or RCC were responsible for physician notification. -He did not know Resident #2's BP was outside the parameters from January 2019 through	{D 273}	See attached Karen Shaw 5-6-19		

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{D 273}	Continued From page 9 March 2019. Interview with Resident #2's PCP on 03/18/19 at 5:55pm revealed: -She expected the staff to call her with BPs greater than 140/85 or less than 100/50. -She did not remember being notified in January, February, or March 2019 of BPs outside of ordered parameters. -She visited the facility every other week. -She reviewed BP results during visits. -Resident #2 was last seen two weeks ago and her BP was within normal limits. -If the facility had notified her of Resident #2's BPs outside of ordered parameters she could have adjusted BP medications. c. Review of Resident #2's current FL-2 dated 05/17/18 revealed an order for nyamyc 100,000 units/gram apply topically to abdominal skin folds twice a day. Review of Resident #2's January 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for nyamyc 100,000 units/gram apply topically to abdominal skin folds twice a day and scheduled for application at 9:00am and 9:00pm. -Nyamyc was not documented as applied for 15 of 62 opportunities. -Nyamyc was not documented as applied at 9:00am on 01/24/19, and on 01/30/19-01/31/19. -Nyamyc was not documented as applied at 9:00pm on 01/01/19-01/03/19, 01/05/19-01/06/19, 01/10/19-01/12/19, and on 01/25/19-01/28/19. -There was documentation nyamyc was not applied on the above dates for the reason the resident refused.	{D 273}	See attached Karen Shaw 5-6-19		

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{D 273}	Continued From page 10 Review of Resident #2's February 2019 eMAR revealed: -There was an entry for nyamyc 100,000 units/gram apply topically to abdominal skin folds twice a day and scheduled for application at 9:00am and 9:00pm. -Nyamyc was not documented as applied for 7 of 56 opportunities. -Nyamyc was not documented as applied at 9:00am on 02/01/19, 02/05/19-02/06/19 and on 02/28/19. -Nyamyc was not documented as applied at 9:00pm on 02/04/19, 02/07/19 and on 02/28/19. -There was documentation nyamyc was not applied on the above dates for the reason the resident refused. Review of Resident #2's March 2019 eMAR revealed: -There was an entry for nyamyc 100,000 units/gram apply topically to abdominal skin folds twice a day and scheduled for application at 9:00am and 9:00pm. -Nyamyc was not documented as applied for 5 of 14 opportunities. -Nyamyc was not documented as applied at 9:00am on 03/01/19, and on 03/05/19-03/06/19. -Nyamyc was not documented as applied at 9:00pm on 03/04/19 and on 03/07/19. -There was documentation nyamyc was not applied on the above dates for the reason the resident refused. Review of Resident #2's record revealed no documentation Resident #2's provider was notified of the 27 refused doses of nyamyc. Interview with Resident #2 on 03/15/19 at 3:55pm revealed: -Staff administer all medications.	{D 273}	See attached Karen Shaw 5-6-19		

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{D 273}	Continued From page 11 -She did not remember refusing nyamyc. Interview with a medication aide (MA) on 03/15/19 at 3:00pm revealed: -Resident #2 refused nyamyc often. -After a resident refused a medication three times the physician should be notified. -Physician notification should be documented in the care notes. -She did not remember if she notified the physician regarding Resident #2's refusal of nyamyc or not. -Many staff did not take the time to document physician notification in the care notes. -Without documentation in the resident care notes there was no way to show the physician was notified regarding refusals. Telephone interview with the facility's contracted pharmacy on 03/18/19 at 1:20pm revealed nyamyc (15 gram bottle) was dispensed on 02/28/19. Interview with the Resident Care Coordinator (RCC) on 03/15/19 at 10:26am revealed: -The RCC was responsible for eMAR audits. -She had not performed eMAR audits since employed at the facility. -She did not know Resident #2 was refusing nyamyc. -The physician should have been notified after the resident refused nyamyc three times. -The Supervisor or RCC were responsible for physician notification regarding medication refusals. -Physician notification should be documented in the resident care notes and without documentation there was no way to show the physician was notified.		{D 273}	<i>See attached</i> <i>Haren Shaver</i> <i>5-6-19</i>	

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{D 273}	Continued From page 12 Interview with the Executive Director on 03/15/19 at 6:30pm revealed: -The Supervisor was responsible for physician notification for medication refusals. -Staff should notify the physician after three refusals. -When staff notified the physician there should be a note documented in the resident care notes. -She did not know Resident #2 had been refusing nyamyc. Interview with the Administrator on 03/18/19 1:55pm revealed: -The physician should be notified if a resident continued to refuse a medication. -Staff were expected to document any physician notification in the care notes. -He did not know Resident #2 was refusing nyamyc. Telephone interview with Resident #2's primary care provider on 03/18/19 at 5:08pm revealed: -She did not know Resident #2 was refusing nyamyc. -She expected staff to make her aware of medication refusals. -If the staff had notified her she could have changed the nyamyc to a different route of administration or discontinued the medication. -If the resident had yeast that went untreated Resident #2 could get cellulitis secondary to yeast. 2. Review of Resident #3's current FL2 dated 12/17/18 revealed diagnoses included pneumonia, lung mass, chronic obstructive pulmonary disease exacerbation, chronic hypoxia, hypertension, hyperglycemia, and generalized anxiety disorder.		{D 273}	See attached Karen Shaver 5-6-19	

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{D 273}	Continued From page 13 a. Further review of Resident #3's current FL2 dated 12/17/18 revealed: -There was a medication order for Lisinopril 10 mg one tablet daily (a medication used to treat high blood pressure). Review of Resident #3's signed physician's orders dated 02/14/19 revealed an order to check blood pressure BP once daily and notify the primary care provider (PCP) if systolic BP (SBP) was greater than 140 or if diastolic BP (DBP) was greater than 85. Review of Resident #3's eMAR for February 2019 revealed: -There was an entry to check and record BP between 7:00am and 3:00pm and notify the primary care physician (PCP) if SBP was greater than 150 or the DBP was greater than 90. -There was no entry on the eMAR to check and record BP and notify the PCP if the SBP was over 140 or if the DBP was greater than 85. -There were nine of twenty-eight BP readings outside of the ordered parameters as follows: -On 02/15/19, the BP reading was 132/88. -On 02/17/19, the BP reading was 138/86. -On 02/18/19, the BP reading was 136/86. -On 02/21/19, the BP reading was 133/95. -On 02/22/19, the BP reading was 142/106. -On 02/23/19, the BP reading was 128/88. -On 02/25/19, the BP reading was 142/79. -On 02/26/19, the BP reading was 148/96. -On 02/27/19, the BP reading was 124/101. Review of Resident #3's eMAR for March 2019 revealed: -There was an entry to check and record BP between 7:00am and 3:00pm and notify the primary care physician (PCP) if SBP was greater	{D 273}	See attached Karen Shaver 5-6-19		

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{D 273}	Continued From page 14 than 150 or the DBP was greater than 90. -There was no entry to check and record BP and notify the PCP if the SBP was over 140 or if the DBP was greater than 85. -There were nine of fifteen BP readings outside of the ordered parameters as follows: -On 03/01/19, the BP reading was 157/70. -On 03/02/19, the BP reading was 169/89. -On 03/03/19, the BP reading was 156/98. -On 03/04/19, the BP reading was 172/89. -On 03/06/19, the BP reading was 142/88. -On 03/08/19, the BP reading was 142/84. -On 03/09/19, the BP reading was 146/79. -On 03/10/19, the BP reading was 149/96. -On 03/12/19, the BP reading was 138/88. Review of Resident #3's Care Notes revealed no documentation the PCP had been notified of the 18 BPs outside of ordered parameters in January, February, or March 2019. Interview with Resident #3 on 03/15/19 at 10:38am revealed: -She had been getting her BP checked daily for a long time because she had high blood pressure. -The MAs checked her BP daily, but she was not told when her BP was high. Interview with a medication aide (MA) on 03/15/19 at 2:53pm revealed: -She knew Resident #3 had an order to check her BP daily and notify the PCP if the BP was outside of the ordered parameters. -The parameters were difficult to read in the eMAR system. -She did not know what Resident #3's BP parameters were without looking at the eMAR. -The MA supervisors or the Resident Care Coordinator (RCC) were responsible for contacting the physician and documenting in the	{D 273}	See attached Karen Shaver 5-6-19		

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{D 273}	Continued From page 15 care notes when a resident's BP was above the ordered parameters. -She did not remember Resident #3's BP being above the parameters when she checked it and she had never contacted Resident #3's PCP regarding blood pressures. -She did not know why there were no notes documenting BPs above the parameter and PCP was contacted. -"It must have got over looked." Interview with the Executive Director (ED) on 03/15/19 at 6:39pm revealed: -She would expect for the MAs to contact a resident's physician if their BP was over the ordered parameters. -Documentation of contact with the physician regarding BPs should be in the care notes. -She did not know Resident #3 had parameters for BP. -"I'm sure the doctor was not called." Interview with the RCC on 03/15/19 at 7:22pm revealed: -She did not know Resident #3's BP parameters without looking at the eMAR and did not know of any changes to BP parameters for Resident #3. -She did not know Resident #3's BP had been above the parameters and there was no documentation the PCP had been contacted. -The MA supervisors were responsible for contacting the PCP when BPs were above the parameters. -The MA supervisors were responsible for documenting in the care notes if the BP was elevated and the PCP had been contacted. Interview with a MA on 03/18/19 at 11:46am revealed: -The MAs were responsible for checking BPs.	{D 273}	See attached Karen Shaver 5-6-19		

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STATE FORM

6809

VX5P13

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{D 273}	Continued From page 16 -She had not seen the parameters for BP for Resident #3. -The MAs and supervisors were responsible for contacting the PCP regarding issues with BPs and it should be documented in the care notes. -She was not sure if she had ever contacted the PCP regarding BPs. Interview with the Administrator on 03/18/19 at 1:55pm revealed: -The RCC, MA supervisors, or MAs were responsible for checking BPs. -He did not know about Resident #3 having BP readings greater than the ordered parameters until 03/15/19. -Staff should have contacted the physician regarding elevated BP according to the physician's orders and document on the eMAR and in the resident's record. -He expected all treatment orders to be completed as ordered. Interview with Resident #3's PCP on 03/18/19 at 4:03pm revealed: -She expected to be contacted by the facility if Resident #3's BP was greater than 140/85. -The facility had not contacted her regarding any BPs. b. Review of Resident #3's current FL-2 dated 12/17/18 revealed an order for Alphagen P instill one drop twice daily to both eyes. Review of Resident #3's electronic Medication Administration Record (eMAR) for January 2019 revealed: -There was an entry for Alphagen P eye drops instill one drop in both eyes twice a day and scheduled for administration at 8:00am and 8:00pm.	{D 273}	See attached Karen Shaver 5-6-19		

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{D 273}	Continued From page 17 -Alphagen P was not documented as administered for 11 of 14 opportunities on the following dates: 01/25/19 at 8:00am and 8:00pm; 01/26/19 at 8:00am and 8:00pm; 01/27/19 at 8:00pm; 01/29/19 at 8:00am and 8:00pm; 01/30/19 at 8:00am and 8:00pm; and 01/31/19 at 8:00am and 8:00pm. -There was documentation Alphagen P was not administered for the reasons, "Patient unable to take medication" and "Waiting on pharmacy." Review of Resident #3's eMAR for February 2019 revealed: -There was an entry for Alphagen P eye drops instill one drop in both eyes twice a day and scheduled for administration at 8:00am and 8:00pm. -Alphagen P was not documented as administered for 17 of 22 opportunities on the following dates: 02/01/19 through 02/07/19 at 8:00am and 8:00pm; 02/08/19 and 02/10/19 at 8:00am; and 02/11/19 at 8:00pm. -There was documentation Alphagen P was not administered for the reasons, "Patient unable to take medication" and "Waiting on pharmacy." Review of Resident #3's care notes revealed no documentation the PCP or ophthalmologist had been notified of Resident #3 was not administered Alphagen P eye drops 28 times in January or February 2019. Interview with Resident #3 on 03/15/19 at 10:50am revealed: -She received one eye drop in the morning and two different eye drops in the evening. -She did not get her eye drops for about two weeks, but did not remember when or why she did not get them..	{D 273}	See attached Karen Shaver 5-6-19		

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{D 273}	Continued From page 18 Interview with a medication aide (MA) on 03/15/19 at 2:53pm revealed: -She remembered Alphagan P eye drops not being administered to Resident #3 in January and February 2019 because staff was waiting on the pharmacy to send. -She would have normally told an RCC, but there was not an RCC employed at the facility during that time. -She did not know what the hold-up was with the pharmacy. -She did not know why she had not contacted the primary care provider (PCP) when the eye drops were not administered. Interview with Resident #3's ophthalmologist's office on 03/15/19 at 3:54pm revealed: -The office had not been contacted regarding Resident #3 not being administered eye drops for 28 times between 01/25/19 and 02/11/19. -Resident #3 was seen in the office on 03/15/19. Interview with the contracted pharmacy on 03/15/19 at 3:59pm revealed: -There was an order for Alphagan P instill one drop in both eyes twice a day. -The Alphagan P was not on a cycle fill and had to be requested by the facility. -There was a request to refill Alphagan P on 01/23/19 and it was delivered to the facility on 01/24/19. -There was another request to refill Alphagan P on 01/29/19, but the pharmacy did not dispense, because it had been delivered to the facility on 01/24/19. -Alphagan P was also dispensed on 02/13/19 and on 03/05/19. Interview with the Executive Director (ED) on 03/18/19 at 6:05pm revealed:	{D 273}	<i>See attached Karen Shaver 5-6-19</i>	

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{D 273}	Continued From page 19 -She did not know Resident #3 did not receive her eye drops as ordered by the physician for 28 times between 01/25/19 and 02/11/19. -She expected the MA supervisor or RCC to contact the physician regarding medication not being administered and document in the care notes. -She thought staff may have gotten the eye drops in from the pharmacy and put them in the medication cart without notifying the incoming staff the eye drops came in from the pharmacy. Interview with the Resident Care Coordinator (RCC) on 03/15/19 at 7:22pm revealed: -She did not know Resident #3's eye drops were not documented as administered for 28 times between 01/25/19 and 02/11/19. -The MAs or supervisors were responsible for contacting the physician when medication was not administered as ordered and documenting in the resident's care notes. Interview with a MA on 03/18/19 at 11:46am revealed: -Alphagen P eye drops were not administered for sixteen days between 01/24/19 and 02/11/19 because they were not in the facility. -She contacted the pharmacy regarding the eye drops, but did not contact Resident #3's ophthalmologist or PCP to let them know eye drops had not been administered. -She did not remember when she contacted the pharmacy and did not remember if she documented contacting the pharmacy. -Any documentation of contacts with physicians should be in the care notes. Interview with the Administrator on 03/18/19 at 1:55pm revealed: -The RCC or MA would be responsible for	{D 273}	See attached Karen Shaw 5-6-19		

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{D 273}	Continued From page 20 notifying the physician and documenting when medication was not administered. -He did not know until 03/15/19 Resident #3 did not receive her eye drops as ordered. -He expected for medication to be administered as ordered. The facility failed to notify the primary care providers for 2 of 3 sampled residents regarding notification of 18 fingerstick blood sugars (FSBS) greater than 350 placing the resident at increased risk for chronic hyperglycemia and 27 refused doses of an antifungal medication (Resident #2), an eye drop not available for administration with no documentation for administration 28 times between 01/25/19 to 02/11/19 (#2), and 21 blood pressure results outside of ordered parameters between 01/10/19 to 03/15/19 (Resident #2) and 18 blood pressure results outside of ordered parameters between January, February and March 2019 (Resident #3) placing the residents at increased risk for organ damage or stroke. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Continuing Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/15/19.	{D 273}	See attached Karen Shaw 5-6-19	
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or	{D 276}		

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{D 276}	Continued From page 21 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 3 of 3 sampled residents (Resident #1, #2, and #3) related to orders for continuous positive airway pressure (CPAP) and blood pressures (BP) (#3); orders for laboratory tests regarding an antipsychotic medication (#2); and orders for finger stick blood sugars (FSBS) and continuous oxygen (#1). The findings are: 1. Review of Resident #3's current FL2 dated 12/17/18 revealed diagnoses included pneumonia, lung mass, chronic obstructive pulmonary disease exacerbation, chronic hypoxia, hypertension, hyperglycemia, and generalized anxiety disorder. a. Further review of Resident #3's current FL2 dated 12/17/18 revealed there was no order listed on the FL2 for a CPAP. Review of Resident #3's physician's order dated 12/21/18 revealed an order to restart CPAP. Review of Resident #3's electronic Medication	{D 276}	See attached Karen Shauky 5-6-19		

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{D 276}	Continued From page 22 Administration Records (eMARs) and electronic Treatment Administration Record (eTAR) for January, February, and March 2019 revealed there was no entry for CPAP on either eMAR or eTAR. Observation of Resident #3's room on 03/14/19 at 4:34pm revealed: -There was a CPAP machine covered in a layer of dust sitting on the floor beside Resident #3's bed. -There was an oxygen mask lying on the floor beside the CPAP machine with tubing attached. -There was no power cord attached to the CPAP machine. -Resident #3 was present and did not exhibit any difficulty breathing or shortness of breath. Interview with Resident #3 on 03/15/19 at 10:38pm revealed: -She used to use the CPAP machine, but it was torn up and beeped when it was turned on. -She had not used the CPAP machine in about six months. -"They know it beeps and I don't know what to do to get it stopped." -"The CPAP machine helped her with breathing." Interview with a representative from the contracted pharmacy on 03/15/19 at 11:04am revealed: -The pharmacy did not have any physician orders for a CPAP. -The pharmacy was responsible for entering all medication orders on the eMAR and the facility was responsible for entering treatment orders which would show up on the eTAR. -She did not see where CPAP had been entered onto the eTAR by the facility staff. Interview with a medication aide (MA) on	{D 276}	See attached Karen Shaver 5-6-19		

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{D 276}	Continued From page 23 03/15/19 at 2:53pm revealed: -The Resident Care Coordinator (RCC) and MA supervisors were responsible for reviewing new orders and sending them to the pharmacy. -She knew Resident #4 had a CPAP machine, but she had not used it for months because air seeped from around the mask. -She thought the orders for the CPAP had been discontinued since it was not on the eMAR -She did not know about the physician's order dated 12/21/19 for Resident #3 to restart the CPAP. Interview with the Executive Director on 03/15/19 at 6:37 pm revealed: -The RCC and the MA supervisors were responsible for reviewing new orders and making sure they were implemented. -She did not know about the physician's order dated 12/21/18 for Resident #3 to restart CPAP. -She did not know if Resident #3 was not using the CPAP machine as ordered by the physician. Interview with the RCC on 03/15/19 at 7:22pm revealed: -She did not know if Resident #3 currently used her CPAP machine or not. -She did not know about the physician's order dated 12/21/19 for Resident #3 to restart CPAP. -The RCC and the MA supervisors were responsible for reviewing new orders and making sure they were implemented. -The RCC was responsible for conducting record audits, but she had not conducted one since she started worked at the facility in February 2019. -She did not know when a record audit was last completed. Interview with a MA on 03/18/19 at 9:28am revealed:	{D 276}	<i>See attached</i> <i>Baren Shaw</i> <i>5-6-19</i>	

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{D 276}	Continued From page 24 -She knew Resident #3 had a CPAP machine, but she would not wear it. -She did not know if the CPAP machine was working properly or not. -If the CPAP machine was not working properly, it would be the RCC's or the Executive Director's responsibility to make sure it was repaired. -She did not know if anyone told the RCC or the Executive Director the CPAP machine was not working properly. -She thought Resident #3 last wore the CPAP over six months ago. -She used to document Resident #3's use of the CPAP on the eMAR, but she had not seen the CPAP listed on the eMAR in a while. Attempted telephone interview with Resident #3's pulmonologist on 03/18/19 at 11:02am was unsuccessful. Interview with a second MA on 03/18/19 at 11:46am revealed: -The RCC was responsible for reviewing new orders when they came into the facility and the RCC or MA would fax the new orders to the pharmacy. -She had not seen an order for Resident #3 to wear a CPAP and the CPAP order was not on the eMAR. -She had never seen Resident #3 wear the CPAP. Interview with the Administrator on 03/18/19 at 1:55pm revealed: -The RCC was responsible for reviewing new orders when they came into the facility and faxing them to the pharmacy. -He did not know until 03/15/19 Resident #3 was not using CPAP as ordered. -He expected treatment orders to be completed	{D 276}	See attached Karen Shaw 5-6-19		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{D 276}	Continued From page 25 as ordered. Interview with the primary care physician (PCP) on 03/18/19 at 4:03pm revealed: -She knew Resident #3 had CPAP ordered by the pulmonologist, but she thought Resident #3 had been refusing to wear the CPAP. -She sent Resident #3 to the pulmonologist due to her respiratory status. -She expected Resident #3 to use the CPAP as ordered by the pulmonologist. b. Review of Resident #3's current FL2 dated 12/17/18 revealed: -There was no order to check blood pressure (BP) listed on the FL2. -There was a medication order for Lisinopril 10 mg one tablet daily (a medication used to treat high blood pressure). Review of Resident #3's signed physician's orders dated 2/14/19 revealed: -There was an order to discontinue Lisinopril. -There was an order to check blood pressure BP once daily and notify the primary care provider (PCP) if systolic BP (SBP) was greater than 140 or if diastolic BP (DBP) was greater than 85. Review of Resident #3's electronic Treatment Administration Record (eTAR) for February 2019 revealed: -There was an entry to check and record BP between 7:00am and 3:0 pm and notify the primary care physician (PCP) if SBP was greater than 150 or the DBP was greater than 90. -There was no entry to check and record BP and notify the PCP if the SBP was over 140 or if the DBP was greater than 85. -Resident #3's SBP ranged from 124 to 148 and the DBP ranged from 66 to 100.	{D 276}	See attached Karen Shaver 5-6-19		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621			
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(D 276)	Continued From page 26 Review of Resident #3's eTAR for March 2019 revealed: -There was an entry to check and record BP between 7:00am and 3:00pm and notify the primary care physician (PCP) if SBP was greater than 150 or the DBP was greater than 90. -There was no entry to check and record BP and notify the PCP if the SBP was over 140 or if the DBP was greater than 85. -Resident #3's SBP ranged from 120 to 169 and the DBP ranged from 70 to 96. Interview with Resident #3 on 03/15/19 at 10:38am revealed: -She had been getting her BP checked daily for a long time because she had high blood pressure. -The MAs checked her BP daily, but she was not told when her BP was high. Interview with a representative from the contracted pharmacy on 03/15/19 at 11:04am revealed: -The pharmacy was responsible for entering all medication orders on the eMAR and the facility was responsible for entering treatment orders including BP checks which would show up on the eTAR. -The latest order on the eTAR was dated 07/30/15 to check BP daily and notify PCP if greater than 150/90. Interview with a medication aide (MA) on 03/15/19 at 2:53pm revealed: -She knew Resident #3 had an order to check her BP daily and notify the PCP if the BP was outside of the ordered parameters. -The parameters were difficult to read in the eMAR system. -She administered medication and treatments	(D 276)	See attached Karen Shaver 5-6-19		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 276}	Continued From page 27 according to what was on the eMAR. -She did not know what Resident #3's BP parameters were without looking at the eMAR or if there had been any recent changes in the BP order. -She did not remember Resident #3's BP reading being outside of the ordered parameters. -She had never contacted Resident #3's PCP regarding BP readings outside of the parameters. -The Resident Care Coordinator (RCC) and MA supervisors were responsible for reviewing new orders and sending them to the pharmacy to be updated on the eMAR. Interview with the Executive Director (ED) on 03/15/19 at 6:39pm revealed: -The RCC and the MA supervisors were responsible for reviewing new orders and making sure they were implemented. -She did not know there was an order dated 02/14/19 to check and record BP and notify the PCP if the SBP was over 140 or if the DBP was greater than 85. -She expected treatment orders to be implemented as ordered by the physician. Interview with the RCC on 03/15/19 at 7:22pm revealed: -The RCC and the MA supervisors were responsible for reviewing new orders and making sure they were implemented. -The RCC or MA supervisors were responsible for entering treatment orders onto the eTAR. -She did not know Resident #3's BP parameters without looking at the eTAR and did not know Resident #3's BP orders were changed on 02/14/19. -She did not know why the BP orders to contact PCP if BP was over 140/85 was not entered on the eTAR.	{D 276}	See attached Karen Shaver 5-6-19		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621	
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{D 276}	Continued From page 28 Interview with a MA on 03/18/19 at 11:46am revealed: -The RCC was responsible for reviewing new orders and the RCC or MA would fax the new orders to the pharmacy. -The MAs were responsible for checking BPs. -She had not seen the parameters for BP for Resident #3 and did not know if there had been any changes to Resident #3's BP parameters. Interview with the Administrator on 03/18/19 at 1:55pm revealed: -The RCC was responsible for reviewing new orders and faxing them to the pharmacy. -The RCC, MA supervisors, or MAs were responsible for checking BPs and following physician's orders. -He expected all treatment orders to be completed as ordered. Interview with the PCP on 03/18/19 at 4:03pm revealed: -She changed the order for BP checks with parameters when she discontinued the Lisinopril for Resident #3. -She did not know Resident #3's BP had been outside the parameters of 140/85. -She expected the facility to follow the order dated 02/14/19 and to contact her if Resident #3's BP was greater than 140/85. 2. Review of Resident #2's current FL2 dated 12/06/18 revealed: -The diagnoses included gastroesophageal reflux disease, hypertension, anxiety, type II diabetes mellitus, schizophrenia, congestive heart failure, and chronic obstructive pulmonary disease. -There was an order for divalproex 500 mg (used	{D 276}	<i>See attached</i> <i>Karen Shaver</i> <i>5-6-19</i>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 276}	Continued From page 29 to treat mental health disorders like schizophrenia) two times a day. Review of Resident #2's physician orders dated 01/07/19 revealed: -There was an order for divalproex 500 mg every morning, 250mg at 3:00pm, and 500mg at bedtime. -There was an order to obtain a valproic acid level (VPA) (a blood test that reflects the level of valproic acid in the system and is essential to monitor to ensure therapeutic levels of the medication and avoid toxicity). Review of Resident #2's laboratory results revealed there were no results for the VPA level ordered 01/07/19. Interview with Resident #2 on 03/15/19 at 3:55pm revealed she knew home health obtained labs on her every week, but she did not know if a VPA level was drawn in January 2019. Interview with a medication aide (MA) on 03/15/19 at 3:00pm revealed: -Home Health (HH) drew all labs for Resident #2. -The Resident Care Coordinator (RCC) was responsible for assuring labs were drawn and faxed the labs to the pharmacy. -She did not know Resident #2's VPA level ordered 01/07/19 was not obtained. Interview with the RCC on 03/18/19 at 4:49pm revealed: -The Supervisor or RCC were responsible for faxing lab orders to the HH agency and assuring the labs were obtained. -The RCC was responsible for conducting eMAR audits and she had not completed eMAR audits since starting at the facility on 02/25/19.	{D 276}	See attached Karen Shaver 5-6-19	

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STATE FORM

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VX5P13

If continuation sheet 30 of 88

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621			
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{D 276}	Continued From page 30 -The MA or RCC were responsible for faxing lab orders to the HH agency. -The RCC was responsible for assuring the labs were drawn. -She did not know why the VPA level ordered 01/07/19 was not obtained. Interview with the Executive Director on 03/18/19 at 5:55pm revealed: -The RCC was responsible for faxing the lab order to the HH agency and assuring the labs were obtained. -She thought the lab order may have remained in the wall folder and was not faxed to the HH agency as ordered. Interview with the Administrator on 03/18/19 at 1:55pm revealed: -The RCC was responsible for assuring labs were obtained as ordered. -He did not know Resident #2's VPA level ordered 01/07/19 was not obtained. Interview with a representative from the contracted HH agency on 03/18/19 at 2:24pm revealed: -She obtained a VPA level on 03/15/19 (37.8) (Therapeutic range for valproic acid (total) is 50-125 µg/mL.) -The last VPA prior to 03/15/19 was obtained on 11/28/18 (45.7). -The HH did not receive the order for a VPA level on 01/07/19. Telephone interview with Resident #2's primary care provider on 03/18/19 at 5:08pm revealed: -She did not know Resident #2's VPA level was not obtained after the order was written on 01/07/19. -She expected staff to ensure labs were obtained	{D 276}	See attached Karen Sharver 5-6-19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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(D 276)	Continued From page 31 as ordered. -The divalproex dosage depended on the VPA level. -If the VPA was not obtained, the divalproex could be out of the therapeutic level. -If Resident #2's VPA was not therapeutic there could be behavior changes. 3. Review of Resident # 's current FL2 dated 02/20/19 revealed diagnoses included hypercapnic hypoxemic respiratory failure, chronic obstructive pulmonary disease exacerbation, bibasilar pneumonia, history of coronary artery disease, history of hypertension, diabetes, spinal stenosis, obstructive sleep apnea, and altered mental status/resolving. a. Further review of Resident #1's current FL2 dated 02/20/19 revealed a physician's order for fingerstick blood sugars four times a day, before meals, at night, and as needed. Review of Resident # 's February 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check fingerstick blood sugars on Monday and Friday at 7:00 am, the order was dated 09/20/18. -There was documentation FSBS were obtained from 02/01/19 to 02/28/19 at 7:00 am. -Resident #1's FSBS ranged from 160 to 247. Review of Resident # 's March 2019 (eMAR) revealed: -There was an entry to check fingerstick blood sugars on Monday and Friday from 03/01/19 through 03/12/19 at 7:00 am. -There was an entry to check fingerstick blood	(D 276)	See attached Karen Shaw 5-6-19		

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E OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621
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{D 276} Continued From page 32

sugars four times a day beginning 03/13/19 at
7:00am, 11:30am, 4:30pm, and 8:00pm.

Interview with Resident #1 on 03/14/19 at
11:00am revealed:

-He had been in the hospital with pneumonia and
had returned to the facility on 02/20/19.

-The medication aides were checking his blood
sugar before meals and at night as of yesterday
(03/13/19), but before that, they were checking it
twice per week.

-He did not know the physician at the hospital had
ordered his blood sugar to be checked four times
a day when he returned from the hospital.

Telephone interview with a medication aide (MA)
on 03/18/19 at 12:15pm revealed:

-She checked Resident #1's FSBS twice daily
during her shift.

-She had never added fingerstick blood sugars to
the eMAR as she did not know how and thought
the pharmacy entered all orders.

-She thought before Resident # went to hospital,
his blood sugar was checked one time a day.

-She thought fingerstick blood sugars had been
increased to three times a day and one time at
night, but she was unsure when this happened.

-The order for the increase in checking blood
sugars had been entered on the eMAR one day
last week.

Interview with the Executive Director on 03/18/19
at 6:00pm revealed:

-She did not know why the order for the increase
in finger stick blood sugars was not entered on
the eMAR or eTAR until 03/13/19.

-The physician had not been notified of the finger
stick blood sugars not being started until 03/13/19
when the original order was dated 02/20/19.

{D 276}

See attached
Baren Shaver
5-6-19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 276}	Continued From page 33 b. Review of Resident #1's current FL2 dated 02/20/19 revealed: -Resident #1 was semi-ambulatory and used a manual wheelchair as an assistive device. -There was a physician's order for oxygen at 3 liters per minute (L/m) continuous. Review of Resident #1's hospital discharge summary dated 02/20/19 revealed: -Resident #1's date of admission was on 02/12/19. -Resident #1's date of discharge was on 02/20/19 -Resident #1 was admitted with acute respiratory failure secondary to chronic obstructive pulmonary disorder exacerbation and possible pneumonia. -He was discharged from the hospital with continuous oxygen at 3 L/m, which was ordered by the physician at the hospital, and delivered to the facility by the local medical equipment company. Observation of Resident #1 on 03/14/19 at 11:00am revealed: -He was wearing a nasal cannula with oxygen from the concentrator set at 3 L/m. -He was not having any difficulty with breathing. Interview with Resident #1 on 03/14/19 at 11:00am revealed: -He had been in the hospital in February 2019 and had returned to the facility on 02/20/19. -He did not have oxygen before going to the hospital. -He was sent home from the hospital with oxygen at 3 L/m. -He knew that he was supposed to use oxygen continuous, but he used it when he needed it. -The staff had told him that he needed a portable oxygen tank on the back of his wheelchair to use	{D 276}	See attached Harun Shauy 5-6-19		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621

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{D 276}	Continued From page 35 medication administration or tar administration records. -She did not know why oxygen at 3 L/m was not entered on the February 2019 eTAR. -She entered oxygen at 3 L/m continuous to the eTAR on 03/12/19. -Resident #1 had been wearing oxygen intermittently since she began working in February 2019. -The physician had not been notified Resident #1 was not wearing oxygen at 3 L/m continuous. Interview with the Executive Director on 03/18/19 at 6:00 pm revealed: -She did not know why oxygen was not entered on the eMAR or eTAR upon Resident #1's return from the hospital on 02/20/19. -She did not know why oxygen was not entered on the eTAR until 03/12/19. -She knew that Resident #1 had been wearing oxygen in his room when he would come in from smoking or when he was short of breath, and she did not know if the physician had been informed that the resident was not using the oxygen continuous. The facility failed to assure implementation of physician's orders for 3 of 3 residents (Residents #1, #2, and #3) with orders for continuous positive airway pressure (CPAP) and an order for daily blood pressures with parameters resulting in blood pressures not obtained between February and March 2019 for a resident with diagnoses of chronic obstructive pulmonary disease and hypertension (#3); laboratory tests to monitor the level of valproic acid necessary for ordering dosage changes of an antipsychotic medication with results less than therapeutic ranges which could result in possible behavioral changes (#2); and finger stick blood sugars ordered 4 times	{D 276}		

*See attached
Karen Shaw
5-6-19*

Division of Health Service Regulation

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{D 276}	Continued From page 36 daily and were obtained only 1 time daily from 02/01/19 to 02/28/19 and an order for continuous oxygen being utilized as needed by a resident with diagnoses of hypercapnic hypoxemic respiratory failure, chronic obstructive pulmonary disease exacerbation, bibasilar pneumonia, obstructive sleep apnea, and diabetes (#1). The facility's failure to implement physician's orders for residents was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 04/12/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2019.	{D 276}	See attached Karen Shaw 5-6-19		
{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.	{D 358}			

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{D 358}	Continued From page 37 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, and #3) in regards to a medication used to treat chronic obstructive pulmonary disease and a medication used to treat glaucoma (#3), an antipsychotic medication (#2), and an antibiotic and a steroid (#1). The findings are: 1. Review of Resident #3's current hospital FL2 dated 12/17/18 revealed diagnoses included pneumonia, lung mass, chronic obstructive pulmonary disease (COPD) exacerbation, chronic hypoxia, hypertension, hyperglycemia, and generalized anxiety disorder. a. Further review of Resident #3's FL2 dated 12/17/18 revealed there was an order for ipratropium bromide albuterol sulfate (Duoneb) inhale one vial four times daily (a medication used to treat symptoms of COPD). Review of Resident #3's pulmonologist physician's order dated 12/21/18 revealed there was an order to continue duonebs as needed. Review of Resident #3's electronic Medication Administration Record (eMAR) for January 2019 revealed: -There was an entry for duoneb one vial via nebulizer at 8:00am, 12:00pm, 4:00pm and 8:00pm (scheduled times of administration and	{D 358}	See attached Karen Shaver 5-6-19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
{D 358}	Continued From page 38 not as needed). -Scheduled duoneb was documented as administered 123 out of 124 opportunities on the following dates: 01/01/19 through 01/09/19 at 8:00 am, 12:00pm, 4:00pm; 01/10/19 at 8:00am, 4:00pm, and 8:00pm; and 01/11/19 through 01/31/19 at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was an entry for duoneb one vial every four hours as needed. -There were no as needed doses of duoneb documented as administered. Review of Resident #3's eMAR for February 2019 revealed: -There was an entry for duoneb one vial via nebulizer at 8:00am, 12:00pm, 4:00pm and 8:00 pm (scheduled times of administration and not as needed). -Scheduled duoneb was documented as administered 110 out of 112 opportunities on the following dates: 02/01/19 through 02/9/19 at 8:00am, 12:00pm, 4:00pm, and 8:00pm; 02/20/19 at 4:00pm and 8:00pm; and 02/21/9 through 02/28/19 at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was an entry for duoneb one vial every four hours as needed. -There were no as needed doses of duoneb documented as administered. Review of Resident #3's eMAR for March 2019 revealed: -There was an entry for duoneb one vial via nebulizer at 8:00am, 12:00pm, 4:00pm and 8:00pm (scheduled times and not as needed). -Scheduled Duoneb was documented as administered 52 out of 54 opportunities on the following dated: 03/01/19 through 01/04/19 at 8:00am, 12:00pm, 4:00pm, and 8:00pm, 03/05/19	{D 358}	See attached Karen Shawee 5-6-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{D 358}	Continued From page 39 at 8:00am, 4:00pm, and 8:00pm; 03/06/19 at 8:00am, 12:00 pm, 4:00pm, and 8:00pm; 03/07/19 at 12:00pm 4:00pm, and 8:00pm, 03/18/19 through 03/13/19 at 8:00am, 12:00pm, 4:00pm, and 8:00pm; and 03/14/19 at 8:00am and 12:00pm. -There was an entry for duoneb one vial every four hours as needed. -There were no as needed doses of duoneb documented as administered. Observation of Resident #3's medication on hand on 03/15/19 at 10:58am revealed: -There were two vials of duoneb available for administration. -The package was labeled: inhale one vial via nebulizer every four hours as needed and 30 vials were dispensed on 01/23/19. -Duoneb every four hours scheduled was not available in the facility for administration. Interview with Resident #3 on 3/15/18 at 10:38am and 10:50am revealed: -She received nebulizer treatments four times daily. -She could request a nebulizer treatment if she was having "bad" breathing. -She did not know when she last had difficulty breathing and did not know if there had been any changes in her medication. Interview with the pulmonologist assistant at Resident #3's pulmonologist's office on 03/18/18 at 11:02am revealed: -Resident #3 had current nebulizer treatment orders dated 02/21/19 for duoneb four times daily as needed and two other routine pulmonary medications. -She did not know duonebs were being administered to Resident #3 four times daily.	{D 358}	See attached Karen Shaver 5-6-19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621			
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{D 358}	Continued From page 40 routinely. -Duoneb should have only been used when Resident #3 was having difficulty breathing. -Regular use of duoneb could possibly increase the heart rate. Interview with a medication aide (MA) on 03/15/19 at 11:09am and 2:53pm revealed: -Resident #3 received duonebs four times daily. -She administered a duoneb vial to Resident #3 this morning at 8:00am. -She thought the last scheduled duoneb vial was administered on yesterday (03/14/19). -Sometimes MAs used the as needed duonebs when the scheduled duonebs ran low instead of reordering scheduled duonebs. -She usually tried to reorder medication when there was a week's worth of medication remaining in the facility. -She just went into the eMAR system to reorder the scheduled and as needed duonebs. -She did not know of any changes in the orders for duoneb. -The Resident Care Coordinator (RCC) and the MA supervisors were responsible for reviewing new orders and sending them to the pharmacy. -No facility staff had completed cart or record audits since she has been employed at the facility. -The pharmacy completed record audits, but she did not know how often. Interview with the Executive Director (ED) on 03/15/19 at 6:39pm revealed: -The RCC and the MA supervisors were responsible for reviewing new orders that came into the facility. -New medication orders were to be sent to the pharmacy to be added to the eMAR for medication administration.	{D 358}	<i>See attached</i> <i>Harun Shariq</i> <i>56-19</i>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
(D 358)	Continued From page 41 -She did not know of any changes in duoneb orders for Resident #3. -She expected for medication to be administered as ordered by the physician. Interview with the RCC on 03/15/19 at 7:22pm revealed: -The RCC and the MA supervisors were responsible for reviewing new orders and sending them to the pharmacy. -She did not know there were any new orders for duoneb for Resident #3. -She had not completed any record reviews and had not seen the new order for duoneb. Interview with a second MA on 03/18/19 at 11:46am revealed: -The RCC was responsible for reviewing new orders and the RCC or MA would fax the new orders to the pharmacy. -Resident #3 had orders for duoneb nebulizer treatments four times daily, but she was not sure whether or not she had orders for nebulizer treatments as needed. -She administered duoneb to Resident #3 during her shift. -She did not know of any changes in the order for duoneb for Resident #3. Interview with a representative from the contracted pharmacy on 03/18/19 at 1:44pm revealed: -There was an order dated 04/19/17 for duoneb inhale one vial four times daily. -Duoneb four times daily was last dispensed on 10/15/18 and 03/15/19 with one hundred and fifty vials. -There was an order dated 09/20/18 for duoneb four times daily as needed. -Duoneb four times daily as needed was last	(D 358)	See attached Karen Shaver 5-6-19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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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 358}	Continued From page 42 dispensed on 01/23/19, 02/19/19, and 03/04/09 with thirty vials. (There was no documented use of as needed duoneb.) Interview with the Administrator on 03/18/19 at 1:55pm revealed: -The RCC was responsible for reviewing new orders and faxing them to the pharmacy. -He expected all medication to be administered as ordered by the physician. b. Review Resident #3's current FL2 dated 12/17/18 revealed an order for Alphagan P instill one drop twice daily to both eyes. Review of Resident #3's electronic Medication Administration Record (eMAR) for January 2019 revealed: -There was an entry for Alphagan P eye drops instill one drop in both eyes twice a day at 8:00am and 8:00pm. -Alphagan P was documented as not administered for 11 of 14 opportunities on the following dates: 01/24/19 at 8:00am and 8:00pm; 01/25/19 at 8:00am and 8:00pm; 01/27/19 at 8:00pm; 01/29/19 at 8:00am and 8:00pm; 01/30/19 at 8:00am and 8:00pm; and 01/31/19 at 8:00am and 8:00pm. -There was documentation Alphagan P was not administered between 01/25/19 and 01/31/19 for the reasons, "Patient unable to take medication" and "Waiting on pharmacy." Review of Resident #3's eMAR for February 2019 revealed: -There was an entry for Alphagan P eye drops instill one drop in both eyes twice a day at 8:00am and 8:00pm. -Alphagan P was documented as not administered for 17 of 22 opportunities on the	{D 358}	<i>See attached</i> <i>Karen Shawe</i> <i>5-6-19</i>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621			
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{D 358}	Continued From page 43 following dates 02/01/19 through 02/07/19 at 8:00am and 8:00pm; 02/08/19 and 02/10/19 at 8:00am; and 02/11/19 at 8:00pm. -There was documentation Alphagan P was not administered between 01/25/19 and 01/31/19 for the reasons, "Patient unable to take medication" and "Waiting on pharmacy." Observation of Resident #3's medication on hand on 03/15/19 at 10:58am revealed: -There was one package of Alphagen-P eye drops available for administration . -The package was labeled: instill one drop in both eyes twice daily and was dispensed on 03/05/19. Interview with Resident #3 on 03/15/19 at 10:50am revealed: -She received one eye drop in the morning and two different eye drops in the evening. -She did not receive her eye drops for about two weeks, but did not remember when. Interview with a medication aide (MA) on 03/15/19 at 2:53pm revealed: -She remembered Alphagan P eye drops not being administered to Resident #3 in January and February 2019 because staff was waiting on the pharmacy to send. -She did not remember if she had contacted the pharmacy or not. -The MAs and the RCC were responsible for contacting the pharmacy regarding medications. -She did not know if anyone else contacted the pharmacy and did not know what the hold-up was with the pharmacy. -No one had completed an eMAR or cart audit since she has worked at the facility. Interview with an assistant at Resident #3's ophthalmologist's office on 03/15/19 at 3:54pm	{D 358}	See Attached Karen Shaver 5-6-19		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 358}	Continued From page 44 revealed: -Resident #3 was seen in the office on 03/15/19 and there were no current concerns. -Eye drops were expected to be administered as ordered. Interview with a representative from the contracted pharmacy on 03/15/19 at 3:59pm revealed: -There was an order dated 10/23/18 for Alphagan P instill one drop in both eyes twice a day. -There was a request to refill Alphagan P on 01/23/19 and it was delivered to the facility on 01/24/19. -There was another request to refill Alphagan P on 01/29/19, but the pharmacy did not dispense, because it had been delivered to the facility on 01/24/19. -Alphagan P was also dispensed on 02/13/19 and on 03/05/19. Interview with the Executive Director (ED) on 03/18/19 at 6:05pm revealed: -The MAs and supervisors were responsible for medication administration. -The MAs, supervisors, and the RCC were responsible for reviewing physician's orders that came into the facility and faxing them to the pharmacy to be updated on the eMAR. -She did not know Resident #3 did not receive her eye drops as ordered by the physician for fifteen days between 01/25/19 and 03/05/19. -She expected expected medication to be administered as ordered by the physician. Interview with the Resident Care Coordinator (RCC) on 03/15/19 at 7:22pm revealed: -She had not reviewed the eMARs since being employed at the facility and did not know Resident #3's eye drops were documented as not	{D 358}	See attached Karen Shaw 5-6-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 358}	Continued From page 45 administered for fifteen days between 01/25/19 and 02/11/19, -She did not know why the eye drops were not administered because she was not employed at the facility during that time. Interview with a second MA on 03/18/19 at 11:46am revealed: -Alphagan P eye drops were not administered for fifteen days between 01/25/19 and 03/05/19 because they were not in the facility. -She contacted the pharmacy regarding the eye drops, but did not know the eye drops had been delivered to the facility. -There was no process to ensure all MAs knew when medication had been delivered to the facility. Interview with the Administrator on 03/18/19 at 1:55pm revealed: -He thought the RCC was responsible for eMAR and record audits, but did not know how often they were completed. -He did not know until 03/15/19 Resident #3 did not receive her eye drops as ordered by the physician. -He expected for medication to be administered as ordered by the physician. 2. Review of Resident #2's current FL2 dated 12/06/18 revealed: -The diagnoses included gastroesophageal reflux disease, hypertension, anxiety, type II diabetes mellitus, schizophrenia, congestive heart failure, and chronic obstructive pulmonary disease. -There was an order for clozapine (a medication used to treat schizophrenia) 200 mg twice a day. Review of Resident #2's physician orders dated	{D 358}	<i>See attached</i> <i>Karen Shauer</i> <i>5-6-19</i>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 358}	Continued From page 46 11/20/18 revealed an order for clozapine 25mg (with 200mg to equal 225mg) at bedtime. Review of Resident #2's January 2019 electronic medication administration record (eMAR) revealed: -There was an entry for clozapine 200mg twice a day and scheduled for administration at 9:00am and 9:00pm. -There were 5 of 62 opportunities clozapine 200 mg was not documented as administered as follows: -Clozapine 200mg was not documented as administered at 9:00am on 01/06/19. Staff documented clozapine was not administered because the resident was unable to take the medication. -Clozapine 200mg was not documented as administered at 9:00pm on 01/01/19-01/05/19. Staff documented clozapine was not administered because the resident was unable to take the medication. -There was an entry for clozapine 25 mg (at bedtime along with 200mg to equal 225mg) at bedtime scheduled at 9:00pm. -There were 13 of 31 opportunities clozapine 25 mg was not documented as administered as follows: -Clozapine 25mg was not documented as administered at 9:00pm on 01/03/19-01/05/19, 01/09/19-01/11/19, and on 01/25/19-01/31/19. -On 01/03/19-01/25/19 at 9:00pm, staff documented clozapine was not administered because the resident was unable to take the medication. -On 01/26/19 at 9:00 pm, there was documentation clozapine was not administered because the resident refused the medication. -On 01/27/19 at 9:00 pm, staff documented clozapine was not administered because the		{D 358}	See attached Barn Shaw 5-6-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019	
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{D 358}	Continued From page 47 resident was unable to take the medication. -On 01/28/19-01/31/19 at 9:00 pm, there was documentation clozapine was not administered because the facility was waiting on the pharmacy. Review of Resident #2's February 2019 eMAR revealed: -There was an entry for clozapine 200mg twice a day and scheduled for administration at 9:00am and 9:00pm. -Clozapine 200 mg was documented as administered at 9:00am and 9:00pm daily from 02/01/19 through 02/28/19. -There was an entry for clozapine 25 mg (at bedtime along with 200mg to equal 225mg) at bedtime scheduled at 9:00pm. -There were 14 of 31 opportunities clozapine 25 mg was not documented as administered as follows: -Clozapine 25mg was not documented as administered at 9:00pm on 02/01/19-02/06/19, and on 02/08/19 through 02/14/19. -On 02/01/19-02/03/19 at 9:00 pm, there was documentation clozapine 25 mg was not administered because the facility was waiting on the pharmacy. -On 02/04/19-02/05/19 at 9:00 pm, there was documentation clozapine 25mg was not administered because the resident was unable to take the medication. -On 02/06/19 at 9:00 pm, there was documentation clozapine 25mg was not administered because the facility was waiting on the pharmacy. -On 02/08/19-02/11/19 at 9:00 pm, there was documentation clozapine 25mg was not administered because the resident was unable to take the medication. -On 02/12/19-02/14/19 at 9:00 pm, there was documentation clozapine 25mg was not	{D 358}	<i>see attached</i> <i>Haren Shaw</i> <i>5-6-19</i>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{D 358} Continued From page 48

{D 358}

administered because the facility was waiting on the pharmacy.

Observation of Resident #2's medication on hand for administration on 03/15/19 at 3:57pm revealed:

-Clozapine 200mg was available for administration.

-On 02/14/19, clozapine 200mg was dispensed for a total of 56 tablets. There were 16 tablets remaining in the bubble pack.

-On 03/13/19, clozapine 200mg was dispensed for a total of 56 tablets. There were two bubble packs full (56 tablets were remaining).

-Clozapine 25mg was available for administration.

-On 02/14/19, clozapine 25mg was dispensed for a total of 28 tablets. There were 3 tablets remaining in the bubble pack.

-On 03/13/19, clozapine 25mg was dispensed for a total of 28 tablets (28 tablets were remaining).

Interview with Resident #2 on 03/15/19 at 3:55pm revealed:

-Staff administered all medications.

-She knew she was prescribed clozapine.

-She did not know why she was prescribed clozapine.

-She did not know the dose or frequency for clozapine.

-She did not know if she had missed any doses.

Interview with a representative from the contracted pharmacy on 03/18/19 at 1:20pm revealed:

-The pharmacy had to have lab results in order to dispense clozapine.

-There were several occasions when Resident #2 would have been without clozapine because the pharmacy did not receive lab results.

-Dispense dates for clozapine were as follows:

*See attached
Karen Shaw
5-6-19*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD

ELKIN, NC 28621

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{D 358}	Continued From page 49 -On 12/19/18, clozapine 200mg was dispensed for 14 tablets. -On 01/04/19, clozapine 200mg was dispensed for 14 tablets. -On 01/11/19, clozapine 200mg was dispensed for 6 tablets. -On 01/15/19, clozapine 200mg was dispensed for 4 tablets. -On 01/17/19, clozapine 200mg was dispensed for 10 tablets. -On 01/22/19, clozapine 200mg was dispensed for 4 tablets. -On 01/24/19, clozapine 200mg was dispensed for 42 tablets. -On 02/14/19, clozapine 200mg was dispensed for 56 tablets. -On 03/13/19, clozapine 200mg was dispensed for 56 tablets. -On 12/19/18, clozapine 25mg was dispensed for 7 tablets. -On 01/04/19, clozapine 25mg was dispensed for 7 tablets. -On 01/11/19, clozapine 25mg was dispensed for 3 tablets. -On 01/15/19, clozapine 25mg was dispensed for 2 tablets. -On 01/17/19, clozapine 25mg was dispensed for 5 tablets. -On 01/22/19, clozapine 25mg was dispensed for 2 tablets. -On 02/14/19, clozapine 25mg was dispensed for 28 tablets. -On 03/13/19, clozapine 25mg was dispensed for 28 tablets. Interview with a medication aide (MA) on 03/15/19 at 3:00pm revealed: -She knew of several occasions the clozapine 200mg and clozapine 25mg was not available to be administered.	{D 358}	See attached Hans Shum 5-6-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{D 358}	Continued From page 50 -She thought the delay in the clozapine being dispensed from the pharmacy was due to labs not getting faxed to the pharmacy. -The pharmacy had to receive the lab results before the clozapine would be dispensed. -The MA/Supervisor was responsible for faxing over labs to the pharmacy. -She felt the labs were drawn and staff did not fax labs to the pharmacy for a few days. -A contracted home health (HH) agency obtained labs for Resident #2. -She had not noticed any change of in behaviors. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 9:20am revealed: -She knew Resident #2 had labs drawn weekly for clozapine. -She was responsible for making sure labs were obtained as ordered. -She or the Supervisor were responsible for faxing lab results to the contracted pharmacy. -The pharmacy required labs to dispense clozapine. -She did not know clozapine was not administered as ordered in January and February 2019. -She was responsible for eMAR audits. -She had not conducted eMAR audits at the facility because she had been focusing on other areas. Interview with the Executive Director on 03/18/19 at 1:00pm and 5:55pm revealed: -She did not know Resident #2 missed doses of clozapine 200 mg and 25mg in January 2019 and February 2019. -The Supervisor or RCC were responsible for faxing lab orders to the home health agency. -The Supervisor or RCC were responsible for faxing labs results to the pharmacy.	{D 358}	<i>See attached</i> <i>Karen Shaw</i> <i>5-4-19</i>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621			
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{D 358}	Continued From page 51 -No one was performing a double check to make sure labs were done or they were faxed to the pharmacy so the medication was delayed from the pharmacy. -She remembered getting a fax and call from the pharmacy requesting lab results. She did not know the date of the contact. -She found the lab results in a folder and assured the results were faxed immediately to the pharmacy. Interview with the Administrator on 03/18/19 at 1:55pm revealed: -He did not know if the facility was conducting eMAR audits. -He did not know Resident #2 missed doses of clozapine 200mg and 25mg in January and February 2019. -The Supervisor or RCC were responsible for making sure labs were obtained and faxed to the pharmacy when necessary. Interview with the a nurse from the facility's contracted HH agency on 03/18/19 at 2:24pm revealed: -She obtained weekly labs from Resident #2 for clozapine. -The facility faxed lab orders to the HH agency. -The HH agency faxed the facility the lab results. -The facility was responsible for faxing the labs to the pharmacy. -The clozapine would not be dispensed without the lab results. Interview with Resident #2's primary care provider (PCP) on 03/18/19 at 5:08pm revealed: -She visited the facility every other week. -Not administering clozapine as ordered could cause Resident #2 to go into a psychotic state. -She did not know Resident #2 missed scheduled	{D 358}	See attached Karen Shawe 5-6-19		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 52 clozapine in January and February 2019. 3. Review of Resident #1's current FL-2 dated 02/20/19 revealed diagnoses included hypercapnic hypoxemic respiratory failure, chronic obstructive pulmonary disease exacerbation, bibasilar pneumonia, history of coronary artery disease, history of hypertension, diabetes, spinal stenosis, obstructive sleep apnea, and altered mental status/resolving. a. Further review of Resident #1's current FL-2 dated 02/20/19 revealed there was an order for Levaquin 750 mg, one tablet at 9:00am for seven days. Review of Resident #1's electronic Medication Administration Record (eMAR) for February 2019 revealed: -There was an entry for Levaquin 750 mg scheduled to be administered at 9:00am. -Resident #1's Levaquin 750 mg was documented as administered on the eMAR on 02/21/19, 02/22/19, 02/23/19, 02/25/19, 02/26/19, and 02/27/19, but eMAR exception notes indicated "waiting on pharmacy" on the same dates. -Resident #1's Levaquin 750 mg was documented as not administered due to "waiting on pharmacy" on 02/27/19. -The order for Levaquin 750 mg was documented as expired on 02/28/19. Review of Resident #1's eMAR for March 2019 revealed: -There was an entry for Levaquin 750 mg scheduled to be administered at 9:00am. -Resident #1's Levaquin 750 mg was documented as administered at 9:00am beginning 03/02/19 through 03/10/19.	{D 358}	See attached Karen Shaver 5-6-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

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ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD

ELKIN, NC 28621

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(D 358)	Continued From page 53 -On 03/01/19, Levaquin 750 mg was not administered for the noted reason of "waiting on pharmacy". Review of the care notes on 03/15/19 at 4:30pm revealed: - There was an entry on 02/23/19 that the computer crashed during the morning medication pass and showed all morning medications as administered, but the Levaquin 750 mg was not administered due to waiting on medication from pharmacy. -There was an entry on 02/27/19 that the medication aide had accidentally "hit administer for the Levaquin order, but I meant to hit did not administer, waiting on meds from pharmacy". Interview with the Resident Care Coordinator (RCC) on 03/15/19 at 4:00pm revealed: -She reviewed the medication orders for Resident #1 on either 02/26/19 or 02/27/19, when she discovered the Levaquin 750 mg was not in the medication cart. -The transportation staff member had transported Resident #1 to his eye appointment on 02/27/19, which was where the pharmacy was also located. -The RCC had advised the transportation staff member to ask someone with the pharmacy if they would overnight the Levaquin 750 mg to the facility for Resident #1. -The pharmacy did not overnight the Levaquin 750 mg tablets. -She called the pharmacy on 02/27/19 and the Levaquin 750 mg, was shipped to the facility on 03/01/19 and Resident #1 began taking the medication on 03/02/19. -She knew when Resident #1 returned to the facility from the hospital on 02/20/19, the hard prescription for Levaquin 750 mg was given to the medication aide on duty.	(D 358)	See attached Karen Shaw 5-6-19	

Division of Health Service Regulation

PRINTED: 04/12/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 358}	Continued From page 54 -The medication aide on duty had faxed the hard prescription for Levaquin 750 mg to the facility contracted pharmacy instead of the pharmacy Resident #1 used. -She did not know why the medication aide on duty had faxed the hard prescription to the wrong pharmacy, other than the medication aide was not told or the medication aide was told, and she did not remember. -She did not know why Levaquin 750 mg was initiated as administered on 02/21/19, 02/22/19, 02/23/19, 02/25/19, 02/26/19, and 02/27/19 because she knew the medication was not in the medication cart. -The primary care physician was not notified that Resident #1 had not started taking the Levaquin as per the order from the physician at the hospital. Interview with the Medication Aide/Supervisor on 03/15/19 at 2:50pm revealed she had initialed that she had administered the Levaquin 750 mg to Resident #1 on 02/23/19 and 02/27/19 at 9:00 am, but she had documented in the care notes that it was not administered. Attempted telephone interview with a medication aide on 03/18/19 at 10:00am was unsuccessful. Attempted telephone interview with Resident #1's primary care physician on 03/18/19 at 1:45pm was unsuccessful. Interview with Executive Director on 03/18/19 at 6:00pm revealed: -The medication aide on duty on 02/20/19 faxed the Levaquin 750 mg prescription to the facility contracted pharmacy instead of the pharmacy Resident #1 used. -The medication aide on duty had been told that	{D 358}	<i>See attached</i> <i>Haren Shave</i> <i>5-6-19</i>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621

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{D 358}	Continued From page 55 Resident #1 used a different pharmacy, but she either was not listening or she had just forgotten. -She did not follow up on the discharge orders/current FL-2 for Resident #1 to ensure he received the Levaquin in a timely manner. b. Review of Resident #1's current FL-2 dated 02/20/19 revealed there was an order for Prednisone 40 mg (a steroid used to treat breathing disorders) twice daily for three days, then 20 mg twice daily for three days, then 10 mg twice daily for three days, then 10 mg daily for three days. Review of Resident #1's electronic Medication Administration Record (eMAR) for February 2019 revealed: -There was an entry for Prednisone 40 mg scheduled for administration twice daily for three days, 20 mg twice daily for three days, 10 mg twice daily for three days, and 10 mg daily for three days. -Prednisone 40 mg was documented as not administered and the was was "waiting on pharmacy". Review of Resident #1's eMAR for March 2019 revealed: -There was an entry for Prednisone 40 mg scheduled for administration twice daily for three days, 20 mg twice daily for three days, 10 mg twice daily for three days, and 10 mg daily for three days. -Prednisone 40 mg was documented as administered twice a day on 03/02/19 and 03/03/19; a morning dose on 03/04/19, but it was documented as not administered for the evening dose with the reason documented as waiting on pharmacy; -Prednisone 20 mg was documented as	{D 358}		

See attached
Haren Shaw
5-6-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

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ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621(X4) ID
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DEFICIENCY)(X5)
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{D 358} Continued From page 56

{D 358}

administered twice daily from 03/04/19 through 03/06/19.

-Prednisone 10 mg was documented as administered twice daily from 03/10/19 through 03/12/19.

Interview with the Resident Care Coordinator (RCC) on 03/15/19 at 4:00pm revealed:

-She saw on the eMAR for March 2019 that a 40 mg dose was initiated as administered on 03/04/19 for the morning, but also on 03/4/19 a morning dose for 20 mg was initiated as administered.

-The medication aide that had initiated a morning dose of Prednisone 40 mg and a morning dose of Prednisone 20 mg administered was no longer a medication aide.

-The medication aide initiated the wrong date and was not paying attention.

-She reviewed orders for Resident #1 on either 02/26/19 or 02/27/19 when she discovered Prednisone was not in the medication cart.

-The transportation staff member had transported Resident #1 to his eye appointment on 02/27/19, which was where the pharmacy was also located.

-The RCC had advised the transportation staff member to ask someone with the pharmacy if they would overnight the prednisone to the facility for Resident #1.

-The pharmacy did not overnight the Prednisone prescription.

-She called the pharmacy on 02/27/19 and the Prednisone was shipped to the facility on 03/01/19 and Resident #1 began taking the medication on 03/02/19.

-She knew when Resident #1 returned to the facility from the hospital on 02/20/19, the hard prescription for Prednisone was given to the medication aide on duty.

-The medication aide on duty had faxed the hard

*See attached
Karen Shaw
06-19*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

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ELKIN ASSISTED LIVING

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ELKIN, NC 28621

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{D 358} Continued From page 57

{D 358}

prescription for Prednisone to the facility contracted pharmacy instead of the pharmacy Resident #1 used.
-She did not know why the medication aide on duty had faxed the hard prescription to the wrong pharmacy, other than the medication aide was not told or the medication aide was told, and she did not remember.
-The doctor was not notified that Resident #1 had not started taking Prednisone as per the order from the physician at the hospital.

Telephone interview with a representative from the facility contracted pharmacy on 03/14/19 at 11:30am revealed:

-On 02/20/19, an order for a Prednisone was faxed to them for Resident #1.
-The order was for Prednisone 40 mg twice daily for 3 days, 20 mg twice daily for three days, 10 mg twice daily for three days, and 10 mg daily for three days.
-The pharmacy did not fill the prescription because it was noted in their system that Resident #1 received his medications from another pharmacy.
-On 02/28/19, the facility faxed an update for the eMAR only, no medications were sent for Resident #1.

Attempted telephone interview with a medication aide on 03/18/19 at 10:00am was unsuccessful.

Attempted telephone interview with Resident #1's primary care physician on 03/18/19 at 1:45pm was unsuccessful.

Interview with Executive Director on 03/18/19 at 6:00pm revealed:

-The medication aide on duty on 02/20/19 faxed the prescription for Prednisone to the wrong

*See attached
Karen Shaver
5-6-19*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 358}	Continued From page 58 pharmacy as Resident #1 did not use the facility contracted pharmacy. -The medication aide on duty had been told that Resident #1 used a different pharmacy, but she either was not listening or she had just forgotten. -She did not follow up on the discharge orders for Resident #1 to ensure he received Prednisone in a timely manner. The facility failed to assure medications were administered as ordered which resulted in an antibiotic not being administered until nine days after it was ordered and a steroid not being administered as ordered and a steroid not being administered until ten days after it was ordered (#1) an antipsychotic medication was not administered due to lab results not being faxed to the pharmacy (#2) which could lead to a psychotic state; and a medication used to treat chronic obstructive pulmonary disease was used four times daily when it should have been used every four hours as needed which could lead to increased heart rate and a medication used to treat glaucoma was not administered twenty eight times (#3). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/15/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 2, 2019.	{D 358}	See attached Karen Shaver 5-6-19		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	{D 367}			

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ELKIN, NC 28621

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(X5)
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DATE

{D 367} Continued From page 59

{D 367}

- (j) The resident's medication administration record (MAR) shall be accurate and include the following:
 - (1) resident's name;
 - (2) name of the medication or treatment order;
 - (3) strength and dosage or quantity of medication administered;
 - (4) instructions for administering the medication or treatment;
 - (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
 - (6) date and time of administration;
 - (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
 - (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to assure the medication administration records (MARs) were accurate and complete for 1 of 3 sampled residents (Resident #1).

The findings are:

Review of Resident #1's current FL2 dated 02/20/19 revealed:

- Diagnoses included hypercapnic hypoxemic

See attached
Karee Snave
5-6-19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 367}	Continued From page 60 respiratory failure, chronic obstructive pulmonary disease exacerbation, bibasilar pneumonia, history of coronary artery disease, history of hypertension, diabetes, spinal stenosis, obstructive sleep apnea, and altered mental status/resolving. -Resident #1 was semi-ambulatory and used a manual wheelchair as an assistive device. -There was a physician's order for oxygen at 3 liters per minute continuously. Review of a hospital discharge summary dated 02/20/19 revealed: -Resident #1 was admitted to the hospital on 02/12/19 with acute respiratory failure secondary to chronic obstructive pulmonary disorder exacerbation and possible pneumonia. -He was discharged from the hospital on 02/20/19 with a physician's order for oxygen, which was ordered by the physician at the hospital, and delivered to the facility by the local durable medical equipment company. Observation of Resident #1 on 03/14/19 at 11:00 am revealed he was wearing a nasal cannula via the oxygen concentrator at 3 liters per minute. Interview with Resident #1 on 03/14/19 at 11:00am revealed: -He had been in the hospital in February 2019 and had returned to the facility on 02/20/19. -He did not have oxygen before going to the hospital. -He was sent home from the hospital with oxygen at 3 liters per minute. -He knew he was supposed to use oxygen continuous, but he used it when he needed it. -The staff had told him that he needed a portable oxygen tank on the back of his wheelchair to use when he was out of his room.	{D 367}	See attached Karen Shaw 56-19		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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{D 367}	Continued From page 61 -He told staff he was not able to get up from the wheelchair, walk outside and leave oxygen inside, while he went out to smoke. -He knew when his oxygen level was low and knew when he needed to go to his room and use the oxygen. -He knew his oxygen level was low when he would come back in from smoking and when he was short of breath. Review of Resident #1's February 2019 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) revealed no entry for oxygen at 3 L/m via nasal cannula. Review of Resident #1's March 2019 eMAR and eTAR revealed an entry on the eTAR for oxygen at 3 L/m via nasal cannula beginning on 03/12/19. Interview with Medication Aide/Supervisor on 03/15/19 at 2:50pm revealed: -The Resident Care Coordinator (RCC) was responsible for reviewing physician orders. -Sometimes the pharmacy would enter the order for oxygen on the (eMAR/eTAR) and sometimes the medication aides would enter the order. -She knew that Resident #1 had been wearing oxygen, but she did not realize that it was not entered on the eMAR or eTAR. -She had not told the RCC that oxygen was not on the eMAR or eTAR. Interview with the RCC on 03/18/19 at 1:00pm revealed: -Oxygen should be entered on the eMAR or eTAR by either the RCC or the medication aides. -The pharmacy did not enter oxygen on the eMAR or eTAR. -She did not know why oxygen at 3 liters per	{D 367}	See attached Karen Shaw 5-6-19	

Division of Health Service Regulation

STATE FORM

6599

VX5P13

If continuation sheet 62 of 88

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD

ELKIN, NC 28621

(X4) ID
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(X5)
COMPLETE
DATE

{D 367} Continued From page 62

{D 367}

minute was not entered on the February 2019 eMAR.

- She entered oxygen at 3 liters per minute continuous to the eMAR on 3/12/19.
- Resident #1 had been wearing oxygen intermittently since she came to work in February 2019.
- The physician had not been notified that Resident #1 was not wearing oxygen at 3 L/m continuous.

Interview with the Executive Director on 03/18/19
at 6:00pm revealed:

-She did not know why oxygen was not entered on the eMAR or eTAR upon his return from the hospital on 02/20/19.

-She did not know why oxygen was not entered on the eTAR until 03/12/19.

-She knew that Resident #1 had been wearing oxygen in his room when he would come in from smoking or when he was short of breath, but she did not know if the doctor had been informed that he was not using the oxygen continuous

{D912} G.S. 131D-21(2) Declaration of Residents' Rights

{D912}

G.S. 131D-21 Declaration of Residents' Rights

Every resident shall have the following rights:

2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

This Rule is not met as evidenced by:

In attached
Hare Shaw
56-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
{D912}	{D912} Continued From page 63 Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care, medication administration, and adult care home infection prevention requirements. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to notify the primary care providers for 2 of 3 sampled residents (Residents #2 and #3) regarding fingerstick blood sugars (FSBS) greater than 350 and antifungal medication and blood pressure (BP) results outside the ordered parameters(#2), an eye drop not available for administration and blood pressure results outside of ordered parameters (#3). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Continuing Unabated Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 3 of 3 sampled residents (Resident #1, #2, and #3) related to orders for continuous positive airway pressure (CPAP) and blood pressures (BP) (#3); orders for laboratory tests regarding an antipsychotic medication (#2); and orders for finger stick blood sugars (FSBS) and continuous oxygen (#1). [Refer to Tag 0276 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, and #3) in regards to a		{D912}	<i>See attached Karen Shaw 5-6-19</i>	

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{D912}	Continued From page 64 medication used to treat chronic obstructive pulmonary disease and a medication used to treat glaucoma (#3), an antipsychotic medication (#2), and an antibiotic and a steroid (#1). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 5 of 5 diabetic residents sampled (Residents #2, #4, #5, #6, and #7) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. [Refer to Tag 932 G.S. 131D-4.4(A)(b) ACH Infection Prevention Requirements (Type B Violation)].	{D912}	See attached Karen Shaw		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents.	D932			

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DEFICIENCY)

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D932 | Continued From page 65

D932

- b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.
 - c. Accessibility of infection control devices and supplies.
 - d. Blood and bodily fluid precautions.
 - e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.
 - f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.
- (2) Require and monitor compliance with the facility's infection control policy.
- (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.

See attached
Kaur Shaw
5-6-19

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to implement a written

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D932	Continued From page 66 infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 5 of 5 diabetic residents sampled (Residents #2, #4, #5, #6, and #7) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. The findings are: Interview with the Executive Director on 03/15/19 at 6:30pm revealed there were 14 residents with fingerstick blood sugar (FSBS) and 1 resident was in the hospital. Observation of a FSBS for Resident #6 on 03/15/19 at 4:30pm revealed: -The medication aide (MA) wore gloves to obtain the FSBS. -The MA retrieved a plastic bag labeled with Resident #7's name. -The glucometer pouch inside the plastic bag was labeled with Resident #7's name. -The glucometer inside the pouch was labeled with Resident #7's name. -The MA obtained a FSBS check using a single use disposable lancing device and proper infection prevention techniques. -The MA disposed of the single use lancing device in a biohazard container and placed the testing strip in trash. -The MA cleaned the glucometer with an alcohol pad and placed the glucometer back in the pouch. Observation of two medication carts on 03/15/19 at 3:57pm revealed: -The two medication carts contained 12 residents' glucometers and a house glucometer.	D932	See attached Karen Shene 5-19	

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D932	Continued From page 67 -Each resident and the house glucometer had a clear plastic bag containing a glucometer labeled with a resident's name or house glucometer. -The glucometer pouches (Brand A and B) were labeled with the 5 residents' names and the house glucometer was labeled as house glucometer. -There were single use disposable lancing devices available on both medication carts. -There were no Environmental Protection Agency (EPA) approved disinfecting wipes available for staff. Review of the Centers for Disease Control and Prevention (CDC) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the manufacturer's user manual for the Brand A glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended. Review of the manufacturer's user manual of the Brand B glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended. 1. Review of Resident #6's current FL2 dated 12/26/19 revealed: -The diagnoses included diabetes mellitus. -There was no order to check fingerstick blood	D932		

See attached
Karen Shaver
5-6-19

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D932	Continued From page 68 sugars (FSBS). Review of the Resident Register for Resident #6 revealed an admission date of 03/01/19. Review of Resident #6's subsequent order dated 03/13/19 revealed an order for FSBS before meals and at bedtime. Observation of Resident #6's FSBS on 03/15/19 at 4:52pm revealed: -Resident #6 did not have an assigned glucometer. -Resident #6's FSBS reading was 300. -The MA used Resident #7's glucometer. Review of Resident #6's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS before meals and at bedtime scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm from 03/13/19 at 4:30pm through 03/13/19 at 8:00pm. This entry was discontinued on 03/14/19. -There was second entry to check FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm from 03/14/19 at 7:30pm through 03/15/19 at 8:00pm. -FSBS values were documented before meals and at bedtime from 03/13/19 through 03/15/19 with a FSBS range from 120 to 300. -There were days when multiple FSBS values documented on Resident #6's March 2019 MAR that did not match FSBS readings recorded in the glucometer history with examples as follows: -On 03/13/19 at 4:30pm, the FSBS reading was 275, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/15/19 at 4:30pm, the FSBS reading was 300, and there was a corresponding FSBS value	D932		

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D932	Continued From page 69 recorded in the Resident #7's glucometer. None of the FSBS readings recorded in the history of the glucometer used for Resident #2 could be matched to FSBS values documented on the MARs of sampled residents (#2, #4, or #5). Interview with Resident #6 on 03/15/19 at 7:40pm revealed: -She did not have an assigned glucometer. -The glucometer the staff used to obtain her FSBS did not have her name on it. -She did not know if the staff cleaned the glucometer after each use. Interview with the Executive Director on 03/15/19 at 6:35pm revealed: -She knew Resident #6 did not have a glucometer. -She did not know Resident #6 was ordered FSBS. Attempted interview with Resident #6's primary care provider (PCP) on 03/18/19 at 10:30am. Refer to interview with a medication aide (MA) on 03/15/19 at 4:15pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/15/19 at 7:18pm. Refer to interview with the Executive Director on 03/15/19 at 6:32pm. Refer to interview with the Administrator on 03/18/19 at 1:55pm. 2. Review of Resident #4's current FL2 dated 09/25/18 revealed:	D932	<i>See attached</i> <i>Karen Shaver</i> <i>5-6-19</i>	

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D932	Continued From page 70 -Diagnoses included diabetes mellitus with diabetic neuropathy. -There was an order to check fingerstick blood sugars (FSBS) twice a day. Observation of the glucometer identified for Resident #4 on 03/15/19 at 4:52pm revealed: -The plastic bag was labeled with Resident #4's name. -The pouch was not labeled with Resident #4's name. -The Brand A glucometer located in the pouch was not labeled with the resident's name. -The date and time was not set to the correct time. -The date and time was set for 02/05/19 1:01am. Review of Resident #4's Brand A glucometer's history compared with Resident #4's electronic administration record (eMAR) on 03/15/19 at 4:52pm revealed: -The FSBS readings recorded in the glucometer's history compared to values documented on Resident #4's March 2019 MAR were inconsistent for FSBS values documented on the MAR. -The FSBS values documented on Resident #4's March 2019 MAR were not recorded in Resident #4's glucometer's history. -There were days when multiple FSBS readings were recorded in the glucometer's history within a short period of time and none matched FSBS values documented on Resident #4's March 2019 MAR with examples as follows: -On 01/22/19 at 11:08am, the FSBS reading was 327, and there was no corresponding FSBS value recorded on the MAR. -On 01/25/19 at 5:39am, the FSBS reading was 390, and there was no corresponding FSBS value recorded on the MAR. -On 01/26/19 at 5:06pm, the FSBS reading was	D932	<i>See attached</i> <i>Karen Shaver</i> <i>5-6-19</i>		

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D932	Continued From page 71 247, and there was no corresponding FSBS value recorded on the MAR. -On 01/27/19 at 1:31am, the FSBS reading was 483, and there was no corresponding FSBS value recorded on the MAR. -On 01/27/19 at 4:27pm, the FSBS reading was 458, and there was no corresponding FSBS value recorded on the MAR. -On 01/29/19 at 3:37pm, the FSBS reading was 597, and there was no corresponding FSBS value recorded on the MAR. -On 01/29/19 at 5:36pm, the FSBS reading was 289, and there was no corresponding FSBS value recorded on the MAR. -On 01/29/19 at 8:15pm, the FSBS reading was 314, and there was no corresponding FSBS value recorded on the MAR. -On 01/29/19 at 8:24pm, the FSBS reading was 527, and there was no corresponding FSBS value recorded on the MAR. -On 01/29/19 at 8:25pm, the FSBS reading was 170, and there was no corresponding FSBS value recorded on the MAR. -On 01/29/19 at 8:31pm, the FSBS reading was 371 and there was no corresponding FSBS value recorded on the MAR. -On 01/29/19 at 8:36pm, the FSBS reading was 375, and there was no corresponding FSBS value recorded on the MAR. -On 01/29/19 at 8:41pm, the FSBS reading was 329, and there was no corresponding FSBS value recorded on the MAR. -On 01/30/19 at 2:17am, the FSBS reading was 261, and there was no corresponding FSBS value recorded on the MAR. -On 01/30/19 at 2:34pm, the FSBS reading was 545, and there was no corresponding FSBS value recorded on the MAR. Review of Resident #4's March 2019 electronic	D932	<i>See attached</i> <i>Karen Shave</i> <i>5-6-19</i>	

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D932	Continued From page 72 Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS twice a day before breakfast and before supper scheduled at 7:00am and 4:30pm. -On 03/12/19 the FSBS times changed to 6:00am and 4:30pm. -FSBS values were documented twice a day from 03/01/19 through 03/15/19 with a FSBS range from 236 to 593. -There were FSBS values documented on Resident #4's March 2019 MAR that did not match FSBS readings recorded in the glucometer history with examples as follows: -On 03/01/19 at 4:30pm, the FSBS reading was 243, and there was no corresponding FSBS value recorded in the glucometer. -On 03/02/19 at 4:30pm, the FSBS reading was HI, and there was no corresponding FSBS value recorded in the glucometer. -On 03/03/19 at 7:00am, the FSBS reading was 399, and there was no corresponding FSBS value recorded in the glucometer. -On 03/03/19 at 4:30pm, the FSBS reading was 269, and there was no corresponding FSBS value recorded in the glucometer. -On 03/04/19 at 7:00am, the FSBS reading was 428 and there was no corresponding FSBS value recorded in the glucometer. -On 03/05/19 at 7:00am, the FSBS reading was 236, and there was no corresponding FSBS value recorded in the glucometer. -On 03/06/19 at 7:00am, the FSBS reading was 289, and there was no corresponding FSBS value recorded in the glucometer. -On 03/06/19 at 4:30pm, the FSBS reading was 423, and there was no corresponding FSBS value recorded in the glucometer. -On 03/07/19 at 7:00am, the FSBS reading was 458, and there was no corresponding FSBS value	D932		

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VX5P13

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D932	Continued From page 73 recorded in the glucometer. -On 03/07/19 at 4:30pm, the FSBS reading was HI, and there was no corresponding FSBS value recorded in the glucometer. -On 03/08/19 at 7:00am, the FSBS reading was 248, and there was no corresponding FSBS value recorded in the glucometer. -On 03/08/19 at 4:30pm, the FSBS reading was 270, and there was no corresponding FSBS value recorded in the glucometer. -On 03/09/19 at 7:00am, the FSBS reading was 593, and there was no corresponding FSBS value recorded in the glucometer. -On 03/09/19 at 4:30pm, the FSBS reading was 322, and there was no corresponding FSBS value recorded in the glucometer. -On 03/10/19 at 7:00am, the FSBS reading was 345, and there was no corresponding FSBS value recorded in the glucometer. -On 03/11/19 at 7:00am, the FSBS reading was 278, and there was no corresponding FSBS value recorded in the glucometer. -On 03/12/19 at 6:00am, the FSBS reading was 236, and there was no corresponding FSBS value recorded in the glucometer. -On 03/13/19 at 6:00am, the FSBS reading was 345, and there was no corresponding FSBS value recorded in the glucometer. -On 03/14/19 at 6:00am, the FSBS reading was 395, and there was no corresponding FSBS value recorded in the glucometer. -On 03/15/19 at 12:00pm, the FSBS reading was 276, and there was no corresponding FSBS value recorded in the glucometer. None of the FSBS readings recorded in the history of the glucometer used for Resident #2 could be matched to FSBS values documented on the MARs of sampled residents (#2, #5, #6, or #7).	D932	See attached Karen Shaver 5-6-19	

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D932	Continued From page 74 Interview with Resident #4 on 03/15/19 at 7:35pm revealed: -Staff checked his FSBS once daily. -He did not know if he had an assigned glucometer with his name on it. Interview with Resident #4's primary care provider (PCP) on 03/18/19 at 10:20am revealed: -He prescribed Resident #4's FSBS testing. -He expected Resident #4 to have his own assigned glucometer. -She did not know the staff had used another resident's glucometer to check Resident #4's FSBS. -The staff sharing glucometers was concerning due to the possible transmission of blood borne diseases between residents. Refer to interview with a medication aide (MA) on 03/15/19 at 4:15pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/15/19 at 7:18pm. Refer to interview with the Executive Director on 03/15/19 at 6:32pm. Refer to interview with the Administrator on 03/18/19 at 1:55pm. 3. Review of Resident #5's current FL2 dated 11/26/18 revealed: -Diagnoses included hyperglycemia. -There was an order to check fingerstick blood sugars (FSBS) before meals and at bedtime. Observation of the glucometer identified for Resident #5 on 03/15/19 at 7:25pm revealed: -The plastic bag was labeled with Resident #5's	D932	See attached Karen Shaw 5-6-19	

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STATE FORM

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VX5P13

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NAME OF PROVIDER OR SUPPLIER ELKIN ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 500 JOHNSON RIDGE ROAD ELKIN, NC 28621		
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D932	Continued From page 75 name. -The pouch was labeled with Resident #5's name. -The Brand A glucometer located in the pouch was not labeled with the resident's name. -Resident #5's glucometer would not turn on. Review of Resident #5's March 2019 electronic Medication Administration Record (eMAR) compared to the house glucometer on 03/15/19 revealed: -There was an entry to check FSBS three times a day scheduled at 7:00am, 12:00pm, and 4:30pm. -The FSBS readings recorded in the house glucometer's history compared to values documented on Resident #5's March 2019 MAR were inconsistent for FSBS values documented on the MAR. -The FSBS values documented on Resident #5's March 2019 MAR were not recorded in the house glucometer's history. -FSBS values were documented three times a day from 03/01/19 through 03/15/19 with a FSBS range from 197 to 456. -There were days when multiple FSBS readings were recorded in the glucometer's history within a short period of time and none matched FSBS values documented on Resident #5's March 2019 MAR with examples as follows: -On 03/26/19 at 8:04am, the FSBS reading was 430, and there was no corresponding FSBS value recorded on the MAR -On 03/26/19 at 8:07am, the FSBS reading was 169, and there was no corresponding FSBS value recorded on the MAR -On 03/26/19 at 8:09am, the FSBS reading was 215, and there was no corresponding FSBS value recorded on the MAR -On 03/30/19 at 5:40pm, the FSBS reading was 157, and there was no corresponding FSBS value recorded on the MAR	D932	See attached Karen Shaw 5-6-19		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 76 -On 03/30/19 at 6:37am, the FSBS reading was 263, and there was no corresponding FSBS value recorded on the MAR -On 03/30/19 at 8:04am, the FSBS reading was 233, and there was no corresponding FSBS value recorded on the MAR -On 03/30/19 at 8:11am, the FSBS reading was 257, and there was no corresponding FSBS value recorded on the MAR. -On 03/30/19 at 8:20am, the FSBS reading was 315, and there was no corresponding FSBS value recorded on the MAR -On 03/30/19 at 8:28am, the FSBS reading was 173, and there was no corresponding FSBS value recorded on the MAR -On 03/30/19 at 9:36am, the FSBS reading was 274, and there was no corresponding FSBS value recorded on the MAR -On 03/30/19 at 3:44pm, the FSBS reading was 334, and there was no corresponding FSBS value recorded on the MAR -On 03/30/19 at 5:49pm, the FSBS reading was 275, and there was no corresponding FSBS value recorded on the MAR -There were days when FSBS values documented on Resident #5's March 2019 MAR matched FSBS readings recorded in the house glucometer history with examples as follows: -On 03/01/19 at 7:00 am, the FSBS reading was 212, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/01/19 at 12:00pm, the FSBS reading was 254, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/02/19 at 12:00pm, the FSBS reading was 357, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/04/19 at 12:00pm, the FSBS reading was 260, and there was a corresponding FSBS value recorded in the house glucometer.	D932	See attached Karen Shaw 5-6-19	

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D932	Continued From page 77 -On 03/05/19 at 7:00am, the FSBS reading was 230, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/06/19 at 5:00pm, the FSBS reading was 252, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/07/19 at 5:00pm, the FSBS reading was 235, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/10/19 at 5:00pm, the FSBS reading was 337, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/10/19 at 12:00pm, the FSBS reading was 392, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/10/19 at 7:00am, the FSBS reading was 292, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/11/19 at 5:00pm, the FSBS reading was 377, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/11/19 at 7:00am, the FSBS reading was 262, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/12/19 at 5:00pm, the FSBS reading was 456, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/14/19 at 7:00am, the FSBS reading was 228, and there was a corresponding FSBS value recorded in the house glucometer. -On 03/15/19 at 7:00am, the FSBS reading was 361, and there was a corresponding FSBS value recorded in the house glucometer. -There were FSBS values documented on Resident #5's March 2019 MAR that did not match FSBS readings recorded in the house glucometer history with examples as follows: -On 03/09/19 at 5:00pm, the FSBS reading was 288, and there was no corresponding FSBS value recorded in the glucometer.	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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D932	Continued From page 78 -On 03/11/19 at 12:00pm, the FSBS reading was 248, and there was no corresponding FSBS value recorded in the glucometer. -On 03/12/19 at 7:00am, the FSBS reading was 300, and there was no corresponding FSBS value recorded in the glucometer. -On 03/12/19 at 12:00pm, the FSBS reading was 224, and there was no corresponding FSBS value recorded in the glucometer. -On 03/13/19 at 7:00am, the FSBS reading was 212, and there was no corresponding FSBS value recorded in the glucometer. -On 03/13/19 at 12:00pm, the FSBS reading was 230, and there was no corresponding FSBS value recorded in the glucometer. -On 03/13/19 at 5:00pm, the FSBS reading was 352, and there was no corresponding FSBS value recorded in the glucometer. -On 03/14/19 at 12:00pm, the FSBS reading was 276, and there was no corresponding FSBS value recorded in the glucometer. -On 03/14/19 at 5:00pm, the FSBS reading was 258, and there was no corresponding FSBS value recorded in the glucometer. -On 03/15/19 at 12:00pm, the FSBS reading was 322, and there was no corresponding FSBS value recorded in the glucometer. -On 03/15/19 at 5:00pm, the FSBS reading was 299, and there was no corresponding FSBS value recorded in the glucometer. None of the FSBS readings recorded in the history of the glucometer used for Resident #2 could be matched to FSBS values documented on the MARs of sampled residents (#2, #4, #6, or #7). Interview with Resident #5 on 03/15/19 at 7:30pm revealed: -Staff checked her FSBS at least three times a	D932	<i>See attached</i> <i>Baren Shaver</i> <i>56-12</i>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD

ELKIN, NC 28621

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D932	Continued From page 79 day. -She did not know if her glucometer was labeled with her name. Interview with the Executive Director on 03/15/19 at 6:35pm revealed staff told her on 03/15/19 that Resident #5's glucometer was not working and the MA used the house glucometer. Interview with Resident #5's primary care provider (PCP) on 03/18/19 at 10:30am. Refer to interview with a medication aide (MA) on 03/15/19 at 4:15pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/15/19 at 7:18pm. Refer to interview with the Executive Director on 03/15/19 at 6:32pm. Refer to interview with the Administrator on 03/18/19 at 1:55pm. 4. Review of Resident #2's current FL2 dated 12/06/18 revealed: -Diagnoses included diabetes mellitus. -There was an order to check fingerstick blood sugar (FSBS) before meals and at bedtime. Observation of the glucometer identified for Resident #2 on 03/15/19 at 4:47pm revealed: -The plastic bag was labeled with Resident #2's name. -The pouch was labeled with Resident #2's name. -The Brand B glucometer located in the pouch was not labeled with the resident's name. -The date and time was not set to the correct time. -The date was set for 03/15/19 and times was set	D932	See attached Karen Shaver 5-6-19	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/18/2019
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D932	Continued From page 80 for 4:52pm. Review of Resident #2's Brand B glucometer history compared with Resident 2's electronic administration record (eMAR) on 03/15/19 at 4:47pm revealed: -The FSBS readings recorded in the glucometer's history compared to FSBS values documented on Resident #2's March 2019 eMAR were inconsistent for FSBS values documented on the MAR. -There were days when multiple FSBS readings were recorded in the glucometer's history within a short period of time and none matched FSBS values documented on Resident #2's March 2019 MAR with examples as follows: -On 03/11/19 at 5:59am, the FSBS reading was 214, and there was no corresponding FSBS value recorded on the MAR. -On 03/11/19 at 4:51pm, the FSBS reading was 327, and there was no corresponding FSBS value recorded on the MAR. -On 03/11/19 at 9:47pm, the FSBS reading was 157, and there was no corresponding FSBS value recorded on the MAR. -On 03/13/19 at 5:55am, the FSBS reading was 260, and there was no corresponding FSBS value recorded on the MAR. -On 03/13/19 at 4:58pm, the FSBS reading was 352, and there was no corresponding FSBS value recorded on the MAR. -On 03/13/19 at 5:11pm, the FSBS reading was 303, and there was no corresponding FSBS value recorded on the MAR. -On 03/15/19 at 6:22am, the FSBS reading was 221, and there was no corresponding FSBS value recorded on the MAR. Review of Resident #2's March 2019 electronic Medication Administration Record (eMAR)	D932	See attached Barry Shaw 5-6-19		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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D932	Continued From page 81 revealed: -There was an entry to check FSBS before meals and at bedtime scheduled at 7:00am, 12:00pm, 5:00pm, and 9:00pm. -FSBS values were documented before meals and at bedtime from 03/01/19 to 03/14/19 with a FSBS range from 172 to 470. -There were FSBS values documented on Resident #4's March 2019 MAR that did not match FSBS readings recorded in the glucometer history with examples as follows: -On 03/11/19 at 7:00am, the FSBS reading was 217, and there was no corresponding FSBS value recorded in the glucometer. -On 03/11/19 at 12:00pm, the FSBS reading was 232, and there was no corresponding FSBS value recorded in the glucometer. -On 03/11/19 at 5:00pm, the FSBS reading was 337, and there was no corresponding FSBS value recorded in the glucometer. -On 03/12/19 at 12:00pm, the FSBS reading was 245, and there was no corresponding FSBS value recorded in the glucometer. -On 03/12/19 at 9:00pm, the FSBS reading was 297, and there was no corresponding FSBS value recorded in the glucometer. -On 03/13/19 at 7:00am, the FSBS reading was 241 and there was no corresponding FSBS value recorded in the glucometer. -On 03/13/19 at 12:00pm, the FSBS reading was 237, and there was no corresponding FSBS value recorded in the glucometer. -On 03/13/19 at 9:00pm, the FSBS reading was 302, and there was no corresponding FSBS value recorded in the glucometer. -On 03/14/19 at 12:00pm, the FSBS reading was 214, and there was no corresponding FSBS value recorded in the glucometer. None of the FSBS readings recorded in the	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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D932	Continued From page 82 history of the glucometer used for Resident #2 could be matched to FSBS values documented on the MARs of sampled residents (#4, #5, #6, or #7). Interview with Resident #2 on 03/15/19 at 3:55pm revealed: -Staff checked her FSBS three times a day. -She had an assigned glucometer, but the glucometer did not have her name on it. Interview with Resident #2's primary care provider (PCP) on 03/18/19 at 5:08pm revealed: -She expected Resident #2 to have her own assigned glucometer. -She did not know the staff had used another resident's glucometer to check Resident #2's FSBS. -The staff sharing glucometers was concerning due to the possible transmission of blood borne diseases between residents. Refer to interview with a medication aide (MA) on 03/15/19 at 4:15pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/15/19 at 7:18pm. Refer to interview with the Executive Director on 03/15/19 at 6:32pm. Refer to interview with the Administrator on 03/18/19 at 1:55pm. 5. Review of Resident #7's current FL2 dated 02/13/19 revealed: -Diagnoses included diabetes mellitus. -There was an order to check fingerstick blood sugars (FSBS) once daily before lunch.	D932	<i>See attached</i> <i>Karen Shaw</i> <i>5-6-19</i>	

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D932 Continued From page 83

D932

Observation of the glucometer identified for Resident #7 on 03/15/19 at 4:52pm revealed:

- The plastic bag was labeled with Resident #7's name.
- The pouch was labeled with Resident #7's name.
- The Brand A glucometer located in the pouch was not labeled with the resident's name.
- The date and time was not set to the correct time.
- The date and time was set for 12/23/19 4:01am.

Review of Resident #7's Brand A glucometer's history compared with Resident #7's electronic administration record (eMAR) on 03/15/19 at 4:51pm revealed:

- The FSBS readings recorded in the glucometer's history compared to values documented on Resident #7's March 2019 MAR were inconsistent for FSBS values documented on the MAR.
- The FSBS values documented on Resident #7's March 2019 MAR were not recorded in Resident #7's glucometer's history.
- There were FSBS readings recorded in the glucometer's history within a short period of time and none matched FSBS values documented on Resident #4's March 2019 MAR with examples as follows:
- On 12/05/19 at 7:20pm, the FSBS reading was 353, and there was no corresponding FSBS value recorded on the MAR.
- On 12/05/19 at 10:52pm, the FSBS reading was 570, and there was no corresponding FSBS value recorded on the MAR.
- On 12/05/19 at 10:53pm, the FSBS reading was 302, and there was no corresponding FSBS value recorded on the MAR.
- On 12/23/19 at 3:36am, the FSBS reading was 300, and there was no corresponding FSBS value recorded on the MAR.

See attached
Hares Shave
5-6-19

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D932	Continued From page 84 Review of Resident #7's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS once daily before lunch scheduled at 11:30am. -FSBS values were documented once daily from 03/01/19 through 03/15/19 with a FSBS range from 135 to 472. -There were FSBS values documented on Resident #4's March 2019 MAR that did not match FSBS readings recorded in the glucometer history with examples as follows: -On 03/01/19 at 11:30am, the FSBS reading was 204, and there was no corresponding FSBS value recorded in the glucometer. -On 03/03/19 at 11:30am, the FSBS reading was 254, and there was no corresponding FSBS value recorded in the glucometer. -On 03/04/19 at 11:30am, the FSBS reading was 408, and there was no corresponding FSBS value recorded in the glucometer. -On 03/05/19 at 11:30am, the FSBS reading was 211, and there was no corresponding FSBS value recorded in the glucometer. -On 03/06/19 at 11:30am, the FSBS reading was 211, and there was no corresponding FSBS value recorded in the glucometer. -On 03/09/19 at 11:30am, the FSBS reading was 413, and there was no corresponding FSBS value recorded in the glucometer. -On 03/11/19 at 11:30am, the FSBS reading was 211, and there was no corresponding FSBS value recorded in the glucometer. -On 03/12/19 at 11:30am, the FSBS reading was 198, and there was no corresponding FSBS value recorded in the glucometer. -On 03/13/19 at 11:30am, the FSBS reading was 345, and there was no corresponding FSBS value recorded in the glucometer. -On 03/14/19 at 11:30am, the FSBS reading was	D932		

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D932	Continued From page 85 143, and there was no corresponding FSBS value recorded in the glucometer. -On 03/15/19 at 11:30am, the FSBS reading was 135, and there was no corresponding FSBS value recorded in the glucometer. None of the FSBS readings recorded in the history of the glucometer used for Resident #7 could be matched to FSBS values documented on the MARs of sampled residents (#2, #4, #5, or #6). Interview with Resident #7 on 03/15/19 at 7:45pm revealed: -Staff checked her FSBS once a day. -She had a glucometer assigned to her and had her name written on the pouch. Interview with Resident #7's primary care provider (PCP) on 03/18/19 at 10:20am revealed: -He prescribed Resident #7's FSBS testing. -He expected Resident #7 to have his own assigned glucometer. -She did not know the staff had used another resident's glucometer to check Resident #7's FSBS. -The staff sharing glucometers was concerning due to the possible transmission of blood borne diseases between residents. Refer to interview with a medication aide (MA) on 03/15/19 at 4:15pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/15/19 at 7:18pm. Refer to interview with the Executive Director on 03/15/19 at 6:32pm. Refer to interview with the Administrator on	D932		

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D932	Continued From page 86 03/18/19 at 1:55pm. Interview with a medication aide (MA) on 03/15/19 at 4:15pm revealed: -The glucometers were shared between residents. -Two residents did not have an assigned glucometers including Resident #6. -She knew glucometers were not supposed to be shared between residents. -Staff had been sharing glucometers because the facility had a difficult time getting testing strips for certain glucometers because of insurance. -She routinely cleaned the glucometer after each use with an alcohol swab as directed by another MA when she hired. -She only used single used disposable lancing devices to stick residents' fingers when obtaining FSBS. -She told the Resident Care Coordinator (RCC) and the Administrator. Interview with the RCC on 03/15/19 at 7:18pm revealed: -She did not know staff were sharing glucometers between residents. -She did not know there were residents without an assigned glucometer. -She did not know there were residents with orders for FSBS checks without an assigned glucometer. -She did not know there was an issue with getting test strips for glucometers. Interview with the Executive Director on 03/15/19 at 6:32pm revealed: -She did not know staff were sharing assigned residents' glucometers. -She knew staff were sharing the house glucometer and cleaning it after each FSBS.	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/18/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELKIN ASSISTED LIVING

500 JOHNSON RIDGE ROAD
ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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D932

- She did not refer to the manual or call customer service for Brand A or Brand B glucometers to question if the glucometers could be shared.
- The facility did not have any residents with blood borne pathogen diseases.
- She knew the facility had a problem getting test strips for glucometers in the past but did not know it was a current issue.
- She would make sure new glucometers were purchased for all residents with FSBS ordered as of 03/15/19.

Interview with the Administrator on 03/18/19 at 1:55pm revealed:

- He was made aware on 03/15/19 the staff had been sharing glucometers.
- He expected every resident to have their own assigned glucometer.

The facility failed to implement infection control procedures consistent with CDC guidelines placing residents receiving finger stick blood sugar checks with glucometers at risk due to possible exposure to blood borne pathogens because staff were sharing glucometers for Residents #2, #4, #5, #6, and #7. This failure was detrimental to the health safety and welfare of the residents and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/15/19.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2019.

*See attached
Karen Shave
5-6-19*

**ELKIN ASSISTED LIVING
HAL-086-013
PLAN OF CORRECTION
DHSR FOLLOW-UP**

10A NCAC 13F. 0902(b) Referral & Follow Up

- RCC/Designee reviewed all new resident orders to ensure residents receive services in a timely manner. 3/15/19 and ongoing
- RCC/ Designee completed chart audits to ensure each order is referred to an appropriate agency if indicated. 3/15/19 to 3/21/19
- RCC/Med Aides reviewed orders for resident refusals, parameters and durable medical equipment and contact the physician for follow-up as needed. 3/15/19 and ongoing

10A NCAC 13F. 0902(c)(3-4) Documentation

- RCC/Designee will document physician contact as necessary according to any parameters ordered for the resident. 4/12/19 and ongoing
- Any staff member found not following policy and procedures will be disciplined up to and including termination. 4/12/19 and ongoing

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

- Executive Director/RCC completed medication carts and MAR audits to ensure residents' medications are available in the facility. Any medications found not in the facility were immediately sent to pharmacy to ensure availability. 3/18/19 to 3/21/19
- RCC/Designee reviewed daily orders notebook to follow up on any new medication orders to ensure residents receive medications timely. 3/27/19 and ongoing

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

- RCC/Designee will ensure that medications and treatments appear on the MAR's as ordered by physician. 3/25/19 and ongoing
- Executive Director/Designee reviewed MAR's weekly x4, then monthly to ensure medications/treatments are documented correctly. 4/8/19 and ongoing

**ELKIN ASSISTED LIVING
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DHSR FOLLOW-UP**

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

- Staff were retrained on residents' rights. 5/2/2019
- Any staff found not following policies and procedures will receive disciplinary action up to and including termination. 5/2/19 and ongoing

G.S. 131D-4.4 ACH Infection Prevention Requirements

- RCC/Designee immediately ordered & obtained all new glucometers for all diabetic residents needing finger stick blood sugars. 3/15/19
- RCC/Med Aides/SIC all received diabetic retraining. 3/18/19-4/1/2019
- RCC/Designee will review orders notebook 5 x per week to ensure any resident needing finger stick blood sugars receives a glucometer. 3/15/19 and ongoing
- Med Aide/SIC will immediately report any issues with a residents' glucometer to the RCC/ Executive Director. 3/18/19 and ongoing
- Surry County Health Dept. completed on-site visit to monitor compliance of infection control. Health Department representative state that we were in compliance and they were closing the case. 4/22/2019