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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023047	A. BUILDING: ~~ADULT CARE LICENSURE SECTION~~ RALEIGH B. WING	05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPENVIEW RETIREMENT HOME	112 PONY BARN ROAD LAWNDALE, NC 28090

(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 and the Cleveland County Department of Social Services conducted and initial licensure survey on 05/07/19 with a telephone exit on 05/08/19.	D 000	TAG D 356 MEASURES PUT IN PLACE TO CORRECT THE DEFICIENT AREA **PLAN:** All Therapeutic Diets that include thickened liquids will be clarified by MD for the consistency.	7-1-19
D 356	13F .0904(e)(1) Nutrition and Food Service 10A NCAC 13F .0904 NUTRITION AND FOOD SERVICE (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on observation, interviews and record review the facility failed to clarify a physicians order for 1 of 1 sampled resident (Resident #4) who had a diet order for "thickened liquids". The findings are: Observation of a list of therapeutic diets on the refrigerator door in the kitchen on 05/07/19 at 9:29am revealed Resident #4 was on "thickened liquids". Review of the current FL2 for Resident #4 dated 09/01/18 revealed: Diagnoses included type 2 diabetes, hyperglycemia, hypertension, aortic stenosis and	D 356	MEASURES TO PREVENT THE PROBLEM FROM OCCURRING AGAIN **PLAN: AA/RCD will call and get clarification from MD on consistency. Admin/ will sign off with AA/RCD. Staff will be inservice and consistency will be posted in Kitchen** MONITORING THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN **PLAN: AA/RCD /Admin will monitor all Therapeutic diet orders for consistency monthly (chart aduits)** HOW OFTEN WILL IT BE MONITOR **PLAN: AA/RCD will monitor x2 Monthly Admin/Corp RN will monitor monthly** COMPLETION DATE: **7-1-19**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bernice R Hosch Bernice R Hosch	Administrator	6-3-19
Bernardell Hopper Bernardell R Hopper	Admin/Asst	6/3/19

Reviewed and Accepted 6/10/19 rm

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D 356	Continued From page 1 chronic obstructive pulmonary disease (COPD). Review of the care plan dated 01/03/19 for Resident #4 revealed "staff to assist and monitor to prevent choking". Review of the record for Resident #4 revealed there was no order for the thickened liquids. Observation on 05/07/19 at 12:01pm of the noon beverage for Resident #4 revealed: -He was given milk to drink with his meal. -The milk he received appeared to be of normal consistency for milk. -He had no issues with his milk or episodes of choking during the meal. -At 12:15 pm Resident #1 had eaten his meal he was given a glass of "water" that appeared to have a white substance in it. Observation of a container the staff were using to thicken Resident #4's drinks with on 05/07/19 at 4:54pm revealed: -A container of "Thick It" (a food and beverage thickener) with Resident #4's name on it. -The container had directions that documented "use as directed". The manufactures usage chart for 4 fluid ounces of beverages documented "Mix pureed foods and beverages with the correct amount of Thick It Original Food and Beverage Thickener for the desired consistency, using the measuring scoop provided." -"Adjust the amount used to suit your requirements." -One side of the measuring scoop was a teaspoon and the other side of the measuring scoop was a Tablespoon. -The adjusted amount of thickener for milk was documented as 5-5 1/2 teaspoons of thickener for	D 356	**Please see Page (1) For Corrections**	

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D 356	Continued From page 2 4 ounce(oz.) of milk. -The adjusted amount of thickener for water was documented as 4-5 teaspoons of thickener for 4 oz. of water. -The mixing instructions for the beverage thickener was to pour 4 fluid oz. of cold or hot liquid into a glass; slowly add level measured thickener to liquid, stirring with fork or whisk as you pour; stir briskly until thickener has dissolved; before serving let water and juice stand for 30 seconds to 1 minute, let milk and supplements stand for 5-10 minutes, stir and serve. Interview with Resident #4 on 05/07/19 at 12:07pm revealed: -"There must be something in it because its (the milk) thicker than regular milk. -"They (staff) always fix it (his milk) this way." -"I think the thickener settles to the bottom or they just don't stir it up." -He was not aware how much thickener nor the consistency it was supposed to be but some amount of thickener was put in his liquids. -He had to be careful when he swallowed or he would get choked. -He had not had any recent episodes of choking while drinking. Interview with the Supervisor on 05/07/19 at 3:55pm revealed: -She had prepared the residents thickened milk for his lunch meal. -She had always used 1 scoop (1 Tablespoon) of thickener in whatever liquid Resident #4 was drinking. -She had been taught by previous staff at the facility to use one scoop in all thickened liquids and she had taught the new cook this as well. -She was not aware of any order documenting the desired consistency for Resident #4 of either	D 356	**Please see Page (1) For Corrections**	

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D 356	Continued From page 3 honey, nectar or pudding thick liquids. -She was not aware there was different consistencies for thickened liquids. -She was aware he was "just on thickened liquids". -She had followed the instructions on the container of thickener to mix the beverages for Resident #4. -Staff had been trained Resident #4 was at risk for choking and was on thickened liquids. Interview with the cook on 05/07/19 at 4:30pm revealed: -She had been employed since August of 2018. -She had been trained that Resident #4 was on "thickened liquids". -She had been trained by the Supervisor to use 1 scoop of thickener in Resident #4's liquid. -She was not aware of what his consistency were, only that he was on thickened liquids. -Resident #4 had a "hard time swallowing". Interview with the Supervisor on 05/07/19 at 4:50pm revealed: -The previous pharmacy had provided an inservice on thickened liquids but she could not recall when it had been given. -They had been told to" follow the directions on the container". -She was not aware she should have called the physician to get a clarification on the thickened liquids order. -She had not used the chart on the container of thickener to make the correct consistency. -She went by the mixing instructions and pictures on the thickener container. Interview with the new facility contract pharmacy on 05/07/19 at 5:15pm revealed: -The pharmacy had began a new contract with	D 356	**Please see Page (1) For Corrections**	

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D 356	Continued From page 4 the facility. -On 04/19/19 the facility had sent a fax to the pharmacy with a request to have "Thick-It Powder" be sent to facility for Resident #4. -The pharmacy supplied the facility with thickener for Resident #4 on 04/19/19. -There was no order sent to the pharmacy so the pharmacy had placed the "use as directed" on the label. Interview with the Administrator on 05/07/19 at 5:25pm revealed: -She had taken over the facility on 08/21/17. -Resident #4 was already on "thickened liquids". -She was not aware where the 1 scoop came from but the staff went by the mixing instructions on the container. -She called the facility's Nurse Practioner (NP) for Resident #4 on 05/07/19 at 5:30pm and stated she received an order for honey thickened liquids. Interview with the facility's NP on 05/07/19 at 5:38pm revealed: -Resident #4 had always been on honey thick consistency for his liquids. -Resident #4 had come to the facility with an order for honey thickened liquids as best she could recall. -Resident #4 needed to be on a honey consistency for all his liquids as he had problems with choking. -She was not aware the facility had not been administering the thickener at a honey thick consistency. -Resident #4 had not had any ill effects from the way the facility had been preparing the thickener. -She was not aware of the facility calling her in regards to clarifying the thickened liquids order for Resident #4. -She would have preferred the facility call her if	D 356	**Please see Page (1) For Corrections**	

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D 356	Continued From page 5 they had any question about the consistency of thickened liquids for Resident #4.	D 356		7-1-19
D 416	13F .1001 - 13G .1004(a) Medication Administration 10A NCAC 13F .1001 MANAGEMENT OF MEDICATIONS The rules stated in 10A NCAC 13G .1000 shall control for this Subchapter .1004 MEDICATION ADMINISTRATION (a) The facility shall assure that staff administer medications, prescription and non-prescription, and treatments according to orders by a licensed prescribing practitioner which are maintained in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #2) related to a medication used to treat depression and anxiety. Review of Resident #2's current FL2 dated 11/01/18 revealed: -Diagnoses included anxiety, dementia, Parkinson's disease, and hypertension. -There was a physician's order for Zoloft 100mg take 1 tablet daily (used to treat depression and anxiety). Review of Resident #2's record revealed no current order for Zolofot 100mg take 2 tablets daily. Review of Resident #2's March 2019 Medication	D 416	**TAG D 416** **MEASURES PUT IN PLACE TO CORRECT THE DEFICIENT AREA** **PLAN: All orders will be clarified by MD.** MEASURES TO PREVENT THE PROBLEM FROM OCCURRING AGAIN **PLAN: AA/RCD will call and get clarification from MD AA/RCD will get a faxed copy of the Order.** **AA/RCD will notifiy MD if Order and Card do not match** MONITORING THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN **PLAN: AA/RCD will (Team) up and check all orders and labeling if orders are unclear AA/RCD will inform MD** HOW OFTEN WILL IT BE MONITOR **PLAN: AA/RCD will monitor weekly Admin/Corp RN will monitor monthly** **COMPLETION DATE: 7-1-19**	

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D 416	Continued From page 6 Administration Record (MAR) revealed: -There was a computer generated entry for Zoloft 100mg take 2 tablets daily scheduled to be administered at 7:00am. -Zoloft 100mg 2 tablets daily was documented as administered daily from 03/01/19 to 03/31/19. Review of Resident #2's April 2019 MAR revealed: -There was a computer generated entry for Zoloft 100mg take 2 tablets daily scheduled to be administered at 7:00am. -Zoloft 100mg 2 tablets daily was documented as administered daily from 04/01/19 to 04/30/19. Review of Resident #2's May 2019 MAR revealed: -There was a computer generated entry for Zoloft 100mg take 2 tablets daily scheduled to be administered at 7:00am. -Zoloft 100mg 2 tablets daily was documented as administered daily from 05/01/19 to 05/07/19. Observation of Resident #2's medication on hand on 05/07/19 at 12:30pm revealed: -There were 2 partially used bottles of Zoloft 100mg available to be administered. -Both partially used bottles of Zoloft were dispensed from Resident #2's pharmacy. -One bottle was dispensed on 10/23/18 originally containing 180 tablets with the directions Zoloft 100mg take 2 tablets by mouth daily. -Another bottle was dispensed 04/11/19 originally containing 90 tablets with the directions Zoloft 100mg take 1 tablet by mouth daily Interview with Resident #2 on 05/07/19 at 3:04pm revealed he did not know he was taking Zoloft and was not sure how much he was being administered.	D 416	**Please see Page (6) For Corrections**	

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D 416	Continued From page 7 Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/08/19 at 10:02pm revealed: -The pharmacy did not fill medications for Resident #2 unless the facility needed an emergency supply. -The pharmacy never dispensed Zoloft to Resident #2. -Zoloft 100mg take 2 tablets daily was the current order on file. -The only physician's order the pharmacy had received for Zoloft for Resident #2 was 100mg take 2 tablets daily. -She did not know the dose for Resident #2's order for Zoloft had decreased. -The pharmacy was responsible for printing Resident #2's MAR each month for the facility. -The facility was responsible for faxing new orders for Resident #2 to the pharmacy for the MAR to be updated. Interview with the medication aide (MA) on 05/07/19 at 3:29pm revealed: -She did not remember how many tablets of Zoloft she had administered to Resident #2 during the morning medication pass on 05/07/19. -She was responsible for administering medications based on the directions on the MAR. -She "probably gave 2 tablets since that is what was on the MAR." -The Administrator or Assistant Administrator (AA) was responsible for processing new medication orders or new FL2s. Telephone interview with the office assistant from Resident #2's primary care provider's office on 05/07/19 at 2:43pm revealed Resident #2's Zoloft was decreased to 100mg take 1 tablet daily in November 2018.	D 416	**Please see Page (6) For Corrections**	

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D 416	Continued From page 8 Interview with the AA on 05/07/19 at 3:40pm revealed: -She did not know Resident #2's current physician's order for Zoloft that did not match the entry on the MAR. -She was responsible for auditing and updating the MARs at the beginning of each month. -She compared the new MAR to the previous month's MAR and to the current FL2. -The current FL2 for each resident was copied and stored in the notebook with each resident's current MAR. Interview with the Administrator on 05/07/19 at 3:50pm revealed: -She did not know Resident #2 was not being administered the correct dose of Zoloft. -The AA was responsible updating the MARs for each resident monthly. -The AA was responsible for updating the most recent FL2 for each resident in the notebook with the MARs. -The AA was responsible for comparing the previous month's MAR and the resident's current FL2 to make sure the MARs were accurate. -Resident #2 did not have a copy of his current FL2 in the MAR notebook. -The AA was auditing Resident #2's MAR with an old FL2 that had a different order for Zoloft. -The MAs were responsible for administering medications to the residents based on the physician orders. -She and the AA was responsible for auditing MARs weekly. -She was responsible for auditing all new medication orders three times weekly. Attempted telephone interview with a nurse from Resident #2's primary care provider office on	D 416	**Please see Page (6) For Corrections**	

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D 416	Continued From page 9 05/07/19 at 3:17pm was unsuccessful.	D 416	TAG D 450 MEASURES PUT IN PLACE TO CORRECT THE DEFICIENT AREA **PLAN: All DC Controlled Substance will be returned to Pharmacy.**	7-1-19
D 450	13F .1001 - 13G .1008(a) Controlled Substances 10A NCAC 13F .1001 MANAGEMENT OF MEDICATIONS The rules stated in 10A NCAC 13G .1000 shall control for this Subchapter .0008 CONTROLLED SUBSTANCES (a) The facility shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to account for the disposition of and to ensure accurate reconciliation of a controlled pain medication for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL-2 dated 03/05/2019 revealed diagnoses included schizoaffective disorder, history of delirium, hyper-ammonia, rectal prolapse, asthma, history of hypertension. Review of a physician's order for Resident #3 dated 03/08/2019 revealed: -Oxycodone HCL 5mg, one tablet three times daily (TID). -The quantity ordered was 90 tablets. Review of a subsequent physician's order for Resident #3 dated 04/24/2019 revealed:	D 450	MEASURES TO PREVENT THE PROBLEM FROM OCCURRING AGAIN **PLAN: AA/RCD will call Pharmacy and Admin and inform that Controll Substance are being returned to pharmacy.** **AA/RCD will fax the return sheet to Corp Admin/Owner** **AA/RCD will have a staff member to sign with them.** MONITORING THE SITUATION TO ENSURE IT WILL NOT OCCUR AGAIN **PLAN: Admin will follow up with Pharmacy Jennifer to ensure all Controll Substance were recieved.** **If Medication was not recieved by Pharmacy all staff will be reported to local Police (Cleveland County) and HCPR Cleveland County DSS AHS will also be inform.** HOW OFTEN WILL IT BE MONITOR **PLAN: AA/RCD will monitor weekly-When Meds are returned to Pharmacy** **Admin/Corp RN will monitor monthly** COMPLETION DATE: 7-1-19	

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D 450	Continued From page 10 -An order for Oxycodone HCL 5mg, ½ tablet, every 8 hours as needed (PRN) for pain. -An order to discontinue Oxycodone HCL 5mg TID. Review of the April 2019 pharmacy generated Medication Administration Record (MAR) for Resident #3 revealed: -There was an entry for Oxycodone 5mg tablet one tablet three times daily. -The scheduled administration times were documented as 7:00am, 12:00pm and 7:00pm. -The Oxycodone HCL 5mg, one tablet, three times daily was documented as being administered 57 times out of 57 opportunities from 04/01/2019 to 04/24/2019. -An entry for Oxycodone HCL 5mg ½ tablets every 8 hours PRN for pain. -The Oxycodone HCL 5mg PRN was documented 20 times as administered. Review of the May 2019 pharmacy generated MAR for Resident #3 revealed: -There was an entry for Oxycodone 5mg ½ tablet every 8 hours PRN for pain. -The Oxycodone HCL 5mg ½ tablets was documented 19 times as administered. Review of the April 2019 controlled substance count sheet for Oxycodone HCL 5mg TID revealed: -There was a dispense date of 04/05/2019. -The pharmacy dispensed 90 Oxycodone 5mg TID. -There were 57 tablets documented as administered and 33 tablets unaccounted for. Review of the April, May 2019 controlled substance count sheet for Oxycodone 5mg ½ tablets, PRN revealed:	D 450	**Please see Page (10) For Corrections**	

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D 450	Continued From page 11 -There was a dispense date of 04/24/2019. -The pharmacy had dispensed 90 Oxycodone 5mg ½ tablets, PRN. -There should be 6 tablets remaining on the medication cart. Observation of medication on hand for Resident #3 on 05/07/2019 at 12:55pm revealed: -A packet of Oxycodone 5mg ½ tablets PRN for pain. -There were 6 tablets available for administration, which matched the controlled substance count sheet. Telephone interview with contract pharmacy on 05/07/2019 at 12:32 pm revealed: -On 04/05/2019, the contract pharmacy provided the facility with 90 Oxycodone 5 mg for Resident #3. -On 04/24/2019, the contract pharmacy provided the facility with the Oxycodone 5mg ½ tablets, PRN for Resident #3. -The contract pharmacy had not received any remaining dosage units of Oxycodone 5mg that was provided to the facility on 04/05/2019. Interview with Assistant Administrator (AA) on 05/07/2019 at 2:15pm revealed: -The remaining dosage units of Oxycodone 5mg TID were sent back to the pharmacy the week of 04/29/2019. -There was no documentation produced to verify facility's account. -The missing dosages were not located in the medication room. Interview with Administrator and medication aide (MA) on 05/07/2019 at 3:03pm revealed: -Remaining dosage units of Oxycodone 5mg TID were to be sent back to the pharmacy last week.	D 450	**Please see Page (10) For Corrections**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPENVIEW RETIREMENT HOME	112 PONY BARN ROAD LAWNDALE, NC 28090

(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 450	Continued From page 12 -The facility had changeover with medication last week where used blister packets were replaced with new blister packets. -The Administrator and MA stated that the remaining medication must have been thrown away by accident when discarding used blister packets. -The Administrator would follow the proper protocol and file reports with the state and local law enforcement about the missing medication. A telephone interview on 05/08/19 at 4:39pm with the local police department revealed there was a report made regarding the missing medications earlier on 05/08/19.	D 450	NEW POLICY: AA/RCD will do Change Over NO Empty Bubble packs are to be placed with full bubble packs. AA will handle empty packs RCD will handle full packs	