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
	HAL002007	A. BUILDING: _____ B. WING _____	05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(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 conducted an annual and follow-up survey on 05/20/19-05/22/19.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up to meet the healthcare needs for 1 of 3 sampled residents related to a HgA1C blood test, used to monitor glucose control for diabetics, ordered quarterly on 09/21/18 for a resident diagnosed as diabetic (Resident #3) and not completed. The findings are: Review of Resident #3's current FL2 dated 03/13/19 revealed: -Diagnoses included moderate mental retardation, depressive disorder and hypertension. -There was a physician's order for Metformin 500mg twice a day. -There was a physician's order to check and record finger stick blood sugar (FSBS) weekly.	D 273	Rule 10A NCAC 13F.0902(b) Health Care Rule met as evidenced by facility secured a new lab company to ensure all labs are drawn. To prevent future occurrence the Medication aide will make sure all labs are sent to home health and lab company for timely draws daily. RCC will monitor weekly and as needed. Administrator will monitor monthly and as needed.	6/30/19

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-There was a physician order for a no concentrated sweets (NCS) diet with no consistency restrictions.

Review of Resident #3's primary care provider's (PCP) New Patient Encounter Summary dated 09/21/18 revealed:
-Diagnoses included hypoglycemia.
-There was an order for laboratory blood draws every 4 months to test Resident #3's HgA1C (a test to measure the average blood sugar readings for the past 3 months).

Review of Resident #3's PCP Patient Encounter Summary dated 02-06-19 revealed:
-Diagnoses included diabetes mellitus II.
-There was an order that a HgA1C was needed.
-The HgA1C was to be obtained at the next available laboratory draw.

Review of Resident #3's record revealed:
-Resident #3's last documented HgA1C test results were dated 06/07/18.
-The results on 06/07/18 were 95mg/dl.
-The American Diabetes Association (ADA) defined normal glucose reference ranges as 70-99mg/dl.
-The previous laboratory results dated 02/16/18 documented the HgA1C results as 198mg/dl, and flagged as "High".
-There were no documented results of a HgA1C test in Resident #3's record since 06/07/18.

Review of the March 2019 through May 21, 2019's electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS to be checked weekly.
-The readings ranged from 122-199 from 03/01/19-05/21/19.

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D 273	Continued From page 2 Interview with the PCP on 05/21/19 at 8:50am revealed: -She ordered quarterly HgA1C testing on all the diabetic residents in her care as best practice. -She typed her Encounter Visit Summary with the residents she had seen and sent a copy to the facility. -On the Encounter Visit Summary there was a section for the resident's diagnoses and a section below for the Plan (of care). -Under the Plan, she entered the HgA1C blood draw quarterly for Resident #3. -She knew Resident #3 had not had her HgA1C checked since she became a new patient in September of 2018. -She gave an additional order on the Encounter Visit Summary dated 02/16/19 to have the HgA1C checked at the next available blood draw. -She did not know until this week the contracted laboratory, which sent a phlebotomist to the facility, had withdrawn their services. -She did not know why the laboratory had not drawn the HgA1C quarterly since the order on 09-21-18. -She relied on the facility to execute her orders. -She had not questioned anyone at the facility regarding the HgA1C blood draw for Resident #3. -She usually spoke to the Supervisor or the assistant to the Administrator regarding the residents' orders and concerns. -She did not know who followed up with the physician orders at the facility. -She was trying to assist the facility in locating another in house laboratory service. Interview with the previously contracted laboratory manager on 05/21/19 at 9:40am revealed: -The laboratory was currently offering more specialized services to facilities.	D 273		

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D 273	Continued From page 3 -They were not performing routine laboratory blood draws to residents in facilities in the area. -She contacted the PCP office on 05/10/19 and informed the practitioners the phlebotomist would no longer be coming to the facility to do routine blood draws. Interview with the PCP's office receptionist on 05/21/19 at 9:50am revealed: -The laboratory provider notified the physician's office on 05/10/19 they were discontinuing services to the facility. -She had notified the providers in the office the same day. -It was the reponsibility of the providers to notify their facilities regarding the discontinuation of laboratory services. Interview with the Administrator in Charge on 05/21/19 at 2:20pm revealed: -She did not know the laboratory provider was no longer servicing the community. -She thought the previous assistant to the Administrator scheduled the phlebotomist to provide blood draws when ordered by the PCP. -The Administrator and the assistant to the Administrator reviewed physician orders. -She did not know why HgA1C quarterly testing was not completed for Resident #3 as ordered by the physician since 06/07/18. Interview with the Supervisor on 05/21/19 at 10:10am revealed: -She did not know Resident #3 was supposed to have quarterly HgA1C blood tests. -The physician's Encounter Visit Summary's were reviewed by the Administrator or the previous assistant to the Administrator. -The Visit Summary was filed in the Resident's record after review.	D 273		

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D 273	Continued From page 4 -The orders were conveyed to the MAs by the assistant to the Administrator or the Administrator. -The phlebotomist would come weekly to the facility if there were any routine blood work to be drawn. -The MAs or the assistant to the Administrator would schedule the phlebotomist. -She did not know Resident #3 had orders for quarterly HgA1C blood tests. -She knew the phlebotomist was not coming to the facility any longer for resident blood draws and testing. -She had been informed of this by the assistant to the Administrator "a few weeks ago." Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.	D 273		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home 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 such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure records of the administration of controlled substances were	D 392	Rule 10A NCAC 13F .1008(a) Controlled Substances Rule met as evidenced by all Med staff completed a Medication continuing education in service with the LHPS nurse. To prevent future occurrence, all medication staff will continue to complete medication administration training with the LHPS nurse annually and as needed. RCC will follow up weekly to ensure trainings are up to date. Administrator will oversee monthly and PRN.	6/30/19

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maintained, accurate and reconciled for 1 of 3 residents sampled (Resident #1) who was prescribed Percocet as a controlled substance.

Review of Resident #1's FL2 dated 04/03/19 revealed diagnoses included wound infection, hypertension and diabetes.

Review of Resident #1's record revealed:
-A copy of a prescription dated 03/06/19 for Percocet 10/325mg(a narcotic opioid medication used to treat severe pain) take 1 every four hours as needed for pain with a dispensed quantity of 30 tablets.
-There was another copy of a prescription dated 03/27/19 for Percocet 10/325mg take 1 every four hours for pain with a dispensed quantity of 20 tablets.
-There was a signed physician's order dated 04/25/19 to discontinue the Percocet 10/325mg.

Observation of Resident #1's medications on hand on 05/20/19 at 12:45pm revealed there were no Percocet 10/325mg available for administration.

Review of the facility's Control Substance Count Sheet (CSCS) book revealed there were no CSCS for Resident #1's Percocet 10/325mg for the month of March 2019 and April 2019.

Review of Resident #1's March 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Percocet 10/325mg 4 hours as needed for pain.
-There were documented doses of the Percocet 10/325mg administered on 03/15/19 at 11:16am, 03/16/19 at 7:42am, 03/17/19 at 7:33pm, 03/19/19 at 11:32am, 03/19/19 at 7:09pm,

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D 392	Continued From page 6 03/23/19 at 2:28pm and on 03/30/19 at 7:21am. -There was no other documentation Percocet 10/325mg had been administered the month of March 2019 on the eMAR. -There were a total of 7 Percocet 10/325mg signed out as administered during the month of March 2019. Review of Resident #1's April 2019 eMAR revealed: -There was a computer-generated entry for Percocet 10/325mg 4 hours as needed for pain. -There were documented doses of Percocet 10/325mg administered on 04/01/19 at 7:36pm, 04/03/19 at 11:25am, 04/09/19 at 7:24am, 04/23/19 at 11:49pm and on 04/28/19 at 10:06pm. -There was no other documentation Percocet 10/325mg had been administered the month of April 2019 on the eMAR. -There was a computer generated "DC'd" on the entry for the Percocet 10/325mg with no stop date documented. -There were a total of 5 Percocet 10/325mg signed out as administered during the month of April 2019. Review of Resident #1's May 2019 eMAR revealed there was no computer-generated entry for the Percocet 10/325mg. Telephone interview with a pharmacy representative on 05/20/19 at 2:10pm revealed: -The pharmacy had dispensed for Resident #1's Percocet 10/325mg every 4 hours as needed for pain to the facility on 03/11/19 with a dispense quantity of 30 tablets. -The pharmacy dispensed for Resident #1 Percocet 10/325mg every 4 hours as needed for pain again on 03/29/19 with a dispense quantity	D 392		

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of 20 tablets.
-The pharmacy sent a CSCS to the facility with each dispensed date for the Percocet 10/325mg.
-There was a physician ordered dated 04/25/19 on file to discontinue the Percocet 10/325mg for Resident #1.
-There was no documentation of the facility returning any of the Percocet 10/325mg for Resident #1 after they were discontinued.
-The procedure for returning narcotics for destruction to the pharmacy was as follows:
-After the narcotics were discontinued or the resident had been discharged the facility was responsible for returning narcotics to the pharmacy. The facility staff were to fill out a return form with documentation of how many tablets were to be sent back and include a signature. The pharmacy courier would pick up the narcotics nightly at the facility.

Interview with Resident #1's facility Nurse Practitioner on 05/21/19 at 9:30am revealed:
-Resident #1 had been prescribed Percocet 10/325mg by another medical provider in March 2019.
-She had discontinued the Percocet order 04/25/19 due to Resident #1 not complaining of pain.
-She never reviewed Resident #1's eMAR for how many times he had used the Percocet 10/325mg March or April 2019.
-She did not know the facility's process for returning a narcotic to the pharmacy to be destroyed.

Interview with Resident #1 on 05/20/19 at 3:52pm revealed:
-He was not having pain currently.
-He had taken a "pain pill" a few times because of pain from the infection in "his stump."

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D 392	Continued From page 8 -He could not recall how many times he had been administered the Percocet 10/325mg for pain. Interview with the Supervisor on 05/201/9 at 2:45pm revealed: -She worked as the supervisor for about a week. -She knew Resident #1 had an order and was administered Percocet 10/325mg for his pain in March and in April 2019. -She remembered signing out on the CSCS the Percocet 10/325mg for Resident #1. -She knew the physician for Resident #1 had discontinued the Percocet in April 2019. -"When a narcotic is discontinued then we complete and sign a return to pharmacy form and slide the form and the narcotic under the Administrator's door." -The assistant to the Administrator reviewed the narcotic and the form for accuracy and she signed the form. She gave the narcotic and the return to pharmacy form back to the MA to secure on the medication cart until the pharmacy picked up the narcotic on the night shift. The night shift MA and the pharmacy courier both signed the return to pharmacy form and the MA made a copy for the files. -She could not find the return to pharmacy form or the CSCS for Resident #1's Percocet 10/325mg tablets. -She could not remember how many Percocet 10/325mg were to be returned to the pharmacy for Resident #1, but she remembered there were some. -She recalled sliding the Percocet 10/325mg "punch card" and the signed return to pharmacy form under the Administrator's office door sometime im the end of April 2019, but she could not remember the date. -The former assistant to the Administrator was no longer with the facility.	D 392		

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D 392	Continued From page 9 Review of the facility's return to pharmacy form revealed: -The form was for the return of control medications for destruction to the pharmacy. -The facility name and the date were to be placed at the top of the form. -The form had documentation for the residents name, drug, drug strength, drug form, and the quantity to be returned for destruction. -The form had places for signatures of the administrator or the designee, for the pharmacy, with the place to document the date beside each signature. Interview with a MA on 05/20/19 at 3:28pm revealed: -She knew Resident #1 had been prescribed Percocet 10/325mg for his pain. -She had signed out the Percocet 10/325mg on the CSCS for Resident #1 when he had complained of pain. -She knew the physician had discontinued the Percocet for Resident #1 in April 2019. -The assistant to the Administrator reviewed all narcotic that were discontinued prior to sending them back to the pharmacy. -If the physician discontinued the narcotic during the day the assistant to the Administrator would count the narcotics and sign the return to pharmacy form. The MAs could send the narcotic back that same night. -She could not locate Resident #1's return to pharmacy form for the Percocet 10/325mg or the CSCS. Telephone interview with the Administrator on 05/21/19 at 3:20pm revealed: -She was currently out of the facility. -The process for returning narcotic to the	D 392		

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pharmacy was as follows:
-The MAs were responsible for counting the narcotic, completing and signing the return to pharmacy form. They were to give the return form and the narcotic to the assistant to the Administrator for review. The assistant to the Administrator was responsible for reviewing the discontinued order, counting the narcotics again, signing and completing the return to pharmacy form. The assistant to the Administrator would store the narcotics in a plastic bin in the office until the pharmacy courier would pick the narcotic up. The pharmacy courier did not come every night to the facility. The MA on the night shift and the courier would both sign the return to pharmacy form, the MAs were to make a copy for our files.
-She did not know the CSCS were not available in the facility.
-She was not aware the pharmacy never received the Percocet 10/325mg after they were discontinued for Resident #1.
-She did not know what had happened to the Percocet 10/325mg or the CSCS.
-She relied on the assistant to the Administrator to handle the process of narcotics returned to the pharmacy.

Telephone interview with the assistant to the Administrator on 05/21/19 at 10:20pm revealed:
-She was not employed by the facility, her last day was 05/15/19.
-The MAs were responsible for returning all narcotic to the pharmacy after they had been discontinued by the physician.
-The MAs were to use the facility's return to pharmacy form when they returned the narcotics to the pharmacy.
-The night shift MAs were to count the narcotics with the pharmacy courier and both sign the

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return to pharmacy form. The MAs were to make a copy of the form for the facility files.
-She and the Administrator shared an office in the facility.
-She was not aware the MAs were "sliding narcotics" under the door of the office.
-She had never seen narcotics in the office.
-She did not know what had happened to the CSCS for Resident #1's Percocet 10/325mg.
-She was unsure why the MAs would say they were placing the narcotics under the door to the office.
-She knew there was a large plastic bin under the desk but thought it was a "foot prop" to rest her feet on.
-She had never looked inside the plastic bin.
-She had not seen the Percocet 10/325mg that was to be returned to the pharmacy for Resident #1.

Interview with the Administrator in Charge of the facility on 05/20/19 at 3:00pm revealed:
-The assistant to the Administrator was no longer employed at the facility.
-The Administrator of the facility was out of the facility.
-The MAs were to use the return to pharmacy form when returning narcotics to the pharmacy.
-The MAs were to put the narcotic and the return to pharmacy form under the Administrator's door if the Administrator or the assistant to the Administrator were not available or if it was at night.
-The assistant to the Administrator was responsible for re-counting the narcotics and assuring the discharge order and the pharmacy return form was completed.
-The assistant to the Administrator was to return the narcotic and the return to pharmacy form to the MAs and secure in the medication cart until

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D 392	Continued From page 12 the pharmacy courier picked up. -She did not know where the CSCS or the return to pharmacy form for Resident #1's Percocet was located. -She did not know where Resident #1's Percocet 10/325mg that were to be returned to the pharmacy were located. -"I have no idea what happened to the Percocet or the control sheets." Review of the facility's policy on medication disposal revealed: -Medications will be disposed of in a manner that guards against drug diversion. -Documentation will specify the client's name, medication name, strength, quantity, deposable date and method, the signature of the person disposing of the medication, and the witnessing destruction. Observation on 05/22/19 between 12:38pm and 1:45pm revealed the local sheriff department was in the facility to initiate an investagation of the missing Percocet 10/325mg from the facility. Observation on 05/22/19 between 12:38pm and 1:45pm revealed the facility Administrator had initiated a 5 day investigation and was reporting the missing Percocet 10/325mg to the Health Care Personnel Registry (HCPR). _____ The facility failed to assure 1 of 3 residents had a readily retrievable record of a controlled substance by documenting disposition of the Percocet 10/325mg for Resident #1. The failure of the facility to locate the CSCS or the 38 Percocet 10/325mg that were to be returned to the pharmacy after the physician had discontinued, was detrimental to the safety,	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002007	A. BUILDING: _____ B. WING _____	05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(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 392	Continued From page 13 health, 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 05/21/19 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related controlled substances. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and	D912	Refer to tag 392	6/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002007	A. BUILDING: _____ B. WING _____	05/22/2019

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D912	Continued From page 14 reconciled for 1 of 3 residents sampled (Resident #1) who was prescribed Percocet a controlled substance. [Refer to tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].	D912		