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ADULT CARE LICENSURE SECTION
RALEIGH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017040	A. BUILDING: _____ B. WING _____	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
G ANTHONY RUCKER REST HOME	1196 HODGES DAIRY ROAD YANCEYVILLE, NC 27379

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D 000	Initial Comments The Adult Care Licensure Section and the Caswell County Department of Social Services conducted an annual and follow-up survey on August 1, 2019 with an exit conference via telephone on August 2, 2019.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 residents sampled (#2) was tested upon admission for tuberculosis (TB) disease. The findings are: Review of Resident #2's current FL-2 dated 07/19/19 revealed there were no diagnoses listed. Review of Residents #2's Resident Register dated 07/15/19 revealed: -Resident #2 was admitted on 07/15/19. -She was "blind' and had difficulty hearing. -She lived at home with a family member prior to	D 234		

Reviewed and accepted with addendums 09/12/19.
Kathy Gray

Division of Health Service Regulation

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D 234	Continued From page 1 admission on 07/15/19. -There was no responsible party listed and no contact information. Interview with Resident #2 on 08/01/19 at 4:10pm revealed: -She had been taken to a physician's office that day and she received a TB skin test. -She lived at home before being admitted into the facility. Interview with a medication aide (MA) on 08/01/19 at 9:45am revealed: -She did not know who filled out the FL-2s or the Resident Register. -The Administrator was responsible for admissions and "paperwork" and she did not know anything about the residents' records. -She did not know if Resident #2 had a TB skin test prior to admission. Interview with a second MA on 08/01/19 at 10:10am revealed: -The physician filled out the FL-2; the Administrator filled out all other "paperwork" for the residents. -Resident #2 came from her niece's home; but she did not have the contact information for the niece. -She did not know if Resident #2 had a TB test prior to admission. Telephone interview with the Administrator on 08/01/19 at 10:50am revealed: -Resident #2 had a TB test prior to admission. -Documentation of Resident #2's TB test should have been in her record; he did not know where the document was, and he would try to find it. Telephone interview with the Administrator on	D 234		

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D 234	Continued From page 2 08/01/19 at 4:15pm revealed: -He could not find documentation of Resident #2's first TB step. -He knew residents were required to have a two step TB skin test done and the first step must be complete prior to admission. -The Administrator was responsible for assuring residents had the first step of the TB skin test completed prior to admission and he was responsible for the resident records. -He had staff take Resident #2 to get a TB skin test on 08/01/19 so she would have documentation in her record.	D 234	Administrator will assure that all new admission TB-skin test be placed in residents chart. Administrator will assure that all new admission have TB skin test and will be placed in resident charts when resident is admitted. -The Administrator will audit all residents charts immediately to make sure all TB's are on file. -The Administrator will audit resident charts every 6 months to assure ongoing compliance.	9/10/19
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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to refer 2 of 2 sampled residents (#6 and #8), who needed their toenails trimmed, to a podiatrist. The findings are: 1. Review of Resident #8's current FL-2 dated	D 273		

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D 273	Continued From page 3 02/28/19 revealed a diagnosis of schizophrenia, hypertension, constipation, back pain, and panic attack. Interview with Resident #8 on 08/01/19 at 7:02pm revealed: -Her toenails needed to be cut; she did not recall when her toenails had last been cut. -Her feet hurt and walking was painful because her toenails needed to be cut. -She needed to go to the doctor and have her toenails cut. -She had not told anyone her toenails needed to be cut. Observation of Resident #8's toenails on 08/01/19 at 7:02pm revealed: -The first toenail on her left foot was approximately three-fourth to one-inch long; it was turned toward the inside of her second toe and was thick, brownish/gray in color and rippled in appearance. -The first toenail on her right foot was broken in half; the broken half was thick and discolored. -The toenails on all other toes on both the left and right feet were approximately one-half to three-fourths an inch long; they were thick, pointed and a dark gray/brownish color. Interview with the Medication Aide (MA) on 08/01/19 at 7:39pm revealed: -The Administrator was responsible for making appointments for residents. -She knew Resident #8's toenails needed to be cut; she helped her with her bath on Monday, 0729/19. -She did not say anything to the Administrator on 07/29/19. -She had mentioned to the Administrator Resident #8's toenails needed to be cut; she did	D 273		

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D 273	Continued From page 4 not remember when she mentioned it to him, "but, he is aware." Telephone interview with a nurse at Resident #8's Primary Care Provider (PCP) on 08/02/19 at 11:55am revealed they would make a referral for Resident #8 with a podiatrist. Telephone interview with the Administrator on 08/01/19 at 7:40pm revealed: -Resident #8 would not let staff cut her toenails. -Resident #8's PCP was aware of her long toenails, and she did not always let the PCP cut her nails. -He thought Resident #8's toenails were last cut six months ago by her PCP; Resident #8 wanted her toenails cut on "her time", only when she was ready. -Resident #8 had not complained to him or the staff that about her toenails. Refer to telephone interview with the Administrator on 08/01/19 at 7:40pm. 2. Review of Resident #6's current FL2 dated 02/28/19 revealed diagnoses included hypertension and fatigue. Observation of Resident #6's toenails 08/01/19 at 8:35am revealed: -Her toenails on both feet extended past the end of each toe by approximately one-fourth an inch. -The toenail on Resident #6's left big toe was broken in half and was ragged around the edge. Interview with Resident #6 on 08/01/19 at 8:55am revealed: -Her toenails needed to be cut. -She could not cut her own toenails. -No one had offered to cut her toenails.	D 273	Administrator will assure that resident #8 toenail be trimmed. PCP has made referral to Podiatrist so resident can get toenail done. Administrator called PCP to get referral made for resident #8 to get toenails trimmed. -The Administrator will re-educate the Medication Aides on completing assessments on the residents to make sure any needs are identified and referrals made. -The Administrator will make referrals as needed. -The Administrator will make sure all physician summary's/discharge summary's are reviewed and referrals made as needed. -The Administrator will monitor monthly.	9/10/19

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D 273	Continued From page 5 -She would like to go to a doctor to have her toenails cut. -Her toenails caused her feet to hurt when she walked in shoes. Interview with the Medication Aide (MA) on 08/01/19 at 7:39pm revealed: -The Administrator was responsible for making appointments for residents. -She knew Resident #6's toenails needed to be cut. -She had mentioned to the Administrator Resident #6's toenails needed to be cut; she did not remember when she mentioned it to him, "but, he is aware." Telephone interview with the Administrator on 08/01/19 at 7:40pm revealed: -Resident #6 had not complained about her feet or toenails in the last year. -He did not know the last time Resident #6 toenails were cut. Telephone interview with a nurse at Resident #6's Primary Care Provider on 08/02/19 at 11:55am revealed they would make a referral for Resident #6 with a podiatrist. Refer to telephone interview with the Administrator on 08/01/19 at 7:40pm. Telephone interview with the Administrator on 08/01/19 at 7:40pm revealed: -Some of the residents went to the podiatrist for foot care; the PCP would schedule the referral appointment with the podiatrist and inform the facility of the date for the appointment. -Facility staff were responsible for taking the residents to their appointments. -He was not sure which residents had their	D 273	Administrator will assure that resident #6 toenails be cut by podiatrist. Administrator called PCP and got referral for resident #6 to get toenails cut/trimmed by a podiatrist.	9/10/19

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D 273	Continued From page 6 toenails cut by their PCP or which residents had their toenails cut by staff. -He expected the staff to check the residents' toenails on a regular basis. -Staff checked the toenails of residents who could not cut their own toenails every time those residents were given a bath. -He checked the toenails of the residents that complained about their toenails or their feet, but no one had complained about their feet or toenails this year. The facility failed to assure 2 of 2 residents, who needed their toenails trimmed, were referred to a podiatrist, which resulted in Resident #8 having long, thick and sharp toenails that were painful; and Resident #6, who complained of her toenail length causing it to be painful to wear shoes and ambulate. This failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/02/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 16, 2019.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored,	D 283		

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D 283	Continued From page 7 prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure foods were free from contamination related to staff preparing ready to eat sandwiches for residents with their hands and wearing no gloves. The findings are: Observation of lunch preparation on 08/01/19 at 12:50pm revealed: -The personal care aide/medication aide (PCA/MA) was assembling cold sandwiches for the lunch meal with her hands; she was not wearing gloves. -She was opening individual slices of cheese and placing them on slices of white bread; she was also placing sliced deli turkey on the sliced bread. Interview with the PCA/MA on 08/01/19 at 12:50pm revealed: -She had washed her hands and thought that was enough to handle the ready to eat food. -She usually wore gloves when she cooked and made food for the residents, but she did not have gloves to wear at that time. -There were no gloves in the kitchen for her to wear; gloves were kept in the Administrator's office and the office stayed locked. -She usually brought her own gloves to work, but she forgot her gloves that morning. -She would get gloves from the medication cart for the rest of the day. Interview with a second MA on 08/01/19 at 4:05pm revealed:	D 283	Administrator will assure that extra boxes of gloves be kept in the food preparing area for staff to use when wearing gloves. -The Administrator has provided the facility with (2) full boxes of gloves. -The MAs have been instructed when the current box opened is 1/2 full to notify the Administrator so he can restock to make sure there is 2 full boxes at all times. -The Administrator will monitor this ongoing.	9/10/19

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D 283	Continued From page 8 -Gloves were kept in the Administrator's office; he brought gloves out one box at a time. -She brought he own gloves from home "in case" she ran out of gloves on the medication cart, but she had run out of her own gloves that morning. -There should have been an extra box of gloves in the supply room but there was only one glove left in the box and it was used at lunch time. -She called the Administrator when she needed more gloves; the Administrator had gloves delivered after lunch. Telephone interview with the Administrator on 08/01/19 at 4:15pm revealed: -Extra boxes of gloves were kept locked in his office, but there should always have been a box on the medication cart. -Staff were supposed to call him when they were running low on gloves so he could put a new box out for use. -He had ran low on gloves for the facility. -Some of the staff provided and used their own gloves; he preferred they used the gloves he provided. -Staff were supposed to wear gloves when preparing and handling food and were not supposed to wear the same gloves all day. -An "emergency" box of gloves was kept in the supply closet, but staff had called him and told him the box was empty. -He had gloves delivered to the facility after lunch that day.	D 283		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be	D 292		

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D 292	Continued From page 9 of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to document substitute menu items on the substitution log to indicate the foods served to residents. The findings are: Review of the breakfast menu for 08/01/19 revealed orange juice, pancakes with syrup, toast, sausage patty, milk, water and coffee were to be served. Observation of the breakfast meal service on 08/01/19 at 8:35am revealed: -The residents were served a bowl of oatmeal, a slice of untoasted bread with margarine spread on it, coffee, water, orange juice and milk. -There were small bowls of tortilla chips in the middle of each table; some of the residents ate the chips from the bowls. Observation of the trash can in the kitchen on 08/01/19 at 8:51am revealed there was an empty gallon container of whole milk, but there were no other food packages or containers in the trash can. Review of the substitution log for 08/01/19 revealed there were no substitutions documented for the breakfast meal. Review of the lunch menu for 08/01/19 revealed a turkey and cheese sandwich on white bread, potato chips, okra, Jell-O, a beverage and water	D 292	Administrator will assure that staff follow menu for breakfast, lunch, and dinner. Administrator will assure that all staff write up an substitutions for the meal before the meal is served. Administrator will assure that staff write up substitutions if an food item has to be substituted. -The Administrator will monitor monthly.	9/10/19

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D 292	Continued From page 10 were to be served. Observation of the lunch meal service on 08/01/19 at 12:55pm revealed: -The residents were served two turkey and cheese sandwiches each, pita chips, peas and carrots, water and a beverage. -Honey buns were served to residents. Review of the substitution log on 08/01/19 at 5:27pm revealed there was documentation dated 08/01/19 for substitution of mixed vegetables for okra; nothing was documented to indicate which meal the substitution was made and there was no other documentation for that date. Interview with the medication aide (MA) on 08/01/19 at 9:50 am revealed: -She knew she was supposed to document when food items were substituted, but she never documented anything on the substitution log because she never substituted anything. -She prepared breakfast on 08/01/19 and she followed the menu posted in the kitchen -She did not make pancakes because she thought oatmeal was on the menu that morning. -She did not have sausage to serve to the residents for breakfast, so she served them sliced deli ham on a slice of bread. -She used all the ham at breakfast and threw away the empty package. -The Administrator brought the food to the facility for her to prepare; he always gave her what she needed for the menu, so she never had to substitute anything. Interview with two residents on 08/01/19 at 9:00am revealed: -They did not see a menu, so they did not know what was supposed to be served daily.	D 292	Administrator will assure that all substitution for meals are wrote up before meal is served.	9/10/19

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D 292	Continued From page 11 -They did not have ham at breakfast that morning; the bread only had margarine on it. -They had sausage and eggs for breakfast the day before, but they got oatmeal most days for breakfast. Interviews with a third and fourth resident on 08/01/19 at 9:15am and 9:45 am revealed: -Sausage was served for breakfast the day before. -They had margarine on their bread; they did not get ham at breakfast that morning. -They had never had ham for breakfast. -They could ask what was for lunch or dinner; they did not have a menu to look at. -They got oatmeal for breakfast "about" every day. Interviews with the MA on 08/01/19 at 12:30 pm and 1:25pm revealed: -She called the Administrator to let him know when she needed any missing menu items for the meals that day, -The Administrator would bring her the needed menu items before the meal time so she would not have to use substitute menu items. -The Administrator bought groceries for the week on Fridays and when she told him she needed something; the Administrator had delivered groceries yesterday, 07/31/19. -She did not have okra for the lunch meal that day and had to use mixed vegetables; she had brought in the pita chips that morning. -She had "missed" the Jell-O on the lunch menu when she looked at it and did not have time to make any when the residents asked for dessert, so she gave them the honey buns. Telephone interview with the Administrator on 08/01/19 at 4:30pm revealed:	D 292		

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D 292	Continued From page 12 -He periodically checked the substitution log; the last time he checked the log was in February 2019 and there was nothing documented on it. -The staff usually called him to let him know ahead of time if they needed something for a meal, but they usually only called him once a week. -He tried to rarely have substitutions to the menu. -The staff knew to document substitutions on the substitution log; if there were substitutions for breakfast and lunch on 08/01/19 then the staff should have documented the items. -He shopped for groceries once a week on Thursdays but brought other food to the facility as needed; he had not been to the facility the day before with groceries. -He sent a driver with missing menu items for the dinner meal for 08/01/19, but no one had let him know there were missing items for breakfast or lunch on 08/01/19. -He did not know pancakes were not served for breakfast and ham was substituted for sausage, and he did not know okra, potato chips and Jell-O were substituted at lunch on 08/01/19. -Substitutions should have been documented by the MA on the substitution log for each meal if the food items served were different from the menu. -He wondered if staff were substituting items without telling him.	D 292		
D 300	10A NCAC 13F .0904(d)(3)(B) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or	D 300		

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	HAL017040	A. BUILDING: _____ B. WING _____	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
G ANTHONY RUCKER REST HOME	1196 HODGES DAIRY ROAD YANCEYVILLE, NC 27379

(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 300	Continued From page 13 cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on observation, record review, and interviews the facility failed to assure two servings of fruit daily were included on the menu and provided to the residents. The findings are: Review of the posted menu for 08/01/19 revealed: -There was a half a cup of orange juice on the menu for breakfast that morning. -There was a half cup of applesauce on the menu for dinner that evening. Observation of the facility's food supply on 08/01/19 at 8:45am revealed: -There was a half a quart of fresh 100% orange juice available and four cans of frozen 100% orange juice available. -There was an unopened bag of fresh apples that had begun to rot. -There was an opened bag of tangerines that had twelve tangerines; the tangerines were hard and dry. -There was no other citrus fruit, no other fresh fruit, no canned fruit, and no dried fruit available in the facility.	D 300	Administrator will assure that servings of fruits on the menu be provided to residents. -The Administrator will purchase fruit during weekly shopping. -The Administrator will continue to discuss this with the residents at quarterly resident council meetings. Administrator will assure that more fresh fruit be available and for residents in the facility.	9/10/19 9/10/19

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D 300	Continued From page 14 Interview with three residents on 08/01/19 at 9:00am and 9:15am revealed: -They did not get fruit with meals and fruit was not offered by staff. -They had canned peaches occasionally but could not remember the last time they had canned fruit. -They had stewed apples once but that was a long time ago. -They liked fruit, including apples and oranges but it had been a long time since they had fresh oranges or apples. -They never got bananas and would eat bananas if they were available or offered. Interview with three residents on 08/01/19 between 3:55pm and 4:15pm revealed: -The facility had offered apples before; the residents with teeth problems could not eat the apples. -They might be offered fruit once a month; the residents did not remember the last time fruit was offered. -No one had ever asked them what fruit they liked. -They would love to have bananas, oranges, tangerines, grapes and other fresh fruits. Interview with the personal care aide/medication aide (PCA/MA) on 08/01/19 at 4:05pm revealed: -Fresh bananas and apples had been delivered after lunch that day. -She did not know there were fresh apples and oranges in the cabinet that were rotting. -Staff served bananas two times a week; fresh fruit was set out in the kitchen and residents could help themselves. -Canned peaches were on the menu. -She did not always work in the facility so she could not say how often other fruit was served.	D 300	Administrator will assure that residents be offered more fresh fruits ex. apples bannans, grapes, orange, tangeriners etc.	9/10/19

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D 300	Continued From page 15 Interview with a MA on 08/01/19 at 6:00pm revealed: -She served some sort of fruit to the residents every day. -She knew bananas had been served to residents last week but could not say how often or the exact time they were served. -She could not say when the last meal canned fruit was served. Telephone interview with the Administrator on 08/01/19 at 4:30pm revealed: -Fresh fruit was cut up and put on a tray in the living room once a week for the residents to eat. -The residents had fresh pineapple and grapes the week before. -The staff put out cut up apples for residents to eat and bananas were offered two times a week. -He stopped putting out a bowl of whole fruit because the residents would put the food in their pockets and pocketbooks. -Canned fruit was served when it was on the menu.	D 300		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the residents were treated with respect, consideration and dignity, related to meals served on broken plates and cups.	D 338		

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D 338	Continued From page 16 The findings are: Observation of the dining room on 08/01/19 at 12:15pm revealed: -The dining room was preset for lunch; there were place settings for eleven residents. -There were two coffee mugs with chips around the top of the mug; one of the mugs had multiple chips. -There were five plates with multiple chips around the edge of the plates; one of the plates had seven chips on it. Interview with the medication aide (MA) on 08/01/19 at 12:15pm revealed: -Staff used the plates that were in the cabinet and bin for meal service. -There were more than enough plates in the facility to serve the residents and not use the broken plates. -She had not thought about the risk of a resident cutting their mouths on the cups or hands on the broken plates. Interview with the personal care aide/medication aide (PCA/MA) on 08/01/19 at 12:15pm revealed: -She had not been told to discard any of the broken plates and did not think anything was wrong with using them to serve the resident meals. -She would remove the broken plates and discard them. Interview with two residents on 08/01/19 at 1:30am revealed: -They noticed the cups and plates were in "bad shape", but thought those were the only plates and cups the facility had to use. -They would like to eat off of nicer plates and drink out of nicer cups to drink from.	D 338	Administrator will assure that broken plates, cups, bowls, and dishes be replaced with new ones. Administrator will make sure old dishes are disguarded and new dishes are placed in facility. -The medication aides will be reminded to monitor this at every meal and discard of broken and chipped plates as needed. -The Administrator will monitor a meal at least quarterly to observe dishes being used.	9/16/19

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D 338	Continued From page 17 Telephone interview with the Administrator on 08/01/19 at 6:25pm revealed: -He did not go into the facility and observe the meals because he tried to stay out of the way at meal times. -He did not know there were chipped cups and plates until the staff called him that day and told him. -He told the staff to throw out the broken cups and plates. -There were enough plates for each resident for meal service; he recently bought new plates, so he did not know why the PCA and MA were using the broken ones. -He was concerned the broken pieces of plate could get into the residents' food and he was concerned they could also cut their hands and mouths.	D 338		
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 18	D 358		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 2 of 4 sampled residents (#1, #4) for an inhaler for chronic obstructive pulmonary disease (#1, #4).

The findings are:

1. Review of Resident #1's current FL-2 dated 02/28/19 revealed diagnosis included "aftercare".

Review of a physician's encounter form dated 02/15/16 revealed diagnoses included encounter for other specified aftercare, difficulty walking, muscle weakness and chronic obstructive pulmonary disease (COPD) with acute exacerbation, bipolar disease, current episode depressed and anxiety disorder.

Review of Resident #1's FL-2 dated 02/18/19 revealed an order for Ventolin inhaler 18gm inhale two puffs four times a day. (Ventolin is bronchodilator used to treat COPD).

Review of Resident #1's June 2019 through August 2019 Medication Administration Records (MAR) revealed:
-There were computer-generated entries for medications with scheduled times on the MARs.
-There was a handwritten entry for Ventolin two puffs four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Ventolin was administered at 8:00am,12:00pm, 4:00pm and 8:00pm daily from 06/01/19 through 08/01/19.

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D 358	Continued From page 19 Observation of Resident #1's medications on hand on 08/01/19 at 11:24am revealed there was a Ventolin inhaler with a dispense date of 07/10/19; the count on the inhaler was 100. Interview with Resident #1 on 08/01/19 at 1:59pm revealed: -She did not use her Ventolin every day. -She only used her Ventolin when she asked for it; no one ever offered her the Ventolin to use. -She had not asked for her Ventolin since last month. -She thought she used it for a couple of weeks last month; she was not sure how many times a day she used the Ventolin during that time. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/01/19 at 3:10pm revealed: -Resident #1's Ventolin inhaler was dispensed on 12/13/18 and 07/10/19. -Each inhaler had 200 inhalations which would provide 2 puffs four times a day for 25 days. -The Ventolin inhaler was considered a bulk medication and was only refilled when requested by the facility staff. -There had been no request to reorder Resident #1's Ventolin other than the dates noted. -The Primary Care Provider (PCP) had sent a prescription to the pharmacy on 07/25/19 for Ventolin four times a day for two days and then as needed (PRN); it should have been administered four times a day on 07/26/19 and 07/27/19. Interview with the medication aide (MA) 08/01/19 at 5:41pm revealed: -Resident #1 used her Ventolin inhaler four times per day. -She documented Resident #1 used her inhaler	D 358	-The Administrator will make sure medications are being administered as ordered. -The Administrator will complete cart audits monthly. -Cart audits will include comparing medications on hand, dispensed dates and MARs. Administrator will assure that Ventolin be ordered on a regular bases and that Ventolin be administred as ordered. Administrater will assure that resident get Ventolin on a daily bases as ordeal if resident do not need Vetolin the Administrater will assure that order for Vetolin be D/C or that it be changed to PRN.	9/10/19

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D 358	Continued From page 20 today, 08/01/19 by mistake; she did not use it today. -She could not explain why the Ventolin was documented as being administered four times a day when the Ventolin inhaler dispensed on 12/13/18 would not have had enough doses four times a day from 12/13/18 until 07/10/19. -She could not say what others did but she knew if she documented she administered the Ventolin, she administered it. -Maybe the other MA's documented they administered the Ventolin when they did not. Telephone interview with the Administrator on 08/01/19 at 5:41pm revealed: -He was concerned the MAs were signing off Resident #1's Ventolin inhaler was administered if it had not been. -The MAs should not be documenting they had administered the Ventolin inhaler if they had not administered it. -The MAs let him know when the medication was low and he re-ordered it. -He audited the medication cart monthly; he only looked to make sure there was medication on hand. -He did not look at the dispensed dates on the medication or the count on the inhaler. Telephone interview with Resident #1's primary care provider (PCP) on 08/02/19 at 1:21pm revealed Ventolin could be administered prn. Based on observations, interviews, and record reviews, Resident #1's Ventolin inhaler could not have been administered daily as documented on Resident #1's MAR's according to the amount of Ventolin dispensed from the pharmacy compared to the amount required for daily administration.	D 358		

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D 358	Continued From page 21 2. Review of Resident #4's current FL-2 dated 02/28/19 revealed: -Diagnosis included left Middle cerebral artery (MCA) stroke, atrial fibrillation, hyperthyroidism, and constipation. -There was an order for Ventolin 18gm two puffs four times a day. (Ventolin is used to treat or prevent bronchospasm). Review of signed Physician Orders dated 05/28/19 revealed a hand-written order for Ventolin inhaler 18g inhale two puffs four times daily. Review of Resident #4's June 2019, July 2019, and August 2019 Medication Administration Records (MAR) revealed: -There was a handwritten entry for Ventolin inhaler 18g inhale two puffs four times daily. -Ventolin inhaler was documented as administered daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 06/01/19-08/01/19. Observation of Resident #4's medications on hand on 08/01/19 at 5:09pm revealed: -There was a Ventolin inhaler with a dispensed date of 07/09/18; the count on the inhaler was 25. -The pharmacy label directions were to administer two puffs four times daily. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/01/19 at 3:10pm revealed: -Resident #4 had a prescription filled on 12/18/18 for Ventolin two puffs PRN (as needed). -There should not be an entry on the MAR for Ventolin two puffs four times a day; it was listed as a PRN (as needed) on the MARs. -He remembered getting the order clarified and it was prn, not daily as ordered on the current FL-2.	D 358	Administrator will assure that Ventolin be ordered on a regular bases and that Vetolin be administered as ordered. Administrator will assure that resident get Ventolin on regular bases as ordered. Administrator will assure that resident need Ventolin if resident do not need Ventolin Administrator will assure that order is discontinued or changed to PRN.	9/10/19

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D 358	Continued From page 22 Interview with Resident #4 on 08/01/19 at 4:00pm revealed: -He did not use his Ventolin inhaler today; he only used his Ventolin inhaler when he had a cold. -He did not recall when he used his Ventolin inhaler, but it had been "a long, long time." Interview with the medication aide (MA) 08/01/19 at 5:41pm revealed: -Resident #4 used his Ventolin inhaler four times per day. -She documented Resident #4 used his inhaler today, 08/01/19 by mistake; he did not use it today. -She could not explain why the Ventolin inhaler was documented as being administered four times a day when the Ventolin inhaler dispensed on 12/18/18 would not have had enough doses for four times a day from 12/18/18 until today, 08/01/19. -She could not say what others did but she knew if she documented she administered the Ventolin , she administered it. -Maybe the other MA's documented they administered the Ventolin when they did not,"she could not say for sure what they did, she only knew what she did." Telephone interview with the Administrator on 08/01/19 at 5:41pm revealed: -He was concerned the MAs were documenting they had administered a medication Resident #4's Ventolin inhaler was administered if it had not been. -The MAs should not be writing down they had administered Resident #4's Ventolin inhaler if they had not administered it. -The MAs let him know when a medication was low and he re-ordered it.	D 358		

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D 358	Continued From page 23 -He audited the medication cart monthly; he only looked to make sure there was medication on hand. -He did not look at the dispensed dates on the medication or the count on the inhaler. Telephone interview with Resident #4's primary care provider (PCP) on 08/02/19 at 1:21pm revealed Ventolin could be administered prn. Based on observations, interviews, and record reviews, Resident #4's Ventolin inhaler could not have been administered daily as documented on Resident #4's MAR's according to the amount of Ventolin dispensed from the pharmacy compared to the amount required for daily administration.	D 358	Type text here	
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #5, #7) with medications to be administered at 12:00pm that were not administered until 2:00pm, including a blood pressure medication and a supplement (#1); a laxative (#5); and a medication used to treat anxiety (#7). Observation of the medication cart and	D 364	Administrator will assure that gloves are at medication cart at all times so that medication can be administrated at the correct time frame. Administrator will assure that staff know to administer medication at correct times everyday all day. -The Administrator will monitor monthly during cart audits.	9/10/19

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D 364	Continued From page 24 medication aide (MA) on 08/01/19 between 12:00pm and 2:00pm revealed no medications were administered to the residents. 1. Review of Resident #1's current FL-2 dated 02/28/19 revealed: -Diagnosis included "aftercare". -There was an order for Hydralazine 25mg four times daily. (Hydralazine is used to treat high blood pressure). -There was an order for Oyster Shell Calcium 500mg twice daily at lunch and dinner. (Oyster shell calcium is a supplement). -There was an order for Acetaminophen 325mg every 8-hours. (Acetaminophen is used to treat minor aches and pains, and reduces fever). Review of a physician's encounter form for Resident #1 dated 02/15/16 revealed diagnoses included encounter for other specified aftercare, difficulty walking, muscle weakness and chronic obstructive pulmonary disease (COPD) with acute exacerbation, bipolar disease, current episode depressed and anxiety disorder. Observation of the medication aide (MA) on 08/01/19 at 1:46pm revealed: -Resident #1 approached the MA and asked for her 12:00 and 2:00pm medication. -The MA responded that she could not give both the 12:00 pm and 2:00pm medications that close together and she would "get with her in a minute to go sit down." -At 1:53pm she administered Resident #1 her 2:00pm dose of Acetaminophen. -Resident #1 asked the MA about her 12:00 medication and the MA responded, "I have to wait until they leave." Interview with Resident #1 on 08/01/19 at 1:59pm	D 364	Administrator will assure that gloves be kept on medicine Cart at all times. Administrator will assure that all medications are administered in correct time frame. Administrator will assure that all med techs know to administer medication at correct time frame. Administrator will assure that all med tech know to administer medication at correct time all day everyday.	9/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017040	A. BUILDING: _____ B. WING _____	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
G ANTHONY RUCKER REST HOME	1196 HODGES DAIRY ROAD YANCEYVILLE, NC 27379

(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 364	Continued From page 25 revealed: -She had not been administered her 12:00pm medications today, 08/01/19. -She usually took a blood pressure pill and a calcium supplement. Second interview with Resident #1 on 08/01/19 at 4:10pm revealed: -The MA administered her Hydralazine around 2:30pm. -She did not receive her calcium supplement; she did not know why she did not receive her calcium supplement. Observation of Resident #1's medications on hand on 08/01/19 at 5:18pm revealed: -Resident #1's 2:00pm Acetaminophen 325mg had been punched. -Resident #1's 12:00 pm Hydralazine 25mg had been punched. -Resident #1's 12:00pm Oyster Shell Calcium 500mg had not been punched. Review of Resident #1's August 2019 Medication Administration Records (MAR) at 4:36pm revealed: -There was a computer generated-entry for Acetaminophen 325mg scheduled at 6:00am, 2:00pm and 10:00pm. -Acetaminophen was documented as administered at 6:00am and 2:00pm. -There was a computer-generated entry for Hydralazine 25mg four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Hydralazine 25mg was administered at 8:00am and 12:00pm on 08/01/19. -There was a computer-generated entry for Oyster Shell Calcium 500mg to be administered at 12:00pm and 5:00pm with a meal.	D 364	Administrator will assure that gloves are kept at medication cart Administrator will assure that all med techs know to give medication within the correct time frame. Administrator will assure that med tech know to administer medications at correct time frame every day all day so that medication can have the proper effect.	9/10/19

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D 364	Continued From page 26 -Oyster Shell Calcium was not documented as administered. Telephone interview with Resident #1's primary care provider (PCP) on 08/02/19 at 1:21pm revealed: -Resident #1 took Hydralazine for high blood pressure. -If Resident #1 did not take her Hydralazine as ordered her blood pressure could be elevated. -Resident #1 took Oyster Shell as a supplement; there was no concern Resident #1 missed her 12:00pm calcium supplement. Refer to the interview with the medication aide (MA) 08/01/19 at 5:33pm Refer to the telephone interview with the Administrator on 08/01/19 at 5:41pm. 2. Review of Resident #5's current FL-2 dated 02/28/19 revealed: -Diagnoses included hypertension, cognitive communication deficit, altered mental status and schizo affective disorder. -There was an order for Enulose 10g/ml take 60ml four times daily. (Enulose is used to treat constipation). Interview with Resident #5 on 08/01/19 at 2:02pm revealed he had not taken any medications at lunch today, 08/01/19. Review of Resident #5's August 2019 Medication Administration Records (MAR) at 4:36pm revealed: -There was a computer-generated entry for Enulose 10g/ml take 60ml four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.	D 364	Administrator will assure that gloves are kept on medication Cart. Administrator will assure that med techs administer medication at the correct time so medications can have proper effect Administrator will assure that all medication be administered by medication tech at the correct time frames. Administrator will assure that med tech know to administer medication at correct time frame all day every day.	9/10/19

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D 364	Continued From page 27 -Enulose 60ml was documented as administered at 8:00am. -Enulose 60ml was not documented as administered at 12:00pm. Telephone interview with Resident #5's primary care provider (PCP) on 08/02/19 at 1:21pm revealed: -Resident #5 took Enulose for constipation. -There was no concern Resident #5 missed a dose of Enulose. Observation of Resident #5's medications on hand on 08/01/19 at 5:18pm revealed Resident #5 had multiple bottles of liquid Enulose available to be administered. Refer to the interview with the MA 08/01/19 at 5:33pm Refer to the telephone interview with the Administrator on 08/01/19 at 5:41pm. 3. Review of Resident #7's current FL-2 dated 02/28/19 revealed: -Diagnosis included hypertension, and paranoid schizophrenia. -The was an order for hydroxyzine 50mg take four times daily, (Hydroxyzine is used to treat anxiety.) Observation of the medication aide (MA) on 08/01/19 at 1:45pm revealed: -Resident #7 approached the MA and said, "I don't feel good", and asked about taking his 12:00pm medication. -The MA told Resident #7 he did not feel good "because of the heat" to which he responded, "no, because I did not get my meds". -The MA sent Resident #7 away.	D 364	1-Administrator will assure that gloves are kept at medication cart. Administrator will assure that med techs know to pass out medication at the correct time frame. Administrator will assure that staff is aware of the importance of correct medication time so the medication can have the correct effect. Administrator will assure med tech know to administrator medication within time frame everyday all day.	9/10/19

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D 364	Continued From page 28 Interview with Resident #7 on 08/01/19 at 1:50pm revealed: -He took a "pill" everyday at lunch after he ate; he took the same pill four times a day. -He usually took his medication on time, but he had not taken his noon medication and he was worried. -He was concerned about taking his 12:00pm dose at 2:00pm because then the 4:00pm dose would be too close together. -It made him sick when he did not take his medication four times a day. -The MA told him she would call him when it was time to take his medication. Observation of the MA on 08/01/19 at 1:55pm revealed: -She tried to administer Resident #7 his medication; he refused to take his medication because he said it was too close to his 4:00pm dose. -She told him to go ahead and take this dose and not wait until the 4:00pm dose. -Resident #7 took the medication at 1:58pm. A second interview with Resident #7 on 08/01/19 at 3:30 pm revealed he would choose to "skip" his 4:00pm dose of hydroxyzine because it made him feel sick to take the doses too close together. Observation of Resident #7's medication on hand on 08/01/19 at 6:10pm revealed: -Resident #7's hydroxyzine had been removed from the 12:00pm medication card. -Resident #7's hydroxyzine was still in the 4:00pm medication card. Review of Resident #7's August 2019 medication administration record (MAR) revealed:	D 364	Administrator will assure that gloves are kept at medicine cart. Administrator will assure that med tech know the importance of administing medication at the correct time frame so the medication can have the correct and proper effect that the medication is suppose to have. Administrator will assure that medication tech know the importance of not administering medication to close and administering it at the allowed time frame. Administrator will assure that med tech know to administer medication within correct time frame everyday all day.	9/10/19

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D 364	Continued From page 29 -There was a computer-generated entry for hydroxyzine 50mg four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation on 08/01/19 that Resident #7 was administered hydroxyzine 50mg at 8:00am and 12:00pm; there was documentation Resident #7 refused his 4:00pm administration of hydroxyzine 50mg. Telephone interview with a representative from Resident #7's mental health provider on 08/02/19 at 2:40pm revealed: -Resident #7 was ordered hydroxyzine 50mg four times daily for anxiety. -She would consider the late administration of the hydroxyzine 50mg a missed dosage. -Resident #7 could become anxious and cause him to "act out" if he missed a dosage. -If Resident #7 was administered his doses of hydroxyzine 50mg too close together he could become lethargic and drowsy. -She had not been notified of a missed dosage or refusal of hydroxyzine for Resident #7. Refer to the interview with the medication aide (MA) 08/01/19 at 5:33pm Refer to the telephone interview with the Administrator on 08/01/19 at 5:41pm. Interview with the medication aide (MA) 08/01/19 at 5:33pm revealed: -She did not administer 12:00pm medications today (08/01/19) because she got behind. -She administered 12:00pm medications around 2:00pm. -She called the Administrator to let him know what had happened, and he told her to "go ahead and give the medication." -She did not notify the primary care provider	D 364	Administrater will assure that medication tech know not to administer medication so closely due to medication reason ex. lethargic and resident becoming drowsy. Administrater will assure that medication tech know to administer medication within the allowed time from all day every day of the week.	9/10/19

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D 364	Continued From page 30 (PCP) she had not administered the 12:00 pm medication until two hours after the scheduled time; the Administrator was responsible for notifying the PCP. Telephone interview with the Administrator on 08/01/19 at 5:41pm revealed: -The MA had called him about the 12:00 pm medication and said she did not have gloves available to do her medication pass and was waiting until the gloves arrived. -He had gloves being delivered to the facility, and he told her to administer the medication when the gloves arrived. -He usually called the PCP to let them know medication was administered an hour past the allowed time frame. -The MA had not told him the specific medications she had not administered at 12:00pm but had told him the residents' names. -He had not called the PCP to let him know the residents' medications had not been administered at 12:00pm as ordered, but he was going to do so.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (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	D 367		

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D 367	Continued From page 31 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, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 1 of 5 residents sampled (#1) including inaccurate documentation of an anti-depressant (#1). The findings are: Review of Resident #1's current FL-2 dated 02/28/19 revealed diagnosis included "aftercare". Review of a physician's encounter form dated 02/15/16 revealed diagnoses included encounter for other specified aftercare, difficulty walking, muscle weakness and chronic obstructive pulmonary disease (COPD) with acute exacerbation, bipolar disease, current episode depressed and anxiety disorder. Review of a physician's order dated 06/14/19	D 367		

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D 367	Continued From page 32 revealed an order to increase Paroxetine 10mg to Paroxetine 20mg at bedtime. Review of Resident #1's June 2019 Medication Administration Record (MARs) revealed: -There was a computer-generated entry for Paroxetine 10mg daily scheduled at 8:00pm. -There was documentation Paroxetine 10mg was administered daily from 06/01/19-06/13/19. -There was a handwritten note Paroxetine 10mg was discontinued on 06/14/19. -Beginning 06/14/19 Paroxetine 10mg was marked out through the remainder of the month. -There was a second computer-generated entry for Paroxetine 20mg daily scheduled at 8:00pm with a start date of 06/19/19. -The dates prior to 06/19/19 were blacked out; there were hand drawn blocks under the blacked out area from 06/14/19 through 06/18/19 that were initialed indicating this medication had been administered on those dates. -There was documentation Paroxetine 20mg was administered at 8:00pm daily from 06/14/19 through 06/30/19. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/01/19 at 3:10pm revealed Paroxetine 20mg was dispensed and delivered to the facility for Resident #1 on 06/19/19. Interview with the medication aide (MA) 08/01/19 at 5:41pm revealed: -She was not the MA who documented they had administered Paroxetine 20mg when the medication had not been delivered to the facility. -She did not know why the Paroxetine 10mg had been marked out when it was still an active order. Telephone interview with the Administrator on	D 367	Administrator will assure that medication documentation is done proper. Administrator will assure that new medications and medication changes be change when medication come into the facility. Administrator will assure that once medication is brought in from the pharmacy that it will be documented correct and placed on MAR. -The Administrator will monitor monthly during cart audits -MARs will be audited during monthly cart audits as well.	9/10/19

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D 367	Continued From page 33 08/01/19 at 5:41pm revealed: -He was concerned the MA documented Paroxetine 20mg was administered when the medication had not been delivered to the facility. -He did medication cart audits last month. -If he looked at the Paroxetine for Resident #1 he probably saw the order for 06/14/19 and would not have known the medication was not in the building until 06/19/19. Attempted interview with a second MA on 08/01/19 at 6:11pm was unsuccessful. Based on observations, interviews, and record reviews, Resident #1's Paroxetine 20mg could not have been administered as documented on Resident #1's MAR's from 06/14/19 through 06/19/19 according to the date the medication was dispensed and delivered to the facility.	D 367		
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: 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 reconciled for 1 of 2 residents sampled	D 392		

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D 392	Continued From page 34 (Residents #1) who was prescribed controlled substances. The findings are: Review of Resident #1's current FL-2 dated 02/28/19 revealed: -Diagnosis included "aftercare." -There was an order for Lorazepam 0.5mg ½ tablet every 12 hours as needed for anxiety. Review of a physician's encounter form for Resident #1 dated 02/15/16 revealed diagnoses included encounter for other specified aftercare, difficulty walking, muscle weakness and chronic obstructive pulmonary disease (COPD) with acute exacerbation, bipolar disease, current episode depressed and anxiety disorder. Review of Resident #1's June 2019 through August 2019 Medication Administration Records (MAR) revealed: -There were computer-generated entries for medications with scheduled times on the MARs. -There was a computer-generated entry for Lorazepam 0.5mg ½ tablet every 12 hours as needed for anxiety. -Lorazepam was documented as administered 34 times. Observation of Resident #1's medications on hand on 08/01/19 at 11:24am revealed: -There was a punch card for Lorazepam 0.5mg with a dispense date of 03/05/19 for 25 one-half tablets; there were no tablets available to be administered. -There was a second punch card for Lorazepam 0.5mg with a dispense date of 03/05/19 for 35 one-half tablets; there were 30 one-half tablets available to be administered.	D 392	Administrator will assure that all med tech know to count off medications that are controlled to next med tech. Administrator will assure that all med tech know the importance of documentation on control substance and correct count down on control substances. -Control logs will be monitored during monthly cart, MAR audits by the Administrator.	9/10/19

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D 392	Continued From page 35 -There was a total of 60 one-half tablets dispensed on 03/05/19 with 30 tablets available to be administered. Telephone interview with a Pharmacist at the contracted pharmacy on 08/01/19 at 3:10pm revealed Lorazepam 0.5mg had been dispensed for Resident #1 on 03/05/19 for 60 tablets; a punch card with 25 one-half tablets and a punch card with 35 one-half tablets. Review of Resident #1's Controlled Substance Count Sheets (CSCS) revealed: -There was a CSCS generated by the contracted pharmacy for Lorazepam 0.50 mg, take ½ tablet (0.25mg) every twelve hours as needed for anxiety dated 08/22/17 for 30 tablets. -There was a handwritten number 60 written on the CSCS. -The count started on 06/11/19 with a dose administered at 3:00pm leaving a balance of 59. -The last entry was dated 07/15/19 with a dose administered at 8:00am leaving a balance of 33. -There were 27 entries documented that a dose was administered. -There was one dose documented on the MAR on 07/21/19 that was not documented on the CSCS. Interview with the medication aide (MA) on 08/01/19 at 11:50am revealed: -The MAs count off at change of shift on all controlled substances. -She had counted off controlled substances with another MA on Monday, 07/29/19, when she came on duty. -She did not know why the CSCS did not match the medication on hand.; she must have missed counted the medication.	D 392		

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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 392	Continued From page 36 Telephone interview with the Administrator on 08/01/19 at 5:41pm revealed: -The MAs were supposed to count off together to make sure control medication on hand matched the control logs. -He thought someone may have administered the Lorazepam for Resident #1 and did not document it. -His concern was someone administered the medication and did not document. -He was concerned the staff did not count off the control medication on the last change of shift. -He expected the staff to count control medication at the change of shift and to notify him of any discrepancies. Based on observation of medications on hand, reviews of the MAR and CSCS, and interviews there were two doses of Lorazepam unaccounted for.	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 were adequate,	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017040	A. BUILDING: _____ B. WING _____	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
G ANTHONY RUCKER REST HOME	1196 HODGES DAIRY ROAD YANCEYVILLE, NC 27379

(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
D912	Continued From page 37 appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews and record reviews, the facility failed to refer 2 of 2 sampled residents (#6 and #8), who needed their toenails trimmed, to a podiatrist. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912	Administrator will assure that resident receive the correct toenail care. Administrator will assure that PCP make referall to podiatrist so the residents can get their toenails trimmed / cut.	9/10/19