STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081008	A. BUILDING: _____ B. WING _____	11/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN MANOR REST HOME	390 HARDIN ROAD FOREST CITY, NC 28043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Rutherford County Department of Social Services conducted an annual survey on 11/05/19.	D 000	Cook will not store meat inside the sink to be thawed unless it is in a separate Container with running water over it. And if meat is not thawed out and is put in the sink it will be put in a separate Container and will have running water over it until meat is thawed out completely. Meat that is taken out the night before will be placed in a separate Container and put at the bottom of the Refrigerator to thaw out. Sic will Check once a week and the Director will Check once a month to ensure that we are in Compliance and that it is done properly 12/13/19 RP	
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food being thawed for resident meals was protected from contamination related to ground beef thawing in the kitchen sink. The findings are: Observations in the facility kitchen on 11/05/19 at 11:45am, 12:00pm and 12:22pm revealed: -There was a 4.32-pound package of ground beef in the original package was sitting in the kitchen sink. -The ground beef was not in a separate container and did not have running water over it. Interview with the cook on 11/05/19 at 12:22pm revealed: -He took the ground beef out at 11:30am today. -He was going to use it for the evening meal. -He usually sits meat out to thaw in the sink but does not set it in water or run water over it. -He usually sits the meat back in the bottom of the refrigerator to finish thawing.	D 282		

Rhonda Cash 12/13/19

Accepted with revisions 12/16/19 RP

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D 282	Continued From page 1 -Upon touching the meat in the sink with his gloved hand he stated, "it's still frozen." Review of the facility Kitchen Training check off list initialed, dated and signed on 03/16/13 by the cook revealed the following statement: "Meats thawing must be laid out in pan in bottom of fridge with ample time to thaw for next day. If not completely thawed, they may be thawed in container in sink with water running on them. Water must remain running until thawed." Interview with the Supervisor on 11/05/19 at 3:25pm revealed she was unaware the ground beef was being thawed in the sink in the original container without running water. Interview with the Administrator on 11/05/19 at 3:55pm revealed: -The cook had just taken the meat out of the freezer before it was seen in the sink. -The cook was going to put it in the refrigerator to thaw. -He usually does this right.	D 282		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	D 358		

Rhonda ah

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D 358	Continued From page 2 Based on observations, interviews and record review the facility failed to assure the administration of medications were in accordance with orders by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #1) related to a medication used to treat movement disorders. The findings are: Review of Resident #1's current FL-2 dated 06/10/19 revealed diagnoses included bipolar disorder and depression. Review of Resident #1's medication order dated 09/04/19 revealed Cogentin was to be discontinued. Review of Resident #1's Medication Administration Record (MAR) for September 2019 revealed: -There was an entry for benztropine (generic for Cogentin) 1 milligram (mg) at 8:00am and 8:00pm. -Benztropine was documented as administered twice daily from 09/01/19 through 09/30/19. Review of Resident #1's Medication Administration Record (MAR) for October 2019 revealed: -There was an entry for benztropine 1mg at 8:00am and 8:00pm. -Benztropine was documented as administered twice daily from 10/01/19 through 10/31/19. Review of Resident #1's Medication Administration Record (MAR) for November 2019 revealed: -There was an entry for benztropine 1mg at 8:00am and 8:00pm.	D 358	Medication Aide Supervisor will make sure that all D/C orders are corrected on MAR's before putting them out. She will have the SIC on duty to double check alone with the Admin as well and they will initial the mar's as well before putting them out. This is to ensure that no medication errors take place and that any Medication that is D/C will not be administered to any resident. The Medication Aide Supervisor will make sure that the pharmacy receives all D/C orders will given by doctor per resident. The Director will check once a month to ensure that this is being done and that the facility is in Compliancy 12/13/19 RP	

Rhonda Cash

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D 358	Continued From page 3 -Benztropine was documented as administered twice daily from 11/01/19 through 11/04/19. -Benztropine was documented as administered at 8:00am on 11/05/19. Interview with Resident #1 on 11/05/19 at 8:59am revealed: -She did not know the names of medication she was on. -The staff gave her medications every day. -She usually got her medications on time, but not always. Interview with the pharmacy manager on 11/05/19 at 2:20pm revealed: -They packaged Resident #1's medications for the facility. -They were responsible for printing the information given to them by the facility for the MAR. -They dispense medications to the facility two weeks at a time. -The most recent two weeks packaging for Resident #1's benztropine was sent on 10/24/19. -Resident #1's next medication delivery is scheduled for 11/07/19. -They had not received an order from the facility to discontinue the benztropine for Resident #1. Interview with the Medication Aide Supervisor on 11/05/19 at 3:20pm revealed: -She checked the MAR for accuracy. -The benztropine should have been discontinued 09/04/19. -She often got interrupted by residents and must have been distracted which caused her to miss the discontinue order for the benztropine. -The continuation of the administration of benztropine by facility staff was a mistake.	D 358		

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D 358	Continued From page 4 Review of the medication cart on 11/05/19 at 3:39pm revealed benztropine 1mg tab was available in a 14-day dosing package for 8:00am and 8:00pm daily. Interview with the Medication Aide on 11/05/19 at 3:45pm revealed: -She administered benztropine to Resident #1 this morning at 8:00am. -Resident #1 received benztropine twice daily. -She didn't know what benztropine was used for. -The Medication Aide Supervisor talks with the doctor and the pharmacy about medication orders. Interview by phone with the Physician's Assistant on 11/05/19 at 12:31pm revealed: -She had previously initiated a gradual dose reduction of benztropine for Resident #1. -The benztropine medication should have been discontinued on 09/04/19. -Resident #1 now takes a different medication and no longer needed to take the benztropine. -There were no adverse side effects from Resident #1 continuing this dose of benztropine.	D 358		

Rhonda Cash