STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL100005	A. BUILDING: _____ B. WING _____	02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEY HOUSE	4 COOPER LANE BURNSVILLE, NC 28714

(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 completed an annual survey February 18-19, 2020.	D 000		
D 262	10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to ensure the care plan assessor had signed the care plan upon its completion for 5 of 5 sampled residents (Residents #1, #2, #3, #4 and #5). The findings are: 1. Review of Resident #3's current FL2 dated 01/03/20 revealed: -Diagnoses included general anxiety and bipolar disorder. -Resident #3 was documented as ambulatory with no assistive device and continent of bowel and bladder. Review of the care plan for Resident #3 dated 02/05/20 revealed there was no signature or date documented under the Facility Representative Section. Refer to the interview with the Medication Aide (MA) on 02/18/20 at 3:10pm. Refer to the interview with the RCC on 02/19/20 at 1:40pm. Refer to the interview with the Administrator on	D 262	* See attached * plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bernie Robinson — TITLE: Administrator — (X6) DATE: 3/27/20

Reviewed and accepted 3/30/20 AMJ

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D 262	Continued From page 1 02/19/20 at 4:35pm. 2. Review of Resident #4's current FL2 dated 05/13/19 revealed: -Diagnoses included hypertension, diabetes, dysphagia and metabolic encephalopathy. -Resident #4 had no documentation of his ambulatory status but was documented to be continent of bowel and bladder. Review of the care plan for Resident #4 dated 05/21/19 revealed there was no signature or date documented under the Facility Representative Section. Refer to the interview with the Medication Aide (MA) on 02/18/20 at 3:10pm. Refer to the interview with the RCC on 02/19/20 at 1:40pm. Refer to the interview with the Administrator on 02/19/20 at 4:35pm. 3. Review of Resident #5's current FL2 dated 12/13/19 revealed: -Diagnoses included dementia, major depressive disorder, anxiety disorder and osteoarthritis. -Resident #5 was documented as ambulatory with no assistive device and continent of bowel and bladder. Review of the care plan for Resident #5 dated 01/09/20 revealed there was no signature or date documented under the Facility Representative Section. Refer to the interview with the Medication Aide (MA) on 02/18/20 at 3:10pm.	D 262		

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D 262	Continued From page 2 Refer to the interview with the RCC on 02/19/20 at 1:40pm. Refer to the interview with the Administrator on 02/19/20 at 4:35pm. 4. Review of the current FL2 for Resident #1 revealed: -Diagnoses of dementia, alcohol abuse, schizophrenia, chronic obstructive pulmonary disease, depression and pulmonary hypertension. -Resident #1 was documented as ambulatory with a walker, had intermittent disorientation and was incontinent of bowel and bladder. Review of the care plan for Resident #1 dated 12/20/19 revealed there was no signature or date documented under the Facility Representative section. Refer to the interview with the Medication Aide on 02/18/20 at 3:10pm. Refer to the interview with the SCC on 02/19/20 at 9:30am. Refer to the interview with the RCC on 02/19/19 at 1:40pm.	D 262		

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D 262	Continued From page 3 Refer to the interview with the Administrator on 02/19/20 at 4:35pm. 5. Review of the current FL2 for Resident #2 revealed: -Diagnoses of dementia, chronic obstructive pulmonary disease, depression, insomnia, post traumatic stress disorder, anxiety, and gastroesophageal reflux disease. -Resident #1 was documented as non-ambulatory, was constantly disoriented and was incontinent of bowel and bladder. Review of the care plan for Resident #2 dated 01/29/20 revealed there was no signature or date documented under the Facility Representative section. Refer to the interview with the Medication Aide on 02/18/20 at 3:10pm. Refer to the interview with the SCC on 02/19/20 at 9:30am. Refer to the interview with the RCC on 02/19/19 at 1:40pm. Refer to the interview with the Administrator on 02/19/20 at 4:35pm. _____ Interview with the Medication Aide on 02/18/20 at 3:10pm revealed: -She was not responsible for completing resident care plans. -The supervisor for the special care unit completed the residents care plans.	D 262		

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D 262	Continued From page 4 Interview with the SCC on 02/19/20 at 9:30am revealed: -She and the Resident Care Coordinator were responsible for completing resident care plans. -She was responsible for completing Resident's #4 and Resident #5's care plan. -She had not signed the assessment. -She was not aware she was to sign the assessment. -The physician or physician's assistant was to sign the care plan after she did the assessment. Interview with the RCC on 02/19/19 at 1:40pm revealed: -She was responsible for completing resident care plans. -She was not aware she was to sign the care plan after she completed the assessment. -She had been taught by the previous contract nurse consultant to complete the care plan assessment and have the physician or physician's assistant sign it and then turn it in. -No one had ever told her to sign the care plan as the person who assessed the resident for the care plan. Interview with the Administrator on 02/19/20 at 4:35pm revealed: -She was not aware the person completing the care plan assessment should be signing the care plans. -They were told by a contracted nurse the facility completed the assessment and had the physician or physician's assistant to sign the care plan and then place it in the residents medical record. -She would make sure the assessor who had completed the care plan signed the care plan from now on.	D 262		

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D 274	Continued From page 5	D 274		
D 274	10A NCAC 13F .0902(c)(1) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure contact with a resident's physician for 1 of 1 sampled resident (#5) related to the delay of implementing a physician's order for enoxaparin (a medication used to prevent blood clots). The findings are: Review of Resident #5's current FL2 dated 12/13/19 revealed diagnoses included dementia, major depression disorder, anxiety disorder, muscle weakness and osteoarthritis. Review of Resident #5's hospital discharge summary dated 12/06/19 revealed: -Resident #5 was discharged from the hospital and readmitted back to the facility on 12/06/19. -Resident #5 had a physician's order for enoxaparin, 30mg SQ (SQ), to be administered twice daily for 14 days. Review of Resident #5's December 2019	D 274		

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D 274	Continued From page 6 electronic Medication Administration Record (eMAR) revealed: -There was an entry for enoxaparin 30mg SQ to be administered twice daily for 14 days with a start date of 12/10/19. -There was no documentation enoxaparin 30mg SQ was administered from 12/6/19 through 12/19. -The first dose of enoxaparin 30mg SQ, was documented as administered on 12/12/19 at 8:00am. Interview with the Resident Care Coordinator (RCC) on 02/19/20 at 11:10am revealed: -Resident #5 was admitted back to the facility from the hospital at 6:42pm on Friday 12/06/19. -The RCC was not present when Resident #5 returned from the hospital. -She did not know what medications Resident #5 had been ordered upon discharge from the hospital. -She was informed of the order for enoxaparin when she returned to work on Monday 12/09/19. -Resident #5 did not receive enoxaparin over the weekend because she did not know it had been ordered upon discharge from the hospital. -She knew that enoxaparin was a medication the Medication Aides (MAs) were not allowed to administer, so she attempted to contact the hospital physician to have the order changed. -The hospital physician returned her call on the evening of 12/09/19 and was unwilling to change the order for enoxaparin, telling the RCC that the medication needed to be administered as he had ordered. -She did not inform the physician that the medication had not been administered as ordered since Resident #5 had been discharged from the hospital on 12/06/19.	D 274		

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D 274	Continued From page 7 Interview with the Physician Assistant (PA) from Resident #5's surgeon's office on 02/19/20 at 4:20pm revealed: -Ordering Enoxaparin was standard protocol for patients after surgery because the first 2 weeks after surgery was the time of highest risk for developing a blood clot. -Resident #5 was ordered enoxaparin when she was discharged from the hospital and she would have expected Resident #5 to receive it twice a day for 14 days. -She had not been informed that there was a delay in Resident #5 receiving enoxaparin twice a day for 14 days. -Resident #5 had been seen in the office for follow-up and had not developed any blood clots so the physician "probably would have been okay if they had told us at that appointment that she had not received the enoxaparin as ordered". Interview with the Administrator on 02/19/20 at 4:37pm revealed: -It was the facility's policy to clarify orders, when needed, within 24 hours. -She became aware on 12/09/19 that the RCC was trying to get the enoxaparin order changed and that the physician was unwilling to change it and wanted the enoxaparin administered as he had ordered. -She was not aware that the physician had not been informed that the enoxaparin had not yet been administered. -She would expect the RCC to know all discharge orders before any resident was accepted back to the facility after a hospital admission.	D 274		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 8 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: Based on observations, interviews and record reviews, the facility failed to ensure medication was administered as ordered for 1 of 1 sampled resident (#5) related to enoxaparin, a medication used to prevent blood clots. The findings are: Review of Resident #5's current FL2 dated 12/13/19 revealed diagnoses included dementia, major depression disorder, anxiety disorder, muscle weakness and osteoarthritis. Review of Resident #5's hospital discharge summary dated 12/06/19 revealed: -Resident #5 was discharged from the hospital and readmitted back to the facility on 12/06/19. -There was an order for enoxaparin, 30mg SQ (SQ), to be given twice daily for 14 days. Review of Resident #5's physician orders revealed: -There was an order written by the facility's Primary Care Provider (PCP), dated 12/10/19, for enoxaparin, 30mg SQ, to be given twice daily for 14 days. -There was an order written by the PCP, dated 12/20/19 for enoxaparin, 30mg SQ, to be given by home health daily on Saturday, Sunday,	D 358		

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D 358	Continued From page 9 Monday and Tuesday. Review of Resident #5's December 2019 electronic medication administration record (eMAR) revealed: -There was not an entry to administer enoxaparin 30mg SQ, with a start date of 12/06/19. -There was an entry for Enoxaparin 30mg SQ to be administered twice daily for 14 days with a start day of 12/10/19. -Enoxaparin was first documented as administered on 12/12/19 at 8:00am. -Enoxaparin 30 mg SQ twice daily was documented as administered at 8:00am and 8:00pm from 12/12/19 through 12/20/19 for a total of 18 doses. -Enoxaparin 30 mg SQ twice daily was documented as administered at 8:00am on 12/21/19. -There was an entry dated 12/20/19 for Enoxaparin 30mg SQ to be administered daily on Saturday, Sunday, Monday and Tuesday with a start day of 12/21/19. -Enoxaparin 30mg SQ daily was documented as administered at 10:00am on 12/22/19 through 12/24/19 for a total of 3 doses. -Enoxaparin 30mg SQ was documented as administered on the December 2019 eMAR 22 of 28 opportunities. Telephone interview with a representative from the facility's contracted pharmacy on 02/19/20 at 10:09am revealed: -The pharmacy received a faxed order for Resident #5 on 12/10/19 at 1:24pm for enoxaparin 30mg SQ twice daily for 14 days but did not dispense the prescription because the facility requested the medication only be put on Resident #5's eMAR. -The pharmacy received a faxed order for	D 358		

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D 358	Continued From page 10 Resident #5 on 12/20/19 at 1:05pm for enoxaparin 30mg SQ daily on Saturday, Sunday, Monday and Tuesday by home health but did not dispense the prescription because the facility requested the medication only be put on Resident #5's eMAR. Telephone interview with a representative from the facility's local back-up pharmacy on 02/19/20 at 11:33am revealed: -The pharmacy received a faxed order for Resident #5 on 12/10/19 at 12:02pm for enoxaparin 30mg SQ twice daily for 14 days. -A portion of the enoxaparin was picked up by the facility's employee on 12/10/19 at 12:30pm because the pharmacy did not have all 28 doses in stock. -The remainder of the enoxaparin was picked up by the facility on 12/13/19 at 9:32am. -A total of 28 syringes were dispensed between 12/10/19 and 12/13/19. -The pharmacy representative did not know how many syringes were dispensed each day, only that a total of 28 were dispensed. -No enoxaparin had been returned to the pharmacy. Interviews with the Resident Care Coordinator (RCC) on 02/19/20 at 11:10am and 3:50pm revealed: -Resident #5 was admitted back to the facility from the hospital at 6:42pm on Friday 12/06/19. -The RCC was not present when Resident #5 returned from the hospital. -She did not know what medications Resident #5 had been ordered upon discharge from the hospital. -She was informed of the order for enoxaparin when she returned to work on Monday 12/09/19. -She knew that enoxaparin was a medication the	D 358		

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D 358	Continued From page 11 Medication Aides (MAs) were not allowed to administer, so she attempted to contact the hospital physician to have the order changed. -The hospital physician returned her call on the evening of 12/09/19 but was unwilling to change the order for enoxaparin, telling the RCC that the medication needed to be administered as he had ordered. -She spoke with the facility's PCP on 12/09/19 to determine how this medication would be administered as the MA's could not administer it. -The RCC and the PCP determined that the RCC would administer the medication. -When the PCP came to the facility on 12/10/19 she ordered enoxaparin, 30mg SQ twice daily for 14 days. -The enoxaparin was not documented on the eMAR until 12/12/19 because that was the first time it appeared on the eMAR. -She used a controlled substance count sheet to document who administered the enoxaparin and it indicated the first dose was given on 12/10/19. -The RCC was not scheduled to work every day that the enoxaparin was ordered to be administered so the PCP arranged for home health nurses to administer it. -She did not notice that the 12/20/19 order for home health to administer enoxaparin was written as daily instead of twice a day as she thought the PCP intended. -She thought Resident #5 received all 28 doses of enoxaparin because she used the last dose that was in the medication cart when she administered the enoxaparin on 12/24/19. Interview with the Physician Assistant (PA) from Resident #5's surgeon's office on 02/19/20 at 4:20pm revealed: -Patients were discharged from the hospital with orders for enoxaparin twice a day for 14 days.	D 358		

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D 358	Continued From page 12 -Resident #5 was ordered enoxaparin when she was discharged from the hospital and she would have expected Resident #5 to receive it as ordered.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff who administered medication was the person who documented the administration on the electronic Medication Administration Record (eMAR) for 1 of 1 sampled resident (#5) related to enoxaparin, a medication used to prevent blood clots. The findings are: Review of Resident #5's current FL2 dated 12/13/19 revealed diagnoses included dementia, major depression disorder, anxiety disorder, muscle weakness and osteoarthritis.	D 366		

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D 366	Continued From page 13 Review of Resident #5's physician orders revealed: -There was a 12/10/19 order written by the facility's Primary Care Provider (PCP) for Enoxaparin 30mg subcutaneous (SQ) to be administered twice daily for 14 days. -There was a 12/20/19 order written by the PCP for Enoxaparin 30mg SQ to be administered daily on Saturday, Sunday, Monday and Tuesday. Review of Resident #5's controlled substance count sheet dated December 10-23, 2019 revealed: -This count sheet was being used to document who administered enoxaparin. -This count sheet indicated that enoxaparin was first administered on 12/10/19 and last administered on 12/23/19. -The Resident Care Coordinator's (RCC) signature appeared 6 times on the document as the administrator of enoxaparin. -A home health nurse's signature appeared 3 times on the document as the administrator of enoxaparin. -The remainder of the signature lines contained either initials or an illegible signature with the RCC's initials written out to the side. Review of Resident #5's December 2019 eMAR revealed: -There was an entry for Enoxaparin 30mg SQ to be administered twice daily for 14 days. -There was an entry for Enoxaparin 30mg SQ to be administered daily on Saturday, Sunday, Monday and Tuesday. -Enoxaparin 30 mg SQ twice daily was documented as administered at 8:00am and 8:00pm from 12/12/19 through 12/21/19 by 6 different Medication Aides (MA's). -There were 5 entries documenting Enoxaparin	D 366		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEY HOUSE	4 COOPER LANE BURNSVILLE, NC 28714

(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 366	Continued From page 14 30 mg SQ was administered by a MA which contained comments that a nurse had actually administered it. -There were 12 entries documenting Enoxaparin 30 mg SQ was administered by a MA which did not contain comments and the supplemental controlled substance count sheet was unclear if a MA or a nurse had administered it. -There was documentation that enoxaparin 30 mg SQ was administered by a MA on 12/24/19 and the controlled substance count sheet indicated that the enoxaparin was last administered on 12/23/19. Interview with a MA on 02/19/20 at 2:05pm revealed: -MAs were not allowed to administer enoxaparin; only registered nurses were allowed. -The MA who was signed into the eMAR system when the enoxaparin needed to be administered was the one who documented administration. -Sometimes, but not always, a MA would write a note as to who administered the enoxaparin. -She never administered any enoxaparin even though the eMAR indicated that she did. -When she documented administration of the enoxaparin on the eMAR she also signed a supplemental paper indicating who did the administration. Telephone interview with a second MA on 02/19/20 at 2:25pm revealed: - MAs were not allowed to administer enoxaparin. -The MA who was signed into the eMAR system when the enoxaparin needed to be administered was the one who documented administration. -She never administered any enoxaparin even though the eMAR indicated that she did. Interview with the RCC on 02/19/20 at 11:10am	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL100005	A. BUILDING: _____ B. WING _____	02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEY HOUSE	4 COOPER LANE BURNSVILLE, NC 28714

(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 366	Continued From page 15 revealed: - MAs, by policy, were not allowed to administer enoxaparin. -The MA who was signed into the eMAR system when the enoxaparin was scheduled to be administered was the one who documented administration. -A controlled substance count sheet document was used for the MAs and the nurses to sign indicating who had administered the enoxaparin. -She thought that this supplemental document would suffice as proper documentation for the eMAR. Interview with the Administrator on 02/19/20 at 4:37pm revealed: -Resident #5's enoxaparin was only administered by nurses, even though the eMAR indicated differently. -She knew the regulation stated the person who administered a medication was the person who had to document administration. -She thought that the supplemental paper they used would be "good enough" documentation.	D 366		

Plan of Correction

Yancey House

Annual Survey

March 27, 2020

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts or alleged conclusions set forth in the statement of deficiencies or the corrective action report; the plan of correction is prepared solely as a matter of compliance with state law.

D262 pg. 1 **10A NCAC 13F. 0802 (d)**

A care plan will be completed in conjunction with the Resident assessment within 30 days of admission. The care plan will be individualized to each Resident and will reflect a program of care for each Resident. The assessor will sign and date the care plan upon completion. The Director of Resident Care, and Memory Care Manager will audit Resident records on a weekly basis to assure that care plans are signed and dated by the assessor. A tracker system will be developed that includes dates of all Resident care plans. The Executive Director will keep a copy of this tracker and review each new Resident care plan for signature and date of assessor on a weekly basis**. Completion date for this citation will be 3/30/2020**.

D274 pg. 6 **10 A NCAC 13F .0902 c (1)**

All orders from Health Care Providers will be received and administered as ordered by the Provider. In the event an order needs clarification, the Resident Care Director or Memory Care Manager will contact the provider upon receipt of the order. The Resident Care Director or Memory Care Manager will document in the Resident record the clarification of the order to include the date and time the order was received from the Provider. For orders received after hours or the weekend, the Med-Tech will contact the Resident Care Director or Memory Care Manager to make them aware of the order, and receive any direction or support as needed. The Resident Care Director or Memory Care Manager will review and approve the order within 24 hours.

All orders will be sent to the suppling pharmacy and implemented upon receipt of the medication. Orders are to be reviewed by management by the end of the business day to assure accuracy and timely administration.

Management will provide re-training for all Med-Techs on the above procedure and documentation of in-service will be available for review as needed.

Completion date for this correction will be 3/30/20

D358 pg. 8 **10 A NCAC 13F .1004 (a)**

All orders from Health Care Providers will be implemented upon receipt. To assure that orders are implemented, The Resident Care Director or Memory Care Manager will review the Matrix order entry system daily. Orders will be checked for accuracy and documentation of the order, as well as appropriate administration or completion of the ordered medication or treatment. **Completion date for this correction will be 3/30/20.**

D366 pg. 13 **10A NCAC 13F .1004 (i)**

It is the policy of Affinity Living Group and each of their communities that medications and treatments implemented will be documented via the Matrix Care administration record by the person who performs the procedure. Medications and treatments will be completed by the administering Med-Tech and documented by the person performing the procedure. Management will review the MatrixCare administration compliance report on a weekly basis to assure compliance with the implementation of medications and procedures. Orders received that require administration from a 3rd Party Provider/Agency, will be documented in the resident's record by the individual responsible for the administration. **Completion date for this correction will be 3/30/20**