NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 4, 2020

Charles E. Trefzger, Jr., Executive Officer
RV Assisted Living, Licensee
Rich Square Manor
P.O. Box 2568
Hickory, NC 28603-2568

Email: mdeaton@affinitylivinggroup.com

Re: Receipt of Plan of Correction (COG411)
Facility: Rich Square Manor
Licensure Number: HAL-066-011
County: Pitt

Dear Mr. Trefzger:

Based on a telephone conversation on May 1, 2020 with Ms. Deanna Lanier, Administraor, there was an addendum to the Plan of Correction for the Statement of Deficiencies dated February 11, 2020. The pages noting the addendum are provided for your records.

Please do not hesitate to contact us at 910-990-0051, if you have questions or we may be of further assistance.

Sincerely,

Lisa Clewis RN

Lisa Clewis, RN, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure: Statement of Deficiencies with the plan of correction

cc: Deanna Lanier, Administrator w/enclosures
Rhonda Taylor, Supervisor, Northampton County Department of Social Services
Suzy Morgan, Team Supervisor, Eastern 5 Region, Adult Care Licensure Section
Raleigh Facility File

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

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D 000	Initial Comments The Adult Care Licensure Section and the Northhampton County Department of Social Services conducted an annual and follow-up survey on 02/10/20 - 02/11/20.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Defeciencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure nectar thickened liquids and double portions were served as ordered by the primary care provider to 2 of 3 sampled residents (#1 and #4), including a mechanical soft diet and nectar thickened liquids (#4) and a pureed diet with double portions and nectar thickened liquids (#1). The findings are: 1. Review of Resident #1's current FL-2 dated 11/18/19 revealed: -Diagnoses included dementia, functional dyspepsia, adult failure to thrive and abnormal liver function results. -There was an order for a pureed diet. Review of a diet order dated 01/27/20 for Resident #1 revealed there was an order for pureed meals with double portions and nectar	D 310	It is the policy of Rich Square Manor to assure that all residents receiving a therapeutic diet including nutritional supplements and thickened liquids shall be served as ordered by the resident's physician. 1. Staff has been inserviced on 10A NCAC 13F .0904 Nutrition and Food Service including therapeutic diets with nutritional supplements and thickened liquids as ordered by physician. A copy of the inservice can be found in the Administrators office located in the QA binder. — 3/4/2020 2. The Memory Care Manager will update the diet list upon each new admission, change in resident diet and every Monday from Matrix Care and reviewed with dietary Manager. The list is located in a binder located in dining room for staff access. — 2/14/2020	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deanna Lanier — TITLE: Executive Director — (X6) DATE: 3/19/2020

STATE FORM 6899 C0G411 If continuation sheet 1 of 25

Reviewed and accepted with Revisions be 05/01/2020 12:27pm

RECEIVED
MAR 27 2020
ADULT CARE LICENSURE SECTION
RALEIGH

revised date 3/27/2020

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D 310	Continued From page 1 thickened liquids. Observation of the diet list posted on the bulletin board in the dining room on 02/11/20 at 10:48am revealed Resident #1 was listed for a pureed diet with double portions and nectar thickened liquids. Review of Resident #1's current care plan dated 10/23/19 revealed: -Resident #1 was on a pureed diet with nectar thickened liquids. -Resident #1 was always disoriented and had significant memory loss. -Resident #1 was totally dependent on staff for assistance with eating and drinking. Review of a Licensed Health Professional Support (LHPS) evaluation dated 01/31/20 for Resident #1 revealed: -Resident #1 was on a pureed diet with thickened liquids and staff assisted the resident with meals. -There was a recommendation to notify the physician of a seven and one half-pound weight loss. Review of a physician's notification form dated 01/06/20 for Resident #1 revealed: -There was documentation Resident #1's weight was 100 pounds for November 2019. -There was documentation Resident #1's weight was 101 pounds for December 2019. -There was documentation Resident #1's weight was 93.5 pounds for January 2020. Review of hospital records dated 02/02/20 for Resident #1 revealed Resident #1 was admitted to the hospital with diagnoses including a urinary tract infection (UTI), moderate protein calorie malnutrition and dehydration on 02/02/20 and discharged back to the facility on 02/06/20.	D 310	3. The dietary staff will assure that the refrigerator is stocked with thickened juice, water and milk for staff members to ensure residents on thickened liquids are provided as noted in guidelines of State Rules and Regulations. 2/14/2020 4. The Med Aide will assure that residents receiving thickened liquids will receive with the med pass. 2/12/2020 5. The Memory Care Manager and Administrator will review the current diet orders with chart audits on residents weekly x4 weeks in the at risk meeing then monthly in the Q/VQI meetings. 3/2/2020 6. Staff was inserviced immediatly on 2/11/2020 and on 3/4/2020 on properly feeding residents as related to resident right's and dignity and respect and on rule area .0904 by the Administrator. A copy is located in the QA binder in the Administrators office. 3/4/2020 7. The Ombudsman Inserviced staff on Resident Rights and Dignity on 2/28/2020. A copy of the Inservice is located in the Administrators office in the QA binder. 2/28/2020 8. The DMA 3050R was updated and signed in accordance to resident #6 and the residents assistance level on 2/12/2020 and is located in the residents chart. All DMA 3050R will be reviewed on residents by the Memory Care Manager and updated as related to residents assistance level and rule area .0904 (e)(f). 3/4/2020 9. The Memory Care Manager and Med Aides will monitor meals during dining services to assure that residents are fed with dignity and respect and assistance is being provided to those residents accordingly as referenced in rule area .0904. 2/12/2020 Spoke with Deanna Lanier, Administrator on 05/01/2020 at 12:27pm addendum to #310, 1. = .0904(e)(f) inservice By Deanna Lanier, Administrator addendum to Rule #310, 2 = Admin, mcm, RCC, RDM perform Chart audits every week to Review diet Orders. Then every Monday diet Orders for the resident Records are compared to the electronic diet orders then to the diet list (resident) in the dining room and reviewed in the Monday Stand up meeting IC	

addendum to Tag # 310 #'s 6-9 are for tag # 312 . 0904 (F)(2)
#9 = Admin. also perform random meal monitoring daily when at facility. No logs are kept. IC

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D 310	Continued From page 2	D 310		

a. Review of physician's notification form dated 09/09/19 for Resident #1 revealed:
-There was documentation the resident had a five-pound weight loss in 30 days.
-The physician ordered double meal portions.

Review of physician's notification form dated 01/06/20 for Resident #1 revealed:
-There was documentation the resident had a seven and one half-pound weight loss in 30 days.
-The physician ordered an increased dose of mirtazapine. (Mirtazapine is an antidepressant used to treat low appetite.)

Review of the menus for 02/10/20 posted at the entrance of the dining room revealed the list for the breakfast meal included juice of choice, cereal of choice, eggs of choice, toast, jelly, margarine and coffee or tea.

Observation on 02/11/20 from 9:04am until 9:20am revealed:
-Regular meal place settings included a cup of water, cup of orange juice, a prepackaged bowl of cereal and a carton of milk.
-At 9:04am, a plate of pureed sausage, eggs and oatmeal of equal amount to a single portion plate of regular sausage, eggs, oatmeal and toast was placed on the table in front of Resident #1.
-Resident #1 was not served pureed cereal or nectar thickened milk.
-At 9:20am, Resident #1 completed the breakfast meal having ate 100% of his meal.
-Resident #1 was not offered additional food prior to leaving the dining room.

Interview with the dietary aide on 02/10/20 at 5:35pm revealed:
-The pureed plates were prepared and wrapped

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D 310	Continued From page 3	D 310		

at the facility that catered the meals.
-The facility that prepared the meals had a copy of the same diet list posted in the dining room at the facility.

Interview with the Administrator on 02/11/20 at 10:48am revealed:
-Pureed plates were measured and prepared in the kitchen of the contracted caterer.
-The caterer had a copy of the current diet list which included double portions for Resident #1.

b. Observation on 02/11/20 at 8:22am revealed there were three 4-ounce containers of premixed nectar thickened water in the refrigerator in the dining room.

Observation on 02/11/20 from 9:04am until 9:20am revealed:
-A 4-ounce container of premixed nectar thickened orange juice was placed on the table in front of Resident #1.
-Resident #1 was not served thickened water or un-thickened water.
-At 9:20am, Resident #1 completed the breakfast meal having drank 100% of the nectar thickened orange juice.
-Resident #1 was not offered additional drink prior to leaving the dining room.

Observation on 02/11/20 at 9:51am revealed there were three containers of premixed nectar thickened water in the refrigerator in the dining room.

Interview with the dietary aide on 02/11/20 at 9:51am revealed:
-There were three 4-ounce premixed nectar thickened waters in the refrigerator in the dining room.

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D 310	Continued From page 4	D 310		

-He was responsible for keeping the refrigerator stocked with premixed nectar thickened liquids.

Interview with the personal care aide (PCA) on 02/11/20 at 9:53am revealed:
-Resident #1 was supposed to get thickened liquids.
-She gave Resident #1 thickened water whenever the dietary aide put it on the table.
-The dietary aide did not put any thickened water on the table for Resident #1, so she did not give the resident any water with breakfast.

Interview with the dietary aide on 02/11/20 at 12:14pm revealed:
-The staff who assisted the resident with eating got the resident's drinks and placed them on the table.
-He was responsible for bringing and setting up the meal and serving plates to residents.
-There was usually a PCA in the dining room who helped place table settings including napkins, silverware and beverages.

Interview with the Memory Care Manager (MCM) on 02/11/20 at 12:20pm revealed staff were expected to serve water with every meal and snacks to all residents including thickened water for residents on thickened liquids.

Telephone interview with Resident #1's physician on 02/11/20 at 2:00pm revealed Resident #1 had been doing better over the last several months so there would not be a concern for not getting water or a double portion for one meal.

Interview with the Administrator on 02/11/20 at 5:27pm revealed:
-Medication aides (MAs) gave water with medications and PCAs gave water with snacks

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D 310	Continued From page 5	D 310		

and as needed and requested throughout the day.
-The dietary dietary aide put the water on the table for residents at meals.
-Residents ordered to have thickened liquids were expected to be served thickened water with medications, snacks, meals and as needed or requested.

Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.

Refer to interview with the Administrator on 02/10/20 at 10:59am.

Refer to telephone interview with the Dietician on 02/10/20 at 5:01pm.

Refer to interview with the Memory Care Manager (MCM) on 02/11/20 at 10:48am.

Refer to interview with the Administrator on 02/11/20 at 10:48am.

2. Review of Resident #4's current FL-2 dated 03/11/19 revealed:
-Diagnoses included dementia without behavioral disturbances, left artificial hip joint, generalized muscle weakness, anxiety disorder, intracapsular fracture of the left femur, allergic rhinitis and sexually aggressive behavior.
-There was no specified diet order.

Review of a diet order dated 08/26/19 for Resident #4 revealed there was an order for a mechanical soft diet and nectar thickened liquids.

Review of Resident #4's current care plan dated 11/25/19 revealed:

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D 310	Continued From page 6	D 310		

-Resident #4 was on a mechanical soft diet with nectar thickened liquids.
-Resident #4 was always disoriented and had significant memory loss.
-Resident #4 was totally dependent on staff for assistance with eating and drinking.

Observation of the diet list posted on the bulletin board in the dining room on 02/11/20 at 10:48am revealed Resident #4 was listed for a mechanical soft diet and nectar thickened liquids.

Observations of the breakfast meal on 02/11/20 from 8:03am until 9:23am revealed:
-At 8:49am, a personal care aide (PCA) assisted Resident #4 with eating the breakfast meal of scrambled eggs, chopped sausage, toast and oatmeal with un-thickened orange juice and un-thickened water.
-Between 8:49am and 9:16am, the PCA stopped assisting Resident #4 with eating multiple times in order to help other residents.
-Resident #4 drank all the orange juice and sips of water without coughing.
-At 9:16am, Resident #4 finished eating breakfast and left the dining room.

Interview with the PCA on 02/11/20 at 11:24am revealed:
-She had given Resident #4 un-thickened orange juice and water.
-She did not know Resident #4 was supposed to get nectar thickened liquids.
-The dietary aide was supposed to put thickened beverages on the table when a resident was ordered thickened liquids.
-Resident #4 did not have any problems with coughing when he ate and drank.
-She was told about any diet change orders for the residents by the dietary aide.

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D 310	Continued From page 7	D 310		

Interview with a medication aide (MA) on 02/11/20 at 11:18am revealed:
-She had a copy of the diet list in the drawer of the medication cart which listed the residents who were on thickened liquids.
-Resident #4 was on the list for a mechanical soft diet and nectar thickened liquids.
-She administered nectar thickened water to Resident #4 with his medications.

Interview with the Memory Care Manager (MCM) on 02/11/20 at 10:48am revealed:
-The order for nectar thickened liquids for Resident #4 was not a new order.
-Nectar thickened liquids for Resident #4 was listed on the diet order sheet posted in the dining room.

Telephone interview with Resident #4's physician on 02/11/20 at 2:00pm revealed:
-He could not recall the details of why Resident #4 was ordered to have nectar thickened liquids.
-Thickened liquids were usually ordered because of issues with choking on un-thickened liquids.
-Resident #4 drinking un-thickened liquids was concerning for risk of coughing, choking and aspiration of liquids into the lungs.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

Refer to interview with the Administrator on 02/10/20 at 10:59am.

Refer to telephone interview with the Dietician on 02/10/20 at 5:01pm.

Refer to interview with the Memory Care Manager

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D 310	Continued From page 8 (MCM) on 02/11/20 at 10:48am. Refer to interview with the Administrator on 02/11/20 at 10:48am. Interview with the Administrator on 02/10/20 at 10:59am revealed: -The diet list, including therapeutic diets and residents on thickened liquids, was reviewed and updated every Monday morning during the morning stand up. -She posted the new diet list every Monday in the dining room. -All meals were catered in from a nearby facility. -The Dietician at the nearby facility coordinated meals for the facility. Telephone interview with the Dietician on 02/10/20 at 5:01pm revealed: -She was responsible for overseeing the catering of residents' meals at the facility. -Meals were prepared outside the facility and transported to the facility by the dietary aide. -She had a copy of the current diet list and a copy of the therapeutic diet menus was sent with dietary aide for each meal. Interview with the Memory Care Manager (MCM) on 02/11/20 at 10:48am revealed: -She communicated any diet changes to the MA and PCAs on duty whenever the physician wrote new orders. -She and the Supervisor monitored the dining room service; she was in the dining room at least four times each week assisting residents. Interview with the Administrator on 02/11/20 at 10:48am revealed: -The MAs were responsible for communicating new diet orders to PCAs.	D 310		

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D 310	Continued From page 9 -The dietary dietary aide was responsible for what was on the table for each resident. -There was a list in the dining room for the dietary dietary aide to know what diet each resident was on. -She hoped staff were communicating to know what each resident needed.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there were enough staff to provide respectful and unhurried feeding assistance to 4 of 4 sampled residents (#1, #4, #5 and #6) for the breakfast meal. The findings are: Observations of the breakfast meal on 02/11/20 from 8:03am until 9:23am revealed: -At 8:25am, residents were assisted to the dining room and seated by personal care aides (PCAs). -The dietary aide poured orange juice in cups set out on the tables and placed a carton of milk at each place setting. -At 8:31am, there were 15 residents in the dining room; there were 6 residents in wheelchairs and 1 resident in an upright geriatric chair.	D 312		

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D 312	Continued From page 10 -The dietary aide was preparing and serving plates to residents and one PCA was assisting other residents with opening bowls of cereal and cartons of milk. -At 8:34am, a second PCA began assisting residents while the first PCA poured and served cups of water to residents. -At 8:36am, the second PCA was assisting the resident in the geriatric chair with eating the breakfast meal while standing beside the resident. -A third PCA was assisting a newly seated resident; the first PCA was assisting a resident with leaving the dining room and there were 17 total residents in the dining room. -Between 8:36am and 8:49am, two additional residents were seated in the dining room and three residents left the dining room. -At 8:49am, the first PCA was assisting Resident #4 with eating the breakfast meal while standing beside the resident who was in a geriatric chair. -Between 8:49am and 8:55am, the first PCA stopped assisting Resident #4 with eating several times in order to assist other residents with getting in and out of the dining room and with opening packages. -The second PCA assisted residents with leaving the dining room and the third PCA continued assisting a resident with eating. -At 8:55am, there were 12 residents in the dining room. -At 8:57am, the first PCA stopped assisting Resident #4 with eating and assisted another resident out of the dining room; the PCA returned to Resident #4 at 8:58am. -The second PCA returned from assisting the resident in the geriatric chair out of the dining room and told the dietary aide there were three residents waiting to eat breakfast. -At 9:00am, Resident #1 and Resident #6 were	D 312		

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D 312	Continued From page 11	D 312		

brought to the dining room in a wheelchair by the second PCA.
-At 9:02am the second PCA had left the dining room and the first PCA stopped assisting Resident #4 with eating to help Resident #6.
-At 9:05am, Resident #1 was served his breakfast and the second PCA stood beside his wheelchair assisting the resident to eat.
-The third PCA brought Resident #5 to the dining room in a wheelchair.
-At 9:08am, Resident #6 was attempting to eat oatmeal and drink from her cup, but was unable to grasp the bowl, cup and spoon with her right hand and spilled food and juice on the table and her lap.
-The second PCA was assisting Resident #1 with eating at the same table as Resident #6; the second PCA attempted to reach over and assist Resident #6 also saying, "Hold on (name of Resident #6), I'll help you."
-Simultaneously, the third PCA was standing next to Resident #5 at the same table trying to keep the resident from grabbing drinks, sugar packets and other resident's plates.
-The first PCA was still assisting Resident #4; the dietary aide was clearing dishes from the tables, the Activity Director (AD) was in the front common area with residents, and the medication aide (MA) was down the hallway.
-There were no other staff in or near the dining room.
-At 9:12am, Resident #6 attempted to drink from her cup and spilled the drink, Resident #5 was grabbing at cups and the table cloth with the third PCA attempting to intervene and the second PCA hurrying to finish assisting Resident #1.
-Upon request, the Administrator came into the dining room.
-At 9:16am, the MA went into the dining room to assist residents at the direction of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

(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 312	Continued From page 12 Administrator. -Resident #4 finished eating breakfast and left the dining room assisted by the first PCA. -At 9:20am, Resident #1 finished eating the breakfast meal and left the dining room assisted by the second PCA. -The third PCA remained in the dining room with Resident #5 and the MA was assisting Resident #6. Interview with a PCA on 02/11/20 at 8:55am revealed: -She did not usually stand to assist residents with eating; she usually brought a chair in. -There were no chairs available to bring in that morning; the chairs normally at the front desk were not there. Interview with a MA on 02/10/20 at 10:45am revealed: -The dining room was not big enough for all 27 residents at one time; there were 4 tables with 4 chairs at each table. -There were two "seatings" for each meal; meaning some residents were brought in to eat and then a second set of residents were brought in after the first seating finished their meal. Interview with the Memory Care Manager (MCM) on 02/11/20 at 10:48am revealed she and the Supervisor monitored the dining room service; she was in the dining room at least four times each week assisting residents. Interview with the Administrator on 02/11/20 at 10:48am revealed: -All staff were trained in dining room procedures and assisting residents with meals. -All staff were expected to be in the dining room at each meal to help with dining services.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

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D 312	Continued From page 13	D 312		

1. Review of Resident #4's current FL-2 dated 03/11/19 revealed:
-Diagnoses included dementia without behavioral disturbances, left artificial hip joint, generalized muscle weakness, anxiety disorder, intracapsular fracture of the left femur, allergic rhinitis and sexually aggressive behavior.
-Resident #4 needed assistance with eating meals.
-There was no specified diet order.

Review of Resident #4's current care plan dated 11/25/19 revealed:
-Resident #4 was on a mechanical soft diet with nectar thickened liquids.
-Resident #4 was always disoriented and had significant memory loss.
-Resident #4 was totally dependent on staff for assistance with eating and drinking.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

2. Review of Resident #1's current FL-2 dated 11/18/19 revealed:
-Diagnoses included dementia, functional dyspepsia, adult failure to thrive and abnormal liver function results.
-Resident #1 needed assistance with eating meals.
-There was an order for a pureed diet.

Review of Resident #1's current care plan dated 10/23/19 revealed:
-Resident #1 was on a pureed diet with nectar thickened liquids.
-Resident #1 was always disoriented and had significant memory loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

(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 312	Continued From page 14	D 312		

-Resident #1 was totally dependent on staff for assistance with eating and drinking.

Review of a Licensed Health Professional Support (LHPS) evaluation dated 01/31/20 for Resident #1 revealed Resident #1 was on a pureed diet with thickened liquids and staff assisted the resident with meals.

Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.

3. Review of Resident #5's current FL-2 dated 07/01/19 revealed:
-Diagnoses included dementia with behavioral disturbances, 4th to 9th closed rib fractures, severe sepsis, arthritis, hypertension, chronic obstructive pulmonary disease, depression and anxiety.
-Resident #5 needed assistance with eating meals.
-There was no specified diet order.

Review of a diet order dated 12/02/19 for Resident #5 revealed there was an order for pureed meals.

Review of Resident #5's current care plan dated 12/09/19 revealed:
-Resident #5 was on a pureed diet.
-Resident #5 was always disoriented and had significant memory loss.
-Resident #5 was totally dependent on staff for assistance with eating and drinking.

Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

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D 312	Continued From page 15	D 312		

4. Review of Resident #6's current FL-2 dated 01/31/20 revealed:
-Diagnoses included Alzheimer's dementia, type II diabetes mellitus, anemia, chronic kidney disease, hypothyroidism, hyperlipidemia, osteoporosis and lack of coordination.
-There was an order a mechanical soft diet.

Review of Resident #6's current care plan dated 02/03/20 revealed:
-Resident #6 was on a mechanical soft diet.
-Resident #6 was sometimes disoriented and forgetful.
-Resident #6 required limited assistance with eating and drinking.

Interview with the Administrator on 02/11/20 at 9:23am revealed:
-Resident #6 had just returned from the hospital on 02/10/20; prior to going to the hospital Resident #6 was able to eat independently.
-The hospital reported Resident #6 had a stroke.

Review of hospital records dated 02/10/20 for Resident #6 revealed:
-Resident #6 presented to the emergency room on 02/07/20 with right sided facial droop and right sided weakness and was diagnosed with a transient ischemic attack (TIA).
-Discharge instructions included assistance with meals as necessary.

Interview with a personal care aide (PCA) on 02/11/20 at 9:53am revealed:
-Resident #6 had just started needing assistance with eating meals; the resident had a stroke.
-Staff in the dining room needed more help with assisting residents with eating breakfast.

Interview with a medication aide (MA) on 02/11/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

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D 312	Continued From page 16 at 4:44pm revealed: -Resident #6 needed assistance with eating dinner on 02/10/20 after returning from the hospital. -It was In Resident #6's hospital discharge paperwork that she needed assistance with meals. Interview with the Memory Care Manager (MCM) on 02/11/20 at 5:23pm revealed: -Staff had told her on 02/10/20, that Resident #6 needed assistance with eating. -The PCAs working during breakfast on 02/11/20 "definitely" knew Resident #6 needed help with eating. -She did not think breakfast that morning would "go like that;" meal services were usually "much smoother." Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.	D 312		
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: Based on observations, interviews, and record reviews, the facility failed to administer	D 358	It 's the policy of Rich Square Manor to assure the preparation and administration of medications are in accordance with the orders of licensed prescribed practitioner and maintained in the residents record as evidenced in rule 10A NCAC 13 F .1004 a. (1)(2). 1. The Med Aide on duty was immediatly inserviced on Med Administration on 2/11/2020 and relation to prescribed and discontinued medication orders by a licensed practitioner by the Administrator. 2/12/2020 2. Inservice on Med Administration was provided to Med Aides on 2/11/2020 and 3/4/2020. A copy of the inservice can be found in the QA binder in the Administrator's office. 3/4/2020 3. Facility Memory Care Manager and Med Aide will conduct weekly med cart audits to reconcile orders and compare med to cart with meds on hand to assure all medications are current and those that are discontinued are marked through with a red marker and marked as discontinued on the multi dose packaging. Facility Administrator will sign off med cart audits weekly. 2/14/2020	

Spoke i Deanna Lenier, Administrator on 05/01/2020 at 1227PM
Tag #358 - #2 - inservice was provided x Deanna Lenier Administrator
Tag #358 - #6 - LHPS Nurse Submit verification of med pass observation to the Administrator when requested for Administrator reviewed.
5/01/2020 K

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 17 medications as ordered for 2 of 4 residents observed during the medication passes including errors with a laxative (#7) and a non-steroidal anti-inflammatory (#8). The findings are: The medication error rate was 8% as evidenced by observation of 2 errors out of 25 opportunities during the 8:00am and 2:00pm medication passes on 02/11/20. Review of Resident #8's current FL-2 dated 01/06/20 revealed: - Diagnoses included organic dementia and hypertension. -The resident was constantly disoriented, wandered, and was semi-ambulatory. Review of Resident #8's pharmacy recommendation report dated 01/30/20 revealed: -There was a recommendation to change Naproxen [Naproxen is a non-steroidal anti-inflammatory (NSAID) used to treat pain and/or swelling. Side effects can include bleeding and ulcers in the stomach and intestines which could be fatal. Taking with food may reduce risk of upset stomach.] to as needed or stopping or consider adding a proton pump inhibitor or a gastric acid blocker. -There was documentation routine non-steroidal anti-inflammatory drug (NSAID) use was associated with increased risk for gastrointestinal bleeding in high risk groups (age greater than 75 years old), increased the risk for renal failure, hypertension, stroke, heart attack, and heart failure. -There was handwritten documentation to discontinue Naproxen. -The pharmacy recommendation report was	D 358	4. Facility Memory Care Manager will assure all pharmacy recommendations are reviewed by licensed practitioner and orders are carried out and represented on the MAR and multi dose packaging as discontinued. 5. LHPS nurse will complete a med administration pass and inservice with med aide observed on 2/11/2020 during State Survey to ensure that med aide is in compliance with State Rules and Regulations of Med Administration. LHPS nurse will leave documentation of inservice and will be located in the QA binder in the Administrators office. 6. LHPS nurse will conduct a med administration pass and inservice with med aides 1x month to assure they are in compliance with State Rules and Regulations of Med Administration.	2/14/2020 3/14/2020 3/14/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 18 signed by Resident #8's Primary Care Provider (PCP) on 02/03/20. Observation of the 8:00am medication pass on 02/11/20 revealed: -Resident #8 was sitting in the common living area. -The MA punched Resident #8's medications including Naproxen from a pre-filled medication pack. -The MA crushed Resident #8's medications including the Naproxen. -The MA mixed Resident #8's crushed medications with pudding. -The MA spooned the crushed medications including the Naproxen mixed with pudding to Resident #8 at 7:40am. Interview with the MA on 02/11/20 at 1:10pm revealed: -Resident #8's medications came pre-filled from the facility's contracted pharmacy. -She would compare the resident's eMARs to the resident's medications before administering the medications. -She compared the medications listed on Resident #8's eMAR to the resident's pre-filled medication card before punching the medications for administration. -The Naproxen was in the same bubble pack as Resident #8's other morning medications. -When a medication was discontinued the discontinued medication would remain in the prefilled bubble pack until the mediations were punched to administer to the residents. -The discontinued medication would then be discarded when the medications were punched for administration. -She would know a medication was discontinued because the Memory Care Manager (MCM)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 19	D 358		

would document the medication was discontinued beside the name of the medication on the medication card.
-She did not remember seeing Naproxen on Resident #8's eMAR when she administered the resident's medications this morning (02/11/20).
-She did not know Resident #8's Naproxen was discontinued on 02/03/20.

A second interview with the MA on 02/11/20 at 1:18pm revealed:
-After she now reviewed Resident #8's prefilled medication card she saw where the Naproxen had been documented as discontinued.
-After she now reviewed Resident #8's eMAR in the laptop located on the medication cart she saw the Naproxen had a discontinued dated of 02/03/20.

Review of Resident #8's February 2020 eMAR revealed:
-There was an entry for Naproxen 375mg to be administered twice daily at 8:00am and 5:00pm with breakfast and supper.
-There was a Naproxen discontinuation date of 02/03/20.
-There was no documentation Naproxen was administered at 8:00am on 02/11/20.

Observation of Resident #8's pre-filled medication pack on 02/11/20 at 1:16pm revealed:
-On the left inside page of the medication card was a list of Resident #8's medications.
-There was an entry for Naproxen 375mg take one tablet with breakfast and supper.
-On the same line and to the right of the documentation for Naproxen was handwritten documentation in black ink of "Dc'd".
-On the second page were prepackaged doses of medications.

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D 358	Continued From page 20 -On the back of the second page the prefilled doses were labeled morning, evening, and bedtime. -The morning doses from 02/12/20 - 02/16/20 included an entry of Naproxen 375mg tablet. -The evening doses from 02/11/20 - 02/16/20 included an entry of Naproxen 375mg tablet with a single black line drawn through. -To the right of the evening doses from 02/11/20 - 02/16/20 Naproxen was hand written in black ink of "DC'd". Interview with the MCM on 01/16/20 at 1:30pm revealed: -Resident #8's medications came prefilled from the facility's contracted pharmacy. -The MAs were supposed to review the resident's eMAR's and compare the orders to the prefilled medication cards prior to administering resident medications to ensure administering correctly. -She expected the MA to have removed Resident #8's Naproxen from the prefilled medication bubble when she punched the morning medications for the resident. -When a medication was discontinued, she would mark through the medication name and document discontinued beside the medication name in the resident's prefilled medication card. -She would discontinue the medication in the residents' eMAR. -The MA would know a medication was discontinued by reviewing the resident's eMAR and pill pack before administration. -The discontinued medication would stay in the residents prefilled pack until the medications were punched for administration. -The MA would know which pill to discard by comparing the pills in the medication bubble to the picture of the pill located under the medication name listed on the medication card.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 21 -The MA would then discard the discontinued medication when the medications were punched and before administered to the resident. -She expected the MA to have discarded Resident #8's Naproxen because it was discontinued. Interview with the Executive Director (ED) on 01/16/20 at 1:43pm revealed: -She expected the MAs to review the resident's eMARs and compare the orders to the resident's medications prior to administering medications to ensure administering correctly. -She expected the MA to have compared Resident #8's eMAR to the prefilled medication card prior to administration. -The MCM was to document on the resident's prefilled medication card when a medication was discontinued. -She expected the MA to have removed the Naproxen and discarded before administering morning medications to Resident #8. Telephone interview with Resident #8's Primary Care Provider (PCP) on 02/11/20 at 2:00pm revealed: -Normally he would write an order for Naproxen for 30 days due to the increased risk for bleeding. -Naproxen was an NSAID that could cause irritation to the stomach lining. -Naproxen also thinned the blood and could cause an increase in bleeding with trauma. -Naproxen was prescribed to Resident #8 because of back pain. -He discontinued Resident #8's Naproxen on 02/03/20 per pharmacy recommendation because it placed the resident at an increased risk for bleeding. -He did not expect the Naproxen to have been administered to Resident #8 after it was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

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D 358	Continued From page 22	D 358		

discontinued because Naproxen put the resident at an increased risk for bleeding.

Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.

2. Review of Resident #7's current FL-2 dated 12/23/19 revealed:
-Diagnoses included dementia, hypertension, and gastrointestinal hemorrhage.
-The resident was constantly disoriented, wandered, and incontinent of bowel and bladder.
-There was an order for Miralax 17 grams (g) dissolved in 8 ounces (oz) of beverage of choice daily.

Observation of the 8:00am medication pass on 02/11/20 revealed:
-The medication aide (MA) reviewed Resident #7's eMAR.
-Resident #7 walked out of her room to the medication cart located outside of her room door
-The MA prepared and administered three medications to Resident #7 with water.
-Miralax was not administered to Resident #7.

Interview with the MA on 02/11/20 at 1:20pm revealed:
-She did not remember administering Miralax to Resident #7.
-She would have to look at Resident #7's eMAR to see if she administered Miralax to Resident #7.
-She remembered she did not administer Miralax to Resident #7 because she was nervous.
-After reviewing Resident #7's eMAR for 02/11/20, she did not know why she documented Miralax was administered because she did not administer the Miralax to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

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D 358	Continued From page 23 Review of Resident #7's electronic medication administration record (eMAR) for February 2020 revealed: -There was an entry for Miralax 17g with 8oz of beverage of choice to be administered at 8:00am daily. -There was documentation the MA administered Miralax to the resident at 8:00am on 02/11/20. Interview with the Memory Care Manager (MCM) on 02/11/20 at 1:45pm revealed: -She expected the MAs to review the resident eMARs and compare to the resident medications prior to administering to ensure the correct medications were administered. -She expected the MA to have administered the ordered Miralax to Resident #7. Interview with the Executive Director (ED) on 02/11/20 at 1:48pm revealed: -She expected the MAs to review the resident's eMARs for all medications due and compare the eMARs to the resident's medications prior to administering. -She expected the MA to have administered the Miralax to Resident #7. Telephone interview with Resident #7's Primary Care Provider (PCP) on 02/11/20 at 2:00pm revealed: -Miralax was prescribed to Resident #7 because of chronic constipation. -He expected the MA to have administered Miralax to Resident #7 as ordered to prevent constipation. -If Miralax was not administered to Resident #7 as scheduled the resident could develop constipation which could lead to abdominal pain. -He had not been informed of Resident #7 being constipated.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL066011	A. BUILDING: _____ B. WING _____	R 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

(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 358	Continued From page 24 Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.	D 358		