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 _____	R 09/01/2022

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, follow-up and complaint investigation survey from 08/30/22 through 09/01/22.	D 000	* See attached plan of correction	
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: Type B Violation Based on observations, record reviews, and interviews, the facility failed to respond immediately and in accordance with the facility's policy and procedures for 1 of 1 sampled residents (#1) who had an unwitnessed fall; found with head injuries along with multiple other injuries, was moved by facility staff into the shower, which delayed emergency medical services being provided due to waiting for staff to complete shower upon their arrival. The findings are: Review of the facility's Fall Policy dated September 2021 revealed:	D 271		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Grace Renee Robinson — TITLE: Executive Director — (X6) DATE: 10/11/22

10/19/22 Reviewed & Acknowledged

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D 271	Continued From page 1 -Call 911 for Emergency Medical Services (EMS) if necessary. -If injury is apparent or possible, do not move the resident. -Continue emergency intervention until EMS arrives. Review of Resident #1's current FL2 dated 01/07/22 revealed: -Diagnoses included Alzheimer's disease. -She was ambulatory. -She was intermittently disoriented. -The level of care was documented as Special Care Unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 07/06/21. Review of Resident #1's Progress Notes dated 08/25/22 at 9:20am revealed Resident #1 was transported to the local hospital by EMS due to a fall. Review of Resident #1's Incident and Accident Report dated 08/25/22 at 8:37am revealed: -Resident #1 had an unwitnessed fall in her room. -The level of care was documented as special care unit (SCU). -The description of the fall was documented as "resident was laying on the floor next to the bed face down". -The resident exhibited or complained of pain and/or injury related to the fall. -Resident #1's right leg and both knees included redness and bruising, redness to her upper right arm near shoulder, blister on right wrist, bruise/redness on the right hand, skin tear to the right elbow, and fluid around the eyes. -The type of injury was documented as redness, bruising, skin tear, and swelling.	D 271		

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D 271	Continued From page 2 -Resident #1 was transported by EMS to the local hospital for a medical evaluation of injuries on 08/25/22 at 9:04am. Interview with Resident #1's personal caregiver on 08/30/22 at 9:16am revealed: -When she arrived for her shift at 8:30am on 08/25/22, two of the facility's staff were walking Resident #1 to the shower room to "get cleaned up" because she was wet from being incontinent of urine. -Staff reported Resident #1 fell, was found lying face down on the floor, and sustained multiple injuries. -She followed Resident #1 into the shower room to look at Resident #1's injuries when staff undressed Resident #1 to shower her before EMS arrived. -Resident #1's face was "puffy" with bruising, right arm was bleeding from a skin tear and there was a large, raw area with a blister on the right wrist, the right knee had a large red area with bruising, and Resident #1 had many smaller reddened and bruised areas on her body. Observation of Resident #1 on 08/30/22 revealed: -There was a purple colored bruise approximately 1 ½ inches long on the outside of her right knee. -There was a band-aid on the right elbow. -There was a non-adherent dressing to Resident #1's right wrist with yellowish brown shadow drainage present. -There was a small reddened area to the outside of Resident #1's left knee. -Resident #1 was sent to the local hospital for evaluation. Interview with the medication aide (MA) on 08/30/22 at 2:46pm revealed: -She was taking Resident #1 her morning	D 271		

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D 271	Continued From page 3 medications on 08/25/22 around 8:20am and found Resident #1 lying face down on the floor in Resident #1's room. -She took Resident #1's vital signs and called for a personal care aide (PCA) to assist her with getting Resident #1 off the floor and "cleaned up" because Resident #1 had been incontinent of urine. -Resident #1 had swelling and redness on the face, bruising to both knees, skin tear to the right arm, a bruised right elbow, and blister on the right wrist. -Resident #1's personal caregiver arrived just after she found Resident #1 lying on the floor in her room. -She called 911 for EMS to transport Resident #1 to the local hospital for a medical evaluation since Resident #1 hit her head and was found lying face down on the floor. -Two PCA's took Resident #1 to the community bathroom to give Resident #1 a shower and apply clean clothing since Resident #1 had urinated on herself. -She did not apply any dressings to Resident #1's wounds because EMS arrived to pick Resident #1 up as soon as staff finished giving Resident #1 a shower. -She did not usually move residents who fell and sustained injuries including head injury unless they were in immediate danger. -The facility's policy regarding falls with an unknown extent of injuries was to call 911 and wait for EMS personnel to arrive but she wanted to get Resident #1 "cleaned up" before sending Resident #1 to the hospital. Interview with the Special Care Coordinator (SCC) on 08/30/22 at 3:04pm revealed: -She received a telephone call from a MA on 08/25/22 around 8:25am and was told Resident	D 271		

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D 271	Continued From page 4 #1 had fallen, hit her head, face was "puffy", and was found face down lying on the floor. -She told the MA to call 911 and send Resident #1 to the hospital since Resident #1 hit her head. -Resident #1 had received 2 skin tears, bruises, and a blister on the wrist from pushing on the floor to try to get up. -The facility's policy and procedure for falls included to leave the resident lying where found and not move the resident when the extent of the injuries were unknown and/or if the resident hit their head. Interview with a PCA on 08/30/22 at 3:46pm revealed: -The MA found Resident #1 lying on the floor on 08/25/22 when she was taking Resident #1 her morning scheduled medications. -She helped the MA get Resident #1 up from the floor when the MA called out for assistance. -Resident #1 was "covered" in urine and with the assistance of another PCA walked Resident #1 to the shower room, gave Resident #1 a shower, and dressed Resident #1 in clean clothes. -She saw Resident #1's had bruises on the knees and upper right side of Resident #1's body when she and another PCA undressed Resident #1 to give her a shower. -EMS personnel were waiting outside the shower room to transport Resident #1 to the hospital. -The facility's policy for a resident who fell and hit their head included to leave the resident lying on the floor, call 911, and make sure the resident was "clean" before sending out if the resident had soiled themselves. -She and the MA picked Resident #1 up from the floor, and another PCA helped her walk Resident #1 to the shower room, gave Resident #1 a shower, and dressed Resident #1 in clean clothing before sending Resident #1 to the	D 271		

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D 271	Continued From page 6 hospital for an evaluation because the facility staff did not want to send Resident #1 out dressed in clothing saturated in urine. -She knew it was against the facility's policy to move Resident #1 before EMS arrived but she did not know what to do since Resident #1 was covered in urine so she gave Resident #1 a shower. Interview with an emergency medical technician (EMT) from the local EMS on 08/31/22 at 10:15am revealed: -He responded to the 911 call at the facility on 08/25/22 when Resident #1 was found in the floor. -He had to wait outside the shower room for the facility staff to finish showering and dressing Resident #1 before he could transport Resident #1 to the hospital. -Resident #1 had multiple bruises on her head, both arms and legs, large reddened area to her right knee area, a skin tear on her arm, and a large blister on her right wrist. -It was not a common practice for a facility to shower a resident who had fallen and sustained multiple injuries with an unknown extent of the injuries before sending the resident to the local hospital for a medical evaluation. -Typically, residents who fell in a facility would be left in the same position until EMS arrived because moving the resident could cause additional harm. Telephone interview with a deputy from the local sheriff's department on 08/31/22 at 10:37am revealed: -He received a call from a Nurse Supervisor at the local hospital on 08/25/22 regarding concerns Resident #1 may have been left lying in the floor for an extended period of time after Resident #1	D 271		

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D 271	Continued From page 6 fell due to pressure sores found and other injuries that may have been caused by "flailing around" on the ground, like the blister on Resident #1's right wrist. -He interviewed the local EMS personnel who responded to the 911 call and they expressed concerns Resident #1 was moved from the floor and showered after sustaining multiple injuries with an unknown extent of the injuries that occurred. Interview with Resident #1's Nurse Practitioner (NP) on 08/31/22 at 11:31am revealed: -The facility staff sent her a text message to notify her Resident #1 was found face down lying on the floor on 08/25/22 and the facility was sending Resident #1 to the local hospital to be evaluated. -She expected the facility staff to not move or shower Resident #1 after a fall not knowing the extent of Resident #1's injuries that occurred from the fall. -There was no way for facility staff to know if Resident #1 had injured her neck, hip, or acquired a brain injury from the fall on 08/25/22. -The facility staff could have caused increased damage to Resident #1 by moving her after the fall on 08/25/22. Interview with a second PCA on 08/31/22 at 12:03pm revealed: -The MA called 911 when Resident #1 fell on 08/25/22 and asked her around 8:30am to help another PCA get Resident #1 "cleaned up" because Resident #1 had fallen and was wet from urine. -Resident #1 was sitting in a recliner chair when she entered Resident #1's room. -She along with another PCA assisted Resident #1 with walking to the community bathroom to give Resident #1 a shower.	D 271		

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D 271	Continued From page 7 -When she undressed Resident #1 for the shower she noticed Resident #1 had bruises on the right arm, redness to both knees, a "puffy" right eye, and a blister on the right wrist so she reported the areas to the MA so the MA would be able to see and document the injuries. -She did not move residents when they fell if they hit their head or complained of pain. -Resident #1 complained her wrist hurt after she fell on 08/25/22. -She took Resident #1 to the community bathroom to give her a shower because she was instructed to do so by the MA. Interview with the Administrator on 08/31/22 at 4:07pm revealed: -She knew Resident #1 fell on 08/25/22 and was transported by EMS to the local hospital for a medical evaluation. -The facility's policy and procedures for falls included assessing the resident for injuries, calling 911, and if an injury was present to not move the resident. -The staff moved Resident #1 after Resident #1 fell on 08/25/22 because she was saturated in urine and staff did not want to send Resident #1 to the hospital covered in urine. -She expected staff to follow the facility's policy and procedures for falls in case a resident was injured. Telephone interview with the Registered Nurse (RN) Supervisor from the local hospital on 08/31/22 at 5:00pm revealed: -She received Resident #1 as a patient the morning of 08/25/22 when she was brought to the hospital by EMS after a fall. -Resident #1's eye was swollen with pooling of fluid around the right eye and temple. -Resident #1's right side of her body took the	D 271		

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D 271	Continued From page 8 "brunt" of injuries acquired with the fall. -Resident #1's right knee was bruised, and she had multiple bruises on her body. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. The facility failed to follow policies and procedures for Resident #1 who fell and sustained multiple injuries, without knowing the extent of the injuries by moving and walking her to the community bathroom, showering and dressing her, delaying EMS transport. This failure placed the resident at risk for increased damage to injuries (#1). This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/31/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.	D 271		
D 356	10A NCAC 13F .1003 (e) Medication Labels 10A NCAC 13F .1003 Medication Labels (e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for administration to a resident.	D 356		

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D 356	Continued From page 9 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled residents (Residents #7 and #8) prescribed medications were not transferred to containers dispensed by a pharmacy which allowed for potential contamination and medication errors. The findings are: Review of Resident #7's current FL2 dated 03/15/22 revealed diagnoses included type 2 diabetes, neurocognitive disorder, coronary artery disease, legally blind, and peripheral disease. Review of Resident#7's Nurse Practitioner's (NP) orders dated 04/29/22 revealed: -There was an order for acetaminophen (used to treat fever and pain) 325mg 2 tablets three times daily. -There was an order for amlodipine (used to treat high blood pressure) 10mg 1 tablet daily. -There was an order for atorvastatin (used to lower cholesterol) 40mg 1 tablet daily at bedtime. -There was an order for carvedilol (used to treat high blood pressure) 3.125mg 1 tablet every 12 hours. -There was an order for cholecalciferol (used to supplement vitamin D levels) 50mcg 1 tablet daily. -There was an order for Eliquis (used to prevent blood clots) 5mg 1 tablet twice daily. -There was an order for furosemide (used to treat high blood pressure and swelling) 20mg 1 tablet every morning. -There was an order for guaifenesin (used to treat	D 356		

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D 356	Continued From page 10 cough) 200mg 1 tablet three times daily as needed for congestion. -There was an order for losartan (used to treat high blood pressure) 50mg 1 tablet daily at bedtime. -There was an order for omeprazole (used to treat indigestion) 20mg 1 tablet daily at bedtime. -There was an order for potassium chloride (used to supplement potassium level) 20meq ½ tab daily. -There was an order for sertraline (used to treat depression) 25mg 1 tablet daily. -There was an order for trazodone (used to treat depression) 50mg 1 tablet daily at bedtime. -There was an order for vitamin B complex (used to supplement B vitamins) 1 capsule daily. Observation of Resident #7's medications on 08/31/22 at 4:43pm revealed: -The bubble pack labels on the acetaminophen, amlodipine, atorvastatin, carvedilol, cholecalciferol, Eliquis, furosemide, guaifenesin, losartan, omeprazole, potassium chloride, sertraline, trazodone, and vitamin B complex were not pharmacy generated labels. -The front label on the bubble packs were handwritten with the following information: resident name, name of the medication, strength of the medication, and instructions on how the medication was to be given. -The back label on the bubble packs were handwritten with the following information: name of the medication, strength of the medication, expiration date of the medication, the lot number of the medication, and the date filled. -The handwritten labels on the acetaminophen, amlodipine, atorvastatin, carvedilol, cholecalciferol, Eliquis, furosemide, guaifenesin, losartan, omeprazole, potassium chloride, sertraline, trazodone, vitamin B complex bubble	D 356		

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D 356	Continued From page 11 pack labels all matched the current physician orders. Refer to the interview with the Resident Care Coordinator (RCC) on 08/31/22 at 8:45am. Refer to the interview with the Special Care Coordinator (SCC) on 08/31/22 at 2:52pm. Refer to the interview with the Administrator on 08/31/22 at 3:55pm. Telephone interview with a pharmacist from the facility's backup pharmacy on 09/01/22 at 8:32am revealed: -They did not repackage medications dispensed in bottles from other pharmacies. -Medications they dispensed to the facility were in bubble packs. -They did not know anything about the facility staff repacking prescription medications into bubble packs. -The pharmacy sold bubble pack supplies to the facility. -They did not know what the facility did with the bubble pack supplies after they purchased them. -There was no law against selling bubble pack supplies to the facility. Telephone interview with the facility's contracted pharmacy on 09/01/22 at 9:19am revealed: -They would repackage bottle medications from the resident's preferred pharmacy into bubble packs upon request of the facility. -Repackaging of medications should be done in a pharmacy. Interview with Resident #7's Nurse Practitioner (NP) on 09/01/22 at 9:50am revealed repacking medications from a bottle into a bubble pack was	D 356		

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D 356	Continued From page 12 considered dispensing. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. 2. Review of Resident #8's current FL2 dated 02/18/22 revealed: -Diagnoses included dementia, diabetes, atrial fibrillation and atherosclerotic heart disease. -There was an order for Eliquis (used to prevent blood clots) 5mg 1 tablet twice daily. -There was an order for glipizide (used to treat diabetes) 5mg 1 tablet every morning. -There was an order for mirtazapine (used to treat depression) 15mg 1 tablet daily at bedtime. -There was an order for trazodone (used to treat depression) 150mg 1 tablet daily at bedtime. Observation of Resident #7's medications on 08/31/22 at 4:46pm revealed: -The bubble packs were labeled with labels not from the pharmacy on the Eliquis, glipizide, mirtazapine, and trazodone and did not have pharmacy generated labels. -The front label on the bubble packs for the Eliquis, mirtazapine and trazodone were handwritten with the following information: resident name, name of the medication strength of the medication, and instructions on how the medication was to be given. -The front label on the bubble pack for the glipizide was handwritten with the following information: resident name, name of the medication, strength of the medication, instructions on how the medication was to be given, the lot number of the medication, the date filled and the expiration date for the medication. -The back label on the bubble packs for the Eliquis, mirtazapine and trazodone were	D 356		

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D 356	Continued From page 13 handwritten with the following information: name of the medication, strength of the medication, the date filled and the expiration date for the medication. -The back label area on the bubble pack for the glipizide had no information printed or written. Interview with the Medication Aide (MA) on 08/31/22 at 4:46pm revealed: -Resident #8 received his medications from the resident's preferred pharmacy that supplied his oral medications in a plastic bottle. -After the most recent medication delivery for Resident #8 from the VA pharmacy, she was told by the Resident Care Coordinator (RCC) to repackage Resident #8's medication from the plastic bottles into a bubble package for each medication. -The MA was following directions from the RCC and stated she was not aware she could not repackage medications. Refer to the interview with the RCC on 08/31/22 at 8:45am. Refer to the interview with the SCC on 08/31/22 at 2:52pm. Refer to the interview with the Administrator on 08/31/22 at 3:55pm. --- Interview with the RCC on 08/31/22 at 8:45am revealed: -She and the SCC repackaged prescription medications received in bottles from the pharmacy into bubble packages. -They obtained empty bubble packs from their backup pharmacy. -They would take the prescription medication	D 356		

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 _____	R 09/01/2022

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

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D 356	Continued From page 14 from the bottle and place the medication into the empty bubble packs and affix an adhesive seal to the back of the filled bubble pack. -They would remove the label off the original container and put it on the newly filled bubble pack. -Medications left in bottles were missed by the medication aides (MAs). -Repackaging the medications into bubble packs allowed them to easily track the supply of each medication they had on hand. -She did not know if the facility had a policy about repackaging prescription medications. Interview with the Special Care Coordinator (SCC) on 08/31/22 at 2:52pm revealed: -She routinely repackaged bottled medications received from the residents preferred pharmacies into bubble packs. -She and the RCC routinely repackaged bottle medications received from new admission residents into bubble packs. -The MAs missed seeing medications on the medication carts stored in bottles. -She did not know if the facility had a policy about repackaging prescription medications. Interview with the Administrator on 08/31/22 at 3:55pm revealed: -She was aware the RCC and SCC repackaged prescription medications into bubble packs. -She did not know repacking medications was considered dispensing prescription medications and could only be performed by a pharmacist. The facility's failure to ensure prescribed medications were not transferred from containers dispensed by a pharmacy increased the risk of contamination and medication administration errors which was detrimental to the health, safety,	D 356		

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 356	Continued From page 15 and welfare and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/01/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.	D 356		
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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 5 residents (Resident #6) observed during the morning medication pass including errors with medications used to treat high blood pressure. The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 12:00pm medication	D 358		

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D 358	Continued From page 16 pass on 08/30/22 and 8:00am medication pass on 08/31/22. Review of Resident #6's current FL2 dated 04/29/22 revealed diagnoses included unspecified dementia without behavioral disturbance, paroxysmal atrial fibrillation, anxiety disorder, and muscle weakness. 1. Review of Resident #6's Nurse Practitioner's (NP) order dated 06/10/22 revealed there was an order for amlodipine (used to treat high blood pressure) 5mg 1 tablet daily at 8:00am hold if pulse less than 60. Observation of the medication pass for Resident #6 on 08/31/22 at 8:08am revealed: -The medication aide (MA) placed 15 oral medications into a medication cup for Resident #6. -The medications included one tablet of amlodipine 5mg. -At 8:10am, the MA handed the medication cup to Resident #6 and watched the resident swallow the medications. -The MA did not check Resident #6's pulse prior to administering the medications. Review of Resident #6's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amlodipine 5mg 1 tablet daily hold if pulse if less than 60 scheduled daily at 8:00am. -The amlodipine was documented as administered daily from 08/01/22 to 08/31/22. -There were no documented heart rates on the eMAR for 08/01/22 to 08/31/22. Interview with Resident #6's Nurse Practitioner	D 358		

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D 358	Continued From page 17 (NP) on 09/01/22 at 9:50am revealed: -The pulse rate should be checked right before administering Resident #6's amlodipine. -Resident #6 received narcotic medications which can slow the resident's pulse rate. -A pulse checked at 6:30am could be above 60, but could be 50 if rechecked at 8:00am. Refer to the interview with the MA on 08/31/22 at 9:45am. Refer to the interview with the Resident Care Coordinator (RCC) on 08/31/22 at 10:30am. Refer to the interview with the Special Care Coordinator (SCC) on 08/31/22 at 2:52pm. Refer to the interview with the Administrator on 08/31/22 at 3:55pm. Refer to the interview with Resident #6 on 08/31/22 at 5:00pm. Refer to the facility's policy on blood pressure and/or pulse readings required for medication administration. 2. Review of Resident #6's Nurse Practitioner's (NP) order dated 06/10/22 revealed there was an order for metoprolol ER (extended release) 25mg 1 tablet daily at 8:00am check pulse and hold if less than 60. Observation of the medication pass for Resident #6 on 08/31/22 at 8:08am revealed: -There were 15 total oral medications placed into a medication cup for Resident #6. -The medications included one tablet of metoprolol ER 25mg.	D 358		

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D 358	Continued From page 18 Observation of the medication aide (MA) on 08/31/22 at 8:10am revealed: -The MA handed the medication cup to Resident #6 and watched the resident -The (MA) did not check Resident #6's pulse prior to administering the medications. Review of Resident #6's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol ER 25mg 1 tablet daily check pulse and hold if less than 60 do not crush scheduled daily at 8:00am. -The metoprolol ER was documented as administered daily from 08/01/22 to 08/31/22. -There were no documented heart rates on the eMAR for 08/01/22 to 08/31/22. Interview with Resident #6's Nurse Practitioner (NP) on 09/01/22 at 9:50am revealed: -The pulse rate should be checked right before administering Resident #6's Metoprolol ER. -Resident #6 received narcotic medications which can slow the resident's pulse rate. -A pulse checked at 6:30am could be above 60, but could be 50 if rechecked at 8:00am. Refer to the interview with the MA on 08/31/22 at 9:45am. Refer to the interview with the Resident Care Coordinator (RCC) on 08/31/22 at 10:30am. Refer to the interview with the Special Care Coordinator (SCC) on 08/31/22 at 2:52pm. Refer to the interview with the Administrator on 08/31/22 at 3:55pm. Refer to the interview with Resident #6 on	D 358		

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D 358	Continued From page 19 08/31/22 at 5:00pm. Refer to the facility's policy on blood pressure and/or pulse readings required for medication administration. Interview with the MA on 08/31/22 at 9:45am revealed: -She administered Resident #6's medications on 08/31/22 at the 8:00am medication pass. -The eMAR used to prompt for a pulse rate prior to administration of the amlodipine and metoprolol ER. -The prompt for a daily pulse rate for Resident #6 no longer appeared on the eMAR as of 08/01/22. -She checked Resident #6's pulse when she had come in at 7:00am on 08/31/22 and the pulse was 72. -She documented Resident #6's pulse rate she had taken at 7:00am in the shift report notes. Interview with the RCC on 08/31/22 at 10:30am revealed: -The facility changed to a different contracted pharmacy on 07/01/22. -The facility discontinued all of the orders in the eMAR on 06/30/22. -All of the orders had to be sent to the new pharmacy on 07/01/22. -The pulse check required for Resident #6's medications no longer appeared in the eMAR as of 08/01/22. Interview with the Special Care Coordinator (SCC) on 08/31/22 at 2:52pm revealed: -Pulse results should be documented in the resident's eMAR -Pulse checks should be obtained right before the medication was administered.	D 358		

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D 358	Continued From page 20 Interview with the Administrator on 08/31/22 at 3:55pm revealed it was the facility's policy to follow the order and check the pulse prior to administering the medication. Review of the facility's policy on blood pressure and/or pulse readings required for medication administration dated 09/2021 revealed: -Vital signs will be taken to meet the parameters for administering medications. -Parameters for giving the medication are indicated on the MAR. -A written record is made on the MAR. The facility's failure to follow the prescribing practitioner's order to check Resident #6's pulse rate just prior to administration of amlodipine and metoprolol ER increased the risk of a slow heart rate. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/01/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.	D 368		
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	D 392		

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D 392	Continued From page 21 accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a two-person witness of the destruction of used fentanyl patches destroyed at the facility and maintain records of the destruction for 1 of 1 sampled resident (Resident #6) with an order for fentanyl patches. The findings are: Review of Resident #6's current FL2 dated 04/29/22 revealed diagnoses included unspecified dementia without behavioral disturbance, paroxysmal atrial fibrillation, anxiety disorder, and muscle weakness. Review of Resident #6's Nurse Practitioner's (NP) order dated 08/10/22 revealed fentanyl patch 72-hour (used to relieve severe pain) 100mcg/hr, apply 1 patch topically every 72 hours (remove old patch first). Observation of the 8:00am medication pass on 08/31/22 at 8:15am revealed: -The medication aide (MA) removed a 100mcg/hour fentanyl patch dated 08/28/22 from the skin of Resident #6's right upper back. -The MA affixed the used fentanyl patch to the palm of the glove on her left hand. -The MA applied a 100mcg/hour fentanyl patch dated 08/31/22 to the skin of Resident #6's left upper back. -The MA removed the glove on her left hand with	D 392		

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D 392	Continued From page 22 the used fentanyl patch affixed to it and placed the glove and fentanyl patch into the biohazard sharps container with her right gloved hand. -The MA did not seek a second staff to witness the destruction of the used fentanyl patch she placed in the biohazard sharps container. -The MA did not document the destruction of the used fentanyl patch in the electronic Medication Administration Record (eMAR) or in any other location. Interview with the same MA on 08/31/22 at 8:15am revealed: -She did not know what the facility policy was regarding the waste of used fentanyl patches. -There was no documentation required for the waste of a used fentanyl patch. -She had been trained to place used fentanyl patches into the biohazard sharps container, so no one could access the used patch. -She was not required to seek the assistance of a staff member to witness the destruction of the used fentanyl patch. Review of Resident #6's August 2022 eMAR revealed: -There was an entry for fentanyl patch 72-hour 75mcg/hour apply 1 patch to clean, dry skin every 72 hours with 25mcg to equal 100mcg) scheduled for 8:00am. -The fentanyl patch 75mcg/hour was documented as administered as ordered on 08/02/22 and 08/05/22. -There was an entry for fentanyl patch 25mcg/hour apply 1 patch to clean, dry skin every 72 hours with 75mcg to equal 100mcg) scheduled for 8:00am. -The fentanyl patch 25mcg/hour was documented as administered as ordered on 08/02/22 and 08/05/22.	D 392		

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D 392	Continued From page 23 -There was an entry for fentanyl patch 72-hour 100mcg/hour apply 1 patch to clean, dry skin every 72 hours scheduled for 8:00am. -The fentanyl patch 100mcg/hour was documented as administered on 08/10/22, 08/13/22, 08/16/22, 08/19/22, 08/22/22, 08/25/22, 08/28/22, and 08/31/22. -There was no documentation of a two-person witness of the destruction of the used fentanyl patches. Review of the facility's policy on narcotic medications dated September 2021 revealed: -Only single dose destruction/disposal can be done at the Community. -Another staff member must witness the disposal of a narcotic and initial the count sheet. Interview with the Resident Care Coordinator (RCC) on 08/31/22 at 8:45am revealed: -All narcotic counts and single dose wastes were maintained electronically in the eMAR system. -The facility eMAR system did not prompt the MAs to witness and document the destruction of a used fentanyl patch. -They trained the MAs to placed used fentanyl patches in the biohazard sharps container for disposal. Interview with the Special Care Coordinator (SCC) on 08/31/22 at 2:58pm revealed: -The MAs were supposed to have two staff members witness single dose destruction of narcotics inside the facility. -The facility eMAR system did not prompt the MAs for documentation of removal and destruction of a used fentanyl patch. -The only way she could think of to document the removal and destruction of a used fentanyl patch would be to create a progress note in the	D 392		

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D 392	Continued From page 24 resident's record. Interview with the Administrator on 08/31/22 at 3:55pm revealed: -Getting a witness for the destruction of a used fentanyl patch was not required. -The documentation of the destruction/disposal of a used fentanyl patch occurred when a new fentanyl patch was administered and documented in the eMAR. Interview with Resident #6's NP on 00/01/22 at 9:50am revealed: -The waste of a used fentanyl patch should be witnessed by two people. -The destruction of a used fentanyl patch should be documented. The facility's failure to use a two-person witness to destroy fentanyl patches, known to be highly addictive and can cause respiratory distress and death. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/01/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.	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	D912		

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D912	Continued From page 26 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, medication labels, medication adminstration and controlled substances. The findings are: Based on observations, record reviews, and interviews, the facility failed to respond immediately and in accordance with the facility's policy and procedures for 1 of 1 sampled residents (#1) who had an unwitnessed fall; found with head injuries along with multiple other injuries, was moved by facility staff into the shower, which delayed emergency medical services being provided due to waiting for staff to complete shower upon their arrival. [Refer to Tag 0271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type B Violation)]. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled residents (Residents #7 and #8) prescribed medications were not transferred to containers dispensed by a pharmacy which allowed for potential contamination and medication errors. [Refer to Tag 0356, 10A NCAC 13F .1003(e) Medication Labels (Type B Violation)]. Based on observations, record reviews, and	D912		

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D912	Continued From page 26 Interviews, the facility failed to administer medications as ordered for 1 of 5 residents (Resident #6) observed during the morning medication pass including errors with medications used to treat high blood pressure. [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. Based on observations, interviews, and record reviews, the facility failed to ensure a two-person witness of the destruction of used fentanyl patches destroyed at the facility and maintain records of the destruction for 1 of 1 sampled resident (Resident #6) with an order for fentanyl patches. [Refer to Tag 0392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].	D912		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL100005 Y1	A. Building B. Wing Y2	9/1/2022 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0262 Reg. # 10A NCAC 13F .0802 (d) LSC	Correction Completed 09/01/2022	ID Prefix D0276 Reg. # 10A NCAC 13F .0902(c) (3-4) LSC	Correction Completed 09/01/2022	ID Prefix D0386 Reg. # 10A NCAC 13F .1004 (l) LSC	Correction Completed 09/01/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Michelle Jennings	DATE 09/02/22
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/19/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

Yancey House

Plan of Correction

Annual, Follow Up and Complaint Investigation Survey

September 1, 2022

Responses to the 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 Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."

D271--10A NCAC 13F .0901(c) Personal Care and Supervision--page 1

Staff were re-trained on safety and security of residents that have experienced a fall to include evaluation of the resident for visible injury, and if injury is apparent or suspected, call Emergency Management Medical Services, and do not move the resident. Training included responsibility for immediate notification to the Supervisor in Charge (SIC), Lead Supervisor in Charge (LSIC), Resident Care Coordinator (RCC), Special Care Coordinator (SCC) and Executive Director (ED) of the incident.

Date of Completion—October 16, 2022

D912--G.S. 131D-21(2) Declaration of Residents' Rights—page 26

Retraining has been completed for all staff on Resident Rights related to evaluation and care of Residents when an incident such as a fall have occurred, and the resident has known or suspected injury. Training included notification responsibilities to Supervisor in Charge (SIC), Lead Supervisor in Charge (LSIC), Resident Care Coordinator (RCC), Special Care Coordinator (SCC) and Executive Director (ED) of the incident.

Date of Completion—October 16, 2022

D356—10A 13F .1003 (e) Medication Labels—page 9

An audit of Resident medications was completed to ensure all ordered medications were packaged in the original packaging by the dispensing pharmacy.

Re-training will be completed for the ED, RCC, SCC, LSIC and Medication Technicians on the importance of Residents receiving all Physician/Provider ordered medications in the pharmacy provided packaging and no re-packaging of medications is allowed. All medications are to be dispensed only from the properly packaged and labeled bottle, bubble pack or multi-dose packaging and repackaged only for a 1time dose of medication(s) for a leave of absence.

Date of Completion: October 16, 2022

D912--G.S. 131D-21(2) Declaration of Residents' Rights—page 26

Retraining has been completed for the ED, RCC, SCC, LSIC and Medication Technicians on Resident Rights related to administration of medications to Residents only from original pharmacy provided packaging to avoid contamination and medication errors.

Date of Completion—October 16, 2022

D358 10A NCAC 13F .1004(a) Medication Administration--page 16

An audit of Resident orders and Medication Administration Records was completed and all ordered medications and treatments with ordered vital signs, including blood glucose levels, and parameters for administration were reviewed for completion with specific space for the documentation of the vital sign(s) or blood glucose. The ED, RCC, SCC and LSIC were retrained on completion of a review of all orders when the order is received to ensure ordered vital signs and blood glucose levels, and parameters for the administration of the medication are correct. Any findings where this has not occurred will be immediately corrected.

The RCC and SCC will complete weekly Medication Administration Records audits, checking for accuracy and completeness, as well as appropriate documentation for any ordered vital signs and parameters for the medication's administration. The ED will complete audits of the Medication Administration Records weekly for 8 weeks to assist with compliance, and then will complete random audits on a monthly basis.

The Medication Technicians were retrained on accurate documentation procedures for administration of medications and treatments, to include vital signs and blood glucose levels, parameters as ordered for medication administration. In addition, training was completed with the Med Techs regarding notification responsibilities to the Resident/Special Care Coordinators for any incidence where the previous vital signs/blood glucose levels and parameter orders are not showing on the Medication Administration Record, so that the missing information can be added back to the MAR. Training was also completed for notification to the Provider and documentation of the notification, for any parameter results that were ordered for Provider notification.

Date of Completion: October 16, 2022

D912--G.S. 131D-21(2) Declaration of Residents' Rights—page 27

Retraining has been completed for the Executive Director, Resident Care Coordinator, Special Care Coordinators, Lead Supervisor in Charge and Medication Technicians on Resident Rights related to administration of medications and completing vital signs/blood glucose levels prior to medication administration as ordered by the Provider.

Date of Completion—October 16, 2022

D392 10A NCAC 13F .1008(a) Controlled Substances--page 21

All narcotic/controlled substances, including used/completed Fentanyl patches, will be destroyed by the Medication Technician and witnessed by a second person, limited to the Executive Director (ED), Resident Care Coordinator (RCC). Special Care Coordinator (SCC), Lead Supervisor in Charge (LSIC) or a Medication Technician. The destroyed narcotic/controlled medications will be placed in the Drug Buster (oral and liquid medications) or the sharps/biohazard container (Fentanyl patch).

The ED, RCC, SCC, LSIC were retrained on the procedure for destruction of narcotic/controlled substances, documentation of the destruction, to include the witness to the destruction. The destruction documentation will be completed using the Medication Destruction form as well as in the narcotic/controlled substance count in MatrixCare or other applicable e-MAR System.

The RCC, SCC and LSIC will complete audits of the MARs and Narcotic/Controlled substance counts on a weekly basis to ensure compliance with destruction and witness documentation. The ED will complete random audits of the MARs and Narcotic/Controlled substance counts to assist with compliance.

Date of Completion—October 16, 2022

D912--G.S. 131D-21(2) Declaration of Residents' Rights—page 27

Retraining has been completed for the Executive Director, Resident/Special Care Coordinators, Lead Supervisor in Charge and Medication Technicians on Resident Rights related to the procedure for destruction of narcotic/controlled substances, documentation of the destruction, to include the witness to the destruction.

Date of Completion—October 16, 2022

Grace Renee Robinson