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
	HAL100005	A. BUILDING: _____ B. WING _____	R 12/07/2022

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 conducted a follow up survey on 12/06/22 - 12/07/22.	{D 000}		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to obtain a Health Care Personnel Registry (HCPR) check for 1 of 3 sampled staff (Staff A) prior to working in the facility. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired as a medication aide (MA) on 05/18/22. -There was documentation a HCPR check was completed 04/17/19. -There was no other documentation of a HCPR check. Interview with Staff A on 12/07/22 at 9:25am revealed: -She started working in the facility on 05/18/22. -She previously worked at another facility and gave management her personnel record from that facility. -The HCPR check dated 04/17/19 must have been in the personnel record from the previous facility.	D 137	* See attached plan of correction	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Renee Robinson — Executive Director — 1/4/23

Reviewed and acknowledged 01/04/23

RP

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D 137	Continued From page 1 Interview with the Administrator on 12/07/22 at 9:32am revealed: -She or the Business Office Manager (BOM) would complete a HCPR check on newly hired employees within 1 week prior to starting work. -Sometimes she or the BOM would perform personnel record audits but there was not a set schedule for the audits. -She thought the previous BOM had misfiled the HCPR that was completed within 1 week prior to work for Staff A. Review of a HCPR check for Staff A dated 12/07/22 revealed there were no substantiated findings.	D 137		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (#1) related to notifying the primary care provider (PCP) that antibiotic therapy to treat pneumonia had not been initiated. The findings are: Review of the facility's Medication Services Policy and Procedure dated 09/2021 revealed in the event that an antibiotic is not started, the physician shall be notified immediately.	D 273		

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Resident #1's current FL2 dated 11/17/22 revealed:
-Diagnoses included dementia and cardiac disease.
-Level of care was a special care unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 11/16/22.

Review of Resident #1's hospital discharge instructions dated 11/29/22 revealed:
-Resident #1 was seen in the emergency department (ED) on 11/29/22 for a fall.
-The results of an x-ray of the chest revealed "left lower lobe opacities (hazy gray areas) favored to represent pneumonia (infection of the lungs) or aspiration (an object entering the lungs which may cause pneumonia)".
-Medication orders for doxycycline (antibiotic) 100mg twice a day for 10 days and amoxicillin-clavulanate (antibiotic) 875mg-125mg every 12 hours for 10 days.
-The prescriptions for the medications were electronically sent to a local pharmacy.

Review of Resident #1's electronic Medication Administration Record (eMAR) for 11/29/22 - 12/06/22 revealed there were no entries for doxycycline or amoxicillin-clauvulanate on the eMAR.

Observation of Resident #1's medications on hand for administration on 12/06/22 at 11:00am revealed there was not any doxycycline or amoxicillin-clauvulanate available for administration.

Telephone interview with a medication aide (MA) on 12/06/22 at 12:11pm revealed:

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D 273	Continued From page 3 -She was on duty the morning of 11/30/22 and reviewed Resident #1's hospital discharge instructions. -She had telephoned the local pharmacy and asked if they would send the prescriptions to the facility's contracted pharmacy so they could dispense the doxycycline and amoxicillin-clauvulante. -The facility's contracted pharmacy would normally deliver medications within 1 or 2 days. -She had faxed the discharge instructions to the facilty's contracted pharmacy. -She had not followed up with a phone call to determine if the fax had been received by the pharmacy. -She "thought" the medications would arrive. -She had not let anyone in management know that the medications had not been delivered. -The MA or the Special Care Coordinator (SCC) was responsible for notifying the PCP when there was an issue getting a medication for a resident. -She did not notify the PCP Resident #1's medications had not arrived to the facility to administer. Interview with a second MA on 12/06/22 at 2:05pm revealed: -She did not know Resident #1 had antibiotic medication orders. -She knew the PCP should be notified if a medication was not administered to a resident. Interview with a third MA on 12/06/22 at 2:15pm revealed: -It was not reported to her that Resident #1 had orders for antibiotic medications. -The MA or the SCC was responsible for notifying the PCP when there were issues getting a medication for a resident.	D 273		

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D 273	Continued From page 4 Interview with the SCC on 12/06/22 at 11:50am and 12:30pm revealed: -The MAs were responsible for faxing discharge instructions to the facility's contracted pharmacy and then putting the discharge instructions on her desk for review. -She knew the MA had called the local pharmacy and requested the facility's contracted pharmacy dispense the medications. -She reviewed Resident #1's hospital discharge instructions but she had not seen the medication orders on it. -The MA should have faxed the orders to the pharmacy and informed her that the medications had not been delivered. -It was her responsibility to follow up on physician orders but she had missed it. -She or the MA were to inform the PCP when there were issues administering medications as ordered. -She had not notified the PCP that Resident #1 had not been administered the antibiotic medications because she had not seen the orders on the discharge instructions. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 12/06/22 at 12:20pm and 12/07/22 at 9:00am revealed: -She reviewed Resident #1's hospital discharge instructions on 12/01/22 when she was in the facility to see Resident #1. -The doxycycline and amoxicillin-clauvulanate were antibiotics ordered to treat pneumonia. -The facility should have notified her that Resident #1 was not administered the antibiotic medications. -If she had been notified she would have immediately telephoned the pharmacy and ensured the medications arrived at the facility. -Not notifying her of the delay in antibiotic therapy	D 273		

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D 273	Continued From page 5 put Resident #1 at risk of worsening pneumonia and sepsis requiring hospitalization. Interview with the Administrator on 12/07/22 at 12:45pm revealed: -The SCC or the MA were responsible for ensuring the medications were received from the pharmacy. -She did not know why the SCC or the MA had not followed up on the antibiotics for Resident #1. -The SCC or the MA were responsible for notifying the PCP immediately if a resident missed a dose of a medication. -She did not know why the SCC or MA had not notified the PCP that the antibiotic therapy had not been initiated. Based on observations, interviews and record reviews, Resident #1 was not interviewable. The facility failed to notify the PCP that antibiotic medications to treat pneumonia were not administered to Resident #1 for 7 days which put the resident at risk of worsening pneumonia and sepsis requiring hospitalization. This failure was detrimental to the health of Resident #1 and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 21, 2023.	D 273		
{D 358}	10A NCAC 13F .1004(a) Medication Administration	{D 358}		

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{D 358}	Continued From page 6 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: FOLLOW UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 2 of 6 sampled residents (#1 and #6) related to medications to treat pneumonia (#1) and a medication to treat a pressure ulcer (#6). The findings are: Review of the facility's Medication Services Policy and Procedure dated 09/2021 revealed: -Administration of any medication order for a systemic antibiotic shall be started no later than 9:00am of the following day. -All orders are reviewed by the Resident Care Coordinator RCC) or designee. -The RCC (MA if after hours/weekends) will fax the order to the pharmacy. 1. Resident #1's current FL2 dated 11/17/22 revealed: -Diagnoses included dementia and cardiac disease. -Level of care was a special care unit (SCU).	{D 358}		

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Review of Resident #1's Resident Register revealed an admission date of 11/16/22.

Review of Resident #1's hospital discharge instructions dated 11/29/22 revealed:
-Resident #1 was seen in the emergency department (ED) on 11/29/22 for a fall.
-The results of an x-ray of the chest revealed "left lower lobe opacities (hazy gray areas) favored to represent pneumonia (infection of the lungs) or aspiration (an object entering the lungs which may cause pneumonia)".
-Medication orders for doxycycline (antibiotic) 100mg twice a day for 10 days and amoxicillin-clavulanate (antibiotic) 875mg-125mg every 12 hours for 10 days.
-The prescriptions for the medications were electronically sent to a local pharmacy.

Review of Resident #1's electronic Medication Administration Record (eMAR) for 11/29/22 - 12/06/22 revealed there were no entries for doxycycline or amoxicillin-clavulanate on the eMAR.

Observation of Resident #1's medications on hand for administration on 12/06/22 at 11:00am revealed there was not any doxycycline or amoxicillin-clavulanate available for administration.

Telephone interview with a pharmacist at the local pharmacy on 12/06/22 at 11:10am revealed:
-The pharmacy had received electronic prescriptions for the doxycycline and amoxicillin-clavulanate from a local hospital on 11/29/22.
-They did not dispense the antibiotics for Resident #1 because there was a notation on

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{D 358}	Continued From page 8	{D 358}		

each prescription that another pharmacy would dispense the medications.

Telephone interview with a medication aide (MA) on 12/06/22 at 12:11pm revealed:
-She worked the morning of 11/30/22 and reviewed Resident #1's hospital discharge instructions.
-She telephoned the local pharmacy and asked if they would send the prescriptions to the facility's contracted pharmacy so they could dispense the doxycycline and amoxicillin-clavulanate.
-The facility's contracted pharmacy would normally deliver medications within 1 or 2 days.
-She faxed the discharge instructions to the facilty's contracted pharmacy.
-She did not follow up with a phone call to determine if the fax had been received by the pharmacy.
-She "thought" the medications would arrive.
-She did not let anyone in management know that the medications had not been delivered.
-All the MAs knew they were waiting on the medications to arrive.

Interview with a second MA on 12/06/22 at 2:05pm revealed:
-The MAs were responsible for faxing the discharge instructions to the facility's contracted pharmacy and then to telephone the pharmacy to ensure they received the fax.
-If a medication was not delivered by the pharmacy the MA was to inform the Special Care Coordinator (SCC).
-She did not know Resident #1 had antibiotic medication orders.

Interview with a third MA on 12/06/22 at 2:15pm revealed:
-The discharge instructions were to be faxed to

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the facility's contracted pharmacy.
-She would then send a photo of the instructions to the facility's contracted Nurse Practitioner (NP) and the SCC.
-It had not been reported to her that Resident #1 had orders for antibiotic medications.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 12/06/22 at 11:31am revealed the pharmacy did not receive the discharge instructions with the doxycycline and amoxicillin-clavulanate medication orders or any prescriptions from a local pharmacy.

Interview with the SCC on 12/06/22 at 11:50am and 12:30pm revealed:
-The MAs were responsible for faxing discharge instructions to the facility's contracted pharmacy and then putting the discharge instructions on her desk for review.
-The pharmacy entered new medication orders into the eMAR system.
-She approves the new medication orders via the eMAR once the medications are delivered to the facility.
-She knew the MA had called the local pharmacy and requested the facility's contracted pharmacy dispense the medications.
-She reviewed Resident #1's hospital discharge instructions on her desk but she had not seen the medication orders on it.
-The MA should have faxed the orders to the pharmacy and informed her that the medications had not been delivered.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 12/06/22 at 12:20pm revealed:
-She reviewed Resident #1's hospital discharge instructions on 12/01/22 when she was in the

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facility to see Resident #1.
-The doxycycline and amoxicillin-clavulanate were antibiotics ordered to treat pneumonia.
-Not receiving these antibiotics put Resident #1 at risk of worsening pneumonia and sepsis (a life-threatening complication of an infection), leading to hospitalization.

Interview with the Administrator on 12/06/22 at 12:00pm revealed:
-The SCC or the MA were responsible for faxing discharge instructions to the facility's contracted pharmacy and following up with a telephone call to ensure the fax was received.
-The pharmacy would then enter the orders into the eMAR system.
-The SCC or the MA were responsible for ensuring the medications were received from the pharmacy.
-She did not know why the SCC or the MA had not followed up on the antibiotics for Resident #1.

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

2. The medication error rate was 3% as evidenced by the observation of 1 error out of 29 opportunities during the 8:00am medication pass on 12/07/22.

Review of Resident #6 's current FL2 dated 10/27/22 revealed:
-Diagnoses included Alzheimer 's disease.
-Level of care was a special care unit (SCU).

Review of Resident #6 's physician order dated 11/08/22 revealed Betadine solution 10% apply topically to the right outer ankle pressure area wound twice a day.

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Observation of the medication pass in the SCU for Resident #6 on 12/07/22 at 8:05am revealed:
-The medication aide (MA) prepared Resident #6 's medications on the medication cart then walked down the hallway to the living room where Resident #6 was sitting and reclined in a geriatric chair.
-The MA donned gloves and poured Betadine solution onto a gauze pad.
-The MA pulled Resident #6 's sock down from his left ankle and foot and used the guaze to apply the Betadine solution to the left interior ankle and pulled Resident #6 's sock back up over the foot and ankle.

Review of Resident #6 's December 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Betadine solution 10% apply to the right outer ankle twice daily at 8:00am and 8:00pm.
-There was documentation the Betadine solution was applied to the right outer ankle.

Interview with the MA on 12/07/22 at 10:03am revealed:
-She thought the Betadine solution was supposed to be applied to Resident #6 's left ankle and when she removed Resident #6 's sock she saw 2 small "spots" and applied the Betadine.
-Applying the Betadine solution to Resident #6 's left ankle instead of right ankle was a "mistake".
-The facility 's policy for medication administration included to administer medications as ordered on the eMAR.

Observation of the MA on 12/07/22 at 10:06am revealed:
-The MA removed the betadine from the

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medication cart, applied the betadine to guaze, and donned gloves.
-The MA walked from the medication cart parked in the living room over to Resident #6 and removed the sock from Resident #6's right ankle and foot.
-The MA applied betadine to Resident #6's nickel sized pressure ulcer wound on the right outer ankle and reapplied Resident #6's sock.

Interview with the hospice licensed practical nurse (LPN) on 12/07/22 at 12:09pm revealed:
-She last saw Resident #6 about 2 weeks ago.
-Resident #6 developed a stage 2 pressure ulcer on the outer portion of his right ankle and was ordered a Betadine solution on 11/08/22 to be applied to the right outer ankle twice daily.
-The Betadine would promote healing of the pressure ulcer by toughening the skin, drying the wound, and encourage scabbing.
-The Betadine was applied to Resident #6's left inner ankle instead of the right outer ankle because the yellowish stain from the betadine was on the left side.
-If the Betadine was not applied to the pressure ulcer on Resident #6, it would not assist the ulcer to heal and the wound could worsen.

Interview with the Administrator on 12/07/22 at 10:26am revealed:
-The MA should have followed the order on Resident #6 's eMAR and applied the Betadine solution to the correct site.
-If the MA could not remember which of Resident #6 's ankles to apply the Betadine, the MA should have rechecked the eMAR to verify the site before applying the Betadine.
-She expected the MA to apply the Betadine solution to the correct site as ordered for Resident #6.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 13 Based on observations, interview, and record review it was determined Resident #6 was not interviewable. The facility failed to administer medications as ordered to Resident #1, related to antibiotic medications used to treat pneumonia. This failure placed the resident at risk of worsening pneumonia and sepsis requiring hospitalization and constitutes a Type B Violation. The facility provided a plan of protection on 12/06/22 for this violation in accordance with G.S. 131D-34.	{D 358}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL100005 Y1	A. Building B. Wing Y2	12/7/2022 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 D0271	Correction	ID Prefix D0356	Correction	ID Prefix D0392	Correction
Reg. # 10A NCAC 13F .0901(c)	Completed	Reg. # 10A NCAC 13F .1003 (e)	Completed	Reg. # 10A NCAC 13F .1008(a)	Completed
LSC	10/16/2022	LSC	10/16/2022	LSC	10/16/2022
ID Prefix D912	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # G.S. 131D-21(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/16/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Renata Pacheco	DATE 12/14/22
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☑ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/1/2022	☑ YES ☐ NO

STATE FORM: REVISIT REPORT (11/06) EVENT ID: RG5U12

Yancey House
Plan of Correction
Follow up survey
December 6, 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.

D137-10A NCAC 13F .0407(a)(5): Other Staff Qualification

An audit of personnel files was conducted 12/12/22 to ensure all personnel files obtained HCPR certificate, stating employee was eligible for employment.

Business Office Coordinator will ensure all new employees will have HCPR certificate that states they are eligible for employment, in their file prior to employee start date. Business Office Coordinator will conduct weekly audits of employee files to ensure all state requirements are being met, and all mandatory paperwork is placed in files for compliance to all regulations. The Executive Director will conduct weekly random audits to help ensure compliance in this area.

Date of Completion: 1/4/2023

D273-10A NCAC 13F .0902(b) Health Care

An audit of Resident orders was completed on 12/9/22, and all medication orders, referrals, appointments, and procedures were reviewed for implementation and completion.

Retraining was completed on 12/9/22 for Executive Director, Resident Care Coordinator, Memory Care Coordinator/Designee, Medication Aides, and Transporter on the importance of Residents receiving all Physician/Provider Medication orders, referrals, procedures, and Physician/Provider appointments.

Retraining was completed on 12/9/22 for the Executive Director, Resident Care Coordinator, Memory Care Coordinator, and Medication Aides on the requirements for notification to the Physician/Provider for any medications or orders not implemented or administered for any reason (refusals, meds not delivered by pharmacy, etc.) within 24 hours of the missed medication,

The Executive Director, Resident Care Coordinator and Memory Care Coordinator/Designee will track ordered follow up procedures, labs, x-rays, and appointments via use of a calendar/scheduler system. When a resident is sent to hospital, or goes to an appointment

with a physician or provider, the discharge paperwork, or appointment documentation will be reviewed in stand up the following business day to ensure completion of all new orders or appointment referral and follow up.

The Resident Care Coordinator and Memory Care Coordinator will complete weekly audits for all orders received for implementation and completion of the order.

The Executive Director will complete random audits of MAR's for completion of scheduled medication orders and follow up, to assist with compliance.

Date of Completion: 1/4/23

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

An audit was completed on 12/7/22 of Physician Orders, Discharge Orders from ER, Hospital, or Rehab stay, and a cart audit was completed on 12/7/22 to ensure all ordered medications and treatments are available and implemented, and Medication Administration Record (MAR) reflects the applicable order. Any findings indicated medications or treatments were not available for administrations, or were not reflected on the MAR, were corrected, and the Physician/Provider was notified for any additional orders.

The Executive Director, Resident Care Coordinator and Memory Care Coordinator/Designee were retrained on the procedures for approving orders and verification of receipt of medication and implementation of the orders, as well as procedure for notifying the Physician/Provider in the event there will be a delay in implementation of the medication, and obtaining applicable orders for an amended start date.

The Resident Care Coordinator/Memory Care Coordinator will review all orders once received, including ER and/or hospital visits, and provide follow up with the pharmacy to ensure orders have been received by the Pharmacy and will approve the orders in Matrix Care once the medications are received from the Pharmacy.

Any follow up documentation received from the ER, hospital, or rehab stay, including new medication orders, will be brought to the morning manager stand up to be reviewed by the Executive Director, to ensure orders have been processed and implemented.

All Medication Techs/ Aides will receive additional training on medication Administration procedures, including the importance of notifying the ED and/or the RCC/MCC for any medications that do not appear on the MAR during their Medication pass, or any medications that are not available for administration.

Completion Date: 1/4/23

Renie Robinson, Executive Director 1/4/23