

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL-013-05	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/05/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

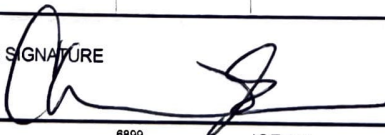
ANN STREET SENIOR LIVING

**302 ANN STREET
KANNAPOLIS, NC 28081**

(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
C 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an initial survey on 05/05/23.	C 000		
C 268	10A NCAC 13G .0904 (c)(5) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (5) Menus as served, invoices, and other receipts for food or beverage purchases shall be maintained in the facility for 30 days. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve what was on the planned menu for 2 of 4 sampled residents (#1 and #4) who were on a regular diet. The findings are: Observation of the facility on 05/05/23 at 9:19am revealed a weekly menu was posted in the dining area for week one of May 2023. Review of the week one menu for the regular diet on 05/05/23 revealed: -The planned breakfast included baked hash browns with bacon, fresh fruit, 100% juice, fresh biscuits and milk. -The planned lunch included an Italian club panini, cantaloupe, Greek salad, chips, beverage of choice and an ice cream sandwich. 1.Review of Resident #1's current FL2 dated	C 268		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE **EB/RW**

(X6) DATE

6/12/23

STATE FORM

6899

ISF311

If continuation sheet 1 of 9

Reviewed and acknowledged 06/16/23
Brianna Jameson RD, LDN

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C 268	Continued From page 1 09/01/22 revealed: -Diagnoses included Alzheimer's disease, aphasia and hypertension. -An order for a regular diet. Observation of Resident #1's breakfast meal on 05/05/23 at 9:44am revealed scrambled eggs, two sausage patties, a biscuit and water. Observation of Resident #1's lunch meal on 05/05/23 at 12:08pm revealed spaghetti noodles with a meat sauce, green beans, a biscuit, iced tea and a slice of cake. Refer to interview with the medication aide (MA) on 05/05/23 at 12:57pm. Refer to interview with the Administrator on 05/05/23 at 1:04pm. 2. Review of Resident #4's current FL2 dated 04/10/23 revealed: -Diagnoses included cardiac arrest and Alzheimer's type dementia with late onset with behavioral disturbance. -An order for a regular, easy to chew diet. Observation of Resident #4's breakfast meal on 05/05/23 at 9:19am revealed scrambled eggs, two sausage patties, a biscuit and water. Observation of Resident #4's lunch meal on 05/05/23 at 12:08pm revealed spaghetti noodles with a meat sauce, green beans, a biscuit, iced tea and a slice of cake. Refer to interview with the MA on 05/05/23 at 12:57pm. Refer to interview with the Administrator on	C 268		

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C 268	Continued From page 2 05/05/23 at 1:04pm. Interview with the MA on 05/05/23 at 12:57pm revealed: -She was aware the meals being served did not match what was posted on the menu. -The third shift employee usually started making breakfast and she would finish the meal and serve it to the residents. -The sausage patties were already cooking when she arrived this morning, so she served them to the residents with scrambled eggs and a biscuit. -She was not sure how third shift knew what food to prepare for breakfast since they did not strictly follow the menu. Interview with the Administrator on 05/05/23 at 1:04pm revealed: -She wanted the residents to eat the meals and maintain their weight so the facility typically served food that the residents liked instead of following the menu. -Most of the residents did not like to drink milk so it was not offered to drink with meals. -She did not keep track of any substitutions that were made to the posted menu and was not aware of how many servings of each food group were required to be served daily.	C 268	The plan of correction is to follow the menu and substitute when needed but keep track of it in a binder. The ED/nurse will be responsible for ordering and enforcing menu plan. There will be a binder located in Ed office with daily signature of ED/ sic to audit daily.		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of	C 342			

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C 342 Continued From page 3

medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3) related to documentation of an antibiotic.

The findings are:

Review of Resident #3's current FL2 dated 11/21/22 revealed diagnoses included hydronephrosis (excess urine accumulation in the kidneys that causes swelling of the kidneys), stage 3 chronic kidney disease and severe aortic stenosis.

Review of Resident #3's hospital discharge paperwork dated 04/03/23 revealed a signed physician's order for ciprofloxacin 500mg daily for seven days.

Review of Resident #3's April 2023 medication administration record (MAR) revealed there was not an entry for ciprofloxacin 500mg (an antibiotic

C 342

Plan of Correction is to update MAR, and followup with pharmacy when new orders are given.

ED/RN/SLC will be responsible when new orders are received and a new order log will be kept for audits to reassess orders are completed.

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C 342	Continued From page 4 used to treat bacterial infections) daily for seven days. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/05/23 at 3:22pm revealed Resident #3's ciprofloxacin was dispensed with seven tablets to the facility on 04/03/23. Interview with the Administrator on 05/05/23 at 12:44pm revealed: -She remembered administering ciprofloxacin to Resident #3 for seven days after he returned from the hospital in April 2023. -She typically compared the medication that the pharmacy delivered to the medication on the MAR and entered new medication on the MAR when necessary. -The pharmacy printed and sent MARs once a month and she was responsible for updating the MARs with any changes that happened after the MARs were sent. -She is not sure why she did not make an entry for ciprofloxacin on Resident #3's April 2023 MAR. Based on observations and interviews, Resident #3 was uninterviewable.	C 342		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during	C 375		

Plan of correction, Called
Medicine Shoppe spoke to
Sue to make a contract
to oversee pharmaceutical

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C 375	Continued From page 5 monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain the services of a licensed pharmacist, prescribing practitioner, or registered nurse for the provision of quarterly pharmaceutical care for 3 of 3 sampled residents. (Resident #1, #2 and #3). The findings are: 1. Review of Resident #1's current FL2 dated 09/01/22 revealed diagnoses included congestive heart failure, Alzheimer's disease and aphasia.	C 375	Care. She stated contract was received and she made initial visit on May 12th to walk through and meet over contract. EO will be responsible of contacting pharmacy when audit is due quarterly and ensuring audit is in resident chart.	

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C 375	Continued From page 6 Review of Resident #1's resident register revealed an admission date of 09/19/22. Review of Resident #1's record on 05/05/23 revealed there were no medication reviews in the resident's record to identify, prevent and resolve medication related problems since his admission on 09/19/22. Refer to telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 05/05/23 at 3:30pm. Refer to interview with the Administrator on 05/05/23 at 11:10am. 2. Review of Resident #2's current FL2 dated 10/26/22 revealed diagnoses included age related cognitive decline and unspecified dementia without behavioral disturbance. Review of Resident #2's resident register revealed an admission date of 11/04/22. Review of Resident #2's record on 05/05/23 revealed there we no medication reviews in the resident's record to identify, prevent and resolve medication related problems since her admission on 11/04/22. Refer to telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 05/05/23 at 3:30pm. Refer to interview with the Administrator on 05/05/23 at 11:10am. 3. Review of Resident #3's current FL2 dated 11/21/22 revealed diagnoses included stage 3 chronic kidney disease, severe aortic stenosis	C 375			

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C 375	Continued From page 7 and cardiac amyloidosis. Review of Resident #3's resident register revealed an admission date of 11/23/22. Review of Resident #3's record on 05/05/23 revealed there were no medication reviews in the resident's record to identify, prevent and resolve medication related problems since his admission on 11/23/22. Review of Resident #3's medication orders and medication administration records (MAR) revealed medication related problems were identified during the survey that could have been identified during a medication review. Refer to telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 05/05/23 at 3:30pm. Refer to interview with the Administrator on 05/05/23 at 11:10am. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 05/05/23 at 3:30pm revealed: -The pharmacy had not been conducting medication reviews at the facility and the Administrator left a message this morning (05/05/23) requesting to set up the service. -The pharmacy was able to complete medication reviews for the facility on a quarterly basis. -The medication review included: looking at each resident's medication, ensuring residents did not have duplicate medications and reviewing the resident's records. -The pharmacy would inform the Primary Care Provider and facility of anything they found during the medication review.	C 375		

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C 375	Continued From page 8 Interview with the Administrator on 05/05/23 at 11:10am revealed: -The contracted pharmacy had not discussed visiting the facility for quarterly pharmaceutical reviews. -She was not aware quarterly pharmaceutical reviews were required.	C 375		