STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001141	A. BUILDING: _____ B. WING _____	09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF BURLINGTON	118 ALAMANCE ROAD BURLINGTON, NC 27215

(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 an annual survey on September 27-29, 2017.	D 000		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 3 of 5 sampled staff (C, F, and G) had completed within the last 24 months a course on Cardio-Pulmonary Resuscitation (CPR) and choking management. The findings are: Review of Staff C's personnel record on 09/29/2017 revealed: -She was hired to work at the facility on 3/29/2013.	D 167		

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D 167	Continued From page 1 -She worked full time as a Medication Aide (MA) and Supervisor on the 11 pm to 7 am shift in the Special Care Unit (SCU). -Her most current CPR training was done on 01/14/2015 with the American Heart Association with a two year expiration. -Staff C's Cardio-Pulmonary Resuscitation (CPR) and choking management certification training was not done within the last 24 months and had expired. Review of Staff F's personnel record on 09/29/2017 revealed: -She was rehired to work at the facility on 08/22/2017. -She worked as a Medication Aide (MA) and Supervisor. -Her most current CPR training was completed on 04/25/2015 with an approved CPR trainer. -The validity period printed on the 04/25/2015 CPR training certificate was "2 years". -Staff F's Cardio-Pulmonary Resuscitation (CPR) and choking management certification training was not done within the last 24 months and had expired on 04/25/2015. Review of Staff G's personnel record on 09/29/2017 revealed: -She was hired to work at the facility on 02/04/2014. -She worked as a Medication Aide (MA) and Supervisor. -Her most current CPR training was done in 03/20/2015 with an unapproved CPR curriculum. -There was a recommended renewal date of 03/2017 printed on the 03/20/2015 CPR certification card. -There was a CPR card dated 09/28/2017 documenting completion of a CPR curriculum with an online health care academy.	D 167		

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D 167	Continued From page 2 -Staff G's CPR and choking management certification training was not done within the last 24 months and had expired on 03/2017. Review of the staffing schedule for September 14, 2017 through September 27, 2017 revealed: -There was no CPR certified staff person on the premises during the 7am - 3pm shift on 09/16/2017. -There was no CPR certified staff person on the premises during the 3pm - 11pm shift on 09/16/2017. -There was no CPR certified staff person on the premises during the 11pm - 7am shift on 09/14/2017, 09/16/2017, 09/18/2017, 09/19/2017, 09/21/2017, 09/25/2017, 09/26/2017, and 09/27/2017. Interview with the Business Office Manager (BOM) on 09/29/2017 at 9:10am revealed: -Staff F had informed the BOM that Staff F's CPR training was current but the staff could not access her CPR card because it was in storage. -She had contacted a previous employer about Staff F's CPR and the previous employer did not have record for CPR training for Staff F. -She did not think Staff F had a current CPR certification. Interview with the BOM on 09/29/2017 at 12:00pm revealed: -She had previously scheduled all medication aides employed at the facility for CPR certification but Staff C and Staff G did not attend the class. -She knew Staff C and Staff G did not have a current CPR certification because they did not attend the 04/26/2017 scheduled CPR training. -She was responsible to ensure staff personnel records included appropriate documentation for required training.	D 167		

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-She got a copy of staff CPR certifications when the staff was hired.
-She had been employed at the facility for 8 years and was not aware of the need for CPR to be performed in the facility since her hire date.
-She monitored staff personnel records by use of a spread sheet tickler system which she reviewed regularly.
-She could not give a frequency on how often she reviewed the tickler system but opened it all the time to look at different things.
-There had been a lot of staff changes at the facility.

-Interview on 09/29/17 at 12:08pm with the BOM revealed:
-She was responsible for having current documentation of CPR in Staff C's personnel files.
-The BOM asked for CPR certification cards at staff orientation when they were hired.
-She had a "tickler" system to trigger reviewing staff qualifications, including CPR.
-She did not know how often Staff C's CPR training documentation had been reviewed.
-She was not aware Staff C's CPR training had expired.

Interview with the Executive Director (ED) on 09/29/2017 at 12:05pm revealed:
-The Business Office Manager (BOM) was responsible for having current documentation of CPR in staff records.
-She was responsible for completing the staff work schedule.
-She thought Staff C and Staff G were certified in CPR because the staff had told her they were certified.
-She had never seen the staffs CPR cards.
-She had not asked anyone if the staff had

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D 167	Continued From page 4	D 167		

provided the facility with a copy of their current CPR certifications.

Attempted phone interviews with Staff C on 09/29/17 between 12:15 pm and the end of the survey were unsuccessful.

Telephone interview with Staff G on 09/29/2017 at 1:30pm revealed:
-She had been employed at the facility for 4 years.
-She worked at the facility 5 - 6 days each week.
-She was CPR certified through the Red Cross.
-She took an online CPR course on the evening of 09/28/2017 because she knew her CPR was due to expire.
-A list of staff needing to get CPR certified had been posted at the facility that included her name.
-Normally the Executive Director (ED) or Business Office Manager (BOM) would let staff know if training was needed.
-She did not know when her CPR expired.
-She normally participated in a classroom setting CPR course which included a return demonstration of CPR performance.
-She was not able to participate in the last classroom CPR course offered at the facility.
-She had never taken a CPR course at the facility.

Telephone interview with Staff F on 09/29/2017 at 1:40pm revealed:
-She had been employed at the facility for about a little over a month.
-She had "recently" started working as a Supervisor at the facility.
-She was the only medication aide in the facility when she worked.
-Her work schedule was for a full time employee, including working every other weekend.

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D 167	Continued From page 5 -She was certified in CPR. -Her CPR certification card was stored in a storage building. -She had taken a classroom CPR course at a previous employer "if not mistaken". -She did not remember the date she had taken the CPR training. -She had been contacted by the BOM on 09/28/2017 and requested to provide a copy of her CPR card. -She thought she had been asked by the BOM upon hire to provide a copy of her CPR card, but was "not sure". The facility's failure to assure at least one staff on duty for each shift every day were adequately trained by having completed a course on CPR and choking management within the last 24 months was detrimental to the health and safety of the residents in case of an emergency requiring cardio-pulmonary resuscitation or management of a choking resident. This constitutes a Type B Violation. Review of the Plan of Protection submitted by the Executive Director on 09/29/2017 revealed the following: -The facility will ensure that every shift has a CPR certified staff member. -The schedule will clearly indicate the person who is CPR certified. -A CPR class will be scheduled immediately. -Personnel records were reviewed on 09/29/2017 and a list was compiled for identification of immediate CPR training needs. -Staff records will be reviewed quarterly to ensure CPR certifications are current. -The facility will make sure classes are scheduled in advance so there are no lapses. -Copies of valid CPR cards will be obtained	D 167		

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D 167	Continued From page 6 during orientation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2017.	D 167		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure milk was served at least twice daily for 1 of 3 residents (Resident #1) served meal trays in their rooms. The findings are: Review of the Registered Dietitian's menus for 9/27-29/2017 revealed residents were to be served milk with breakfast, lunch, and dinner. Review of Resident #1's current FL-2 dated 2/06/17 revealed: -Diagnoses included organic brain syndrome, osteoarthritis, gastritis, anemia, and delirium tremors.	D 299		

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D 299	Continued From page 7 -There was an order for regular, pureed diet, with nectar thickened liquids. -The resident had slurred speech and needed feeding assistance. Observations of the dinner meal served to Resident #1 on 09/27/2017 at 5:35 pm revealed: -Resident #1's plate was taken in the resident's room by the Personal Care Aide (PCA). -There were four pureed food items on the resident's plate. -There were no beverages on the resident's food tray. -The PCA removed a carton of pre-mixed nectar thickened water from the refrigerator in the resident's room and poured a small cup of the nectar thickened water in a small clear plastic cup. Interview with the PCA on 09/27/2017 at 5:40 pm revealed: -She thought the clear plastic cup contained "around 4 ounces (oz) of water. -She normally gave Resident #1 cranberry juice. -She thought Resident #1 had been served milk by the morning shift staff. -Every once in a while she offered Resident #1 milk. -Milk was not on the menu for the supper meal for Resident #1. Observations in the refrigerator on 09/27/2017 in Resident #1's room revealed: -There was a 46 oz carton of pre-mixed nectar thickened consistency sweetened tea. -There was a 8 oz carton of pre-mixed nectar thickened consistency reduced fat milk. -There was an opened carton of pre-mixed nectar thickened consistency water.	D 299		

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D 299	Continued From page 8 Observations of the breakfast meal served to Resident #1 on 09/28/2017 at 8:15 am revealed: -Resident #1's plate was taken in the resident's room by another PCA. -There were four pureed food items on the resident's plate. -There were no beverages on the resident's food tray. Interview with the second PCA on 09/28/2017 at 8:20 am revealed: -She had already given Resident #1 nectar thickened consistency cranberry juice. -She would give Resident #1 nectar thickened consistency water with her meal. -Resident #1 did not drink milk. -She did not recall serving Resident #1 milk. -She had not seen Resident #1 with nectar thickened consistency milk. -Resident #1 would be served nectar thickened consistency tea for lunch. -She knew what liquids to serve Resident #1 based on the dietary tray menu card. Observation of the second PCA on 09/28/2017 at 8:25 am revealed she looked in the refrigerator in Resident #1's room and removed an 8 oz carton of nectar thickened consistency reduced fat milk. Interview with the second PCA on 09/28/2017 at 8:25 am revealed: -There was nectar thickened consistency milk in the refrigerator. -She did not know there was nectar thickened consistency milk in the refrigerator. -She would give Resident #1 the milk from the refrigerator with her breakfast. -She usually worked on another floor. -Sometimes Resident #1 was served yogurt, but there was no yogurt served for the breakfast meal	D 299		

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D 299	Continued From page 9 on 09/28/2017. Interview with the Dietary Manager (DM) on 9/27/17 at 5:50 pm and on 9/28/17 at 12:10 pm revealed: -Residents with room trays had menu sheets, prepared for each meal, for each resident, indicating the type of diet to be served and the drinks to be placed on the cart, for delivery, to the room tray residents. -The menu sheets were placed under the plates for the PCAs to know to which resident the plate was to be served. -The residents' choice of drinks were documented on the menu sheets except for Resident #1. -Resident #1's pre-thickened liquid drinks were stored in her room refrigerator; staff would take the resident's drinks out of the refrigerator at mealtime to serve to the resident. - The DM did not know which drinks were served to Resident #1, there were choices of water, milk, tea, and cranberry juice. -The PCAs doing feeding assistance for Resident #1 chose the drinks offered to Resident #1 at meals. Observation, interview, and record review for Resident #1 revealed the resident was not interviewable. Observation on 9/29/17 at 8:55 am revealed there were 8 oz. cartons of pre-made of nectar thickened tea, water, cranberry juice, and milk in Resident #1's room refrigerator. Interview with the DM on 9/29/17 at 9:52 am revealed: -Resident #1 would mumble when spoken to; it was difficult to understand what her preferences	D 299		

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D 299	Continued From page 10	D 299		

were for meals, she needed to be offered the food to see if she wanted it.
-On the RD's menus, milk was documented to be served at every meal.
-The PCAs had not been specifically directed to offer milk to Resident #1 at every meal, there was an assortment of drinks in Resident #1's room refrigerator and the PCAs chose the drinks for her.
-PCAs had not received dietary training on dietitians' prepared menus.
-The DM was responsible for having milk documented on Resident #1's meal tray menu sheet for every meal to prompt the PCAs to offer milk to Resident #1 at meals.
-The DM would change the menu sheets to have the drinks listed and to indicate milk was to be served at each meal for Resident #1.

Attempted interview with Resident #1's Power of Attorney (POA) on 9/29/17 at 10:50 am and at 3:00 pm was unsuccessful.

Interview with Resident #1's Primary Care Provider (PCP) on 9/29/17 at 11:00 am revealed:
-The PCP was not aware Resident #1 had not been offered milk with her meals.
-On 2/06/17, Resident #1 was ordered a regular diet of pureed foods with nectar thickened liquids; the resident should have been offered milk with her meals as per the registered dietitian's (RD) meal plan.
-The PCP would be sending the facility a dietary order for Resident #1 to have milk offered at every meal.

Interview with the Administrator on 9/29/17 at 10:15 am revealed:
-She was unaware Resident #1 was not being offered milk with every meal.

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D 299	Continued From page 11 -Resident #1 should have been offered milk with her meals as per the RD's menu instructions. -Milk and other drinks were kept stocked in Resident #1's refrigerator. -Staff should have been told to offer milk 3 times a day to Resident #1. -Staff who fed Resident #1 should have been offering milk to the resident to drink at every meal.	D 299		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to contact the physician for clarification of a Humalog sliding scale insulin medication order for 1 of 2 residents sampled (Resident #1) who were receiving sliding scale insulin. The findings are:	D 344		

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D 344	Continued From page 12	D 344		

Review of Resident #1's current FL-2 dated 08/01/2017 revealed:
-Diagnoses included Insulin Dependent Diabetes Mellitus.
-There was a physician's order for Humalog Insulin (an injectable medication used to lower blood glucose levels) per sliding scale parameters.

Review of a subsequent physician's order for Humalog sliding scale insulin dated 08/08/2017 revealed:
-There were instructions to add the following sliding scale to base Humalog if pre-meal glucose is greater than 250: 250 to 350 = plus 1 unit, 350 to 450 = plus 2 units, and greater than 450 = plus 3 units.
-The SSI parameter beginning range and ending range were duplicated with each increase in the prescribed amount of insulin to be administered.

Further review of physician's orders revealed there were no clarification orders or communications between the staff and Primary Care Provider regarding the 08/08/2017 Humalog sliding scale insulin order.

Review of August 2017 Medication Administration Records (MARs) for Resident #1 revealed:
-The 08/08/2017 Humalog SSI physician's order was handwritten on the MAR with instructions of sliding scale Humalog for pre-meal glucose over 250: 250 to 350 give 1 unit, 351 to 450 give 2 units, and greater than 450 give 3 units.
-The handwritten instructions on the MAR did not match the instructions on the 08/08/2017 order.
-There were no documented blood glucose levels of 350 or 450.
-There was documentation of the resident's blood glucose levels ranging from 89 to 270.

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D 344	Continued From page 13 Review of a hospital discharge summary physician's order for Humalog sliding scale insulin dated 08/17/2017 revealed: -There were instructions to add the following scale to base Humalog according to pre-meal glucose level: for finger stick blood glucose of 180 - 240 = plus 1 unit, 240 - 300 = plus 2 units, 300 - 360 = plus 3 units, 360 - 420 = plus 4 units, 420 - 480 = plus 5 units, 480 - 540 = plus 6 units, greater than 540 = plus 7 units. -The SSI parameter beginning range and ending range were duplicated with each increase in the pre-scribed amount of insulin to be administered. Further review of physician's orders revealed there were no clarification orders or communications between the staff and Primary Care Provider regarding the 08/17/2017 Humalog sliding scale insulin order. Review of August 2017 Medication Administration Records (MARs) for Resident #1 revealed: -The 08/17/2017 Humalog SSI physician's order was handwritten on the MAR with instructions to add the following scale to base Humalog according to pre-meal glucose level: for finger stick blood glucose of 180 - 240 = 1 unit, 240 - 300 = 2 units, 300 - 360 = 3 units, 360 - 420 = 4 units, 420 - 480 = 5 units, 480 - 540 = 6 units, greater than 540 = 7 units. -There were no documented blood glucose levels when the Humalog SSI parameter instructions for administering the SSI were unclear and needed clarification. -There was documentation of the resident's blood glucose levels ranging from 50 to 214. Review of September 2017 Medication	D 344		

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	HAL001141	A. BUILDING: _____ B. WING _____	09/29/2017

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Administration Records (MARs) for Resident #1 revealed:
-The 08/17/2017 Humalog SSI physician's order was handwritten on the MAR with instructions to add the following scale to base Humalog according to pre-meal glucose level: for finger stick blood glucose of 180 - 240 = 1 unit, 240 - 300 = 2 units, 300 - 360 = 3 units, 360 - 420 = 4 units, 420 - 480 = 5 units, 480 - 540 = 6 units, greater than 540 = 7 units.
-There were no documented blood glucose levels when the Humalog SSI parameter instructions for administering the SSI were unclear and needed clarification.
-There was documentation of the resident's blood glucose levels ranging from 74 to 429.

Review of a subsequent physician's order for Humalog sliding scale insulin dated 09/19/2017 revealed:
-There were instructions for Humalog SSI as follows: 160 - 210 = 1 unit, 210 - 260 = 2 units, 260 - 310 = 3 units, 310 - 360 = 4 units, 360 - 410 = 5 units, 410 - 460 = 6 units, greater than 460 = 7 units.
-The SSI parameter beginning range and ending range were duplicated with each increase in the prescribed amount of insulin to be administered.

Further review of physician's orders revealed there were no clarification orders or communications between the staff and Primary Care Provider regarding the 09/19/2017 Humalog sliding scale insulin order.

-The 09/19/2017 Humalog SSI physician's order was handwritten on the MAR with instructions to add the following scale: 160 - 210 = 1 unit, 210 - 260 = 2 units, 260 - 310 = 3 units, 310 - 360 = 4 units, 360 - 410 = 5 units, 410 - 460 = 6 units,

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greater than 460 = 7 units.
-There was documentation of the resident's blood glucose levels ranging from 93 to 325.
-There were no documented blood glucose levels when the Humalog SSI parameter instructions for administering the SSI were unclear and needed clarification.

Interview with the Resident Care Director (RCD) on 09/28/2017 at 4:30pm revealed:
-The Medication Aides (MAs) were responsible to transcribe new orders to the MARs.
-The MAs placed a tracking form in her box with each new order and included a copy of the new order attached.
-The MAs faxed all new orders to the provider pharmacy.
-She was responsible to check the MARs to ensure the physician's order was transcribed correctly to the MAR.
-Resident #1's insulin orders changed every week.
-She remembered the Humalog SSI order for Resident #1.
-She remembered saying to a Medication Aide that the Humalog SSI order needed to be clarified.
-She guessed the clarification order for the Humalog SS never happened.
-She did not have a clarification order for the Humalog SSI.

Interview with Executive Director (ED) on 09/28/2017 at 4:35pm revealed:
-She was not sure why the Humalog SSI order had not been "picked up".
-There was a Consultant Nurse who was in the facility every Friday and Saturday and she had asked the nurse to review Resident #1's record

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due to the resident's medical status.
-She would not administer any Humalog insulin because she would not know what amount of Humalog insulin to administer for certain blood glucose levels based on the way the current Humalog sliding scale order was written.

Interview with a Medication Aide (MA) on 09/29/2017 at 9:40am revealed:
-She had administered insulin to Resident #1.
-She thought the Humalog SSI order was clear now.
-There had been lots of changes with Resident #1's insulin orders.
-According to the order on the MAR, Resident #1's Humalog SSI was still unclear and needed to be clarified.
-The physician would need to be contacted via fax for a clarification order.
-According to the current 09/19/2017 Humalog SSI order, she would not know what amount to administer to Resident #1 if the resident's blood glucose level was 210, 260, 310, 360, 410, or 460.
-She would probably give the lower amount of Humalog insulin prescribed if the resident's blood glucose was 210, 260, 310, 360, 410, or 460.
-She did not have a clear answer of what she would administer to the resident.
-She did not know if the 09/19/2017 Humalog SSI order had been clarified.

Interview with a second MA on 09/29/2017 at 9:55am revealed:
-The 09/19/2017 Humalog SSI order was unclear.
-She could not make a decision on what amount of Humalog insulin to administer, therefore the SSI order should be clarified.
-If Resident #1's blood glucose level was 210, 260, 310, 360, 410, or 460, she would not

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D 344	Continued From page 17 administer any amount of Humalog insulin until the order was clarified. -She had not noticed the duplicate the SSI parameter beginning range and ending range were duplicated with each increase in the prescribed amount of insulin. -She had never gotten a blood glucose reading that was one of the duplicated parameters. Interview with Physician's office staff on 09/29/2017 at 10:30am revealed: -The facility had not contacted the physician's office until the morning of 09/29/2017 to get the Humalog SSI order clarified. -The current SSI order seemed "a little questionable". -The Humalog SSI order needed clarification. Interview with the ED on 09/29/2017 at 11:15am revealed she had just received a clarified Humalog SSI order for Resident #1. The ED provided a copy of the 09/29/2017 clarified Humalog SSI order for review. Review of the Humalog sliding scale insulin orderdated 09/29/2017 for Resident #2 revealed the following instructions: 160 - 210 add 1 unit, 211 - 260 add 2 units, 261 - 310 add 3 units, 311 - 360 add 4 units, 361 - 410 add 5 units, 411 - 460 add 6 units, 461 - 510 add 7 units, over 511 add 8 units.	D 344		
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 relevant federal and state laws and rules and	D912		

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D912	Continued From page 18 regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that residents received care and services were were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as it relates to training on cardio-pulmnary resuscitation. The findings are: Based on record reviews and interviews, the facility failed to assure 3 of 5 sampled staff (C, F, and G) had completed within the last 24 months a course on Cardio-Pulmonary Resuscitation (CPR) and choking management. [Refer to Tag D0167, 10A NCAC 13F. 0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].	D912		