STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL095008	A. BUILDING: _____ B. WING _____	01/23/2025

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DEERFIELD RIDGE ASSISTED LIVING	287 BAMBOO ROAD BOONE, NC 28607

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D 000	Initial Comments The Adult Care Licensure Section and the Watauga Department of Social Services conducted an annual survey from January 22, 2025-January 23, 2025.	D 000		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure mealtime service consisted of non-disposable place settings for 3 of 9 residents. The findings are: Review of Resident #1 FL2 dated 11/7/24 revealed: -Diagnoses of chronic obsturctive pulmonary disease, diabetes melliuts type 2, and hypertension. -He had a diet order of a no concentratd sweets diet.	D 286		

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D 286	Continued From page 1 Review of Resident #1's care plan revealed he was independent with eating. Observation during the noon meal service on 01/22/25 at 12:35pm revealed a Medication Aide holding three Styrofoam containers, containing the noon meal, ready to be delivered to three residents. Observation of Resident #1 on 01/22/25 at 12:45pm revealed: -He received a Styrofoam container for the noon meal service in his room. -He was served sheperds pie, mashed potatoes cornbread stuffing and grape juice. -Resident #1 took a few bites of his mashed potatoes and set the tray on his bedside table. Observation on 01/23/25 at 11:00am revealed a Styrofoam container in second resident's room from the breakfast meal service. Interview with a Resident sitter on 01/23/25 at 11:00am revealed: -She sits with the resident from 6:00am to 4:00pm. -She assisted the resident while the resident ate her meals. -The resident's breakfast this morning were served in a Styrofoam container. Based on observations, record reviews and interviews the resident was not interviewable. Interview with a third Resident on 01/23/25 at 12:50pm revealed: -He preferred to eat in his room. -His breakfast this morning was served in a Styrofoam container.	D 286		

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D 286	Continued From page 2 -It did not bother him that he had Styrofoam but on occasion they can be flimsy and break. -During the interview a MA delievered the noon meal service in a Styrofoam container and handed it to the Resident. Interview with the Dietary Manager (DM) on 01/22/25 at 12:50pm: -He used Styrofoam containers and cups when residents ate their meals in their rooms.since he started working at the facility in September 2024. -There were three Residents who chose to eat in their rooms. -He was not aware there was a rule pertaining to the use of non-disposable plates. Interview with the Dietary Manager (DM) on 01/23/25 at 10:00am revealed: -He had gotten conflicting messages from two different people and was confused about what type of place settings were to be used when residents ate in their rooms. -He was told by the Director of Clinical Services (a Licensed Practical Nurse) that Styrofoam was used for infection control, but then was told by the Administrator to use non-disposable place settings for any or the residents who ate in their rooms. Interview with the Administrator on 01/23/25 at 2:40pm revealed if a resident chose to eat their meal in their they should be served their meal on non-disposable place settings and non-disposable utensils.	D 286		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with	D 344		

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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 observations, interviews and record reviews the facility failed to ensure clarification of a medication order for 1 of 5 residents (Resident #2) related to an order for oxygen.

The findings are:

Review of Resident #2's current FL2 dated 04/01/24 revealed:
-Diagnoses included dementia, heart failure and venous insufficiency, and metabolic encephalopathy.
-Her level of care was Special Care Unit (SCU).

Review of Resident #2's record revealed:
-She was receiving hospice care.
-A signed order for oxygen, as needed, for shortness of breath dated 01/13/25.

Review of Resdient #2's January 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen.

Review of Resdient #2's record revealed no

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documentation her oxygen was administered.

Observation of Resident #3 on 01/23/25 at 11:35am revealed she was wearing her oxygen.

Interview with a Medication Aide (MA) on 01/23/25 at 1:20pm revealed:
-Resident #2's oxygen was checked with a pulse oxyimeter (a device that measures oxygen levels in a person's blood) on her finger and if below 90 her oxygen was applied.
-The resident was checked every two hours and look for signs of shortness of breath.
-She knew to set the oxygen at 2 liters per minute because a hospice representative verbally told her when they started the order.
-If we put the oxygen on Resident #3 we would document she needed oxygen in a notebook and shred the note at the end of the shift.
-Resident #3 has had to wear oxygen approximately three times since she had this order as of 01/13/25.

Interview with the Director of Clinical Services and Special Care Coordinator (SCC) on 01/23/25 at 2:30pm revealed:
-The order should of stated the amount of oxygen Resident #3 was to be administered.
-The order required clarification.
-The Director of Clinical Services or the SCC was responsible for clarifying an order.
-The hospice representative verbally told staff the oxygen setting was 2 liters, and set the oxygen up at 2 liters.

Interview with the Administrator on 01/23/25 at 2:40pm revealed:
-When a new order is received it should be placed on a new order form and is placed in the new order notebook.

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D 344	Continued From page 5 -A MA or manager (SCC or Director of Clinical Services) is responsible for filling out the form. -The form should be faxed to the pharmacy. -All medications should be compared to the order and make sure it all matches. -It was her expectation the process was being followed.	D 344		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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 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	D 367		

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facility failed to ensure the electronic Medication Administration Records (eMAR) were accurate for 2 of 5 sampled residents (#2 and #3) related to an order for oxygen and a medication used to treat constipation.

The findings are:

1.Review of Resident #2's current FL2 dated 04/01/24 revealed:
-Diagnoses included dementia, heart failure and venous insufficiency, and metabolic encephalopathy.
-She resided on the Special Care Unit (SCU).

Review of Resident #2's record revealed an order dated 01/13/25 for oxygen, as needed, for shortness of breath.

Review of Resident #2's January 2025 electronic medication administration record (eMAR) revealed there was no entry for oxygen.

Observation of Resident #2 on 01/23/25 at 11:35am revealed she was wearing oxygen.

Interview with a Medication Aide (MA) on 01/23/25 at 1:20pm revealed:
-If we put the oxygen on Resident #2 they documented she needed oxygen in a notebook, communicated this to the next shift and shred the note at the end of the shift.
-Resident #2 had to wear oxygen approximately three times since she had this order of 01/13/25.
-She knew other residents who had oxygen on an 'as needed' basis or continuous oxygen was entered and documented on the eMAR .
-She could not explain why Resident #2's oxygen order was not on the eMAR.

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Interview with the Director of Clinical Services on 01/23/25 at 10:30am revealed:
-She was a Licensed Practical Nurse
-The MAs received the order from hospice and gave it to her or the Special Care Coordinator (SCC).
-She or the SCC were responsible for putting the oxygen order on the eMAR.
-She did not realize Resident #2's oxygen was not on the eMAR.

Interview with the Administrator on 01/23/25 at 2:40pm revealed it was her expectation that all medications should be put on the eMAR.
2. Review of Resident #3's current FL2 dated 08/21/24 revealed:
-Diagnoses included delirium with underlying progressive dementia, chronic atrial fibrillation, esophageal cancer and a history of rectal pain.
-There was an order for Polyethylene Glycol 3350 powder 17g/dose mix 17g in 8 oz of fluid give by mouth every other day for 14 days.

Review of Resident #3's physician's orders dated 09/16/24 revealed Polyethylene Glycol 3350 17gm/dose mix 17 g in 8 oz of fluid and give by mouth every other day.

Review of Resident #3's November 2024 eMAR revealed:
-There was an entry for Polyethylene Glycol 3350 Powder mix 1 capful in 8 ounces liquid of choice and take by mouth daily every other day for 14 days.
-Polyethylene Glycol 3350 Powder was documented as administered daily from 11/01/24 through 11/02/24, 11/04/24 through 11/15/24, 11/19/24 through 11/20/24 and 11/22/24 through 11/30/24.
-Polyethylene Glycol was not given on 11/03/24

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due to refused by resident, 11/16/24 was not given due to "other", 11/17/24 refused by resident, 11/18/24 hold per physician order and 11/21/24 refused by resident.

Review of Resident #3's December 2024 eMAR revealed:
-There was an entry for Polyethylene Glycol 3350 Powder mix 1 capful in 8 ounces liquid of choice and take by mouth daily every other day for 14 days.
-Polyethylene Glycol 3350 Powder was documented as administered daily from 12/01/24 through 12/13/24, 12/15/24 through 12/19/24, 12/21/24 through 12/27/24 and 12/29/24 through 12/31/24.
-Polyethylene Glycol was not given 12/14/24, 12/20/24 and 12/28/24 because the resident refused it.

Review of Resident #3's January 2025 eMAR revealed:
-There was an entry for Polyethylene Glycol 3350 Powder mix 1 capful in 8 ounces liquid of choice and take by mouth daily every other day for 14 days.
- Polyethylene Glycol 3350 Powder was documented as administered daily from 01/03/25 through 01/16/25 and 01/18/25 through 01/22/25.
-Polyethylene Glycol was not given 01/01/25, 01/02/25 and 01/17/25 because the resident refused it.

Observation of Resident #3's medications on hand on 01/23/25 at 9:55am revealed there was no Polyethylene Glycol on hand.

Interview with a medication aide (MA) on 01/23/25 at 10:00am revealed:
-She gave Resident #3 his Polyethylene Glycol

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that morning.
-The dose was given that morning, and the bottle was finished and needed to be reordered.
-Resident #3 had been receiving Polyethylene Glycol every day according to the MARS.
-The facility's contracted pharmacy was responsible for preparing the eMARS.
-Polyethylene Glycol was discontinued 09/16/24 by the physician upon Resident #3's admission to the facility.

Telephone interview with the facility's contracted pharmacy on 01/23/25 at 10:40am revealed:
-Polyethylene Glycol was on Resident #3's MAR as "profile only".
-Profile Only means it was over the counter and the family provided the medication.
-Polyethylene Glycol was never dispensed by the pharmacy.
-Polyethylene Glycol was discontinued 09/16/24.

Telephone interview with Resident #3's Power of Attorney on 01/23/25 at 11:35am revealed:
-The resident was taking Polyethylene Glycol due to an impaction at Resident #3's previous facility.
-The family had not provided Polyethylene Glycol to the facility since admission.

Interview with the Director of Clinical Services on 01/23/25 at 11:50am revealed:
-The Polyethylene Glycol bottle came from the previous facility on admission 09/16/24.
-She was unsure how long a bottle of Polyethylene Glycol would last if it was given every day.
-She checked the eMARs for accuracy.

Interview with the Administrator on 01/23/25 at 11:55am revealed:
-New orders and discontinued medication were

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D 367	Continued From page 10 written in a notebook. -New orders were checked off when they came into the facility and discontinued medications were taken off the eMARs -She did not know how the MAs were giving the same bottle of Polyethylene Glycol since Resident #3's admission. -The physician orders were a way to clarify orders on admission. -The physician orders were sent to the primary care physician (pcp) and then faxed to the pharmacy.	D 367		