

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL087005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/05/2015
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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{D 000}	Initial Comments The Adult Care Section and the Swain County Department of Social Services conducted a follow-up survey on August 04 - 05, 2015.	{D 000}		
{D 273}	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION</p> <p>Based on these findings, the previous Type B Violation was not abated.</p> <p>Based on record review, interviews, and observations, the facility failed to contact the physician regarding admission orders for 2 of 4 sampled residents (#1 and #4) after the residents returned to the facility following hospitalizations. The facility failed to coordinate services with home health to administer an anticoagulant for Resident #1, who was at risk for blood clots following surgery, and failed to obtain orders to meet routine health care needs for Resident #4, who returned to the facility following rehabilitation with diagnosis of congestive heart failure.</p> <p>The findings are:</p> <p>A. Review of Resident #1's current FL2 dated 12/22/14 revealed diagnoses that included anemia.</p>	{D 273}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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{D 273}	<p>Continued From page 1</p> <p>Review of a Hospital Discharge Summary, dated 07/27/15 for Resident #1, revealed the Hospital Course included:</p> <ul style="list-style-type: none"> - An admitting diagnosis on 07/24/15 of right hip fracture. - The resident underwent open reduction internal fixation surgery of right hip on 07/26/15. - Gastrointestinal prophylaxis (prevention), PPI (proton pump inhibitor, reflux prevention). - DVT (Deep Vein Thrombosis) prophylaxis (blood clot prevention). - Discharge diagnoses on 07/27/15 included right hip fracture, acute anemia loss and DVT prophylaxis and "plan Lovenox 21 days total post op" [after surgery] (Lovenox is used to prevent blood clots). <p>Further review of the Hospital Discharge Summary for Resident #1, dated 07/27/15, revealed Discharge Medications included:</p> <ul style="list-style-type: none"> - Enoxaparin sodium 40mg subcutaneous once a day/duration 19 days, (generic name for Lovenox). <p>Review of Resident #1's Medication Administration Records for July and August 2015 revealed the Enoxaparin, listed above, had not been administered.</p> <p>Review of Resident #1's record revealed no documentation of contact with a home health agency or physician regarding the administration of the Enoxaparin.</p> <p>Interview with Resident #1 on 08/04/15 at 10:27am revealed the resident was alert and oriented however, could not name current medications.</p> <p>Interview with the Resident Care Coordinator</p>	{D 273}		

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{D 273}	<p>Continued From page 2</p> <p>(RCC) on 08/04/15 at 4:10pm revealed:</p> <ul style="list-style-type: none"> - The Medication Aides (MA) were supposed to review all new orders including discharge orders when a resident returned from the hospital. - It "did not look like" Resident #1's discharge orders had been reviewed or processed when the resident returned to the facility on 07/27/15. <p>Interview with the Administrator on 08/04/15 at 4:35pm revealed:</p> <ul style="list-style-type: none"> - The facility's policy when a resident returned from a hospital stay was the MAs or RCC were to review any new discharge orders and send them to the Primary Care Provider (PCP) for approval or clarification if needed. - She did not know if Resident #1's hospital discharge orders for 07/27/15 had been processed, but would check into it. <p>Interview with the Administrator on 08/05/15 at 11:20am revealed:</p> <ul style="list-style-type: none"> - She expected the MA or RCC to have reviewed the discharge orders for Resident #1 once the resident returned to the facility on 07/27/15, send the orders to the PCP for approval, and then to the pharmacy. - It did not look like the new orders for Resident #1 had been processed. <p>Telephone interview conducted on 08/05/15 at 10:40am with the Hospitalist, who wrote Resident #1's discharge medication orders on 07/27/15, revealed:</p> <ul style="list-style-type: none"> - The Hospitalist stated she was "shocked and appalled...this is bad...this is a terrible thing" that Resident #1 had not received the DVT prophylaxis. - Resident #1 "is very high risk" for developing blood clots after hip surgery and was now "at super high risk" for developing a clot due to not 	{D 273}		

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{D 273}	<p>Continued From page 3</p> <p>receiving the anticoagulant as ordered.</p> <p>Review of a Physician Order (written by the facility's Primary Care Provider) dated 08/04/15 revealed:</p> <ul style="list-style-type: none"> - Ultrasound of the RLE (right lower extremity) to rule out DVT. - Diagnosis: acute swelling, bruising and inability to ambulate following hip surgery. <p>Review of the results of an ultrasound done 08/05/15 revealed: "No evidence to suggest DVT..."</p> <p>B. Review of Resident #4's most current FL2, dated 08/03/15 revealed diagnoses that included:</p> <ul style="list-style-type: none"> - Osteoarthritis with lumbar degeneration. - Aortic stenosis. - High blood pressure. - Urinary tract infection. - Third degree heart block. - Anemia. <p>Medication listed on the FL2 included:</p> <ul style="list-style-type: none"> - Lasix 10mg every day, used for edema. - Aspirin 81mg every day, used to prevent heart attack and stroke. - Metoprolol 50mg twice a day, used for high blood pressure. - Clopidogrel 75mg every day, used to prevent blood clots in heart disease. - Baclofen 10mg three times a day, used for muscle spasms/pain. - Potassium Chloride 20 milliequivalents every day, used for low potassium levels caused by use of Lasix. - Tramadol 50mg twice a day, used for pain. - Vitamin B12 1000 micrograms every day, used to treat anemia. - Senna 8.6-50mg every day, used for 	{D 273}		

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{D 273}	<p>Continued From page 4</p> <p>constipation.</p> <ul style="list-style-type: none"> - Ativan 0.5mg twice a day as needed for agitation, used for anxiety. - Divalproex 125mg every day, used for seizures or behaviors. <p>Review of the August 2015 Medication Administration Record revealed no medication documented as given until 08/04/15.</p> <p>Review of a Nurse's Note revealed the resident had been admitted to the hospital for urinary tract infection and congestive heart failure on 06/21/15.</p> <p>Interview with the Resident Care Coordinator (RCC), on 08/05/15 at 10:30am and 2:15pm respectively, revealed:</p> <ul style="list-style-type: none"> - Resident #4 had been out of the facility since 06/21/15 for hospitalization and rehabilitation at a SNF (skilled nursing facility) and had returned to the facility 07/31/15 around 3:00pm. - No orders or paper work arrived with the resident except for a list that contained the names of medications that had been released to the resident's family member. This form had been signed by a nurse from the SNF and the resident's family member dated 07/31/15. - She did not believe the resident went all weekend without medications because weekend staff had reported the family member had possession of the resident's discharged medications and had given them to the resident over the weekend. - She had attempted to call the SNF on that Friday when the resident returned, but had been put on hold and never got through to anyone that evening and thought the orders would arrive at the facility later. - When she returned to work the following 	{D 273}		

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{D 273}	<p>Continued From page 5</p> <p>Monday, 08/03/15, there were still no orders or medications on the cart, so she got an FL2 signed by the Primary Care Provider, sent to pharmacy, and the medications were delivered that night.</p> <p>Interview with the Administrator on 08/05/15 at 11:30am revealed:</p> <ul style="list-style-type: none"> - "This [not getting orders for Resident #4 upon admission] is unacceptable." - An FL2 for Resident #4 should have been completed when the resident returned to the facility. - She was unable to say what happened. - The facility's policy for when a resident returned from a hospital stay was the MAs or RCC should review any new discharge orders and send them to the PCP (Primary Care Provider) for approval or clarification if needed. <p>Telephone interview was attempted on 08/05/15 at 2:50pm, to reach Resident #4's family member but was unsuccessful.</p> <p>Observations and interview attempted with Resident #4 during tour on 08/04/15 at 10:05am revealed the resident was determined to not be interviewable.</p> <hr/> <p>A Plan of Protection was submitted by the facility on August 07, 2015 that included:</p> <ul style="list-style-type: none"> - An immediate meeting for re-education of new admissions and returning residents was held with medication aide staff at 8:00am 08/07/15. - State regulations and company policy was reviewed in reference to discharge paper work, FL2s, medications and MARs. - All high acuity residents will be referred to a facility better equipped to meet the resident's 	{D 273}		

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{D 273}	Continued From page 6 needs.	{D 273}		
{D 358}	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION</p> <p>Based on these findings, the previous Type B Violation was not abated.</p> <p>Based on observations, record review and interviews, the facility failed to administer medications as ordered by the primary care provider for 3 of 4 sampled residents, which included Iron, Ascorbic Acid, Pantoprazole for Resident #1; Lasix and Tramadol for Resident #4; and Keflex, Mobic and Lasix for Resident #2.</p> <p>The findings are:</p> <p>A. Review of Resident #1's current FL2 dated 12/22/14 revealed: - Diagnoses that included anemia. - Orders that included Ferrous Sulfate 325mg once a day (an iron supplement used to increase red blood cells in anemia).</p> <p>Review of a Hospital Discharge Summary dated</p>	{D 358}		

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{D 358}	<p>Continued From page 7</p> <p>07/27/15 for Resident #1 revealed the Hospital Course included:</p> <ul style="list-style-type: none"> - An admitting diagnosis on 07/24/15 of right hip fracture. - The resident underwent open reduction internal fixation surgery of right hip on 07/26/15. - Gastrointestinal prophylaxis (prevention), PPI (proton pump inhibitor, reflux prevention). - DVT (Deep Vein Thrombosis) prophylaxis (blood clot prevention). - Acute loss anemia - transfused 2 units of blood; continue iron supplement with vitamin C for enhanced [iron] absorption. - Discharge diagnosis on 07/27/15 included right hip fracture, acute anemia loss and DVT prophylaxis. <p>Further review of the Hospital Discharge Summary for Resident #1, dated 07/27/15 revealed Discharge Medications included an anticoagulant and the following:</p> <ul style="list-style-type: none"> - Ferrous sulfate 325mg twice a day with meals. - Ascorbic acid 500mg twice a day (used to help absorb iron). - Pantoprazole, 40mg once a day (used to prevent gastrointestinal reflux). <p>Review of Resident #1's Medication Administration Records for July and August 2015 revealed the Ferrous Sulfate, Ascorbic Acid and Pantoprazole had not been administered.</p> <p>Interview with with Resident #1 on 08/04/15 at 10:27am revealed the resident was alert and oriented however, could not name current medications.</p> <p>Interview with the Resident Care Coordinator (RCC) on 08/04/15 at 4:10pm revealed:</p> <ul style="list-style-type: none"> - The Medication Aides (MA) were supposed to 	{D 358}		

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{D 358}	<p>Continued From page 8</p> <p>review all new orders including discharge orders when a resident returned from the hospital.</p> <ul style="list-style-type: none"> - It did "not look like" Resident #1's discharge orders had been reviewed or processed when the resident returned to the facility on 07/27/15. <p>Interview with the Administrator on 08/04/15 at 4:35pm revealed:</p> <ul style="list-style-type: none"> - The facility's policy for when a resident returned from a hospital stay was the MAs or RCC were to review any new discharge orders and send them to the Primary Care Provider (PCP) for approval or clarification if needed. - She did not know if Resident #1's hospital discharge orders for 07/27/15 had been processed, but would check into it. <p>Interview with the Administrator on 08/05/15 at 11:20am revealed:</p> <ul style="list-style-type: none"> - She expected the MA or RCC to have reviewed the discharge orders for Resident #1 once the resident returned to the facility on 07/27/15, send the orders to the PCP for approval, and then to the pharmacy. - It did not look like the new orders for Resident #1 had been processed. <p>Telephone interview conducted on 08/05/15 at 10:40am with the Hospitalist, who wrote Resident #1's discharge medication orders on 07/27/15, revealed:</p> <ul style="list-style-type: none"> - The resident was anemic and had to have a blood transfusion after surgery. - The iron supplement was really needed along with the vitamin C for absorption. <p>Review of a Physician Order (written by the facility's Primary Care Provider) dated 08/04/15 revealed:</p> <ul style="list-style-type: none"> - Diagnosis: acute swelling, bruising and inability 	{D 358}		

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{D 358}	<p>Continued From page 9</p> <p>to ambulate following hip surgery.</p> <p>B. Review of Resident #4's most current FL2 dated 08/03/15 revealed diagnoses that included:</p> <ul style="list-style-type: none"> - Osteoarthritis with lumbar degeneration. - Aortic stenosis. - High blood pressure. - Urinary tract infection. - Third degree heart block. - Anemia. <p>Medications listed on the FL2 included:</p> <ul style="list-style-type: none"> - Lasix 10mg every day (used for edema). - Tramadol 50mg twice a day (used for pain). <p>Observations during medication administration pass on 08/05/15 (Wednesday) at 8:35am revealed Tramadol and Lasix were not available for administration.</p> <p>Interview with the Resident Care Coordinator (RCC) on 08/05/15 at 8:35am revealed:</p> <ul style="list-style-type: none"> - The Tramadol and Lasix was not available and had not been available for yesterday's medication pass either. - Both medications "should have been here yesterday." - She was not sure why these medications were not available. - She had an FL2 signed by the physician on Monday, 08/03/15, and all the other medications had been sent by the pharmacy. - She was "on the med cart" and had not been able to leave the cart to make a phone call to follow-up with the pharmacy regarding these medications. <p>Observations and interview attempted with Resident #4 during tour on 08/04/15 at 10:05am revealed the resident was determined to not be</p>	{D 358}		

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{D 358}	<p>Continued From page 10</p> <p>interviewable.</p> <p>C. Review of Resident #2's current FL2 dated 07/09/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses that included lower extremity swelling. - Orders that included Mobic 7.5 mg daily and Keflex 500 mg every 6 hours for 7 days. (Mobic is an anti-inflammatory and pain reliever and Keflex is used to treat infections.) <p>Review of a Physician Order dated 07/29/15 revealed:</p> <ul style="list-style-type: none"> - Discontinue daily Mobic. - Give Furosemide 40mg every day for 5 days (used for edema). <p>Review of documentation on the July, 2015 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> - An entry for Keflex 500mg every 6 hours (4 times a day) for 7 days. - The resident was administered the Keflex on 07/06/15 twice a day at 12pm and 6pm; 07/07/15 three times a day at 12pm, 6pm, and 12am; and 07/12/15 three times a day at 6am, 12pm, and 6pm. - The resident received only 24 of 28 doses of the Keflex, per MAR documentation. - Mobic 7.5 mg was documented as continually administered on July 29, 30 and 31. <p>Further review of the July 2015 MAR for Resident #2 revealed a hand written entry for Furosemide 40mg by mouth daily for 5 days "start 07/31/15" and one dose documented as administered 07/31/15 at 8am.</p> <p>Review of the August 2015 MAR for Resident #2 revealed no Furosemide transcribed on the MAR.</p>	{D 358}		

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{D 358}	<p>Continued From page 11</p> <p>Observation of the medications on hand for Resident #2 on 08/05/15 at 10:00am revealed a 5 pack dose of Furosemide 40mg, and 2 tablets remained.</p> <p>Interview with Resident #2 on 08/04/15 at 10:38am revealed:</p> <ul style="list-style-type: none"> - She was alert and oriented with some confusion to time. - Resident #2 stated she did not get medications the way she should because in the past staff failed to bring the correct number of one of her pills at bedtime, but could not say how often or when this had occurred. <p>Interview with the Resident Care Coordinator (RCC) on 08/05/15 at 10:00am and 3:00pm revealed:</p> <ul style="list-style-type: none"> - The MAs were supposed to review all new orders. - If there was an order it should have been given as it was ordered not partially given or continued to be given after it was discontinued. - The RCC could not answer why the resident was on Furosemide for 5 days. - Furosemide was not transcribed over to the August 2015 MAR and should have already finished the 5 day dose. - When there are holes in the MAR, staff usually had given the medication but forgot to document, usually because they were interrupted. <p>Interview with the Administrator on 08/05/15 at 4:00pm revealed she expected medications were to be given as ordered.</p> <p>_____</p> <p>A Plan of Protection was submitted by the facility on 08/04/15 that included:</p>	{D 358}		

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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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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 12 - Resident #1's (PCP) Primary Care Provider would be contacted for verification of discharge orders. - If approved, orders for any new medications would be sent to back up pharmacy for pick up. - All future discharge orders would be reviewed with Administrator for follow-up. - Medication Aides would be re-inserviced for procedures to verify discharge orders.	{D 358}		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to assure residents were free of neglect regarding medication administration and health care.</p> <p>The findings are:</p> <p>A. Based on record review, interviews, and observations, the facility failed to contact the physician regarding admission orders for 2 of 4 sampled residents (#1 and #4) after the residents returned to the facility following hospitalizations. The facility failed to coordinate services with home health to administer an anticoagulant for Resident #1, who was at risk for blood clots following surgery, and failed to obtain orders to meet routine health care needs for Resident #4, who returned to the facility following rehabilitation with diagnosis of congestive heart failure. [Refer to Tag 273 10A NCAC 13F .0902(b) (Unabated Type B Violation).]</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL087005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/05/2015
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE LIVING CENTER OF BRYSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713
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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
D914	Continued From page 13 B. Based on observations, record review and interviews, the facility failed to administer medications as ordered by the primary care provider for 3 of 4 sampled residents, which included Iron, Ascorbic Acid, Pantoprazole for Resident #1; Lasix and Tramadol for Resident #4; and Keflex, Mobic and Lasix for Resident #2. [Refer to Tag 358 10A NCAC 13F .1004(a) (Unabated Type B Violation).]	D914		