STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 February 14, 2017 and February 15, 2017.	{D 000}		
D 358	10A NCAC 13F .1004(a) Medication Administration 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: Based on interviews and record reviews the facility failed to administer medication as ordered by a physician for 1 of 5 residents (Resident #2). The findings are: Review of Resident #2's FL-2 dated 8/29/16 revealed: -Diagnoses included Parkinson's disease and hypertension. -Medication for Lopressor (beta blocker used to treat high blood pressure, chest pain and heart failure) 25mg twice daily. Review of the Medication Administration Record (MAR) for January 2017 revealed: -Lopressor 25mg was to be administered twice a day. -It was scheduled for 8am and 8pm.	D 358		

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D 358	Continued From page 1 -On 1/21/17 at 8am and 8pm it was documented med was not given "awaiting new prescription". -On 1/22/17 at 8am it was documented med was not given "awaiting new prescription". Review of Resident #2's medical record revealed: - There were no blood pressure checks for Resident #2. - There were no orders for Blood Pressures to be taken for Resident #2. Interview on 2/14/17 at 10:05am with Resident #2 revealed: - "Sometimes they run out of my medications." - She could not remember the name or the last time the facility had been out of her medication. Telephone interview with the facility's providing pharmacy on 2/15/17 at 11:52am revealed: - All medications were refilled on demand. -An order for Lopressor was refilled and delivered to the facility on 1/16/17 at 8:25pm. -The facility should have had the medications at the facility to give Resident #2. -They did not have any documented notification from the facility Resident #2 did not have her medication. Telephone interview with the prescribing physician's nurse on 2/15/17 at 3:12pm revealed: - The prescribing physician was concerned about Resident #3 missing the Lopressor. - Resident #3 needed to be back on it as soon as possible. - Resident #3 had been "ok". - The prescribing physician had not been notified Resident #3 had missed 3 consecutive doses in January. -The Lopressor was a "medication that she should not miss".	D 358		

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D 358	Continued From page 2 . Interview with the Medication Aide (MA) on 2/15/17 3:25pm revealed: - She remembered the incident when Resident #2 did not receive her Lopressor for three consecutive doses. - She verified her initials on the MAR on 1/21/17 and 1/22/17. - Resident #2's medication card for Lopressor had been misplaced in another residents medication cards and MA thought she was out of the medicine. -"I called the pharmacy but they said the medicine was here." - She checked the records where meds were received by the pharmacy and found the Lopressor had been received on 1/16/17 at 8:25pm. -"I couldn't find it to give." - She did not notify the physician or a supervisor. - She could not remember if she notified the family or not. - She should have notified the Resident Care Coordinator (RCC). Interview with the facility RCC on 2/15/17 at 3:30 pm revealed: - She called Staff A, MA into her office and asked her what happened with Resident #2's medication. - Staff A explained to RCC Resident#2's medication had been misplaced and she was unable to give it. - She was unaware Resident #2 had missed 3 doses of her Lopressor. - Any problems with medication orders or obtaining medications are given to her. - The RCC will call the physician or the backup pharmacy if needed. - She has "repeatedly" trained staff to notify her if	D 358		

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D 358	Continued From page 3 there is a problem with a resident's medication. - "I would have expected her to document the medication was unavailable and notified me immediately." - The RCC could not explain why this process was not followed for Resident #2's ordered medication. Review of the manufacturer's recommendations revealed: -"Patients should be warned against interruption or discontinuation of therapy without the physician's advice." - "Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue Lopressor abruptly even in patients treated only for hypertension." Interview with the Administrator on 01/26/17 at 9:27am revealed: - She was not aware Resident #2 had missed 3 doses of her Lopressor. - The Administrator could not offer an explanation as to why the procedure was not followed.	D 358		