STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075001	A. BUILDING: _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE REST	354 WOODLAND DRIVE COLUMBUS, NC 28722

(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 and the Polk County Department of Social Services conducted an annual survey on May 17-18, 2017.	D 000		
D 355	10A NCAC 13F .1003 (d) Medication Labels 10A NCAC 13F .1003 Medication Labels (d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents (Resident #3) with non-prescription medications had the original manufacturer's label and expiration date resulting in the facility staff relabeling one over-the-counter medication incorrectly. The findings are: Review of Resident #3's current FL2 dated 5/8/17 revealed: -Diagnoses included peripheral vascular disease and kyphosis of dorsal spine. -A physician's order for simethicone (used to	D 355	D355 Facility policy has been put into place. Non-prescription meds will be kept in their original manufacturer's container. Facility staff may write the resident's name on the container and will not obstruct any information on the container, unless the container has been labeled by a licensed pharmacist or dispensing practitioner. This facility will no longer repackage OTC's into bubble packs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Nunnon — TITLE: Administrator — (X6) DATE: 5/31/17

Reviewed and Accepted
Date: 6/7/17 CS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075001	A. BUILDING: _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE REST	354 WOODLAND DRIVE COLUMBUS, NC 28722

(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 355	Continued From page 1 reduce the symptoms of excessive gas) 180mg 1 capsule after each meal. -A physician's order for magnesium oxide (used for magnesium deficiency) 500mg 1 tablet daily. -A physician's order for probiotic (used to aide in digestion) 1 tablet daily. -A physician's order for pain reliever PM (used to reduce pain and as a sleep aide) 2 tablets daily at bedtime. -A physician's order for Tylenol ES (used to reduce pain) 500mg 2 tablets daily at noon. Observation of Resident #3's medications on hand on 5/18/17 at 9:10am revealed: -The bubble pack labels on the simethicone, magnesium oxide, probiotic, pain reliever PM, and Tylenol ES did not have a pharmacy label. -The labels were printed with the following information: resident name, expiration date of the medication, name of the medication, strength of the medication, and instructions on how the medication was to be given. -The label on the simethicone 125mg tablet, take 1 tablet by mouth after each meal, which did not match the most current physician order of simethicone 180mg 1 tablet after each meal. -The labels on the magnesium oxide, probiotic, pain reliever PM, and Tylenol ES bubble packs labels all matched the current physician orders. Review of Resident #3's May 2017 electronic Medication Administration Record (eMAR) revealed: -There were computer generated entries which matched the current physician orders for the simethicone, magnesium oxide probiotic, pain reliever PM, and Tylenol ES. -The simethicone, magnesium oxide probiotic, pain reliever PM, and Tylenol ES were documented as administered for all occurrences	D 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075001	A. BUILDING: _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE REST	354 WOODLAND DRIVE COLUMBUS, NC 28722

(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 355	Continued From page 2 as ordered from 5/1/17 to 5/18/17. Interview with Resident #3 on 5/17/17 at 10:45am revealed: -The staff in the facility were "taking good care" of her. -She had no complaints. Interview with the Administrator-In-Charge (AIC) on 5/18/17 at 9:15am, 9:30am, and 10:15am revealed: -She had made a mistake in creating the label for Resident #3's simethicone by putting 125mg strength instead of 180mg strength tablets. -"I don't have the bottle for the simethicone anymore." -The bottle had been thrown away, when she had repackaged Resident #3's family provided supply of simethicone into bubble packs. -Resident #3's family did not want to purchase the over-the-counter (OTC) medications through the facility pharmacy. -Resident #3's family would bring in the resident's OTC medications and she would repackage the OTC's into bubble packs. -The bubble packs were easier to store than bottles of OTC's and were easier for staff to administer on the medication passes. -Bubble packing the OTC's made it easier to keep track of the inventory of each medication than if it were stored in a bottle. -"According to our pharmacy, we can bubble pack over-the-counter meds." -"So the pharmacy sends us 50 bubble packs and they are blank. I print out the labels based on what's on their FL2 and the bottle label and the expiration date on the bottle." -"Then I print the labels out, so it's listed with the residents name, medicine, dosage, and instructions on when to give it."	D 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075001	A. BUILDING: _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE REST	354 WOODLAND DRIVE COLUMBUS, NC 28722

(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 355	Continued From page 3 -We "repackage" OTC's for only 2 residents of the current 12 who resided in the facility. Interview with the facility Administrator on 5/18/17 at 9:35am revealed: -They had "just recently" begun bubble packing OTC medications for the resident's who did not want to purchase OTC medications from the facility pharmacy. -She had spoken with the facility pharmacy and they told her it was okay for the OTC medications to be repackaged into bubble packs. -"The pharmacy provides the bubble packages." -"We put the meds in the bubble packages, and we have a piece of equipment here that seals the packs." Telephone interview with the facility pharmacy on 5/18/17 at 10:26am revealed: -The pharmacy was aware the facility used repackaged OTC medications for some residents. -The pharmacy was providing the bubble packs for repackaging, however "we didn't provide the sealing equipment." -The facility had notified the facility with concerns that some families did not want to purchase OTC medications from the facility pharmacy "due to cost" and "they were trying to make everything in the same packaging." -"I thought the family members were doing it" referring to repackaging of the medications. -"They wanted to have the meds in the same packaging for safety." -"Simethicone comes in 40mg, 80mg, 125mg, and 180mg strength tablets." Interview with the Administrator on 5/18/17 at 12:00pm revealed: -She was unaware of the rule regarding	D 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075001	A. BUILDING: _____ B. WING _____	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE REST	354 WOODLAND DRIVE COLUMBUS, NC 28722

(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 355	Continued From page 4 non-prescription medications being required to have the original manufacturer's label and expiration date on them and only be relabeled by a licensed pharmacist or dispensing practitioner. -They would immediately stop repackaging OTC's into bubble packs and would administer the OTC's directly from the manufacturer's bottles for the resident's who provided their own OTC's.	D 355		