STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045123	A. BUILDING: _____ B. WING _____	R 06/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HILLS A PACIFICA SENIOR LIVING COMM	2500 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 and follow up survey on 06/18/19.	D 000		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 3 sampled residents (#2) had an updated annual FL-2. The findings are: Review of Resident #2's most recent FL-2 dated 04/06/18 revealed diagnoses including Alzheimer's disease, hypertension, hyperlipidemia and anemia. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 04/06/17. Review of Resident #2's record revealed: -There was no current FL-2 available for review. -There was a care plan for Resident #2 dated	D 235		

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D 235	Continued From page 1 04/11/19. An interview with the Special Care Coordinator (SCC) on 06/18/19 at 3:23 pm revealed: -The SCC did not know Resident #2's FL-2 was outdated. -It was her responsibility to assure there was a current FL-2 in Resident #2's chart. -The facility had a new computer system that issued a report when certain forms are due, but it was not set up to alert when the FL-2 was due. -The FL-2 needed to be updated immediately. An interview with the Administrator on 06/18/19 at 4:09 pm revealed: -He had never seen the computer generate a report that indicated when the annual FL-2's were due to be updated. -He had taken too much comfort in thinking the computer system would include an indication of when the FL-2 was due to be updated.	D 235		
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.	D 358		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to administer medications as ordered by a physician for 1 of 3 sampled residents (Resident #1) related to potassium and vitamin B12 supplements.

The findings are:

Review of Resident #1's current FL2 dated 04/29/19 revealed diagnoses included unspecified dementia without behavioral disturbance, stage 4 chronic kidney disease, and type 2 diabetes.

Review of Resident #1's Resident Register revealed an admission date of 06/05/19.

1. Review of Resident #1's order dated 04/29/19 revealed vitamin B12 500mcg (used to treat vitamin B12 deficiency) 1 tablet every morning.

Observation of Resident #1's medications on hand on 06/18/19 at 3:00pm revealed there was no vitamin B12 500mcg available for administration.

Review of Resident #1's June 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for vitamin B12 500mcg 1 tablet every morning at 9:00am.
-The vitamin B12 was documented as administered for 6 out of 14 opportunities from 06/05/19 to 06/18/19.

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-On 06/05/19 and 06/07/19, the reason the vitamin B12 was not administered was "unavailable."
-On 06/11/19, the reason the vitamin B12 was not administered was "not yet received from resident's pharmacy."
-On 06/12/19, 06/15/19, 06/16/19, and 06/17/19, the reason the vitamin B12 was not administered was "not yet received from pharmacy."
-On 06/18/19, the reason the vitamin B12 was not administered was "not yet come in."

Interview with the Special Care Coordinator (SCC) on 06/18/19 at 3:30pm revealed:
-Resident #1 had a bottle of vitamin B12 when he was admitted to the facility.
-The vitamin B12 had been ordered from contracted pharmacy and would arrive on the evening delivery.
-The physician's order for the vitamin B12 had been faxed to the pharmacy on admission, but for "profile only," which meant the pharmacy made an entry for the order on the eMAR.
-The medication aides had failed to inform her the vitamin B12 had been unavailable for administration.
-"If they didn't have it, they were supposed to order it."

Telephone interview with the contracted facility pharmacy on 06/18/19 at 3:47pm revealed:
-They had received a request on 06/18/19 to send a supply of vitamin B12 for Resident #1.
-The vitamin B12 would be available on the evening delivery.

Telephone interview with Resident #1's physician on 06/18/19 at 3:50pm revealed:
-Vitamin B12 levels "go down very slow."
-It was not a concern to him Resident #1 had

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missed 8 doses of the vitamin B12 supplement, however he wanted the staff to administer the vitamin B12 as it was ordered.

Attempted telephone interview with Resident #1's family member on 06/18/19 at 2:45pm was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Refer to the interview with the SCC on 06/18/19 at 3:25pm.

Refer to the telephone interview with the contracted facility pharmacy on 06/18/19 at 3:45pm.

Refer to the interview with the Administrator on 06/18/19 at 4:05pm.

Refer to the interview with a medication aide on 06/18/19 at 4:10pm.

2. Review of Resident #1's physician order dated 06/14/19 revealed potassium chloride (used to supplement potassium) 10mEq 1 tablet daily.

Review of Resident #1's physician order dated 06/14/19 revealed an order for a blood chemistry test.

Review of Resident #1's potassium level result dated 06/14/19 revealed a level of 3.4mEq/L low (reference range 3.5-5.0 mEq/L).

Review of Resident #1's June 2019 eMAR revealed:
-There was an entry for potassium ER 10mEq 1

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tablet every day at 9:00am.
-The potassium was not documented as administered for 4 out of 4 opportunities from 06/15/19 to 06/18/19.
-On 06/15/19, 06/16/19, and 06/17/19, the reason the potassium was not documented as administered was "not yet received from pharmacy."
-On 06/18/19, the reason the potassium was not documented as administered was "not yet in yet [sic]."

Interview with the Special Care Coordinator (SCC) on 06/18/19 at 3:32pm revealed:
-The physician's order for the potassium had been faxed to the pharmacy, but for "profile only," which meant the pharmacy made an entry for the order on the eMAR.
-The medication aides had failed to inform her the potassium had been unavailable for administration.

Telephone interview with the contracted facility pharmacy on 06/18/19 at 3:48pm revealed:
-They had received a request on 06/18/19 to send a supply of potassium 10mEq tablets for Resident #1.
-The potassium would be available on the evening delivery.

Telephone interview with Resident #1's physician on 06/18/19 at 3:50pm revealed:
-Resident #1's potassium had been "minimally low" when checked on 06/14/19.
-A normal potassium level was 3:5mEq/L to 5.0mEq/L.
-He was not concerned Resident #1 had not yet started the potassium supplement, however he did want the medication to be started and administered as it was ordered.

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D 358	Continued From page 6 Attempted telephone interview with Resident #1's family member on 06/18/19 at 2:45pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with the SCC on 06/18/19 at 3:25pm. Refer to the telephone interview with the contracted facility pharmacy on 06/18/19 at 3:45pm. Refer to the interview with the Administrator on 06/18/19 at 4:05pm. Refer to the interview with a medication aide on 06/18/19 at 4:10pm. _____ Interview with a medication aide on 06/18/19 at 4:10pm revealed: -When the initials beside a medication were circled on the eMAR, it meant the medication had not been administered. -If she discovered a medication was not available, she ordered the medication as soon as possible. -When she "was on the cart" she would check the medications every other day to make sure the medications were available for administration. Interview with the Special Care Coordinator (SCC) on 06/18/19 at 3:25pm revealed: -Resident #1 received his medications from the Veterans Administration (VA). -Resident #1 was a new admission to the facility from out of state.	D 358		

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D 358	Continued From page 7 -The local VA had been notified of Resident #1's arrival to the facility and his need for admission to their care. -The local VA had not yet been to the facility to admit the resident. -The resident had brought a supply of all his medications with him upon admission to the facility. -A list of the medications and quantities of medications Resident #1 had been made upon admission, but was not available. -If the medication aides had ordered a medication from the facility pharmacy and it had not come in as expected, they were supposed to notify the SCC or the Health and Wellness Director. -The medication aides were supposed to perform medication cart audits weekly. -She had spoken with the contracted facility pharmacy and arranged to have them supply all of Resident #1's medications until his admission with the local VA could be completed. Telephone interview with the contracted facility pharmacy on 06/18/19 at 3:45pm revealed: -They had a note on Resident #1's record to "profile" the medications only. -The VA provided Resident #1's medications. Interview with the Administrator on 06/18/19 at 4:05pm revealed: -The facility's policy was to administer medication as they were ordered by the physician. -He would immediately provide an inservice to the medication aide staff to have them alert the SCC and the Health and Wellness Director when medications were not available for administration.	D 358		