

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/28/2020
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 157 GLENDALE DRIVE EDEN, NC 27288			
(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	
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 01/28/20.	C 000	In regards to 10 A NCAC 13 G. 1004(a) Medication Administration	1/28/20	
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 observation, record review and interview, the facility failed to administer medications as ordered by a licensed prescribing physician for 1 of 3 sampled residents (Resident #1) related to a potassium supplement. The findings are: Review of Resident #1's current FL2 dated 04/01/19 revealed: -Diagnoses included hypertension, hyperlipidemia and hyperthyroidism. -There was an order for potassium chloride 20 meq 2 tablets daily (a supplement used to treat low potassium). Review of Resident #1's physician's order dated 12/30/19 revealed potassium 20 meq 1 tablet twice daily. Review of Resident #1's November 2019	C 330	The facility clarified the order with the physician and the pharmacy for Potassium Chloride 20meq 2 tablets daily. The order was clarified and signed by the physician and placed in the residents record. The administrator will conduct random monthly audits to insure that Medication aides review all MARs and medication to insure accuracy with all physician orders. Additionally, the facility will insure that all physician orders are faxed to the pharmacy upon any visit that residents with their physician to insure accuracy and clarification. All orders will then be placed in the resident record	1/28/20 and on- going	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Daphne S. Williams

Administratoor

3/5/2020

STATE FORM

0022

XDOG11

If continuation sheet 1 of 4

Reviewed + Acknowledged
3-6-20 *Daphne Williams*

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C 330	Continued From page 1 Medication Administration Record (MAR) revealed: -There was an entry for potassium chloride 20 meq 2 tablets daily at 8:00am. -Potassium chloride was documented as administered daily at 8:00am from 11/01/19 through 11/31/19. Review of Resident #1's December 2019 MAR revealed: -There was an entry for potassium chloride 20 meq 2 tablets daily at 8:00am. -Potassium chloride was documented as administered daily at 8:00am from 11/01/19 through 12/31/19. Review of Resident #1's January 2020 MAR revealed: -There was an entry for potassium chloride chloride 20 meq 2 tablets daily at 8:00am. -Potassium chloride was documented as administered daily at 8:00am from 01/01/20 through 01/28/20. Observation on 01/28/20 at 11:00pm of medications on hand for Resident #1 revealed: -The medication was prepackaged in a multi-medication dose package. -All medications scheduled for administration at one time were packaged together. -Potassium chloride 20 meq was available for administration. -The potassium chloride 20 meq was packaged and labeled for administration at 8:00 am with 2 tablets once daily. Interview with pharmacy representative on 01/28/20 at 9:05 am revealed: -The pharmacy entered all orders for medication. -The pharmacy had an order dated 12/30/19 for	C 330			

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C 330	Continued From page 2 potassium chloride 20 meq 1 tablet twice daily. -Resident #1's MAR entry was potassium chloride 20 meq 2 tablets daily at 8:00am. -He did not know why the order dated 12/30/19 for potassium chloride 20 meq 1 tablet twice daily had not been entered into the system. -The pharmacy had not entered the order dated 12/30/19 for potassium chloride 20 meq 1 tablet twice daily into the system. -This order must have been missed by pharmacy staff. Interview on 01/28/20 at 11:20 with a representative from Resident #1's the physician's office revealed: -The most current order for Resident #1's potassium chloride 20 meq 1 tablet twice daily dated 12/30/19. -The previous order for Resident #1 was potassium chloride 20 meq 2 tablets once daily. -Resident #1 still received the same amount of potassium chloride daily. -There was no outcome to Resident #1 receiving potassium chloride 20 meq 2 tablets once daily as opposed to receiving potassium chloride 20 meq 1 tablet twice daily. -The physician expected facility staff to follow orders as written and to clarify any orders that were not clear. Interview on 01/28/20 at 10:30 am with the assistant to the Administrator revealed: -The pharmacy printed new MARs monthly. -When the new MARs were received from the pharmacy, the Medication Aides (MA) on duty checked the MARs for accuracy. -If any medication entry was noted to be wrong, the MA would notify the pharmacy for clarification. -The pharmacy would reprint the MARs as needed.	C 330	

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C 330	Continued From page 3 -He was not aware of the order change on 12/30/19 for potassium. Interview on 01/28/20 at 12:50 pm with a MA revealed: -A new order was faxed to the pharmacy when the order was received. -The pharmacy would reprint any MAR as needed, it depended on how the new order was written. -Sometimes the pharmacy did not have to reprint a MAR if the order was a renewal of a medication already taken by a resident. -She was not aware of the order change for potassium dated 12/30/29. Interview on 01/28/20 at 1:00pm with Resident #1 revealed; -She did not know what medication she took. -She depended on the facility to provide medication as ordered by the physician.	C 330			