Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065036	A. BUILDING: _____ B. WING _____	R 11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HANOVER HOUSE	3915 STEDWICK COURT WILMINGTON, NC 28412

(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 and a COVID-19 focused Infection Control survey with an onsite visit on November 18, 2020 to November 19, 2020.	{D 000}	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the fact alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared soley as a matter of compliance with State Law.	
{D 344}	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medication orders were clarified for 1 of 5 sampled residents (Resident #3) related to aspirin (used as a preventative nonsteroidal anti-inflammatory agent). The findings are: Review of Resident #3's current FL2 dated 02/07/20 revealed: -Diagnoses included dementia, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), hypertension, depression and congestive heart failure (CHF). -There was an order for aspirin 81 mg one tablet	{D 344}	Current resident hospital discharge summaries were reviewed to assure orders were clarified as indicated. All hospital discharge summaries will be reconciled by the Med Tech; then reviewed by the Care Manager to assure accuracy and/or clarification as indicated. All hospital discharge summaries will be brought to morning meeting for review to assure continued compliance. This will be monitored by the Care Managers and the Executive Director.	1/1/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Ash

TITLE: Executive Director

(X6) DATE: 12/17/2020

Reviewed + Accepted
01/11/21 JBNielsen RN MSN

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{D 344}	Continued From page 1 once a day. Review of Resident #3's Hospital Discharge Summary dated 08/13/20 revealed instructions not to restart aspirin. Review of Resident #3's Hospital Discharge Medication list dated 08/13/20 revealed aspirin 81 mg one tablet daily listed to continue the medication without change. Review of Resident #3's August 2020 electronic medication administration record (eMARs) revealed: -There was an entry for aspirin 81 mg one tablet daily. -Aspirin 81 mg one tablet daily was documented as administered from 08/01/20 to 08/11/20 and from 08/14/20 to 08/31/20 at 9:00 am. Review of Resident #3's September 2020 eMARs revealed: -There was an entry for aspirin 81 mg one tablet daily. -Aspirin 81 mg one tablet daily was documented as administered from 09/01/20 to 09/21/20 and from 09/23/20 to 09/30/20 at 9:00 am. Review of Resident #3's October 2020 eMARs revealed: -There was an entry for aspirin 81 mg one tablet daily. -Aspirin 81 mg one tablet daily was documented as administered on 10/01/20, 10/03/20, and from 10/05/20 to 10/31/20 at 9:00 am. Review of Resident #3's November 2020 eMARs dated 11/01/20 to 11/17/20 revealed: -There was an entry for aspirin 81 mg one tablet daily.	{D 344}		

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{D 344}	Continued From page 2 -Aspirin 81 mg one tablet daily was documented as administered from 11/01/20 to 11/17/20 at 9:00 am. Interview with a medication aide (MA) on 11/19/20 at 12:04 pm revealed: -When residents returned from the Emergency Room the MA on duty was responsible for medication reconciliation. -The discharge paperwork should have been faxed by the MA to the resident's Primary Care Provider (PCP) for review of any new orders. -Once the medication reconciliation was completed the MA was to place the hospital discharge paperwork in the Memory Care Manager's (MCM) box for her review. -The MA was responsible for medication clarification. -The MA should have completed an order clarification form in the documentation system. -The Administrator provided training in medication reconciliation and discharge paperwork process in October 2020. -She was not familiar with the previous process for medication reconciliation and discharge paperwork because she started in October 2020. Interview with the MCM on 11/19/20 at 12:20 pm revealed: -There was a training for all MAs on 10/21/20 regarding medication reconciliation upon return from an Emergency Room visit or hospitalization. -She was not sure why the order for aspirin was not clarified. Interview with the Administrator on 11/19/20 at 12:45 pm revealed: -The MA was responsible for reconciling medications from the Emergency Room and faxing a copy to the resident's PCP for review.	{D 344}		

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{D 344}	Continued From page 3 -The MCM was to review the discharge paperwork and check behind the MA. -There was a training for all MAs on 10/21/20 regarding medication reconciliation upon return from an Emergency Room visit or hospitalization. Telephone interview with Resident #3's PCP on 11/19/20 at 12:51 pm revealed she would have expected staff to clarify the aspirin discrepancy.	{D 344}		
{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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #3) including oxymetazoline (used for nasal decongestion). The findings are:	{D 358}	Resident orders were reviewed to assure medication administration as directed by provider. Resident Hospital Discharge Summary will be reconciled by the Med Tech; reviewed by the Care Manager to assure accurate implementation of new orders. All Hospital Discharge Summaries will be brought to morning meeting for review to assure reconciliation process is ongoing. This will be monitored by the Care Manager and Executive Director.	1/1/2020

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{D 358}	Continued From page 4 Review of Resident #3's current FL2 dated 02/07/20 revealed diagnoses included dementia, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), hypertension, depression and congestive heart failure (CHF). Review of Resident #3's Hospital Visit Summary dated 09/22/20 revealed orders to start taking oxymetazoline 0.05% 2 sprays by nasal route two times daily as needed (PRN) for nose bleeds for up to five days. Review of Resident #3's Hospital Discharge Medication list dated 09/22/20 revealed oxymetazoline 0.05% 2 sprays by nasal route two times daily as needed for nose bleeds for up to five days listed under new medications to start. Review of Resident #3's September 2020 electronic medication administration record (eMARs) revealed no entry for oxymetazoline 0.05% 2 sprays by nasal route two times daily as needed for nose bleeds for up to five days and no documentation of administration. Review of Resident #3's electronic progress note completed on 09/22/20 at 5:51 pm by a medication aide (MA) revealed the resident returned with a new order for oxymetazoline as a PRN for nose bleeds. Interview with a MA on 11/19/20 at 12:04 pm revealed: -When residents returned from the Emergency Room, the MA on duty was responsible for medication reconciliation. -The discharge paperwork should be faxed to the resident's Primary Care Provider (PCP) for review of any new orders. -Once the medication reconciliation was	{D 358}		

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{D 358}	Continued From page 5 completed, the MA placed the hospital discharge paperwork in the Memory Care Manager's (MCM) box for her review. -The Administrator provided training in medication reconciliation and discharge paperwork process in October 2020. -She was not familiar with the previous process for medication reconciliation and the discharge paperwork because she started in October 2020. Interview with the MCM on 11/19/20 at 12:20 pm revealed: -There was a training for all MAs on 10/21/20 regarding medication reconciliation upon return from an Emergency Room visit or hospitalization. -She was not sure why the order for oxymetazoline was not entered on Resident #3's eMAR. Interview with the Administrator on 11/19/20 at 12:45 pm revealed: -The MA was responsible for reconciling medications from the Emergency Room and faxing a copy to the resident's PCP for review. -The MCM was to review the discharge paperwork and check behind the MA. -There was a training for all MAs on 10/21/20 regarding medication reconciliation upon return from an Emergency Room visit or hospitalization.	{D 358}		

Re: [External] FW: POC

Nielsen, Tina B <tina.nielsen@dhhs.nc.gov>
Mon 1/11/2021 10:51 AM

To: 'hano.adm@affinitylivinggroup.com' <hano.adm@affinitylivinggroup.com>
Cc: Vogel, Abigail L <abigail.vogel@dhhs.nc.gov>; Lloyd, Theresa A <theresa.lloyd@dhhs.nc.gov>; Mozell, Nikia R <nikia.mozell@dhhs.nc.gov>

1 attachments (209 KB)
resurvey POC.pdf;

Good Morning Ms. Ash,
Thank you for talking with me on Friday regarding the Plan of Correction. I was glad we were able to ascertain the original send date of the POC as 12/17/20 but that my name was misspelled. Thank you for forwarding the original email to my teammates. They forwarded it to my correct email address, so I have received it as I told you in the second phone call. Thank you again.

From: Vogel, Abigail L <abigail.vogel@dhhs.nc.gov>
Sent: Friday, January 8, 2021 2:06 PM
To: Nielsen, Tina B <tina.nielsen@dhhs.nc.gov>
Subject: FW: [External] FW: POC

From: New Hanover, ADM- Ash, Lisa <hano.adm@algsenior.com>
Sent: Friday, January 8, 2021 2:04 PM
To: Lloyd, Theresa A <theresa.lloyd@dhhs.nc.gov>; Mozell, Nikia R <nikia.mozell@dhhs.nc.gov>; Vogel, Abigail L <abigail.vogel@dhhs.nc.gov>; 'tina.nielson@dhhs.nc.gov' <tina.nielson@dhhs.nc.gov>
Subject: [External] FW: POC

Lisa K. Ash, NHA, NCALA, CDP
Executive Director/Area Director of Operations
New Hanover House Assisted Living and Memory Care
Office (910) 632-2671 | **Fax** (910) 632-2678
hano.adm@affinitylivinggroup.com

From: New Hanover, ADM- Ash, Lisa
Sent: Thursday, December 17, 2020 4:14 PM

To: 'tina.nielson@dhhs.nc.gov' <tina.nielson@dhhs.nc.gov>
Subject: POC

Tina,
Please find attached the Plan of Correction for the re-survey 11/18/2020. If you should need any further information please feel free to contact me.

Happy Holidays!

Lisa K. Ash, NHA, NCALA, CDP
Executive Director/Area Director of Operations
New Hanover House Assisted Living and Memory Care
Office (910) 632-2671 | **Fax** (910) 632-2678
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