

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/03/2021
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN ADULT CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 165 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 and follow-up survey on 03/02/21 and 03/03/21.	C 000		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the medication administration records (MARs) were accurate for 1 of 3 sampled residents (#1) related to documentation of a vitamin supplement and an anti-hypertensive medication.	C 342		

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

TITLE

(X6) DATE

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C 342	Continued From page 1 The findings are: a. Review of Resident #1's current FL2 dated 12/28/20 revealed: -Diagnoses included hypertension, diabetes mellitus Type II, neuropathy, heart attack, and stroke. -There was an order for vitamin D3 (a vitamin supplement used to treat low Vitamin D levels) 50,000 units weekly. Review of Resident #1's subsequent physician orders dated 02/04/21 revealed there was an order for cholecalciferol (vitamin D3) 50 mcg (2,000 units) take one tablet daily and to discontinue vitamin D 50,000 units weekly. Review of Resident #1's February 2021 medication administration record (MAR) revealed: -There was an entry for vitamin D 1.25mg (50,000 units) take one capsule weekly scheduled for 8:00 am. -There was documentation of administration from 02/01/20 to 02/28/20 at 8:00 am. -There was not an entry for Vitamin D3 50mcg (2,000units) daily on the MAR. Review of Resident #1's March 2021 MAR revealed: -There was an entry for vitamin D 1.25mg (50,000units) take one capsule weekly scheduled for 8:00 am. -There was documentation of administration from 03/01/20 to 03/02/20 at 8:00 am. -There was not an entry for Vitamin D3 50mcg (2,000units) daily on the MAR. Observation of medications on hand on 03/03/21 at 9:30 am revealed: -Resident #1 had a bottle of vitamin D3 50mcg	C 342			

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C 342	Continued From page 2 (2,000 units). -The label on Resident #1's vitamin D3 bottle had instructions to administer 1 tablet daily. -The label read this prescription replaced Vitamin D 1.25mg (50,000units). -The vitamin D3 was filled on 02/04/21. Interview with Resident #1 on 03/03/21 at 9:30 am revealed he took vitamin D daily but did not recall the dosage. Telephone interview with the pharmacist from the contracted pharmacy on 03/03/21 at 9:04 am revealed: -The pharmacy had not dispensed vitamin D 1.25mg (50,000units). -The pharmacy dispensed vitamin D3 50mcg (2,000units) on 02/04/21. Interview with the Supervisor-in-Charge (SIC) on 03/03/21 at 2:45 pm revealed: -The February 2021 and March 2021 MARs reflected an oversight on her part and the other SIC's part for not changing the order from Vitamin D 1.25mg (50,000units) to Vitamin D3 50 mcg (2,000 units) on the MARs. The SIC' were responsible for making all changes to the MARs and ensuring they were accurate. Refer to interview with the Supervisor- in-Charge (SIC) on 03/03/21 at 2:45 pm. Refer to telephone interview with the pharmacist from the contracted pharmacy on 03/03/21 at 9:04 am. Refer to telephone interview with the Administrator on 03/03/20 at 11:45 am revealed: b. Review of Resident #1's current FL2 dated	C 342		

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C 342	Continued From page 3 12/28/20 revealed: -Diagnoses included hypertension, diabetes mellitus Type II, neuropathy, heart attack, and stroke. -There was an order for metoprolol 25mg (used to treat high blood pressure) twice daily. Review of Resident #1's subsequent physician orders dated 12/28/20 revealed there was an order for Metoprolol 25mg take ½ tablet twice daily and to discontinue Metoprolol 25mg twice daily. Review of Resident #1's February 2021 medication administration record (MAR) revealed: -There was an entry for metoprolol 25mg twice daily scheduled for 8:00 am and 8:00 pm. -There was documentation of administration from 02/01/21 to 02/28/21 at 8:00 am and 8:00 pm. -There was an entry for metoprolol 25mg take ½ tablet twice daily scheduled for 8:00 am and 8:00 pm. -There was documentation of administration from 02/01/21 to 02/28/21 at 8:00 am and 8:00 pm. Review of Resident #1's March 2021 MAR revealed: -There was an entry for metoprolol 25mg twice daily scheduled for 8:00 am and 8:00 pm. -There was documentation of administration from 03/01/20 to 03/02/21 at 8:00 am and 8:00 pm. -There was an entry for metoprolol 25mg take ½ tablet twice daily scheduled for 8:00 am and 8:00 pm. -There was documentation of administration from 03/01/20 to 03/02/21 at 8:00 am and 8:00 pm. Observations of medications on hand on 03/03/21 at 9:30 am revealed: -Resident #1 had a bottle of metoprolol 25 mg	C 342		

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C 342	Continued From page 4 tablets. -The label on Resident #1's metoprolol bottle had instructions to administer 1 tablet daily. -The metoprolol tablets were scored and there were several ½ tablets of metoprolol in the bottle. -The metoprolol was filled on 02/04/21 for 100 tablets. Interview with Resident #1 on 03/03/21 at 9:30 am revealed he took half a tablet of metoprolol daily but did not recall the dosage. Telephone interview with the pharmacist from the contracted pharmacy on 03/03/21 at 9:04 am revealed the pharmacy dispensed metoprolol 25mg tablets (whole tablets that were scored to easily break in half) quantity of 100 on 02/04/21. Interview with the Supervisor-in-Charge (SIC) on 03/03/21 at 2:45 pm revealed: -The February 2021 and March 2021 MARs reflected an oversight on her part and the other SIC's part for not discontinuing the metoprolol 25mg on the MARs. -Resident #1 was administered only a half tablet of metoprolol because his dosage had been decreased to a half tablet. -The facility did not have any dosage change stickers to place on the bottle of metoprolol to indicate a dosage change. Refer to interview with the Supervisor- in-Charge (SIC) on 03/03/21 at 2:45 pm. Refer to telephone interview with the pharmacist from the contracted pharmacy on 03/03/21 at 9:04 am. Refer to telephone interview with the Administrator on 03/03/20 at 11:45 am revealed:	C 342			

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C 342	Continued From page 5 Telephone interview with the SIC on 03/03/21 at 2:45 pm. -The SICs were responsible for making all changes to the MARs and ensuring they were accurate. --The February 2021 and March 2021 MARs reflected an oversight on her part and the other SIC's part for not making the appropriate changes and sending them to the pharmacy. -They were supposed to make any medication order changes on the MARs and send the changes to the pharmacy so they would be reflected on the following month's MARs. Telephone interview with the pharmacist from the contracted pharmacy on 03/03/21 at 9:04 am revealed: -The pharmacy supplied the resident's MARs and if there was a medication order change, the facility was responsible to make any necessary changes on the MAR. -The facility staff was responsible to make the pharmacy aware of all changes and to ensure the MAR was correct. Telephone interview with the Administrator on 03/03/20 at 11:45 am revealed: -She did not review the MARs or orders for the residents. -The SICs were supposed to fax new orders to the pharmacy. -The SICs were supposed to check the MARs at the end of the month to ensure they were correct when the new month MAR started. -The SICs were supposed to send any needed corrections on the MARs to the pharmacy. -She expected the SIC to document new medication changes on the current month MARs and ensure they were accurate.	C 342		

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C 342	Continued From page 6 -She held the SIC responsible for the accuracy of the MARs.	C 342			