STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL090025	A. BUILDING: _____ B. WING _____	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE ASSISTED LIVING FACILITY	2515 FOWLER SECREST ROAD MONROE, NC 28110

(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 09-01-21 through 09-02-21.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 6 residents (Resident #6) observed during the medication pass related to medications to treat vitamin deficiencies. The findings are: The medication error rate was 8% as evidenced by the observation of 2 errors out of 26 opportunities during the 12:00pm medication pass on 09/01/21 and the 8:00am medication pass on 09/02/21. Review of Resident #6's current FL2 dated 08/18/21 revealed diagnoses included acute ischemia of large intestine, unspecified lack of coordination, essential hypertension, and chronic atrial fibrillation.	D 358		

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D 358	Continued From page 1 1. Review of Resident #6's current FL2 dated 08/18/21 revealed there was an order for vitamin D 2000u 1 tablet daily. Observation of the 8:00am medication pass on 09/02/21 revealed: -The Medication Aide (MA) prepared Resident #6's medications according to the electronic Medication Administration Record (eMAR) for 8:00am medications. -The MA placed one vitamin D3 1000u tablet in a clear plastic medication cup along with Resident #6's other morning medications. -The vitamin D3 1000u tablet was administered to Resident #6 at 7:51am. Review of Resident #6's August eMAR revealed: -There was an entry for vitamin D 2000u one tablet daily scheduled at 8:00am. -Vitamin D 2000u was documented as administered daily from 08/01/21 to 08/31/21. Review of Resident #6's September eMAR revealed: -There was an entry for vitamin D 2000u one tablet daily scheduled at 8:00am. -Vitamin D 2000u was documented as administered daily from 09/01/21 to 09/02/21. Interview with the MA on 09/02/21 at 11:25am revealed: -She routinely gave two tablets of vitamin D3 1000u on the morning medication pass to Resident #6. -She administered one tablet of vitamin D3 that morning. -She had been trained to check the medication label and compare it to the eMAR, before placing medications in the medication cup for administration.	D 358		

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D 358	Continued From page 2	D 358		

-She had just missed putting the second tablet of vitamin D3 into the cup for administration.
-Resident #6's family member provided the bottle of vitamin D3 1000u tablets for Resident #6.

Telephone interview with the facility's contracted pharmacy representative on 09/02/21 at 10:33am revealed:
-Resident #6's order for vitamin D3 2000u one tablet daily was dated 10/19/20.
-The pharmacy had provided Resident #6's supply of vitamin D3 2000u tablets from 10/19/20 until 07/30/21.
-The family had decided to supply the resident's over-the-counter medications after 07/30/21.
-The pharmacy supply of vitamin D3 2000u tablets would have lasted through 08/06/21.

Telephone interview with Resident #6's primary care provider (PCP) on 09/02/21 at 11:15am revealed:
-The concern with receiving inappropriate dosing of vitamin D3 was the resident could develop increased blood calcium levels.
-The resident should be asked if she had experienced recent nausea, vomiting, shaking, and tremors.
-As long as the resident was not symptomatic, she was not "worried."
-She would send an order to check Resident #6's blood calcium levels.

Interview with Resident #6 on 09/02/21 at 11:30am revealed she denied experiencing any nausea, vomiting, shaking or tremors recently.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/02/21 at 11:05am.

Refer to the interview with the Administrator on

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D 358	Continued From page 3 09/02/21 at 12:30pm. Refer to the facility's medication management policy. 2. Review of Resident #6's current FL2 dated 08/18/21 revealed there was an order for vitamin B-12 250mcg 1 tablet every other day. Observation of the 8:00am medication pass on 09/02/21 revealed: -The Medication Aide (MA) prepared Resident #6's medications according to the electronic Medication Administration Record (eMAR) for 8:00am medications. -The MA placed one vitamin B-12 1000mcg tablet in a clear plastic medication cup along with Resident #6's other morning medications. -The vitamin B-12 1000mcg tablet was administered to Resident #6 at 7:51am. Review of Resident #6's August eMAR revealed: -There was an entry for vitamin B-12 250mcg one tablet every other day scheduled at 8:00am. -Vitamin B-12 250mcg was documented as administered every other day from 08/01/21 to 08/31/21. Review of Resident #6's September eMAR revealed: -There was an entry for vitamin B-12 250mcg one tablet every other day scheduled at 8:00am. -Vitamin B-12 250mcg was documented as administered on 09/02/21. Interview with the MA on 09/02/21 at 11:25am revealed: -She had been trained to check the medication label and compare it to the eMAR, before placing medications in the medication cup for	D 358		

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administration.
-She had not noticed the vitamin B-12 strength was 1000mcg instead of 250mcg as ordered.
-Resident #6's family member had provided the bottle of vitamin B-12 1000mcg tablets.

Telephone interview with the facility's contracted pharmacy representative on 09/02/21 at 10:33am revealed:
-Resident #6's order for vitamin B-12 250mg one tablet every other day was dated 05/25/21.
-The pharmacy had provided Resident #6's supply of vitamin B-12 tablets until 07/30/21.
-The family had decided to supply the resident's over-the-counter medications after 07/30/21.

Telephone interview with Resident #6's primary care provider (PCP) on 09/02/21 at 11:15am revealed there were no ill-effects to the resident for having received increased dosing of vitamin B-12 since 08/06/21.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/02/21 at 11:05am.

Refer to the interview with the Administrator on 09/02/21 at 12:30pm.

Refer to the facility's medication management policy.

_____

Interview with the Resident Care Coordinator (RCC) on 09/02/21 at 11:05am revealed:
-She checked the medications against the eMAR entries once a month for a "couple" of residents.
-She checked for expired medications weekly.
-The MAs were trained to check the bottle label against the eMAR entry prior to administering a medication.

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D 358	Continued From page 5 Interview with the Administrator on 09/02/21 at 12:30pm revealed: -It was the facility's policy the MAs should check the medication label with the entry in the eMAR prior to administering a medication. -The MAs were trained to look at the label on the medication and compare it to the eMAR entry prior to administration of a medication. -The pharmacy was supposed to audit all the residents' medications on the medication carts with the eMAR during the pharmacy reviews. -The last pharmacy review occurred on or around 08/06/21. Review of the facility's medication management policy revealed observe the six rights of medication administration: right resident, right medication, right dose, right time, right route, and right documentation.	D 358		