STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084009	A. BUILDING: _____ B. WING _____	C 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN COURT	1930 WOODHAVEN DRIVE ALBEMARLE, NC 28001

(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 survey on 09/21/21 through 09/22/21.	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 interviews, observations and record reviews the facility failed to discontinue a medication for sleeplessness, after a discontinue order was written by the provider for one of five residents sampled (Resident #5). The findings are: Review of Resident #5's current FL2 dated 02/22/21 revealed: -Diagnoses included insomnia, fibromyalgia and hypertension. -A physician's order for melatonin 3mg for administration before bedtime. Review of Resident #5's physician's orders signed on 09/09/21 revealed an order to discontinue melatonin 3mg. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 1 -An entry for melatonin 3mg scheduled for administration at 8:00pm. -Documentation Resident #5 refused to take melatonin on 09/07/21 and 09/19/21. -Documentation that Melatonin 3mg was administered before bedtime from 09/09/21-09/18/21 and on 09/20/21. Interview with a medication aide (MA) on 09/22/21 at 2:00pm revealed: -Resident #5's melatonin 3mg was listed as an active medication on the September 2021 eMAR and the medication was for administration in the medication cart. -Resident #5's PCP typically sent electronic orders to the pharmacy and if an order was discontinued then it would no longer show as active on the eMAR. -The Resident Care Manager (RCM) also received a paper copy of the order for the facility to file. Telephone interview with Resident #5's Primary Care Provider (PCP) on 09/22/21 at 3:27pm revealed: -Resident #5 frequently refused her medications. -When she refused a medication 3 times in one week, the PCP discontinued the medication. -She gave the facility a verbal order on 09/06/21 to discontinue melatonin 3mg and signed the order on 09/09/21. -She expected the facility to follow her order and fax the discontinued medication order to the pharmacy. -She was not aware that Resident #5 continued to receive Melatonin 3mg after 09/06/21. Telephone interview with Pharmacist at the facility's contracted pharmacy on 09/22/21 at 2:58pm revealed:	D 358		

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D 358	Continued From page 2 -Melatonin 3mg scheduled for administration before bedtime and the order was written for Resident #5 on 04/01/21. -The pharmacy had not received an order to discontinue melatonin 3mg. Interview with the RCM on 09/22/21 at 3:40pm revealed: -Resident #5's PCP sent electronic orders directly to the pharmacy and gave the facility verbal orders. -When the PCP gave a verbal order to the facility, the RCM would fax the order to the pharmacy and keep a record of the fax receipt confirmation. -When a medication was discontinued, she was responsible for faxing the order to the pharmacy and discontinuing the order on the eMAR. -She thought she sent the order to discontinue melatonin 3 mg to the pharmacy but was not able to locate the fax receipt confirmation. Interview with the Executive Director (ED) on 09/22/21 at 3:50pm revealed: -She or the RCM were able to discontinue medications on the eMAR and fax orders to the pharmacy. -When the facility received an order to discontinue a medication, she expected the RCM to discontinue the medication on the eMAR, fax the order to the pharmacy and send any unused medication back to the pharmacy. -She was not aware that the facility had received an order to discontinue Resident #5's melatonin 3mg.	D 358		