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
	HAL079105	A. BUILDING: _____ B. WING _____	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S AGAPE ASSISTED LIVING	5767 HWY 135 STONEVILLE, NC 27048

(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 09/16/21 and 09/17/21.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to meet the health care needs for 1 of 3 residents sampled (Resident #1) who had a physician's order for a follow up visit with a urologist after surgery. Review of Resident #1's current FL2 dated 02/05/21 revealed diagnoses included anxiety, hypertension, urinary retention, and benign prostatic hyperplasia. Review of a physician discharge summary for Resident #1 dated 07/16/21 revealed the resident was to follow up with his Primary Care Provider (PCP) and a urologist in 1 to 2 weeks. Review of a face-to-face PCP encounter for Resident #1 dated 07/30/21 revealed the resident's clinical note directive included the resident was to see a urologist for management of his foley catheter. Review of Resident #1's medical record on 09/16/21 revealed: -There was no documentation for a face-to-face encounter note with Resident #1's urologist. -There was no documentation of a scheduled urologist appointment.	D 273	-All hospital discharge summaries will be review by the RCC upon readmission to the community. Any referral and follow-up appointments will be made within 24hrs. Any discrepancies will be addressed immediately with PCP. The discharge summary and FL2 must match. If not a clarification order must be obtained from PCP. The Administrator will check all hospital summa to ensure accuracy.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hazel Feelman - Administrator — TITLE — (X6) DATE: 10/11/2021

Reviewed and acknowledged by Sharon Dunton RN on 10/29/21

Sharon Dunton RN

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D 273	Continued From page 1 Attempted telephone interview with Resident #1's PCP on 09/16/21 was unsuccessful. Interview with Resident #1 on 09/16/21 at 12:15pm revealed: -He had a foley catheter that was replaced after his surgery in July 2021. -His foley catheter bothered him sometimes so he told his PCP. -His PCP referred him to a urologist, but he had not seen one yet. Interview with the Resident Care Coordinator (RCC) on 09/16/21 at 3:15pm revealed: -She was responsible for ensuring directives given on the residents' PCP face-to-face encounter notes were addressed. -She knew Resident #1 had a referral to see a urologist. -She attempted to contact Resident #1's urologist numerous times but did not know when because she did not make a note of her attempts. -She was not able to schedule an appointment until today (09/16/21) when it was brought to her attention Resident #1 did not have an appointment. Interview with the Administrator on 09/17/21 at 9:45am revealed: -She did not know Resident #1 needed a referral to see a urologist. -She depended on the RCC to review all the residents' PCP's notes and arrange referrals to set up with the medical specialist. -The RCC was expected to attempt to contact the medical specialist within 24 hours. -The RCC was expected to track all the residents' referrals and follow up with additional telephone calls until an appointment was made.	D 273		

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D 273	Continued From page 2 -If the RCC was not successful with obtaining a referral after 2 attempts she was supposed to be notified.	D 273		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record.	D 400		

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D 400	Continued From page 3	D 400		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure quarterly pharmaceutical reviews were completed for 3 of 3 sampled residents (#1, #2, and #3).

The findings are:

1. Review of Resident #1's current FL2 dated 02/05/21 revealed:
-Diagnoses included anxiety, hypertension, urinary retention, and benign prostatic hyperplasia.
-Resident #1 was admitted to the facility on 02/01/21.

Review of Resident #1's record on 09/16/21 revealed there was no documentation of a quarterly pharmacy review completed since admission on 02/01/21.

Refer to telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/16/21 at 1:39pm.

Refer to interview with the Resident Care Coordinator (RCC) on 09/16/21 at 3:15pm.

Refer to interview with the Administrator on 09/17/21 at 9:45am.

2. Review of Resident #2's current of FL2 dated 04/01/21 revealed:
-Diagnoses included hypertension, cerebrovascular accident, and depression.
-Resident #2 was admitted to the facility on 02/18/20.

All quarterly pharmacy reviews will be completed by licensened personnel and placed in the appropiate section of the residents chart for immediate review. The RCC will ensure the reviews are placed on a monthly basis. The Administrator will check every three months for accuracy.

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D 400	Continued From page 4 Review of Resident #2's record on 09/16/21 revealed there was no documentation of a quarterly pharmacy review completed since admission on 02/18/20. Refer to telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/16/21 at 1:39pm. Refer to interview with the Resident Care Coordinator (RCC) on 09/16/21 at 3:15pm. Refer to interview with the Administrator on 09/17/21 at 9:45am. 3. Review of Resident #3's current FL2 dated 04/01/21 revealed: -Diagnoses included bipolar disorder, hypertension, depression, and hyperlipidemia. -Resident #3 was admitted to the facility on 10/14/16. Review of Resident #3's record on 09/16/21 revealed there was no documentation of a quarterly pharmacy review completed since 01/07/21. Refer to telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/16/21 at 1:39pm. Refer to interview with the Resident Care Coordinator (RCC) on 09/16/21 at 3:15pm. Refer to interview with the Administrator on 09/17/21 at 9:45am. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/16/21 at	D 400		

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D 400	Continued From page 5 1:39pm revealed: -She last visited the facility 07/15/21 and completed pharmacy reviews for all the residents. -She emailed the completed pharmacy reviews to the Administrator. Interview with the Resident Care Coordinator (RCC) on 09/16/21 at 3:15pm revealed: -She was responsible for placing the residents' pharmacy reviews in the physician's notebook for the physician to sign and address the pharmacy recommendations. -The pharmacist visited the facility sometime in July 2021. -The pharmacist did not provide her with copies of the residents' pharmacy reviews in July 2021. -She had not contacted the pharmacist until today (09/16/21) to obtain copies of the residents' pharmacy review. Interview with the Administrator on 09/17/21 at 9:45am revealed: -The RCC was responsible for placing pharmacy reviews in the physician's notebook to be addressed. -She did not receive the residents' pharmacy reviews until today (09/17/21) by email. -She depended on the RCC to make sure the pharmacy reviews were addressed. -She did not know the pharmacy reviews were not completed quarterly.	D 400		