September 9, 2021

Sharon Dunton, Licensure Consultant
Adult Care Licensure Section
Division of Health Services Regulations

Re: Annual Survey and Compliant Investigation Completed on August 5, 2021
Facility: Heath House
County: Lincoln County
License Number: HAL-055-007

Dear Ms. Dunton,

Enclosed is Heath House plan of correction for the Standard of Deficiency that was issued on August 5, 2021, along with the signed statement of deficiency.

I greatly appreciate your help and look forward to working with you in the future.

Sincerely,

Terry B Black

Terry Black
Administrator

Cc: Melissa Silverman/Connolly,
Regional Director

Received via email 09/09/21 at 4:51pm

PRINTED: 08/23/2021
FORM APPROVED

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
	HAL055007	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATH HOUSE	919 WILMA SIGMON ROAD LINCOLNTON, NC 28092

(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 and a complaint investigation on August 4, 2021 and August 5, 2021.	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 for 2 of 5 residents (Resident #4 and #5), including a medication to treat hypertension and a medication used to open the airways in the lungs (Resident #4), and a medication to treat gastroesophageal reflux disease (Resident #5). The findings are: 1. Review of Resident #4's current FL2 dated 03/24/21 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypertension, heart failure and aortic valve stenosis (narrowing of the aortic heart valve). -There was an order for carvedilol (a medication used to treat hypertension) 25mg, one tablet twice daily. -There was an order for albuterol sulfate solution	D 358	See Attached plan of Correction.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Terry Black TITLE Administrator (X6) DATE 9-9-21

Reviewed and acknowledged by Sharon Dunton RN on 09/14/21
Sharon Dunton RN

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D 358	Continued From page 1 (a medication used to treat narrowing of the airways in the lungs) 1.25mg/3ml, one inhalation three times daily. a. Review of Resident #4's electronic prescription dated 05/22/21 revealed a new order for carvedilol 6.25mg one tablet twice daily. Review of Resident #4's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for carvedilol 6.25mg scheduled at 8:00am and 8:00pm. -There was documentation the medication was administered twice daily from 06/01/21 to 06/30/21. Review of Resident #4's July 2021 eMAR revealed: -There was an entry for carvedilol 6.25mg scheduled at 8:00am and 8:00pm. -There was documentation the medication was administered twice daily from 07/01/21 to 07/31/21. Review of Resident #4's August 2021 eMAR revealed: -There was an entry for carvedilol 6.25mg scheduled at 8:00am and 8:00pm. -There was documentation the medication was administered twice daily from 08/01/21 to 08/03/21 and at 8:00am on 08/04/21. Observation of medications on hand for Resident #4 on 08/05/21 at 11:55am revealed: -There was a medication bottle labeled carvedilol 25mg, take one tablet twice daily. -The label indicated 180 tablets were dispensed on 05/09/21. -There were 102 medication tablets remaining in	D 358		

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D 358	Continued From page 2 the bottle. Interview with a representative from Resident #4's pharmacy on 08/05/21 at 12:17pm revealed: -Carvedilol 6.25mg 60 tablets was dispensed once on 05/28/21. -The facility or Resident #4's family member was responsible for ordering medication refills. -They had not received any refill requests for carvedilol 6.25mg for Resident #4. Interview with a medication aide (MA) on 08/05/21 at 12:00pm revealed: -Resident #4's carvedilol 25mg was discontinued on 05/24/21 and the bottle containing carvedilol 25mg should not be on the medication cart. -Beginning on 05/24/21, Resident #4 was to receive carvedilol 6.25mg twice daily. -The last time she had administered medications to Resident #4 was about five months ago. Interview with a medication aide (MA) on 08/05/21 at 3:30pm revealed: -She was trained to compare medication orders on the eMAR with the label on the medication three different times prior to administering the medication to a resident. -She had administered carvedilol 25mg to Resident #4 the previous evening. -She was unsure how many times she had administered the carvedilol 25mg to Resident #4. -She did not compare the medication label to the eMAR as she was trained, or she would have caught the discrepancy in the dosage. -When medications were changed the old medications were to be placed in a box and the Resident Care Director (RCD) disposed of them. -She thought the bottle containing carvedilol 25mg was accidentally placed in the overflow cabinet when the dosage was changed instead of	D 358		

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D 358	Continued From page 3 in the box containing medications to be destroyed. Interview with Resident #4 on 08/05/21 at 10:05am revealed: -She was not able to identify all her medications. -She did not recall a time she did not receive her medications. Interview with the RCD on 08/05/21 at 12:03pm revealed: -When medication orders were changed, the old medication was to be put in a box to be destroyed. -It was the responsibility of the staff member receiving the new medication order to place the old medication in the box. -She did not know how Resident #4's previous carvedilol medication got in the medication cart. -She expected the MAs to compare medication labels with the eMAR three times prior to administering a medication to a resident. Interview with the Administrator on 08/05/21 at 3:58pm revealed: -She expected medications to be administered as ordered. -When a resident had a medication change, she expected the unused medication to be placed in the box of medications to be destroyed. Interview with Resident #4's Primary Care Provider on 08/05/21 at 12:37pm revealed: -She started as Resident #4 PCP in May of 2021. -She did not know when Resident #4 was prescribed carvedilol 25mg. -The medication list provided to her by the facility when she started as Resident #4's PCP listed carvedilol 6.25mg, twice daily. -Carvedilol was used to treat high blood pressure.	D 358		

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D 358	Continued From page 4 -Possible outcomes of receiving a higher than prescribed dose of carvedilol included hypotension (low blood pressure), increased risk of falls, and excessive fatigue. -She expected the MAs to compare the medication label with the order on the eMAR to ensure medications were given as ordered. -She expected medications to be disposed of when medications orders were changed. b. Review of Resident #4's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for albuterol 1.25mg/3ml, one inhalation three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -There was documentation the medication was administered 31 times from 06/14/21 to 06/30/21. -There was documentation Resident #4 refused the medication 12 times from 06/14/21 to 06/30/21. -There were 4 instances documented from 06/14/21 to 06/30/21 the medication was not administered because it was not available Review of Resident #4's July 2021 eMAR revealed: -There was an entry for albuterol 1.25mg/3ml, one inhalation three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -There was documentation the medication was administered 79 times from 07/01/21 to 07/31/21. -There was documentation Resident #4 refused the medication 14 times from 07/01/21 to 07/31/21. Review of Resident #4's August 2021 eMAR revealed: - There was an entry for albuterol 1.25mg/3ml, one inhalation three times daily scheduled at	D 358		

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D 358	Continued From page 5 8:00am, 2:00pm and 8:00pm. -There was documentation the medication was administered 8 times from 08/01/21 to 08/03/21 and on 08/04/21 at 8:00am. -There was documentation Resident #4 refused the medication 2 times from 08/01/21 to 08/04/21 at 8:00am. Observation of medications on hand for Resident #4 on 08/05/21 at 11:55am revealed: -There was a partial box of albuterol vials available for administration for Resident #4. -A new box of albuterol contained 25 vials. -The partial box had 10 vials remaining. Interview with a representative from Resident #4's pharmacy on 08/05/21 at 12:17pm revealed albuterol 1.25mg/3ml 25 vials was last dispensed on 06/14/21. Interview with a medication aide (MA) on 08/05/21 at 11:06am revealed: -Resident #4 frequently refused her albuterol inhalation treatments. -She thought there may have been times MAs documented the medication was given when Resident #4 had refused it. -It was the MA's or RCD's responsibility to ensure medications were available for administration. Interview with Resident #4 on 08/05/21 at 10:05am revealed she often refused her inhalation treatments because she did not feel she needed them. Interview with the RCD on 08/05/21 at 12:03pm revealed she expected MAs to accurately document on resident eMARs. Interview with the Administrator on 08/05/21 at	D 358		

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D 358	Continued From page 6 3:58pm revealed: -She expected medications to be administered as ordered. -It was the responsibility of the MAs or RCD to ensure resident medications were available for administration. Interview with Resident #4's Primary Care Provider on 08/05/21 at 12:37pm revealed: -She was aware Resident #4 frequently refused her albuterol inhalation treatments. -She did not want to change Resident #4's albuterol treatments to as needed because she wanted the medication to be offered to the resident three times daily. 2. Review of Resident #5's current FL2 dated 02/26/21 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypertension, and atrial fibrillation. -There was an order for famotidine 20mg once per day. Review of Resident #5's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for famotidine 20mg daily scheduled for 8:00am. -There was documentation the famotidine 20 mg had not been administered between 06/27 through 06/27 because the medication had not been available. -There was a total of 4 missed doses. Review of Resident #5's July 2021 eMAR revealed: -There was an entry for famotidine 20mg daily	D 358		

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D 358	Continued From page 7 scheduled for 8:00am. -There was documentation the famotidine 20 mg had not been administered between 07/01 through 07/06 because the medication had not been available. -There was a total of 6 missed doses. Interview on 08/04/21 at 10:00am with a medication aide (MA), who had documented the famotidine had not been available for administration, revealed she had called the pharmacy on several occasions regarding Resident #5's famotidine, but had not documented the communication. Interview on 08/04/21 at 10:15am with a second MA, who had documented the famotidine not being available for administration revealed the medication had not been available for administration for the 10 consecutive doses. Interview with a representative from the facility pharmacy on 08/05/21 at 9:40am revealed: -The facility was responsible for ordering Resident #5's medications. -They had sent a 30 day supply of famotidine 20mg to the facility for Resident #5 on 06/03/21. -They had not received any calls from the facility regarding the famotidine for Resident #5. Attempted interview with Resident #5's primary care provider on 08/05/21 at 9:50am was unsuccessful. Interview with Resident #5 on 08/05/21 at 10:05am revealed: -She took so many medications that she did not know if her famotidine had ever been missed. -She had not had any problems with her GERD (gastroesophageal reflux disease).	D 358		

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D 358	Continued From page 8 Interview with the Resident Care Director (RCD) on 08/05/21 at 10:25am revealed: -She did not know why the famotidine had not been available for administration. -The MAs did not maker her aware there was no famotidine available for Resident #5. -The MA's should have let her know the medication was not available after one or two missed doses. -If she had known the medication had not been available she would have contacted the pharmacy and had the medication delivered. Interview with the Administrator on 08/05/21 at 11:30am revealed. -The RCD was responsible for assuring all the medications were available for administration. -It was her expectation for all medications to be available for administration to the residents.	D 358		

Plan of Correction for Annual State Survey and Complaint Investigation Completed on August 5, 2021

Facility: Heath House
License: HAL-055-007
County: Lincoln

10A NCAC 13F .1004(a) Medication Administration
Tag D358

All Medication Aides will be retrained on policies, protocols and expectations including but not limited to obtaining medications, administering medications and documentation.

Completion Date: September 14, 2021

The Administrator, Resident Care Director or designee will review the QuickMAR Exceptions Report no less than twice per week to ensure that medications are administered, and will follow up on any entries noting a medication was not administered.

A Medication Unavailable Log will be implemented where Medication Aides will document when a medication is not available and the action(s) taken to secure the medication. This form will be maintained at the wellness desk until the RCD's review. The RCD will review this Log least weekly and will compare it to the week's Exceptions Reports as a method of ensuring accountability, and will be used as a tool to identify retraining needs. Upon review, the RCD will initial the Log, which will then remain on file with the RCD for a period of 3 months.

Completion Date: September 17, 2021

Random medication cart audits will be conducted twice monthly by the Resident Care Director or qualified designee to ensure medications, as ordered, are available on the cart. The cart audit results will be documented and the Administrator will review cart audit results monthly. Cart audit results will be maintained on file for 3 months.

Completion Date: September 30, 2021

These interventions will be implemented in an effort to ensure compliance with the rule area noted above.

Respectfully submitted,

Terry Black

Terry Black, Administrator