

PRINTED: 02/14/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 conducted a follow-up survey and complaint investigation on 01/19/22-01/24/22.	{D 000}	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions, set forth in the statement of deficiencies, the plan of correction is prepared solely as a matter of compliance with the law.		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff E) had no substantiated findings on the North Carolina Personnel Registry (HCPR) according to G. S. 131E-256. The findings are: Review of Staff E's Medication Aide (MA) personnel record revealed: -He was hired as a Personal Care Aide (PCA) on 01/19/21 and became a MA on 08/10/21. -There was no documentation of a HCPR check for Resident E upon hire. Interview with Staff E on 01/24/22 at 11:12am revealed: -He was aware a HCPR check was a requirement for working at the facility. -He did not know there was no HCPR check documentation in his personnel record. -The Business Office Manager (BOM) was responsible for having a HCPR check	D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications The Community will assure that all employees have a NC Health Care Personnel Registry check completed prior to hire, with no substantiated findings listed. The Community has completed a check of all existing staff in the Health Care Personnel Registry and has included documentation that there are no substantiated findings in each staff member's file The Executive Director and/or Business Office Coordinator (BOC) will maintain copies of registry search results in permanent staff files All new hires will be checked in the Health Care Personnel Registry prior to hire, in addition to other the Community's other standard background check procedures Community ED and RDO(Regional Director of Operations) completed employee file audit for all current employees. Community ED and/or Business Office Coordinator (BOC) will conduct review of employee files, to include NCHPC but not limited too, of no less than 5 employee files monthly. Community has hired a new Business Office Coordinator(BOC) who will receive training in employee file audits and required NC HCPR paperwork.	3/10/2022 3/10/2022 3/10/2022 3/10/2022 3/10/2022	

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

5899

BSJL12

If continuation sheet 1 of 108

Reviewed and acknowledged 03/08/22.

Kg

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D 137	Continued From page 1 documentation placed in his personnel record. Interview with the BOM on 01/24/22 at 11:10am revealed: -She started working at the facility on 01/04/22 and was responsible for managing staff personnel records. -She was not aware there was no HCPR check documentation in Staff E's personnel record. -She had audited some staff personnel records but had not reviewed the personnel records for Staff E. -It was her and the Administrator's responsibility to ensure documentation of HCPR checks were in all staff records upon hire. Interview with the Administrator on 01/24/22 at 11:15am revealed: -She was not aware there was no documentation of a HCPR check in Staff E's personnel record; the HCPR check should be in his record. -Obtaining the HCPR report for staff was part of the hiring process. -She wanted to know if there were any concerns before the first interview with the prospective staff. -An audit needed to be done of all personnel records to ensure staff records were complete. An HCPR check was received, prior to exit on 01/24/22, verifying there were no pending investigations or substantiated findings for Staff E.	D 137		
(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	(D 273)	10A NCAC 13F .0902(b) Health Care The community will assure all referral and follow-up to meet the routine and acute health care needs of the residents	3/10/2022

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{D 273}	Continued From page 2 of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the Primary Care Provider (PCP) was notified for 2 of 5 sampled resident (#1, #5) of elevated finger stick blood sugars (FSBS) (#1, #5) and referral and follow appointments were scheduled for an endocrinologist appointment, an ophthalmologist appointment and a hematologist appointment (#5) in a timely manner. The findings are: 1. Review of Resident #5's current FL2 dated 07/12/21 revealed diagnoses included type II diabetes with hyperglycemia, anemia in chronic kidney disease, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. a. Review of Resident #5's physician order dated 07/12/21 revealed: -There was an order for fingerstick blood sugar checks (FSBS) three times a day with meals. -There was an order for Novolog (used to treat elevated blood sugar) sliding scale insulin (SSI) with meals as follows; less than 150 - 0 units; 151 - 200, 4 units; 201 - 250, 6 units; 251 - 300, 8 units; 301 - 350, 10 units; 351 - 400, 12 units; greater than 401 - 14 units. Review of Resident #5's physician order dated 12/02/21 revealed an order to notify the Primary Care Provider (PCP) for blood sugar greater than 500.	{D 273}	Continued from page 2 Community has implemented Daily Stand-Up Meetings to include all managers and department heads. Resident transports and appointments to outside providers will be reviewed during meetings. Community has implemented an appointment calendar located outside of Executive Director (ED), Resident Care Coordinator (RCC), Memory Care Coordinator (MCC) and/or ED will review calendar daily. Community has implemented a Daily Care Coordinator Checklist. Checklist includes but is not limited to reviewing of Fasting Blood Sugars logs and Glucometer checks vs EMARS. Community ED will review CC Daily Checklist no less than weekly. Community Area Clinical Director (ACD) will review CC Daily Checklist no less than twice monthly during on site visits. Community Regional Director of Operations (RDO) and/or Divisional Clinical Director, RN (DCD) will review CC Daily Checklist no less than monthly during on site visits Community has completed audit of all diabetic supplies, including Glucometers. ED, RCC and/or MCC will pull Matrix Care reports and progress notes no less than weekly to review and access for parameters outside of Physicians orders to assure notification to physician was completed DCD and/or RDO will pull Matrix Care Reports weekly for four weeks then monthly thereafter to review Fasting Blood Sugars, parameters and progress notes to assure timely follow-up on physicians visits/ appointments and timely notification of any FBS outside of parameters.	3/10/2022 3/10/2022 3/10/2022 3/10/2022 3/10/2022 1/26/2022 3/10/2022 3/10/2022

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{D 273}	Continued From page 3 Review of Resident #5's electronic medication administration record (eMAR) for December 2021 revealed: -There was an entry for FSBS checks three times a day with meals. -There was an entry for Novolog sliding scale insulin (SSI) with meals as follows; less than 150 - 0 units; 151 - 200, 4 units; 201 - 250, 6 units; 251 - 300, 8 units; 301 - 350, 10 units; 351 - 400, 12 units; greater than 401 - 14 units. -There was documentation on 12/15/21 at 4:31pm of FSBS reading of 534. -There was documentation on 12/21/21 at 4:21pm of FSBS reading of 557. -There was documentation on 12/23/21 at 4:26pm of FSBS reading of 504. -There was no documentation that Resident #5's PCP was notified of FSBS readings greater than 500 on 12/15/21, 12/21/21 and 12/23/21. Interview with Resident #5 on 01/24/22 revealed: -She knew her blood sugar ran in the 300's to 500's. -She knew the MAs were to call the PCP when her blood sugars were high. Interview with a medication aide (MA) on 01/20/22 at 4:05pm revealed: -She thought she called the PCP regarding Resident #5's elevated blood sugar. -She forgot to document the conversation in the progress notes. Interview with Resident #5's PCP on 01/20/22 at 11:00am revealed: -She had received a few phone calls regarding Resident #5's elevated blood sugars. -She did not know if she was notified of all elevated blood sugars. -She needed to know about blood sugars greater	{D 273}	Continued from page 3 Community RCC and MCC have received training on the following: - Proper clean, clearing and auditing of Glucometers - Pulling FSBS, Progress Notes and Matrix documentation - Daily Care Coordinator Checklist Training conducted by RN All Medication Staff have completed retraining with 5/10 or 15 hour State Medication Training Training conduct by RN All Medication Staff have been retrained on FSBS, Proper use and cleaning of Glucometers, Parameters, and Documentation of notification to Physicians Training conducted by RN Order processing system has been put in place. This has a folder for outside providers orders and treatments. RCC/MCC have been educated to check this folder daily. ED and/or designee will randomly audit any communications from outside providers.	1/26/2022	1/31/2022	1/25/2022	3/10/2022	3/10/2022

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STATE FORM

6859

BSJL12

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(D 273)	Continued From page 4 than 500 in order to adjust medication. Interview with the Memory Care Coordinator (MCC) on 01/24/22 at 12:15pm revealed: -She had worked as a medication aide (MA) frequently. -She had obtained FSBS readings that were elevated and reportable to the PCP. -She would text the PCP the elevated reading and they would respond by text. -She did not recall documenting in the progress notes. Interview with the Licensed Practical Nurse (LPN) on 01/24/22 at 10:40am revealed: -The MAs were expected to follow PCP orders. -The MAs were expected to notify the PCP when the blood sugar was elevated. -The MAs should document in the progress notes when the PCP was notified. Interview with the Area Clinical Director on 01/24/22 at 10:08am revealed: -The MAs were expected to follow PCP orders and call blood sugars that were out of the recommended range to the PCP. -The MAs were expected to document all conversations with the PCP in the progress notes. Interview with the Administrator on 01/24/22 at 1:20pm revealed: -The MAs were responsible for notifying the PCP when FSBS were elevated. -The MAs should document in the progress notes all communication with the PCP. -The MAs were expected to follow PCP orders. b. Review of Resident #5's signed physician's orders dated 10/19/21 revealed there was an	(D 273)			

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(D 273)	Continued From page 5 order for an endocrinology appointment related to diabetes mellitus with skin ulcer. Review of Resident #5's primary care provider's (PCP) visit report dated 11/02/21 revealed resident #5 had an endocrinologist appointment scheduled for 11/03/21. Review of Resident #5's PCP visit report dated 12/02/21 revealed resident #5's presented with chronic, poor healing leg wounds. Review of Resident #5's PCP visit report dated 12/30/21 revealed: -Resident #5 continued to wait for endocrinology appointment. -Resident #5 had multiple blood sugar readings greater than 500 in the past few weeks. -Resident #5 had changes in diabetic medications. -Resident #5 has had increase in thirst (polydipsia), increase hunger (polyphagia) and increase urination (polyuria). -Resident #5's HbA1c (Hemoglobin A1c) was 8.1 percent in October 2021 (an HbA1c test is a blood test that reflects an average blood glucose level over the past three months. An HbA1c level of 5.7 or lower was considered normal). Telephone interview with the receptionist at the endocrinologist office on 01/24/22 at 8:30am revealed: -Resident #5 was scheduled for an appointment on 11/03/21; Resident #5 was a no show. -Resident #5 was re-scheduled for an appointment on 01/06/21; Resident #5 was a no show. -Spoke with the Memory Care Coordinator (MCC) on 01/12/22 and reschedule Resident #5's appointment for 03/25/22.	(D 273)			

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(D 273)	Continued From page 6 -Resident #5 was unable to keep the appointment due to transportation issues. Telephone interview with Resident #5 on 01/21/22 at 9:03am revealed: -She had not seen the endocrinologist in a long time. -The facility had not been able to transport her to scheduled appointments -She was not aware of an up-coming appointment with an endocrinologist. -The PCP wanted her to see the endocrinologist because her blood sugars were elevated and the wounds on her legs would not heal. Interview with Resident #5's PCP on 01/20/22 revealed: -Resident #5 was experiencing problems with increased blood sugars. -Resident #5's medications had been adjusted several times. -Resident #5 had increased thirst, increased hunger and increased urination. -She wanted Resident #5 to see an endocrinologist to assist with management of diabetes. -Resident #5 had not been seen by the endocrinologist since the referral was ordered. Interview with the MCC on 01/24/22 at 12:15pm revealed: -Resident #5 had an appointment with the endocrinologist on 01/06/22. -The county transportation van did not show to transport Resident #5 to the appointment. -Resident #5's appointment had been rescheduled for 03/26/22. -She was not aware of the appointment in November 2021.	(D 273)			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

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{D 273}	Continued From page 7 Interview with the Administrator on 01/24/22 at 12:48pm revealed: -The facility's van did not have a wheelchair lift. -Resident #5 was in a wheelchair and had to be transported by the county transport. -The county transport required a three-day notice to schedule transportation. -It was imperative that referrals made were scheduled and appointments kept. -The RCC and MCC were responsible for making sure transportation was available for resident who had appointments. c. Review of Resident #5's signed physician's orders dated 12/27/21 revealed there was an order for an ophthalmology appointment related to visual disturbances. Review of Resident #5's physician's visit report dated 12/30/21 revealed: -Resident #5 reported visual changes and an urgent referral to ophthalmology was initiated. -Spoke with Memory Care Coordinator (MCC) to schedule an appointment with the ophthalmologist for Resident #5 related to visual changes. Telephone interview with Resident #5 on 01/21/22 at 1:32pm revealed: -She did not remember the last time she had an eye exam. -Her eyes had been acting "a little funny". -She was seeing shadows and floaters in her eyes. -She did not know if she had an appointment scheduled. Telephone interview with receptionist at the ophthalmologist office on 01/21/22 at 1:11pm revealed:	{D 273}		

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{D 273}	Continued From page 8 -Resident #5 had an appointment scheduled in June 2022. -The last time Resident #5 was seen was in March 2021. -The reason for the appointment was for a routine diabetic examination. -The appointment was made by the MCC on 01/12/22. -June 2022 was the earliest appointment available for a routine visit for Resident #5. -The ophthalmologist office would have worked Resident #5 in earlier if they had known it was urgent. -There was documentation in Resident #5's ophthalmology chart that a referral was faxed on 12/27/21 for the Primary Care Provider (PCP). -The ophthalmologist office called the facility on 12/27/21, 12/29/21 and 01/03/22 and left a message to schedule the appointment. Interview with Resident #5's PCP on 01/20/22 revealed: -She wanted Resident #5 to see an ophthalmologist related to changes in vision. -Resident #5 had not been seen by the ophthalmologist since the referral was ordered. Interview with the MCC on 01/24/22 at 12:15pm revealed: -The PCP faxed the referral to the ophthalmologist. -She called and scheduled an appointment for June 2022 a few weeks ago. -She did not know the appointment was for urgent needs of Resident #5. -Transportation would be scheduled through the county transport. -She did not recall receiving any messages from the ophthalmologist office regarding scheduling an appointment on 12/27/21, 12/29/21 or	{D 273}		

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{D 273}	Continued From page 9 01/03/22. Interview with the Administrator on 01/24/22 at 12:48pm revealed: -She did not know Resident #5 had an order for a ophthalmologist referral. -She expected referrals to be scheduled as soon as possible. -The Resident Care Coordinator (RCC) or the MCC were responsible for making sure all referrals were scheduled. d. Review of Resident #5's signed physician's orders dated 10/19/21 revealed there was an order to schedule hematology appointment related to anemia. Review of Resident #5's signed physician's orders dated 11/02/21 revealed there was an order to schedule hematology appointment related to anemia. Interview with Resident #5's Primary Care Provider (PCP) on 01/20/22 revealed: -She wanted Resident #5 to see a hematologist related too low hemoglobin and anemia. -Resident #5 had not been seen by the hematologist since the referral was ordered. Interview with the Memory Care Coordinator (MCC) on 01/24/22 at 12:15pm revealed: -She was unaware Resident #5 had an order for a hematology referral. -A referral to a hematologist had not been made for Resident #5. Interview with the Administrator on 01/24/22 at 12:48pm revealed: -She did not know Resident #5 had an order for a hematology referral.	{D 273}		

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(D 273)	Continued From page 10 -She expected the referral to be scheduled as soon as possible. -The Resident Care Coordinator (RCC) or the MCC were responsible for making sure all referrals were scheduled. -The RCC and MCC were responsible for making sure transportation was available for resident who had appointments. 2. Review of Resident #1's current FL2 dated 07/29/21 revealed diagnoses included dementia, bipolar disorder, chronic obstructive pulmonary disease, non-Hodgkin's lymphoma, type 2 diabetes and essential hypertension. Review of Resident #1's physician order dated 07/29/21 revealed: -There was an order for fingerstick blood sugar (FSBS) checks three times a day before meals. -There was an order for insulin lispro (used to treat elevated blood sugar) sliding scale insulin (SSI) before meals as follows; less than 69 - call PCP; 70 - 150, 12 units; 151 - 200, 14 units; 201 - 250, 16 units; greater than 250 - 18 units and call the Primary Care Provider (PCP). Review of Resident #1's electronic medication administration record (eMAR) for January 2022 revealed: -There was an entry for FSBS checks three times a day before meals. -There was an entry for insulin lispro sliding scale insulin before meals as follows; less than 69 - call PCP; 70 - 150, 12 units; 151 - 200, 14 units; 201 - 250, 16 units; greater than 250 - 18 units and call PCP. -There was documentation on 01/01/22 at 11:30am of FSBS reading of 293. -There was documentation on 01/12/22 at 7:30am of FSBS reading of 262.	(D 273)			

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(D 273)	Continued From page 11 -There was documentation on 01/13/22 at 11:30am of FSBS reading of 279. -There was documentation on 01/13/22 at 5:30pm of FSBS reading of 258. -There was documentation on 01/14/22 at 7:30am of FSBS reading of 288. -There was documentation on 01/14/22 at 11:30am of FSBS reading of 355. -There was documentation on 01/19/22 at 11:30am of FSBS reading of 256. -There was documentation on 01/19/22 at 5:30pm of FSBS reading of 291. -There was no documentation that Resident #1's PCP was notified of FSBS readings greater than 250. Review of Resident #1's progress notes for January 2022 revealed there was no documentation of the PCP being notified of FSBS readings greater than 250. Interview with a medication aide (MA) on 01/20/22 at 4:05pm revealed: -She had called the PCP regarding Resident #1's FSBS readings greater than 250. -She would document in the progress notes when she called Resident #1's PCP. -She did not know why the PCP notification of elevated FSBS reading was not documented in the progress notes. -She would let the Memory Care Coordinator (MCC) know of the elevated FSBS readings and the MCC would notify the PCP. Interview with another MA on 01/24/22 at 9:07am revealed: -She called the PCP regarding the elevated bloods sugar on 01/19/22. -She failed to document the conversation in the progress notes..	(D 273)			

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{D 273}	Continued From page 12 Interview with the MCC on 01/24/22 at 12:15pm revealed: -She had worked as a MA frequently. -She had obtained FSBS readings that were elevated and reportable to the PCP for Resident #1. -She would text the PCP the elevated reading and they would respond by text. -She did not recall documenting in the progress notes. Interview with the Licensed Practical Nurse (LPN) on 01/24/22 at 10:40am revealed: -The MAs were expected to follow PCP orders. -The MAs were expected to notify the PCP when the blood sugar was elevated. -The MAs should document in the progress notes when the PCP was notified. Interview with the Area Clinical Director on 01/24/22 at 10:08am revealed: -The MAs were expected to follow PCP orders and call blood sugars that were out of the recommended range to the PCP. -The MAs were expected to document all conversations with the PCP in the progress notes. Interview with the Administrator on 01/24/22 at 1:20pm revealed: -The MAs were responsible for notifying the PCP when FSBS were elevated. -The MAs should document in the progress notes all communication with the PCP. -The MAs were expected to follow PCP orders. Attempted to interview Resident #1's PCP on 01/24/22 at 3:30pm was unsuccessful.	{D 273}			

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(D 273)	Continued From page 13 The facility failed to ensure the Primary Care Provider was notified of elevated finger stick blood sugars (FSBS) as ordered for 2 residents including a resident (#1) who had FSBS readings greater than 250; a resident (#5) who had FSBS readings greater than 500 resulting in increased visual disturbances and poor wound healing and failed to schedule referrals for an endocrinologist, ophthalmologist and hematologist related to elevated FSBS, visual disturbances and anemia (#5). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/11/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 10, 2022.	(D 273)		
(D 310)	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to serve a No	(D 310)	10A NCAC 13F .0904(e)(4) Nutrition and Food Service Community will ensure that all residents are serviced the correct diet ordered by the residents physician. Community Care Coordinators (CCs) have reviewed and audited all diet orders for current residents. Community ED, RDO, ACD, DCD and/or CCs have contacted all current residents primary care physicians to request updated diet orders. Community has implemented Daily Stand-Up Meetings to include all managers and department heads, Dietary Manager, CCs and ED review menus and any diet order changes during meetings.	3/10/2022 3/10/2022 3/10/2022 3/10/2022

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{D 310}	Continued From page 14 Concentrated Sweets (NCS) diet to 1 of 3 sampled residents (#1) having therapeutic diet orders. The findings are: Review of Resident #1's current FL-2 dated 07/29/21 and signed by a physician revealed: -Diagnoses included type 2 diabetes, dementia, essential hypertension and bi-polar disorder. -Resident #1 was intermittently disoriented and resided on the special care unit (SCU). -The diet ordered for Resident #1 was Regular. Record review for Resident #1 revealed a physician's order for a NCS diet on 09/10/21. Review of the Physician Order Report for 10/01/21 - 01/10/22 revealed an NCS diet start date of 09/11/21. Review of the facility's resident diet order listing sheet revealed: -There was no date for the document. -There were no dates for the changes on the document. -There were handwritten comments for resident preferences, new diet additions and lines marking through discontinued diets. -The diet documented for Resident #1 was Mechanical Soft with Chopped Meats, a texture modification for a Regular diet. Observation of the lunch meal on 01/19/22 at 11:50 in the SCU revealed Resident #1 was served a hot dog with chili, potato chips, coleslaw (mayonnaise base) and gelatin dessert with water and unsweetened iced tea. Interview with Resident #1 on 01/19/22 12:03pm	{D 310}	Continued from page 14 ED and Dietary Manager have posted a copy of all current resident diets in kitchen for dietary staff review and reference. CCs and/or Dietary Manager will ensure that any changes or updated diet orders are posted in kitchen. All dietary staff have been in-serviced on training on menus, prescribed diets, and proper food consistency Community ED and/or CC will observe no less than one meal service three times a weekly. Community RDO will make site visits no less than three times a month to ensure continued compliance. RDO will review diet order posting in kitchen and observe no less than meal service monthly Community Divisional Vice President of Operations (DVPO) and Divisional Clinical Director (DCD) will make monthly site visits, which will include review of updated diet list in kitchen and monitoring of no less than one meal service.	3/10/2022 1/31/2022 3/10/2022 3/10/2022 3/10/2022

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{D 310}	Continued From page 15 and at 3:20pm revealed: -She just finished her lunch meal and it was good, but she had diabetes and thought she was to be served an NCS meal. -She was told by facility staff the kitchen only served Regular diet meals, but her physician wrote an order for her to be served an NCS diet. -She was supposed to be given NCS meals when she was admitted (07/09/21), but she was always served Regular diet meals and given sweets to eat for snacks. Observation of the contracted dietitian's Diet Extensions spreadsheet revealed: -There were listings for Regular/No Added Salt, Mechanical Soft/Chopped, Mechanical Soft, Pureed, No Added Table Salt and Finger Foods. -There was no entry for a NCS diet on the dietitian's spreadsheet. Interview with a Medication Aide (MA) on 01/20/22 at 11:45am revealed: -She did not know Resident #1 had a NCS diet order. -A NCS diet was not listed on the diet spreadsheet in the kitchen. -The facility did not offer NCS diets. Interview with the Dietary Manager (DM) on 01/20/22 at 12:25pm revealed: -The kitchen has a listing of residents and their ordered diets. -Any changes of diets were placed on the resident listing and posted in the kitchen. -This facility offered Regular/NAS (no added salt) diets with mechanical soft/chopped meat textures. -Resident #1 had always been on a Regular with mechanical soft/chopped meats as per the resident diet listing.	{D 310}		

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{D 310}	Continued From page 16 -NCS diet was not on the diet listing because the facility did not offer an NCS diet. Interview with the SCU Manager on 1/20/22 at 2:05pm revealed: -When dietary orders were added or changed hard copy was given to the DM to place on the resident list in the kitchen -The DM was responsible for ensuring the diet orders were carried out as ordered. -Resident #1's Primary Care Provider (PCP) submitted a diet order for an NCS diet dated 09/10/21. -The facility did not offer an NCS diet and the PCP was notified but he did not make a change in the order. -The DM continued giving Resident #1 the Regular with Mechanical Soft/Chopped meats diet. Interview with the Registered Dietitian (RD) for the contracted menu planner on 01/21/22 at 9:06am revealed: -She planned and wrote the menus for the facility. -She wrote the menus for the spreadsheet according to the diet types requested. -About 2-3 years ago the corporate office policy directed that the facility would offer Regular diets with textures only. -The spreadsheet she used could accommodate an NCS selection if it were to be offered. -The facility dietary staff were to refer to the ADA suggestions for what foods to serve Resident #1. -There was not an NCS diet plan, signed by a registered dietitian, for preparation of Resident #1's meals. Interview with Resident #1's Power of Attorney (POA) on 01/21/22 at 10:21am revealed: -Because of Resident #1 having diabetes and	{D 310}			

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(D 310)	Continued From page 17 having to take insulin, she was on an NCS diet before she was moved to the facility. -Management at the facility accepted Resident #1 knowing she was ordered an NCS diet. -After Resident #1 was admitted, she was told dietary did not offer the physician ordered NCS diet to Resident #1. -Her expectation was for the facility to follow the physician's order for the NCS diet to help with treatment of her diabetes. Telephone interview with Resident #1's PCP's nurse (relaying questions to the PCP in the adjacent room) on 1/24/22 at 3:40pm revealed: -Resident #1 was given an order for an NCS diet on 09/10/21 due to her Type 2 diabetes and high A1c (blood test that measures the average blood sugar levels over the past 3 months) level of 10% (preferred range for a person with diabetes is 6.5% to 7.0%). -The PCP was concerned for Resident #1's health by having a high A1c level of 10%. -He wanted to get Resident #1's A1c down to the 7% level. -The NCS diet was part of the treatment and management of Resident #1's diabetes. -The PCP's expectation was for Resident #1 to be served the NCS diet as ordered. Interview with Administrator on 01/24/22 at 11:20am revealed: -She started as the facility Administrator in December 2021 after Resident #1 was admitted. -She was aware Resident #1 was not receiving the NCS diet as it was company policy to only serve Regular diets. -The facility had not made any changes in Resident #1's diet from Regular to NCS since the last survey (10/04/21). -She was not aware that any change of diet would	(D 310)			

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(D 310)	Continued From page 18 come from the PCP for Resident #1. - "An order from the physician (NCS diet) should be followed." - "Resident #1 was our resident, her needs needed to be met."	(D 310)			
(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: ~~FOLLOW-UP TO TYPE B-VIOLATION~~	(D 358)	10A NCAC 13F .1004(a) Medication Administration Community will assure that all medications and treatments are administered as ordered Community has hired an Area Clinical Director (ACD) who is an Registered Nurse to provide morer fequent oversight and training. ACD will make on-site visits to community no less than twice weekly for six weeks, then no less than weekly there after. Type text here The CCs have completed cart audits against electronic medication records for all current residents including both a review of the accuracy of the EMAR and an audit of the EMAR against the medication cart. CC will conduct weekly medication cart audits to ensure all medications are available. ED and CC will review Medication Administration utilizing Matrix Care Reporting and weekly Medication Cart audits during Stand-Up meetings	1/31/2022 and ongoing 3/10/2022 1/31/2022 and ongoing 1/31/2022 1/31/2022 and ongoing 1/31/2022 and ongoing	
	Based on these findings, the previous Type B Violation was not abated.				
	Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 5 of 6 sampled residents (#2, #3, #4, #5, #6) related to Insulin administration and anti-diabetic medication (#3,#5,#6); a proton pump inhibitor, an antioxidant, a fibric acid derlvative thyrold medication and two medications to help prevent heart disease (#2); two vitamin supplements, two stool softeners, an iron supplement, a receptor antagonist, an anticholinergic, a blood thinner and an alphasadrenergic agonist medication (#3); a blood thinner, an anti-anxiety medication, two		Community has implemented a Daily Care Coordinatord Checklist. Checklist includes but is not limited to reviewing pulling of Matrix Care Reports for medication administration, review of progress notes, and order approval. Community ED will review CC Daily Checklist no less than weekly. Community Area Clinical Director (ACD) will review CC Daily Checklist no less than twice monthy during on site visits. Community Regional Director of Operations (RDO) and for Divisional Clinical Director, RN (DCD) will review CC Daily Checklist no less than monthly during on site visits	1/31/2022 and ongoing 1/31/2022 and ongoing 1/31/2022 and ongoing	

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(D 358)	Continued From page 19 antipsychotic medications, a medication used to treat dementia, an anti-hypertensive, an iron supplement and an antidepressant (#4); an antihypertensive medication. (#5). The findings are: 1. Review of Resident #5's current FL2 dated 07/12/21 revealed diagnoses included type II diabetes with hyperglycemia, anemia in chronic kidney disease, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. a. Review of Resident #5's physician's orders dated 07/12/21 revealed an order for Victoza (used to help lower blood sugar levels) inject 0.6mg/0.1ml subcutaneously daily. Review of Resident #5's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Victoza 0.6/0.1ml every morning with a scheduled administration time of 8:00am. -There was documentation Victoza was administered from 11/01/21 - 11/27/21. -There were exceptions documented on 11/28/21 - 11/30/21; the exception documented was the pharmacy. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for Victoza 0.6/0.1ml every morning with a scheduled administration time of 8:00am. -There was documentation Victoza was administered daily from 12/02/21 - 12/24/21 and 12/31/21. -There were exceptions documented on 12/01/21	(D 358)	Continued from page 19 Community ACD, RN has conducted and will continue to conduct Medication Pass Observations for medication staff. Medication Pass Observations will be conducted no less than once monthly with different medication staff members. Medication Pass Observations will be reviewed with community ED and/or CCs when completed. Community has implemented an order processing system to review and assure all medications are administered as ordered by Providers. RCC and/or MCC are responsible for checking order processing system no less than 3 times daily to assure all medication orders are processed timely. Community RCC and MCC have been trained on utilizing/processing of orders, as well as use of the "Order Processing System" Training conducted by RN Community RCC and MCC have received training on the following: - Proper clean, clearing and auditing of Glucometers - Pulling FSBS, Progress Notes and Matrix documentation, pulling of Matrix Care Reporting - Daily Care Coordinator Checklist - Completing a Medication Cart Audit Training conducted by RN All Medication Staff have completed retraining with 5/10 or 15 hour State Medication Training and been revalidated. Training conduct by RN The ACD has in-serviced all Medication Staff on Medication Administration, which included but was not limited to the six rights of medication administration and documents The ACD has in-serviced all Medication Staff on Infection Control RDO, DCD and/or DVPO will randomly pull Medication Administration reporting from Matrix Care system to monitor compliance with Medication Administration	1/31/2022 and ongoing 1/31/2022 and ongoing 1/31/2022 and ongoing 1/31/2022 1/26/2022 1/26/2022 1/31/2022 1/26/2022 1/31/2022 1/26/2022, and ongoing	

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{D 358}	Continued From page 20 and 12/25/21 - 12/30/21; the exception documented was the pharmacy. Review of Resident #5's January 2022 eMAR revealed: -There was an entry for Victoza 0.6/0.1ml every morning with a scheduled administration time of 8:00am. -There was documentation Victoza was administered daily from 01/01/22 - 01/09/22. -There were exceptions documented on 01/10/22 - 01/20/22; the exception documented was the pharmacy. Interview with Resident #5 on 01/20/22 at 4:15pm revealed: -She knew she received multiple injections each day. -She knew she was on 2 to 3 different injectable medications for her diabetes. -She could not recall missing any injections. Observation of Resident #5's medications on hand on 01/20/22 at 2:36pm revealed Victoza 0.6mg/0.1ml was not available to administer.	{D 358}			
	Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/22/22 at 11:06am revealed: -The pharmacy dispensed Victoza one 3ml pen on 10/12/21. -The pharmacy dispensed Victoza one 3ml pen on 11/07/21. -The pharmacy dispensed Victoza one 3ml pen on 12/01/21. -The pharmacy dispensed Victoza one 3ml pen on 12/28/21. -The pharmacy dispensed Victoza one 3ml pen on 01/21/22. -The facility faxed a request a refill for Victoza on				

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{D 358}	Continued From page 21 01/11/22. -The request to refill Victoza on 01/11/22 was too early; the insurance would not pay. -The pharmacy dispensed Victoza one 3ml pen on 01/21/22, which was the next day for refill after the 12/28/21 refill. -This was the only request for an early refill, 01/11/22, received from the facility. -The pharmacy did not receive any requests for early refills for November 2021 or December 2021. -The pharmacy had only been dispensing Victoza one 3ml pen each month. -One Victoza 3ml pen would last for 10 days. -The pharmacy should have been sending Victoza three 3ml pens each month. Telephone interview with the pharmacist at the facility's contracted pharmacy on 01/21/22 at 11:45am revealed: -Victoza was not an insulin but an anti-diabetic medication. -Victoza helped to lower blood sugar and promote weight loss when used with an insulin. -One Victoza 0.6mg/0.1ml, 3ml pen would last 10 days when administering 1.8mg/0.3ml every morning. -The pharmacy should have been sending Victoza, three 3ml pens each month -The pharmacy would start sending Victoza three, 3ml pens each month. Observation of Resident #5's medications on hand on 01/24/22 at 8:18am revealed: -Victoza 0.6mg/0.1ml one 3ml pen was available to be administered. -There was one pen of Victoza in a zip lock bag. -The prescription label on the zip lock bag read "Victoza 3-pak, 3 pens".	{D 358}		

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{D 358}	Continued From page 22 Interview with a medication aide (MA) on 01/20/22 at 3:00pm revealed when she documented the exception of the pharmacy, there was no medication on the medication cart or the facility for administration. Interview with the same medication aide (MA) on 01/24/22 at 8:20am revealed: -There was only one 3ml pen on the medication cart. -She did not know if there were more Victoza pens in the medication refrigerator. -The Victoza pen was delivered over the weekend. -Resident #5 had not had any Victoza in about a week. Observation of the medication refrigerator on 01/24/22 at 8:30am revealed there were no Victoza 3ml pens in the refrigerator. Interview with a MA on 01/24/22 at 7:56am revealed: -There had been one time when Victoza was not available to administer as ordered. -He would notify the Memory Care Coordinator (MCC) when the medication was not in the facility to administer. Interview with the Memory MCC on 01/21/22 at 2:09pm revealed: -Victoza was an insulin. -She tried to re-order Victoza on 01/11/22. -This was the first time on 01/11/22, she had been notified that there was no Victoza available for administration. -She spoke with the pharmacy on 01/20/22 and was informed a 30-day supply was sent. -She did not know how many Victoza pens were delivered by the pharmacy each month. She did	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2786 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 23 not check the delivered medications in since the medication arrived during third shift. -She thought the pharmacy sent 3 pens of Victoza each month, since that was what was listed on the delivery sheet. -She did not know the pharmacy was only sending one pen a month. -She did not know how long one Victoza pen would last. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident#5 should be receiving medication as ordered. -There must be accountability with each employee. -There was no excuse not to have medications available for administration as ordered. Based on eMAR documentation, medications dispensed and medications on hand between 10/12/21 - 01/21/22, there would have been one Victoza 3ml pen available for administration each month. Based on the physician's orders dated 07/12/21 3 pens of Victoza 3ml were needed each month. Attempted interview with the primary care provider (PCP) on 01/24/22 at 8:45am was unsuccessful. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 24 Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. b. Review of Resident #5's physician's orders dated 07/12/21 revealed an order for Basaglar (used to control high blood sugar levels) inject 50 units subcutaneously daily and 22 units at bedtime. Review of Resident #5's physician's orders dated 12/16/21 revealed an order to discontinue thr previous order of Basaglar 50 units daily. Review of Resident #5's physician's orders dated 12/22/21 revealed an order to administer 5 units of Basaglar every morning. Review of Resident #5's physician's orders dated 12/27/21 revealed an order to discontinue previous order of Basaglar and administer 10 units subcutaneously every morning and 25 units at bedtime. Review of Resident #5's physician's orders dated	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 25 12/30/21 revealed an order to discontinue previous order of Basaglar and administer 15 units subcutaneously every morning and 25 units at bedtime. Review of Resident #5's November 2021 electronic medication administration record (eMAR) revealed: -There was no entry for Basaglar 50 units every morning. -There was an entry for Basaglar 22 units at bedtime with a scheduled administration time of 8:00pm. -There was documentation Basaglar 22 units was administered at from 11/01/21 to 11/30/21 at 8:00pm. Review of Resident #5's December 2021 eMAR revealed: -There was an entry dated 12/13/21 for Basaglar 50 units every morning with a scheduled administration time of 8:00am. -There was no documentation Basaglar 50 units was administered in December 2021. -There were exceptions documented on 12/15/21 and 12/16/21; the exception documented was medication was on hold for clarification. -There was a second entry dated 12/22/21 for Basaglar 5 units every morning with a scheduled administration time of 8:00am. -There was documentation Basaglar 5 units was administered on 12/23/21. -There was a third entry dated 12/23/21 for Basaglar 5 units every morning with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Basaglar 5 units was administered on 12/24/21 at 8:00am. -There was an exception documented on 12/23/21 at 8:00pm; the exception documented was the order states to be given in the morning.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 26 -There was a fourth entry dated 12/24/21 for Basaglar 5 units every morning with an administration time of 8:00am. -There was documentation Basaglar 5 units was administered on 12/25/21 - 12/27/21. -There was a fifth entry dated 12/27/21 for Basaglar 10 units every morning with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Basaglar 10 units was administered 12/28/21 - 12/30/21 at 8:00am and 12/27/21 - 12/28/21 at 8:00pm. -There was an exception documented on 12/29/21 at 8:00pm; the exception documented was the order states to give in the morning. -There was a sixth entry dated 12/30/21 for Basaglar 15 units every morning. -There was documentation Basaglar 15 units was administered on 12/31/21 at 8:00am. -There was a seventh entry dated 09/03/21 for Basaglar 22 units at bedtime with a scheduled administration time of 8:00pm. -There was documentation Basaglar 22 units was administered on 12/01/21 - 12/11/21. -There were exceptions documented on 12/12/21 to 12/13/21; the exceptions documented was the pharmacy. -There was an electronic entry dated 12/14/21 to discontinue Basaglar 22 units -There was an eighth entry dated 12/16/21 for Basaglar 25 units at bedtime with a scheduled administration time of 8:00pm. -There was documentation Basaglar 25 units was administered on 12/17/21 to 12/31/21. Review of Resident #5's January 2022 eMAR revealed: -There was an entry for Basaglar 15 units every morning with a scheduled administration time of 8:00am. -There was documentation Basaglar 15 units was	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 27 administered daily from 01/02/22 - 01/13/22. -There were exceptions documented on 01/01/22 and 01/14/22; the exceptions documented were need of clarification and the order increased to 18 units. -There was a second entry for Basaglar 18 units every morning with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Basaglar 18 units was administered twice a day from 01/14/22 - 01/20/22. -There was an exception documented on 01/17/22 at 8:00am; the exceptions documented were residents blood sugar was 89 and the medication was ordered to be administered in the morning. -There was a third entry for Basaglar 25 units at bedtime with a scheduled administration time of 8:00pm. -There was documentation Basaglar 25 units was administered on from 01/01/22 - 01/12/22. Observation of Resident #5's medications on hand on 01/20/22 at 2:36pm revealed: -There was one Basaglar pen in the top drawer of the medication cart. -There was a hand-written opened date of 01/19/22 noted on the Basaglar pen. Observation of the medication refrigerator on 01/24/22 at 7:48am revealed: -There was a zip lock bag with 2 Basaglar pens in the medication refrigerator with a dispensed date of 12/01/21. -There was another zip lock bag with 1 Basaglar pen in the medication refrigerator with a dispensed date of 12/30/21. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 01/21/22	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 28 at 11:06am revealed: -The pharmacy dispensed 5 Basaglar 3ml pens 100 units/1ml on 12/11/21. -The pharmacy dispensed 4 Basaglar 3ml pens 100 unit/1ml on 12/30/21. -The pharmacy dispensed 4 Basaglar 3ml pens 100 unit/1ml on 01/20/22. Interview with a medication aide (MA) on 01/20/22 at 3:00pm revealed when she documented the exception of the pharmacy, there was no medication in the facility. Interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm revealed: -The initial order for Basaglar 50 units was written on her FL2 dated 07/12/22. -She did not know how Basaglar 50 units every morning appeared on December 2021 eMAR. She thought the pharmacy had entered it. -She had discussed it with the Primary Care Provider (PCP) in December 2021 and Resident #5 had been re-started on Basaglar. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #5 should be receiving her insulin as ordered. -There was no excuse not to have medications available for administration as ordered. -She was concerned that Resident #5's blood sugars would be elevated if Resident #5 was not getting her medication as ordered. Based on interviews, eMAR documentation, medications dispensed and medications on hand between 11/01/22 - 01/20/22 revealed: -There should have been enough Basaglar available to administer medication as ordered for 12/12/21 - 01/19/22.	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 29 -Basaglar was available for administration on 12/12/21 and 12/13/21. -There were entries for November 2021 and December 2021 where a daily medication was scheduled as twice a day and administered as entered on eMAR and not as ordered. Attempted interview with the primary care provider (PCP) on 01/24/22 at 8:45am was unsuccessful. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. c. Review of Resident #5's physician's orders	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215
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(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)	(X6) COMPLETE DATE
{D 358}	Continued From page 30 dated 09/14/21 revealed an order for losartan (used to treat elevated blood pressure) 25mg one daily. Review of Resident #5's physician's orders dated 12/16/21 revealed: -There was an order to discontinue losartan 25 mg. -There was an order to administer losartan 50 mg daily. Review of Resident #5's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for losartan 25mg every morning with a scheduled administration time of 8:00am. -There was documentation losartan 25mg was administered daily from 11/01/21 - 11/30/21. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for losartan 25mg every morning with a scheduled administration time of 8:00am. -There was documentation losartan 25mg was administered daily from 12/01/21 - 12/12/21. -There was an entry for losartan 50mg every morning with a scheduled administration time of 8:00am. -There was documentation losartan 50mg was administered on 12/15/21, 12/17/21, 12/24/21-12/26/21 and 12/31/21. -There were exceptions documented on 12/13/21 - 12/14/21, 12/16/21, 12/18/21 - 12/23/21 and 12/27/21 - 12/29/21; the exceptions documented were the pharmacy. Review of Resident #5's January 2022 eMAR revealed:	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

(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 358}	Continued From page 31 -There was an entry for losartan 25mg every morning with a scheduled administration time of 8:00am. -There was documentation losartan 25mg was administered on 01/05/22. -There was one exception documented on 01/13/22; the exception documented was the dosage had been discontinued. -There was an entry for losartan 50mg every morning with a scheduled administration time of 8:00am. -There was documentation losartan 50mg was administered on 01/07/22 and from 01/10/22 - 01/14/11. -There were exceptions documented on 01/01/22 - 01/06/22, 01/08/22 - 01/09/22 and 01/15/22 - 01/16/22; the exception documented was the pharmacy. Observation of Resident #5's medications on hand on 01/20/22 at 2:36pm revealed: -Resident #5 had a multi-dose package and a blister pack of medication. -The losartan 25mg was dispensed in the multi-dose package for administration each morning. -The multi-dose package was dispensed weekly, on Thursday. -There was a blister pack with 22 of 30 losartan 25mg tablets available for administration, dispensed on 01/05/22. -The pharmacy directions on the blister pack of losartan 25mg was to administer one daily. -There was no losartan 50mg in the facility. Telephone interview with the pharmacy technician from the facility's contracted pharmacy on 01/21/22 at 11:06am revealed: -The pharmacy dispensed losartan 25 mg in a multi-dose pack weekly on Thursdays.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 32 -The pharmacy dispensed a bubble pack of 30 losartan 25mg on 01/05/22. -The pharmacy did not have an order for losartan 50mg. Interview with a medication aide (MA) on 01/20/22 at 3:00pm revealed when she documented the exception of the pharmacy, there was no medication in the facility. Interview with the same MA on 01/24/22 at 8:23am revealed: -She knew losartan 25mg was dispensed weekly in the multi-dose pack. -She would administer losartan 25mg from the bubble pack along with the losartan 25mg that was in the multi-dose pack for a total of 50mg daily. -Some on the MAs continued to document an exception of the pharmacy because there were no losartan 50mg on the medication cart. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #5 should be receiving medication as ordered. -Resident #5 could have problems with an increase in her blood pressure if medication was not administered as ordered. -There was no excuse not to have medications available for administration as ordered. Attempted interview with the primary care provider on 01/24/22 at 8:45am was unsuccessful. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 33 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. 2. Review of Resident #3's current FL2 dated 07/27/21 revealed diagnoses included dementia schizophrenia, cellulitis left toe, acute renal failure, chest pain, cerebral infarction, chronic obstructive pulmonary disease, and diabetes. a. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for vitamin B complex (used as a supplement) daily. Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin B complex daily with a scheduled administration time of 9:00am. -There was documentation vitamin B complex	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 34 was administered daily from 11/01/21 - 11/30/21. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for vitamin B complex daily with a scheduled administration time of 9:00am. -There was documentation vitamin B complex was administered from 12/01/21 - 12/27/21 and 12/29/21 - 12/31/21. -There was one exception documented on 12/28/21; the exception documented was the pharmacy. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for vitamin B complex daily with a scheduled administration time of 9:00am. -There was documentation vitamin B complex was administered on 01/01/22, 01/03/22 - 01/04/22, 01/06/22 - 01/14/22 and 01/17/22 - 01/19/22. -There were exceptions documented on 01/02/22, 01/05/22, 01/15/22 and 01/16/22; the exceptions documented were the pharmacy. Observation of Resident #3's medications on hand on 01/19/22 at 4:40pm revealed there were no vitamin B complex available for administration. Interview with the Pharmacist at the facility's second contracted pharmacy on 01/20/22 at 9:03am revealed: -The pharmacy had not dispensed vitamin B complex since April 2021. -Vitamin B complex had multiple B vitamins that was used as a supplement. Based on eMAR documentation, medications dispensed and medications on hand between 11/01/21 - 01/20/22, there would have been no	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 35 Vitamin B 12 complex available to be administered between 11/01/21 - 01/20/22 due to the medication had not been reordered. Interview with a medication aide (MA) on 01/20/22 at 10:59am revealed: -The pharmacy was called a few days ago and the facility was informed that Resident #3 needed a new prescription for vitamin B complex. -He had to see his primary care provider (PCP). He was scheduled to see his PCP on 02/10/22. -Resident #3 had been without his vitamin B complex for several weeks. Interview with the nurse from the Resident #3's PCP's office on 01/24/22 at 2:10pm revealed: -Resident #3 should be taking his Vitamin B complex as ordered. -Resident #3 needed to make an appointment for a visit to review his medications. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #3 should be administered his medication as ordered. -There was a reason the PCP ordered the medication. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
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(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 358)	Continued From page 36 Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. b. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for docusate sodium (used to treat constipation) 100mg two capsules daily. Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for docusate sodium 100mg two capsules daily with a scheduled administration time of 9:00am. -There was documentation docusate sodium was administered on 11/01/21, 11/07/21, 11/13/21 - 11/28/21. -There were exceptions documented on 11/02/21-11/06/21, 11/08/21-11/12/21 and 11/29/21-11/30/21; the exceptions documented were refused. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for docusate sodium 100mg two capsules daily with a scheduled administration time of 9:00am.	(D 358)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 37 -There was documentation docusate sodium was administered on 12/04/21, 12/11/21 - 12/12/21, 12/18/21, 12/24/21 - 12/27/21. -There were exceptions documented on 12/01/21-12/03/21, 12/05/21-12/10/21, 12/13/21-12/17/21, 12/19/21-12/23/21 and 12/26/21-12/31/21; the exceptions documented were refused and the pharmacy. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for docusate sodium 100mg two capsules daily with a scheduled administration time of 9:00am. -There was documentation docusate sodium was administered from 01/01/22 - 01/02/22, 01/09/22, 01/12/22 and 01/19/22. -There were exceptions documented on 01/03/22-01/08/22, 01/10/22-01/11/22 and 01/13/22-01/18/22; the exceptions documented were the pharmacy and refusal. Telephone interview with the pharmacy technician from the facility's second contracted pharmacy on 01/20/21 at 8:10am revealed: -The pharmacy dispensed 60 docusate sodium 100mg capsules on 11/03/21. -The pharmacy dispensed 60 docusate sodium 100mg capsules on 12/10/21. -The pharmacy dispensed 90 docusate sodium 100mg capsules on 01/19/22. -The pharmacy order was for docusate sodium 100mg twice daily as needed. -The pharmacy was not aware that docusate sodium 100mg was on the eMAR as a scheduled medication. -The docusate Sodium 100mg 2 tablets daily was discontinued in March 2021 and was ordered as needed.	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27216		
(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 358)	Continued From page 38 Observation of Resident #3's medications on hand on 01/19/22 at 4:40pm revealed there were no docusate sodium available for administration. Based on eMAR documentation, medications dispensed and medications on hand between 10/08/21 - 01/20/22, there would have been no docusate sodium 100mg available to be administered from 1/02/22 - 01/20/22, when the medication was reordered. Interview with a medication aide (MA) on 01/20/22 at 4:05pm revealed: -Resident #3 did not like to take docusate sodium. -Resident #3 refused to take docusate sodium most of the time. -She had spoke to the Memory Care Coordinator (MCC) about having the docusate sodium discontinued since Resident #3 refused to take it. -She always had docusate sodium to administer. -She would ask Resident #3 if he wanted to take the docusate sodium before she popped it. -She spoke to the MCC about changing the scheduled administration time from 6:00am. -She thought he may would take the docusate sodium if offered at a different time. -She had not noticed the discrepancy in directions on the entry in the eMAR compared to the directions on the prescription label. Interview with the nurse from Resident #3's primary care provider's (PCP) office on 01/24/22 at 2:10pm revealed: -Resident #3's docusate sodium was ordered on an as needed basis. -The scheduled dosage was discontinued in March 2021. -Resident #3 needed to make an appointment for a visit to review his medications.	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 39 Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #3 should be administered his medication as ordered. -The MAs were expected to read the labels and compare them to the eMAR. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. c. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for ferrous sulfate (used to treat low iron) 325mg daily.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 40 Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for ferrous sulfate 325mg daily with a scheduled administration time of 6:00am. -There was documentation ferrous sulfate was administered on 11/01/21, 11/07/21, 11/13/21 - 11/28/21. -There were exceptions documented on 11/02/21-11/06/21, 11/08/21-11/12/21 and 11/29/21-11/30/21; the exceptions documented were refused. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for ferrous sulfate 325mg daily with a scheduled administration time of 6:00am. -There was documentation ferrous sulfate was administered on 12/04/21, 12/11/21 - 12/12/21, 12/18/21 and 12/24/21 - 12/27/21. -There were exceptions documented on 12/01/21-12/03/21, 12/05/21-12/10/21, 12/13/21-12/17/21, 12/19/21-12/23/21 and 12/28/21-12/31/21; the exceptions documented were refused and the pharmacy. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for ferrous sulfate 325mg daily with a scheduled administration time of 6:00am. -There was documentation ferrous sulfate was administered from 01/01/22-01/02/22, 01/09/22, 01/12/22, -There were exceptions documented on 01/03/22-01/08/22, 01/10/22-01/11/22, 01/13/22-01/18/22; the exceptions documented were the pharmacy and refusal.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
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{D 358}	Continued From page 41 Observation of Resident #3's medications on hand on 01/19/22 at 4:40pm revealed that there were no ferrous sulfate tablets available for administration. Telephone interview with the pharmacy technician from the facility's second contracted pharmacy on 01/20/21 at 8:10am revealed: -The pharmacy had not dispensed any ferrous sulfate 325 mg tablets. -The medication was not on Resident #3's pharmacy profile. Based on eMAR documentation, medications dispensed and medications on hand between 11/01/21 - 01/20/22, there would have been no Vitamin B 12 complex available to be administered between 11/01/21 - 01/20/22 due to the medication had not been ordered. Interview with a medication aide (MA) on 01/20/22 at 10:59am revealed: -The pharmacy had been called and the facility was informed that Resident #3 needed a new prescription for ferrous sulfate. -He had to see his primary care provider (PCP). He was scheduled to see his PCP on 02/12/22. -Resident #3 had been without his ferrous sulfate for several weeks. -She made a mistake when she documented that the medications had been given when it was not in the facility. Interview with a second MA on 01/20/22 at 4:05pm revealed: -Resident #3 always refused to take his ferrous sulfate -She would ask Resident #3 if he wanted to take the ferrous sulfate before she popped it.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 42 -She spoke to the MCC about changing the scheduled administration time from 8:00am. -She thought he may would take the ferrous sulfate if offered at a different time. Interview with the nurse from Resident #3's primary care provider's (PCP) office on 01/24/22 at 2:10pm revealed: -Resident #3's ferrous sulfate did not appear on his profile. -She did not know if Resident #3 should be taking ferrous sulfate. -Resident #3 needed to make an appointment for a visit to review his medications. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #3 should be administered his medication as ordered. -The MAs were expected to have the medication in the facility to administer as ordered. -If the medication was not in the facility, the MAs should let the Resident Care Coordinator (RCC) or Memory Care Coordinator (MCC) aware. Refer to interview with a MA on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the MCC on 01/20/22 at 12:30pm.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
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{D 358}	Continued From page 43 Refer to telephone interview with the MCC on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. d. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for montelukast (used to control and prevent symptoms caused by asthma) 10mg every other day. Review of Resident #3's physician's orders dated 11/24/21 revealed an order for montelukast 10mg daily. Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for montelukast 10mg every other day with a scheduled administration time of 9:00am. -There was documentation montelukast 10mg was administered every other day from 11/01/21 - 11/30/21. -There was no entry for montelukast 10mg daily on the eMAR. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for montelukast 10mg every other day with a scheduled administration time of 9:00am. -There was documentation montelukast 10mg	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 44 was administered every other day from 12/01/21 - 12/31/21. -There was no entry for montelukast 10mg daily on the eMAR. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for montelukast 10mg every other day with a scheduled administration time of 8:00am. -There was documentation montelukast 10mg was administered every other day from 01/01/22 - 01/19/22. -There was no entry for montelukast 10mg daily on the eMAR. Observation of Resident #3's medications on hand on 01/19/22 at 4:40pm revealed: -There was one bubble pack with 5 of 30 montelukast 10mg tablets remaining with a dispensed date of 11/24/21.	{D 358}			
	-There was a second bubble pack with 30 of 30 montelukast 10mg tablets remaining with a dispensed date of 01/07/22. -The instructions on both bubble packs was to administer montelukast 10mg daily. Telephone interview with the pharmacy technician from the facility's second contracted pharmacy on 01/20/21 at 8:10am revealed: -There was an order for montelukast 10mg daily dated 11/24/21. -The pharmacy dispensed 30 tablets of montelukast 10mg on 10/08/21. -The pharmacy dispensed 30 tablets of montelukast 10mg on 11/24/21. -The pharmacy dispensed 30 tablets of montelukast 10mg on 01/07/22. Based on staff documentation, medications				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27216

(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 358)	Continued From page 45 dispensed and medications on hand between 10/08/21 - 01/20/22, there should have been no midodrine 10mg tablets available to be administered from 01/07/22 - 01/19/22 and there were 35 tablets remaining for administration. Based on eMAR documentation, medications dispensed and medications on hand between 10/08/21- 01/19/22 revealed: -There would have been 90 montelukast tablets available to be administered from 10/08/21 - 01/19/22. -There were 103 opportunities to administer montelukast from 10/08/21 - 01/19/22 at 9:00am. -Of the 90 montelukast tablets dispensed from 10/08/21 - 01/07/22, there were 35 remaining for administration on 01/19/22 at 4:40pm. Interview with the medication aide (MA) on 01/20/22 at 12:23pm revealed: -She had administered montelukast every other day as ordered. -The montelukast order on the eMAR was correct. -She had not noticed that the prescription label on the blister pack was for every day and the instructions on the eMAR were every other day. Interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm revealed: -She had not noticed the discrepancy in the entry on the eMAR and the instructions on the blister pack for montelukast. -The primary care provider (PCP) must have sent the prescription directly to the pharmacy. -The MA should bring it to my attention once it was noticed. Interview with the nurse from Resident #3's PCP's office on 01/24/22 at 2:10pm revealed:	(D 358)		

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(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 358}	Continued From page 46 -Resident #3's montelukast was increased to daily on 08/17/21. -Resident #3 needed to make an appointment for a visit to review his medications. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #3 should be administered his medication as ordered. -The MAs were expected to compare the instructions on the label with the instructions on the eMAR. -She did not know why the most recent order was not entered on the eMAR. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm.	{D 358}			
	Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am.				

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{D 358}	Continued From page 47 Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. e. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for vitamin D3 (a vitamin supplement) 125mcg weekly on Monday. Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 125mcg every week on Monday with a scheduled administration time of 9:00am. -There was documentation Vitamin D3 was administered 4 of 5 Mondays in November 2021. -There was one exception documented on 11/29/21; the exception documented was the resident was unavailable. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for Vitamin D3 125mcg every week on Monday with a scheduled administration time of 9:00am. -There was documentation Vitamin D3 was administered 4 of 4 Mondays in December 2021. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for Vitamin D3 125mcg every week on Monday with a scheduled administration time of 9:00am. -There was documentation Vitamin D3 was administered 3 of 3 Mondays in January 2022. Observation of Resident #3's medications on hand on 01/19/22 at 4:40pm revealed there was a bubble pack with 4 of 4 vitamin D complex capsules with a dispense date of 01/07/22.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2768 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 48 Telephone interview with the pharmacy technician from the facility's second contracted pharmacy on 01/20/21 at 8:10am revealed: -The pharmacy dispensed 4 tablets of Vitamin D3 125mcg on 09/24/21. -The pharmacy dispensed 4 tablets of Vitamin D3 125mcg on 11/10/21. -The pharmacy dispensed 4 tablets of Vitamin D3 125mcg on 01/07/22. Based on eMAR documentation, medications dispensed and medications on hand between 09/24/21 - 01/20/21, there should have been no Vitamin D3 tablets available to be administered from 12/20/21 to 01/17/22 and there were 4 tablets remaining for administration. Based on eMAR documentation, medications dispensed and medications on hand between 09/24/21 - 01/20/22 revealed: -There would have been 12 Vitamin D3 tablets available to be administered from 09/24/21 - 01/20/22. -There were 17 opportunities to administer Vitamin D3 weekly on Monday from 09/24/21 - 01/20/22 at 9:00am. -Of the 12 tablets dispensed from 09/24/21 to 01/07/22, there were 4 tablets remaining for administration as of 01/19/21 at 4:40pm. Interview with the nurse from Resident #3's Primary Care Provider's (PCP) office on 01/24/22 at 2:10pm revealed: -Resident #3's needed to be administered his Vitamin D3 weekly as ordered. -Resident #3 needed to make an appointment for a visit to review his medications. Interview with the Administrator on 01/24/22 at	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

(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 358)	Continued From page 49 11:50am revealed: -Resident #3 should be administered his medication as ordered. -The MAs were expected to have the medication in the facility to administer as ordered. -If the medication was not in the facility, the MAs should let the Resident Care Coordinator (RCC) or Memory Care Coordinator (MCC) aware. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. f. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for benztropine (used to manage tremors) 1mg three times daily.	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215			
(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 358)	Continued From page 50 Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for benztropine 1mg three times daily with a scheduled administration time of 9:00am, 1:00pm and 9:00pm. -There was documentation benztropine was administered three times a day from 11/01/21 to 11/30/21 in November 2021. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for benztropine 1mg three times daily with a scheduled administration time of 9:00am, 1:00pm and 9:00pm. -There was documentation benztropine was administered from 12/01/21 to 12/25/21, 12/26/21 at 9:00am and 9:00pm, 12/28/21, 12/30/21 at 9:00am and 1:00pm and 12/31/21. -There were exceptions documented on 12/26/21 at 1:00pm; 12/27/21, 12/29/21 and 12/30/21 at 9:00pm; and 12/28/21 at 9:00am, 1:00pm and 9:00pm; the exception document was the pharmacy. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for benztropine 1mg three times daily with a scheduled administration time of 9:00am, 1:00pm and 9:00pm. -There was documentation benztropine was administered three times a day from 12/01/21 to 12/31/21 in January 2022. -There were exceptions documented on 01/02/22 and 01/05/22 at 9:00am and 1:00pm; 01/03/22 and 01/06/21 at 9:00pm; the exceptions document was the pharmacy and refused. Observation of Resident #3's medications on	(D 358)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 51 hand on 01/19/22 at 4:40pm revealed there was 62 of 90 tablets remaining with a dispensed date of 01/07/22 Telephone interview with the pharmacy technician from the facility's second contracted pharmacy on 01/20/21 at 8:10am revealed: -The pharmacy dispensed 90 tablets of benztropine 1mg on 09/30/21. -The pharmacy dispensed 90 tablets of benztropine 1mg on 11/10/21. -The pharmacy dispensed 90 tablets of benztropine 1mg on 01/07/22. Based on eMAR documentation, medications dispensed and medications on hand between 09/30/21 - 01/20/21, there would have been no benztropine 1mg available for administration from 12/01/21 - 01/07/22 when the medication was reordered, and from 01/08/22 - 01/20/22 based on documentation there should have been 54 tablets of midodrine 10mg tablets available to be administered and there were 62 tablets remaining for administration. Interview with the nurse from Resident #3's primary care provider's (PCP) office on 01/24/22 at 2:10pm revealed: -Resident #3's benztropine should be administered as ordered. -Resident #3 was ordered benztropine for his tremors. -Resident #3 needed to make an appointment for a visit to review his medications. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #3 should be administered his medication as ordered. -There should not be any extra medications	(D 358)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 52 unless the resident had been in the hospital. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. g. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for polyethylene glycol 17gm's in 8 ounces of liquid daily. Review of Resident #3's physician's orders dated 10/08/21 revealed an order for polyethylene glycol (used to treat constipation) 17gm's in 8 ounces of liquid daily as needed. Review of Resident #3's November 2021	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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)	(X6) COMPLETE DATE
(D 358)	Continued From page 53 electronic medication administration record (eMAR) revealed: -There was an entry for polyethylene glycol 17gm's in 8 ounces of liquid daily with a scheduled administration time of 6:00am. -There was documentation polyethylene glycol was administered in 8 ounces of liquid on 11/01/21, 11/07/21, 11/13/21 - 11/21/21 and 11/23/21 - 11/28/21. -There were exceptions documented on 11/02/21 - 11/06/21; 11/08/21 - 11/12/21; 11/22/21; and 11/29/21 - 11/30/21. The exception documented was refused. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for polyethylene glycol 17gm's in 8 ounces of liquid daily with a scheduled administration time of 6:00am. -There was documentation polyethylene glycol was administered in 8 ounces of liquid on 12/04/21 12/11/21 -12/12/21, 12/18/21, 12/24/21 - 12/27/21. -There were exceptions documented on 12/01/21 - 12/03/21; 12/05/21- 12/10/21; 12/13/21 - 12/17/21; 12/19/21 - 12/23/21 and 12/28/21 - 12/31/21. The exception documented was refused. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for polyethylene glycol 17gm's in 8 ounces of liquid daily with a scheduled administration time of 6:00am. -There was documentation polyethylene glycol was administered in 8 ounces of liquid from 01/01/22 - 01/05/22, 01/08/22 - 01/09/22, 01/12/22, 01/15/22. -There were exceptions documented on 01/06/22 and 01/07/22; 01/10/22 and 01/11/21; 01/13/22	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 54 and 01/14/22; and 01/16/22 - 01/18/22; the exception document was the pharmacy and refused. Observation of Resident #3's medication on hand on 01/19/22 at 4:40pm revealed there was one bottle of polyethylene glycol that was ¼ full with a dispensed dated of 10/08/21. Telephone interview with the pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am revealed: -The pharmacy dispensed 1 bottle of polyethylene glycol 17gm on 02/17/21. -The pharmacy dispensed 1 bottle of polyethylene glycol 17gm on 03/22/21. -The pharmacy dispensed 1 bottle of polyethylene glycol 17gm on 10/08/21. -One bottle of polyethylene glycol 17gm's should last 30 days if taken daily. -The pharmacy did not have an order for polyethylene glycol 17gm in 8 ounce of liquid as needed. Interview with a medication aide (MA) on 01/20/22 at 4:05pm revealed: -Resident #3 always refused to take his polyethylene glycol. -She would ask Resident #3 if he wanted to take the polyethylene glycol before she poured it -She spoke to the Memory Care Coordinator (MCC) about changing the schedule administration time from 6:00am. -She thought he may would take the polyethylene glycol if offered at a different time. -She had not noticed the instruction on the prescription label were different from the entry on the eMAR. Interview with the nurse from Resident #3's	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 55 primary care provider's (PCP) office on 01/24/22 at 2:10pm revealed: -Resident #3's polyethylene was changed to as needed on 10/08/21. -Resident #3 needed to make an appointment for a visit to review his medications. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #3 should be administered his medication as ordered. -The MAs were expected to compare the instructions on the eMAR with the instructions on the prescription label. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215
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(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 358}	Continued From page 56 Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. h. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for aspirin (used as a blood thinner) 81 mg daily. Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81 mg daily with a scheduled administration time of 9:00am. -There was documentation aspirin was administered daily from 11/01/21 to 11/30/21 in November 2021. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for aspirin 81 mg daily with a scheduled administration time of 9:00am. -There was documentation aspirin was administered daily from 12/01/21 to 12/31/21 in December 2021. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for aspirin 81 mg daily with a scheduled administration time of 9:00am. -There was documentation aspirin was administered daily from 01/01/22 - 01/19/22 in January 2022. -There were exceptions documented on 01/02/22 and 01/05/22 at 9:00am in January 2022; the exception documented was the pharmacy. Observation of Resident's medication on hand on 01/19/22 at 4:40pm revealed there was a bubble pack with 18 of 30 tablets remaining with a dispense date of 01/07/22.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27216		
(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 358}	Continued From page 57 Telephone interview with the pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am revealed: -The pharmacy dispensed 30 aspirin 81 mg on 10/26/21. -The pharmacy dispensed 30 aspirin 81 mg on 11/24/21. -The pharmacy dispensed 30 aspirin 81 mg on 01/07/22. Based on eMAR documentation, medications dispensed and medications on hand between 10/26/21 - 01/19/21, there should have been 5 aspirin tablets available to be administered and there were 18 tablets available for administration. Interview with the nurse from Resident #3's primary care provider's (PCP) office on 01/24/22 at 2:10pm revealed: -Resident #3's aspirin should be administered as ordered. -Resident #3 was taking aspirin as a blood thinner. -Resident #3 needed to make an appointment for a visit to review his medications. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #3 should be administered his medication as ordered. -She did not know why there were so many extra tablets available. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER

ALAMANCE HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE
2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27216

(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 358}	Continued From page 58 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm.	{D 358}		
	I. Review of Resident #3's physician's orders dated 07/27/21 revealed an order for midodrine (used to treat low blood pressure) 10mg 1/2 tablet three times a day. Review of Resident #3's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for midodrine 10mg 1/2 tablet three times a day with a scheduled administration time of 9:00am, 1:00pm and 9:00pm. -There was documentation midodrine was administered three time daily from 11/01/21 to 11/30/21. Review of Resident #3's December 2021 eMAR revealed: -There was an entry for midodrine 10mg 1/2			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 59 tablet three times a day with a scheduled administration time of 9:00am, 1:00pm and 9:00pm. -There was documentation midodrine 10mg 1/2 tablets was administered three time daily from 12/01/21 to 12/31/21. Review of Resident #3's January 2022 eMAR revealed: -There was an entry midodrine 10mg 1/2 tablet three times a day with a scheduled administration time of 9:00am, 1:00pm and 9:00pm. -There was documentation midodrine was administered three time daily from 01/01/22 - 01/02/22, 01/03/22 at 9:00am and 1:00pm, 01/04/22 - 01/18/22 and 01/19/22 at 9:00am and 1:00pm. -There was one exception documented on 01/03/22 at 9:00pm; the exception documented was refused on 01/03/22. Observation of Resident #3's medications on hand on 01/19/22 at 4:40pm revealed there was a bubble pack with 36 of 90 1/2 tablets with a dispensed date of 01/07/22. Telephone interview with the pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am revealed: -The pharmacy dispensed 90 midodrine 10mg 1/2 tablets on 10/26/21. -The pharmacy dispensed 90 midodrine 10mg 1/2 tablets on 11/24/21. -The pharmacy dispensed 90 midodrine 10mg 1/2 tablets on 01/07/22. -The 45 midodrine 10mgs are cut in half and packaged in a bubble pack with 1/2 tablet in each bubble. Based on eMAR documentation, medications	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 60 dispensed and medications on hand between 10/26/21 - 01/20/21, there should have been 5 tablets of midodrine 10mg tablets available to be administered and there were 36 tablets remaining for administration. Interview with the nurse from Resident #3's primary care provider's (PCP) office on 01/24/22 at 2:10pm revealed: -Resident #3's midodrine should be administered as ordered. -Resident #3 needed to make an appointment for a visit to review his medications. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #3 should be administered his medication as ordered. -The MAs were expected to have the medication in the facility to administer as ordered. -She did not know why there were so many extra tablets available. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's second contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory	(D 358)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2768 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 61 Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. 3. Review of Resident #2's current FL2 dated 07/08/21 revealed diagnoses included bipolar disorder, gastroesophageal reflux disease, dysphagia, slow transient constipation, dermatitis, asthma, candida's of skin and nail, mixed hyperlipidemia, and respiratory disorder. a. Review of Resident #2's physician's orders dated 07/08/21 revealed an order for pantoprazole (used to treat heartburn and reflux) 40mg one daily. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for pantoprazole 40mg one daily with a scheduled administration time of 8:00am. -There was documentation pantoprazole was administered daily from 11/01/21 - 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for pantoprazole 40mg one daily with a scheduled administration time of 8:00am. -There was documentation pantoprazole was administered daily from 12/01/21 - 12/31/21.	(D 358)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 62 Review of Resident #2's January 2022 eMAR revealed: -There was an entry for pantoprazole 40mg one daily with a scheduled administration time of 8:00am. -There was documentation pantoprazole 40mg was administered daily from 01/01/22 - 01/19/22. Observation of Resident #3's medication on hand on 01/19/21 at 3:20pm revealed there were 23 of 30 pantoprazole tablets remaining on hand. Interview with the pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am revealed: -The pharmacy dispensed 30 tablets of pantoprazole 40mg on 10/08/21. -The pharmacy dispensed 30 tablets of pantoprazole 40mg on 11/23/21. -The pharmacy dispensed 30 tablets of pantoprazole 40mg on 01/06/22. Based on eMAR documentation, medications dispensed and medications on hand between 10/08/21 - 01/20/22, there would have been no pantoprazole 40mg to be administered from 01/07/22 - 01/20/22, but there were 23 pantoprazole remaining for administration. Interview with Resident #2's primary care provider (PCP) on 01/20/22 at 11:00am revealed: -Pantoprazole was used to treat gastroesophageal reflux. -Resident #2 could have an increase in gastric reflux if not receiving her pantoprazole as ordered. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #5 should be receiving her reflux	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215			
(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 358}	Continued From page 63 medication as ordered. -She could have increase discomfort due to increase gastric reflux. -She did not know why there were so many extra tablets available. Refer to the interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. b. Review of Resident #2's physician's orders dated 07/08/21 revealed an order for coenzyme (used to treat elevated cholesterol levels) 30mg one daily. Review of Resident #2's November 2021	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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)	(X6) COMPLETE DATE
{D 356}	Continued From page 64 electronic medication administration record (eMAR) revealed: -There was an entry for coenzyme 30mg one daily with a scheduled administration time of 8:00am. -There was documentation coenzyme was administered daily from 11/01/21 - 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for coenzyme 30mg one daily with a scheduled administration time of 8:00am. -There was documentation coenzyme was administered daily from 12/01/21 - 12/27/21 and 12/29/21 - 12/31/21. -There was one exception documented on 12/28/21; the exception documented was the pharmacy. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for coenzyme 30mg one daily with a scheduled administration time of 8:00am. -There was documentation coenzyme was administered daily from 01/03/22 - 01/19/22. -There were two exceptions documented on 01/01/22 - 01/02/22; the exceptions documented was the pharmacy. Interview with the pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am revealed: -The pharmacy dispensed 30 tablets of coenzyme 30mg on 08/24/21. -The pharmacy dispensed 30 tablets of coenzyme 30mg on 10/20/21. -The pharmacy dispensed 30 tablets of coenzyme 30mg on 12/27/21.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215			
(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 358)	Continued From page 65 Observation of Resident #3's medication on hand on 01/19/21 at 3:20pm revealed there were 15 of 30 coenzyme tablets on hand. Based on eMAR documentation, medications dispensed and medications on hand between 08/24/21 - 01/19/21, there would have been no coenzyme 30mg available for administration from 11/24/21 - 01/20/22, but there were 15 capsules remaining for administration. Interview with the primary care provider (PCP) on 01/20/22 at 11:00am revealed: -Coenzyme 30mg could be used for multiple reasons. -Resident #2 was ordered coenzyme to help with her cholesterol. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #5 should be receiving coenzyme as ordered. -She did not know why there were so many extra tablets available. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care	(D 358)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

(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 358}	Continued From page 66 Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. c. Review of Resident #2's physician's orders dated 07/08/21 revealed an order for fenofibrate (used to treat high cholesterol levels) 48mg on daily. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for fenofibrate 48mg one daily with a scheduled administration time of 8:00am. -There was documentation fenofibrate was administered daily from 11/01/21 - 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for fenofibrate 48mg one daily with a scheduled administration time of 8:00pm. -There was documentation fenofibrate was administered daily from 12/01/21 - 12/31/21. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for fenofibrate 48mg one daily with a scheduled administration time of	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 67 8:00pm. -There was documentation fenofibrate was administered daily from 01/01/22 - 01/19/22. Observation of Resident #2's medication on hand on 01/19/22 at 3:20pm revealed there were 24 of 30 fenofibrate 48mg tablets available for administration. Interview with the pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am revealed: -The pharmacy dispensed 30 tablets of fenofibrate 48mg on 10/15/21. -The pharmacy dispensed 30 tablets of fenofibrate 48mg on 11/24/21. -The pharmacy dispensed 30 tablets of fenofibrate 48 mg on 01/07/22. Based on eMAR documentation, medications dispensed and medications on hand between 10/15/21 to 01/20/22, there would have been no fenofibrate available to be administered from 01/16/22 - 01/20/22, but there was 24 remaining for administration. Interview with Resident #2's primary care provider (PCP) on 01/20/22 at 11:00am revealed: -Fenofibrate was used to help decrease cholesterol levels. -Resident #2's cholesterol levels could increase if fenofibrate were not administered as ordered. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #5 should be receiving her cholesterol medication as ordered. -She could be at risk for additional complications such as stroke. -She did not know why there were so many extra	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 68 tablets available. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. d. Review of Resident #2's physician's orders dated 07/08/21 revealed an order for fish oil (used to lower cholesterol levels) 1000mg twice daily. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for fish oil 1000mg twice daily with a scheduled administration time of	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 69 8:00am and 8:00pm. -There was documentation fish oil was administered twice daily from 11/01/21 - 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for fish oil 1000mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation fish oil was administered twice daily from 12/01/21 - 12/31/21. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for fish oil 1000mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation fish oil was administered twice daily from 01/01/22 - 01/18/22 and at 8:00am on 01/19/22. Observation of Resident #2's medication on hand on 01/19/21 at 3:20pm revealed there were 14 of 60 fish oil capsules remaining for administration. Interview with the pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am revealed: -The pharmacy dispensed 56 tablets of fish oil capsules 1000mg on 09/07/21. -The pharmacy dispensed 60 tablets of fish oil capsules 1000mg on 10/20/21. -The pharmacy dispensed 60 tablets of fish oil capsules 1000 mg on 12/06/21. Based on eMAR documentation, medications dispensed and medications on hand between 09/07/21 to 01/20/21, there would have been no fish oil capsules available to be administered	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 70 from 12/14/21 to 01/20/22, but there were 14 capsules remaining for administration. Interview with Resident #2's primary care provider (PCP) on 01/20/22 at 11:00am revealed: -Fish oil capsules could help to decrease cholesterol levels. -Resident #2's cholesterol levels could increase if the fish oil capsules were not administered as ordered. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #5 should be receiving her cholesterol medication as ordered. -She did not know why there were so many extra tablets available. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am.	(D 368}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 71 Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. e. Review of Resident #2's signed physician's orders dated 07/08/21 revealed an order for levothyroxine (used to treat thyroid disease) 75mcg in the morning on an empty stomach. Review of Resident #2's signed physician's orders dated 11/04/21 revealed there was an order to change levothyroxine to 50mcg in the morning on an empty stomach. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 50mcg in the morning on an empty stomach with a scheduled administration time of 6:30am. -There was documentation levothyroxine 50mcg was administered every morning from 11/04/21 - 11/30/21. -There was an entry for levothyroxine 75mcg in the morning on an empty stomach with a scheduled administration time of 6:30am. -There was documentation levothyroxine 75mcg was administered every morning from 11/01/21 - 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for levothyroxine 50mcg in the morning on an empty stomach with a scheduled administration time of 6:30am. -There was documentation levothyroxine 50mcg was administered every morning from 12/01/21 - 12/31/21.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215			
(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 358)	Continued From page 72 -There was an entry for levothyroxine 75mcg in the morning on an empty stomach with a scheduled administration time of 6:30am. -There was documentation levothyroxine 75mcg was administered every morning from 12/01/21 - 12/31/21. -There were exceptions documented exceptions documented on 12/01/21 - 12/03/21, 12/05/21 - 12/11/21 and 12/14/21- 12/23/21; the exceptions documented were the pharmacy and medication discontinued. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for levothyroxine 50mcg in the morning on an empty stomach with a scheduled administration time of 6:30am. -There was documentation levothyroxine 50mcg was administered every morning from 01/01/22 - 01/19/22. Observation of Resident #2's medication on hand on 01/19/21 at 3:21pm revealed: -There were 5 of 30 tablets on hand with a dispensed date of 12/06/21. -There were 20 of 30 tablets on hand with a dispensed date of 01/07/22. Interview with the pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am revealed: -The pharmacy dispensed 30 tablets of levothyroxine on 11/04/21. -The pharmacy dispensed 30 tablets of levothyroxine on 12/06/21. -The pharmacy dispensed 30 tablets of levothyroxine on 01/07/22. Based on eMAR documentation, medications dispensed and medications on hand between	(D 358)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 73 11/04/21 - 01/20/22, there should have been 14 tablets of levothyroxine available to administered and there were 25 tablets remaining for administration. Interview with the primary care provider (PCP) on 01/21/22 at 11:00am revealed: -Levothyroxine was ordered to manage Resident #2's thyroid disease. -She could have issues with her blood pressure and increase in anxiety. Interview with the Administrator on 01/24/22 at 11:50am revealed: -Resident #5 should be receiving her thyroid medication as ordered. -She did not know why there were so many extra tablets available. -There was no excuse not to have medications available for administration as ordered. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm.	{D 358}		

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{D 358}	Continued From page 74 Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. 5. Review of Resident #6's current FL-2 dated 10/15/21 revealed: -Diagnoses included rheumatoid arthritis, and right below the knee amputation. -There was an order for Humalog U-100 sliding scale insulin (SSI) (used to treat diabetes) administered before meals and at bedtime based on a sliding scale: 151-200=6 units, 201-250=10 units, 251-300=14 units, 301-350=18 units, and 350+-18 units. Review of Resident #6's electronic Medication Administration Record (eMAR) for November 2021 revealed: -There was an entry for Humalog U-100 SSI administered before meals and at bedtime; 151-200=6 units, 201-250=10 units, 251-300=14 units, 301-350=18 units, and 350+-18 units. -There were 7 of 118 opportunities when Humalog SSI was documented as administered incorrectly with examples as follows: -There was documentation on 11/14/21 at 12:00pm Resident #6's finger stick blood sugar (FSBS) result was 330 and 14 units of Humalog were administered; 18 units should have been administered. -There was documentation on 11/14/21 at 5:00pm Resident #6's FSBS result was 363 and 14 units of Humalog were administered; 18 units should have been administered. -There was documentation on 11/18/21 at 7:00am	{D 358}			

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(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 358)	Continued From page 75 Resident #6's FSBS result was 204 and 20 units of Humalog were administered; 10 units should have been administered. -There was documentation on 11/19/21 at 7:00pm Resident #6's FSBS result was 255 and 10 units of Humalog were administered; 14 units should have been administered. Review of Resident #6's eMAR for December 2021 revealed: -There was an entry for Humalog U-100 SSI administered before meals and at bedtime based on a sliding scale: 151-200=6 units, 201-250=10 units, 251-300=14 units, 301-350=18 units, and 350+=18 units. -There were 4 of 115 opportunities when Humalog SSI was documented as administered incorrectly with examples as follows: - There was documentation on 12/03/21 at 5:00pm Resident #6's FSBS result was 344 and 14 units of Humalog were administered; 18 units should have been administered. -There was documentation on 12/04/21 at 5:00pm Resident #6's FSBS result was 288 and 18 units of Humalog were administered; 14 units should have been administered. -There was documentation on 12/17/21 at 12:00pm Resident #6's FSBS result was 268 and 10 units of Humalog were administered; 14 units should have been administered. Attempted interviews on 01/24/21 at 12:02pm and 12:04pm with the two medication aides (MA) who documented on Resident #6's eMAR for the FSBS and SSI administered were unsuccessful. Review of Resident #6's January 2022 eMAR FSBS readings revealed: -On 01/17/22 there was an exception documented at 12:30pm; the exception was	(D 358)		

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 76 documented as the pharmacy. -On 01/18/22 there were exceptions documented at 12:30pm and 5:30pm; the exceptions documented were no test strips. -On 01/19/22 there were exceptions documented at 7:30am and 12:30pm; the exceptions documented were "no test strips". Observation of Resident #6's medications on hand on 01/20/22 at 2:16pm revealed there was a Humalog insulin pen on hand for SSI administration. Interview with Resident #6 on 01/20/22 at 3:58pm. revealed: -His FSBS was ordered to be checked four times a day, before breakfast, lunch and dinner and then before bedtime. -He did not know how much SSI was administered when he had his FSBS checked. Interview with the Area Clinical Director on 01/24/22 at 10:08am revealed: -He was at the facility once a week. -The matrix system (eMAR) would display the units that would need to be administered based on the FSBS entered. -He expected the MA to compare the number of units displayed in the matrix system to be administered to the SSI to ensure the correct amount of insulin was being administered. -If there was a discrepancy in the number of units displayed in the matrix system compared to the SSI the MA should notify someone in management for clarification. -He did not audit the SSI insulin coverage provided but thought someone at the facility probably did. -He expected the MAs to implement the PCP's orders correctly.	{D 358}			

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{D 358}	Continued From page 77 -Resident #6 was a brittle diabetic and was concerned the resident was not receiving the correct amount of insulin based on his FSBS. Interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am revealed: -She covered multiple facilities. -She was not sure if the matrix system automatically documented the amount of insulin that should be administered or if the MA had to manually document the amount of insulin administered. -She had not compared the eMAR for the units of SSI documented compared to the order to ensure the correct amount of insulin had been administered. Interview with the Memory Care Coordinator (MCC) on 01/24/22 at 11:22am and 2:45pm revealed: -Some of the resident's SSI was automatically entered in the eMAR when the FSBS was entered, and for other residents the number of units administered had to be manually entered. -She did not know if Resident #6's SSI was automatically entered or if the MA had to enter the number of units administered manually. -She did not know why Resident #6's SSI number of units that were documented as administered did not match the order for the sliding scale. -She was concerned Resident #6's FSBS was not checked on 01/17/22, 01/18/22, and 01/19/22 because if the FSBS was not obtained the MA would not know if the SSI needed to be administered. -It was concerning the residents FSBS could have been too high or too low. Observation of Resident #6's FSBS check on	{D 358}		

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(D 358)	Continued From page 78 01/24/22 at 11:34am revealed the MA entered the resident's FSBS results in the matrix system and the amount of insulin to be administered was automatically displayed on the screen. Interview with a MA on 01/24/22 at 11:34am revealed: -He had worked at the facility in August 2021 and at that time the number of units had to be determined by looking at the order for SSI and then the amount of insulin administered would be documented by the MA. -He did not know when the SSI directed to administer began to automatically populate in the eMAR.	(D 358)		
	Interview with another MA on 01/24/22 at 11:40am revealed: -Resident #6's SSI order automatically directed the MA on how much insulin to be administered. -She always compared the number directed to administer to the sliding scale before administering the insulin. -She had not seen a discrepancy in the number directed to administer and the number of units in the order based on the FSBS. Interview with the Administrator on 01/24/22 at 11:51am revealed: -She was not aware Resident #6 had been administered the wrong SSI based on FSBS readings documented. -She was concerned insulin was not administered based on the sliding scale and Resident #6 did not get his medication as ordered. -She expected Resident #6's medication to be administered as ordered. Telephone interview with Resident #6's primary care provider (PCP) on 01/24/22 at 2:20pm			

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
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{D 358}	Continued From page 79 revealed: -She expected Resident #6's FSBS to be checked as ordered and the SSI to be administered based on the FSBS obtained. -If Resident #6 was administered the wrong amount of SSI, it would cause the resident to be hypoglycemic or hyperglycemic. -If Resident #6's A1C was elevated they would increase his medication unnecessarily thinking the resident had been administered the correct amount when he had not. -The last A1C she could locate was dated 06/13/21 and it was 8.5. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm. Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the	{D 358}		

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{D 358}	Continued From page 80 Administrator on 01/21/22 at 4:15pm. 6. Review of Resident #4's current FL-2 dated 07/22/21 revealed diagnoses included vascular dementia with behavioral disturbances, bipolar disorder, severe protein caloric malnutrition, and essential hypertension. a. Review of Resident #4's physician's orders dated 07/22/21 revealed an order for Haloperidol 0.5mg twice daily. (used to treat behaviors related to mental illness). Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Haloperidol 0.5mg twice daily with scheduled administration times at 8:00am and 8:00pm. -Haloperidol was documented as administered from 11/01/21-11/30/21 at 8:00am and 8:00pm. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Haloperidol 0.5mg twice daily with scheduled administration times at 8:00am and 8:00pm. -Haloperidol was documented as administered from 12/01/21-12/13/21 and 12/15/21-12/31/21 at 8:00am and 8:00pm. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Haloperidol 0.5mg twice daily with scheduled administration times at 8:00am and 8:00pm. - Haloperidol was documented as administered from 01/01/22-01/04/22 at 8:00am and 8:00pm; 01/05/22 at 8:00pm; 01/06/22 - 01/10/22 at 8:00am and 8:00pm; 01/11/22 at 8:00am and	{D 358}		

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(D 358)	Continued From page 81 01/12/22 - 01/14/22 at 8:00am and 8:00pm -There were exceptions documented on 01/05/22 at 8:00am, 01/11/22 at 8:00pm, and 01/15/22-01/17/22 at 8:00am and 8:00pm; the exception was documented as the pharmacy. -There were exceptions documented on 01/18/22 at 8:00am as pharmacy and at 8:00pm as refused. Observation of Resident #4's medications on hand on 01/19/22 at 3:33pm revealed Haloperidol 0.5mg was not available to be administered. Telephone interview with a pharmacist at the pharmacy's contracted pharmacy on 01/20/22 at 10:07am revealed: -Sixty tablets of Haloperidol 0.5mg were dispensed for Resident #4 on 11/08/21. -Fifteen tablets of Haloperidol 0.5mg were dispensed for Resident #4 on 12/11/22. -Haloperidol 0.5mg was requested for a refill for Resident #4 on 01/19/22 and fifteen tablets were dispensed. -Resident #4 was listed as being on hospice which meant the resident would only get a 15-day supply. -She was not sure why the November 2021 dispensing was for 30 days and the subsequent orders was dispensed for only 15 days as it had been the same order since 07/19/21. -Haloperidol was added to Resident #4's profile on 02/11/21 for behavior issues. -Haloperidol was typically used for agitation. -If Resident #4 did not receive the Haloperidol as ordered, the resident's agitation would be worse, and made it harder for staff to care for the resident. Telephone interview with a pharmacy technician at the pharmacy's contracted pharmacy on	(D 358)			

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(D 358)	Continued From page 82 01/21/22 at 1:30pm revealed: -Resident #4's medications were not cycle filled. -Resident #4's medications had to be requested by the facility staff for refill. Based on eMAR documentation, medications dispensed and medications on hand between 11/08/21-01/19/22, there would have been no Haloperidol available to be administered between 12/20/21-01/19/22 when the medication was reordered. Interview with Resident #4's primary care provider (PCP) on 01/20/22 at 11:01am revealed: -Resident #4 was prescribed Haloperidol for behaviors. -Resident #4 was at risk of a change in her behavior, increased anxiety, and agitation if Haloperidol was not administered correctly. -She expected Resident #4's Haloperidol to be administered as ordered. Telephone interview with Resident #4's mental health provider on 01/21/22 at 10:26am revealed: -Haloperidol should not be stopped abruptly. -Haloperidol would need to be tapered off slowly or there would be a rebound effect. -If Resident #4's Haloperidol was not tapered off slowly she would have increased agitation. -Resident #4 had significant behavior problems "about a year ago" and it took a while to get Resident #4 stable to improve the resident's quality of life and decrease her fearfulness. -If Resident #4's medication was not being administered as ordered may be the reason Resident #4 had some changes recently in her behavior, not as bad as one year ago, but the resident would continue to decline if the medication was not administered correctly.	(D 358)			

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{D 358}	Continued From page 83 Interview with a second shift medication aide (MA) on 01/20/22 at 4:38pm revealed: -Resident #4 was "really good" about taking her medication. -She had administered Resident #4's Haloperidol. -She did not recall when she had last administered Resident #4's Haloperidol. -She remembered Resident #4 had a lot of Haloperidol on the cart at "one time" but she did not recall when. -She always prepped her medication in the matrix system as she popped the medication into a cup and would then mark all as administered. - "Maybe someone had marked the medication had been administered when it had not been." -She had administered an as needed (prn) medication to Resident #4 on several occasions due to the resident showing increased anxiety. Interview with a first shift MA on 01/20/22 at 4:57pm revealed: -She administered Resident #4's Haloperidol when she worked. -She did not know why Resident #4's Haloperidol was not re-ordered when the medication would have run out. -When medication needed to be reordered, she took the reorder sticker, placed it on a pharmacy sheet, and gave it to the Memory Care Coordinator (MCC). Telephone interview with the MCC on 01/21/22 at 1:59pm revealed: -She knew Resident #4's Haloperidol was not on the cart on 01/19/22 when she did a cart audit. -She did not know Resident #4's Haloperidol needed to be reordered prior to her cart audit. Interview with the Administrator on 01/24/22 at 12:48pm revealed:	{D 358}			

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(D 358)	Continued From page 84 -She was not aware Resident #4 did not have Haloperidol available to be administered. -She expected Resident #4's Haloperidol to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. b. Review of Resident #4's physician's orders dated 07/22/21 revealed an order for Olanzapine 20mg once daily. (used to treat manic-depressive	(D 358)		

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 85 disorders). Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Olanzapine 20mg daily with scheduled administration time at 8:00pm. -Olanzapine 20mg was documented as administered from 11/01/21-11/30/21 at 8:00pm. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Olanzapine 20mg daily with scheduled administration time at 8:00pm. - Olanzapine 20mg was documented as administered from 12/01/21-12/31/21 at 8:00pm. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Olanzapine 20mg daily with scheduled administration time at 8:00pm. - Olanzapine 20mg was documented as administered from 01/01/22-01/15/22 at 8:00pm. - Olanzapine 20mg was not documented as administered on 01/16/22-01/17/22 with documentation for the reason not administered as the pharmacy. - Olanzapine 20mg was not documented as administered on 01/18/22 at 8:00pm with documentation for the reason not administered as refused. Observation of Resident #4's medications on hand on 01/19/22 at 3:33pm revealed there was no Olanzapine 20mg available to be administered. Telephone interview with a pharmacist at the pharmacy's contracted pharmacy on 01/20/22 at 10:07am revealed:	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 86 -Thirty tablets of Olanzapine 20mg were dispensed for Resident #4 on 11/07/21 and 12/01/21. -Fifteen tablets of Olanzapine 20mg were ordered for Resident #4 on 01/19/22. -Resident #4's Olanzapine was prescribed for anxiety and depression. -If Resident #4's Olanzapine was not administered she would be at risk for increased anxiety. Based on eMAR documentation, medications dispensed and medications on hand between October 2021 and January 2022, there would have been no Olanzapine available to be administered from 01/06/22-01/19/22 when the medication was reordered. Interview with Resident #4's primary care provider (PCP) on 01/20/22 at 11:01am revealed: -Resident #4 was prescribed Olanzapine for behaviors. -Resident #4 was more likely to have behaviors if her Olanzapine was not administered correctly. -She expected Resident #4's Olanzapine to be administered as ordered. Telephone interview with Resident #4's mental health provider on 01/21/22 at 10:28am revealed: -Olanzapine should not be stopped abruptly. -Olanzapine would need to be tapered off slowly or there would be a rebound effect. -If Resident #4's Olanzapine was not tapered off slowly she would have increased agitation. -Resident #4 had significant behavior problems "about a year ago" and it took a while to get Resident #4 stable to improve the resident's quality of life and decrease her fearfulness. -If Resident #4's medication was not being administered as ordered may be the reason	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 87 Resident #4 had some changes recently in her behavior, not as bad as one year ago, but the resident would continue to decline if the medication was not administered correctly. Interview with a second shift medication aide (MA) on 01/20/22 at 4:46pm revealed: -She administered Resident #4's Olanzapine when she worked. -She did not recall Resident #4's Olanzapine running out. -She did not order Resident #4's Olanzapine and she had not ordered any medications for the resident. -She had administered an as needed (prn) medication to Resident #4 on several occasions due to the resident showing increased anxiety. Interview with a first shift MA on 01/20/22 at 4:57pm revealed: -She administered Resident #4's Olanzapine when she worked. -Resident #4's Olanzapine should be "on track" and she did not know when the medication ran out. -She administered Resident #4's Olanzapine as ordered. Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:18pm revealed: -She noted Resident #4's Olanzapine was not on the cart during her audit on 01/19/22. -There was no documentation she had been notified Resident #4's Olanzapine needed to be ordered prior to her cart audit. -She was concerned Resident #4's Olanzapine needed to have been ordered and she was not notified.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

(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 358}	Continued From page 88 Interview with the Administrator on 01/24/22 at 12:48pm revealed she expected Resident #4's Olanzapine to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. c. Review of Resident #4's physician's orders dated 07/22/21 revealed an order for Aspirin 81mg once daily. (Aspirin is used as a blood thinner).	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215			
(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 358}	Continued From page 89 Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Aspirin 81mg daily with scheduled administration time at 8:00am. -Aspirin was documented as administered from 11/01/21-11/30/21 at 8:00am. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Aspirin 81mg daily with scheduled administration time at 8:00am. -Aspirin was documented as administered from 12/01/21-12/13/21 and 12/15/21-12/31/21 at 8:00am. -Aspirin was not documented as administered on 12/14/21. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Aspirin 81mg daily with scheduled administration time at 8:00am. -Aspirin was documented as administered from 01/01/22-01/04/22 and 01/06/22-01/19/22 at 8:00am. -Aspirin was not documented as administered on 01/05/22. Observation of Resident #4's medications on hand on 01/19/22 at 3:33pm revealed: -There was a bubble pack of 30 Aspirin dispensed on 12/11/21. -Nineteen tablets had been administered; 11 tablets were available to be administered. -There was a second bubble pack of thirty Aspirin dispensed on 01/04/22. -Eleven tablets had been administered; 19 tablets were available to be administered.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 90 Telephone interview with a pharmacy technician at the pharmacy's contracted pharmacy on 01/19/22 at 6:55pm revealed: -Thirty tablets of Aspirin 81mg were dispensed on 10/15/21, 12/11/21 and 01/04/22. -Resident #4's medication had to be requested for refill by facility staff. -Aspirin was not requested for a refill in November 2021. Based on eMAR documentation, medications dispensed and medications on hand between October 2021 and January 2022, there would have been no Aspirin available to be administered from 11/14/21-12/11/21, and from 12/11/21-01/19/22 when there should have been twenty tablets remaining and there were thirty tablets remaining. Telephone interview with a pharmacist at the pharmacy's contracted pharmacy on 01/20/22 at 9:33am revealed: -Resident #4's Aspirin was prescribed as a blood thinner. -If Resident #4's Aspirin was not administered correctly it increased her risk for stroke, heart attack, and blood clots. Interview with Resident #4's primary care provider (PCP) on 01/20/22 at 11:01am revealed: -Resident #4 was prescribed Aspirin for secondary prevention of cardiac events. -Resident #4 was at increased risk of stroke, myocardial infarctions, and cardiac events if her Aspirin was not administered correctly. -She expected Resident #4's Aspirin to be administered as ordered. Interview with a medication aide (MA) on 01/20/22 at 5:11pm revealed:	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27216		
(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 358}	Continued From page 91 -She administered Resident #4's medication when she worked. -She was not working in November 2022 when Resident #4's Aspirin would have needed to be ordered. -She did not know why there was more Aspirin on hand than there should be based on dispensing records. Interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:18pm revealed: -She did not know why there were extra Aspirin tablets on hand. -She was concerned Resident #4 was not receiving her Aspirin as ordered. Interview with the Administrator on 01/24/22 at 12:48pm revealed: -She was not aware Resident #4 had excess Aspirin on hand based on dispensing records and documentation of medications administered. -She expected Resident #4's Aspirin to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358}	Continued From page 92 Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. d. Review of Resident #4's physician's orders dated 07/22/21 revealed an order for Buspirone 10mg twice daily. (Buspirone is used treat anxiety). Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Buspirone 10mg twice daily with scheduled administration times at 8:00 am and 8:00pm. -Buspirone was documented as administered from 11/01/21-11/30/21 at 8:00am and 8:00pm. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Buspirone 10mg twice daily with scheduled administration times at 8:00 am and 8:00pm. -Buspirone was documented as administered from 12/01/21-12/13/21 and 12/15/21-12/31/21 at 8:00am and 8:00pm. Review of Resident #4's January 2022 eMAR	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
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(D 358)	Continued From page 93 revealed: -There was an entry for Buspirone 10mg twice daily with scheduled administration times at 8:00 am and 8:00pm. -Buspirone was documented as administered from 01/01/22-01/19/22 at 8:00am. - Buspirone was documented as administered 01/01/22-01/17/22 at 8:00pm. -There was documentation Resident #4 refused Buspirone on 01/18/22 at 8:00pm. Observation of Resident #4's medications on hand on 01/19/22 at 3:33pm revealed: -There was a bubble pack of 30 Buspirone 10mg dispensed on 12/02/21; the pack was labeled 2 of 2. -Twenty-seven tablets had been administered; 3 tablets were available to be administered. -There was a second bubble pack of 30 Buspirone 10mg dispensed on 01/13/22; the pack was labeled 1 of 2. -One tablet had been administered; 29 tablets were available to be administered. - There was a third bubble pack of 30 Buspirone 10mg dispensed on 01/13/22; the pack was labeled 2 of 2. -No tablets had been administered; 30 tablets were available to be administered. Telephone interview with a pharmacy technician at the pharmacy's contracted pharmacy on 01/19/22 at 6:55pm revealed 60 tablets of Buspirone 10mg were dispensed on 11/8/21, 12/02/21, and 01/13/22. Telephone interview with a pharmacy technician at the pharmacy's contracted pharmacy on 01/21/22 at 1:30pm revealed: -Resident #4's medications were not cycle filled. -Resident #4's medications had to be requested	(D 358)		

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 94 by the facility staff for a refill. Based on eMAR documentation, medications dispensed and medications on hand between 11/08/22-01/19/22, there would have been no Buspirone available to be administered from 01/07/22-01/13/22 when the medication was reordered, and from 01/14-01/19/22 based on documentation there should have been 48 tablets remaining and there were 59 tablets remaining. Telephone interview with a pharmacist at the pharmacy's contracted pharmacy on 01/20/22 at 9:33am revealed -Buspirone was typically prescribed to treat anxiety and improve mood. -If Resident #4's Buspirone was not administered as ordered the resident could experience a relapse with increased anxiety and a worsening of her mood. Interview with Resident #4's primary care provider (PCP) on 01/20/22 at 11:01am revealed: -Resident #4 was prescribed Buspirone for anxiety and behaviors, as well as it would help Resident #4 with sleeping. -Resident #4 was at risk of a change in her behavior, increased anxiety, and lack of sleep if her Buspirone was not administered as ordered. -She expected Resident #4's Buspirone to be administered as ordered. Telephone interview with Resident #4's mental health provider on 01/21/22 at 10:26am revealed: -Resident #4 had significant behavior problems "about a year ago" and it took a while to get Resident #4 stable to improve the resident's quality of life and decrease her fearfulness. -If Resident #4's medication was not being administered as ordered may be the reason	(D 358)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27216		
(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 358)	Continued From page 95 Resident #4 had some changes recently in her behavior, not as bad as one year ago, but the resident would continue to decline if the medication was not administered correctly. Interview with a second shift medication aide (MA) on 01/20/22 at 4:38pm revealed: -Resident #4 was "really good" about taking her medication. -She had administered Resident #4's Buspirone when she worked. -She did not know why Resident #4's Buspirone had excess tablets available that had not been administered. -She always prepped her medication in the matrix system as she popped the medication into a cup and would then mark all as administered. - "Maybe someone had marked the medication had been administered when it had not been." -She had administered an as needed (prn) medication to Resident #4 on several occasions due to the resident showing increased anxiety. Interview with a first shift MA on 01/20/22 at 5:11pm revealed: -She administered Resident #4's Buspirone when she worked. -She did not know why there was more Buspirone on hand than there should be based on dispensing records. Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 1:59pm revealed: -She did not know why there were extra Buspirone tablets on hand. -She was concerned Resident #4 was not receiving her Buspirone as ordered. -A MA could have missed prepping the Buspirone when putting medications in the cup.	(D 358)			

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STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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{D 358}	Continued From page 96 Interview with the Administrator on 01/24/22 at 12:48pm revealed: -She was not aware Resident #4 had excess Buspirone on hand based on dispensing records and documentation of medications administered. -She expected Resident #4's Buspirone to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm.	{D 358}		

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(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 358}	Continued From page 97 e. Review of Resident #4's physician's orders dated 07/22/21 revealed an order for Metoprolol Tartrate 25mg twice daily. (Metoprolol is used to treat high blood pressure). Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Metoprolol Tartrate 25mg twice daily with scheduled administration times at 8:00 am and 8:00pm. - Metoprolol Tartrate 25mg was documented as administered from 11/01/21-11/30/21 at 8:00am and 8:00pm. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Metoprolol Tartrate 25mg twice daily with scheduled administration times at 8:00 am and 8:00pm. - Metoprolol Tartrate 25mg was documented as administered from 12/01/21-12/13/21 and 12/15/21-12/31/21 at 8:00am and 8:00pm. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Metoprolol Tartrate 25mg twice daily with scheduled administration times at 8:00 am and 8:00pm. -Metoprolol Tartrate 25mg was documented as administered from 01/01/22-01/17/22 at 8:00am and 8:00pm and on 01/18/22 at 8:00am. -There was an exception documented on 01/18/22 at 8:00pm as refused. Observation of Resident #4's medications on hand on 01/19/22 at 3:33pm revealed: -There was a bubble pack of 30 Metoprolol Tartrate 25mg dispensed on 11/02/61; the pack	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 358)	Continued From page 98 was labeled 2 of 2. -Fifty-eight tablets had been administered; 2 tablets were available to be administered. -There was a second bubble pack of 30 Metoprolol Tartrate 25mg dispensed on 11/26/21; the pack was labeled 1 of 2. -Thirty-six tablets had been administered; 24 tablets were available to be administered. -There were two bubble packs of 30 tablets of Metoprolol Tartrate 25mg dispensed on 12/20/21. -No tablets had been administered and 60 tablets were available to be administered. Telephone interview with a pharmacy technician at the pharmacy's contracted pharmacy on 01/19/22 at 6:55pm revealed: -Sixty tablets of Metoprolol Tartrate 25mg were dispensed on 11/02/21. -Sixty tablets of Metoprolol Tartrate 25mg were dispensed on 11/26/21. -Sixty tablets of Metoprolol Tartrate 25mg were dispensed on 12/20/21. Based on eMAR documentation, medications dispensed and medications on hand between 11/02/21-01/19/22, there should have been 33 tablets of Metoprolol Tartrate available to be administered and there were 86 tablets remaining. Telephone interview with a pharmacist at the pharmacy's contracted pharmacy on 01/20/22 at 9:33am revealed: -Resident #4 had a diagnosis of hypertension and Metoprolol Tartrate would be used to lower blood pressure, lower heart rate (pulse). -If Resident #4's Metoprolol was not administered as ordered the resident could experience an increase in her blood pressure, heart rate (pulse).	(D 358)			

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(D 358)	Continued From page 99 Interview with Resident #4's primary care provider (PCP) on 01/20/22 at 11:01am revealed: -Resident #4 was prescribed Metoprolol Tartrate for her blood pressure and atrial fibrillation. -If Resident #4's blood pressure was high for an extended period, there could be long-term effects including stroke and heart attack. -She expected Resident #4's Metoprolol Tartrate to be administered as ordered. Interview with a second shift medication aide (MA) on 01/20/22 at 4:38pm revealed she knew she had administered Resident #4's Metoprolol Tartrate as ordered so she did not know why there were extra Metoprolol Tartrate tablets available. Interview with a first shift MA on 01/20/22 at 4:57pm revealed: -She administered Resident #4's medication when she worked. -She did not know why Resident #4's Metoprolol Tartrate had extra tablets on the medication cart from previous months. -She administered Resident #4's Metoprolol as ordered. Telephone interview with the Memory Care Manager (MCC) on 01/21/22 at 1:59pm revealed: -She did not notice Resident #4 had extra tablets of Metoprolol on the cart when she completed her cart audit on 01/19/22. -She did not know why there would be so many tablets available if the medication had been administered as ordered. Interview with the Administrator on 01/24/22 at 12:48pm revealed: -She was not aware Resident #4 had more Metoprolol Tartrate available than there would be	(D 358)		

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(D 358}	Continued From page 100 had the medication been administered as ordered. -She expected Resident #4's Metoprolol Tartrate to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. f. Review of Resident #4's physician's orders dated 07/22/21 revealed an order for Donepezil 10mg once daily. (Donepezil is used to treat	(D 358}		

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NAME OF PROVIDER OR SUPPLIER

ALAMANCE HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

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{D 358}	Continued From page 101 Alzheimer's). Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Donepezil 10mg daily with scheduled administration time at 8:00pm. - Donepezil 10mg was documented as administered from 11/01/21-11/30/21 at 8:00pm. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Donepezil 10mg daily with scheduled administration time at 8:00pm. -Donepezil 10mg was documented as administered from 12/01/21-12/31/21 at 8:00pm. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Donepezil 10mg daily from with scheduled administration time at 8:00pm. -Donepezil 10mg was documented as administered 01/01/22-01/15/22 at 8:00pm. -Donepezil 10mg was not documented as administered from on 01/16/22-01/17/22 with documentation as the pharmacy. -Donepezil 10mg was not documented as administered on 01/18/22 at 8:00pm with documentation reason as refused. Observation of Resident #4's medications on hand on 01/19/22 at 3:33pm revealed there was no Donepezil 10mg available to be administered. Telephone interview with a pharmacy technician at the pharmacy's contracted pharmacy on 01/21/22 at 1:30pm revealed: -Resident #4's medications were not cycle filled. -Resident #4's medications had to be requested	(D 358)		

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{D 358}	Continued From page 102 by the facility staff for a refill. -Thirty tablets of Donepezil 10mg were dispensed on 10/28/21, 11/22/21, and 01/19/22. Based on eMAR documentation, medications dispensed and medications on hand between October 2021 and January 2022 revealed there would have been no Donepezil 10mg available to be administered between 01/01/22-01/19/22 when the medication was reordered. Telephone interview with a pharmacist at the pharmacy's contracted pharmacy on 01/20/22 at 9:33am revealed: -Resident #4's Donepezil 10mg was prescribed to treat Alzheimer's. -If Resident #4's Donepezil was not administered as ordered she would be at risk of a progression of her dementia. Interview with Resident #4's primary care provider (PCP) on 01/20/22 at 11:01am revealed: -Resident #4 was prescribed Donepezil for Alzheimer's. -Resident #4 could have a decline in her memory if the medication was not administered as ordered. -She expected Resident #4's Donepezil to be administered as ordered. Interview with a second shift medication aide (MA) on 01/20/22 at 4:46pm revealed: -She administered Resident #4's Donepezil when she worked. -She did not recall if Resident #4's Donepezil ran out or not, "I am not sure." -She did not order Resident #4's Donepezil and she had not ordered any medications for the resident.	{D 358}			

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(D 358)	Continued From page 103 Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:18pm revealed: -She noted Resident #4's Donepezil was not on the cart during her audit on 01/19/22. -There was no documentation she had been notified Resident #4's Donepezil needed to be ordered prior to her cart audit. -She was concerned Resident #4's Donepezil needed to have been ordered and she was not notified. Interview with the Administrator on 01/24/22 at 12:48pm revealed she expected Resident #4's Donepezil to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director	(D 358)		

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{D 358}	Continued From page 104 on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. g. Review of Resident #4's physician's orders dated 07/22/21 revealed an order for a prenatal vitamin once daily. (Prenatal vitamins are a dietary supplement). Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Prenatal vitamin daily with scheduled administration time at 8:00am. -Prenatal vitamin was documented as administered from 11/01/21-11/30/21 at 8:00am. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for Prenatal vitamin daily with scheduled administration time at 8:00am. - Prenatal vitamin was documented as administered from 12/01/21-12/13/21 at 8:00am. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Prenatal vitamin daily with scheduled administration time at 8:00am. - Prenatal vitamin was documented as administered from 01/01/22-01/19/22 at 8:00am. Observation of Resident #4's medications on hand on 01/19/22 at 3:33pm revealed: -There was a bubble pack of 30 Prenatal vitamins dispensed on 12/02/21. -Twenty-two tablets had been administered; 8	{D 358}			

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{D 358}	Continued From page 105 tablets were available to be administered. Telephone interview with a pharmacy technician at the pharmacy's contracted pharmacy on 01/19/22 at 6:55pm revealed 30 tablets of Prenatal vitamins were dispensed on 10/08/21; 11/08/21, and 12/02/21. Based on eMAR documentation, medications dispensed and medications on hand between October 2021 and January 2022, there would have been no Prenatal vitamins available to be administered from 01/08/22-01/19/22; there were eight tablets remaining. Telephone interview with a pharmacist at the pharmacy's contracted pharmacy on 01/20/22 at 9:33am revealed: -Resident #4's Prenatal vitamin was prescribed most likely because of an iron deficiency. -If Resident #4's Prenatal vitamin was not administered correctly the resident's blood cells would go down and it would affect the residents' overall well-being. Interview with Resident #4's primary care provider (PCP) on 01/20/22 at 11:01am revealed: -Resident #4 was prescribed a Prenatal vitamin daily for an iron deficiency. -She expected Resident #4's Prenatal vitamin to be administered as ordered. Interview with a medication aide (MA) on 01/20/22 at 5:11pm revealed: -She administered Resident #4's Prenatal vitamin when she worked. -She did not know why there was more Prenatal vitamins on hand than there should be based on dispensing records.	{D 358}		

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(D 358)	Continued From page 106 Interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:18pm revealed: -She did not know why there were extra Prenatal vitamin tablets on hand. -She was concerned Resident #4 was not receiving her Prenatal vitamin as ordered. Interview with the Administrator on 01/24/22 at 12:48pm revealed: -She was not aware Resident #4 had excess Prenatal vitamins on hand based on dispensing records and documentation of medications administered. -She expected Resident #4's Prenatal vitamins to be administered as ordered. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with a medication aide (MA) on 01/20/22 at 12:10pm. Refer to interview with another MA on 01/20/22 at 12:18pm Refer to interview with a third MA on 01/20/22 at 4:05pm. Refer to telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/22 at 8:10am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 12:30pm. Refer to telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm. Refer to interview with the Area Clinical Director	(D 358)		

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{D 358}	Continued From page 107 on 01/24/22 at 10:08am. Refer to interview with the facility's Area Licensed Practical Nurse (LPN) on 01/24/22 at 10:48am. Refer to telephone interview with the Administrator on 01/21/22 at 4:15pm. Interview with a medication aide (MA) on 01/20/22 at 12:10pm revealed: -The MCC ordered all the medications. -The MCC checked all medications when they were delivered to ensure the medication that was ordered, was delivered. Interview with another MA on 01/20/22 at 12:18pm revealed: -She was used to being able to fax refills to the pharmacy and calling to confirm the refills request had been received, but the procedure was different at this facility. -If medications were getting low, she would pull the sticker from the prescription, place the sticker on the pharmacy refill form and give the refill form to the MCC or RCC or place the refill request form under the MCC/RCC door if after hours. Interview with a third medication aide on 01/20/22 at 4:05pm revealed: -When medication needed to be reordered, she pulled the sticker off the prescription and placed the sticker on the pharmacy refill request form. -The pharmacy refill request form was given to the RCC or MCC to send to the pharmacy. -The MAs could no longer request refills of medications due to changing over to e-faxing. -She usually re-ordered medication when there were "about 10-days left," so the resident did not run out of medication.	{D 358}		

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(D 358)	Continued From page 108 -Ten days would give the pharmacy time to deliver medication to the facility. -The MAs received the ordered medication on second and third shift. -The MAs would sign the kiosk that medication was delivered and received. -The medications were checked against the delivery sheet before the delivery person left the facility. -The MAs would place the received medications in the medication carts upon arrival. -Up until about two months ago, she would fax a refill request to the pharmacy, now the refill requests were placed under the MCC or RCC door and it was processed when they came in the next day. -There had been times when a resident did not have medications on hand to be administered, and she would let the manager know. -If she knew the medication had been ordered (the sticker was removed) she documented waiting on the pharmacy in the exception. -If she did not know if the medication had been reordered or not, she documented the medication as, not on the cart. -She had not completed a cart audit in "about four months." Telephone interview with the pharmacy technician from the contracted pharmacy on 01/20/21 at 8:10am revealed: -The facility re-ordered medications when needed. -They pulled the sticker off the medication label, placed it on a pharmacy form and faxed it to the pharmacy. -This was the way to order all medications that were not in a multi-dose pack. Those medications were on auto-fill every week. -New medication orders were entered by the	(D 358)		

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{D 358}	Continued From page 109 pharmacy and the facility receives a notification. -The facility staff could approve or disapprove the new order in order for it to populate. -The facility staff could make changes on the eMAR without notifying the pharmacy. Interview with the MCC on 01/20/22 at 12:29pm revealed: -Medications that were from the facility's contracted pharmacy, would be requested to be refilled by the MA placing the refill sticker on the pharmacy refill request form and giving the form to the MCC or RCC. -The MCC and RCC would e-fax the refill request form to the pharmacy. -She expected medications to be re-ordered when there was one week left of the medication. -The RCC and MCC were responsible for completing cart audits weekly. -She completed a cart audit on 01/18/22 and before that one, she had completed a cart audit at the end of December 2021-first week of January 2022. -She did not keep her cart audit check sheets for the December 2021/January 2022 cart audit. -The MA or MCC could order the medication if it was not on the medication cart. -The MAs should be checking the medications with the eMAR three times before administering the medication. -The MAs should re-order the medication within a week before on hand medication was completed. -The medications were received by the MA and placed on the medication cart. -She did not check to see if the medication that was ordered was delivered. -There was no check and balance system to ensure that medications ordered were delivered and were correct. -Medication cart audits should be done weekly.	{D 358}		

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{D 358}	Continued From page 110 -When she did cart audits she would check to see if medications were on the cart, if medications had expired, and checked the dosage and frequency of the medication. -The most recent medication cart audit was done on 01/18/22, on third shift. -She had not been able to do medication cart audits weekly due to having to work the floor as a MA. -She was aware that some medications were not on the medication cart. -She had not had a chance to re-order the medications because she had been working third shift. Telephone interview with the MCC on 01/21/22 at 2:09pm revealed: -She did not routinely audit the medication carts. -The MAs should be administering medications as ordered. -The MAs should document on the eMAR when the medication was administered. -If the medication was not available for administration, the MA should document an exception. -The MAs should report to the RCC/SCC if a medication was not in the facility. -Medications were re-ordered by the MAs by pulling the sticker and placing it on a re-order form. -She faxed the re-order forms to the facility's contracted pharmacy. -Medications were delivered to the facility on third shift. -The third shift MA would sign for the medications and put them away. -She was only responsible for ordering medications, not checking them in. Telephone interview with the RCC on 01/21/22 at	{D 358}		

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(D 358)	Continued From page 111 2:12pm revealed: -She had been working at the facility for about 15-days. -She or the MCC could re-order medications for the residents. -She had noted residents were running out of medications frequently. -Sometimes the pharmacy would say it was too early to re-order the medication. -She had not completed a cart audit since she started working at the facility. -She had to work as a MA at times because the facility was short-staffed. Interview with the Area Clinical Director on 01/24/22 at 10:08am revealed: -The medication carts should be audited at least once a week and as needed. -He did not remember the last time he audited the medication cart. -The LPN audited the medication carts in October 2021. -The RCC/SCC were responsible for e-faxing orders of medications to the pharmacy and checking medications when they were delivered to the facility for accuracy. -He had never been notified that medications were not on the medication carts. Interview with the facility's Area LPN on 01/24/22 at 10:48am revealed: -She covered multiple facilities. -She had not audited the medication carts since October 2021. -She thought the RCC and MCC were completing cart audits. -She thought the cart audits should be completed at least weekly. -Cart audits should include looking for medications that were getting low and needed to	(D 358)		

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(D 358)	Continued From page 112 be reordered and medications not on the cart. -If medications were not on the cart, the RCC/MCC/MAs would need to order and/or follow up with the pharmacy to see why the medication had not been sent to the facility. -If a medication was out, she would expect the medication to be back in the facility and available to be administered within 24-hours. -Residents should not be going 3-4 days without medication. Telephone interview with the Administrator on 01/21/22 at 4:15pm revealed: -She expected medication to be in the facility and available to be administered. -If a resident missed one day of their medication, that was a medication error. -The RCC and MCC were responsible for ordering medications. -She had expected medications to be ordered before the medication ran out. The facility failed to ensure medications were administered as ordered for 5 residents including a resident who did not receive their insulin as ordered (#5) resulting in insulin injections not being administered due to medication not available and the resident presenting with visual disturbances; and a resident (#6) who did not receive the correct amount of sliding scale insulin which could result in hyperglycemia or hypoglycemia; a resident (#2) who did not receive her gastric reflux medication as ordered which could result in increased discomfort leading to esophageal and stomach problems, a medication used to treat elevated cholesterol levels which could result in cardiac issues, a medication to treat thyroid disease which could result in low thyroid levels and two medications used to help prevent heart disease, which could result in	(D 358)		

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{D 358}	Continued From page 113 increased risk of heart disease; a resident (#3) a medication used to treat asthma which could result in increased shortness of breath or difficulty breathing, a medication to help manage tremors which could result in an increase in tremors, a blood thinner which could result in a stroke or cardiac issues, and a medication to treat blood pressure which could result in elevated blood pressure readings and increase the risk of stroke; a resident (#4) who did not receive her blood thinner as ordered which could result in a stroke and cardiac issues, a medication used to treat high blood pressure which could result in elevated blood pressure readings and an increased risk of a stroke, and multiple medications used to treat anxiety and behavioral issues which were not be stopped abruptly, which could result in increased behaviors and anxiety; and a resident (#5) who did not receive her blood pressure medication as ordered which could result in blood pressure readings and an increased risk of a stroke. This failure was detrimental to the health, safety and welfare of the resident which constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/21/22 for this violation.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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	D 367	10A NCAC 13F .1004(j) Medication Administration Community will ensure Medication Administration records (EMARs) are accurate and include all required information	3/10/2022

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D 367	Continued From page 114 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, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 4 of 4 sampled residents (#2, #3, #4, #5) including inaccurate documentation of a vitamin, a medication to manage tremors (#2); a B-12 vitamin (#3); a medication used to treat high blood pressure (#4); an ointment and a medication used to treat high blood pressure (#5). The findings are: 1. Review of Resident #2's current FL2 dated 07/08/21 revealed diagnoses included bipolar disorder, gastroesophageal reflux disease, dysphagia, slow transient constipation, dermatitis, asthma, candida's of skin and nail, mixed hyperlipidemia, and respiratory disorder. a. Review of Resident #2's signed physician's orders dated 07/08/21 revealed: -There was an order for a multivitamin (used as a supplement) daily.	D 367	Continued from page 114 Community has hired an Area Clinical Director (ACD) who is an Registered Nurse to provide morer fequent oversight and training. ACD will make on-site visits to community no less than twice weekly for six weeks, then no less than weekly there after. The CCs have completed cart audits against electronic medication records for all current residents including both a review of the accuracy of the EMAR and an audit of the EMAR against the medication cart. Community CCs will conduct Medicaiton Cart audits no less than weekly, to include review of accuracy of EMARs. CCs will conduct weekly medication cart audits to ensure all medications are available and EMARs are accurate. ED and CCs will review Medication Administration utilizing Matrix Care Reporting and weekly Medication Cart audits during Stand-Up meetings Community ACD, RN has conducted and will continue to conduct Medication Pass Observations for medication staff. Medication Pass Observations will be conducted no less than once monthly with different medication staff members. ACD will monitor for EMAR accuracy during Medication Pass Observation. RDO, DCD and/or DVPO will randomly pull Medication Administration reporting from Matrix Care system to monitor compliance with Medication Administration and review or EMARs accuracy. Community RCC and MCC have been trained on utilizing/processing of orders, as well as use of the "Order Processing System" to include reviewing for accuracy of EMARs Training conducted by RN	3/7/2022 3/10/2022 3/10/2022 3/10/2022 3/10/2022 3/10/2022 3/10/2022 3/10/2022 1/31/2022	

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D 367	Continued From page 115 -There was an order for a daily-vite (used as a supplement) daily. Review of Resident #2's November 2021 and December 2021 electronic medication administration record (eMAR) revealed daily-vite and multivitamin were both documented as being given the entire month. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for a multivitamin with a scheduled administration time of 8:00am. -The multivitamin was documented as administered 01/01/22-01/19/22 at 8:00am. -There were no exceptions documented from 01/01/22-01/19/22. -There was an entry for a daily-vite with a scheduled administration time of 8:00am. -The daily-vite was documented as administered 01/01/22-01/19/22 at 8:00am. Observation of Resident #2's medications on hand on 01/19/22 at 8:45am revealed: -There was a multi-dose pack that contained one daily-vite. -There were no additional multivitamins on the medication cart for administration. Telephone interview with the pharmacy technician on 01/20/21 at 8:10am revealed: -The pharmacy had an order for a daily-vite daily. -The pharmacy did not have a duplicate entry for a multivitamin. -The pharmacy had discontinued the multivitamin entry because it was a duplicate. -The facility would get a notification from the pharmacy through the computer when they discontinued a medication. -This notification would alert the staff that the	D 367	Continued from page 115 Community RCC and MCC have received training on the following: - Proper clean, clearing and auditing of Glucometers -Pulling FSBS, Progress Notes and Matrix documentation -Daily Care Coordinator Checklist -Order Processing System Training conducted by RN All Medication Staff have completed retraining with 5/10 or 15 hour State Medication Training Training conduct by RN The ACD has in-serviced all Medication Staff on Medication Administration, which included but was not limited to the six rights of medication administration, reviewing EMAR for accuracy and documentation Training conducted by RN The ACD has in-serviced all Medication Staff on Infection Control Training conducted by RN	1/31/2022	
				3/10/2022	
				1/26/2022	
				1/31/2022	

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D 367	Continued From page 116 medication had been discontinued and they would need to do the same on their system since they did not link. Interview with a medication aide (MA) on 01/19/22 at 8:30am revealed: -She knew there was an entry for daily-vites and multivitamins. -She had notified the Memory Care Coordinator (MCC) that there were two entries for the vitamin. -She was instructed to document medication was given in both entries. Interview with a MA on 01/24/22 at 7:56am revealed: -He had noticed that there were two entries for administration of the multivitamin. -He would initial one entry as administered and the other entry an exception; the exception documented would be duplicate order. -He informed the SCC a few days ago about the duplicate entry. Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm revealed: -She was told a few days ago the Resident #2 had two vitamin entries on her eMAR. -The MAs should have documented medication administered on one entry and duplicate on the other until the duplicate entry was removed from the eMAR. -She did not know why there was a duplicate order for the multivitamin on the eMAR. -The pharmacy would have to discontinue the duplicate order and send the facility a notification to discontinue the duplicate order on our end. Attempted interview with the Primary Care Provider (PCP) on 01/24/22 at 8:45am was	D 367			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

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D 367	Continued From page 117 unsuccessful. Refer to interview with Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm. Refer to interview with Administrator on 01/24/22 at 1:20pm. b. Review of Resident #2's signed physician's orders dated 10/23/21 revealed there was an order for Ingrezza (used to treat tremors) 40mg daily. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Ingrezza 40mg with a scheduled administration time of 8:00am. -Ingrezza was documented as administered from 11/01/21-11/05/21 and 11/12/21 - 11/19/21 at 8:00am. Observation of Resident #2's medications on hand on 01/19/22 at 8:45am revealed there was no Ingrezza available for administration. Telephone interview with the PCP on 01/19/21 at 4:10pm revealed: -She had ordered the Ingrezza to assist Resident #2 with tremors. -Resident #2's insurance would not pay for Ingrezza, so it was discontinued. Telephone interview with the pharmacy technician on 01/21/22 at 11:06am revealed: -They received an order for Ingrezza 40mg daily dated 10/23/21. -Resident #2's insurance would not pay for Ingrezza. -The Primary Care Provider (PCP) was notified	D 367		

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D 367	Continued From page 118 and the medication was discontinued. -Ingrezza was never dispensed from the pharmacy. Interview with the MA on 01/20/22 at 4:05pm revealed: -She thought she had prepped the medication for administration. -When she clicked on complete her initials were automatically entered. Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm revealed: -She was aware that the insurance would not pay for Resident #2's Ingrezza. -She did not know there was an entry on the eMAR until a MA told her. -She should have been notified immediately when there was no medication available to administer. Attempted interview with the Primary Care Provider on 01/24/22 at 8:45am was unsuccessful. Refer to interview with Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm. Refer to interview with Administrator on 01/24/22 at 1:20pm. 2. Review of Resident #3's current FL2 dated 07/27/21 revealed diagnoses included dementia schizophrenia, cellulitis left toe, acute renal failure, chest pain, cerebral infarction, chronic obstructive pulmonary disease, and diabetes. Review of Resident #3's physician's orders dated 08/04/21 revealed an order for vitamin B-12 (used as a supplement) 1000mcg daily.	D 367			

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D 367	Continued From page 119 Review of Resident #3's physician's orders dated 10/06/21 revealed an order to discontinue vitamin B-12 1000mcg daily. Review of Resident #2's November 2021 and December 2021 electronic medication administration record (eMAR) revealed vitamin B-12 1000mcg was documented as being given the entire month. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for vitamin B-12 1000mcg daily with a scheduled administration time of 8:00am. - There was documentation vitamin B-12 1000mcg was administered daily from 01/01/22 - 01/20/22. Observation of Resident #3's medications on hand on 01/19/22 at 4:40pm revealed there were no vitamin B-12 1000mcg available for administration. Interview with the Pharmacist at the facility's second contracted pharmacy on 01/20/22 at 9:03am revealed: -The pharmacy dispensed 30 vitamin B-12 1000mcg on 09/24/21. -The pharmacy had an order dated 10/06/21 to discontinue vitamin B-12. Interview with a medication aide on 01/20/22 at 12:10pm revealed: -She did document on Resident #3's eMAR that she had been administering Vitamin B-12. -She may have "prepped" the medication by accident, and then when she entered complete, it would initial as if she administered.	D 367		

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D 367	Continued From page 120 -She made a mistake and needed to be careful. Interview with nurse at Resident #3's Primary Care Provider's (PCP) office on 01/24/22 at 2:10pm revealed vitamin B-12 was discontinued on 10/06/21. Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm revealed: -She did not know vitamin B-12 was still entered on the eMAR. -She knew the PCP had written an order to discontinue. Refer to interview with Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm. Refer to interview with Administrator on 01/24/22 at 1:20pm. 3. Review of Resident #5's current FL2 dated 07/12/21 revealed diagnoses included type II diabetes with hyperglycemia, anemia in chronic kidney disease, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. a. Review of Resident #5's signed physician's orders dated 11/24/21 revealed there was an order for mupirocin 2% apply topically to abdominal wound twice a day for 10 days. Review of Resident #5's November 2021 electronic medication administration record (eMAR) revealed: -There was an electronic entry on 11/24/21 for mupirocin ointment 2% apply topically to abdominal wound twice a day for 10 days with a scheduled administration time of 8:00am and	D 367			

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D 367	Continued From page 121 8:00pm. -The mupirocin ointment was documented as administered 11/26/21-11/30/21 at 8:00am and 8:00pm. -There were no exceptions documented from 11/26/21-11/30/21. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for mupirocin ointment 2% apply topically to abdominal wound twice a day for 10 days with a scheduled administration time of 8:00am and 8:00pm. -The mupirocin ointment was documented as administered 12/01/21-12/31/21 at 8:00am and 8:00pm. -There were no exceptions documented from 12/01/21-12/31/21. Review of Resident #5's January 2022 eMAR revealed: -There was an entry for mupirocin ointment 2% apply topically to abdominal wound twice a day for 10 days with a scheduled administration time of 8:00am and 8:00pm. -The mupirocin ointment was documented as administered 01/01/22-01/04/22 at 8:00am and 8:00pm. -There were exceptions documented from 01/01/22-01/03/22; the exceptions documented was the pharmacy. Observation of Resident #5's medications on hand on 01/20/22 at 2:36pm revealed there was no mupirocin ointment on the medication cart for administration. Telephone Interview with the pharmacy technician on 01/21/22 at 11:06am revealed the pharmacy had an order for mupirocin ointment to be	D 367		

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D 367	Continued From page 122 administered for 10 days. Interview with a medication aide on 01/20/22 at 4:05pm revealed: -She had administered mupirocin ointment longer than 10 days. -There was no stop date on the eMAR and she did not notice the medication was ordered for only 10 days. -She needed to be careful and read the order completely. Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm revealed: -She was not aware that mupirocin ointment was ordered for 10 days. -She thought the pharmacy would have entered a stop date. -She discontinued mupirocin ointment on the eMAR when she was told by a MA that it was still there after only being ordered for 10 days. Interview with the Administrator on 01/24/22 at 11:51am revealed she was concerned medication was documented as administered when the medication was only ordered for 10 days. Attempted interview with the Primary Care Provider on 01/24/22 at 8:45am was unsuccessful. Refer to interview with Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm. Refer to interview with Administrator on 01/24/22 at 1:20pm. b. Review of Resident #5's signed physician's orders dated 07/12/21 revealed there was an	D 367			

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D 367	Continued From page 123 order for metoprolol (used to treat elevated blood pressure) 25mg daily. Review of Resident #5's signed physician's orders dated 12/22/21 revealed there was an order for metoprolol increase to 50mg daily. Review of Resident #5's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol 25mg daily with a scheduled administration time of 8:00am. -The metoprolol was documented as administered 11/01/21-11/30/21 at 8:00am. -There were no exceptions documented from 11/01/21-11/30/21. Review of Resident #5's December 2021 eMAR revealed: -There was an entry for metoprolol 25mg daily with a scheduled administration time of 8:00am. -The metoprolol 25mg was documented as administered 12/01/21-12/31/21 at 8:00am. -There was an electronic entry on 12/30/21 to discontinue metoprolol 25mg. -There were exceptions documented from 12/25/21-12/27/21 and 12/29/21-12/30/21; the exceptions documented were medication discontinued and need clarification. -There was an electronic entry for metoprolol 50mg daily entered on 12/22/21 with a scheduled administration time of 8:00am. -The metoprolol 50mg was documented as administered 12/23/21-12/31/21 at 8:00am. -There was an exception documented on 12/29/21; the exception documented was need clarification. Review of Resident #5's January 2022 eMAR revealed:	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27216		
(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 367	Continued From page 124 -There was an entry for metoprolol 25mg daily with a scheduled administration time of 8:00am. -The metoprolol was documented as administered 01/01/22-01/20/22 at 8:00am. -There were no exceptions documented from 01/01/22-01/20/22. Observation of Resident #5's medications on hand on 01/22/22 at 2:36pm revealed: -There was a blister pack with 3 of 8 metoprolol 50mg tablets dispensed on 12/22/21. -There was a multi-dose pack that contained metoprolol 50mg tablets to be administered each morning at 8:00pm. Telephone interview with the pharmacy technician on 01/21/22 at 11:06am revealed: -The pharmacy had an order dated 12/22/21 for metoprolol to be increase to 50mg daily. -The pharmacy would enter the change in their system, but the facility would have to enter the discontinued order for metoprolol 25mg in their system. Interview with the medication aide (MA) on 01/20/21 at 4:06pm revealed: -She had prepped the medication for administration. -She must have prepped both the 25mg and the 50mg of metoprolol. -When she clicked on complete her initials were automatically entered into both entries. -She needed to be careful when comparing medications to the eMAR. Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm revealed: -She was not aware that metoprolol 25 mg was not discontinued on the eMAR when the 50mg	D 367		3/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2768 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 367	Continued From page 125 was added. -She thought the pharmacy would have discontinued metoprolol 25mg from the eMAR. -She discontinued metoprolol 25mg when she was notified by a MA that there was a 25mg and a 50mg entry for metoprolol. Attempted interview with the Primary Care Provider on 01/24/22 at 8:45am was unsuccessful. Refer to interview with Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm. Refer to interview with Administrator on 01/24/22 at 1:20pm. 4. Review of Resident #4's current FL-2 dated 07/22/21 revealed diagnoses included vascular dementia with behavioral disturbances, bipolar disorder, severe protein caloric malnutrition, and essential hypertension. Review of Resident #4's physician's orders dated 07/22/21 revealed an order for Lisinopril 10mg daily. (Lisinopril is used to treat high blood pressure). Review of Resident #4's electronic Medication Administration Record (eMAR) November 2021 revealed: -There was an entry for Lisinopril 10mg with a scheduled administration time of 9:00am. -Lisinopril 10mg was documented as administered 11/01/21-11/09/21 at 9:00am. Observation of Resident #4's medications on hand on 01/19/22 at 3:33pm revealed there was no Lisinopril available to be administered.	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

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D 367	Continued From page 126 Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/19/22 at 6:55pm revealed: -Lisinopril 10mg had been discontinued on 05/21/21. -They did not receive Resident #4's FL-2 dated 07/22/21. -They did not use FL-2's as orders except for new admissions or readmissions. -There had been no Lisinopril 10mg dispensed for Resident #4 since prior to the medication being discontinued. Interview with a medication aide (MA) on 01/20/22 at 4:38pm revealed: -She popped all of Resident #4's medication based on the MAR and medications on hand, administered the medication, and then entered as administered all. -She may have "prepped" the medication by accident, and then when she entered all it would initial as if she administered. -It was an error in documentation. Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 2:09pm revealed: -She did not know Resident #4's Lisinopril had been documented when the medication had been discontinued. -Lisinopril should not have been an active order in the eMAR system. Interview with the Administrator on 01/24/22 at 11:51am revealed: -She was concerned medication was documented as administered when the medication had been discontinued and was not available to be administered.	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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D 367	Continued From page 127 Refer to interview with Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm. Refer to interview with Administrator on 01/24/22 at 1:20pm. Interview with the medication aide (MA) on 01/20/21 at 2:50pm revealed: -She did not do MAR audits. -She did not think anyone audited the MARs. -She thought the pharmacy discontinued orders from the eMARs. -She did not audit the eMAR when she audited the medication carts. Interview with the Administrator on 01/24/22 at 1:20pm revealed: -MAs should document accurately on the eMAR. -The MAs should notify their supervisor when there was a discrepancy. -Falsifying records was not acceptable.	D 367		
{D 375}	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	{D 375}	10A NCAC 13F .1005(a) Self-Administration of Medications Community will ensure that residents with self administration orders have a self administration order perscribed by physician, have received instruct, and have a documented "Self Administration Accessment" completed. Community has implemented an order processing system to review and assure all medications are administered as ordered, to include any Self Administration orders	3/10/2022 3/10/2022

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
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(D 375)	Continued From page 128 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 4 of 6 residents sampled (#2, #5, #6, #7) had a physician's order to self-administer a medication mouthwash (#2); an inhaler (#5); a pain reliever (#6) and an anti-acid (#7). The findings are: Review of the facility's self-management of medications policy revealed: -Any resident who desired to self-manage their medication must complete the self-administration assessment. -The Resident Care Coordinator (RCC) was responsible for completing the self-administration assessment. -The RCC would obtain a physician's order for a resident to self-administer the medication once the self-administration assessment was successfully completed by the resident. 1. Review of Resident #7's current FL-2 dated 06/03/21 revealed diagnoses included major depressive disorder, diabetes, hypertension, spinal stenosis, chronic kidney disease, and anemia. Observation of the top drawer of Resident #7's dresser on 01/20/22 at 1:50pm revealed: -A bottle of Ibuprofen (used to treat fever and mild to severe pain); there were 3 of 30 tablets in the bottle. -A box of Cetirizine 10mg tablets (used to treat allergy symptoms, hives, and itching); there were	(D 375)	Continued from page 128 Community ED, RCC, and MCC have conducted resident room visits to check for self administered and unprescribed medications that were unsecure Community has hired an Area Clinical Director (ACD) who is an Registered Nurse to provide more frequent oversight and training. ACD will make on-site visits to community no less than twice weekly for six weeks, then no less than weekly there after. ACD will completed "Self Administration Assessments" for any residents with self administration orders. Community ED and/or Designee will visit residents rooms no less than weekly to ensure no unprescribed medications are located in residents room without physicians orders. ACD, RCC and/or MCC will complete "Self Administration Assessments" for any resident who is prescribed to self administrator medications no less than quarterly. Community ACD, RDO and/or DCD will make resident room visits with residents who are prescribed self administration orders during on site visits. ACD, RCC and MCC received training on completing "Self Administration Assessments". Training conduct by RN	3/10/2022 3/7/2022 3/10/2022 3/10/2022 3/10/2022 3/10/2022 1/25/2022

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

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(D 375)	Continued From page 129 7 of 14 tablets in the package. -There was a bottle of Loratadine 10mg tablets (used to treat allergy symptoms, hives, and itching); the bottle contained 150 tablets and was over one-half full. -There was a plastic bag that contained a bottle of Nystop powder dispensed on 11/13/21 with directions to apply twice daily for 14-days. -There were two tubes of Diclofenac sodium topical gel (used to relieve pain, swelling, inflammation, and joint stiffness). -There was one tube of Biofreeze pain relief (cream used to treat sore muscles, backaches, sore joints, and arthritis). Interview with Resident #7 on 01/20/22 at 1:50pm revealed: -She did not recall when she used the allergy tablets or why she had them in her room. -She did not take Ibuprofen on a regular basis, "now and then" when the medication aide (MA) did not bring her Tylenol. -She had her own tubes of diclofenac sodium and Biofreeze because the MA never gave her enough to use. -She did not use her own tubes of diclofenac sodium and Biofreeze every day and did not recall when she last used her own tubes, just when she was achy. -She did not know she had to have an order from her primary care provider (PCP) to have medication in her room for self-administration. Review of Resident #7's physician's orders dated 06/03/21 revealed: -There was an order for Biofreeze to be applied topically twice a day as needed; there was no order to self-administer. -There was an order for diclofenac sodium to apply 2 grams to the lower back twice daily; there	(D 375)		

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{D 375}	Continued From page 130 was no order to self-administer. Review of a physician's order dated 11/11/21 revealed an order for Nystop powder to be applied twice daily for 14-days. Review of Resident #7's physician's order on 01/20/22 at 10:00am revealed: -There was no order for Ibuprofen. -There was no order for Cetirizine. -There was no order for Loratadine. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/20/22 at 9:45am revealed: -Resident #7 did not have an order for Ibuprofen or Cetirizine/Loratadine. -Resident #7 had orders for Nystop, diclofenac sodium, and Blofreeze. -Resident #7 did not have any self-administration orders on file. -The concern with Resident #7 having medications to self-administer without monitoring was taking ibuprofen could cause stomach issues such as ulcers, as well as contribute to kidney disease. -Diclofenac Sodium should be monitored because if it was not used as ordered the resident could have increased pain, but if too much was used, for a long period of time it could increase the risk of strokes and heart attacks. -Taking too much Cetirizine/Loratadine could cause dizziness, which would increase risk of falls. -It was important to follow recommended dosing, which needed to be monitored. Interview with Resident #7's PCP on 01/20/22 at 11:15am revealed: -Resident #7 should not have Ibuprofen in her	{D 375}		

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(D 375)	Continued From page 131 room as it could affect the resident's kidney functions if the amount administered was not monitored. -She would not want Resident #7 to be administered ibuprofen. -Resident #7 would be able to manage her own Biofreeze and she thought she had written a self-administration order. -Diclofenac Sodium can affect kidney function as well. -She did not know Resident #7 had allergy tablets in her room. -She preferred all medications be administered by the MAs but would be okay with Resident #7 administering the medications she had orders for. Interview with a personal care aide (PCA) on 01/20/22 at 2:02pm revealed: -She knew Resident #7 had creams in her room. -She had not told the MA Resident #7 had creams in her room. Interview with a medication aide (MA) on 01/20/22 at 4:14pm revealed: -She did not know Resident #7 had medication in her room. -Resident #7's family took her out and the resident would be able to purchase things that the staff would not necessarily know about. Telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm revealed: -She did not know Resident #7 had medications in her room. -She did not know if Resident #7 had any orders to self-administer medications. Interview with the Administrator on 01/24/22 at 11:51am revealed she did not know Resident #7	(D 375)			

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STATE FORM

6099

BSJL12

If continuation sheet 132 of 168

Division of Health Service Regulation		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2022	
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{D 375}	Continued From page 132 had medications in her room to self-administer. Refer to the telephone interview with the RCC on 01/21/22 at 12:42pm. Refer to interview with the LPN on 01/24/22 at 10:40am. Refer to the interview with the Administrator on 01/24/22 at 11:51am. 2. Review of Resident #6's current FL-2 dated 10/15/21 revealed diagnoses included rheumatoid arthritis and right below-knee amputation. Interview with Resident #6 on 01/20/22 at 2:00pm revealed: -He purchased his own bottle of acetaminophen because he had asked a medication aide (MA) for the medication "about 1-2 months ago" and was told they did not have any to give him -No one told him he could not have the medication in his room. -He had not asked anyone if he could have the medication in his room. -He did not recall when he last used the medication. Observation of Resident #6's room on 01/19/22 at 9:20am revealed a bottle acetaminophen (used to treat mild pain and discomfort). Review of Resident #6's physician's orders on 01/20/22 revealed there was no order for acetaminophen. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/20/22 at 9:45am revealed:	{D 375}					

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{D 375}	Continued From page 133 -Resident #6 did not have an order to self-administer acetaminophen. -If acetaminophen was used, it could potentially mask other issues, such as fever, and would not know the resident had other underlying issues. -Long-term overuse of acetaminophen can cause liver damage. Interview with Resident #6's PCP on 01/20/22 at 11:15am revealed: -She did not know Resident #6 had acetaminophen that he was self-administering. -She would prefer acetaminophen for Resident #6 to be administered by the MAs. Interview with a personal care aide (PCA) on 01/20/22 at 2:02pm revealed she did not know Resident #6 had acetaminophen in his room. Interview with a medication aide (MA) on 01/20/22 at 4:14pm revealed she did not know Resident #6 had acetaminophen in his room. Telephone Interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm revealed: -She did not know Resident #6 had acetaminophen in his room. -She did not know if Resident #6 had an order to self-administer acetaminophen. Interview with the Administrator on 01/24/22 at 11:51am revealed she did not know Resident #6 had medication in his room to self-administer. Refer to the telephone interview with the RCC on 01/21/22 at 12:42pm. Refer to Interview with the LPN on 01/24/22 at 10:40am.	{D 375}		

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{D 375}	Continued From page 134 Refer to the interview with the Administrator on 01/24/22 at 11:51am. 3. Review of Resident #2's current FL2 dated 07/08/21 revealed diagnoses included bipolar disorder, gastroesophageal reflux disease, dysphagia, slow transient constipation, dermatitis, asthma, candida's of skin and nail, mixed hyperlipidemia, and respiratory disorder. Observation of Resident #2's room on 01/19/22 at 8:45am revealed a bottle of Biotene mouthwash (used to treat dry mouth) on a shelf in the bathroom. Interview with Resident #2 on 01/19/22 at 2:08pm revealed: -She kept Biotene mouthwash on the shelf in her bathroom. -She has had it in her room for several months. -She used Biotene as she needed for dry mouth. -She would hold the bottle of Biotene up to her mouth and squirt the mouthwash into her mouth. -She did not measure how much Biotene she was using. -She would use Biotene 2 to 4 times a day when her mouth was dry. -Some days she did not need to use Biotene. -She would rinse her mouth and then spit the mouthwash out. -She would tell the staff that she used the mouthwash if they asked. Review of Resident #2's physician's orders on 07/08/21 revealed: -There was an order for Biotene dry mouth oral rinse, swish and spit 5mls daily. -There was no self-administration order.	{D 375}		

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(D 375)	Continued From page 135 Interview with the Primary Care Provider (PCP) on 01/20/21 at 11:00am revealed: -Biotene mouthwash was used to treat dry mouth which was caused by medications. -Resident #2 should not have Biotene at her bedside. -Resident #2 would not know how to use the mouthwash correctly. -The PCP was concerned of correct usage of Biotene related to Resident #2's recent decline in her memory. Interview with the pharmacist at the facility's contracted pharmacy on 01/19/22 at 10:50am revealed: -The pharmacy had an order for Biotene swish and spit 5mls daily, do not swallow. -There was no order to keep at bedside and self administer. Interview with a medication aide (MA) on 01/19/22 at 8:45am revealed: -She knew Resident #2 had Biotene mouthwash in her room. -She would ask Resident #2 each morning if she had used the mouthwash and document accordingly. -She did not know that Resident #2 did not have a self-administration order for Biotene. Telephone Interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm revealed: -She did not know Resident #2 had Biotene in her room. -She did not know if Resident #2 had an order to self-administer Biotene. Interview with the Licensed Practical Nurse (LPN)	(D 375)		

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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 375}	Continued From page 136 on 01/24/22 at 10:40am revealed she did not know Resident #2 had medications in her room to self-administer. Interview with the Administrator on 01/24/22 at 11:51am revealed she did not know Resident #2 had medications in her room to self-administer Refer to the telephone interview with the RCC on 01/21/22 at 12:42pm. Refer to Interview with the LPN on 01/24/22 at 10:40am. Refer to the interview with the Administrator on 01/24/22 at 11:51am. 4. Review of Resident #5's current FL2 dated 07/12/21 revealed diagnoses included type II diabetes with hyperglycemia, anemia in chronic kidney disease, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. Observation of Resident #5's medication on hand on 01/20/22 at 2:33pm revealed: -There was an empty Combivent inhaler (used for wheezing and shortness of breath) box on hand. -There was no Combivent inhaler in the box or on the medication cart. Review of Resident #5's physician's orders on 07/12/21 revealed: -There was an order for Combivent inhaler, inhale 1 puff every 6 hours. -There was no self-administration order. Interview with Resident #5 on 01/20/22 at 4:15pm revealed: -She kept her Combivent inhaler for	{D 375}			

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{D 375}	Continued From page 137 self-administration. -She had used inhaler for years and was comfortable using them. -She would use the inhaler 6 to 7 times in a 24-hour period. -She inhaled one puff each time. -She did not tell the staff each time she used the inhaler. Interview with a medication aide (MA) on 01/24/22 at 7:56am revealed: -He knew Resident #5 had an inhaler in her room for self-administration. -He did not know Resident #5 did not have a self-administration order. Interview with the Primary Care Provider (PCP) on 01/20/21 at 11:00am revealed: -She thought Resident #5 had a self-administration order for the Combivent inhaler. -Resident #5 would be fine to have her inhaler in her room. -Resident #5 should be administering the Combivent inhaler as ordered if she wanted to keep it at her bedside. Interview with the pharmacy technician at the facility's contracted pharmacy on 01/21/22 at 11:06am revealed: -The pharmacy had an order for Combivent inhaler one puff every 6 hours. -There was no order to keep the Combivent inhaler at bedside and self-administer. Telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm revealed: -She did know Resident #5 had the Combivent inhaler in her room.	{D 375}		

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{D 375}	Continued From page 138 -She did not know if Resident #2 had an order to self-administer the Combivent Inhaler. Interview with the Licensed Practical Nurse (LPN) on 01/24/22 at 10:40am revealed she did not know Resident #5 had medications in her room to self-administer. Interview with the Administrator on 01/24/22 at 11:51am revealed she did not know Resident #5 had medications in her room to self-administer. Refer to the telephone interview with the RCC on 01/21/22 at 12:42pm. Refer to Interview with the LPN on 01/24/22 at 10:40am. Refer to the interview with the Administrator on 01/24/22 at 11:51am. Telephone Interview with the Resident Care Coordinator (RCC on 01/21/22 at 12:42pm revealed if medications were to be kept at the bedside, the resident must have an order. Interview with the Licensed Practical Nurse (LPN) on 01/24/22 at 10:40am revealed: -There was a policy for residents to keep medications at their bedside. -There was a long process the resident would have to go through and complete to ensure they were safe to self-administer medications. -The medication aids should make sure residents with medications in their rooms have self-administration orders. Interview with the Administrator on 01/24/22 at 11:51am revealed: -Residents had to have an order to	{D 375}		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27215

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{D 375}	Continued From page 139 self-administer any medication kept in their room. -She would like to make sure medications were being administered correctly, even if self-administered. -She expected staff to contact a resident's power of attorney and PCP to discuss self-administration orders and follow the recommendations provided by the PCP.	{D 375}		
{D 377}	10A NCAC 13F .1006(a) Medication Storage 10a NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that the residents' medications were stored in a safe and secure manner for 2 of 6 sampled residents (Resident #8, #9) who self-administered medications. The findings are: Review of the facility's medication storage policy for self-administered medications revealed all resident medications must be kept in a secure, locked area only accessible to the resident and the staff. 1. Review of Resident #9's current FL-2 dated 08/16/21 revealed diagnoses included	{D 377}	10A NCAC 13F .1006(a) Medication Storage Community will ensure that residents who have self administration orders will have a safe and secure place to store medications Community ACD, ED, RCC and MCC conducted resident room visits to ensure no unprescribed medications or prescribed self administration medications were in rooms unsecured. RCC and MCC contact physicians to clarify self administration orders for residents. Community ED has implemented/provided lockable, safe and secure spaces for all residents who have orders to self administer. ED, RCC, MCC and ACD recieved training on ensuring all residents who have self administer orders or medications at bedside must have a lockable space to store medications Commuinty ED and/or Designee will do resident room visits no less than weekly to ensure any self administer medications are in a safe and secured storage Community ACD, RDO and/or DCD will make resident room visits with residents who are prescribed self administration orders during on site visits.	3/10/2022 2/1/2022 3/10/2022 3/10/2022 1/31/2022 3/10/2022 3/10/2022

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(D 377)	Continued From page 140 hypertension and polyneuropathy. Review of Resident #9's physician's visit summary dated orders dated 09/16/21 revealed: -Resident #9 was seen for exacerbation of her chronic obstructive pulmonary disease (COPD). -There was an order for ipratropium albuterol solution every six hours as needed for shortness of breath or wheezing; may be kept at the bedside and self-administer. -There was an order for an albuterol inhaler; may be kept at the bedside and self-administer. Observation of Resident #9's room on 01/19/22 at 8:29am revealed: -There was a plastic bag with 10 vials of a nebulizer solution laying on the nightstand. -There was an albuterol inhaler laying on the nightstand. Interview with Resident #9 on 01/19/22 at 8:29am revealed: -Resident #9's Primary Care Provider (PCP) told her she could keep the medication in her room. -No one told her where the medication needed to be stored. Interview with a personal care aide (PCA) on 01/20/22 at 2:02pm revealed she had not seen medication in Resident #9's room. Interview with a medication aide (MA) on 01/20/22 at 4:14pm revealed she had not seen medication in Resident #9's room. Telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm revealed: -If Resident #9 had an order to self-medicate, the medication could be kept at the bedside, but the	(D 377)		

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(D 377)	Continued From page 141 medication should not be left out because another resident may try to take the medication. -She had not seen Resident #9's medication on her nightstand, "the medication should be in her drawer." Refer to the interview with a personal care aide (PCA) on 01/20/22 at 2:02pm. Refer to the interview with a medication aide (MA) on 01/20/22 at 4:14pm. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm. Refer to the interview with the Administrator on 01/24/22 at 11:51am. 2. Review of Resident #8's FL-2 dated 09/09/21 revealed: -Diagnoses included chronic obstructive pulmonary disease and anxiety disorder, -There was an order for Nystatin powder to be applied topically to the area under the abdomen three times daily as needed for stomach rash. Observation of Resident #8's room on 01/19/22 at 8:45am revealed: -There was a container of medicated body powder. -There was a name hand-written on the medicated body powder container that was not Resident #8's name. Interview with Resident #8 on 01/20/22 at 1:46pm revealed: -The staff had brought the container of medicated powder in her room when they ran out of her Nystatin. -She did not recall how long she had been without	(D 377)			

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{D 377}	Continued From page 142 the Nystatin powder. -She thought the staff accidentally left the medicated powder in her room. -Staff removed the medicated powder from her room "yesterday afternoon." Interview with a personal care aide (PCA) on 01/20/22 at 2:02pm revealed: -She had seen the medicated powder in Resident #8's room. -She thought it was okay for Resident #8 to have the powder in her room. Interview with a medication aide (MA) on 01/20/22 at 4:45pm revealed she had not seen the medicated powder in Resident #8's room. Telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm revealed she had not seen the medicated body powder in Resident #8's room. Refer to the interview with a personal care aide (PCA) on 01/20/22 at 2:02pm. Refer to the interview with a medication aide (MA) on 01/20/22 at 4:14pm. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm. Refer to the interview with the Administrator on 01/24/22 at 11:51am. Interview with a personal care aide (PCA) on 01/20/22 at 2:02pm revealed: -She had not been instructed on what to do if she saw medication in a resident's room. -She did not know where medications should be kept in a resident's room but "probably a drawer."	{D 377}		

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{D 377}	Continued From page 143 Interview with a medication aide (MA) on 01/20/22 at 4:14pm revealed: -Residents were not supposed to have medication in their rooms. -No one had told her where medication should be stored if a resident had an order to keep medication at their bedside. Telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 12:42pm revealed: -If a resident had an order to self-medicate, the medication could be kept at bedside, but the medication should not be left out because another resident may try to take the medication. -She expected the PCAs and MAs to look for medications in residents' rooms when they made rounds. -If staff saw medication in a resident's room, she expected to be notified so it could be verified there was an order and properly store the medication. Interview with the Administrator on 01/24/22 at 11:51am revealed: -Residents who had an order to self-medicate should be educated on the proper storage of medication kept in their room. -Medication with orders to be kept at the bedside should be out of sight. -If medications were not stored out of sight, other residents would have access to the medication.	{D 377}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	{D912}	G.S 131D-21(2) Declaration of Residents' Rights	

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{D912}	Continued From page 145 Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 4 of 4 sampled diabetic residents (#1, #3, #5, and #6) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. [Refer to Tag D932, G.S. 131D-4.4A(b) (1) Adult Care Home Infection Prevention Requirements (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure the Primary Care Provider (PCP) was notified for 2 of 5 sampled resident (#1, #5) of elevated finger stick blood sugars (FSBS) (#1, #5) and referral and follow appointments were scheduled for an endocrinologist appointment, an ophthalmologist appointment and a hematologist appointment (#5) in a timely manner. [Refer to Tag D273, 10A NCAC 13F .0902 Health Care (Type B Violation)].	{D912}	Continued from page 145 Community has completed audit of all diabetic supplies, including Glucometers. All Medication Staff have completed retraining with 5/10 or 15 hour State Medication Training and been revalidated. Training conduct by RN The ACD has in-serviced all Medication Staff on Medication Administration, which included but was not limited to the six rights of medication administration and documents The ACD has in-serviced all Medication Staff on Infection Control (Refer to Tag D273 and D932) Community Staff have been in-serviced on Resident Rights. Training conducted by RN Community ED has contacted Obudmans to request 1st available Resident Rights training	3/10/2022 3/10/2022 3/10/2022 3/10/2022 1/26/2022 3/2/2022
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable	D932	G.S. 131D-4.4A(b) ACH Infection Prevention Requirements Community has implemented a Daily Care Coordinator Checklist. Checklist includes but is not limited to reviewing of Fasting Blood Sugars logs and Glucometer checks vs EMARS. Community ED will review CC Daily Checklist no less than weekly. Community Area Clinical Director (ACD) will review CC Daily Checklist no less than twice monthly during on site visits. Community Regional Director of Operations(RDO) and /or Divisional Clinical Director, RN (DCD) will review CC Daily Check list no less than monthly during site visits	3/10/2022 3/10/2022 3/10/2022 3/10/2022

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D932	Continued From page 147 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 4 of 4 sampled diabetic residents (#1, #3, #5, and #6) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the Center for Disease Control and Prevention (CDC) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the facility's diabetic testing policy revealed: -Each individual resident will have their own glucometer and it will be labeled with their name.	D932		

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D932	Continued From page 148 -Individual glucometers are kept inside the zippered glucometer bag and the glucometer bag should be labeled with the resident's name. Observation of the facility's medication treatment cart on 01/20/22 at 3:36pm revealed there were multiple black zippered cases labeled with resident's names (Brand A). Observation of a glucometer provided by the medication aide (MA) on 01/24/22 at 9:24am revealed an unlabeled black glucometer (Brand B). Review of the manufacturer's manual for Brand A and Brand B glucometers revealed the glucometers were single-use and should not be used between multiple residents. 1. Review of Resident #5's current FL2 dated 07/12/21 revealed diagnosis included type II diabetes with hyperglycemia. Review of Resident #5's physician's orders dated 07/12/21 revealed an order for fingerstick blood sugar (FSBS) checks three times a day with meals. Review of Resident #5's Brand A glucometer's history on 01/20/22 at 3:34pm revealed: -The glucometer was in a black zippered bag labeled with Resident #5's name. -The glucometer was not labeled with Resident #5's name. -The current date on the glucometer was 01/20/22 at 3:42pm. -On 01/16/22 there was a reading of 112 at 11:23am. -On 01/17/22 there was a reading of 89 at 8:39am.	D932		

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D932	Continued From page 149 -On 01/19/22 there was a reading of 204 at 5:02pm -On 01/20/22 there was a reading of 135 at 7:43am. Review of Resident #5's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks three times a day with meals at 7:30am, 12:30am and 5:30pm. -On 01/17/22 there was an exception documented at 12:30pm; the exception was NA. -On 01/17/22 there was a documented reading of 209 at 5:30pm; this FSBS reading was not recorded in Resident #5's glucometer's history. -On 01/18/22 there was a documented reading of 106 at 7:30am; this FSBS reading was not recorded in Resident #5's glucometer's history. -On 01/18/22 there were exceptions documented at 12:30pm and 5:30pm; the exceptions documented were no test strips. -On 01/19/22 there were exceptions documented at 7:30am and 12:30pm; the exceptions documented were no test strips. -On 01/20/22 there was a documented FSBS reading of 135 at 7:30am; this FSBS reading was recorded in Resident #5's glucometer's history. Review of Resident #5's January 2022 eMAR and glucometer's history revealed: -On 01/18/22, there were three FSBS documented on the eMAR and only one of the three FSBS were in the glucometer's history. -On 01/18/21, there were three FSBS documented on the eMAR and there were no FSBS readings in the glucometer's history. -On 01/19/21, there were three FSBS documented on the eMAR and only one of the three FSBS were in the glucometer's history.	D932		

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STATE FORM

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BSJL12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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
D932	Continued From page 150 Review of the house, Brand B glucometer's history on 01/24/22 at 9:30am revealed: -On 01/17/22 there was a FSBS reading of 209 at 4:27pm that corresponded with Resident #5's FSBS reading recorded on eMAR on 01/17/22 at 5:30pm. -On 01/18/22 there was a FSBS reading of 106 at 7:52am that corresponded with Resident #5's FSBS reading recorded on eMAR on 01/18/22 at 7:30am. Interview with Resident #5 on 01/20/22 at 4:35pm revealed: -Her FSBS was checked three times a day with meals. -She recalled a few times when her FSBS was not checked. -The staff did not take her FSBS yesterday, 01/19/22, at breakfast. -She had run out of test strips needed to obtain the FSBS. Refer to confidential interview with staff. Refer to interview with a medication aide (MA) on 01/20/22 at 2:25pm. Refer to interview with a second MA on 01/20/22 at 4:05pm. Refer to interview with a third MA on 01/24/22 at 7:56am. Refer to interview with a fourth MA on 01/24/22 at 9:07am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm.	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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
D932	Continued From page 151 Refer to telephone interview with the MCC on 01/21/22 at 1:19pm. Refer to interview with the MCC on 01/24/22 at 2:25pm. Refer to telephone interview with the Resident Care Coordinator on 01/21/22 at 2:12pm. Refer to telephone interview with at staff from the medical supply company on 01/21/22 at 1:44pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 01/24/22 at 10:01am. Refer to interview with the Regional Area Director on 01/24/22 at 10:08am. Refer to interview with the Administrator on 01/24/22 at 11:51am. 2. Review of Resident #1's current FL2 dated 07/29/21 revealed diagnosis Included type 2 diabetes. Review of Resident #1's physician's orders dated 07/29/21 revealed an order for fingerstick blood sugar (FSBS) checks three times a day before meals. Review of Resident #1's Brand A glucometer's history on 01/20/22 at 3:46pm revealed: -The glucometer was in a black zippered bag labeled with Resident #1's name. -The glucometer was not labeled with Resident #1's name. -The current date on the glucometer was 04/14/21. The actual date was 01/20/22. -On 04/10/21, the actual date was 01/20/22, there	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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
D932	Continued From page 152 was a FSBS reading of 181 at 3:15pm. -On 04/10/21, the actual date was 01/20/22, there was a FSBS reading of 250 at 7:21pm. -On 04/10/21, the actual date was 01/20/22, there was a FSBS reading of 202 at 11:51am. -On 04/11/21, the actual date was 01/20/22, there was a FSBS reading of 200 at 3:32pm. -On 04/14/21, the actual date was 01/20/22, there was a FSBS reading of 291 at 12:22pm. -On 04/14/21, the actual date was 01/20/22, there was a FSBS reading of 135 at 7:14am. Review of Resident #1's January 2022 electronic medication administration record (eMAR) FSBS readings revealed: -There was an entry for FSBS three times a day before meals at 7:30am, 11:30am and 5:00pm. -On 01/17/22 there was a FSBS documented reading of 200 at 7:30am, this FSBS reading was recorded in Resident #1's glucometer's history. -On 01/17/22 there was a FSBS documented reading of 211 at 11:30pm, this FSBS reading was not recorded in Resident #1's glucometer's history. -On 01/17/22 there was a FSBS documented reading of 187 at 5:00pm, this FSBS reading was not recorded in Resident #1's glucometer's history. -On 01/18/22 there was a FSBS documented reading of 187 at 7:30am, this FSBS reading was not recorded in Resident #1's glucometer's history. -On 01/18/22 there was a FSBS documented reading of 199 at 11:30am, this FSBS reading was not recorded in Resident #1's glucometer's history. -On 01/18/22 there was a FSBS documented reading of 176 at 5:00pm, this FSBS reading was not recorded in Resident #1's glucometer's history.	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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
D932	Continued From page 153 -On 01/19/22 there was a FSBS documented reading of 177 at 7:30am, this FSBS reading was not recorded in Resident #1's glucometer's history. -On 01/19/22 there was a FSBS documented reading of 256 at 11:30am, this FSBS reading was not recorded in Resident #1's glucometer's history. Review of Resident #1's January 2022 eMAR and glucometer's history revealed: -On 01/17/22, there were three FSBS documented on the eMAR and one of the three were recorded in the glucometer's history. -On 01/18/22, there were three FSBS documented on the eMAR and there were no FSBS readings recorded in the glucometer's history. -On 01/19/22, there were three FSBS documented on the eMAR and one of the three were recorded in the glucometer's history. Review of the house, Brand B glucometer on 01/24/22 at 9:30am revealed: -On 01/17/22 there was a FSBS reading of 211 at 11:09am, corresponded with Resident #1's FSBS reading recorded on eMAR on 01/17/22 at 11:30pm. -On 01/17/22 there was a FSBS reading of 187 at 4:14pm, corresponded with Resident #1's FSBS reading recorded on eMAR on 01/17/22 at 5:00pm. -On 01/18/22 there was a FSBS reading of 187 at 7:46am, corresponded with Resident #1's FSBS reading recorded on eMAR on 01/17/22 at 7:30am. -On 01/18/22 there was a FSBS reading of 199 at 11:15am, corresponded with Resident #1's FSBS reading recorded on eMAR on 01/17/22 at 11:30am.	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
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D932	Continued From page 154 -On 01/18/22 there was a FSBS reading of 176 at 4:21pm, corresponded with Resident #1's FSBS reading recorded on eMAR on 01/17/22 at 5:00pm. -On 01/19/22 there was a FSBS reading of 177 at 8:52am, corresponded with Resident #1's FSBS reading recorded on eMAR on 01/17/22 at 7:30am. -On 01/19/22 there was a FSBS reading of 256 at 10:51am, corresponded with Resident #1's FSBS reading recorded on eMAR on 01/17/22 at 11:30am. Interview with Resident #1 on 01/20/22 at 12:35pm revealed that her FSBS was checked three times a day. Interview with a medication aide (MA) on 01/24/22 at 9:07am and 9:12am revealed: -She did not know why all of Resident #1's FSBS readings were not in her glucometer's history, Brand A. -Resident #1 was out of test strips a few days ago. -Resident #1 had a second glucometer, Brand B, that may have some of her FSBS readings. -Resident #1 had two glucometers because she recently received a new glucometer. Refer to confidential interview with staff. Refer to interview with a medication aide (MA) on 01/20/22 at 2:25pm. Refer to interview with a second MA on 01/20/22 at 4:05pm. Refer to interview with a third MA on 01/24/22 at 7:56am.	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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
D932	Continued From page 155 Refer to interview with a fourth MA on 01/24/22 at 9:07am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm. Refer to telephone interview with the MCC on 01/21/22 at 1:19pm. Refer to interview with the MCC on 01/24/22 at 2:25pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 2:12pm. Refer to telephone interview with at staff from the medical supply company on 01/21/22 at 1:44pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 01/24/22 at 10:01am. Refer to interview with the Regional Area Director on 01/24/22 at 10:08am. Refer to interview with the Administrator on 01/24/22 at 11:51am. 3. Review of Resident #3's current FL2 dated 07/27/21 revealed diagnosis included diabetes. Review of Resident #3's physician's orders dated 07/12/21 revealed an order for fingerstick blood sugar (FSBS) checks twice a day. Review of Resident #3's Brand A glucometer's history on 01/20/22 at 3:28pm revealed: -The glucometer was in a black zippered bag labeled with Resident #3's name. -The glucometer was not labeled with Resident	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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
D932	Continued From page 156 #3's name. -The current date on the glucometer was 04/14/21. The actual date was 01/20/22. -On 04/11/21, the actual date was 01/20/22, there was a FSBS reading of 96 at 12:42pm -On 04/11/21, the actual date was 01/20/22, there was a FSBS reading of 199 at 7:18pm. -On 04/12/21, the actual date was 01/20/22, there was a FSBS reading of 84 at 5:38pm. -On 04/15/21, the actual date was 01/20/22, there was a FSBS reading of 139 at 1:32pm. Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS twice a day at 8:00am and 8:00pm. -On 01/17/22 there was a documented FSBS reading of 140 at 8:00pm, this FSBS reading was not recorded in Resident #3's glucometer's history. -On 01/18/22 there was a documented FSBS reading of 90 at 8:00am, this FSBS reading was not recorded in Resident #3's glucometer's history. -On 01/18/22 there was an exception documented of no test strips. -On 01/19/22 there was an exception documented of no test strips. Review of Resident #3's January 2022 eMAR and glucometer's history revealed: -On 01/17/22, there were two FSBS documented on the eMAR and only one of the two FSBS were recorded in the glucometer's history. -On 01/18/21, there was one FSBS documented on the eMAR and there were no FSBS readings recorded in the glucometer's history. Review of the house, Brand B glucometer's	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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
D932	Continued From page 157 history on 01/24/22 at 9:30am revealed: -On 04/12/21 there was a FSBS reading of 140 at 8:16pm, corresponded with Resident #3's FSBS reading recorded on eMAR on 01/17/22 at at 8:00pm. -On 04/13/21 there was a FSBS reading of 90 at 6:44am, corresponded with Resident #3's FSBS reading recorded on eMAR on 01/17/22 at at 8:00am. Interview with Resident #3 on 01/20/22 at 2:20pm reveals: -His FSBS was checked twice a day. -He did not remember any days that his blood sugar was not checked. Interview with the MCC on 01/20/22 at 2:50pm revealed: -She could not place an order for Resident #3's test strips because he needed to see his PCP and have forms completed. -He had a scheduled appointment on 02/10/22 with his PCP. Refer to confidential interview with staff. Refer to interview with a medication aide (MA) on 01/20/22 at 2:25pm. Refer to Interview with a second MA on 01/20/22 at 4:05pm. Refer to interview with a third MA on 01/24/22 at 7:56am. Refer to interview with a fourth MA on 01/24/22 at 9:07am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm.	D932		

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215
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(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
D932	Continued From page 158 Refer to telephone interview with the MCC on 01/21/22 at 1:19pm. Refer to interview with the MCC on 01/24/22 at 2:25pm. Refer to telephone interview with the Resident Care Coordinator on 01/21/22 at 2:12pm. Refer to telephone interview with at staff from the medical supply company on 01/21/22 at 1:44pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 01/24/22 at 10:01am. Refer to interview with the Regional Area Director on 01/24/22 at 10:08am. Refer to interview with the Administrator on 01/24/22 at 11:51am. 4. Review of Resident #6's current FL-2 dated 10/15/21 revealed: -Diagnoses included rheumatoid arthritis, and right below knee amputation. -There was an order for Humalog U-100 insulin administer before meals and at bedtime based on a sliding scale with finger stick blood sugar (FSBS): 151-200=6 units, 201-250=10 units, 251-300=14 units, 301-350=18 units, and 350+-18 units. Review of Resident #6's Brand A glucometer on 01/20/22 at 3:50pm revealed: -The glucometer was in a black zippered bag labeled with Resident #6's name. -The glucometer was not labeled with Resident #6's name.	D932		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALAMANCE HOUSE

2766 GRAND OAKS BOULEVARD
BURLINGTON, NC 27216

(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
D932	Continued From page 159 -The date and time were displayed as 03/24 at 11:04pm. Review of Resident #6's January 2022 electronic medication administration record (eMAR) FSBS readings and glucometer history revealed: -There was a FSBS documented as 248 on 01/17/22 at 5:00pm; this reading was not recorded in Resident #6's glucometer history. -There was a FSBS documented as 96 on 01/17/22 at 7:00pm; this reading was not recorded in Resident #6's glucometer history. -On 01/17/22 there was an exception documented at 12:30pm; the exception was documented as pharmacy. -There was a FSBS documented as 98 on 01/18/22 at 7:00am; this reading was not recorded in Resident #6's glucometer history. -On 01/18/22 there were exceptions documented at 12:30pm and 5:30pm; the exceptions documented were no test strips. -On 01/19/22 there were exceptions documented at 7:30am and 12:30pm; the exceptions documented were "no test strips". Review of the house, Brand B glucometer on 01/24/22 at 9:30am revealed: -On 01/17/22 there was a FSBS reading of 248 at 4:41pm and a FSBS reading of 96 at 6:51pm that corresponded with Resident #6's FSBS readings recorded on the eMAR on 01/17/22. -On 01/18/22 there was a FSBS reading of 98 at 7:48am that corresponded with Resident #6's FSBS reading recorded on the eMAR on 01/18/22. Interview with Resident #6 on 01/20/22 at 3:58pm revealed: -His FSBS was ordered to be checked four times a day, before breakfast, lunch and dinner and	D932		

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215			
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D932	Continued From page 160 then before bedtime. -His glucometer was in a bag with his name on the bag. -He did not know if his glucometer was labeled with his name. -He had not had his FSBS checked on several occasions due to not having test strips available for his glucometer. -He was told on Monday, 01/17/22, that he did not have test strips available to check his FSBS. -He knew he missed several FSBS because he did not have test strips available, but he did not know if his glucometer was used when his FSBS was checked. -This was not the first time he had missed his FSBS because of not having test strips, it happened often, but he could not recall the last time it happened. Interview with a medication aide (MA) on 01/20/22 at 4:05pm revealed: -Resident #6 had his own glucometer. -Resident #6 had never run out of FSBS supplies. -She had never used a house glucometer to check Resident #6's FSBS. Telephone interview with another MA on 01/21/22 at 11:29am revealed: -She had used a house glucometer to check Resident #6's FSBS on 01/18/22 at 7:00am because the resident did not have strips for his glucometer. -She checked with other staff and there were no strips available for Brand A glucometers and was told to use the house glucometer. -She knew she was not supposed to use a glucometer on multiple residents. -She only used the house glucometer "that one time."	D932			

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
(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	
D932	Continued From page 161 Telephone interview with the Memory Care Coordinator (MCC) on 01/21/22 at 1:19pm revealed: -Resident #6's FSBS had only been checked with his glucometer. -She did not know how there were FSBS documented on Resident #6's eMAR that were not recorded in his glucometer history. Interview with the Regional Area Director on 01/24/22 at 10:08am revealed: -Each resident had their own glucometer. -He did not know if Resident #6's glucometer was labeled with his name. -If Resident #6's glucometer was not labeled with his name it could be potentially used on the wrong resident. -Using a glucometer on multiple residents would be an infection prevention problem. Observation of Resident #6's FSBS on 01/24/22 at 11:34am revealed: -The MA removed Resident #6's glucometer bag from the medication cart. -The MA removed a glucometer from the bag labeled for Resident #6, cleaned the glucometer prior to use, used an alcohol pad to wipe the resident's finger, checked the resident's FSBS and cleaned the glucometer with an alcohol pad after use. Interview with the MA on 01/24/22 at 11:40pm revealed: -He used the glucometer in the bag labeled for the resident. -He did not look to see if the glucometer in the bag was labeled to match the bag. Telephone interview with Resident #6's primary care provider (PCP) on 01/24/22 at 2:20pm	D932			

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215			
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D932	Continued From page 162 revealed: -She had not been notified Resident #6 did not have FSBS testing strips available to check his FSBS the week of 01/17/22. -Each resident should have their own glucometer. -She would not want glucometers shared between residents. Refer to confidential interview with staff. Refer to interview with a medication aide (MA) on 01/20/22 at 2:25pm. Refer to interview with a second MA on 01/20/22 at 4:05pm. Refer to interview with a third MA on 01/24/22 at 7:56am. Refer to interview with a fourth MA on 01/24/22 at 9:07am. Refer to interview with the Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm. Refer to telephone interview with the MCC on 01/21/22 at 1:19pm. Refer to interview with the MCC on 01/24/22 at 2:25pm. Refer to telephone interview with the Resident Care Coordinator on 01/21/22 at 2:12pm. Refer to telephone interview with at staff from the medical supply company on 01/21/22 at 1:44pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 01/24/22 at 10:01am.	D932			

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2786 GRAND OAKS BOULEVARD BURLINGTON, NC 27215		
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D932	Continued From page 163 Refer to interview with the Regional Area Director on 01/24/22 at 10:08am. Refer to interview with the Administrator on 01/24/22 at 11:51am. Confidential interview with staff: -When residents did not have diabetic testing strips available, the facility staff had been instructed to use the house glucometer. -They knew a glucometer should not be used on multiple residents. -The facility staff had used the house glucometer on multiple residents because they were instructed to do so. Interview with a medication aide (MA) on 01/20/22 at 2:25pm revealed there were always test strips for glucometers available to check residents' finger stick blood sugar (FSBS.) Interview with a second MA on 01/20/22 at 4:05pm revealed: -There were always test strips in the facility to check FSBS. -Each resident had their own glucometer. -The residents ran out of test strips at times. -She would borrow test strips from another resident if she had to. -She would not share glucometers between residents. -The facility did not have a house glucometer. -She had never used a house glucometer to check residents' FSBS. Interview with a third MA on 01/24/22 at 7:56am revealed: -All diabetic residents who received FSBS had a brand A glucometer.	D932		

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D932	Continued From page 164 -The MAs would borrow FSBS test strips from other residents. -There were times when there were no FSBS test strips in the facility. -The facility had been without FSBS test strips up to 4 days. -The RCC/MCC would order the test trips. -If the RCC/MCC could not get them, we would go to the Administrator. Interview with a fourth MA on 01/24/22 at 9:07am revealed: --The second glucometer, Brand B, was used to check FSBS of any resident who did not have test strips for their Brand A glucometer. -The resident's ran out of test strips when storms were coming, and the supplies could not be delivered. -She thought she was doing a good thing by checking the FSBS with the Brand B glucometer. -She told the Memory Care Coordinator (MCC) when residents were low our out of test strips. -Someone from management bought strips on 01/19/22 at a local pharmacy for the Brand A glucometer. -All resident who ordered FSBS received their test strips from the same supply company. Interview with the Memory Care Coordinator (MCC) on 01/20/22 at 2:50pm revealed: -There were 7 residents who received FSBS checks. -Each resident had their own glucometer, Brand A, and vial of strips. -She ordered all diabetic test strips from the same company. -The last order placed was a few days ago and was shipped on 01/19/22 but had not arrived. -Someone from management went to a local pharmacy yesterday and purchased 4 vials of test	D932		

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D932	Continued From page 165 strips. -She knew the facility was low on strips on Monday, 01/17/22. Telephone interview with the MCC on 01/21/22 at 1:19pm revealed: -The facility did not have a "house glucometer normally." -The facility had a couple of glucometers that were used as a back-up. -When she used the back-up glucometer, she cleaned it between uses. Interview with the MCC on 01/24/22 at 2:25pm revealed: -The facility had to purchase diabetic testing strips last week because they had run out. -She did not know if any residents went without FSBS checks, but the testing strips were purchased as soon as she was made aware on, 01/19/22. Telephone interview with at staff from the medical supply company on 01/21/22 at 1:44pm revealed: -The facility had to re-order all diabetic supplies when needed; it was not a reoccurring order. -The last order for diabetic supplies was sent on 12/09/21 for four residents. Telephone interview with the Resident Care Coordinator (RCC) on 01/21/22 at 2:12pm revealed: -There were residents who had ran out of their diabetic testing supplies. -She was not sure which specific residents because she was new and still learning the residents' names. -She brought testing strips for Brand A glucometer in from a sister facility within the last two weeks because there were no testing strips in	D932			

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D932	Continued From page 166 the building. -She had not seen the house glucometer but was told there was one. -She would never use a glucometer for multiple residents. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/24/22 at 10:01am revealed: -They did not provide glucometers or diabetic supplies for residents. -Each resident should have their own glucometer, for safety. -She would be concerned residents were exposed to blood borne pathogens if glucometers were shared. Interview with the Regional Area Director on 01/24/22 at 10:08am revealed: -He was at the facility once a week. -He taught the MAs how to do FSBS testing. -He expected the MAs to make sure the glucometer being used belonged to the resident being tested. -Each resident should have their own glucometer. -Glucometers should not be shared between residents. -Using a glucometer on multiple residents would be an infection prevention problem. -The house glucometer "went away after the last survey." -He was not aware a house glucometer was being used when residents did not have test strips for their glucometer. -A house glucometer should not be used because of potential cross-contamination. Interview with the Administrator on 01/24/22 at 11:51am revealed: -All diabetic residents had their own glucometer.	D932			

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D932	Continued From page 167 -Glucometers should not be shared between residents. -Every resident's glucometer and glucometer bag should be labeled for that resident. -There was not a house glucometer. -She was not aware there was a house glucometer being used on multiple residents. -If a resident was out of FSBS supplies, she expected supplies to be obtained immediately from a local pharmacy or a sister facility. -Glucometers could not be shared between residents because of blood borne pathogens and risk of cross-contamination. -She expected the MAs to only use the glucometer assigned to that resident. The facility failed to implement infection control procedures consistent with the Centers for Disease Control and Prevention (CDC) guidelines resulted in staff sharing glucometers for 4 of 4 sampled diabetic residents, placing residents at risk for bloodborne pathogen diseases. This failure was detrimental to the health, safety, and welfare of the residents, and constitutes an Unabated Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/24/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 10, 2022.	D932			

