

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 000                                                     | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on September 29, 2021 to October 4, 2021.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | D 000                                                                                              |                                                                                                                          |                                                        |
| D 273                                                     | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 1 of 5 sampled residents (#3) related to a resident who had a rash on multiple areas of her skin that was increasing in size and was a discomfort to the resident.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 07/29/21 revealed diagnoses included type 2 diabetes, hypertension, Chronic Obstructive Pulmonary Disease (COPD), bipolar disorder, dementia, and non-Hodgkin's lymphoma.<br><br>Observation of Resident #3 on 09/29/21 at 11:57am revealed:<br>-She had a large red raised and scaly patch of skin approximately 2 inches in diameter on the top of her ankle and on the back of her right leg.<br>-She had a raised red and raw area on her abdomen about the size of a quarter.<br>-She had two raised, red and raw area on her left arm about the size of a dime.<br><br>Observation of Resident #3 on 10/01/21 at | D 273                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

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| D 273                                                     | <p>Continued From page 1</p> <p>10:52am revealed:<br/>-The large raised, red and scaly patch on her right ankle was larger and was approximately three inches.<br/>-The raised, red and raw area on her abdomen was weeping and bleeding and had increased in size from a quarter to approximately two inches in diameter.<br/>-The raised, red and raw areas on her arm was bleeding and had increased in size from a dime to the size of a quarter.</p> <p>Interview with Resident #3 on 09/29/21 at 11:57am revealed:<br/>-She had several places on her that itched and were sore to the touch.<br/>-She had been itching for about six weeks.<br/>-The areas started off as bumps but had gotten larger over time.<br/>-She had a cream from the PCP that the MAs were supposed to apply twice daily.<br/>-Third shift applied the cream on the spots.<br/>-The cream did not give her relief and the spots were still spreading.<br/>-She thought she had an appointment scheduled with her PCP but was not sure of the date.<br/>-Her family took her to all her appointments.</p> <p>Interview with Resident #3 on 10/01/21 at 10:52am revealed:<br/>-She was still itchy on her stomach, arm and leg.<br/>-She did not know when she would be able to go to her PCP because her family member that took her to her physicians' appointments was sick and could not take her for two weeks.<br/>-She had a cream administered twice daily but she did not get any relief from the cream.<br/>-She had told the medication aide (MA) but the cream was the only medication she had for the rash.</p> | D 273                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 273                                                     | <p>Continued From page 2</p> <p>Telephone interview with Resident #3's family on 10/04/21 at 2:39pm revealed:<br/>-She was told by the MCM she had tried to let the PCP know about the places on Resident #3 when they first developed.<br/>-The facility could contact the PCP if Resident #3 needed anything; they did not have to go through her when the resident needed anything.<br/>-Nothing was being done for Resident #3's rash now that the family was sick and could not contact the PCP or take her to the PCP.<br/>-She had an appointment with a dermatologist on 10/10/21 but she did not know if she would be able to take Resident #3 because she might still be sick.</p> <p>Interview with the MA on 10/04/21 at 11:14am revealed:<br/>-She applied a cream to Resident #3's rash twice daily.<br/>-Resident #3 had the rash for a couple of months.<br/>-She had not complained about the rash itching in the past, but she had not complained recently.<br/>-Resident #3 had requested a Benadryl (an antihistamine) earlier that morning; maybe she was itching and wanted the Benadryl for relief.<br/>-Resident #3 did not have an order for the Benadryl so she could not give her one.<br/>-She had explained why she could not give Resident #3 a Benadryl and she did not ask why the residents requested one.<br/>-She had not reported the increased size in Resident #3's rash to anyone because she knew the resident had an appointment scheduled in October 2021.</p> <p>Interview with the MCM on 10/04/21 at 4:13pm revealed:<br/>-She was made aware of Resident #3's rash on</p> | D 273                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 273                                                     | <p>Continued From page 3</p> <p>Friday, 10/01/21; that was the first time she was aware of the rash.</p> <p>-The family made and took Resident #3 to all her physicians' appointments.</p> <p>-She had tried to contact Resident #3's PCP about the rash but had not been able to get through.</p> <p>-She had tried to reach out the PCP herself because she knew the family was sick and would not be available for almost two weeks.</p> <p>-She had not offered Resident #3 anything for relief because she was waiting to get in touch with the PCP.</p> <p>-She had not had a chance to call the PCP that day, 10/04/21.</p> <p>-The facility would take the resident to the appointment that was scheduled if the family could not take her.</p> <p>-It would be easier if Resident #3 would use the "house PCP"; it was difficult to get in touch with Resident #3's PCP.</p> <p>-She had not done anything else about Resident #3's rash because everything had to go through the PCP.</p> <p>-Resident #3 had so many specialist that she did not know who to call.</p> <p>-It was ultimately the facility's responsibility to take care of Resident #3 and meet her needs; she guessed she could take Resident #3 to an outpatient urgent care center to get her relief, but she had not thought of it.</p> <p>Interview with the Executive Director (ED) on 10/04/21 at 6:08pm revealed:</p> <p>-She was not aware of the rash on Resident #3.</p> <p>-The MCM should be aware and taking care of it.</p> <p>-Resident #3's family was very involved with her care and took her to all of her appointments by choice.</p> <p>-The facility was ultimately responsible for</p> | D 273                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 273                                                     | Continued From page 4<br><br>Resident #3's care and should have follow-up up<br>on Resident #3's rash to give her some relief.<br><br>Attempted telephone interviews with Resident<br>#3's primary care provider (PCP) on 10/01/21 at<br>10:43am and 10/04/21 at 1:50pm were<br>unsuccessful.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | D 273                                                                                              |                                                                                                                          |                                                        |
| D 274                                                     | 10A NCAC 13F .0902(c)(1) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the<br>following in the resident's record:<br>(1) facility contacts with the resident's physician,<br>physician service, other licensed health<br>professional, including mental health<br>professional, when illnesses or accidents occur<br>and any other facility contacts with a physician or<br>licensed health professional regarding resident<br>care;<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record<br>reviews, the facility failed to ensure the primary<br>care provider (PCP) was notified of elevated<br>finger stick blood sugars (FSBS) as ordered for 2<br>of 5 sampled residents (#1, #3)<br><br>The findings are:<br><br>1. Review of Resident #1's current FL2 dated<br>05/27/21 revealed diagnoses included<br>rheumatoid arthritis and partial traumatic<br>amputation below knee amputation right leg.<br><br>Review of Resident #1's previous FL2 dated | D 274                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 274                                                     | <p>Continued From page 5</p> <p>4/12/21 revealed a diagnosis included diabetes mellitus.</p> <p>Review of Resident #1's laboratory values dated 05/13/21 revealed a hemoglobin A1C (HbA1C) value of 8.5. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%).</p> <p>Review of Resident #1's physician order dated 06/27/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for finger stick blood sugar checks (FSBS) before meals and at bedtime.</li> <li>-There was an order for Humalog U-100 (used to treat blood sugar) sliding scale insulin (SSI) before meals and at bedtime as follows; 151 - 200, 6units; 201 - 250, 10units; 251 - 300, 14units; 301 - 350, 18units; greater than 350, 18units and call the primary care provider (PCP).</li> </ul> <p>Review of Resident #1's physician order dated 08/23/21 revealed there was an order for FSBS checks as needed for signs and symptoms of hyperglycemia or hypoglycemia.</p> <p>Review of Resident #1's electronic medication administration record (eMAR) for August 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for FSBS checks before meals and at bedtime.</li> <li>-There was an entry for Humalog U-100 Insulin SSI as follows; 151 - 200, 6units; 201 - 250, 10units; 251 - 300, 14units; 301 - 350, 18units; greater than 350, 18units and call the PCP.</li> <li>-There was documentation on 08/05/21 at 12:00pm of FSBS reading of 364.</li> <li>-There was documentation on 08/06/21 at 8:00pm of FSBS reading of 453.</li> <li>-There was documentation on 08/07/21 at 12:00pm of FSBS reading of 378.</li> </ul> | D 274                                                                         |                                                                                                                          |                          |                                                        |

Division of Health Service Regulation

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| D 274                                                     | <p>Continued From page 6</p> <p>-There was documentation on 08/11/21 at 7:00am of FSBS reading of 484.</p> <p>-There was documentation on 08/12/21 at 12:00pm of FSBS reading of 391.</p> <p>-There was no documentation of PCP being notified of FSBS greater than 350.</p> <p>Review of Resident #1's progress notes for August 2021 revealed there was no documentation of PCP being notified of FSBS greater than 350.</p> <p>Review of Resident #1's eMAR for September 2021 revealed:</p> <p>-There was an entry for FSBS checks before meals and at bedtime.</p> <p>-There was an entry for Humalog U-100 Insulin SSI as follows; 151 - 200, 6units; 201 - 250, 10units; 251 - 300, 14units; 301 - 350, 18units; greater than 350, 18units and call the PCP.</p> <p>-There was documentation on 09/05/21 at 5:00pm of FSBS reading of 404.</p> <p>-There was documentation on 09/08/21 at 5:00pm of FSBS reading of 389.</p> <p>-There was documentation on 09/24/21 at 8:00pm of FSBS reading of 370.</p> <p>-There was documentation on 09/26/21 at 12:00pm of FSBS reading of 369.</p> <p>-There was no documentation of PCP being notified of FSBS greater than 350.</p> <p>Review of Resident #1's progress notes for September 2021 revealed there was no documentation of PCP being notified of FSBS greater than 350.</p> <p>Interview with Resident #1 on 10/04/21 at 10:40am revealed:</p> <p>-The staff would re-check his FSBS at times when it was elevated.</p> | D 274                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 274                                                     | <p>Continued From page 7</p> <ul style="list-style-type: none"> <li>-He did not know if the staff called the PCP for an elevated blood sugar.</li> <li>-The staff should have called the PCP for an elevated blood sugar.</li> <li>-He did not recall receiving any additional insulin when his blood sugar was elevated.</li> </ul> <p>Interview with a medication aide (MA) on 10/04/21 at 10:56am revealed:</p> <ul style="list-style-type: none"> <li>-She had called elevated FSBS readings to the PCP on 10/04/21.</li> <li>-She did not receive a call back before her shift ended.</li> <li>-She did not follow up with PCP the next day.</li> <li>-She documented in the progress notes when she called the PCP regarding elevated FSBS.</li> <li>-There was no documentation to support the PCP was notified of an elevated FSBS.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 10/01/21 at 12:25pm revealed:</p> <ul style="list-style-type: none"> <li>-The PCP should be called for blood sugars greater than 350.</li> <li>-She did not know why the order was not on the eMAR.</li> <li>-The pharmacy was responsible for placing new orders on the eMAR.</li> </ul> <p>Interview with the RCC on 10/04/21 at 11:20am revealed:</p> <ul style="list-style-type: none"> <li>-She could not find documentation that the PCP had been notified of FSBS readings greater than 350.</li> <li>-She called the PCP to verify if they had been called regarding FSBS readings greater than 350.</li> <li>-The PCP could not find documentation that they had been notified of FSBS greater than 350.</li> </ul> <p>Telephone interview with Resident #1's PCP on 10/04/21 at 4:00pm revealed:</p> | D 274                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 274                                                     | <p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-She received a phone call regarding Resident #1's FSBS reading on 08/12/21 of 391.</li> <li>-She had not received any other notifications of Resident #1's FSBS greater than 350.</li> <li>-She wanted to be notified of the Resident #1's elevated blood sugars.</li> <li>-Resident #1's blood sugar was difficult to control.</li> </ul> <p>Interview with the Administrator in 10/04/21 at 5:00pm revealed:</p> <ul style="list-style-type: none"> <li>-The MAs were responsible for notifying the PCP when FSBS were elevated.</li> <li>-The RCC should have noticed the FSBS were elevated above 350 with the weekly eMAR audits.</li> <li>-The RCC should have checked for documentation of the PCP being called.</li> <li>-The RCC should have provided education to the MAs regarding following physician orders.</li> <li>-The RCC should be auditing the eMARs weekly.</li> </ul> <p>2. Review of Resident #3's current FL-2 dated 07/29/21 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included type 2 diabetes, hypertension, Chronic Obstructive Pulmonary Disease (COPD), bipolar disorder, dementia, and non-Hodgkin's lymphoma.</li> </ul> <p>There was an order for finger stick blood sugar checks (FSBS) before meals.</p> <p>There was an order for Humalog U-100 (used to treat blood sugar) sliding scale insulin (SSI) before meals and at bedtime as follows; 150 - 200, 2units; 201 - 250, 3units; 251 - 300, 4units; 301 - 350, 5units; 351 - 400, 6units; greater than 400, notify the endocrinologist.</p> <p>Review of Resident #3's laboratory values dated 07/31/21 revealed a hemoglobin A1C (HbA1C) value of 8.8. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%).</p> | D 274                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 274                                                     | <p>Continued From page 9</p> <p>Review of Resident #3's electronic medication administration record (eMAR) for August 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for FSBS checks before meals.</li> <li>-There was an entry for Humalog U-100 Insulin SSI as follows; 150 - 200, 2units; 201 - 250, 3units; 251 - 300, 4units; 301 - 350, 5units; 351 - 400, 6units; greater than 400, notify the endocrinologist.</li> <li>-There was documentation on 08/30/21 at 11:30am of FSBS reading of 464.</li> <li>-There was documentation on 08/31/21 at 11:30am of FSBS reading of 414.</li> <li>-There was no documentation of PCP or endocrinologist being notified of FSBS greater than 350.</li> </ul> <p>Review of Resident #3's progress notes for August 2021 revealed there was no documentation of PCP or endocrinologist being notified of FSBS greater than 400.</p> <p>Review of Resident #3's eMAR for September 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for FSBS checks before meals.</li> <li>-There was an entry for Humalog U-100 Insulin SSI as follows; 150 - 200, 2units; 201 - 250, 3units; 251 - 300, 4units; 301 - 350, 5units; 351 - 400, 6units; greater than 400, notify the endocrinologist.</li> <li>-There was documentation on 09/01/21 at 11:30am of FSBS reading of 401.</li> <li>-There was documentation on 09/09/21 at 5:00pm of FSBS reading of 439.</li> <li>-There was documentation on 09/11/21 at 11:30am of FSBS reading of 430.</li> <li>-There was documentation on 09/12/21 at</li> </ul> | D 274                                                                         |                                                                                                                          |                          |                                                        |

Division of Health Service Regulation

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| D 274                                                     | <p>Continued From page 10</p> <p>5:00pm of FSBS reading of 414.</p> <p>-There was documentation on 09/14/21 at 5:00pm of FSBS reading of 405.</p> <p>-There was documentation on 09/09/21 at 5:00pm of FSBS reading of 439.</p> <p>-There was documentation on 09/18/21 at 11:30am of FSBS reading of 452.</p> <p>-There was documentation on 09/24/21 at 11:30am of FSBS reading of 403.</p> <p>-There was documentation on 09/27/21 at 11:30am of FSBS reading of 479.</p> <p>-There was documentation on 09/27/21 at 5:00pm of FSBS reading of 405.</p> <p>-There was no documentation of PCP or endocrinologist being notified of FSBS greater than 350.</p> <p>Review of Resident #3's progress notes for September 2021 revealed there was no documentation of PCP being notified of FSBS greater than 400.</p> <p>Review of Resident #3's eMAR for October 2021 revealed:</p> <p>-There was an entry for FSBS checks before meals.</p> <p>-There was an entry for Humalog U-100 Insulin SSI as follows; 150 - 200, 2units; 201 - 250, 3units; 251 - 300, 4units; 301 - 350, 5units; 351 - 400, 6units; greater than 400, notify the endocrinologist.</p> <p>-There was documentation on 10/01/21 at 11:30am of FSBS reading of 480.</p> <p>-There was no documentation of the PCP or the endocrinologist being notified of FSBS greater than 350.</p> <p>Review of Resident #3's progress notes for October 2021 revealed:</p> | D 274                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 274                                                     | <p>Continued From page 11</p> <p>-There was an entry dated 10/01/21 at 1:39pm for FSBS were 480.</p> <p>-There was an entry asking if the provider [endocrinologist or PCP] was notified and no was documented.</p> <p>there was no documentation of PCP or endocrinologist being notified of FSBS greater than 400.</p> <p>Interview with Resident #3 on 10/01/21 at 10:52am revealed:</p> <p>-She knew her FSBS were done before meals.</p> <p>-The Medication aides (MAs) were sometimes late taking her FSBS.</p> <p>-She could not recall what her FSBS readings were.</p> <p>-She did not know if the staff called the PCP or the endocrinologist for an elevated blood sugar.</p> <p>Interview with a medication aide (MA) on 10/01/21 at 11:06am revealed:</p> <p>-Resident #3 did not usually have high FSBS readings.</p> <p>-She did not call the PCP or endocrinologist when Resident #3 had a high FSBS reading.</p> <p>-If Resident #3 had a high FSBS reading she would inform the Memory Care Manager (MCM) and the MCM would call the PCP.</p> <p>Interview with the MCM on 10/01/21 at 12:44pm revealed:</p> <p>-The MAs could call the PCP or endocrinologist when Resident #3 had an elevated FSBS reading.</p> <p>-The MAs documented the call to the PCP or endocrinologist on the progress notes.</p> <p>-The MAs also documented any guidance or instructions from the PCP on the progress notes.</p> <p>-She expected the MAs to follow the orders for Resident #3 and notify the endocrinologist when</p> | D 274                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 274                                                     | Continued From page 12<br><br>her FSBS readings were over 400.<br><br>Interview with the Administrator in 10/04/21 at 5:00pm revealed:<br>-The MAs were responsible for notifying the PCP when FSBS were elevated and documenting the contact on the progress notes.<br>-The MCM should have noticed the FSBS were elevated above 400 with the weekly eMAR audits.<br>-The MCM should have checked for documentation of the PCP being called.<br>-The MCM should have provided education to the MAs regarding following physician orders.<br>-The MCM should be auditing the eMARs weekly.<br>-She was concerned Resident #3's endocrinologist or PCP were not notified when she had FSBS over 400 because the resident was not receiving proper diabetic care.<br><br>Attempted interview with the endocrinologist on 10/04/21 at 3:18pm was unsuccessful. | D 274                                                                                              |                                                                                                                          |                                                        |
| D 310                                                     | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to serve therapeutic                                                                                                                                                                                                                                                                                                                                                                                                           | D 310                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 310                                                     | <p>Continued From page 13</p> <p>diets as ordered by the physician for 1 of 3 sampled residents (#3) with a diet order for no concentrated sweets (NCS) diet.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL-2 dated 07/29/21 revealed diagnoses included type 2 diabetes, hypertension, Chronic Obstructive Pulmonary Disease (COPD), bipolar disorder, dementia, and non-Hodgkin's lymphoma.</p> <p>Review of a signed physician's order for Resident #3 dated 09/10/21 revealed there was an order for a no concentrated sweet diet (NCS).</p> <p>Review of the diet menus for 09/29/21 to 10/01/21 revealed there was no NCS diet menu available for the kitchen staff to follow.</p> <p>Review of a resident diet list posted in the kitchen on 09/30/21 at 2:25pm revealed Resident #3 was not listed as on an NCS diet; none of the residents were listed as an NCS diet.</p> <p>Review of the food storage areas on 09/30/21 at 2:25pm revealed there was sugar free pudding, jelly, artificial sweetener and sugar free ice cream available for service.</p> <p>Observation of the lunch meal on 09/29/21 at 12:00pm revealed Resident #3 was served fish, mixed vegetables, potatoes, a roll, water, unsweetened iced tea and sugar free ice cream.</p> <p>Interview with Resident #3 on 09/29/21 at 12:00pm revealed:<br/>-She was a diabetic and on a diabetic diet ordered by her primary care provider (PCP).<br/>-She was served sugar free ice cream and</p> | D 310                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 310                                                     | <p>Continued From page 14</p> <p>unsweetened iced tea.<br/>-She tried to stay away from sugary sweets.</p> <p>Interview with the cook on 09/30/21 at 2:22pm revealed:<br/>-Resident #3 was ordered a sugar free diet;<br/>Resident #3 was the only resident ordered a sugar free diet.<br/>-She prepared sugar free dessert and provided sugar free tea, juice and ice cream for Resident #3.<br/>-There was no sugar free jelly or syrup available for Resident #3 because she did not like them.<br/>-There was also artificial sweetener available for Resident #3.<br/>-The Memory Care Manager (MCM) provided a diet list once a week.<br/>-There was not an NCS diet on the list or on the weekly menu.</p> <p>Interview with the Food Service Director on 09/30/21 at 2:25pm revealed:<br/>-She knew Resident #3 was on a "diabetic diet" and was served sugar free items.<br/>-She was served sugar free pudding cups, jelly, pancake syrup and beverages.<br/>-She did not have an NCS menu available for the cooks to reference because there were no residents on that diet at the facility.</p> <p>Interview with Resident #3's family on 10/04/21 at 1:59pm revealed:<br/>-Resident #3 was ordered an NCS diet by her PCP at her appointment on 09/10/21.<br/>-She provided the MCM with a copy of the order after the PCP appointment.<br/>-Resident #3 was ordered the NCS diet by the PCP because she was a diabetic and had high glucose and A1C results.</p> | D 310                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 310                                                     | Continued From page 15<br><br>Interview with the MCM on 10/04/21 at 4:04pm revealed:<br>-She knew an NCS diet was not supposed to receive sweets and receive sugar free items.<br>-She did not know if the kitchen had a menu for NCS diets.<br>-She gave new diet orders to the kitchen as she received them.<br>-She did not know the facility did not have an NCS diet as one of their offered diets.<br>-She knew Resident #3 was diabetic and offered sugar free items, but she did not know she had an order for NCS.<br>-She missed the diet order for Resident #3 somehow.<br><br>Interview with the Executive Director (ED) on 10/04/21 at 6:08pm revealed she was not familiar with the diets for the kitchen or for Resident #3.<br><br>Interview with the Divisional Director of Clinical Services for the facility on 10/04/21 at 6:10pm revealed the facility did not offer an NCS diet to residents.<br><br>Attempted telephone interviews with Resident #3's primary care provider (PCP) on 10/01/21 at 10:43am and 10/04/21 at 1:50pm were unsuccessful. | D 310                                                                                              |                                                                                                                          |                                                        |
| D 358                                                     | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 16</p> <p>which are maintained in the resident's record; and<br/>(2) rules in this Section and the facility's policies<br/>and procedures.</p> <p>This Rule is not met as evidenced by:<br/>TYPE B VIOLATION</p> <p>Based on observations, interviews, and record<br/>reviews, the facility failed to administer<br/>medications as ordered for 5 of 9 residents<br/>(#1, #9, #10, #11, #13) observed during the<br/>morning and noon medication pass including<br/>errors with the administration of insulin (#1);<br/>administration of a stool softener instead of a<br/>topical cream for pain (#9); omission of an<br/>antibiotic (#10); administration of an eye drop in<br/>the incorrect eye (#11); failure to offer water after<br/>inhalation therapy (13) and for 5 of 5 residents<br/>sampled for record review including errors with an<br/>anti-inflammatory medication, an anti-allergy<br/>medication, a medication to treat mouth sores<br/>(#1); a blood thinner medication to thin the blood,<br/>a nerve pain medication, an expectorant<br/>medication (#2); a non-insulin injection used to<br/>improve blood sugar, a pain medication, an<br/>inhaler, a vasodilator medication, a vitamin<br/>supplement and a dietary supplement (#3), an<br/>antipsychotic (#4), and a proton pump inhibitor<br/>and a topical skin cream (#5).</p> <p>The findings are:</p> <p>1. The medication error rate was 15% as<br/>evidenced by the observation of 5 errors out of 33<br/>opportunities during the 8:00am/9:00am<br/>medication passes on 09/30/21 and 10/01/21 and<br/>12:00pm on 09/30/21.</p> <p>a. Review of Resident #1's current FL2 dated<br/>05/27/21 revealed diagnoses included</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 17</p> <p>rheumatoid arthritis and partial traumatic amputation below knee amputation, right leg.</p> <p>Review of Resident #1's previous FL2 date 04/12/21 revealed a diagnosis of diabetes mellitus.</p> <p>Review of Resident #1's physician's order dated 05/27/21 revealed there was an order for Humalog U-100 Insulin (used to lower blood sugar) SSI subcutaneously as follows; 151 - 200 = 6units; 201 - 250 = 10units; 251 - 300 = 14units; 301 - 350 = 18units; greater than 350 = 18units and call the primary care provider (PCP).</p> <p>Observation of the noon medication pass on 9/30/21 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>-The finger stick blood glucose (FSBS) at 12:00pm was 279.</li> <li>-The medication aide (MA) administered Humalog insulin 14 units in the right deltoid at 11:50am.</li> <li>-The MA administered Humalog insulin with one hand.</li> <li>-The MA administered Humalog insulin in the deltoid muscle.</li> </ul> <p>Review of Resident #1's medication administration record (MAR) for September 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Humalog U-100 Insulin SSI as follows; 151 - 200 = 6units; 201 - 250 = 10units; 251 - 300 = 14units; 301 - 350 = 18units; greater than 350 = 18units and call the primary care provider (PCP).</li> <li>-There was documentation Humalog 14 units were administered at 12:00pm in the left arm.</li> </ul> <p>Interview with the medication aide (MA) on 09/30/21 at 2:30pm revealed:</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 18</p> <p>-She had always administered insulin with one hand.</p> <p>-She had always administered insulin in the upper arm.</p> <p>-She administered the insulin in the right arm.</p> <p>-She did not know why she documented she administered the insulin in the left arm.</p> <p>Interview with Resident Care Coordinator (RCC) on 09/30/21 at 2:40pm revealed:</p> <p>-She should have given the insulin in the "fatty part of the arm".</p> <p>-She should have used both hands during the administration of the insulin.</p> <p>-She did not observe MAs during medication administration.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>b. Review of Resident #9's current FL2 dated 02/24/21 revealed diagnosis included chronic pain syndrome.</p> <p>Review of Resident #9's physician orders dated 03/11/21 revealed:</p> <p>-There was an order for diclofenac sodium (used to treat pain) gel 1% apply to the right shoulder three times a day.</p> <p>-There was an order for docusate sodium (a stool softener) 100mg twice a day.</p> <p>Observation of the noon medication pass on 9/30/21 at 11:09am revealed:</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 19</p> <p>-The medication aide (MA) administered docusate sodium.</p> <p>-The MA did not apply diclofenac sodium gel.</p> <p>Review of Resident #9's electronic medication administration record (eMAR) for September 2021 revealed:</p> <p>-There was an entry for diclofenac sodium gel 1% topical cream apply 2gms topically to the right shoulder three times daily at 8:00am, 12:00pm and 8:00pm.</p> <p>-There was documentation that the diclofenac sodium gel 1% topical cream was applied to the right shoulder at 12:00pm.</p> <p>-There was an entry for docusate sodium 100mg twice a day at 8:00am and 7:00pm.</p> <p>-There was documentation that docusate sodium had been administered at 8:00am.</p> <p>Observation of Resident #9's medication on hand on 09/30/21 at 2:30pm revealed:</p> <p>-There was a blister pack with 59 docusate sodium 100mg on hand.</p> <p>-There was a tube of diclofenac sodium gel 1% topical cream on hand.</p> <p>Interview with Resident #9 on 10/01/21 at 8:40am revealed:</p> <p>-She knew she had an order for a cream to her shoulder.</p> <p>-She thought the cream was applied a few times a day.</p> <p>-She did not know what the cream was for.</p> <p>-She had not noticed any changes in her bowel movement habits.</p> <p>Interview with the MA on 09/30/21 at 2:30pm revealed:</p> <p>-She was not paying attention during the medication pass.</p> | D 358                                                                         |                                                                                                                          |  |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 20</p> <p>-She should have checked the medication three times with the entry in the eMAR.</p> <p>-She did not follow the instructions that she was taught on how to administer medications.</p> <p>Attempted telephone interview with Resident #9's PCP on 10/01/21 at 11:30am was unsuccessful.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>c. Review of Resident #10's current FL2 dated 08/11/21 revealed diagnoses included chronic obstructive pulmonary disease, carcinoma of skin, rheumatoid arthritis, acute cystitis without hematuria, chronic pain syndrome, hypertension, peripheral vascular disease, non-pressure chronic ulcer of lower extremities.</p> <p>Review of Resident #10's physician order dated 09/23/21 revealed there was an order for cephalexin (used to treat an infection) 500mg one tablet four times a day for 5 days.</p> <p>Observation of the noon medication pass on 09/30/21 at 11:15am revealed the medication aide (MA) did not administer the cephalexin 500mg at 12:00pm.</p> <p>Review of Resident #10's electronic medication administration record (eMAR) for September 2021 revealed:</p> <p>-There was an entry for cephalexin 500mg four times a day for 5 days at 8:00am, 12:00pm,</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 21</p> <p>4:00pm and 8:00pm.<br/>-There was a diagnosis of cellulitis to lower legs.<br/>-There was documentation that the medication was not available for administration.</p> <p>Observation of Resident #10's medication on hand on 09/30/21 at 2:32pm revealed:<br/>-There was a blister pack of 19 cephalexin tablets on hand.<br/>-The pharmacy dispensed 20 cephalexin on 09/28/21.<br/>-The medication was locked in the controlled substance lock box.</p> <p>Observation of Resident #10 on 09/29/21 at 9:42am revealed:<br/>-She had tubular elastic stretch coverings over both lower extremities.<br/>-She had edema of both lower extremities.<br/>-She had dressings noted on both lower extremities that were visible through the tubular elastic stretch coverings.</p> <p>Interview with Resident #10 on 09/29/21 at 9:42am revealed:<br/>-She knew the antibiotic was for the sores on her legs<br/>-She had an order for an antibiotic written by the primary care provider (PCP) but she had not started the medication.<br/>-She did not know why she had not started the medication.<br/>-She had edema of both lower legs and a 4 by 4 dressing on each lower leg.</p> <p>Interview with the MA on 09/30/21 at 2:35pm revealed:<br/>-The antibiotics were kept in the locked controlled substance box.<br/>-The antibiotic would be kept behind the tab with</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 22</p> <p>the resident's name.</p> <p>-She did not see the antibiotics in the controlled substance box.</p> <p>-She overlooked the medication.</p> <p>-She did not ask anyone if the medication was in the facility.</p> <p>Interview with the RCC on 09/30/21 and 2:35am revealed:</p> <p>-The antibiotics were always kept in the controlled substance locked box.</p> <p>-The MA should have asked the RCC about the medication if she did not see it on the medication cart.</p> <p>Telephone interview with the pharmacist from the facility's consulting pharmacy on 10/01/21 at 8:47am revealed:</p> <p>-There was an order for cephalexin 500mg four times a day for 5 days.</p> <p>-The pharmacy dispensed 20 capsules on 09/28/21.</p> <p>-There were enough capsules dispensed to cover four times a day administration for 5 days.</p> <p>-Cephalexin was used to treat infections.</p> <p>Telephone interview with Resident #10's PCP 10/04/21 at 3:00 pm and 4:00pm revealed:</p> <p>-She was prescribed the antibiotic for cellulitis of her bilateral, lower legs.</p> <p>-She had recurrent cellulitis of her bilateral, lower legs.</p> <p>-If the cellulitis was not treated appropriately, it could lead to a systemic infection.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 23</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>d. Review of Resident #11's current FL-2 dated 03/13/20 revealed diagnosis included glaucoma.</p> <p>Review of Resident #11's physician orders dated 02/11/21 revealed there was an order for Simbrinza (used to treat pressure in the eye related to glaucoma) one drop in the left eye twice a day.</p> <p>Observation of the noon medication pass on 09/30/21 at 11:17am revealed:</p> <ul style="list-style-type: none"> <li>-The medication aide (MA) was going to administered Simbrinza to the right eye.</li> <li>-The MA was stopped prior to administering the medication into the incorrect eye.</li> <li>-The MA administered Simbrinza to the left eye once she was corrected.</li> </ul> <p>Review of Resident #11's electronic medication administration record (eMAR) for September 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Simbrinza one drop in left eye twice a day at 12:00pm and 7:00pm.</li> <li>-There was documentation of Simbrinza administered at 12:00pm.</li> </ul> <p>Interview with the medication aide (MA) on 09/30/21 at 11:20 revealed:</p> <ul style="list-style-type: none"> <li>-She knew the eye drop was to be administered in the left eye.</li> <li>-She got confused because the resident was lying down.</li> </ul> <p>Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/01/21 at 8:30am revealed:</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 24</p> <p>-Simbrinza was administered to treat glaucoma caused by ocular hypertension.</p> <p>-If untreated, the resident could experience decreased vision.</p> <p>-Administration of Simbrinza to an eye without glaucoma could cause decrease pressure in the eye and discomfort.</p> <p>Telephone interview with a nurse at Resident #11's primary care provider's (PCP) office on 10/04/21 revealed Simbrinza was for glaucoma.</p> <p>Attempted telephone interview with Resident #11's PCP on 10/04/21 at 2:00pm was unsuccessful.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>e. Review of Resident #13's current FL2 dated 07/12/21 revealed diagnoses included Parkinson's disease, generalized anxiety disorder, polyarthritis, hypertension and hypothyroidism.</p> <p>Review of Resident #13's physician orders dated 07/12/21 revealed there was an order for Advair Diskus (used to treat lung diseases) 1 puff by mouth twice daily.</p> <p>Review of the contracted pharmacy's quarterly review report dated 07/16/21 revealed a recommendation to add rinse mouth with water after each use. Do not swallow to the directions of</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 25</p> <p>Advair Diskus Inhaler.</p> <p>Review of Resident #13's physician's order dated 08/03/21 revealed an order for Advair Diskus inhaler 250-50mcg inhale one puff twice daily. Rinse mouth with water after each use. Do not swallow.</p> <p>Observation of the morning medication pass on 10/01/21 at 8:04am revealed:<br/>-The medication aide (MA) administered 1 puff of Advair Diskus by mouth.<br/>-The MA did not offer Resident #13 any water after inhalation.</p> <p>Review of the Resident #13's electronic medication administration record (eMAR) of October 2021 revealed:<br/>-There was an entry for Advair Diskus 1 puff by mouth twice daily at 8:00am and 8:00pm. Rinse mouth with water after each use. Do not swallow.<br/>-There was documentation that the medication was administered with mouth rinsed on 10/04/21 at 8:00am.</p> <p>Interview with the MA on 10/01/21 at 1:05pm revealed:<br/>-She did not see the order to rinse mouth with water.<br/>-She always followed the primary care provider (PCP) orders.<br/>-She did not know why Resident #13's mouth would need to be rinsed after administration of the inhaler.</p> <p>Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/04/21 at 8:38am revealed:<br/>-Advair was to assist in keeping breathing under control.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 26</p> <p>-The mouth should be rinsed after using Advair so sores would not develop.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>2. Review of Resident #1's current FL2 dated 05/27/21 revealed diagnoses included rheumatoid arthritis and partial traumatic amputation below the knee amputation of right leg.</p> <p>a. Review of Resident #1's physician's orders dated 05/27/21 revealed there was an order for methotrexate sodium (used to treat inflammation) 2.5mg ten tablets weekly.</p> <p>Review of Resident #1's July 2021 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry dated 07/01/21 for methotrexate sodium 2.5mg take 10 tablets weekly with an administration time of 10:00am.</p> <p>-There was no documentation methotrexate 2.5mg was administered on 07/03/21 or 07/10/21.</p> <p>-There was documentation methotrexate 2.5mg was administered on 07/17/21, 07/24/21 and 07/31/21.</p> <p>Observation of Resident #1's medications on hand on 09/29/21 at 4:43pm revealed:</p> <p>-There was a blister pack for methotrexate 2.5mg dispensed on 08/24/21.</p> <p>-The punch card was labeled as 1 of 2 and there</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 27</p> <p>were 40 total tablets dispensed.<br/>-The punch card contained 12 tablets, with 18 tablets being administered.</p> <p>Based on staff documentation on the eMAR and medications dispensed on 08/24/21, there were 40 capsules of methotrexate documented as administered with 18 capsules not accounted for.</p> <p>Interview with Resident #1 on 10/01/04 at 10:40am revealed:<br/>-He complained of discomfort at times.<br/>-He did not know what medications he was administered.</p> <p>Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/01/21 at 8:28am revealed:<br/>-Methotrexate sodium was administered for rheumatoid arthritis.<br/>-The pharmacy dispensed 40 tablets on 06/15/21.<br/>-The pharmacy dispensed 40 tablets on 07/09/21.<br/>-The pharmacy dispensed 40 tablets on 07/31/21.<br/>-The pharmacy dispensed 40 tablets on 08/24/21.<br/>-The resident could have an increased chance of flare ups of rheumatoid arthritis.</p> <p>Telephone interview with Resident #1's primary care provider (PCP) on 10/04/21 at 4:00pm revealed:<br/>-She was not aware that Resident #1 did not receive methotrexate sodium for two weeks in July 2021.<br/>-Resident #1 could experience increased discomfort and pain from his diagnosis of rheumatoid arthritis.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 28</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>b. Review of Resident #1's physician orders dated 08/10/21 revealed there was an order for loratadine (used to treat allergies) 10mg one tablet daily for 7 days.</p> <p>Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry dated 08/11/21 for loratadine 10mg 1 tablet daily for 7 days with an administration time of 8:00am.</li> <li>-There was documentation loratadine was administered at 8:00am from 08/12/21 - 08/17/21.</li> <li>-There was no documentation that loratadine was administered on 08/18/21.</li> </ul> <p>Observation of Resident #1's medications on hand on 09/29/21 at 4:43pm revealed:</p> <ul style="list-style-type: none"> <li>-There was a blister pack for loratadine 10mg and 7 tablets were dispensed on 08/11/21.</li> <li>-The blister pack was labeled as 1 of 1 card.</li> <li>-The blister pack contained 3 tablets, and 4 tablets had been administered.</li> </ul> <p>Based on staff documentation on the eMAR and medications dispensed on 09/29/21, there were 6 tablets of loratadine documented as administered with 4 tablets not accounted for.</p> <p>Interview with Resident #1 on 10/01/04 at 10:40am revealed:</p> <ul style="list-style-type: none"> <li>-He complained of discomfort at times.</li> <li>-He did not know what medications he was administered.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 29</p> <p>Telephone interview with Resident #1's primary care provider (PCP) on 10/04/21 at 4:00pm revealed Resident #1 may have experienced increased signs and symptoms of allergies if the medication was not administered as ordered.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>c. Review of Resident #1's physician's orders dated 09/21/21 revealed there was an order for magic mouthwash swish (used to treat mouth sores) and spit 10mls four times a day for 5 days.</p> <p>Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry dated 09/22/21 for magic mouthwash swish and spit 10mls four times a day for 5 days to be administered at 8:00am, 12:00pm, 4:00pm and 8:00pm.</li> <li>-There was documentation magic mouthwash was administered at 8:00am, 12:00pm, 4:00pm and 8:00pm from 09/23/21-09/26/21.</li> <li>-There was no documentation the magic mouthwash was administered on 09/22/21.</li> </ul> <p>Observation of Resident #1's medications on hand on 09/29/21 at 4:37pm revealed:</p> <ul style="list-style-type: none"> <li>-There was a bottle of magic mouthwash dispensed on 09/22/21.</li> <li>-The bottle was ¾ full.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 30</p> <p>Interview with Resident #1 on 10/01/04 at 10:40am revealed:<br/>-He had mouth sore a few weeks ago.<br/>-He was administered a medication that he had to swish and spit out.<br/>-He did not have mouth sores today.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>3. Review of Resident #2's current FL2 dated 06/03/21 revealed diagnoses included major depressive disorder, osteoarthritis, hyperlipidemia, unspecified falls and chronic systolic heart failure.</p> <p>a. Review of Resident #2's physician orders dated 06/03/21 revealed an order for Eliquis (used as a blood thinner) 5mg twice a day.</p> <p>Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed:<br/>-There was an entry for Eliquis 5mg twice daily to be administered at 8:00am and 8:00pm.<br/>-There was documentation of administration of Eliquis 5mg on 09/29/21 at 8:00pm and on 09/30/21 at 8:00am.</p> <p>Observation of medications on hand for Resident #2 on 09/29/21 at 5:00pm revealed there was no Eliquis available for administration.</p> <p>Observation of medication on hand for Resident</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 31</p> <p>#2 on 09/30/21 at 2:56pm revealed:<br/>-There was a blister pack of 18 Eliquis available for administration on hand.<br/>-The medication label on the blister pack with 18 tablets were dispensed on 09/28/21.<br/>-There were 18 tablets in the blister pack.</p> <p>Interview with Resident #2 on 09/29/21 at 9:30am revealed:<br/>-She had not received her Eliquis in three days.<br/>-She took Eliquis twice a day, in the morning and in the evening.<br/>-Her medications were not always ordered timely.</p> <p>Interview with Resident #2 on 10/01/21 at 10:30am revealed:<br/>-She was administered Eliquis last night, 09/30/21 at 8:00pm.<br/>-Last night was the first time she had received Eliquis in 4 days.<br/>-She checked the medication with each medication pass prior to administration.<br/>-Eliquis was a blood thinner.<br/>-Eliquis would prevent a blood clot from forming.<br/>-She took Eliquis because she had an irregular heartbeat.</p> <p>Interview with a Medication Aide (MA) on 10/04/21 at 1:23pm revealed:<br/>-She did not realize the medication was not in the medication cart.<br/>-She should not have documented the medication was given.<br/>-She would call the facility's contracted pharmacy when medications needed to be re-ordered.<br/>-She would re-order medications when there were 3 to 4 pills left in the blister pack.<br/>-She would peel the sticker from medication and place on a form to be faxed for another pharmacy.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 32</p> <ul style="list-style-type: none"> <li>-The form would be given to the RCC to fax to the pharmacy.</li> <li>-The medications were checked in by the MA when delivered to the facility.</li> </ul> <p>Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 10/01/21 at 8:07am revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for Eliquis 5mg twice a day.</li> <li>-The pharmacy dispensed 30 tablets of Eliquis 5 mg on 08/30/21.</li> <li>-The pharmacy dispensed 12 tablets of Eliquis 5 mg on 09/10/21.</li> <li>-The pharmacy dispensed 18 tablets of Eliquis 5 mg on 09/15/21.</li> <li>-The pharmacy dispensed 18 tablets of Eliquis 5 mg on 09/28/21.</li> </ul> <p>Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/01/21 at 8:34am revealed:</p> <ul style="list-style-type: none"> <li>-Eliquis was administered as a blood thinner.</li> <li>-A blood thinner prevented blood clots from forming.</li> <li>-Residents took blood thinners to make it easier for the heart to pump the blood throughout the body.</li> <li>-Residents who did not take the blood thinners as prescribed would be at risk for pulmonary emboli, stroke and deep vein thrombosis.</li> </ul> <p>Telephone interview with Resident #2's PCP on 10/04/21 at 4:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was on a blood thinner due to atrial-fibrillation.</li> <li>-Resident #2 could have a blood clot and suffer a stroke when multiple doses of blood thinner were missed.</li> <li>-She was not aware that Resident #2 had missed multiple doses of the blood thinner.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 33</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>b. Review of Resident #2's physician's orders dated 07/29/21 revealed an order for gabapentin (used to treat nerve pain) 100mg 1 capsule at bedtime for 7 days, then gabapentin 100mg 2 capsules at bedtime for 7 days, then gabapentin 100mg 3 capsules at bedtime as maintenance dose.</p> <p>Review of Resident #2's July 2021 electronic medication administration record (eMAR) revealed there was no entry for gabapentin 100mg to be administered.</p> <p>Review of Resident #2's August 2021 eMAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry dated 07/29/21 for gabapentin 100mg 1 capsule at bedtime for 7 days with an administration time of 8:00pm.</li> <li>-There was documentation gabapentin was administered at 8:00pm from 08/01/21 - 08/22/21, 08/24/21 - 08/27/21 and 08/30/21 - 0/31/21.</li> <li>-There was a second entry dated 07/29/21 for gabapentin 100mg 2 capsules at bedtime for 7 days with an administration time of 8:00pm.</li> <li>-There was documentation gabapentin was administered at 8:00pm from 08/02/21 - 08/04/21.</li> <li>-There was a third entry dated 07/29/21 for gabapentin 100mg 3 capsules at bedtime as maintenance with an administration time of 8:00pm.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 34</p> <p>-There was documentation gabapentin was administered at 8:00pm from 08/02/21 - 08/06/21, 08/08/21 - 08/31/21.</p> <p>Review of Resident #2's physician's orders dated 09/23/21 revealed an order for gabapentin 300mg at bedtime.</p> <p>Review of Resident #2's September 2021 eMAR revealed:</p> <p>-There was an entry dated 07/29/21 for gabapentin 100mg 1 capsule at bedtime for 7 days with an administration time of 8:00pm.</p> <p>-There was documentation gabapentin was administered at 8:00pm from 09/01/21 - 09/04/21.</p> <p>-There was a second entry dated 07/29/21 for gabapentin 100mg 3 capsule at bedtime as maintenance with an administration time of 8:00pm.</p> <p>-There was documentation gabapentin was administered at 8:00pm from 09/01/21 - 09/04/21.</p> <p>-There was a third entry dated 07/29/21 for gabapentin 100mg 3 capsule at bedtime with an administration time of 8:00pm.</p> <p>-There was documentation gabapentin was administered at 8:00pm from 09/16/21 - 09/18/21 and 09/20/21.</p> <p>-There was a fourth entry dated 09/16/21 for gabapentin 300mg 1 capsule at bedtime with an administration time of 8:00pm.</p> <p>-There was documentation gabapentin was administered at 8:00pm from 09/18/21 - 09/28/28.</p> <p>Observation of Resident #2's medications on hand on 09/29/21 at 5:12pm revealed:</p> <p>-There was a blister pack with 2 gabapentin 300mg dispensed on 09/16/21.</p> <p>-The blister pack contained 9 capsules, with 7 being administered.</p> <p>-There was a multi-dose pack with 7 gabapentin</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 358                                                     | <p>Continued From page 35</p> <p>300mg dispensed on 09/24/21.<br/>-The multi-dose pack contained 2 capsules, with 5 remaining.</p> <p>Based on staff documentation on the eMAR and medications dispensed on 09/16/21, there were 4 capsules of gabapentin documented as administered with 7 capsules not accounted for.</p> <p>Interview with Resident #2 on 10/04/21 at 10:30am revealed:<br/>-She knew what medications she was to be administered.<br/>-She would check her medications before administration.<br/>-She would ask the MA if the medication was not in her cup of medicines.<br/>-The MA would respond "it is not here"<br/>-She had not spoken with anyone regarding medication not on hand.</p> <p>Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 10/04/21 at 8:13am revealed:<br/>-There was an order dated 07/29/21 for gabapentin 100mg capsule every night for 7 days, then 2 capsules every night for 7 days, then 3 capsules every night.<br/>-There was an order dated 09/16/21 for gabapentin 300mg capsule every night.<br/>-The pharmacy dispensed 62 gabapentin 100mg capsules on 07/29/21.<br/>-The pharmacy dispensed 24 gabapentin 100mg capsules on 09/15/21.<br/>-The pharmacy dispensed 9 gabapentin 300mg capsules on 09/16/21.<br/>-The pharmacy dispensed 7 gabapentin 300mg capsules on 09/20/21.</p> <p>Telephone interview with the pharmacist at the</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 36</p> <p>facility's contracted pharmacy on 10/04/21 at 8:48pm revealed gabapentin was used to treat nerve pain.</p> <p>Telephone interview with primary care provider (PCP) on 10/04/21 at 4:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was administered gabapentin for restless leg syndrome.</li> <li>-Resident #2 would experience additional pain if medication was not administered as ordered.</li> <li>-Resident #2 would be drowsy if medication was administered more frequently than ordered.</li> </ul> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>c. Review of Resident #2's physician orders dated 08/19/21 revealed there was an order for Mucinex (used to treat cough and congestion) 600mg two tablets every 12 hours for 5 days.</p> <p>Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry dated 08/20/21 for Mucinex 600mg two tablets every 12 hours for 5 days to be administered at 8:00am and 8:00pm.</li> <li>-There was documentation Mucinex was administered at 8:00am and 8:00pm from 08/21/21 - 08/24/21.</li> <li>-There was no documentation Mucinex was administered on 08/25/21.</li> </ul> <p>Observation of Resident #2's medications on</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 37</p> <p>hand on 09/29/21 at 5:02pm revealed:<br/>-There was a blister pack with 20 Mucinex 600mg dispensed on 08/20/21.<br/>-The blister pack contained 7 tablets, with 13 being administered.</p> <p>Based on staff documentation on the eMAR and medications dispensed on 08/20/21, there were 16 tablets of Mucinex documented as administered with 13 tablets not accounted for.</p> <p>Interview with the pharmacy technician at the facility's contracted pharmacy on 10/01/21 at 8:12am revealed:<br/>-There was an order for Mucinex 600mg two every 12 hours for 5 days.<br/>-Mucinex 600mg 20 tablets were dispensed on 08/20/21.</p> <p>Interview with Resident #2 on 10/04/21 at 10:30am revealed:<br/>-She knew what medications she was to be administered.<br/>-She would check her medications before administration.<br/>-She would ask the MA if the medication was not in her cup of medicines.<br/>-The MA would respond "it is not here"<br/>-She had not spoken with anyone regarding medication not on hand.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 358                                                     | <p>Continued From page 38</p> <p>4. Review of Resident #5's physician orders dated 08/05/21 revealed there was an order for pantoprazole (used to treat heartburn and reflux) 40mg 1 tablet daily.</p> <p>a. Review of Resident #5's physician orders dated 08/27/21 revealed there was an order for pantoprazole 40mg 1 tablet twice a day for 4 weeks then 1 tablet daily.</p> <p>Review of Resident #5's electronic medication administration record (eMAR) for August 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry dated 05/01/21 for pantoprazole 40mg 1 tablet daily with an administration time of 7:00am on 08/01/21 to 08/26/21 and at 8:00am on 08/27/21 to 08/30/21.</li> <li>-There was documentation pantoprazole was administered at 7:00am from 08/01/21 - 08/26/21 and at 8:00am from 08/27/21 - 08/30/21.</li> <li>-There was a second entry dated 08/27/21 for pantoprazole 40mg 1 tablet twice a day for 4 weeks with an administration time of 8:00am and 8:00pm.</li> <li>-There was documentation pantoprazole was administered at 8:00am and 8:00pm on 08/30/21 and 08/31/21.</li> <li>-There was a third entry dated 08/30/21 for pantoprazole 40mg then take 1 tablet daily with administration time of 8:00am.</li> <li>-There was documentation pantoprazole was administered at 8:00am on 08/31/21.</li> </ul> <p>Review of Resident #5's eMAR of September 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry dated 08/27/21 for pantoprazole 40mg 1 tablet twice a day for 4 weeks with an administration time of 8:00am and 8:00pm.</li> <li>-There was documentation pantoprazole was</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 39</p> <p>administered at 8:00am and 8:00pm from 09/01/21 - 09/23/21.</p> <p>-There was a second entry dated 08/30/21 for pantoprazole 40 mg then 1 tablet daily with an administration time of 7:00am.</p> <p>-There was documentation pantoprazole was administered at 7:00am from 09/01/21 - 09/06/21.</p> <p>-There was a third entry dated 09/17/21 for pantoprazole 40mg 1 tablet daily with an administration time of 8:00am.</p> <p>-There was documentation pantoprazole was administered at 8:00am from 09/17/21 - 09/29/21.</p> <p>Observation of Resident #5's medications on hand on 09/30/21 at 7:48pm revealed:</p> <p>-There was a blister pack with pantoprazole 40mg dispensed on 08/27/21.</p> <p>-The blister pack was labeled as 2 of 2 and there were 60 total tablets dispensed.</p> <p>-The blister pack labeled 2 of 2 had 7 tablets remaining.</p> <p>-The two blister packs contained 60 total tablets, with 74 being documented as administered.</p> <p>-The blister pack labeled 2 of 2 contained 7 tablets, with 53 administered.</p> <p>Based on staff documentation on the eMAR and medications dispensed on 08/27/21, there were 74 tablets of pantoprazole documented as administered with 53 not accounted for.</p> <p>Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 10/04/21 at 8:19am revealed:</p> <p>-The pharmacy dispensed 30 pantoprazole 40mg tablets on 04/30/21.</p> <p>-The pharmacy dispensed 60 pantoprazole 40mg tablets on 08/27/21.</p> <p>Telephone interview with the pharmacist at the</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 40</p> <p>facility's contracted pharmacy on 10/04/21 at 8:36am revealed:</p> <ul style="list-style-type: none"> <li>-Pantoprazole was used to treat gastric reflux.</li> <li>-If pantoprazole was administered more frequently than ordered complications of dizziness, tiredness and shakiness could occur.</li> </ul> <p>Interview with primary care provider on 10/04/21 at 3:00pm revealed</p> <ul style="list-style-type: none"> <li>-She had ordered a loading dose of pantoprazole twice a day for 4 weeks followed by a daily dose for maintenance.</li> <li>-Resident #5 could have an increase in discomfort for heartburn or reflux if medication was not administered as ordered.</li> </ul> <p>Interview with Resident #5 on 10/01/21 at 10:35am revealed:</p> <ul style="list-style-type: none"> <li>-He did not always receive his medications as ordered.</li> <li>-The staff did not re-order medications timely.</li> </ul> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>b. Review of Resident #5's physician's orders dated 08/05/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for hydrocortisone cream (used to treat skin irritation) 2.5% apply topically every other day.</li> <li>-There was an order for ketoconazole cream (used to treat skin irritation) 2% apply topically every other day alternating with hydrocortisone cream.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 41</p> <p>Review of Resident #5's July 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for hydrocortisone cream 2.5% apply topically every other day to be applied at 8:00am.</li> <li>-There was an entry for ketoconazole cream 2% apply topically every other day alternating with hydrocortisone cream to be applied at 8:00am.</li> <li>-There was documentation that hydrocortisone cream and ketoconazole cream were applied on the even days of the month of July 2021.</li> <li>-There was no documentation of either cream being applied on the odd days of the month of July 2021.</li> </ul> <p>Review of Resident #5's August 2021 eMAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for hydrocortisone cream 2.5% apply topically every other day to be applied at 8:00am.</li> <li>-There was an entry for ketoconazole cream 2% apply topically every other day alternating with hydrocortisone cream to be applied at 8:00am.</li> <li>-There was documentation that hydrocortisone cream and ketoconazole cream were applied on the odd days of the month of August 2021.</li> <li>-There was no documentation of either cream being applied on the even days of the month of August 2021.</li> </ul> <p>Review of Resident #5's September 2021 eMAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for hydrocortisone cream 2.5% apply topically every other day to be applied at 8:00am.</li> <li>-There was an entry for ketoconazole cream 2% apply topically every other day alternating with hydrocortisone cream to be applied at 8:00am.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 42</p> <p>-There was documentation that hydrocortisone cream and ketoconazole cream were applied on the even days of the month of September 2021.</p> <p>-There was no documentation of either cream being applied on the odd days of the month of September 2021.</p> <p>Observation of medications on hand for Resident #5 on 09/30/21 at 7:43am revealed:</p> <p>-There was one tube of hydrocortisone available for application on hand.</p> <p>-There was one tube of ketoconazole 2% cream available for application on hand.</p> <p>Interview with a medication aide (MA) on 09/30/21 at 11:00am revealed:</p> <p>-She administered hydrocortisone and ketoconazole cream every other day, on the same day of the week.</p> <p>-She had not noticed the order for ketoconazole cream was every other day alternating with hydrocortisone cream.</p> <p>-She was not paying attention when she was administering medications.</p> <p>Refer to interview with RCC on 10/01/21 at 12:25pm and 1:30pm.</p> <p>Refer to interview with the Area Clinical Director on 10/04/21 at 2:45pm.</p> <p>Refer to interview with Administrator on 10/04/21 at 5:00pm.</p> <p>5. Review of Resident #3's current FL-2 dated 07/29/21 revealed diagnoses included type 2 diabetes, hypertension, Chronic Obstructive Pulmonary Disease (COPD), bipolar disorder, dementia, and non-Hodgkin's lymphoma.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 43</p> <p>a. Review of Resident #3's FL-2 dated 07/29/21 revealed an order for Ozempic (a non-insulin once a week injection used to control blood glucose levels) 0.50mg inject subcutaneously scheduled once weekly on Fridays.</p> <p>Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed:<br/>-There was an entry for Ozempic 0.50mg administer once weekly on Fridays scheduled at 8:00am.<br/>-Ozempic was documented as administered on 08/20/21 and 08/27/21.<br/>-Ozempic was not documented as administered on 08/13/21.<br/>-Resident #3's finger stick blood sugar (FSBS) results ranged from 174 to 464.</p> <p>Review of Resident #3's September 2021 eMAR revealed:<br/>-There was an entry for Ozempic 0.50mg once weekly on Fridays scheduled at 8:00am.<br/>-Ozempic was documented as administered on 09/03/21, 09/10/21, 09/17/21, 09/24/21.<br/>-Resident #3's FSBS results ranged from 235 to 479.</p> <p>Review of Resident #3's October 2021 eMAR revealed:<br/>-There was and entry for Ozempic 0.50mg administer once weekly on Fridays scheduled at 8:00am.<br/>-Ozempic was documented as administered on 10/01/21 at 8:00am.<br/>-Resident #3's FSBS results on 10/01/21 ranged from 287 to 480.</p> <p>Observation of Resident #3's medication on hand</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 44</p> <p>on 09/29/21 at 5:17pm revealed:</p> <ul style="list-style-type: none"> <li>-There was an unused and full Ozempic pen available for administration.</li> <li>-The dispense date on the Ozempic pen was 08/06/21.</li> </ul> <p>Telephone interview with a pharmacist from Resident #3's contracted pharmacy on 10/01/21 at 9:23am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3 had a current order for Ozempic 0.5mg scheduled once weekly on Friday.</li> <li>-There was 1.5ml of Ozempic dispensed on 08/06/21.</li> <li>-The 1.5ml of Ozempic should have lasted Resident #3 about three weeks; there was enough extra medication in the pen to prime the pen before each use.</li> <li>-Ozempic was not an insulin but was used with an insulin to control blood glucose levels for people with type 2 diabetes.</li> <li>-An outcome of not administering Ozempic as ordered could be increased FSBS levels; the levels would slowly increase and run higher.</li> </ul> <p>Interview with Resident #3 on 10/01/21 at 10:52am revealed:</p> <ul style="list-style-type: none"> <li>-She had not received her once weekly Ozempic injection.</li> <li>-She had a medication list on the wall, so she knew what her medications were, and they were supposed to be administered.</li> <li>-She knew the Ozempic injection was ordered because she was diabetic.</li> <li>-The facility had not administered her the Ozempic injection in about six weeks.</li> <li>-When she was first admitted to the facility her family member administered the Ozempic medication to her because the facility did not.</li> </ul> <p>Telephone interview with Resident #3's family</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 45</p> <p>member on 10/04/21 at 1:59pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3's Ozempic had not been administered correctly since she had been admitted to the facility.</li> <li>-Resident #3 would tell her the she was not administered her Ozempic.</li> <li>-Resident #3's Ozempic was scheduled to be administered each Friday.</li> <li>-She tried to tell the staff how important it was for Resident #3's Ozempic to be administered as ordered.</li> <li>-She had told the Memory Care Manager (MCM) about Resident #3 not being administered her Ozempic as ordered; MCM told her she would check on it for her.</li> <li>-Resident #3's finger stick blood sugar (FSBS) levels were a little greater than 200 before she was admitted to the facility; now Resident #3's FSBS levels were over 300 and sometimes in the 400's.</li> </ul> <p>Interview with the medication aide (MA) on 10/01/21 at 11:13am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3's Ozempic was administered once a week on Thursdays.</li> <li>-She had not administered Resident #3 her Ozempic injection because she did not work the day before, Thursday.</li> <li>-She had not administered Resident #3 her Ozempic injection that morning, 10/01/21.</li> <li>-She did not know why her initials were documented as having administered Resident #3 the Ozempic injection that morning, 10/01/21.</li> <li>-She thought it must have been a mistake that she documented the medication as administered, but she would give Resident #3 the injection since the resident had not had it.</li> <li>-Resident #3 would let her know if there was a medication that was not administered to her.</li> <li>-Resident #3 had not said anything about the</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 46</p> <p>missed medication to her.<br/>-Sometimes Resident #3's family member would administer her the medication.</p> <p>Interview with the Memory Care Manager (MCM) on 10/01/21 at 1:17pm revealed:<br/>-Resident #3's Ozempic should have been administered once weekly on Friday.<br/>-Resident #3 had a family member that would come to the facility and check to see if the Ozempic medication was administered; the family member had administered the Ozempic in the past because she wanted to administer it.<br/>-She did not check the Ozempic pen when she did cart audits because the medication was kept in the refrigerator and she did not audit the medication refrigerator.<br/>-She looked at the eMAR documentation to see if medication was administered correctly ; if it was not documented then the resident was not administered the medication.<br/>-Resident #3 would let you know when she did not get a medication, she would come to you and remind you it was time to take her medication.<br/>-She was supposed to conduct weekly cart audits with the MA or the Administrator.<br/>-She looked at the medication on the cart and looked for expiration dates, discontinued medications, checked to make sure medications were available and what medications needed to be reordered.<br/>-She did not check the refrigerator when she conducted cart audits.<br/>-MAs had to scan some medications prior to administering and some medication had to be pulled up individually if they were not able to be scanned.<br/>-Each medication had to be "prepped" and then "given" or "not given" in the eMAR system before a MA could document as administered or move</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 47</p> <p>on to administer the next medication.</p> <p>Interview with the Administrator on 10/04/21 at 4:27pm revealed:</p> <ul style="list-style-type: none"> <li>-The medication aides (MAs) should be following the medication orders on the electronic medication administration records (eMAR) exactly; there should be no excuses for not following the eMAR and for not administering medications.</li> <li>-The MCM should be auditing the medication cart and checking for medication counts, compliance reports and if something was not correct then the MAs should be re-educated to correct it.</li> <li>-The MCM should audit the refrigerator when conducting the medication cart audits.</li> <li>-Medication cart audits should be conducted once a week.</li> <li>-MAs should be looking at the medication order on the eMAR and checking for the right dosage, the right person and the right time before administering the medication.</li> <li>-The medication should not be documented as administered until after the MA has watched the resident to make sure the medication was properly taken; then the MA should go to the eMAR and document the medication as administered.</li> <li>-She expected the MAs to administer the medications to the residents as they had been ordered.</li> </ul> <p>Attempted telephone interviews with Resident #3's endocrinologist on 10/04/21 at 1:56pm and 3:18pm were unsuccessful.</p> <p>Attempted telephone interviews with Resident #3's primary care provider (PCP) on 10/01/21 at 10:43am and 10/04/21 at 1:50pm were unsuccessful.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 48</p> <p>b. Review of Resident #3's FL-2 dated 07/29/21 revealed an order for vitamin B-12 (a supplement used to promote healthy blood) 1000 mcg once daily.</p> <p>Review of a signed physicians' order for Resident #3 dated 09/10/21 revealed vitamin B-12 was discontinued.</p> <p>Review of Resident #3's September 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for vitamin B-12 1000mcg once daily scheduled for 8:00am.</li> <li>-Vitamin B-12 was documented as administered on 09/21/21 and 09/22/21.</li> </ul> <p>Review of Resident #3's dispense records from the contracted pharmacy revealed Vitamin-12 1000mg was dispensed on 09/17/21; seven tablets were dispensed in a multipack medication card.</p> <p>Observation of Resident #3's medication on hand on 09/29/21 at 5:17pm revealed:</p> <ul style="list-style-type: none"> <li>-There was a multipack medication card that was dispensed on 09/21/21 and was labeled from the pharmacy with a start date of 09/24/21 and an end date of 09/30/21.</li> <li>-There were separate bubbles for different scheduled administration times on the card.</li> <li>-The back each bubble was color coded for scheduled administration times, a tablet count, the list of medication in each bubble, the day of the week, the date of administration, and the resident's name; there was also a code for scanning.</li> <li>-The bubbles were separated from the card as they were administered to the resident; the</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 358                                                     | <p>Continued From page 49</p> <p>remaining bubbles were scheduled to be administered on future dates.</p> <p>-There was a multipack medication bubble dated for Thursday morning, 09/30/21 attached to the card; the multipack bubble contained nine tablets including a vitamin B-12 1000mcg.</p> <p>Interview with a medication aide (MA) on 09/30/21 at 2:50pm revealed:</p> <p>-Resident #3 had one medication that had recently been discontinued but it was not vitamin B-12.</p> <p>-Vitamin B-12 had not been discontinued.</p> <p>-She compared the eMAR to the multipack bubble and discarded any medication that was discontinued.</p> <p>-She had not discarded the Vitamin B-12.</p> <p>-She did not document discarded medication.</p> <p>Interview with a medication aide (MA) on 10/01/21 at 11:06am revealed:</p> <p>-Discontinued medication was taken off the medication cart by the MA when it was found.</p> <p>-When there was a discontinued medication in a multidose package she would remove the discontinued medication and discard it.</p> <p>-She did not document when she discarded a medication.</p> <p>-She would document the reason not given as discontinued on the electronic Medication Administration Record (eMAR).</p> <p>Interview with a second MA on 10/04/21 at 11:14am revealed:</p> <p>-She knew Resident #3's gabapentin had been discontinued but she was not aware the vitamin B-12 had been discontinued.</p> <p>-She was not aware the discontinued medications were in the multipack medication cards.</p> <p>-She had not discarded any of the discontinued</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 358                                                     | <p>Continued From page 50</p> <p>mediations.</p> <p>Refer to the interview with the MCM on 10/04/21 at 11:00am.</p> <p>Interview with the Memory Care Manager (MCM) on 10/01/21 at 1:17pm revealed:</p> <ul style="list-style-type: none"> <li>-She was supposed to conduct weekly cart audits with the MA or the Administrator.</li> <li>-She looked at the medication on the cart and looked for expiration dates, discontinued medications, checked to make sure medications were available and what medications needed to be reordered.</li> <li>-She did not check the refrigerator when she conducted cart audits.</li> <li>-MAs had to scan some medications prior to administering and some medication had to be pulled up individually if they were not able to be scanned.</li> <li>-Each medication had to be "prepped" and then "given" or "not given" in the eMAR system before a MA could document as administered or move on to administer the next medication.</li> </ul> <p>Interview with the Administrator on 10/04/21 at 4:27pm revealed:</p> <ul style="list-style-type: none"> <li>-The medication aides (MAs) should be following the medication orders on the electronic medication administration records (eMAR) exactly; there should be no excuses for not following the eMAR and for not administering medications.</li> <li>-The MCM should be auditing the medication cart and checking for medication counts, compliance reports and if something was not correct then the MAs should be re-educated to correct it.</li> <li>-The MCM should audit the refrigerator when conducting the medication cart audits.</li> <li>-Medication cart audits should be conducted once</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 51</p> <p>a week.</p> <p>-MAs should be looking at the medication order on the eMAR and checking for the right dosage, the right person and the right time before administering the medication.</p> <p>-The medication should not be documented as administered until after the MA has watched the resident to make sure the medication was properly taken; then the MA should go to the eMAR and document the medication as administered.</p> <p>-She expected the MAs to administer the medications to the residents as they had been ordered.</p> <p>Attempted telephone interviews with Resident #3's primary care provider (PCP) on 10/01/21 at 10:43am and 10/04/21 at 1:50pm were unsuccessful.</p> <p>c. Review of Resident #3's FL-2 dated 07/29/21 revealed an order for magnesium (a dietary supplement that aides the body with blood sugar and blood pressure control)400mg once daily.</p> <p>Review of a signed physicians' order for Resident #3 dated 09/10/21 revealed magnesium 400mg was discontinued.</p> <p>Review of Resident #3's September 2021 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for magnesium 400mg once daily scheduled for 8:00am.</p> <p>-Magnesium was documented as administered on 09/21/21 and 09/22/21.</p> <p>Review of Resident #3's dispense records from the contracted pharmacy revealed magnesium 400mg was dispensed on 09/17/21; seven tablets</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 358                                                     | <p>Continued From page 52</p> <p>were dispensed in a multipack medication card.</p> <p>Observation of Resident #3's medication on hand on 09/29/21 at 5:17pm revealed:</p> <ul style="list-style-type: none"> <li>-There was a multipack medication card that was dispensed on 09/21/21 and was labeled from the pharmacy with a start date of 09/24/21 and an end date of 09/30/21.</li> <li>-There were separate bubbles for scheduled administration times on the card.</li> <li>-The back of each bubble was color coded for a scheduled administration time, and was labeled with a tablet count, the list of medication in each bubble, the day of the week, the date of administration, and the resident's name; there was also a code for scanning.</li> <li>-The bubbles were separated from the card as they were administered to the resident; the remaining bubbles were scheduled to be administered on future dates.</li> <li>-There was a multipack medication bubble dated for Thursday morning, 09/30/21 attached to the card; the multipack bubble contained nine tablets including magnesium 400mg.</li> </ul> <p>Interview with a medication aide (MA) on 09/30/21 at 2:50pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3 had one medication that had recently been discontinued but it was not the magnesium.</li> <li>-Magnesium had not been discontinued.</li> <li>-She had not discarded Resident #3's magnesium.</li> <li>-She compared the eMAR to the multipack bubble and discarded any medication that was discontinued.</li> <li>-She did not document discarded medication.</li> </ul> <p>Interview with a medication aide (MA) on 10/01/21 at 11:06am revealed:</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 53</p> <ul style="list-style-type: none"> <li>-Discontinued medication was taken off the medication cart by the MA when it was found.</li> <li>-When there was a discontinued medication in a multidose package she would remove the discontinued medication and discard it.</li> <li>-She did not document when she discarded a medication.</li> <li>-She would document the reason not given as discontinued on the electronic Medication Administration Record (eMAR).</li> </ul> <p>Interview with a second MA on 10/04/21 at 11:14am revealed:</p> <ul style="list-style-type: none"> <li>-She knew Resident #3's gabapentin had been discontinued but she was not aware the magnesium had been discontinued.</li> <li>-She was not aware the discontinued medications were in the multipack medication cards.</li> <li>-She had not discarded any of the discontinued medications.</li> </ul> <p>Interview with the Memory Care Manager (MCM) on 10/01/21 at 1:17pm revealed:</p> <ul style="list-style-type: none"> <li>-She was supposed to conduct weekly cart audits with the MA or the Administrator.</li> <li>-She looked at the medication on the cart and looked for expiration dates, discontinued medications, checked to make sure medications were available and what medications needed to be reordered.</li> <li>-She did not check the refrigerator when she conducted cart audits.</li> <li>-MAs had to scan some medications prior to administering and some medication had to be pulled up individually if they were not able to be scanned.</li> <li>-Each medication had to be "prepped" and then "given" or "not given" in the eMAR system before a MA could document as administered or move on to administer the next medication.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 54</p> <p>Second interview with the MCM on 10/04/21 at 11:00am revealed:</p> <ul style="list-style-type: none"> <li>-She recalled medication being discontinued by resident #3's primary care provider (PCP) on 09/10/21.</li> <li>-She had entered the discontinuation notice in the eMAR system herself and she had sent the notification to the pharmacy via electronic fax.</li> <li>-She did not know why the pharmacy had included the medication back in the multipack medication card.</li> <li>-Discontinued medication could not be documented on as administered once it was discontinued.</li> <li>-The MAs should have not administered the discontinued medication but removed it from the multipack medication card and discarded it.</li> <li>-Discarded medication was not documented.</li> <li>-She had no way of ensuring the discontinued medication was not administered other than to trust the MAs were not administering the medications.</li> </ul> <p>Interview with the Administrator on 10/04/21 at 4:27pm revealed:</p> <ul style="list-style-type: none"> <li>-The medication aides (MAs) should be following the medication orders on the electronic medication administration records (eMAR) exactly; there should be no excuses for not following the eMAR and for not administering medications.</li> <li>-The MCM should be auditing the medication cart and checking for medication counts, compliance reports and if something was not correct then the MAs should be re-educated to correct it.</li> <li>-The MCM should audit the refrigerator when conducting the medication cart audits.</li> <li>-Medication cart audits should be conducted once a week.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 55</p> <p>-MAs should be looking at the medication order on the eMAR and checking for the right dosage, the right person and the right time before administering the medication.</p> <p>-The medication should not be documented as administered until after the MA has watched the resident to make sure the medication was properly taken; then the MA should go to the eMAR and document the medication as administered.</p> <p>-She expected the MAs to administer the medications to the residents as they had been ordered.</p> <p>Attempted telephone interviews with Resident #3's primary care provider (PCP) on 10/01/21 at 10:43am and 10/04/21 at 1:50pm were unsuccessful.</p> <p>d. Review of Resident #3's FL-2 dated 07/29/21 revealed an order for gabapentin (used to treat pain) 300mg three times daily.</p> <p>Review of a signed physicians' order for Resident #3 dated 09/10/21 revealed gabapentin 300mg was discontinued.</p> <p>Review of Resident #3's September 2021 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for gabapentin 300mg three times daily scheduled for 8:00am, 2:00pm and 8:00pm.</p> <p>-Gabapentin was documented as administered on 09/21/21 at 8:00am, 2:00pm and 8:00pm and 09/22/21 at 8:00am and 2:00pm.</p> <p>Review of Resident #3's dispense records from the contracted pharmacy revealed gabapentin 300mg was dispensed on 09/17/21; 21 tablets</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 358                                                     | <p>Continued From page 56</p> <p>were dispensed in a multipack medication card.</p> <p>Observation of Resident #3's medication on hand on 09/29/21 at 5:17pm revealed:</p> <ul style="list-style-type: none"> <li>-There was a multipack medication card that was dispensed on 09/21/21 and was labeled from the pharmacy with a start date of 09/24/21 and an end date of 09/30/21.</li> <li>-There were separate bubbles for the scheduled administration times on the card.</li> <li>-The back of each bubble was color coded for a scheduled administration time, and was labeled with a tablet count, the list of medication in each bubble, the day of the week, the date of administration, and the resident's name; there was also a code for scanning.</li> <li>-The bubbles were separated from the card as they were administered to the resident; the remaining bubbles were scheduled to be administered on future dates.</li> <li>-There was a multipack medication bubble dated for Thursday morning, 09/30/21 attached to the card; the multipack bubble contained nine tablets including gabapentin 300mg.</li> <li>-There was a multipack medication bubble dated for Thursday afternoon, 09/30/21 attached to the card; the multipack bubble contained two tablets including gabapentin 300mg.</li> <li>-There was a multipack medication bubble dated for Thursday evening, 09/30/21 attached to the card; the multipack bubble contained six tablets including gabapentin 300mg.</li> </ul> <p>Interview with a medication aide (MA) on 09/30/21 at 2:50pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #'s gabapentin had been discontinued but she could not remember the date.</li> <li>-She discarded the gabapentin and did not administer it to Resident #3.</li> <li>-She compared the eMAR to the multipack</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 57</p> <p>bubble and discarded any medication that was discontinued.<br/>-She did not document discarded medication.</p> <p>Interview with a medication aide (MA) on 10/01/21 at 11:06am revealed:<br/>-Discontinued medication was taken off the medication cart by the MA when it was found.<br/>-When there was a discontinued medication in a multidose package she would remove the discontinued medication and discard it.<br/>-She did not document when she discarded a medication.<br/>-She would document the reason not given as discontinued on the electronic Medication Administration Record (eMAR).</p> <p>Interview with a second MA on 10/04/21 at 11:14am revealed:<br/>-She knew Resident #3's gabapentin had been discontinued but she was not aware the vitamin B-12 or the magnesium had been discontinued.<br/>-She was not aware the discontinued medications were in the multipack medication cards.<br/>-She had not discarded any of the discontinued medications.</p> <p>Interview with the Memory Care Manager (MCM) on 10/01/21 at 1:17pm revealed:<br/>-She was supposed to conduct weekly cart audits with the MA or the Administrator.<br/>-She looked at the medication on the cart and looked for expiration dates, discontinued medications, checked to make sure medications were available and what medications needed to be reordered.<br/>-She did not check the refrigerator when she conducted cart audits.<br/>-MAs had to scan some medications prior to administering and some medication had to be</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 58</p> <p>pulled up individually if they were not able to be scanned.</p> <p>-Each medication had to be "prepped" and then "given" or "not given" in the eMAR system before a MA could document as administered or move on to administer the next medication.</p> <p>Second interview with the MCM on 10/04/21 at 11:00am revealed:</p> <p>-She recalled medication being discontinued by resident #3's primary care provider (PCP) on 09/10/21.</p> <p>-She had entered the discontinuation notice in the eMAR system herself and she had sent the notification to the pharmacy via electronic fax.</p> <p>-She did not know why the pharmacy had included the medication back in the multipack medication card.</p> <p>-Discontinued medication could not be documented on as administered once it was discontinued.</p> <p>-The MAs should have not administered the discontinued medication but removed it from the multipack medication card and discarded it.</p> <p>-Discarded medication was not documented.</p> <p>-She had no way of ensuring the discontinued medication was not administered other than to trust the MAs were not administering the medications.</p> <p>Interview with the Administrator on 10/04/21 at 4:27pm revealed:</p> <p>-The medication aides (MAs) should be following the medication orders on the electronic medication administration records (eMAR) exactly; there should be no excuses for not following the eMAR and for not administering medications.</p> <p>-The MCM should be auditing the medication cart and checking for medication counts, compliance</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 59</p> <p>reports and if something was not correct then the<br/>MAs should be re-educated to correct it.</p> <p>-The MCM should audit the refrigerator when<br/>conducting the medication cart audits.</p> <p>-Medication cart audits should be conducted once<br/>a week.</p> <p>-MAs should be looking at the medication order<br/>on the eMAR and checking for the right dosage,<br/>the right person and the right time before<br/>administering the medication.</p> <p>-The medication should not be documented as<br/>administered until after the MA has watched the<br/>resident to make sure the medication was<br/>properly taken; then the MA should go to the<br/>eMAR and document the medication as<br/>administered.</p> <p>-She expected the MAs to administer the<br/>medications to the residents as they had been<br/>ordered.</p> <p>Attempted telephone interviews with Resident<br/>#3's primary care provider (PCP) on 10/01/21 at<br/>10:43am and 10/04/21 at 1:50pm were<br/>unsuccessful.</p> <p>e. Review of Resident #3's FL-2 dated 07/29/21<br/>revealed an order for Trelegy Ellipta (used to treat<br/>Chronic Obstructive Pulmonary Disease (COPD))<br/>inhale one puff daily.</p> <p>Review of Resident #3's August 2021 electronic<br/>medication administration record (eMAR)<br/>revealed:</p> <p>-There was an entry for Trelegy Ellipta inhale one<br/>puff daily scheduled at 8:00am.</p> <p>-The Trelegy Ellipta was documented as<br/>administered 25 of 25 opportunities from<br/>08/01/21 to 08/03/21 and 08/09/21 to 08/31/21.</p> <p>-Resident #3 was out of the facility for 5 days<br/>from 08/04/21 to 08/08/21 .</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 60</p> <p>Review of Resident #3's September 2021 eMAR revealed:<br/>-There was an entry for Trelegy Ellipta inhale one puff daily scheduled at 8:00am.<br/>-The Trelegy Ellipta was documented as administered 30 out of 30 opportunities from 09/01/21 to 09/30/21.</p> <p>Review of Resident #3's October 2021 eMAR revealed:<br/>-There was an entry for Trelegy Ellipta inhale one puff daily scheduled at 8:00am.<br/>-The Trelegy Ellipta was documented as administered 1 of 1 opportunity on 10/01/21.</p> <p>Observation of Resident #3's medication on hand on 09/29/21 at 5:17pm revealed:<br/>-There was one Trelegy Ellipta disk with a dispense date of 08/13/21.<br/>-The indicator for the counter was solid red and there were no numbers visible.</p> <p>Observation of Resident #3 on 09/30/21 at 12:50pm revealed she was coughing and could not speak for a moment when asked a question.</p> <p>Telephone interview with a pharmacist from Resident #3's contracted pharmacy on 10/01/21 at 9:23am revealed:<br/>-Resident #3 had an order for Trelegy Ellipta inhale one puff once daily.<br/>-The Trelegy Ellipta was dispensed on 07/19/21 and 08/13/21.<br/>-The Trelegy Ellipta was not on a cycle fill and had to be ordered by the facility when needed.<br/>-The Trelegy Ellipta should have lasted 30 days.<br/>-There was a counter on the disk that counted down the doses in the disk.<br/>-When the disk had only 10 doses left the counter</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 61</p> <p>indicator would show a partial red line.<br/>-When the counter indicator was at zero the counter indicator would be a solid red and no numbers would be visible.<br/>-Trelegy Ellipta was ordered for COPD; bronchial spasms and shortness of breath due to decreased oxygen levels were possible outcomes of not administering the medication as ordered.</p> <p>Interview with Resident #3 on 09/30/21 at 12:50pm revealed:<br/>-She had been coughing for about two weeks; she always had shortness of breath that was why she had the inhaler.<br/>-She used her Trelegy inhaler every morning.<br/>-She could not taste the inhaler; it did not have a taste.</p> <p>Interview with Resident #3 on 10/01/21 at 10:52am revealed:<br/>-She had not been administered her Trelegy Ellipta inhaler that day.<br/>-Staff had not said anything to her about her Trelegy Ellipta.<br/>-She had been coughing that morning and not breathing "good", so she had her breathing treatment with her nebulizer and that helped.<br/>-She did not tell the medication aide (MA) she was not administered the Trelegy Ellipta because the MA did not like her, and she did not know why.</p> <p>Interview with a MA on 09/30/21 at 2:50pm revealed:<br/>-The solid red and no numbers on the Trelegy indicator meant it was time to reorder another disk.<br/>-She had not administered Resident #3 the Trelegy, so she had not noticed the indicator was red.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 62</p> <p>-The Memory Care Manager (MCM) ordered medications from the pharmacy when it was time to reorder.</p> <p>Interview with a second MA on 10/01/21 at 11:13am revealed:</p> <p>-She reordered Resident #3's Trelegy Ellipta when the counter was indicated 5 doses remained in the disk.</p> <p>-She noticed the counter was down to 10 when she administered the Trelegy Ellipta to Resident #3 on Wednesday, 09/29/21.</p> <p>-She had not administered the Trelegy to Resident #3 today because it was not on the cart.</p> <p>-She had not had a chance to ask the MCM if the Trelegy Ellipta had been reordered.</p> <p>-Resident #3 had not complained about shortness of breath and she had not observed the resident coughing.</p> <p>-Resident #3 was aware of her medications and when they were supposed to be administered; she would "nag you" when it was time to administer her medication.</p> <p>Interview with the MCM on 10/01/21 at 1:17pm revealed:</p> <p>-She looked at inhalers when she did her weekly cart audits.</p> <p>-She looked at the counters on the inhalers as well as for expiration dates.</p> <p>-Resident #3's Trelegy Ellipta had a counter that indicated how many doses were left in the disk.</p> <p>-She had administered Resident #3 her Trelegy Ellipta on Sunday, 09/26/21 and did not see any red on the indicator.</p> <p>-She did not recall the number on the counter, and she did not know what the number on the counter would be on the Trelegy Ellipta when it would begin to show a red line.</p> <p>-She knew the red would show when the counter</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
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| D 358                                                     | <p>Continued From page 63</p> <p>needed reordering.</p> <p>-She was concerned the counter was indicating there was nothing in the disk and another Trelegy had not been reordered.</p> <p>-Resident #3 needed the Trelegy Ellipta for her COPD.</p> <p>-There was no way to tell how long the Trelegy Ellipta had been empty.</p> <p>Interview with the Memory Care Manager (MCM) on 10/01/21 at 1:17pm revealed:</p> <p>-She was supposed to conduct weekly cart audits with the MA or the Administrator.</p> <p>-She looked at the medication on the cart and looked for expiration dates, discontinued medications, checked to make sure medications were available and what medications needed to be reordered.</p> <p>-She did not check the refrigerator when she conducted cart audits.</p> <p>-MAs had to scan some medications prior to administering and some medication had to be pulled up individually if they were not able to be scanned.</p> <p>-Each medication had to be "prepped" and then "given" or "not given" in the eMAR system before a MA could document as administered or move on to administer the next medication.</p> <p>Interview with the Administrator on 10/04/21 at 4:27pm revealed:</p> <p>-The medication aides (MAs) should be following the medication orders on the electronic medication administration records (eMAR) exactly; there should be no excuses for not following the eMAR and for not administering medications.</p> <p>-The MCM should be auditing the medication cart and checking for medication counts, compliance reports and if something was not correct then the</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 64</p> <p>MAs should be re-educated to correct it.</p> <ul style="list-style-type: none"> <li>-The MCM should audit the refrigerator when conducting the medication cart audits.</li> <li>-Medication cart audits should be conducted once a week.</li> <li>-MAs should be looking at the medication order on the eMAR and checking for the right dosage, the right person and the right time before administering the medication.</li> <li>-The medication should not be documented as administered until after the MA has watched the resident to make sure the medication was properly taken; then the MA should go to the eMAR and document the medication as administered.</li> <li>-She expected the MAs to administer the medications to the residents as they had been ordered.</li> </ul> <p>Attempted telephone interviews with Resident #3's primary care provider (PCP) on 10/01/21 at 10:43am and 10/04/21 at 1:50pm were unsuccessful.</p> <p>g. Review of a signed physician's order from Resident #3's Neurologist dated 08/09/21 revealed an order for Emgality (a vasodilator used to prevent migraine headaches, it is not an anticoagulant) 225 inject once monthly.</p> <p>Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Emgality 120mg/ml inject 2ml once monthly.</li> <li>-There was documentation on 08/17/21 that the Emgality had been discontinued.</li> <li>-There was no other documentation for the Emgality on the eMAR.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 65</p> <p>Review of Resident #3's September 2021 eMAR revealed Emgality 225mg was not listed on the eMAR.</p> <p>Telephone interview with a pharmacist from Resident #3's contracted pharmacy on 10/01/21 at 9:58am revealed:</p> <ul style="list-style-type: none"> <li>-There was an order dated 08/02/21 for Resident #3 for Emgality inject 1ml subcutaneously once monthly.</li> <li>-The pharmacy requested prior authorization be obtained from the neurologist by the facility on 08/17/21 and on 09/07/21.</li> <li>-The facility called the pharmacy after the request on 09/07/21 and requested the forms for authorization; the pharmacy faxed the information to the facility, and they had not heard back from anyone.</li> <li>-Emgality was ordered to prevent migraines and cluster headaches; an outcome of not receiving the medication as ordered could be an increase in migraines and their frequency.</li> </ul> <p>Telephone interview with a triage nurse from Resident #3's neurologist office on 10/01/21 at 10:32am revealed:</p> <ul style="list-style-type: none"> <li>-The facility had contacted them that day to request a letter stating the family could administer the medication to Resident #3.</li> <li>-The facility stated they did not have anyone that could inject the Emgality at the facility.</li> <li>-The order was dated 08/09/21 for a loading dose of Emgality 225mg and then 120mg once a month.</li> <li>-Prior authorization was given to the facility on 08/16/21 for the insurance and the pharmacy.</li> <li>-Resident #3 was ordered the Emgality for chronic migraines; an outcome from not being administered the medication as ordered could be an increase in chronic migraines.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 66</p> <p>Telephone interview with Resident #3's family member on 10/04/21 at 2:23pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3 had the Emgality injection once a month to prevent migraines.</li> <li>-The neurologist would not administer the Emgality in the office and the Memory Care Manager (MCM) told her that the facility could not administer the Emgality injection that a Home Health agency would have to administer it.</li> <li>-She administered Resident #3's Emgality injection because the facility did not administer it and they never set up home health to administer it.</li> <li>-The MCM expected the family to administer the Emgality injection every month.</li> <li>-She gave Resident #3 the loading dose of Emgality on 09/11/21 and Resident #3 was due for the next injection on 10/11/21; she guessed she would have to administer that dose as well.</li> <li>-She administered Resident #3's Emgality in the parking lot.</li> <li>-There was no documentation that she gave Resident #3 the Emgality injection.</li> <li>-Resident #3 did not receive the Emgality in August 2021 due to the "back and forth" from the facility; that was why she administered Resident #3's Emgality injection herself.</li> <li>-The MCM told her the facility could not get in touch with the neurologist and the Home Health agency declined to administer the Emgality.</li> <li>-Resident #3 still had an order for Emgality once monthly.</li> </ul> <p>Interview with the MCM on 10/01/21 at 1:17pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #3 was ordered the Emgality injection in August 2021.</li> <li>-The facility's corporate office would not allow the MAs to administer subcutaneous injections for</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 67</p> <p>anticoagulants.</p> <p>-She contacted multiple Home Health agencies to administer Resident #3 the Emgality.</p> <p>-The home health agencies all denied Resident #3 because the Emgality was not on the approved list of medications for reimbursements.</p> <p>-She had asked the facility's contracted PCP to administer the Emgality, but the PCP refused.</p> <p>-She notified Resident #3's family about the home health agencies' denial to administer the Emgality.</p> <p>-The family was insistent Resident #3 was administered the Emgality.</p> <p>-The neurologist that ordered the Emgality asked if the family to administer the Emgality to Resident #3.</p> <p>-The facility would not allow the family to administer Resident #3 medication while she was in the facility but, she could not say what the family did when they picked Resident #3 up and took her out of the facility.</p> <p>-She had not contacted the neurologist herself, the family communicated with the neurologist and told her what the neurologist said.</p> <p>-She had not contacted Resident #3's PCP about administering the Emgality at their office; she had not thought about it.</p> <p>-Resident #3 had not complained to her about migraines; she had other migraine medication she could take as needed.</p> <p>Interview with the Divisional Director of Clinical Services for the facility on 10/01/21 at 11:06am revealed:</p> <p>-The facility did not allow the MAs to administer anticoagulants subcutaneously and Emgality was an anticoagulant.</p> <p>-MAs were only allowed to administer insulin subcutaneously.</p> <p>-The family could not administer the Emgality at</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 68</p> <p>the facility; the resident would need to be taken to a nurse or a physician's office for the injection to be administered.</p> <p>Interview with the Administrator on 10/01/21 at 12:00pm revealed:</p> <ul style="list-style-type: none"> <li>-The neurologist requested the family member administer the Emgality injection.</li> <li>-The facility staff was not trained to administer the subcutaneous anticoagulant injection.</li> <li>-Resident #3 had not been administered the Emgality since she had been given the order by the neurologist.</li> <li>-The MCM had made her aware of the situation about Resident #3's Emgality injection about a week ago.</li> <li>-The process was for a Home Health agency to administer the Emgality injection because it was an anticoagulant.</li> <li>-The MCM had reached out to a Home Health agency to inquire about administering the Emgality to Resident #3.</li> <li>-She was told by the MCM that the Home Health agency said the ordering physician had to administer the injection.</li> <li>-She did not know why the Home Health agency did not want to administer the injection.</li> <li>-She did not know where the MCM was in the process of a referral for the Home Health agency or the injection for Resident #3.</li> </ul> <p>Interview with the ED on 10/04/21 at 5:42pm revealed:</p> <ul style="list-style-type: none"> <li>-The facility struggled to meet the care of Resident #3 because her neurologist was two hours away from the facility and difficult to contact.</li> <li>-She knew it was the facility's responsibility to ensure Resident #3 was administered the Emgality as ordered.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 69</p> <p>-Resident #3 clearly needed Emgality for a reason because the neurologist had ordered the medication.</p> <p>-She did not know why Resident #3 was ordered Emgality; she had not heard of any concerns or complaints from Resident #3.</p> <p>-The facility did not want the MAs to inject anything other than insulin and she knew Emgality was not an insulin.</p> <p>Interview with the Memory Care Manager (MCM) on 10/01/21 at 1:17pm revealed:</p> <p>-She was supposed to conduct weekly cart audits with the MA or the Administrator.</p> <p>-She looked at the medication on the cart and looked for expiration dates, discontinued medications, checked to make sure medications were available and what medications needed to be reordered.</p> <p>-She did not check the refrigerator when she conducted cart audits.</p> <p>-MAs had to scan some medications prior to administering and some medication had to be pulled up individually if they were not able to be scanned.</p> <p>-Each medication had to be "prepped" and then "given" or "not given" in the eMAR system before a MA could document as administered or move on to administer the next medication.</p> <p>Interview with the Administrator on 10/04/21 at 4:27pm revealed:</p> <p>-The medication aides (MAs) should be following the medication orders on the electronic medication administration records (eMAR) exactly; there should be no excuses for not following the eMAR and for not administering medications.</p> <p>-The MCM should be auditing the medication cart and checking for medication counts, compliance</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b>                       |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| D 358                                                     | <p>Continued From page 70</p> <p>reports and if something was not correct then the<br/>MAs should be re-educated to correct it.</p> <p>-The MCM should audit the refrigerator when<br/>conducting the medication cart audits.</p> <p>-Medication cart audits should be conducted once<br/>a week.</p> <p>-MAs should be looking at the medication order<br/>on the eMAR and checking for the right dosage,<br/>the right person and the right time before<br/>administering the medication.</p> <p>-The medication should not be documented as<br/>administered until after the MA has watched the<br/>resident to make sure the medication was<br/>properly taken; then the MA should go to the<br/>eMAR and document the medication as<br/>administered.</p> <p>-She expected the MAs to administer the<br/>medications to the residents as they had been<br/>ordered.</p> <p>Attempted telephone interview with the facility's<br/>contracted Home Health agency on 10/04/21 at<br/>3:18pm was unsuccessful.</p> <p>Attempted telephone interviews with Resident<br/>#3's primary care provider (PCP) on 10/01/21 at<br/>10:43am and 10/04/21 at 1:50pm were<br/>unsuccessful.</p> <p>6. Review of Resident #4's FL-2 dated 08/25/21<br/>revealed:</p> <p>-Diagnoses included Alzheimer's dementia,<br/>anxiety disorder, hyperlipidemia, chronic<br/>obstructive pulmonary disease (COPD) and<br/>coronary artery disease.</p> <p>-There was an order for risperidone (an<br/>antipsychotic used to treat irritability) 1mg give<br/>.25ml twice daily.</p> <p>Review of Resident #4's current FL-2 dated</p> | D 358                                                                         |                                                                                                                          |                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 71</p> <p>09/16/21 revealed:<br/>-There was no diagnosis listed and in the space for listing medication "see attachment" was documented.<br/>-The attached list was electronically printed and was signed by the primary care provider (PCP).<br/>-The order for risperidone 1mg administer .25ml twice daily was not on the medication list.</p> <p>Review of Resident #4's Resident Register revealed she was admitted to the facility on 09/07/21.</p> <p>Review of Resident #4's September 2021 electronic medication administration record (eMAR) revealed:<br/>-There was an electronic entry for Resident #4's risperidone had a start date of 09/17/21 and scheduled for administration at 1:00pm and 8:00pm.<br/>-Liquid risperidone was documented as administered beginning on 09/17/21 at 8:00pm.<br/>-There was a second entry for risperidone solution 1mg/ml administer. 25ml twice dailey scheduled at 8:00am and 8:00pm.<br/>-Risperdone was documented as administered begining 09/21/21 on the second entry.<br/>-Risperidone was documented as administered 20 of 42 opportunities from 09/07/21 to 09/29/21.</p> <p>Observation of Resident #4's medication on hand on 09/29/21 at 5:07pm revealed:<br/>-There were two bottles of liquid Risperidone with various amounts available for administration.<br/>-There was a bubble package of risperidone dispensed on 09/02/21; 30 tablets were dispensed and 9 were available for administration.<br/>-There was an unopened bottle of 180 tablets dispensed on 09/22/21.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 72</p> <p>Review of Resident #4's continuity of care document dated 09/29/21 revealed:<br/>-Risperidone 1mg/ml solution administer .25ml by mouth twice daily at 1:00pm and 8:00pm; use liquid until pill becomes available was electronically documented.<br/>-The electronic entry was dated 09/17/21 to 09/19/21.</p> <p>Telephone interview with the facility's contracted pharmacy on 09/30/21 at 9:08am revealed:<br/>-The facility was responsible for electronically faxing the residents' FL-2s to the pharmacy.<br/>-The pharmacy prepared the eMAR and medication orders from the FL-2.<br/>-Risperidone 1mg/ml solution administer .25ml by mouth twice daily at 1:00pm and 8:00pm was entered into the eMAR on 09/17/21.<br/>-Risperidone .25mg in a tablet form twice daily was entered into the eMAR on 09/21/21.</p> <p>Telephone interview with Resident #4's contracted pharmacy on 10/04/21 at 12:02pm revealed:<br/>-There was an order dated 09/22/21 for risperidone .25mg in a tablet form twice daily; the order was received electronically.<br/>-A 90-day supply of 180 tablets were dispensed on 09/22/21.<br/>-They did not have record of previous dispense dates.</p> <p>Interview with Resident #4's primary care provider (PCP) on 09/30/21 at 11:20am revealed:<br/>-Resident #4's risperidone had been ordered on 09/16/21 after the family brought it to her attention it was an order from her previous PCP; she then notified the facility there was an order for it.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 73</p> <ul style="list-style-type: none"> <li>-The order was sent to the pharmacy electronically on 09/16/21.</li> <li>-The pharmacy only had risperidone in the liquid form for dispensing at the time the order was sent; she approved the liquid form until the tablet for was available if the dosage was the same amount.</li> </ul> <p>Telephone interview with Resident #4's PCP on 10/04/21 at 11:34am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4 did not have an order for risperidone until 09/16/21 when she called the family and compared the resident's medication list.</li> <li>-She did not know if it was transcribed from the FL-2 dated 08/25/21 or not.</li> <li>-The previous order was for a liquid form of risperidone, but she had changed it to a tablet form.</li> <li>-The facility was told to use the liquid form of risperidone that was on hand until the</li> <li>-The risperidone was ordered for Resident #4's paranoia and agitation.</li> <li>-A possible outcome of not receiving risperidone as ordered could be increased agitation.</li> <li>-When a resident was first admitted to a facility there was typically some increased agitation; Resident #4 had increased agitation when she was first admitted to the facility.</li> <li>-The risperidone would have helped with Resident #4's agitation if she had received it as ordered when she was admitted to the facility.</li> </ul> <p>Interview with a medication aide (MA) on 09/30/21 at 2:50pm and 4:32pm revealed:</p> <ul style="list-style-type: none"> <li>-She had administered Resident #4 her risperidone in the tablet form since her order began on 09/17/21.</li> <li>-She did not know why there was confusion over the risperidone because Resident #4 had risperidone when she was admitted to the facility.</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 74</p> <p>-Resident #4 was admitted with both the liquid and the tablet form of her risperidone.</p> <p>-Resident #4 had an active eMAR from the day she was admitted; she did not administer the risperidone until it was visible on the eMAR.</p> <p>Interview with the Memory Care Manager (MCM) on 10/01/21 at 12:44pm revealed:</p> <p>-She was responsible for faxing Resident #4's FL-2 to the pharmacy when she was admitted to the facility.</p> <p>-Resident #4's family provided her medications from a pharmacy other than the facility's contracted pharmacy; she was admitted to the facility with all of her medications.</p> <p>-She was responsible for ensuring all medications were listed correctly on the eMAR.</p> <p>Interview with the MCM on 10/04/21 at 10:05am revealed:</p> <p>-Resident #4 had a profile eMAR from the facility's contracted pharmacy because the family provided the medications from another pharmacy; a profile eMAR was used to document administration of medication.</p> <p>-On 09/07/21, she electronically faxed the pharmacy the FL-2 dated 08/25/21; that was the FL-2 the resident was admitted with.</p> <p>-Resident #4's eMAR was viewable on 09/08/21; that was the date the facility began using it.</p> <p>-She was handed a bag of medication for Resident #4 on the day she was admitted.</p> <p>-She went by the FL-2 and the medication the previous facility had sent; all the medications were in bubble packs.</p> <p>-She checked the medications against the FL-2 when the resident was admitted with medications available.</p> <p>-She did not recall seeing the risperidone among Resident #4's medication when she was</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 75</p> <p>admitted.</p> <p>-All of Resident #4's personal belongings were in a box; she only pulled the bubble packages that were in the bag.</p> <p>-Resident #4's liquid risperidone was found by staff in the box of personal belongings on 09/08/21 and placed on the medication cart.</p> <p>-She checked the medications against the FL-2, but she missed the risperidone.</p> <p>-She did not compare the eMAR profile to the FL-2; she did not have the FL-2 in front of her so she just looked at the eMAR profile.</p> <p>-The signed physicians' orders and the medications for the most recent FL-2 dated 09/16/21 were printed from the eMAR so if the eMAR was incorrect and not checked then the most recent FL-2 would not be correct.</p> <p>-The pharmacy missed the risperidone when they set up the profile in the eMAR.</p> <p>-The family called the PCP and informed the PCP Resident #4 was not receiving the risperidone; she did not know how the family knew the risperidone was not being administered to Resident #4.</p> <p>Interview with the Administrator on 10/04/21 at 4:27pm revealed:</p> <p>-The medication aides (MAs) should be following the medication orders on the electronic medication administration records (eMAR) exactly; there should be no excuses for not following the eMAR and for not administering medications.</p> <p>-The MCM should be auditing the medication cart and checking for medication counts, compliance reports and if something was not correct then the MAs should be re-educated to correct it.</p> <p>-The MCM should audit the refrigerator when conducting the medication cart audits.</p> <p>-Medication cart audits should be conducted once</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 76</p> <p>a week.</p> <p>-MAs should be looking at the medication order on the eMAR and checking for the right dosage, the right person and the right time before administering the medication.</p> <p>-The medication should not be documented as administered until after the MA has watched the resident to make sure the medication was properly taken; then the MA should go to the eMAR and document the medication as administered.</p> <p>-She expected the MAs to administer the medications to the residents as they had been ordered.</p> <p>_____</p> <p>Interview with the Resident Care Coordinator (RCC) on 10/01/21 at 12:25pm and 1:30pm revealed:</p> <p>-The MAs should follow the directions on the electronic medication administration records (eMARs) when administering medications.</p> <p>-The MAs should be checking the medication labels with the eMAR three times.</p> <p>-The MAs should be asking for clarification if needed.</p> <p>-The facility was contracted with two pharmacies.</p> <p>-The MAs would call the facility's contracted pharmacies to re-order medications.</p> <p>-The medications would arrive the same day or the next day.</p> <p>-She faxed re-orders to the second facility contracted pharmacy.</p> <p>-The medications would arrive in 1 to 2 days.</p> <p>-The MAs checked the medications in when they arrived.</p> <p>-She expected the MAs to inform her if medications were not on the medication cart.</p> <p>-She did not audit the medication cart.</p> <p>-She did not audit the eMARs.</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 358                                                     | <p>Continued From page 77</p> <ul style="list-style-type: none"> <li>-She had not been told to audit the medication carts.</li> <li>-She had not been told to audit the eMARs.</li> </ul> <p>Interview with the Area Clinical Director on 10/04/21 at 2:45pm revealed:</p> <ul style="list-style-type: none"> <li>-He was in the facility once a week.</li> <li>-He taught the medication administration class to all new employees.</li> <li>-The RCC should be auditing the medication carts.</li> <li>-The RCC should be auditing the eMARs.</li> <li>-He would audit the medication carts if asked by the District Clinical Director.</li> </ul> <p>Interview with the Administrator on 10/04/21 at 5:00pm revealed:</p> <ul style="list-style-type: none"> <li>-The MAs were expected to follow the six rights of administering medications.</li> <li>-The MAs were expected to administer medications as ordered.</li> <li>-The MAs were to call the PCP if a medication needed to be clarified.</li> <li>-The MAs were to call the pharmacy for refills in a timely manner.</li> <li>-If the MA was not sure how to do a task, such as insulin injections or inhalers, they should ask the RCC.</li> <li>-The RCC should be pulling reports daily to check for medication counts, narcotic counts and compliance reports.</li> <li>-They should correct or educate staff on the problems that are found on the reports.</li> <li>-Staff should be notifying their immediate supervisor if they did not have a medication in the facility that needed to be administered.</li> <li>-The RCC should be auditing the medication carts weekly.</li> <li>-The RCC should be auditing the eMARs weekly.</li> <li>-The MA and the RCC were responsible for</li> </ul> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | <p>Continued From page 78</p> <p>re-ordering medications, timely.</p> <p>Interview with the Administrator on 10/04/21 at 4:27pm revealed:</p> <ul style="list-style-type: none"> <li>-The medication aides (MAs) should be following the medication orders on the electronic medication administration records (eMAR) exactly; there should be no excuses for not following the eMAR and for not administering medications.</li> <li>-The MCM should be auditing the medication cart and checking for medication counts, compliance reports and if something was not correct then the MAs should be re-educated to correct it.</li> <li>-The MCM should audit the refrigerator when conducting the medication cart audits.</li> <li>-Medication cart audits should be conducted once a week.</li> <li>-MAs should be looking at the medication order on the eMAR and checking for the right dosage, the right person and the right time before administering the medication.</li> <li>-The medication should not be documented as administered until after the MA has watched the resident to make sure the medication was properly taken; then the MA should go to the eMAR and document the medication as administered.</li> <li>-She expected the MAs to administer the medications to the residents as they had been ordered.</li> </ul> <p>_____</p> <p>The facility failed to ensure medications were administered as ordered for 5 residents observed during the medication pass and for 5 sampled residents, including a resident's (#1) insulin was administered incorrectly which affected the absorption of the medications; a resident (#9) who was administered a stool softener instead of a topical pain cream; a resident (#10) who did not</p> | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | Continued From page 79<br><br>receive her antibiotic as ordered which could prolong and cause systemic infection; a resident (#11) who was incorrectly administered an eye drop in her eye that was to treat glaucoma; a resident (#13) who was not offered water after an inhalation treatment which could cause mouth sores; a resident (#1) who did not receive medication as ordered to treat rheumatoid arthritis which could lead to inflammation and flare-ups, a medication for allergies as ordered and a mouth wash to treat mouth sores; a resident (#2) who did not receive her blood thinner as ordered which could lead to clotting causing stroke or pulmonary embolism, a medication to treat nerve pain which could result in increase in pain and a medication to treat congestion; a resident (#3) who did not receive injections to improve blood sugar which lead to increased FSBS readings, a medication to reduce pain which could increase pain and a medication to treat chronic obstructive pulmonary disease which could cause difficulty in breathing, a medication to treat migraine headaches which could increase chances of a migraine and a vitamin supplements and a dietary supplement; a resident (#4) who did not receive a medication to treat irritability which could lead to behavioral issues; a resident (#5) who did not receive a medication to treat his reflux which could cause increase in gastric discomfort and a topical cream which was applied every other day on the same day instead of alternating days as ordered. The facility's failure to administer medication as ordered was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/21 for this violation. | D 358                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 358                                                     | Continued From page 80                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D 358                                                                                              |                                                                                                                          |                                                        |
| D 371                                                     | <p>CORRECTION DATE FOR THE TYPE B<br/>VIOLATION SHALL NOT EXCEED</p> <p>10A NCAC 13F .1004(n) Medication<br/>Administration</p> <p>10A NCAC 13F .1004 Medication Administration<br/>(n) The facility shall assure that medications are<br/>administered in accordance with infection control<br/>measures that help to prevent the development<br/>and transmission of disease or infection, prevent<br/>cross-contamination and provide a safe and<br/>sanitary environment for staff and residents.</p> <p>This Rule is not met as evidenced by:<br/>Based on observations and interview, the facility<br/>failed to ensure infection control measures were<br/>implemented as evidenced by a medication aide<br/>(MA), who popped pills into her bare hand prior to<br/>administration; and failed to wash her hands with<br/>soap and water or use hand sanitizer before<br/>donning and doffing gloves when administering<br/>an eye drop and prepping insulin injection for<br/>administration.</p> <p>The findings are:</p> <p>Review of the facility's infection control policy<br/>revealed staff should perform hand hygiene<br/>before donning and after doffing gloves.</p> <p>Observation of the morning medication pass on<br/>09/30/21 at 7:30am revealed:</p> <ul style="list-style-type: none"> <li>-The medication aide (MA) initiated preparing<br/>medications for administration to a resident.</li> <li>-The MA prepared 13 pills for administration to a<br/>resident.</li> <li>-The MA punched 4 pills from the blister packs</li> </ul> | D 371                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 371                                                     | <p>Continued From page 81</p> <p>into her ungloved, bare hand.</p> <p>-The MA donned gloves after the fourth pill had been punched into her hand.</p> <p>-The MA did not cleanse her hands prior to donning gloves.</p> <p>-The MA punched the remaining 9 pills into her gloved hand.</p> <p>-The MA placed the medications into a medication cup.</p> <p>Observation of the medication pass on 09/30/21 at 11:17am revealed:</p> <p>-The MA prepped eye drops for administration.</p> <p>-The MA did not use sanitizer or soap and water to cleanse her hands prior to donning gloves.</p> <p>-The MA donned gloves and administered the eye drops.</p> <p>-The MA doffed gloves and documented the medication was administered.</p> <p>-The MA did not use sanitizer or soap and water to cleanse her hands after doffing gloves.</p> <p>Observation of insulin administration on 09/30/21 at 11:28am revealed:</p> <p>-The MA prepared the insulin for administration.</p> <p>-The MA did not change her gloves after checking fingerstick blood sugar prior to prepping insulin for administration.</p> <p>-The MA administered insulin under the resident's skin.</p> <p>-The MA returned to the medication cart and removed her gloves.</p> <p>-The MA wore the same gloves when performing the FSBS, when prepping and administering the insulin</p> <p>Interview with the MA on 09/30/21 at 2:35pm revealed:</p> <p>-She knew she was not to touch the resident's medications with her bare, ungloved hand.</p> | D 371                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 371                                                     | Continued From page 82<br><br>-She forgot to don her gloves before removing 4 pills from the blister packs.<br>-She failed to change her gloves after the FSBS check.<br>-She used sanitizer after she removed her gloves.<br>-She did not know she was to wash her hands with soap and water after removing her gloves.<br><br>Interview with the Area Clinical Director on 10/04/21 at 2:45pm revealed:<br>-The MAs should pop pills into a souffle or medication cup.<br>-The MAs should wash their hands with soap and water after every third resident or more frequently when their hands were soiled.<br>-The MA should wash their hands after FSBS checks, administration of insulin and eye drops, once gloves were removed.<br><br>Interview with the Administrator on 10/04/21 at 5:00pm revealed:<br>-The MAs should wash their hands with soap and water after administration of medication to every third resident or more frequently when their hands were soiled.<br>-The MAs should wash their hand with soap and water once gloves were removed. | D 371                                                                                              |                                                                                                                          |                                                        |
| D 375                                                     | 10A NCAC 13F .1005(a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications<br>(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:<br>(1) the self-administration is ordered by a physician or other person legally authorized to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | D 375                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 375                                                     | <p>Continued From page 83</p> <p>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.</p> <p>This Rule is not met as evidenced by:<br/>Based on observations, record reviews and interviews, the facility failed to ensure 3 of 3 residents sampled (#2, # 5 #13) had a physician's order to self-administer an eye drop (#2, #5) and an anti-acid (#13).</p> <p>The findings are:</p> <p>Review of the facility's self-management of medications policy revealed:<br/>-Any resident who desired to self-manage their medication must complete the self-administration assessment.<br/>-The Resident Care Coordinator (RCC) was responsible for completing the self-administration assessment.<br/>-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.</p> <p>1. Review of Resident #2's current FL2 dated 06/03/21 revealed diagnoses included major depressive disorder, osteoarthritis, hyperlipidemia, unspecified falls and chronic systolic heart failure.</p> <p>Observation of Resident #2's room on 10/04/21 at 9:00am revealed a bottle of thera-tears (used to treat discomfort caused by dry eyes) sitting on the</p> | D 375                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 375                                                     | <p>Continued From page 84</p> <p>nightstand.</p> <p>Review of Resident #2's physician's orders on 10/04/21 revealed there was no order for thera-tears.</p> <p>Interview with Resident #2 on 10/04/21 at 9:13am revealed:<br/>-Resident #2's Primary Care Provider (PCP) instructed her to administer thera-tears for dry, itchy eyes.<br/>-She administered the eye drops herself.<br/>-She did not tell the staff each time she administered the eye drops.<br/>-The staff were aware that she had the eye drops in her room.</p> <p>Interview with a medication aide (MA) on 10/04/21 at 10:56am revealed:<br/>-She had not noticed the bottle of eye drops in Resident #2's room.<br/>-She had not administered eye drops to Resident #2.<br/>-There was not an order for eye drops for Resident #2.<br/>-The family must have brought the eye drops to Resident #2.<br/>-Resident #2 was able to self-administer eye drops.<br/>-Residents were required to have a physician's order from their PCP to keep medications in their room.</p> <p>Interview with the Resident Care Coordinator (RCC) on 10/04/21 at 11:20am revealed:<br/>-She did not know that Resident #2 had eye drops in her room.<br/>-There was no order for thera-tears for Resident #2 to self-administer.</p> | D 375                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 375                                                     | <p>Continued From page 85</p> <p>Telephone interview with Resident #2's PCP on 10/04/21 at 3:00pm revealed she was not aware that the resident had thera-tears in her room.</p> <p>Refer to interview with the RCC on 10/04/21 at 11:20am.</p> <p>Refer to interview with the Administrator on 10/04/21 at 5:00pm.</p> <p>2. Review of Resident #5's current FL2 dated 08/05/21 revealed diagnoses included anxiety disorder, hypoxemia, major depressive disorder, congestive heart failure, chronic pain syndrome and hyperlipidemia.</p> <p>Observation of Resident #5's room on 10/04/21 at 9:00am revealed a bottle of thera-tears (used to treat discomfort caused by dry eyes) sitting on his nightstand.</p> <p>Review of Resident #5's physician's orders on 10/04/21 revealed there was no order for thera-tears.</p> <p>Interview with Resident #5 on 10/04/21 at 9:11am revealed:<br/>-His family member administered the eye drops for him.<br/>-The eye drops helped with dry, itchy eyes.</p> <p>Interview with Resident #5's family member on 10/04/21 at 9:13am revealed:<br/>-Resident #5's Primary Care Provider (PCP) instructed him to administer thera-tears for dry, itchy eyes.<br/>-He was unable to administer the eye drops himself.<br/>-She would administer the eye drops to Resident #5.</p> | D 375                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 375                                                     | <p>Continued From page 86</p> <ul style="list-style-type: none"> <li>-She did not tell the staff each time she administered eye drops to Resident #5.</li> <li>-The staff were aware that Resident #5 had thera-tears in his room.</li> </ul> <p>Interview with a medication aide (MA) on 10/04/21 at 10:56am revealed:</p> <ul style="list-style-type: none"> <li>-She had not noticed the bottle of eye drops in Resident #5's room.</li> <li>-She had not administered eye drops to Resident #5.</li> <li>-There was not an order for eye drops for Resident #5.</li> <li>-The family must have brought the eye drops to Resident #5.</li> <li>-Resident #5 was not able to self-administer eye drops.</li> <li>-Residents required an order from their PCP to keep medications in their room.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 10/04/21 at 11:20am revealed:</p> <ul style="list-style-type: none"> <li>-She did not know that Resident #5 had eye drops in his room.</li> <li>-There was no order for thera-tears for Resident #5 to self-administer.</li> </ul> <p>Telephone interview with Resident #5's PCP on 10/04/21 at 3:00pm revealed she was not aware that the resident had thera-tears in her room.</p> <p>Refer to interview with the RCC on 10/04/21 at 11:20am.</p> <p>Refer to interview with the Administrator on 10/04/21 at 5:00pm.</p> <p>3. Review of Resident #13's current FL2 dated 07/12/21 revealed diagnoses included Parkinson's disease, generalized anxiety</p> | D 375                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 375                                                     | <p>Continued From page 87</p> <p>disorder, polyarthritis, hypertension and hypothyroidism.</p> <p>Observation of Resident #13's room on 10/04/21 at 9:40am revealed a bottle of anti-acid (used to treat heartburn) sitting on her bedside table.</p> <p>Review of Resident #13's physician's orders on 10/04/21 revealed there was no order for an anti-acid.</p> <p>Interview with a medication aide (MA) on 10/04/21 at 10:56am revealed:</p> <ul style="list-style-type: none"> <li>-She had not noticed the bottle of anti-acid in Resident #13's room.</li> <li>-She had not administered anti-acid to Resident #13.</li> <li>-She did have an order for anti-acid to be administered to Resident #13.</li> <li>-She did not have an order for Resident #13 to self-administer the medication.</li> <li>-She did not know how Resident #13 obtained the anti-acid medication for her room.</li> <li>-Resident #13 was not able to self-administered medications.</li> <li>-Resident #13 required an order from her Primary Care Provider (PCP) to keep medications in their room.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 10/04/21 at 11:20am revealed:</p> <ul style="list-style-type: none"> <li>-She did not know that Resident #13 had anti-acid tablets in her room.</li> <li>-There was no order for anti-acids for Resident #13 to self-administer.</li> </ul> <p>Based on observations, interviews, and record reviews it was determined Resident # 13 was not interviewable.</p> | D 375                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 375                                                     | Continued From page 88<br><br>Attempted interview with the PCP on 10/04/21 at 1:10pm was unsuccessful.<br><br>Refer to interview with the RCC on 10/04/21 at 11:20am.<br><br>Refer to interview with the Administrator on 10/04/21 at 5:00pm.<br><br>Interview with the RCC on 10/04/21 at 11:20am revealed all self-administered medications that were kept in resident rooms must have a physician's order.<br><br>Interview with the Administrator on 10/04/21 at 5:00pm revealed:<br>-She was unaware that residents had medications in their rooms.<br>-She was unaware that residents did not have orders to administer self-medications.<br>-The company has a policy regarding self-administration of medications in resident rooms. | D 375                                                                         |                                                                                                                          |  |                                                        |
| D 377                                                     | 10A NCAC 13F .1006(a) Medication Storage<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure that the                                                                                                                                                                                                                                                                                                 | D 377                                                                         |                                                                                                                          |  |                                                        |

Division of Health Service Regulation

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| D 377                                                     | <p>Continued From page 89</p> <p>residents' medications were stored in a safe and secure manner for 3 of 3 sampled residents (Resident #2, #5, #13) who self-administered medications.</p> <p>The findings are:</p> <p>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.</p> <p>1 Review of Resident #2's current FL2 dated 06/03/21 revealed diagnoses included major depressive disorder, osteoarthritis, hyperlipidemia, unspecified falls and chronic systolic heart failure.</p> <p>Review of Resident #2's physician's orders dated 06/03/21 revealed there was no order for thera-tears (used to treat discomfort caused by dry eyes).</p> <p>Observation of Resident #2's room on 10/04/21 at 9:00am revealed a bottle of thera-tears sitting on the nightstand.</p> <p>Interview with Resident #2 on 10/04/21 at 9:13am revealed:<br/>-Resident #2's Primary Care Provider (PCP) instructed her to administer thera-tears for dry, itchy eyes.<br/>-Staff was aware that she had the eye drops in her room.</p> <p>Interview with a medication aide (MA) on 10/04/21 at 10:56am revealed:<br/>-She had not noticed the bottle of eye drops in Resident #2's room.</p> | D 377                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 377                                                     | <p>Continued From page 90</p> <p>-The family must have brought the eye drops to Resident #2.</p> <p>Interview with the Resident Care Coordinator (RCC) on 10/04/21 at 11:20am revealed she did not know that Resident #2 had eye drops in her room.</p> <p>Refer to interview with the MA on 10/04/21 at 10:56am.</p> <p>Refer to interview with the RCC on 10/04/21 at 11:20am.</p> <p>Refer to interview with the Administrator on 10/04/21 at 5:00pm.</p> <p>2. Review of Resident #5's current FL2 dated 08/05/21 revealed diagnoses included anxiety disorder, hypoxemia, major depressive disorder, congestive heart failure, chronic pain syndrome and hyperlipidemia.</p> <p>Review of Resident #5's physician's orders dated 06/03/21 revealed there was no order for theria-tears (used to treat discomfort caused by dry eyes).</p> <p>Observation of Resident #5's room on 10/04/21 at 9:00am revealed a bottle of theria-tears sitting on his nightstand.</p> <p>Interview with Resident #5's family member on 10/04/21 at 9:13am revealed:<br/>-Resident #5's Primary Care Provider (PCP) instructed him to administer theria-tears for dry, itchy eyes.<br/>-Staff was aware that Resident #5 had theria-tears in his room.</p> | D 377                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 377                                                     | <p>Continued From page 91</p> <p>Interview with a medication aide (MA) on 10/04/21 at 10:56am revealed:<br/>-She had not noticed the bottle of eye drops in Resident #5's room.<br/>-The family must have brought the eye drops to Resident #5.</p> <p>Interview with the Resident Care Coordinator (RCC) on 10/04/21 at 11:20am revealed she did not know that Resident #5 had eye drops in her room.</p> <p>Refer to interview with the MA on 10/04/21 at 10:56am.</p> <p>Refer to interview with the RCC on 10/04/21 at 11:20am.</p> <p>Refer to interview with the Administrator on 10/04/21 at 5:00pm.</p> <p>3. Review of Resident #13's current FL2 dated 07/12/21 revealed diagnoses included Parkinson's disease, generalized anxiety disorder, polyarthritis, hypertension and hypothyroidism.</p> <p>Review of Resident #13's physician's orders dated 07/26/21 revealed there was no order for anti-acid 9 used to treat heart burn.</p> <p>Observation of Resident #13's room on 10/04/21 at 9:40am revealed a bottle of anti-acid sitting on her bedside table.</p> <p>Interview with a medication aide (MA) on 10/04/21 at 10:56am revealed:<br/>-She had not noticed the bottle of anti-acid in Resident #13's room.<br/>-She did not know how Resident #13 obtained the</p> | D 377                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL001148</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b> |                                                                                                                          |                                                        |
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| D 377                                                     | <p>Continued From page 92</p> <p>anti-acid medication for her room.</p> <p>Interview with the Resident Care Coordinator (RCC) on 10/04/21 at 11:20am revealed she did not know that Resident #13 had anti-acid tablets in her room.</p> <p>Based on observations, interviews, and record reviews it was determined Resident # 13 was not interviewable.</p> <p>Attempted interview with the PCP on 10/04/21 at 1:10pm was unsuccessful.</p> <p>Refer to interview with the MA on 10/04/21 at 10:56am.</p> <p>Refer to interview with the RCC on 10/04/21 at 11:20am.</p> <p>Refer to interview with the Administrator on 10/04/21 at 5:00pm.</p> <p>Interview with the medication aide (MA) on 10/04/21 at 5:00pm revealed:<br/>-Another resident could take the medication from the rooms of residents that were self-administering, if the medications were not secure.<br/>-She knew the self-administered medications kept in resident rooms had to be secured and safe from other residents.</p> <p>Interview with the RCC on 10/04/21 at 11:20am revealed all self-administered medications had to be secured in the resident's room.</p> <p>Interview with the Administrator on 10/04/21 at 5:00pm revealed:<br/>-She was not aware of any resident who</p> | D 377                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 377                                                     | Continued From page 93<br><br>self-administered medications.<br>-She was unaware that residents had<br>medications in their rooms.<br>-The company had a policy regarding the storage<br>of self-administrated medications in resident<br>rooms.<br>-All medications that were kept in resident rooms<br>were to be secured in a lock box.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | D 377                                                                                              |                                                                                                                          |                                                        |
| D 382                                                     | 10a NCAC 13F .1006 (f) Medication Storage<br><br>10a NCAC 13F .1006 Medication Storage<br><br>(f) Medications requiring refrigeration shall be<br>stored at 36 degrees F to 46 degrees F (2<br>degrees C to 8 degrees C).<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record<br>review the facility failed to ensure the medications<br>requiring refrigeration were stored in the<br>refrigerator and maintained at a temperature of<br>36 degrees F to 46 degrees F.<br><br>The findings are:<br><br>Review of the facility's medication storage policy<br>revealed:<br>-All medications must be stored in accordance<br>with label instructions.<br>-Medication requiring refrigeration should be<br>stored between 36 degrees F to 46 degrees F.<br>-The refrigerator thermometer should be checked<br>daily and the temperature recorded on the daily<br>refrigerator temperature log.<br><br>Observation of the medication refrigerator in the | D 382                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 382                                                     | <p>Continued From page 94</p> <p>assisted living unit on 10/04/21 at 12:01pm revealed:</p> <ul style="list-style-type: none"> <li>-The medication refrigerator door was partially opened.</li> <li>-There was water on the floor in front of the refrigerator.</li> <li>-There was a refrigerator temperature of 62 degrees F on the facility thermometer.</li> <li>-There were 21 vials of insulin in the refrigerator.</li> <li>-There were three blister packs of acidophilus tablets in the refrigerator.</li> <li>-There were 8 insulin pens in the refrigerator.</li> <li>-There was a medication refrigerator temperature log for July 2021 on the front of the refrigerator.</li> <li>-There were no refrigerator temperatures documented on the July 2021 medication refrigerator temperature log.</li> </ul> <p>Review of the medication refrigerator temperature log for August 2021, September 2021 and October 2021 revealed there was no medication refrigerator temperature log to review.</p> <p>Interview with the Resident Care Coordinator (RCC) on 10/04/21 at 12:05pm revealed:</p> <ul style="list-style-type: none"> <li>-She did not check the medication refrigerator temperature.</li> <li>-She had not been instructed to check the medication refrigerator temperature.</li> <li>-She did not know who was to check the medication refrigerator temperature.</li> <li>-She could not locate a medication refrigerator temperature log for October 2021.</li> <li>-She did not know the medication refrigerator temperature needed to be checked and recorded daily.</li> <li>-She did not know what the medication refrigerator temperature should be.</li> <li>-She did not know she was responsible for auditing the medication refrigerator weekly.</li> </ul> | D 382                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 382                                                     | Continued From page 95<br><br>Interview with the Special Care Unit Coordinator (SCC) on 10/04/21 at 12:15pm revealed the third shift medication aide (MA) should be checking the medication refrigerator temperature.<br><br>Interview with the Administrator on 10/04/21 at 5:00pm revealed:<br>-The MAs should be checking the medication refrigerator temperature daily.<br>-The MAs should be documenting on the medication refrigerator temperature log daily.<br>-The temperature of the medication refrigerator should be between 36 degrees F and 46 degrees F.<br>-The RCC should audit the medication refrigerator temperature weekly.                                                                                             | D 382                                                                                              |                                                                                                                          |                                                        |
| D 612                                                     | 10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp)<br><br>10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM<br>(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.<br><br>This Rule is not met as evidenced by: | D 612                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 612                                                     | <p>Continued From page 96</p> <p>TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 57 residents during the global Coronavirus (COVID-19) pandemic as related to wearing the required personal protective equipment (PPE) and restricting contact with residents during an active occurrence of COVID-19 and signage instructing staff for the COVID-19 isolation area.</p> <p>The findings are:</p> <p>Review of the NC Department of Health and Human Services COVID-19 Long Term Care (LTC) Infection Control and CDC guidance when caring for a resident with COVID-19 dated 09/10/21 related to increased PPE including the use and disposal, contact restrictions and management of staff and residents that have had close contact with the infected resident.</p> <p>Observation of the facility on 09/29/21 at 9:48am revealed:</p> <ul style="list-style-type: none"> <li>-There was an area at the end of a hallway that was partitioned off with thick and transparent plastic.</li> <li>-The plastic hung from the ceiling and pooled slightly on the floor.</li> <li>-There were two zippers on the plastic partition.</li> <li>-There was no signage designating the area as a restricted COVID-19 area or an isolation area.</li> <li>-There was no signage on the partition or on the walls next to patritian instructing staff what to do before entering the isolation area.</li> <li>-There was no PPE available on the outside of</li> </ul> | D 612                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 612                                                     | <p>Continued From page 97</p> <p>the partitioned area.</p> <p>Observation on 09/29/21 at 9:30am revealed a medication aide (MA) entered into the COVID-19 restricted area with only a mask donned.</p> <p>Observation on 09/29/21 at 10:35am revealed a MA entered into the COVID-19 restricted area with only a mask donned.</p> <p>Observation of the partitioned isolation area on 09/30/21 at 5:12pm revealed:</p> <ul style="list-style-type: none"> <li>-There was a contracted maintenance staff inside the area without a gown on; he had on a facemask and a pair of latex gloves and was moving about the area.</li> <li>-He used the zipper to exit the isolation area and did not discard his facemask or gloves.</li> <li>-He entered a resident room that was occupied by two residents; the residents were not in the room.</li> <li>-He entered a second room with the same facemask and gloves that he had on while in the isolation area.</li> </ul> <p>Observation of the inside of the partitioned isolation area on 09/30/21 at 5:14pm revealed:</p> <ul style="list-style-type: none"> <li>-There was a counter with a large bottle of hand sanitizer, a box with one surgical facemask, an opened box of latex gloves and no gowns.</li> <li>-The was a personal care aide (PCA) sitting in a chair across from the counter.</li> <li>-The PCA was wearing a gown, a surgical facemask and gloves.</li> <li>-There was only one surgical gown available in the isolation area.</li> </ul> <p>Observation on 10/01/21 at 10:30am revealed:</p> <ul style="list-style-type: none"> <li>-There was signage instructing staff to don PPE prior to entering the COVID-19 area.</li> </ul> | D 612                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 612                                                     | <p>Continued From page 98</p> <ul style="list-style-type: none"> <li>-The PPE required was a gown, a pair of gloves, a mask and a face shield or goggles.</li> <li>-There was signage instructing the staff how to don and doff PPE prior to entering the restricted COVID-19 area.</li> </ul> <p>Interview with a PCA on 09/30/21 at 5:14pm revealed:</p> <ul style="list-style-type: none"> <li>-She was assigned to care for the residents while they were in the isolation area.</li> <li>-There was one resident in the isolation area.</li> <li>-She offered the contracted maintenance staff a gown, but he declined; he had told her "he did not care" about wearing a gown.</li> <li>-She did not ask him to leave the area because he refused to put on a gown.</li> <li>-She did not know it was a requirement for him to wear a gown.</li> <li>-There was only one resident in the isolation area.</li> <li>-The contracted maintenance staff had gone into the room of the isolated resident; she did not know if he touched anything or how long he was in the room.</li> <li>-He did not discard his gloves or facemask as he left the isolation area.</li> <li>-She thought there were more gowns in the isolation area; she would ask someone to bring her more gowns.</li> <li>-She had training for infection prevention and control related to the care of COVID-19 positive residents when she was hired a few months ago.</li> </ul> <p>Interview with a second PCA and a cook on 09/30/21 at 5:30pm revealed:</p> <ul style="list-style-type: none"> <li>-They were told to wear a gown, facemask and gloves when they entered the isolation area.</li> <li>-They had not seen any staff enter the isolation area without the proper PPE.</li> <li>-They were told by the Administrator earlier that day to not enter the isolation area and to only</li> </ul> | D 612                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D 612                                                     | <p>Continued From page 99</p> <p>pass the cart with the food into the isolation area.<br/>-The PCA had been inside the isolation area and donned and doffed a gown and new facemask each time; the cook had not been inside the isolation area.</p> <p>Interview with the Business Office Manager (BOM) on 09/29/21 at 9:48am revealed:<br/>-There were three residents that had tested positive for COVID-19 and were in a designated isolation area.<br/>-There were two staff assigned exclusively to the isolation unit.<br/>-The isolation unit had an entrance from the exterior of the facility and through a plastic partition in the hallway.<br/>-No other staff were allowed in the isolation unit except for one medication aide (MA) and a housekeeper; food was delivered to the isolation area from the exterior entrance.</p> <p>Interview with the Administrator on 09/30/21 at 5:35pm revealed:<br/>-Staff entering the isolation area should wear proper PPE including gown, facemask, goggles, and gloves.<br/>-There were designated PCA's for the isolation area.<br/>-The MA from the assisted living side of the facility administered the medication to the residents in the isolation area and should donning and doffing PPE properly when entering or leaving the isolation area.<br/>-The PCA that was assigned to work in the isolation area should have instructed the contracted maintenance staff to don and to doff PPE; that was her responsibility.<br/>-The PCA should have denied the contracted maintenance staff access to the isolations area.<br/>-The staff had all been trained on proper donning</p> | D 612                                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALAMANCE HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2766 GRAND OAKS BOULEVARD<br/>BURLINGTON, NC 27215</b>                       |                          |                                                        |
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| D 612                                                     | <p>Continued From page 100</p> <p>and doffing of PPE and should have followed the training to prevent the spread of COVID-19 to the rest of the facility.</p> <p>-There should have been enough PPE in the isolation unit for the PCA to provide anyone going into the isolation area.</p> <p>-She did not think about signage on the outside of the isolation area because all staff had been trained and instructed on PPE usage.</p> <p>-She was very concerned to hear staff were not donning gowns while in the isolation area and not doffing surgical facemask because the facility was working very hard to prevent the spread of COVID-19 to the rest of the facility.</p> <p>_____</p> <p>The facility failed to follow the Centers for Disease Control (CDC), North Carolina Department of Health and Human Services (NC DHHS) guidelines and recommendations, and the facility's policies for coronavirus (COVID-19) during the global pandemic which resulted in inappropriate use of PPE related to wearing and changing PPE and eyewear protection when providing care to residents and restricting contact with residents identified as positive for COVID-19 and negative for COVID-19 who resided in the same area of the facility. The facility's failure to follow the guidance related to infection prevention for COVID-19 was detrimental to the health and safety of the residents which constitutes a type B violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/01/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 18, 2021.</p> | D 612                                                                         |                                                                                                                          |                          |                                                        |

Division of Health Service Regulation

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| D912                                                      | Continued From page 101                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | D912                                                                                               |                                                                                                                          |                                                        |
| D912                                                      | <p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights<br/>Every resident shall have the following rights:<br/>2. To receive care and services which are<br/>adequate, appropriate, and in compliance with<br/>relevant federal and state laws and rules and<br/>regulations.</p> <p>This Rule is not met as evidenced by:<br/>Based on observations, interviews and record<br/>reviews, the facility failed to ensure residents<br/>received care and services which were adequate,<br/>appropriate and in compliance with relevant<br/>federal and state laws and rules and regulations<br/>related to personal care and supervision.</p> <p>The findings are:</p> <p>Based on observations, interviews, and record<br/>reviews, the facility failed to administer<br/>medications as ordered for 5 of 9 residents<br/>(#1, #9, #10, #11, #13) observed during the<br/>morning and noon medication pass including<br/>errors with the administration of insulin (#1);<br/>administration of a stool softener instead of a<br/>topical cream for pain (#9); omission of an<br/>antibiotic (#10); administration of an eye drop in<br/>the incorrect eye (#11); failure to offer water after<br/>inhalation therapy (13) and for 5 of 5 residents<br/>sampled for record review including errors with an<br/>anti-inflammatory medication, an anti-allergy<br/>medication, a medication to treat mouth sores<br/>(#1); a blood thinner medication to thin the blood,<br/>a nerve pain medication, an expectorant<br/>medication (#2); a non-insulin injection used to<br/>improve blood sugar, a pain medication, an<br/>inhaler, a vasodilator medication, a vitamin</p> | D912                                                                                               |                                                                                                                          |                                                        |

Division of Health Service Regulation

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| D912                                                      | Continued From page 102<br><br>supplement and a dietary supplement (#3), an antipsychotic (#4), and a proton pump inhibitor and a topical skin cream (#5). [Refer to Tag D 0358, 10A NCAC 13 F .1004(a) Medication Administration (Type B Violation)]<br><br>Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 57 residents during the global Coronavirus (COVID-19) pandemic as related to wearing the required personal protective equipment (PPE) and restricting contact with residents during an active occurrence of COVID-19 and signage instructing staff for the COVID-19 isolation area. [Refer to Tag D 0612, 10A NCAC 13 F .1801(c) Infection Prevention and Control (Type B Violation)] | D912                                                                                               |                                                                                                                          |                                                        |