| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on 09/07/22-09/08/22. | D 000 | | |
| 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 which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to ensure the administration of medications as ordered for 4 of 5 sampled residents (#2, #3, #4, #5) related to medications used to control blood sugar (#2, #5), 2 medications used to treat bipolar disorder (#2), a medication used to treat heartburn (#3), a medication used to control blood pressure (#5), a medication used to treat depression and anxiety (#4), and a medication used to prevent blood clots (#4).<br><br>The findings are:<br><br>1.Review of Resident #2's current FL-2 dated 08/02/22 revealed diagnoses included type II diabetes and a history of hydrocephalus.<br><br>a. Review of Resident #2's current FL-2 dated | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

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|---|---|---|---|---|
| D 358 | Continued From page 1<br><br>08/02/22 revealed:<br>-There was an order for Lantus Solostar 100 units, 40 units to be administered by subcutaneous injection daily at 6:00am. (Lantus Solostar is a long acting insulin used to treat diabetes.)<br>-There was an order for Lantus Solostar 100 units, 34 units to be administered by subcutaneous injection daily at 6:00pm<br><br>Interview with Resident #2 on 09/07/22 at 9:34am revealed:<br>-She received Lantus twice daily to help control her blood sugar.<br>-She received her medication every day but did not receive it every day in the past due to the facility changing pharmacies.<br><br>Review of Resident #2's medication administration record (MAR) for July 2022 revealed:<br>-There was a computerized entry for Lantus Solostar 100 units, inject 40 units subcutaneously at 6:00am.<br>-The was documentation that Lantus Solostar 40 units was administered each day at 6:00am from 07/01/22 through 07/18/22.<br>-There was documentation Lantus Solostar 40 units was not administered 07/19/22 through 07/31/22 because the medication was not available in the facility.<br>-There was a computerized entry for Lantus Solostar 100 units, inject 34 units subcutaneously at 6:00pm.<br>-There was documentation that Lantus Solostar 34 units was administered each day at 6:00pm from 07/01/22 through 07/17/22.<br>-There was documentation that Lantus Solostar 34 units was not administered 07/18/22 through 07/31/22. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

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|---|---|---|---|---|
| D 358 | Continued From page 2<br>-There were 27 out of 62 doses of Lantus Solostar 100 units that were not administered as ordered in July 2022.<br><br>Review of Resident #2's blood sugar log for July 2022 revealed:<br>-Her blood sugar levels ranged from 107 to 243 at 7:00am.<br>-Her blood sugar levels ranged from 174 to 347 at 11:00am.<br>-Her blood sugar levels ranged from 93 to 407 at 4:00pm.<br>-Her blood sugar levels ranged from 117 to 324 at 8:00pm.<br><br>Review of Resident #2's MAR for August 2022 revealed:<br>-There was a computerized entry for Lantus Solostar 100 units, inject 40 units subcutaneously at 6:00am.<br>-The was documentation that Lantus Solostar 40 units was administered each day at 6:00am from 08/04/22 through 08/22/22.<br>-There was documentation Lantus Solostar 40 units was not administered 08/01/22 through 08/03/22 08/23/22 through 08/31/22 because the medication was not available in the facility.<br>-There was a computerized entry for Lantus Solostar 100 units, inject 34 units subcutaneously at 6:00pm.<br>-There was documentation that Lantus Solostar 34 units was administered each day at 6:00pm on 08/02/22 and 08/03/22 and from 08/05/22 through 08/24/22.<br>-There was documentation that Lantus Solostar 34 units was not administered 08/01/22 and from 08/25/22 through 08/31/22 because the medication was not available in the facility .<br>-There was no documentation that Lantus Solostar 34 units was administered on 08/04/22. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 3 | D 358 | | |

-There was no documentation of the reason Lantus Solostar 34 units was not administered on 08/04/22.
-There were 21 out of 62 doses of Lantus Solostar 1000units that were not administered as ordered in August 2022.

Review of Resident #2's blood sugar log for August 2022 revealed:
-Her blood sugar levels ranged from 122 to 277 at 7:00am.
-Her blood sugar levels ranged from 138 to 395 at 11:00am.
-Her blood sugar levels ranged from 185 to 414 at 4:00pm.
-Her blood sugar levels ranged from 113 to 345 at 8:00pm.

Review of Resident #2's MAR for September 2022 revealed:
There was a computerized entry for Lantus Solostar 100 units, inject 40 units subcutaneously at 6:00am.
-The was documentation that Lantus Solostar 40 units was administered each day at 6:00am on 09/01/22 and from 09/03/22 through 09/07/22.
-There was documentation Lantus Solostar 40 units was not administered on 09/02/22 because the medication was not available in the facility.
-There was a hand-written entry for Lantus Solostar 100 units, inject 34 units subcutaneously at 6:00pm.
-There was documentation that Lantus Solostar 34 units was administered each day at 6:00pm from 09/02/22 through 09/07/22.
-There was documentation that Lantus Solostar 34 units was not administered 09/01/22 because the medication was not available in the facility.
-There were 2 out of 14 doses of Lantus Solostar 100 units that were not administered as ordered

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

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|---|---|---|---|---|
| D 358 | Continued From page 4<br>in September 2022.<br><br>Review of Resident #2's blood sugar log for September 2022 revealed:<br>-Her blood sugar levels ranged from 200 to 273 at 7:00am.<br>-Her blood sugar levels ranged from 245 to 323 at 11:00am.<br>-Her blood sugar levels ranged from 250 to 377 at 4:00pm.<br>-Her blood sugar levels ranged from 223 to 338 at 8:00pm.<br><br>Interview with a medication aide (MA)on 09/08/22 at 2:20pm revealed Resident #2 always had high blood sugar readings because she ate what ever she wanted but noticed a "small increase" in her blood sugars during the time she was not receiving her Lantus.<br><br>Refer to interview with the lead medication aide (MA) on 09/08/22 at 10:00am.<br><br>Refer to interview a MA on 09/08/22 at 9:00am.<br><br>Refer to the interview with a second MA on 09/08/22 at 1:54pm.<br><br>Refer to interview with a third MA on 09/08.22 at 2:20pm.<br><br>Refer to interview with a fourth MA on 09/08/22 at 4:47pm.<br><br>Refer to interview with the Administrator on 09/08/22 at 4:50pm.<br><br>Refer to interview with the facility Owner on 09/08/22 at 5:00pm. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

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|---|---|---|---|---|
| D 358 | Continued From page 5 | D 358 | | |

b. Review of Resident #2's current FL-2 dated 08/02/22 revealed there was an order for depakote delayed release (DR) 125mg to be administered twice daily.(Depakote is an anti-convulsant medication used to treat bipolar disorder.)

Review of Resident #2's physician's order dated 06/07/22 revealed Depakote 125mg was to be administered twice daily.

Review of Resident #2's physician's order dated 08/10/22 revealed Depakote 250mg was to be administered three times daily.

Review of Resident #2's medication administration record (MAR) for July 2022 revealed:
-There was a computerized entry for Depakote DR 125mg to be administered twice daily at 7:00am and 8:00pm.
-There was documentation that Depakote DR 125mg was administered each day at 7:00am and 8:00pm from 07/09/22 through 07/31/22.
-There was documentation that Depakote DR was not administered each day at 7:00am and 8:00pm from 07/01/22 through 07/08/22 because the medication was not available in the facility.
-There was documentation that Depakote DR 125mg was not administered at 7:00am and 8:00pm on 07/08/22 but there was no reason documented.
-There were 16 out of 31 doses of Depakote 125mg that were not administered as ordered in July 2022.

Review of Resident #2's MAR for August 2022 revealed:
-There was a computerized entry for Depakote DR 125mg to be administered twice daily at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 6 | D 358 | | |

7:00am and 8:00pm.
-There was documentation Depakote DR 125mg was administered each day at 7:00am and 8:00pm on 08/01/22 through 08/08/22 and on 08/12/22 at 7:00am.
-There was documentation Depakote DR 125mg was not administered each day at 7:00am and 8:00pm from 08/09/22 through 08/11/22.
-There was documentation the order was discontinued on 08/12/22.
-There were 6 out of 23 doses of Depakote DR 125mg that were not administered as ordered in August 2022.

Refer to interview with the lead medication aide (MA) on 09/08/22 at 10:00am.

Refer to interview a MA on 09/08/22 at 9:00am.

Refer to the interview with a second MA on 09/08/22 at 1:54pm.

Refer to interview with a third MA on 09/08.22 at 2:20pm.

Refer to interview with a fourth MA on 09/08/22 at 4:47pm.

Refer to interview with the Administrator on 09/08/22 at 4:50pm.

Refer to interview with the facility Owner on 09/08/22 at 5:00pm.

c. Review of Resident #2's current FL-2 dated 08/02/22 revealed there was an order for olanzapine 2.5mg to be administered daily. (Olanzapine is an anti-psychotic medication used to treat bipolar disorder.)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 7 | D 358 | | |

Review of Resident #2's mental health provider note dated 05/02/22 revealed:
-Resident #2 was diagnosed with unspecified bipolar disorder.
-She continued to be agitated and irritable despite medication prescribed for her mood.
-There was an order to begin olanzapine 2.5mg each evening.

Review of Resident #2's physician's order dated 07/29/22 revealed an order for olanzapine 7.5mg to be administered each evening with supper.

Review of Resident #2's medication administration record (MAR) for July 2022 revealed:
-There was a hand-written entry for olanzapine 2.5mg to be administered each evening at 5:00pm.
-There was documentation that olanzapine 2.5mg was administered each evening at 5:00pm on 07/29/22 through 07/31/22.
-There was documentation that olanzapine 2.5mg was not administered each evening at 5:00pm from 07/01/22 through 07/28/22 because the medication was not available in the facility.
-There were 28 out of 31 doses of olanzapine 2.5mg that were not administered as ordered in July 2022..
-There was no entry for olanzapine 7.5mg each evening as ordered 07/29/22.

Review of Resident #2's MAR for August 2022 revealed:
-There was a hand-written entry for olanzapine 2.5mg to be administered each evening at 5:00pm.
-There was documentation that olanzapine 2.5mg was administered each evening at 5:00pm on 08/01/22 through 08/26/22, 08/29/22 and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 8 | D 358 | | |

08/31/22.
-There was documentation that olanzapine 2.5mg was not administered each evening at 5:00pm on 08/27/22, 08/28/22 and 08/30/22.
-There was documentation that olanzapine 2.5mg was not administered on 08/27/22 and 08/30/22 because the medication was not available in the facility.
-There was no reason documented for olanzapine 2.5mg not being administered on 08/28/22.
-There was no entry for olanzapine 7.5mg each evening as ordered on 07/29/22 .
-There were 32 doses of olanzapine 7.5mg that were not administered from 07/29/22 through 08/31/22.

Review of Resident #2's MAR for September 2022 revealed:
-There was a computerized entry for olanzapine 7.5mg to be administered each evening with supper but was marked through with a pen and noted "not on new FL-2".
-There was no documentation olanzapine 7.5mg had been administered.
-There was a hand-written entry for olanzapine 2.5mg to be administered each evening.
-There was documentation olanzapine 2.5mg was administered each day 09/01/22 through 09/06/22.
-There were 6 doses of olanzapine 7.5mg that were not administered as ordered from 09/01/22 through 09/06/22.

Interview with the facility's mental health provider on 09/08/22 at 3:15pm revealed she expected Resident #2 to be administered olanzapine 7.5mg each day and she was not aware the dose increase had not been started.

Attempted telephone interview with Resident #2's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 9 | D 358 | | |

primary care provider on 09/08/22 at 2:47pm was unsuccessful.

Refer to interview with the lead medication aide (MA) on 09/08/22 at 10:00am.

Refer to interview a MA on 09/08/22 at 9:00am.

Refer to the interview with a second MA on 09/08/22 at 1:54pm.

Refer to interview with a third MA on 09/08.22 at 2:20pm.

Refer to interview with a fourth MA on 09/08/22 at 4:47pm.

Refer to interview with the Administrator on 09/08/22 at 4:50pm.

Refer to interview with the facility Owner on 09/08/22 at 5:00pm.

2. Review of Resident #3's current FL-2 dated 06/14/22 revealed diagnoses included schizophrenia.

a.Review of Resident #3's current FL-2 dated 06/14/22 revealed:
-There was an order for Depakote ER 500mg to be administered each morning.(Depakote in an anti-convulsant medication used to treat bipolar disorder.)
-There was a physician's order for Depakote ER 250mg to be administered each day at bedtime.

Review of Resident #3's mental health provider note on 07/06/22 revealed:
-Resident #3 was anxious during the visit.
-There was a physician's order to increase a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 10 | D 358 | | |

second psychotropic medication in an effort to improve symptoms.

Review of Resident #3's medication administration record (MAR) for July 2022 revealed:
-There was a computerized entry for Depakote ER 500mg to be administered each day at 7:00am.
-There was documentation that Depakote ER 500mg was administered each day from 07/01/22 through 07/31/22.
-There was a computerized entry for Depakote ER 250mg to be administered each day at 8:00pm.
-There was documentation that Depakote ER 250mg was administered each day at 8:00pm from 07/01/22 through 07/13/22, 07/20/22 and on 07/29/22.
-There was documentation that Depakote ER 250mg was not administered each day at 8:00pm from 07/14/22 through 07/19/22, 07/21/22 through 07/28/22, 07/30/22 and 07/31/22 because the medication was not available in the facility for administration.
-There were 16 out of 31 doses of Depakote ER 250mg that were not administered as ordered for July 2022.

Review of Resident #3's MAR for August 2022 revealed:
-There was a computerized entry for Depakote ER 500mg to be administered each day at 7:00am.
-There was documentation that Depakote ER 500mg was administered each day from 08/01/22 through 08/21/22 and on 08/30/22 and 08/31/22.
-There was documentation that Depakote ER 500mg was not administered each day from 08/22/22 through 08/29/22 because the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 11 | D 358 | | |

medication was not available in the facility for administration.
-There were 8 out of 31 doses of Depakote ER 500mg were not administered each day at 7:00am.
-There was a computerized entry for Depakote ER 250mg to be administered each day at 8:00pm.
-There was documentation that Depakote ER 250mg was administered each day at 8:00pm from 08/15/22 through 08/31/22.
-There was documentation that Depakote ER 250mg was not administered each day at 8:00pm from 08/01/22 through 08/14/22 because the medication was not available in the facility for administration.
-There were 14 out of 31 doses of Depakote ER 250mg that were not administered as ordered for August 2022.

Interview with the facility's mental health provider on 09/08/22 at 3:15pm.
-She increased Resident#3's medication doses because she thought there was little improvement based on the doses currently ordered and believed they were being administered.
-She may not have needed to increase or change medications if the Residents had been administered the medications they were prescribed.

Refer to interview with the lead medication aide (MA) supervisor on 09/08/22 at 10:00am.

Refer to interview a MA on 09/08/22 at 9:00am.

Refer to the interview with a second MA on 09/08/22 at 1:54pm.

Refer to interview with a third MA on 09/08.22 at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 12<br>2:20pm.<br><br>Refer to interview with a fourth MA on 09/08/22 at 4:47pm.<br><br>Refer to interview with the Administrator on 09/08/22 at 4:50pm.<br><br>Refer to interview with the facility Owner on 09/08/22 at 5:00pm.<br><br>b. Review of Resident #3's current FL-2 dated 06/14/22 revealed there was a physician's order for omeprazole 20mg to be administered twice daily. (Omeprazole is a medication used to treat gastroesophageal reflux disease.)<br><br>Review of Resident #3's primary care acute visit summary dated 07/26/22 revealed:<br>-Resident #3 complained of nausea and vomiting that had occurred intermittently over the previous week.<br>-Resident #3 had a history of gastroesophageal reflux disease.<br>-There was a physician's order to increase omeprazole to 40mg twice daily for 30 days.<br><br>Review of Resident #3's medication administration record (MAR) for July 2022 revealed:<br>-There was a computerized entry for omeprazole DR 20mg to be administered each day at 7:00am and 7:00pm.<br>-There was documentation omeprazole DR 20mg was administered each day at 7:00am and 7:00pm from 07/01/22 through 07/31/22.<br>-There was no entry for omeprazole 40mg to be administered twice daily for 30 days ordered on 07/26/22. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 13<br><br>Review of Resident #3's MAR for August 2022 revealed:<br>-There was a computerized entry for omeprazole DR 20mg to be administered each day at 7:00am and 7:00pm.<br>-There was documentation omeprazole DR 20mg was administered each day at 7:00am and 7:00pm from 08/01/22 through 08/31/22.<br>-There was no entry for omeprazole to 40mg twice daily for 30 days as ordered on 07/26/22.<br><br>Interview with a medication aide (MA) on 09/08/22 at 2:20pm revealed:<br>-Resident #3 had approximately one and a half months worth of extra doses of omeprazole 20mg when the order was written to increase the dose to 40mg.<br>-She administered two 20mg pills to make 40mg when the order was written and had seen others administer two pills as well.<br>-She did not know how she knew the order had increased since it was not on the MAR at the time.<br>-She did not know why Resident #3 had extra doses of omeprazole 20mg available.<br><br>Interview with Resident #3 on 09/07/22 at 3:35pm revealed she was not experiencing nausea, vomiting or indigestion.<br><br>Attempted telephone interview with Resident #3's primary care provider on 09/08/22 at 2:47pm was unsuccessful.<br><br>Refer to interview with the lead medication aide (MA) supervisor on 09/08/22 at 10:00am.<br><br>Refer to interview a MA on 09/08/22 at 9:00am. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 14<br>Refer to the interview with a second MA on 09/08/22 at 1:54pm.<br><br>Refer to interview with a third MA on 09/08.22 at 2:20pm.<br><br>Refer to interview with a fourth MA on 09/08/22 at 4:47pm.<br><br>Refer to interview with the Administrator on 09/08/22 at 4:50pm.<br><br>Refer to interview with the facility Owner on 09/08/22 at 5:00pm.<br><br>3. Review of Resident #4's FL-2 dated 06/07/22 revealed:<br>-Diagnoses included Alzheimer's disease, hypertension, depression, anxiety, and acute thrombosis and deep vein thrombosis (DVT).<br>-Resident #4's level of care was the Special Care Unit (SCU).<br><br>Review of Resident #4's Resident Register revealed an admission date of 06/27/19.<br><br>a. Review of Resident #4's physician order report dated 09/01/22 revealed there was a medication order for Lexapro 10mg 1 tablet daily. (Lexapro is a medication used to treat depression and anxiety).<br><br>Review of Resident #4's September 2022 medication administration record (MAR) revealed:<br>-There was an entry for Lexapro 10mg 1 tablet daily to be administered at 6:00am.<br>-There was documentation Lexapro 10mg 1 tablet was not administered at 6:00 am because it was not available on the medication cart from 09/01/22 through 09/08/22. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 15<br><br>Observation of medications on hand for Resident #4 on 09/08/22 at 9:30am revealed there was no Lexapro 10mg on the medication cart.<br><br>Telephone interview with the facility's contracted pharmacy on 09/08/22 at 3:00pm revealed:<br>-They had been the facility's contracted pharmacy for about 2-3 months.<br>-Medication orders for the facility were automatically refilled each month unless the medication order had expired.<br>-The pharmacy would notify the facility and the primary care provider (PCP) when a medication order had expired and needed to be renewed.<br>-The facility was also aware of the expiration date because it was printed on the medication label and the MAR.<br>-Resident #4's medication order for Lexapro 10 mg 1 tablet was last dispensed on 08/01/22.<br>-Resident #4's medication order for Lexapro 10mg 1 tablet daily expired on 08/31/22.<br>-The pharmacy received a renewal medication order for Lexapro 10mg 1 tablet daily on 09/08/22.<br><br>Review of Resident #4's pharmacy log dated 09/08/22 revealed:<br>-The medication order for Lexapro 10mg 1 tablet daily was originally entered into the pharmacy system on 05/16/22.<br>-The Lexapro 10mg 1 tablet was dispensed on 07/01/22 for a 31-day supply.<br>-The Lexapro 10mg 1 tablet was dispensed on 08/01/22 for a 31-day supply.<br><br>Attempted telephone interview with the primary care provider (PCP) on 09/08/22 at 2:47pm was unsuccessful. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 16<br>Refer to interview with the lead medication aide (MA) on 09/08/22 at 10:00am.<br><br>Refer to interview with a MA on 09/08/22 at 9:00am.<br><br>Refer to interview with a second MA on 09/08/22 at 1:54pm.<br><br>Refer to interview with a third MA on 09/08/22 at 2:20pm.<br><br>Refer to interview with a fourth MA on 09/08/22 at 4:47pm.<br><br>Refer to interview with the Administrator on 09/08/22 at 4:50pm.<br><br>Refer to Interview with the facility Owner on 09/08/22 at 5:00pm.<br><br>b. Review of Resident #4's physician order report dated 09/01/22 revealed there was a medication order for Xarelto 20mg 1 tablet daily. (Xarelto is a medication used to prevent blood clots to reduce the risk of a stroke, deep vein thrombosis, and a pulmonary embolism).<br><br>Review of Resident #4's September 2022 MAR revealed:<br>-There was an entry for Xarelto 20mg 1 tablet daily to be administered at 6:00am.<br>-There was documentation that Xarelto was not administered at the 6:00am because it was not available on the medication cart from 09/01/22 to 09/08/22.<br><br>Observation of medications on hand for Resident #4 on 09/08/22 at 9:30am revealed there was no | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 17<br>Xarelto 20mg on the medication cart.<br><br>Telephone interview with the facility's contracted pharmacy on 09/08/22 at 3:00pm revealed:<br>-Resident #4's medication order for Xarelto 20mg 1 tablet was last dispensed on 08/01/22.<br>-Resident #4's medication order for Xarelto 20mg 1 tablet daily expired on 08/31/22.<br>-The pharmacy received a renewal order for Xarelto 20mg 1 tablet daily on 09/08/22.<br><br>Review of Resident #4's pharmacy log dated 09/08/22 revealed:<br>-The medication order for Xarelto 20 mg 1 tablet daily was originally entered into the pharmacy system on 05/16/22.<br>-The Xarelto 20mg 1 tablet was dispensed on 07/01/22 for a 31-day supply.<br>-The Xarelto 20mg 1 tablet was dispensed on 08/01/22 for a 31-day supply.<br><br>Attempted telephone interview with the primary care provider (PCP) on 09/08/22 at 2:47pm was unsuccessful.<br><br>Refer to interview with the lead medication aide (MA) on 09/08/22 at 10:00am.<br><br>Refer to interview with a MA on 09/08/22 at 9:00am.<br><br>Refer to interview with a second MA on 09/08/22 at 1:54pm.<br><br>Refer to interview with a third MA on 09/08/22 at 2:20pm.<br><br>Refer to interview with a fourth MA on 09/08/22 at 4:47pm. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 18 | D 358 | | |

Refer to interview with the Administrator on 09/08/22 at 4:50pm.

Refer to interview with the facility Owner on 09/08/22 at 5:00pm.

c. Review of Resident #4's physician order report dated 09/01/22 revealed there was a medication order for atorvastatin 10mg 1 tablet at bedtime. (Atorvastatin is a medication used to treat high cholesterol and triglycerides levels to reduce the risk of a stroke and a heart attack).

Review of Resident #4's September 2022 MAR revealed:
-There was an entry for atorvastatin 10mg 1 tablet at bedtime to be administered at 8:00pm.
-There was documentation that atorvastatin 10mg 1 tablet was not administered at 8:00pm because the medication was not on the medication cart from 09/01/22 to 09/07/22.

Telephone interview with the facility's contracted pharmacy on 09/08/22 at 3:00pm revealed:
-Resident #4's medication order for atorvastatin 10mg 1 tablet at bedtime was last dispensed on 08/01/22.
-Resident #4's medication order for atorvastatin 10mg daily at bedtime expired 08/31/22.
-The pharmacy received a renewal order for atorvastatin 10mg daily at bedtime on 09/08/22.

Review of Resident #4's pharmacy log dated 09/08/22 revealed:
-The medication order for atorvastatin 10mg 1 tablet daily was originally entered into the pharmacy system on 05/16/22.
-The atorvastatin 10mg 1 tablet was dispensed on 07/01/22 for a 31-day supply.
-The atorvastatin 10mg 1 tablet was dispensed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 19<br>on 08/01/22 for a 31-day supply.<br><br>Observation of medications on hand for Resident #4 on 09/08/22 at 9:30am revealed there was no atorvastatin 10mg on the medication cart.<br><br>Based on observations, record reviews, and interviews, it was determined that Resident #4 was not interviewable.<br><br>Attempted telephone interview with the primary care provider (PCP) on 09/08/22 at 2:47pm was unsuccessful.<br><br>Refer to interview with the lead medication aide (MA) on 09/09/22 at 10:00am.<br><br>Refer to interview with a MA on 09/08/22 at 9:00am.<br><br>Refer to interview with a second MA on 09/08/22 at 1:54pm.<br><br>Refer to interview with a third MA on 09/08/22 at 2:20pm.<br><br>Refer to interview with a fourth MA on 09/08/22 at 4:47pm.<br><br>Refer to telephone interview with the facility's contracted mental health provider on 09/08/22 at 3:21pm.<br><br>Refer to interview with the Administrator on 09/08/22 at 4:50pm.<br><br>Refer to interview with the facility Owner on 09/08/22 at 5:00pm.<br><br>4. Review of Resident #5's FL-2 dated 08/23/22 | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 20 | D 358 | | |

revealed diagnosis included diabetes mellitus type 2, bipolar disorder, chronic obstructive pulmonary disease, hypertension, and morbid obesity.

Review of Resident #5's Resident Register revealed an admission date of 07/08/11.

a. Review of Resident #5's physician order report dated 07/01/22 revealed a medication order for metoprolol 25mg 1/2 tablet twice a day. (Metoprolol is a medication used to treat high blood pressure (BP), chest pain and heart failure).

Review of Resident #5's July 2022 MAR revealed:
-There was an entry for metoprolol 25 mg ½ tablet twice a day at 8:00am and 8:00pm.
-There was documentation that metoprolol 25mg ½ tablet was not administered at the 8:00 am medication pass from 07/05/22 to 07/27/22 because it was not available on the medication cart.
-There was documentation that metoprolol 25mg ½ tablet was not administered at the 8:00pm medication pass from 07/01/22 to 07/27/22 because the medication was not available on the medication cart.

Review of Resident #5's June 2022 BP log revealed:
-There was a range of systolic blood pressure (SBP) (top number) readings of 108 to 149 from 06/17/22 to 06/30/22.
-There was a range of diastolic blood pressure (DBP) (bottom number) readings of 66 to 99 from 06/17/22 to 06/30/22.

Review of Resident #5's July 2022 BP log revealed:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 21 | D 358 | | |

-There was a range of SBP readings of 103 to 161 from 07/01/22 to 07/31/22 except 07/07/22, 07/11/22, 07/12/22, 07/28/22 and 07/30/22 which were blank.
-There was a range of DBP readings of 72 to 99 from 07/01/22 to 07/31/22 except 07/07/22, 07/11/22, 07/12/22, 07/28/22 and 07/30/22 which were blank.

Review of Resident #5's August 2022 BP log revealed:
-There was an SBP reading of 90 to 153 from 08/01/22 to 08/31/22.
-There was a DBP reading of 45 to 94 from 08/01/222 to 08/31/22.

Review of the American Heart Association BP recommendations revealed:
-The normal SBP was less than 120 mm Hg.
-The normal DBP reading was less than 80 mm Hg.
-Uncontrolled high BP could lead to a heart attack, stroke, heart failure, and kidney failure.

Telephone interview with the facility's contracted pharmacy on 09/08/22 at 3:00pm revealed Resident #5's medication order for metoprolol 25mg 1/2 tablet twice a day was dispensed on 07/01/22.

Review of Resident #5's pharmacy log dated 09/08/22 revealed the medication order for metoprolol 25mg ½ tablet twice a day was originally entered into the pharmacy system on 06/06/22 and dispensed on 07/01/22 for 62 tablets for a one-month supply.

Attempted telephone interview with the primary care provider (PCP) on 09/08/22 at 2:47pm was unsuccessful.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 22<br><br>Refer to interview with the lead MA on 09/08/22 at 10:00am.<br><br>Refer to interview with a MA on 09/08/22 at 9:00am.<br><br>Refer to interview with a second MA on 09/08/22 at 1:54pm.<br><br>Refer to interview with a third MA on 09/08.22 at 2:20pm.<br><br>Refer to interview with a fourth MA on 09/08/22 at 4:47pm.<br><br>Refer to interview with the Administrator on 09/08/22 at 4:50pm.<br><br>Refer to interview with the facility Owner on 09/08/22 at 5:00pm.<br><br>b. Review of Resident #5's physician order report dated 07/01/22 revealed a medication order for metformin 500mg 1 tablet twice a day. (Metformin is a medication used to control blood sugar (BS).<br><br>Review of Resident #5's July 2022 MAR revealed:<br>-There was an entry for metformin 500mg 1 tablet twice a day at 7:00am and 8:00pm.<br>-There was documentation metformin 500mg 1 tablet was not administered at the 7:00am medication pass from 07/01/22 to 07/27/22 because the medication was not available on the medication cart.<br>-There was documentation metformin 500mg 1 tablet was not administered at the 8:00pm medication pass from 07/01/22 to 07/27/22 | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 23 | D 358 | | |

because the medication was not available on the medication cart.

Review of Resident #5's June 2022 blood sugar (BS) log revealed there was a a range of BS readings of 109 to 187 from 06/17/22 to 06/30/22.

Review of Resident #5's July 2022 BS log revealed there was a range of BS readings of 119 to 250 from 07/01/22 to 07/31/22.

Review of Resident #5's August 2022 BS log revealed there was a range of BS readings of 121 to 309 from 08/01/22 to 08/31/22.

Review of the American Diabetes Association's recommendations revealed:
-There was a recommendation of a target fasting (before breakfast) BS range of 80 mg/dl to 130 mg/dl.
-There was a recommendation of a target BS range 1-2 hours after a meal of less than 180 mg/dl.
-The long term effects of uncontrolled BS were heart attack, stroke, kidney failure, vision loss, and nerve damage.

Telephone interview with the facility's contracted pharmacy on 09/08/22 at 3:00pm revealed Resident #5's medication order for metformin 500mg 1 tablet twice a day was dispensed on 07/01/22.

Review of Resident #5's pharmacy log dated 09/08/22 revealed the medication order for metformin 500mg 1 tablet twice a day was originally entered into the pharmacy system on 06/06/22 and dispensed on 07/01/22 for 62 tablets for a one-month supply.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 24 | D 358 | | |

Attempted telephone interview with the primary care provider (PCP) on 09/08/22 at 2:47pm was unsuccessful
Refer to interview with the lead medication aide (MA) on 09/08/22 at 10:00am.

Refer to interview with the lead MA on 09/08/22 at 10:00am.

Refer to interview with the MA on 09/08/22 at 9:00am.

Refer to interview with a second MA on 09/08/22 at 1:54pm.

Refer to interview with a third MA on 09/08/22 at 2:20pm.

Refer to interview with a fourth MA on 09/08/22 at 4:47pm.

Refer to interview with the Administrator on 09/08/22 at 4:50pm.

Refer to interview with the facility Owner on 09/08/22 at 5:00pm.

c. Review of Resident #5's physician order report dated 07/01/22 revealed a medication order for pravastatin 40mg 1 tablet at bedtime.
(Pravastatin is a medication used to treat high cholesterol and triglycerides levels to reduce the risk of a heart attack and a stroke).

Review of Resident #5's July 2022 MAR revealed:
-There was an entry for pravastatin 40mg 1 tablet at bedtime to be administered at 8:00pm.
-There was documentation that pravastatin was not administered at the 8:00pm medication pass from 07/01/22 to 07/12/22 because the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 25 | D 358 | | |

medication was not available on the medication cart.

Telephone interview with the facility's contracted pharmacy on 09/08/22 at 3:00pm revealed Resident #5's medication order for pravastatin 40mg 1 tablet at bedtime was dispensed on 07/01/22

Review of Resident #5's pharmacy log dated 09/08/22 revealed the medication order for pravastatin 40mg 1 tablet at bedtime was originally entered into the pharmacy system on 06/06/22 and dispensed on 07/01/22 for a 31-day supply.

Attempted telephone interview with the primary care provider (PCP) on 09/08/22 at 2:47pm was unsuccessful.

Refer to interview with the lead medication aide (MA) on 09/08/22 at 10:00am.

Refer to interview a MA on 09/08/22 at 9:00am.

Refer to interview with a second MA on 09/08/22 at 1:54pm.

Refer to interview with a third MA on 09/08/22 at 2:20pm.

Refer to interview with a fourth MA on 09/08/22 at 4:47pm.

Refer to interview with the Administrator on 09/08/22 at 4:50pm.

Refer to interview with the facility Owner on 09/08/22 at 5:00pm.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 26<br><br>Interview with the lead medication aide (MA) on 09/08/22 at 10:00am revealed:<br>-She normally performed the role of Activities Director (AD).<br>-She would also perform the role of a MA and administered medications to residents when needed.<br>-She had been assisting the Administrator during the leave of absence of the Resident Care Coordinator (RCC) to ensure medications were on the medication cart.<br>-The RCC or the Administrator were responsible for submitting medication refill or renewal orders to the pharmacy.<br>-The MA's were supposed to notify her or the Administrator when a medication needed to be refilled or reordered from the pharmacy.<br>-Medications should be available on the medication cart and administered as ordered.<br><br>Interview with a medication aide (MA) on 09/08/22 at 9:00am revealed:<br>-There were some problems with medications not being on the medication cart when the facility changed their pharmacy in July 2022.<br>-Sometimes medication orders were placed on the MAR before the medications were in the facility.<br>-Sometimes she found medications in the "back-up" room that had not been placed on the medication cart.<br>-She usually would notify the Administrator or the RCC 11-14 days before a medication ran out, after checking the medication "back-up room," so they could notify the pharmacy.<br>-It was the responsibility of the MA on each shift to check the "back up" room for medications that were not on the medication cart. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 27 | D 358 | | |

-It was the responsibility of the MA on each shift to monitor the availability of medications on the medication cart and notify the Administrator or the RCC if a medication needed to be refilled or reordered.

Interview with a second MA on 09/08/22 at 1:54pm revealed:
-There were no problems with medications being available until the facility changed pharmacies.
- There was approximately two weeks following the change in pharmacies that some medications were not available for administration but that had improved.
-Medication refills should be requested when there were seven doses left in the facility.
-When medications were not in the facility for administration, she would notify the Administrator and the Administrator would call the pharmacy.
-The Administrator and the lead medication aide were responsible for follow-up when medications were not received from the pharmacy.
-The Administrator was responsible for ensuring new orders were on the MAR but she did not always write in on the MAR until the medication was received from the pharmacy.

Interview with a third MA on 09/08/22 at 2:20pm revealed:
-It took approximately 2 weeks for medications to be available for administration during the change in pharmacies.
-Resident #3 experienced decreased mood around the middle of August 2022; more depressed and moping.
-She was not aware of a process for auditing carts, MARs or orders to ensure medications were available for administration.

Interview with a fourth MA 09/08/22 at 4:47pm

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 28 | D 358 | | |

revealed:
-When a medication was not available on the medication cart for a resident, she would write a D in the box under the day of the month column and beside the medication to denote the medication was not on the medication cart and not administered.
-She usually informed the Administrator or the RCC when there were 7-10 doses left of a medication on the medication cart.
-The Administrator or the RCC notified the pharmacy when a medication needed to be refilled or re-ordered.
-It was the responsibility of each MA to monitor the availability of medications on the medication cart.

Telephone interview with the facility's contracted mental health provider on 09/08/22 at 3:15pm revealed:
-She was concerned her patients were not receiving their prescribed medication and was told there were pharmacy issues but she thought that was corrected.
-She had discussed concerns with her companies compliance officer 1-2 months ago that many of her psychiatric patients were not receiving their medications because of pharmacy issues.
-She expected new orders to be carried out within seventy hours at most but should be within twenty four hours.
-When medications are not administered as prescribed, providers had to play "catch-up" with medications whether the medication is medical or psychiatric.

Interview with the Administrator on 09/08/22 at 7:40am revealed:
-She was aware that medications being available for administration had been a problem because

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 29 | D 358 | | |

they had recently changed pharmacies.
-She had other pharmacies she could have reached out to for medications during the transition from one pharmacy to another but she did not.
-The RCC was responsible for ensuring medications were available for administration.
-The RCC only worked part time in July 2022 and then as needed in August 2022 until she went out on leave approximately 2 weeks ago.
-She would try to follow-up on medications when she could but she had other duties that required her time and there was no process put into place when the RCC went out on leave.

Second interview with the Administrator on 09/08/22 at 4:50pm revealed:
-The facility changed ownership on 03/22/22.
-The facility gave the existing pharmacy a 30-day notice in June 2022 of its intent to contract with another pharmacy.
-The existing pharmacy dispensed a 28-day supply of residents' medications for June 2022.
-The incoming pharmacy was sent FL-2's and subsequent medication orders on all residents around mid-June 2022.
-The plan was for the incoming pharmacy to prepare the MARs and dispensed residents' medications beginning 07/01/22.
-The process of changing to another pharmacy caused an unforeseen delay in some residents' medications being available in the facility for 2-3 weeks in July 2022.
-The RCC or the Administrator should have reached out to other pharmacies to fill in the gaps ensuring medications were available in the facility for all residents until the change over to the incoming pharmacy was complete.
-She expected the MAs to inform the Administrator, the Resident Care Coordinator

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 30<br>(RCC) or the lead MA 8-10 days before a medication runs out so they could submit a refill request to pharmacy.<br>-She expected medications to be available on the medication cart.<br><br>Interview with the facility Owner on 09/08/22 at 5:00pm revealed:<br>-She was the new owner of the facility starting 03/22/22.<br>-The facility changed their pharmacy at the end of June 2022.<br>-The incoming pharmacy was contracted to start at the beginning of July 2022.<br>-The plan was to have residents' medications available in the facility beginning 07/01/22.<br>-She was aware that the process of changing the facility's contracted pharmacy caused a delay in some of the residents' medications being available in the facility in July 2022.<br>-Medications were received from the contracted pharmacy in a "piece meal" fashion in July 2022.<br>-The medication cart audits were not being done like they were supposed to be done.<br>-The medication cart audit should have included checking the FL-2 against the MAR, and checking the MAR against the medication in the medication cart for accuracy and availability.<br>-The RCC or the Administrator should have reached out to a "back-up" pharmacy to fill in the gaps ensuring medications were available in the facility for all residents until the new pharmacy completed the process of entering all medication orders on the MAR and dispensing all resident's medications.<br>-It was important for residents to receive their medications as ordered for the safety of the residents.<br><br>The facility failed to ensure the administration of | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 358 | Continued From page 31<br><br>medications as ordered for 4 of 5 sampled residents (#2, #3, #4, #5) evidenced by a resident diagnosed with a mental illness who missed 22 doses out of 54 opportunities for 2 months of a psychotropic medication used to treat bipolar disorder and 28 doses out of 31 opportunities of a second psychotropic medication for a period of 1 month used to treat bipolar disorder (#2), a second resident diagnosed with a mental illness who missed 30 doses out of 62 opportunities for a period of 2 months of a psychotropic medication used to treat schizophrenia (#3), a resident with type 2 diabetes who missed 50 doses out of 138 opportunities of insulin used to control blood sugar for a period of 3 months (#2), a resident with a history of deep vein thrombosis who missed 7 doses out of 7 opportunities for a period of 1 month of a medication used to prevent blood clots (#4), a resident with type 2 diabetes who missed 49 doses out of 54 opportunities for a period of 1 month of a medication used to control blood sugar (#5), and a resident with hypertension and a history of a hospital visit due to chest pain and shortness of breath who missed 49 doses out of 54 opportunities for a period of 1 month of a medication used to treat high blood pressure and chest pain (#5). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/08/22.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2022. | D 358 | | |
| D 400 | 10A NCAC 13F .1009(a)(1) Pharmaceutical Care | D 400 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 400 | Continued From page 32<br>10A NCAC 13F .1009 Pharmaceutical Care<br>(a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk.<br>Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following:<br>(1) an on-site medication review for each resident which includes the following:<br>(A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and<br>(B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and<br>(C) documenting the results of the medication review in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure quarterly pharmacy | D 400 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 400 | Continued From page 33 | D 400 | | |

reviews were completed for 5 of 5 sampled residents (#1, #2, #3, #4, #5).

The findings are:

1. Review of Resident #1's FL-2 dated 06/07/22 revealed diagnoses included Alzheimer's disease, hypertension, chronic kidney disease stage 3, and type 2 diabetes.

Resident #1's Resident Register revealed an admission date of 06/02/21.

Review of Resident #1's records revealed the last quarterly pharmacy review was completed on 05/31/22.

Refer to the interview with the Administrator on 09/08/22 at 4:50pm.

2. Review of Resident #2's current FL-2 dated 08/02/22 revealed diagnoses included type II diabetes, high blood pressure, hyperlipidemia and a history of hydrocephalus.

Review of Resident #2's Resident Register revealed an admission date of 03/22/22.

Review of Resident #2's pharmacy review dated 02/16/22 revealed there were no recommendations at that time.

Refer to the interview with the Administrator on 09/08/22 at 4:50pm.

3. Review of Resident #3's current FL-2 dated 06/14/22 revealed diagnoses included mild mental retardation, schizophrenia, leukocytosis and hypokalemia.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 400 | Continued From page 34<br>Review of Resident #3's Resident Register reveal an admission date of 09/14/10.<br><br>Review of Resident #3's pharmacy review dated 02/16/22 revealed there were no recommendations at that time.<br><br>Refer to the interview with the Administrator on 09/08/22 at 4:50pm.<br><br>4. Review of Resident #4's FL-2 dated 06/07/22 revealed diagnoses included Alzheimer's disease, hypertension, depression, anxiety, and acute thrombosis and deep vein thrombosis (DVT).<br><br>Resident Resident #4's Resident Register revealed an admission date of 06/27/19.<br><br>Review of Resident #4's records revealed the last quarterly pharmacy review was completed 02/07/22.<br><br>Refer to the interview with the Administrator on 09/08/22 at 4:50pm.<br><br>5. Review of Resident #5's FL-2 dated 08/23/22 revealed diagnosis included diabetes mellitus type 2, bipolar, chronic obstructive pulmonary disease, hypertension, and morbid obesity.<br><br>Review of Resident #5's Resident Register revealed an admission date of 07/08/11<br><br>Review of Resident #5's records revealed the last quarterly pharmacy review was completed on 05/31/22.<br><br>Refer to the interview with the Administrator on 09/08/22 at 4:50pm. | D 400 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 400 | Continued From page 35<br><br>Interview with the Administrator on 09/08/22 at 4:50pm. revealed:<br>-The facility changed ownership effective 03/22/22.<br>-She was aware pharmacy reviews needed to be completed quarterly for residents.<br>-The facility had been in transition to another contracted pharmacy starting 07/01/22.<br>-The quarterly pharmacy reviews had been delayed due to the transition to a change of ownership and change of the facility's contracted pharmacy. | D 400 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>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 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to medication administration.<br><br>Based on observations, record reviews, and interviews, the facility failed to ensure the administration of medications as ordered for 4 of 5 sampled residents (#2, #3, #4, #5) related to medications not being administered as ordered including medications used to control blood sugar | D912 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL096052 | A. BUILDING: _____ B. WING _____ | R 09/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HELPING HANDS ASSISTED LIVING | 2050 US 70 WEST HWY GOLDSBORO, NC 27534 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D912 | Continued From page 36<br>(#2, #5), a medication used to treat seizures and bipolar disorder (#2, #3), a medication used to treat schizophrenia and bipolar disorder (#2), a medication used to treat heartburn (#3), a medication used to control blood pressure (#5), a medication used to treat depression and anxiety (#4), and a medication used to prevent blood clots (#4). [Refer to Tag 358, 10A NCAC 13F .1004 (a) Medication Administration (Type B Violation)]. | D912 | | |