DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-092-144**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/12/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wake Assisted Living	**2800 Kidd Road, Raleigh, NC 27610**

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)	COMPLETE DATE
0000	Initial Comments The Adult Care Licensure Section conducted a follow- up survey on 10/11/22- 10/12/22.			
358	Medication Administration 1A NCAC 13F. .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non- prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. Based on observations, interviews, and record review, the facility failed to ensure a medication used to treat blood disorders was discontinued as ordered by a prescribing practitioner for 1 of 5 residents (#4). The findings are: Review of the facility Medication Administration Policy (undated) revealed the policy included the following: -The facility would assure medications, prescription and non-prescription, and treatments would be administered in accordance with the prescribing primary care provider's orders.			

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358	Continued From page 1 -The electronic medication administration record (eMAR) would be updated and changed when medication or treatment orders from the primary care provider changes. Review of Resident #4's current FL-2 dated 09/20/22 revealed diagnoses included dementia and hypertension. Review of physician's orders for Resident #4 revealed: -There was a physician's order dated 03/02/22 for Aspirin (ASA) 81mg enteric coated (EC) tablet daily. -There was a subsequent physician's order dated 04/27/22 to discontinue ASA 81mg tablet daily. -There was a physician's order dated 09/20/22 for ASA 81mg EC tablet daily. Review of April 2022 through September 2022 electronic medication administration records (eMARs) for Resident #4 revealed: -There was a printed entry to the eMARs for ASA low tab 81mg EC tablet every day. -Dates for documentation of administration of the ASA 81mg tablet daily at 8:00am included 04/27/22 through 06/10/22, and 07/23/22 through 09/20/22.			

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358	Continued From page 2 Interview with the Administrator on 10/11/22 at 3:12pm revealed: -She did not have any additional physician orders for Resident #4. -All documents should be filed in the resident record and there was no other place that physician orders would be filed. -The Resident Care Coordinator (RCC) was responsible for filing documents in resident records. Interview with the RCC on 10/12/22 at 9:37am revealed: -She had been employed at the facility for two days. -Her responsibilities as the RCC included assisting the Administrator with completing the FL-2's by inputting resident information including diagnoses and prescribed medication orders on the FL-2. -The medications listed on the resident's current eMARs were used to prepare the FL-2's for physician review and signature. -Medications had to be listed on the resident eMARs for the medication to be listed on the FL-2. -Sometimes physician's e-scribed orders to the pharmacy and pharmacy sent a copy of the order to the facility for filing in the resident record. -The consulting pharmacy provider input orders to the eMARs.			

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358	Continued From page 3 -The consulting pharmacy provider input orders to the eMARs. -The Administrator/Owner currently checked the pharmacy copy order with the transcribed order to the eMAR for accuracy and approved the orders. -If there were discrepancies identified, the pharmacy was supposed to be contacted. -The Administrator and Corporate Nurse conducted chart audits “periodically”. -She did not know how often chart audits were conducted. -The Corporate Nurse visited the facility two times a week. Telephone interview with a pharmacy technician at the consulting provider pharmacy on 10/12/22 at 1:40pm revealed: -There were existing orders at the pharmacy for Resident #4’s ASA 81mg tablet daily dated 03/02/22 and 09/20/22. -The pharmacy used existing physician orders to refill medications except narcotics and controlled substances. -There was no order at the pharmacy to discontinue the ASA 81mg tablet. -The pharmacy never received a physician’s order dated 04/27/22 discontinuing ASA 81mg tablet for Resident #4. -The facility usually faxed physician orders to the pharmacy.			

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358	Continued From page 4 Interview with the Administrator/Owner on 10/12/22 at 1:45pm revealed: -She had been functioning as and training a new Administrator and RCC since April 2022. -She had not audited Resident #4's record, and it had not been audited by the Corporate Nurse. -She could not say when Resident #4's record was last audited. -The Corporate Nurse and RCC were responsible for auditing resident records. Telephone interview with the Primary Care Provider (PCP) on 10/12/22 at 2:00pm revealed: -She discontinued the ASA 81mg tablet on 04/27/22. -She never "specifically" restarted the ASA 81mg tablet. -The order for the ASA 81mg tablet should have been caught on the 09/20/22 FL-2 and physician's order report (POR). -Resident #4 had not had a cerebrovascular accident (CVA) or myocardial infarct (MI) that needed prophylactic medication. -She would reorder the discontinuation of the ASA 81mg tablet daily. Interview with the MA on 10/12/22 at 2:50pm revealed: -She administered medication to the residents according to the instructions on the eMARs. -She did not do anything with physician orders.			

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358	Continued From page 5 -She put medications in the medication cart when received from the pharmacy. Based on observations, interviews, and record review, it was determined Resident #4 was not interviewable.			

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