STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034028	A. BUILDING: _____ B. WING _____	R 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 12/20/22 to 12/21/22.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions, set forth in the statement of deficiencies, the plan of correction is prepared solely as a matter of compliance with the law.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#1) related to blood pressure checks, weight checks and a laboratory test. The findings are: Review of Resident #1's current FL-2 dated 09/22/22 revealed diagnoses included hypertension, congestive heart failure and chronic kidney disease stage 3. Review of Resident #1's Resident Register revealed she was admitted to the facility from on 09/22/22. a. Review of Resident #1's physician order clarification sheet dated and signed 10/05/22 revealed there was an order to check blood pressures (BP) daily for 2 weeks.	D 276	10A NCAC 13F .0902(c) (3-4) Health Care Area Clinical Director and Regional Director of Operations provided in-serve training for the RCC, MCM and Lead SIC on processing orders, implementing orders and providing the documentation that all orders are followed correctly. Facility will ensure that all physician orders are implemented as order and that documentation is provided. Lead SIC, RCC and/or MCC will review all orders for accuracy and will send new orders to pharmacy. RCC and/or MCC will follow up with each order to ensure that the order was entered into the EMAR (Matrix) system correctly and the order has been started in a timely manner with correct documentation. Lead SIC, RCC and/or MCC will bring new orders and any order that needs follow up to Stand Up meeting to be reviewed. Executive Director and/or designee will review weekly to ensure new orders have been entered correctly and have the correct documentation.	Type text here 01/13/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Cantel — TITLE: Executive Director — (X6) DATE: 1/31/2023

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D 276	Continued From page 1 Review of Resident #1's October 2022 electronic medication administration record (eMAR) revealed there was no entry for daily BP checks for a 2-week period. Interview with Resident #1 on 12/21/22 at 10:25am revealed: -She did not know she had an order to check her BP that often in October 2022. -Staff had check her BP 1 or 2 times since she was admitted. -She had high blood pressure but has medicine for it. Interview with a medication aide (MA) on 12/21/22 at 10:10am revealed: -She was working at the facility when Resident #1 was admitted in late September 2022. -She did not remember Resident #1 having an order to check BP daily for 2 weeks in October 2022. -The staff would document BPs in the eMAR. -The Resident Care Coordinator (RCC) would make sure orders were on the eMAR for MAs to document. -There was no other place the MAs would document resident BPs. Interview with a second medication aide (MA) on 12/21/22 at 2:15pm revealed: -She was working at the facility when Resident #1 was admitted in late September 2022. -She did not remember Resident #1 having an order to check BP daily for 2 weeks in October 2022. -The staff would document BPs in the eMAR. -The Resident Care Coordinator (RCC) or the facility's contracted pharmacy would put orders on the eMAR for MAs to document. -There was no other place the MAs would	D 276		

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D 276	Continued From page 2 document resident BPs. Interview with the RCC on 12/21/22 at 10/20am revealed: -She and the Lead Supervisor (LS) were responsible to ensure the Primary Care Provider's (PCP) orders were processed and placed on the eMAR for MAs to document. -Both of them sent orders to the facility's contracted pharmacy for the pharmacy to enter the orders on the eMAR for staff document. -She just missed the order for Resident #1 to have daily BP checks for 2 weeks in October 2022. Interview with the LS on 12/21/22 at 3:20pm revealed: -She and the RCC were responsible to ensure the Primary Care Provider's (PCP) orders were processed and placed on the eMAR for MAs to document. -Both of them sent orders to the facility's contracted pharmacy for the pharmacy to enter orders on the eMAR for staff document. -They both missed the order for Resident #1 to have daily BP checks for 2 weeks in October 2022. Interview with Resident #1's Primary Care Provider (PCP) on 12/21/22 at 2:15pm revealed: -She did not remember the daily BP checks for Resident #1 in October 2022 until the RCC made her aware on 12/21/22 that the order had been missed. -Resident #1 received blood pressure medications, but she was controlled when she was admitted, and so missed BP checks did not cause her any harm. -She expected any orders she wrote to be carried out or that she be notified if an order could not be	D 276		

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D 276	Continued From page 3 or was not done. Telephone interview with a representative from the facility's contracted pharmacy on 12/21/22 at 4:02pm revealed: -The pharmacy only entered medications and finger stick blood sugars in the facility's eMAR system. -The pharmacy did not enter any vital signs such as BPs in the facility's eMAR system. -Any vital sign entry would have had to be entered by facility staff. Interview with the Assistant Executive Director (AED) on 12/21/22 at 5:25pm revealed: -The RCC and LS were responsible to check PCP orders and ensure they were carried out. -She expected PCP orders to be implemented as ordered. -She did not know the facility's contracted pharmacy did not enter any vital sign orders such as Resident #1's daily BP for 2 weeks in the eMAR system. b. Review of Resident #1's physician order clarification sheet dated and signed 10/05/22 revealed there was an order to for weekly weights. Review of Resident #1's October 2022 electronic medication administration record (eMAR) revealed there was no entry for weekly weights for 2 weeks on or after 10/05/22. Interview with Resident #1 on 12/21/22 at 10:25am revealed: -She did not know she had an order to check her weight every week in October 2022. -She had her own scale and would weigh herself every day according to what her doctor told her.	D 276		

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D 276	Continued From page 4 -She had congestive heart failure and staff administered a fluid pill to her when she told them she gained 4 pounds. Interview with a medication aide (MA) on 12/21/22 at 10:10am revealed: -She was working at the facility when Resident #1 was admitted in late September 2022. -She did not remember Resident #1 having an order for weekly weights in October 2022. -The staff would document weights on the eMAR. -The Resident Care Coordinator (RCC) would make sure orders were on the eMAR for MAs to document. -There was no other place the MAs would document resident weights. Interview with a MA on 12/21/22 at 2:15pm revealed: -She was working at the facility when Resident #1 was admitted in late September 2022. -She did not remember Resident #1 having an order to check weekly weights in October 2022. -The staff would document weights on the eMAR. -The RCC or the facility's contracted pharmacy would enter orders on the eMAR for MAs to document. -There was no other place the MAs would document resident weights. Interview with the RCC on 12/21/22 at 10/20am revealed: -She and the Lead Supervisor (LS) were responsible to ensure the Primary Care Provider's (PCP) orders were processed and placed on the eMAR for MAs to document. -Both of them sent orders to the facility's contracted pharmacy and the pharmacy entered the orders on the eMAR for staff document. -She just missed the order for Resident #1 to	D 276		

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D 276	Continued From page 5 obtain weekly weights checks in October 2022. Interview with the LS on 12/21/22 at 3:20pm revealed: -She and the RCC were responsible to ensure the PCP orders were processed and placed on the eMAR for MAs to document. -Both of them sent orders to the facility's contracted pharmacy for the pharmacy to enter orders on the eMAR for staff document. -They both missed the order for Resident #1 to have weekly weight checks in October 2022. Interview with Resident #1's PCP on 12/21/22 at 2:15pm revealed: -She did not remember the weekly weights for Resident #1 in October 2022 until the RCC made her aware on 12/21/22 that the order had been missed. -Resident #1 received furosemide 20mg (used to treat fluid retention) once a day as needed for swelling due to congestive heart failure. -Resident #1 had her own weight scale and checked her weight every day and would tell the MAs when she had a 4-pound gain to have furosemide administered to her. -The staff not obtaining Resident #1's weekly weight checks did not cause her any harm to her. -She expected any orders she wrote to be carried out or that she be notified if an order could not be or was not done. Telephone interview with a representative from the facility's contracted pharmacy on 12/21/22 at 4:02pm revealed: -The pharmacy only enter medications and finger stick blood sugars in the facility's eMAR system. -The pharmacy did not enter any vital signs such as weights in the facility's eMAR system. -Any vital sign entry would have had to be entered	D 276		

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D 276	Continued From page 6 by facility staff. Interview with the Assistant Executive Director (AED) on 12/21/22 at 5:25pm revealed: -The RCC and LS were responsible to check PCP orders and ensure they were carried out. -She expected PCP orders to be implemented as ordered. -She did not know the facility's contracted pharmacy did not enter any vital sign orders such as Resident #1's weekly weights. c. Review of Resident #1's physician's orders revealed there was an order on 10/12/22 for a thyroid stimulating hormone test (TSH) (a blood test to measure thyroid hormone levels) in 6 weeks. Interview with Resident #1 on 12/21/22 at 10:25am revealed: -She took thyroid medication, but did not know the name and the dose was lowered after she came to the facility. -She thought she was to have another blood test for her thyroid but was unsure of when. Interview with a medication aide (MA) on 12/21/22 at 10:10am revealed: -She did not know Resident #1 had an order for thyroid blood work. -The Resident Care Coordinator (RCC) was responsible to ensure lab orders were sent to the laboratory and the laboratory came to the facility on their own schedule to collect blood work. -If the laboratory staff were not able to get a resident's blood work, they would tell the MAs or the RCC. Interview with the RCC on 12/21/22 at 10/20am revealed:	D 276		

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D 276	Continued From page 7 -She and the Lead Supervisor (LS) were responsible to ensure the Primary Care Provider's (PCP) orders were processed. -She would send laboratory orders via electronic mail to the facility's contracted laboratory. -The laboratory would send staff to collect samples for ordered tests. -She just missed the order for Resident #1 to have a TSH test. Interview with the LS on 12/21/22 at 3:20pm revealed: -She and the RCC were responsible to ensure the Primary Care Provider's (PCP) orders were processed and carried out. -The RCC sent laboratory orders to the facility's contracted laboratory through electronic mail. -The laboratory came to the facility to obtain blood for tests, but there was no set laboratory day. -They both missed the order for Resident #1 to have a TSH test. Interview with Resident #1's PCP on 12/21/22 at 2:15pm revealed: -She adjusted Resident #1's Synthroid (used to treat hypothyroid disease) on 10/12/22 and ordered a TSH test in 6 weeks to see if it was effective. -The TSH test for Resident #1 should have been obtained in late November 2022. -She expected any orders she wrote to be carried out or that she be notified if an order could not be or was not done. Telephone interview with a representative from the facility's contracted laboratory on 12/21/22 at 3:15pm revealed: -Resident #1 had a thyroid stimulating hormone test on 10/05/22.	D 276		

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D 276	Continued From page 8 -There were no other pending orders for Resident #1. Interview with the Assistant Executive Director (AED) on 12/21/22 at 5:25pm revealed: -The RCC and LS were responsible to check PCP orders and ensure they were carried out. -She expected PCP orders to be implemented as ordered.	D 276	1	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medication as ordered for 1 of 5 sampled residents (#5) who had an order for an anti-anxiety medication. The findings are: Review of Resident #5's current FL2 dated 05/18/22 revealed: -Diagnoses included dementia, intracerebral hemorrhage, metabolic encephalopathy, and physical deconditioning. -There was an order for alprazolam (a Schedule IV medication used to treat symptoms of anxiety)	D 358	10A NCAC 13F .1004(a) Medication Administration Area Clinical Director and Regional Director of Operations provided in-service training for the RCC, MCM and Lead SIC on processing orders, implementing orders and providing the documentation that all orders are followed correctly. Facility will ensure that Medication is prepared and administred according to physician orders. RCC and/or MCC will monitor daily reports to ensure medications have been given as prescribed. Lead SIC, RCC and/or MCC will monitor narcotics weekly to ensure refill requests are sent in a timely manner to ensure refills are available when needed. RCC and/or MCC will report any medication administration issues to the ED in the daily Stand Up meetings. ED and/or designee will perform monthly audits of Medication Administration Report to ensure Medications are available, given and documented correctly.	01/13/2023

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D 358	Continued From page 9 0.25mg, take one half tablet twice daily. Review of Resident #5's psychiatric progress note dated 10/10/22 revealed: -Resident #5 had a diagnosis of anxiety disorder. -She was being treated with alprazolam due to her anxiety associated with chronic dementia. Review of Resident #5's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for alprazolam 0.25mg, take one half tablet (0.125mg) twice daily scheduled at 6:00am and 6:00pm. -There was documentation alprazolam was not administered at 6:00pm on 11/17/22, at 6:00am on 11/18/22, and at 6:00pm on 11/18/22. -The documented reason for not administering alprazolam was awaiting delivery of the medication from the pharmacy. Review of Resident #5's December 2022 eMAR revealed: -There was an entry for alprazolam 0.25mg, take one half tablet (0.125mg) twice daily scheduled at 6:00am and 6:00pm. -There was documentation alprazolam was not administered at 6:00pm on 12/19/22 and at 6:00am on 12/20/22. -The documented reason for not administering alprazolam was awaiting delivery of the medication from the pharmacy. Review of Resident #5's progress notes from November and December 2022 revealed there was no documentation regarding her alprazolam or symptoms of anxiety. Observation of medication on hand for Resident #5 on 12/21/22 at 10:20am revealed:	D 358		

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D 358	Continued From page 10 -There were two medication cards containing 30 half-tablets of alprazolam 0.25mg tablets in each medication card. -The dispensed date from the pharmacy documented as 12/18/22. -There were 58 out of 60 doses remaining in the medication cards. Telephone interview with a representative from the facility's contracted pharmacy on 12/21/22 at 9:50am revealed: -They had dispensed a 30-day supply alprazolam 0.125mg for Resident #5 on 10/06/22, 11/17/22, and 12/18/22. -Since alprazolam was a controlled substance, they did not include it in Resident #5's cycle-fill medications and the facility had to request the refill each month. -It took from one-and-a-half to two-and-a-half days to deliver a medication to the facility from the time it was ordered since they were located in another state. -They had received refill requests from the facility for Resident #5's alprazolam on 11/17/22 and on 12/18/22. Interview with a medication aide (MA) on 12/21/22 at 10:25am revealed: -Refill requests for medications were supposed to be sent to the pharmacy when there were 10 doses of the medication remaining. -She had not requested a refill of Resident #5's alprazolam because she had not worked on that medication cart the 5 days prior to the medication running out. -To reorder alprazolam the MAs were able to click the "resupply" button in their electronic charting system and that would send the request to the pharmacy. -She had not noticed Resident #5 having	D 358		

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increased anxiety in November or December 2022 when she was out of the alprazolam.
-The Memory Care Coordinator (MCC) and Lead Supervisor (LS) did audits of the medication cart where they checked for expired medications or medications that were running low.
-She did not know how often the medication cart audits were done or if they had noticed Resident #5's alprazolam was running low and had not been reordered.

Interview with a personal care aide (PCA) on 12/21/22 at 11:04am revealed:
-Resident #5 rarely had behaviors, agitation or anxiety symptoms.
-She had not noticed Resident #5 having any anxiety symptoms in the middle of November 2022 or in the previous couple of days when she had not received alprazolam.

Interview with the MCC on 12/21/22 at 11:25am revealed:
-The MAs were expected to reorder medications when there were 10 doses remaining.
-The MAs could reorder Resident #5's alprazolam by clicking the "resupply" button in the eMAR.
-She and the LS completed audits of the medication cart but Resident #5's alprazolam refill somehow was missed.
-The facility was not able to obtain controlled substance medications like alprazolam through the back-up pharmacy so if the medication ran out, they had to wait for it to be delivered from their contracted pharmacy.
-She did not recall Resident #5 having any anxiety behaviors in the last couple of months because she never had behaviors in general.

Interview with the LS on 12/21/22 at 3:20pm revealed:

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D 358	Continued From page 12 -The MAs were supposed to reorder medication three days before the medication was going to run out. -The MAs could reorder Resident #5's alprazolam by clicking the "resupply" button in the eMAR. -If the "resupply" button had been clicked by a MA, it would show up on the eMAR as "reordered" so MAs on subsequent shifts knew if the medication refill request had been submitted or not. -She was not aware of any written policy the facility might have regarding medication administration and when to reorder medications. -She had worked on the medication cart one of the days where Resident #5 did not receive alprazolam due to it having run out, and did not observe Resident #5 having symptoms of anxiety that day. -She and the MCC completed medication cart audits every two weeks which included checking quantities remaining of controlled substance medications and requesting refills if needed. -There had been a lot going on at the facility the last two months so they had missed reordering Resident #5's alprazolam during the audits, but the MAs should have caught it and reordered prior to it running out. Interview with a second MA on 12/21/22 at 4:45pm revealed: -He had worked when Resident #5's alprazolam was within 10 doses of running out. -He did not know if any of the other MAs had requested a refill of Resident #5's alprazolam because he was not sure how to find that information out. -He knew to reorder other medications when the quantity remaining reached the shaded area on the medication card, but Resident #5's alprazolam did not have a shaded area to indicate	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034028	A. BUILDING: _____ B. WING _____	R 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

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D 358	Continued From page 13 a refill request was needed. -He would guess the refill request would need to be sent to the pharmacy when there were 5 or 6 doses remaining. -He had not requested a refill of Resident #5's alprazolam from the pharmacy because he did not know how. -He had not told anyone that Resident #5's alprazolam needed to be reorded because he figured one of the other MAs already had. Telephone interview with Resident #5's psychiatric care provider on 12/21/22 at 5:15pm revealed: -She prescribed and managed Resident #5's alprazolam order. -She had been aware that Resident #5 missed a couple doses in both November and December 2022 because the facility staff had contacted her. -There would be no adverse effects to Resident #5 for missing a couple doses of alprazolam. -She expected the facility staff to reorder Resident #5's alprazolam with enough time for the pharmacy to deliver it so that the medication did not run out causing Resident #5 to miss doses. Interview with the Assistant Executive Director on 12/21/22 at 5:30pm revealed: -She was not aware that Resident #5 had missed doses of alprazolam in November and December 2022 due to the medication not being reordered in time. -All the MAs should know to request refills of medication when there were only 10 doses of the medication remaining. -The MAs could reorder Resident #5's alprazolam by clicking the "resupply" button in the eMAR system. -She expected medication refills to be requested	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 14 prior to the medication running out.	D 358		