

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011338	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARBOR TERRACE OF ASHEVILLE

3199 SWEETEN CREEK ROAD
ASHEVILLE, NC 28803

(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 completed an annual and follow-up survey on 04/25/23 and 04/26/23.	D 000		
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: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 1 of 5 residents (Resident #1) related to two medications to treat constipation. The findings are: Review of Resident #1's current FL2 dated 08/19/22 revealed diagnoses included Alzheimer's disease, depression, and anxiety. a. Review of Resident #1's record revealed: -There was an order dated 03/07/23 for Miralax 17 grams daily to be mixed in 8 ounces of water (used to treat constipation). -There was an order dated 04/07/23 for Miralax 17 grams daily to be mixed in 8 ounces of water to treat constipation.	D 358	1. Review of Current Resident's Orders: A review of current resident's orders was completed on 05/01/2023 to confirm that all orders have been processed. 2. Inservice: Med Aides were in-serviced on 04/28/2023 on proper procedures for processing orders through the pharmacy. New orders will be copied. The original order will be filed, and the copy will stay in the hot box until the medication is received. When the medicines are delivered and checked in, a note "received" is written on the copy in the hotbox. This order is then moved from the hotbox to RCD & MCD box for final verification. Each day the RCD, MCD, or shift supervisor will check to verify that all orders have been sent to the pharmacy, transcribed to Quickmar, and the medicines are in the cart.	5/1/23 4/28/23

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

6899

X01Y11

If continuation sheet 1 of 6

Jupe Clappett

ED

7/5/2023

Reviewed & acknowledged 7/10/23 rm

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D 358	Continued From page 1 Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed there was no entry for Miralax 17 grams to be administered daily. Review of Resident #1's April 2023 eMAR revealed: -There was no entry for Miralax 17 grams to be mixed in 8 ounces of water to treat constipation with a start date of 03/07/23. -There was an entry for Miralax 17 grams to be mixed in 8 ounces of water to treat constipation with a start date of 04/07/23. -There was documentation Miralax 17 grams was administered from 04/07/23 through 04/25/23. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 04/26/23 at 10:25am. Refer to interview with a medication aide (MA) on 04/26/23 at 1:49pm. Refer to telephone interview with Resident #1's Primary Care Provider (PCP) on 04/26/23 at 2:16pm. Refer to interview with the Special Care Coordinator (SCC) on 04/26/23 at 10:54am and 4:20pm Refer to interview with the Administrator on 04/26/23 at 4:20pm Based on observations, interviews and record review it was determined Resident #1 was not interviewable. b. Review of Resident #1's record revealed:	D 358	3. 100% Monitoring of New Orders: All new orders will be placed on 100% monitoring for the next 90 days to ensure that all orders are processed correctly. After the initial 90 days, random monitoring will occur on an ongoing basis. These action steps will ensure that all resident's orders are process correctly, and any errors are identified and corrected promptly. 4. QI Monitoring Plan: Ordering med process will be added to the Quality Improvement (QI) monitoring plan. Data will be presented at least bi-weekly to the regional nurse for review. QI monitoring will allow for ongoing monitoring and continuous improvement.	

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D 358	Continued From page 2 -There was an order dated 03/07/23 for Dulcolax suppository 10mg daily for 3 days to treat constipation. -There was an order dated 04/07/23 for Dulcolax suppository 10mg daily for 3 days. -There was an order dated 04/11/23 for Dulcolax suppository 10mg daily. Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed there was no entry for Dulcolax suppository, 10mg to be administered for 3 days. Review of Resident #1's April 2023 eMAR revealed: -There was an entry with an 04/07/23 order date for Dulcolax suppository 10mg daily for 3 days. -There was an entry with an 04/11/23 order date for Dulcolax suppository 10mg daily. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 04/26/23 at 10:25am. Refer to interview with a medication aide (MA) on 04/26/23 at 1:49pm. Refer to telephone interview with Resident #1's Primary Care Provider (PCP) on 04/26/23 at 2:16pm. Refer to interview with the Special Care Coordinator (SCC) on 04/26/23 at 10:54am and 4:20pm Refer to interview with the Administrator on 04/26/23 at 4:20pm Based on observations, interviews and record review it was determined Resident #1 was not	D 358	5. Pharmacy Inspection of Med Carts: The pharmacy will inspect the med carts at least once a quarter. A review of the Medication Administration Records (MARs) and resident's charts will be conducted to ensure that all orders are in the electronic MAR system. The pharmacy's inspection of med carts will ensure that all orders are in the electronic MAR system and that the medication process is efficient and effective.	

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D 358	Continued From page 3 interviewable. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/26/23 at 10:25am revealed: -They had no record of any orders for Resident #1 written on 03/07/23. -The pharmacy never dispensed Miralax or Dulcolax suppositories in March 2023. Interview with a MA on 04/26/23 at 1:49pm revealed: -Resident #1's belly was "extended and hard" and she was not eating well in March 2023, but she did not remember administering any medications to treat constipation to Resident #1. -Resident #1 started receiving medications to treat constipation in April 2023. -The facility did not document residents' bowel movements. Telephone interview with Resident #1's PCP on 04/26/23 at 2:16pm revealed: -He examined Resident #1 on 03/07/23 and her hemorrhoids were worse, and her stomach was distended which indicated to him that she was constipated but her Alzheimer's disease prevented him from gathering information from her about her bowel movement history. -On 03/07/23 he ordered Miralax daily and a Dulcolax suppository for 3 days to see if that relieved her constipation. -He did not know the orders written on 03/07/23 were not implemented until he was informed by the SCC on 04/26/23. -On 04/04/23 he ordered an x-ray of her abdomen to assess her constipation level and it showed significant fecal matter in her intestines. -On 04/07/23 he reordered Miralax and ordered a daily Dulcolax suppository and within 3 days her	D 358		

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D 358	Continued From page 4 constipation was resolved. -If the daily Miralax and the 3-day course of suppositories were implemented on 03/07/23 as he initially ordered Resident #1's constipation would have resolved in March 2023 rather than on 04/14/23. -If the constipation had not resolved, she could have become impacted. -A fecal impaction could lead to intestinal necrosis (death of the intestines due to lack of blood flow). Interview with the SCC on 04/26/23 at 10:54am and 4:20pm revealed: -When an order was received, the MA was responsible for faxing the order to the pharmacy. -After the order was faxed it was put into the "hot box" in the MA's office. -The "hot box" was a file holder in the office where all pending orders were placed until the medication was delivered. -She monitored the hot box daily to compare orders to medications received from the pharmacy. -If a medication was never delivered she would call the pharmacy. -The facility did not document resident bowel movements and she did not know about Resident #1's constipation issues until the beginning of April 2023 when the abdominal x-ray and medications were ordered. -She conducted cart audits weekly by comparing the medications in the cart to the eMAR, not to the actual orders. -She had not considered the possibility that a medication would not be on the eMAR because the orders had not been sent to the pharmacy. Interview with the Administrator on 04/26/23 at 4:20pm revealed: -The SCC was responsible for ensuring MA	D 358		

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D 358	Continued From page 5 supervisors processed orders by faxing them to the pharmacy and placing them in the hot box. -The SCC conducted cart audits weekly, but he did not realize the medications were being compared to the eMAR rather than actual orders. -The SCC monitored the hot box daily but if an order was not placed in the hot box per facility procedure, she had no way of knowing a medication was not received from the pharmacy. -He did not know why the order processing system the facility had in place failed. The facility failed to administer Miralax daily and Dulcolax suppositories for 3 days to Resident #1 who was experiencing constipation, resulting in Resident #1 having continued constipation for another month until she was reassessed by her PCP, who ordered diagnostic imaging which showed a significant amount of fecal matter in the intestines, placing the resident at risk of an impaction. This failure was detrimental to the health of Resident #1 and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 04/26/23 for this Type B Violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 10, 2023.	D 358		