

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/05/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TRINITY VIEW

2533 HENDERSONVILLE ROAD

ARDEN, NC 28704

(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 and the Buncombe County Department of Social Services conducted an annual and a follow-up survey on July 05, 2023.	D 000		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a medication aide (MA) observed 1 of 1 resident (Resident #2) take medications administered resulting in medications left on the resident's table in her room. The findings are: Review of the facility's Policy and Procedure for Medication Administration dated 02/14/02 revealed: -The individual who administers the medication dose records the administration on the resident's medication administration record (MAR) directly after the medication is given. -The resident is observed after administration to ensure that the dose was completely ingested.	D 366	To Prevent the situation from occurring again, ED and RCC have printed off the policy and plan to have all the med techs read and sign the current policy titled: General Guidelines for Medication Administration. They will also be assigned a Relias class "Avoiding Common Medication Errors" all to be completed by 8/25/23. RCC will assign the Relias along with making sure that the staff complete. RCC will ensure that all med techs have read and signed the medication policy. ED will confirm that both are completed by 8/25/23 as well.	8/25/23

Division of Health Service Regulation

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

TITLE

(X6) DATE

[Signature], ED

Executive Director

7/31/23

STATE FORM

6899

8TD811

If continuation sheet 1 of 4

LSB

Reviewed and acknowledged 07-31-23

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D 366	Continued From page 1 Review of Resident #2's current FL2 dated 01/06/23 revealed diagnoses included malaise, fatigue, peripheral vertigo, and hypertensive heart disease. Review of Resident #2's physician's orders revealed: -There were medication orders for Amlodipine (reduces blood pressure) 5mg daily, Lexapro (treats depression 5mg daily, Omeprazole (reduces gastric acid) 10mg daily, and Calcium-Vitamin D (supplement) 600-200mg daily, dated 04/11/23. -There was a medication order for Senna S (treats constipation) 8.6-50mg 2 tablets daily, dated 05/02/23. -There was a medication order for Centrum Silver (supplement) 1 tablet daily, dated 07/06/23. Observation during the initial tour on 07/05/23 at 9:26am revealed: -There was a medication cup with 6 tablets and 1 capsule in it on a table next to Resident #2. -The MA was not in the room. Review of Resident #2's electronic medication administration record (eMAR) for 07/05/23 revealed: -There was an entry for Amlodipine 5mg daily with an administration time of 9:00am and documentation that it was administered at 9:00am on 07/05/23. -There was an entry for Calcium-Vitamin D 600-200mg 1 tablet daily with an administration time of 9:00am and documentation that it was administered at 9:00am on 07/05/23. -There was an entry for Centrum Silver 1 tablet daily with an administration time of 9:00am and documentation that it was administered at 9:00am on 07/05/23.	D 366			

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D 366	Continued From page 2 -There was an entry for Lexapro 5mg 1 tablet daily with an administration time of 9:00am and documentation that it was administered at 9:00am on 07/05/23. -There was an entry for Omeprazole 10mg 1 capsule daily with an administration time of 9:00am and documentation that it was administered at 9:00am on 07/05/23. -There was an entry for Senna S 8.6-50mg 2 tablets daily with an administration time of 9:00am and documentation that it was administered at 9:00am on 07/05/23. Observation of Resident #2's medications available for administration on 07/05/23 at 11:30am revealed: -There were two bubble packs labeled Caltrate (Calcium) 600 + D take 1 tablet twice daily. -There was one bubble pack labeled Omeprazole 10mg take 1 capsule daily. -There was one bubble pack labeled Amlodipine 5mg take one tablet daily. -There was one bubble pack labeled escitalopram (Lexapro) 5mg take 1 tablet daily. -There was one bubble pack labeled Centrum Silver take 1 tablet daily. -There was one bottle labeled Senna S 8.6mg without a prescription label. Interview with Resident #2 on 07/05/23 at 9:28am revealed: -The medications in the cup were her morning medications. -The MA had an emergency call and left the medications in the room. Interview with the MA on 07/05/23 at 9:49am revealed: -She knew to observe residents take their medications because she had been a MA "a long	D 366			

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D 366	Continued From page 3 time". -She had received an emergency call and left the medications for Resident #2 to take because she was alert and oriented. Interview with the Administrator on 07/05/23 at 1:38pm revealed: -The facility's policy was that the MAs were to observe the residents take their medications. -The MA should have observed Resident #2 take her medications.	D 366			