Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey from June 21, 2023 to June 23, 2023.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure referral and follow up to meet the health care needs for 2 of 5 sampled residents (#3) who had physician's orders for monthly B-12 injections and (#2) who had a physician's order to notify for high and low fingerstick blood sugars (FSBS). The findings are: 1. Review of Resident #3's current FL2 dated 03/07/23 revealed: -Diagnoses included vitamin B12 deficiency. -There was an order for vitamin B12 mcg/ml injections (used to treat low vitamin B12 levels) 1 ml every 30 days. Review of Resident #3's physician's orders dated 04/20/23 revealed an order for vitamin B12 1000 mcg/ml inject 1 ml every month. Review of Resident #3's electronic Medication Administration Records (eMAR) for April, May, and June 2023 revealed there was an entry for vitamin B12 1,000 inject 1 ml every month, but there was no documentation of who was to administer the vitamin B12 injections or if the	D 273	Director re-trained staff on reporting change in conditions to physicians with all direct care staff. SIC will notify physician of change in condition within a reasonable amount of time, depending on the routine and acute (as soon as possible) health care needs of residents, as needed; any orders obtained will be implemented timely. SCUC and/or designee will review new orders x 5 days per week to ensure each order is referred to and appropriate agency if indicated. Administrator/Designee audited all orders once per week x4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed.	8/7/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy R. Petty — TITLE: Administrator — (X6) DATE: 8/2/2023

Reviewed and acknowledged 8/3/23. Catherine Prater

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D 273	Continued From page 1 vitamin B12 injections had been administered. Review of Resident #3's record revealed there was no documentation from Resident 3's primary care provider (PCP) or from a home health agency that vitamin B12 injections were administered in April, May, or June 2023, and there were no laboratory results available. Observation of Resident #3's medications available on the cart for administration on 06/21/23 at 3:18pm revealed vitamin B12 was not available for administration. Interview with a medication aide (MA) on 06/21/23 at 3:19pm revealed: -Resident #3 had an order for vitamin B12 injections monthly, but MAs did not administer vitamin B12 injections. -Either a home health agency or the resident's PCP administered vitamin B12 injections. -MAs and supervisors were responsible for setting up home health services for vitamin B12 injections or scheduling with Resident #3's PCP's office to have vitamin B12 injections. Interview with a MA supervisor on 06/22/23 at 9:06am revealed: -She knew Resident #3 had a physician's order for vitamin B12 injections, but the facility did not administer vitamin B12 injections. -To her knowledge, Resident #3 had not been administered vitamin B12 injections since she was admitted to the facility in March 2023. -MAs were responsible for following up with Resident #3's PCP or a home health agency to have vitamin B12 injections administered. -She had not contacted Resident #3's PCP or a home health agency to scheduled to have vitamin B12 injections administered and she did not know	D 273		

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D 273	Continued From page 2 why. Interview with the facility's contracted pharmacy on 06/23/23 at 9:19am revealed: -Resident #3 had an order for vitamin B12 injections monthly, but vitamin B12 injections had not been dispensed to the facility. -The pharmacy had not received a physician's order to discontinue the vitamin B12 injections. Interview with the Special Care Unit Coordinator (SCUC) on 06/22/23 at 8:15am revealed: -She assisted on the assisted living side of the facility. -She knew Resident #3 had an order for vitamin B12 injections. -She though Resident #3 would be administered vitamin B12 injections at her PCP's office. -MAs were responsible for following up with Resident #3's PCP or with a home health agency to schedule her vitamin B12 injections. -Resident #3 had not been administered vitamin B12 injections since she was admitted to the facility in March 2023. -There were no vitamin B12 laboratory results in Resident #3's record. Interview with Resident #3's PCP on 06/22/23 at 5:11pm revealed: -She discussed vitamin B12 injections with a staff from the facility during Resident #3's appointment on 04/20/23. -She told staff that if someone at the facility was not able to administer the vitamin B12 injections, to let her know and the injections could be administered at the office. -She was not notified the facility was unable to administer vitamin B12 injections or Resident #5 had not received vitamin B12 injections since she was admitted to the facility in April 2023.	D 273		

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D 273	Continued From page 3 -Resident #3 had laboratory blood tests completed during her visit on 04/20/23 and her B12 level was within the normal range. -She expected Resident #3 to have her vitamin B12 injections administered as ordered. Interview with the Administrator on 06/23/23 at 10:33am revealed: -She did not know Resident #3 was not administered her vitamin B12 injections as ordered. -The facility did not administer vitamin B12 injections, but she expected MA supervisors to follow up with a home health agency to schedule monthly B12 injections or to contact Resident #3's PCP to have the injections administered in the PCP's office. -She thought MA may have missed following up with a home health agency or Resident #3's PCP. 2. Review of Resident #2's current FL2 dated 03/16/23 revealed: -Diagnoses diabetes mellitus, hypertension and hypothyroidism. -There was an order to check FSBS 2 times a day, notify MD if FSBS less than 70 or greater than 300. Review of Resident #2's physician's orders dated 05/04/23 revealed: -There was an order to check FSBS twice a day, notify MD if BS less than 70 or greater than 300. -There was an order for Levemir (long-acting insulin used to control high blood sugars) 8 units every 12 hours. Review of Resident #2's electronic Medication Administration Record (eMAR) for April 2023 revealed: -There was an entry for FSBS twice a day, notify	D 273		

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D 273	Continued From page 4 MD if FSBS less than 70 or greater than 300 scheduled at 7:00am and 8:00pm. -There was documentation of FSBS for 7:00am of 65 on 04/01/23 and 65 on 04/12/23. -There was documentation of FSBS for 8:00pm of 313 on 04/02/23, 386 on 04/06/23, 357 on 04/08/23 and 314 on 04/18/23. Review of Resident #2's progress notes for April revealed there was no documentation regarding FSBS or contact with Resident #2's PCP. Review of Resident #2's eMAR for May 2023 revealed: -There was an entry for FSBS twice a day, notify MD if FSBS less than 70 or greater than 300 scheduled at 7:00am and 8:00pm. -There was documentation of FSBS for 8:00pm of 320 on 05/18/23, 320 on 05/22/23, 302 on 05/24/23, 388 on 05/26/23 and 314 on 05/29/23. Review of Resident #2's progress notes for May 2023 revealed there was no documentation regarding FSBS or contact with Resident #2's PCP. Review of Resident #2's eMAR for 06/01/23-06/22/23 revealed: -There was an entry for FSBS twice a day, notify MD if FSBS less than 70 or greater than 300 scheduled at 7:00am and 8:00pm. -There was documentation of FSBS for 8:00pm of 315 on 06/01/23, 343 on 06/04/23, 344 on 06/06/23, 348 on 06/08/23, 349 on 06/09/23, 313 on 06/10/23, 365 on 06/11/23, 341 on 06/13/23, 380 on 06/14/23, 429 on 06/15/23, 320 for 06/18/23 and 405 on 06/19/23. Review of Resident #2's progress notes for 06/01/203 through 06/22/23 revealed there was	D 273		

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D 273	Continued From page 5 no documentation regarding FSBS or contact with Resident #2's PCP. Telephone interview with Resident #2's PCP on 06/22/23 at 4:00pm revealed: -She started seeing residents at the facility 2 months ago, around the end of April 2023. -She had not been notified of any FSBS less than 70 or greater than 300. -Resident #2's FSBS parameter of greater than 300 was a little low, but she did not know her well enough yet to change her parameters on the order. -Resident #2's had scheduled Levemir 8 units 2 times a day with her FSBS, but no sliding scale insulin at that time. -Since Resident #2's FSBS were below or above parameters mostly at the 8:00pm time which was after her office hours, she would not have been notified. -She could not see any after office hour notifications and there were no notes of the facility staff calling to report Resident #2's FSBS below 70 or above 300. -She expected the facility to contact her or the after hours provider if Resident #2's FSBS were greater than 300 or less than 70. Interview with a MA on 06/22/23 at 1:40pm revealed: -When Resident #2's FSBS was below 70 or above 300, she was to contact the PCP. -She documented notification to the PCP and FSBS rechecks in the residents' progress notes. -MAs could call the PCP or the on-call provider to report FSBS greater than 300. -She could not remember if she notified Resident #2's PCP of FSBS greater than 300 on days that she worked.	D 273		

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D 273	Continued From page 6 Interview with a MA on 06/22/23 at 2:15pm revealed: -When Resident #2's FSBS was below 70 or above 300, he was to contact the PCP. -She documented notification to the PCP and FSBS rechecks in the residents' progress notes. -MAs could call the PCP or the on-call provider to report FSBS less than 70 or greater than 300. -He attempted to notify Resident #2's on-call PCP of FSBS greater than 300 on shifts that he worked. -Most times he could not get through on the phone and he did not document anything in Resident #2's progress notes. Interview with a MA on 06/22/23 at 2:54pm revealed: -She worked second shift and performed Resident #2's 8:00pm FSBS. -She did not know that Resident #2's FSBS order instructed MAs to notify the PCP when Resident #2's FSBS was below 70 or above 300. -MAs would call the PCP or the on-call provider and documented notification to the PCP and FSBS in the residents' progress notes. -When she called the on-call provider for any notifications, she would get an answer immediately and record any instructions of new orders in the residents' progress notes. -She could not remember if she notified Resident #2's PCP of FSBS greater than 300 on the evenings that she worked. Interview with the Special Care Unit Coordinator (SCUC) on 06/22/23 at 3:00pm revealed: -She had performed Resident #2's FSBS and had a result greater than 300. -She could not remember if she had notified the PCP of Resident #2's FSBS greater than 300.	D 273		

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D 273	Continued From page 7 -Staff documented contact with residents' PCP in the residents' progress notes. -If there was no documentation in the residents' progress notes then the PCP was probably not contacted. -She expected MAs to contact the residents' PCP to report any FSBS above or below ordered parameters. Telephone interview with the Administrator on 06/23/23 at 10:30am revealed: -Resident #2 had an order to notify her PCP if FSBS were greater than 300 or less than 70. -She did not know the MAs had not documented PCP notifications for her FSBS below or above parameters. -She expected MAs to contact Resident #2's PCP when her FSBS were out of ordered parameters document the notification and any new orders in the progress notes.	D 273		
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 observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (#5) related to an order for thrombo-embolic deterrent (TED) hose.	D 276		

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D 276	Continued From page 8 The findings are: Review of Resident #5's current FL2 dated 09/08/22 revealed diagnoses included hypertension, gastroesophageal reflux disease, shortness of breath, leg weakness bilaterally, chronic cystitis, and vitamin B12 deficiency. Review of Resident #5's physician's order dated 04/18/23 revealed an order for TED hose (stocking that help to prevent blood clots and swelling in the legs) apply every morning and remove at bedtime. Review of Resident #5's electronic treatment administration record (eTAR) for June 2023 revealed: -There was an entry for TED hose (need size) apply every morning and remove at bedtime scheduled to be applied at 8:00am and removed at 8:00pm. -There was documentation Resident #5's TED hose were not applied for 5 of 22 opportunities on 06/16/23, 0/19/23, 06/20/23, 06/21/23, and 06/22/23. -The reason documented for Resident #5's TED hose not being applied was resident refused. Observation of Resident #5 on 06/22/23 at 11:42am revealed: -She was sitting in her room in a recliner chair with the legs of the chair in a down position. -Resident #5 did not have TED hose on, but she had on calf length socks. -She had mild swelling in left foot and ankle and moderate swelling in her right foot and ankle. Interview with Resident #5 on 06/22/23 at 11:43am revealed:	D 276	All Medication Aides/SIC completed training for implementation of procedures, orders and treatment as per physician's orders. SCUC/Designee will review MARs weekly to ensure documentation is completed for procedures, orders and treatment as per physician's orders. Director will audit to twice monthly x2 months then randomly thereafter, to ensure documentation is completed for procedures, orders and treatment as per physician's orders.	8/7/2023

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D 276	Continued From page 9 -"They decided she did not need the TED hose." -The TED hose had a zipper and the zipper sometimes pinched her legs. -Her family member took the TED hose home with him to see if she would experience swelling without them. -She knew she had swelling in her feet and ankles, but did not have any pain. -Staff had not asked her to apply her TED hose since her family member took them home. Observation of Resident #5's room on 06/22/23 at 11:44am revealed: -A personal care aide (PCA) looked in Resident #5's top dresser drawer for her TED hose. -The PCA could not find Resident #5's TED hose. Interview with the PCA on 06/22/3 at 11:45am revealed: -Resident #5's family member took her TED hose home 4 or 5 days ago to wash them and he must still have them. -Resident #5 did not have any swelling in her legs when her family member took her TED hose home, but she did now. -Resident #5's feet and ankles started swelling about 3 days ago and she had more swelling in her right foot. -Resident #5's family member told the PCA that the resident did not need the TED Hose. Telephone interview with a MA supervisor on 06/22/23 at 3:02pm revealed: -Resident #5 did not have TED hose because her family member did not want her to wear them and took them home. -She was not sure when Resident #5's family member took her TED hose, but she thought it was around 06/19/23; Resident #5's family member had not returned the TED hose to the	D 276		

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D 276	Continued From page 10 facility. -She documented Resident #5 refused to have her TED hose applied on 06/19/23 and 06/22/23 because Resident #5 did not want to wear her TED hose (Resident #5's TED hose were not in the facility). -She told Resident #5's family member that if Resident #5 did not want to wear her TED hose, there needed an order to discontinue the TED hose. -Resident #5's family member told her, he would contact Resident #5's primary care provider (PCP). -She had not contacted Resident #5's PCP regarding Resident #5 not wearing her TED hose. Interview with a MA on 06/22/23 at 4:47pm revealed: -When she went into Resident #5's room at 8:00pm, if her TED hose were off, then she documented on the MAR that they were off. -PCAS were responsible for taking TED hose off prior to her administering 8:00pm medications. -She would not have known whether the TED hose had been applied that morning or taken off by second shift PCAs. -She was told today by the first shift MA supervisor that Resident #5's family member did not want her to wear her TED hose. Telephone interview with a representative with the facility's contracted pharmacy on 06/23/23 at 9:19am revealed: -Resident #5 had an order for TED hose dated 05/25/22. -The pharmacy did not dispense Resident #5's TED hose, they only entered the TED hose on Resident #5's eMAR. Telephone interview with a representative with	D 276		

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D 276	Continued From page 11 Resident #5's pharmacy on 06/23/23 at 9:37am revealed the pharmacy had not dispensed TED hose to Resident #5. Interview with the Licensed Health Professional Support (LHPS) nurse on 06/23/23 at 9:48am revealed: -Resident #5 had her TED hose on when she visited her for LHPS assessments. -Staff had not informed her Resident #5 did not like or refused to wear her TED hose. -She could not find any documentation regarding Resident #5 having edema during her visits. Observation of Resident #5 on 06/23/23 at 10:00am revealed: -She had on a pair of white open toed TED hose. -The TED hose loose on both her left and right legs. Interview with a PCA on 06/23/23 at 10:00am. -Staff found Resident #5's white TED hose the morning of 06/23/23. -Resident #5 had not worn the white TED hose in a long time as she had been wearing the brown TED hose which her family member took from the facility. -She asked Resident #5's family member to bring back Resident #5's TED hose a few days ago, but he had not brought them back yet. Interview with a nurse at Resident #5's PCP's office on 06/23/23 at 10:22am revealed: -The facility had not informed Resident #5's PCP she had not been wearing her TED hose. -Resident #5 could experience swelling in her legs and feet if she did not wear her TED hose. -The PCP expected the facility to have Resident #5's TED hose available and applied and removed daily as ordered.	D 276		

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D 276	Continued From page 12 Interview with the Administrator on 06/23/23 at 10:33am revealed: -She found out on 06/23/23 that Resident #5's family member took her TED hose home and had not returned them. -The MA supervisor should have reached out to Resident #5's PCP to see what staff needed to do if her TED hose were not in the facility or if she refused to wear them. -The MA supervisor should have also contacted Resident #5's family member to ask that the TED hose be brought back to the facility. Interview with Resident #3's family member on 06/23/23 at 11:33am revealed: -He ordered a pair of TED hose for Resident #3 from an online store. -When he ordered the TED hose for Resident #3, he did not have her measurements for sizing; he just ordered her a size small. -The TED hose had gotten loose on Resident #3's legs and the zipper of the TED hose were pinching the skin on her legs. -He did not want Resident #3 to wear the zippered TED hose anymore, because they pinched her skin, so he took the TED hose home so staff would not apply them to her legs. -He took the TED hose home about a week ago. -The facility staff did not offer to get Resident #3 another pair of TED hose. -A MA supervisor asked him, the day after he took the TED hose home, why he took the TED hose home, but there had been no further discussion with the facility staff regarding Resident #3's TED hose until 06/23/23. -The TED hose Resident #3 was wearing on 06/23/23 was a pair that came back to the facility with her from the hospital throughout the years. -Resident #3 did not have swelling in her ankles	D 276		

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D 276	Continued From page 13 and feet when he took the TED hose home about a week ago, but she did now.	D 276		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure water was served at each meal, in addition to other beverages. The findings are: Observation of the lunch meal service on 06/21/23 between 11:37am and 12:10pm revealed: -There were 28 residents present for the lunch meal service. -The beverages had been placed on the dining tables prior to the residents being seated. -Two glasses of water had been placed on the dining tables for 2 residents, and all the other glasses contained other beverages. -No other residents were served water. Interview with a dietary staff on 06/21/23 at 12:13pm revealed: -Beverages were placed on the tables prior to the	D 306	Dietary Staff were retrained on requirement to serve water in addition to other beverages at each meal. Dietary manager will monitor meals x2 per week x3 weeks then randomly thereafter, to ensure water is served at each meal. Director will monitor randomly to ensure water is served at each meal.	8/7/2023

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D 306	Continued From page 14	D 306		

residents arriving in the dining room.
-She knew what each resident liked to drink and placed the drinks on the tables according to the residents' preferences.
-The residents drank the same beverages every day.
-There were only 2 residents who drank water.

Observation of the breakfast meal service on 06/22/23 between 7:35am and 7:55am revealed:
-Beverages had been placed on the dining tables for 22 residents.
-Beverages included juice, coffee, and milk.
-No water was served to the residents.

Observation of the kitchen on 06/22/23 at 1:24pm revealed:
-There was a large bag of 34 new cups sitting on the counter in the kitchen.
-There were 20 new cups in the dishwasher draining.

Interview with a resident on 06/22/23 at 11:23am:
-Beverages served with meals usually included coffee, juice, and tea.
-If she wanted water with her meals, she had to ask for it.
-She would drink water with every meal if it was served to her with each meal.

Interview with a second resident on 06/22/23 at 11:31am revealed:
-Resident were not served water with each meal.
-She would drink water with her meals if it was served to her.
-She drank what was served to her and did not ask for water.

Interview with a third resident on 06/22/23 at 11:34am revealed she received water with her

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D 306	Continued From page 15 meals, but every resident was not served water. A second interview with the dietary staff on 06/22/23 at 1:25pm revealed: -She knew water should have been served to all residents with each meal. -Water had not been served with the lunch meal on 06/21/23 or with the breakfast meal on 06/22/23 because there were not enough cups in the facility for all residents to have water in addition to another beverage. -She purchased cups today so there would be enough cups to serve water to all residents. -She also had not served water to all residents previously because she did not think all the residents would drink it. Interview with a personal care aide (PCA) on 06/22/23 at 1:45pm revealed: -She assisted in the dining room during meals. -Beverages were already on the tables in the dining room when residents arrived for meals. -Water was not placed on the table or offered to all residents -A few residents were served water, but the other residents preferred tea or juice. -She did not know water should have been served to all residents with each meal. Interview with the Administrator on 06/23/23 at 10:33am revealed: -She knew residents were to be served water daily with each meal. -She did not know residents were not being served water with each meal. -Dietary staff had not told her there were not enough cups in the facility to serve each resident water with each meal.	D 306		

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D 375	Continued From page 16	D 375		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#3) who self-administered medications had orders to self-administer medications for The findings are: Review of Resident #3's current FL2 dated 03/07/23 revealed: -Diagnoses included degenerative disc disease-lumbar, impaired mobility and activities of daily living, frequent falls, and vitamin B12 deficiency. -There was no information related to Resident #3's orientation status. -Medication orders included alpha-lipoic acid (used to treat diabetic neuropathy) 600mg daily, amlodipine (used to treat high blood pressure) 2.5mg daily, vitamin B complex (used to treat or	D 375	Administrator/Designee will ensure all residents who self- administer medication have a signed order from their physician to self-administer medications. RCC/Designee will audit self administration of medication orders monthly to ensure all orders are obtained.	8/7/2023

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D 375	Continued From page 17 prevent vitamin deficiencies) 1 tablet twice a week, vitamin D 2000 (used to treat vitamin D deficiency) units 2 tablets daily, gabapentin (used to treat nerve pain) 300mg at bedtime, lisinopril (used to treat high blood pressure) 5mg daily, meclizine (used to treat nausea and vomiting) 12.5mg 3 times daily, mirtazapine (used to treat depression) 7.5mg at bedtime, omeprazole (used to treat indigestion, heartburn, and acid reflux) 40mg daily, and sodium chloride (ocean) 0.65% solution nasal spray (used to treat dry nose). -There was not an order to self-administer the medications. Observation of Resident #3's medications on hand in the resident's room on 06/21/23 at 9:35am revealed: -Resident #3's medications were in pill bottles and in medication bubble packs in various locations in her room. -There were medications in the top drawer of the night stand beside her bed. -There were medications in a plastic drawer container on the night stand. -There were medications in a plastic basket on top of the plastic drawer container. -Observed medications included vitamin B complex, lisinopril, mirtazapine, gabapentin, amlodipine, -Other observed medications included Ibuprofen 400mg, docusate sodium 100mg, acetaminophen 650mg, and vitamin D3 125mcg (5000 IU) and there was no physician's order for these medications. Observation of Resident #3's medications on hand in the resident's room on 06/21/23 at 2:55pm revealed: -There were medications in a plastic shoe box container on a stand against the wall of Resident	D 375		

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D 375	Continued From page 18 #3's room. -There were additional medications in Resident #3's night stand. -Observed medications included meclizine and sodium chloride nasal spray -Other observed medications included polyethylene glycol 3350 powder, Systane eye drops, 24-hour allergy relief 180mg. Observation of Resident #3's medications in overstock in the medication room on 06/21/23 at 3:20pm revealed: -Omeprazole 40mg was dispensed by the facility pharmacy on 04/11/23 with a quantity of 28 tablets and 28 tablets were remaining. -Alpha lipoic acid 600mg was dispensed by the pharmacy on 04/11/23 with a quantity of 28 tablets and 28 tablets were remaining. -Vitamin D2 2000U was dispensed by the pharmacy on 04/11/23 with a quantity of 28 tablets and 28 tablets were remaining. -These medications were not available in Resident #3's room for administration. Review of Resident #3's April, May and June electronic medication administration records (eMARs) revealed: -There was an entry with instructions to self-administer an eye drop, but there no other medication entries with instructions to self-administer the medication. -There was not a blanket entry for Resident #3 to self-administer her medications. -There was daily documentation of "IS" for each medication which, according to the symbol key on the eMARs, meant Resident #3 self-administered the medications. Interview with Resident #3 on 06/21/23 at 9:40am:	D 375		

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D 375	Continued From page 19 -She was admitted to the facility in March 2023 and had been self-administering her medications since admission. -She did not know if her primary care provider (PCP) knew that she was self-administering her medications at the facility. -The medication aides (MA) did not ask her if she needed any medication; she just told the MAs when she needed a medication. -She may have forgotten to take her medications once in a while. Second interview with Resident #3 on 06/22/23 at 2:49pm revealed: -No facility staff had ever come in her room and looked at all of her medications. -She had not been asked questions regarding her ability to self-administer her medications. Interview with the Special Care Unit Coordinator (SCUC) on 06/22/23 at 8:15am revealed: -She assisted on the assisted living side of the facility. -Resident #3's family requested that she self-administer her medication. -She thought Resident #3 had a current order to self-administer all her medications. -Resident #3's physician's orders to self-administer her medications should have been kept in her record. -She did not know an audit form, as per facility policy, needed to be completed monthly for each resident who self-administered medications. -She looked at Resident #3's medications when she was first admitted to the facility in March 2023, but she did not know if anyone had looked at her medications since then. -MAs and supervisors did not review Resident #3's medications in her room that she self-administered when conducting cart audits for	D 375		

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D 375	Continued From page 20 other residents. -Resident #3 told MAs when she was out of medication and the MAs ordered a refill of the medication for her. -MAs asked Resident #3 if she had taken her medications daily and then they documented on Resident #3's eMAR that she self-administered her medication. -She knew Resident #3 had medications in overstock in the medication room, but she did not know Resident #3 did not have the medications which were in overstock available in her room for self-administration. -She did not know there were medications in Resident #3's room that she did not have physician's orders for and were not on her eMAR. Interview with a MA supervisor on 06/22/23 at 9:06am revealed: -She thought Resident #3 had an order to self-administer her medications and the order should have been in her record. -Resident #3's family was adamant that she self-administered her medications. -MAs were responsible for ensuring residents who self-administered had physician's orders to self-administer. -The physician's order to self-administer medications was sent to the pharmacy and the pharmacy entered the order to self-administer medications on the eMAR. -She did not go into Resident #3's room to look at her medications because Resident #3 was very private. -The SCUC conducted cart audits once a month, but she did no audit Resident #3's medications to make sure all of her medications were available for her. -When Resident #3 was out of a medication, she let the MAs know.	D 375		

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D 375	Continued From page 21 -She did not know all the medications on Resident #3's physician's orders and on her eMARs were not available in her room to self-administer. -She did not know there were medications in Resident #3's room that were not ordered by her PCP. -She did not know about a self-administration audit form that needed to have been completed monthly for residents who self-administered medications. Interview with a second MA supervisor on 06/22/23 at 10:44am revealed: -She knew Resident #3 self-administered her medication and needed a physician's order to self-administer medication. -Resident #3 had an order to self-administer her medications from her previous provider, but there was not an order to self-administered medications from her current primary care provider (PCP). -Resident #3 had physician's orders from her current PCP dated 04/20/23, but they did not include orders for Resident #3 to self-administer her medications. -The MAs knew when Resident #3 ran out of medication because Resident #3 would let them know. -Resident #3's medications were kept in the medication room in overstock until she asked for them. -She did not know the medications that were in overstock were not available in Resident #3's room for self-administration and Resident #3 was not currently self-administering those medications. -She did not know there were medications in Resident #3's room that she did not have physician's orders for.	D 375		

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D 375	Continued From page 22 -She did not know a self-administration audit form was to be completed monthly for residents who self-administered their medications, per facility policy. Interview with Resident #3's PCP on 06/22/23 at 5:11pm revealed: -She had not written an order for Resident #5 to self-administer medications. -Resident #5 was still very mentally sharp, but she did not know if she was able to self-administer her medications. -The facility needed to assess Resident #5 to determine if she was capable of self-administering her medications. -She signed physician's orders for medications on 04/20/23 and expected all Resident #5's medications to be administered. -She had not written any orders to discontinue medications, nor wrote any orders for any medications that were not on her signed physician's orders dated 04/20/23. Interview with the Administrator on 06/23/23 at 10:33am revealed: -MAs asked Resident #3 daily if she had taken her medications and then documented that she self-administered the medications on the eMAR. -There was a compliance form that should have been completed by a MA supervisor initially and monthly. -MA supervisors should have looked at Resident #3's medications monthly to see if any medications needed to be reordered. -She did not know that Resident #3 did not have ordered medications available for her in her room. -She did not know Resident #3 had medications available in her room that were not ordered by her PCP.	D 375		

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D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that the residents' medications were stored in a safe and secure manner for 1 of 1 sampled resident (#4) who self-administered medications. The findings are: Review of the facility's undated Resident Self-Administration of Medications policy revealed: -The resident would be competent and physically able to administer their own medications. -Self-administration would be ordered by a physician or other legally authorized person to prescribe and the order was to be kept in the	D 377	Director/Designee retrained medication aides on ensuring self-administered medications are stored in the resident's room in a safe and secure manner. SCUC will monitor x 5 days per week to assure medications self-administered medications are stored in the resident's room in a safe and secure manner. Director will conducting random monitoring through observations to ensure medications self-administered medications are stored in the resident's room in a safe and secure manner.	8/7/2023

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D 377	Continued From page 24	D 377		

resident's record.
-Specific instructions for administration of the medications would be printed on the label.
-All medications would be listed on the self-administration form and signed by the physician.

Review of the facility's Management of Resident Self-Administration of Medications policy dated 07/06/12 revealed:
-The purpose of the policy was to insure the resident who self-administered their medications were safely administering, storing, and were competent to manage their medications independently.
-A signed self-administration of medication order for all medications the resident self-administered was to be obtained.
-The Supervisor/designee was to audit the resident compliance with self-administration of medications using a compliance audit form.
-The checklist was to be placed in the front of the residents MAR and was to be completed prior to the end of each month.

Review of Resident #3's current FL2 dated 03/07/23 revealed:
-Diagnoses included degenerative disc disease-lumbar, impaired mobility and activities of daily living, frequent falls, and vitamin B12 deficiency.
-There was no information related to Resident #3's orientation status.
-Medication orders included alpha-lipoic acid (used to treat diabetic neuropathy) 600mg daily, amlodipine (used to treat high blood pressure) 2.5mg daily, vitamin B complex (used to treat or prevent vitamin deficiencies) 1 tablet twice a week, vitamin D 2000 (used to treat vitamin D deficiency) units 2 tablets daily; gabapentin (used to treat nerve pain) 300mg at bedtime, lisinopril

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D 377	Continued From page 25 (used to treat high blood pressure) 5mg daily, meclizine (used to treat nausea and vomiting) 12.5mg 3 times daily, mirtazapine (used to treat depression) 7.5mg at bedtime, omeprazole (used to treat indigestion, heartburn, and acid reflux) 40mg daily, and sodium chloride (ocean) 0.65% solution nasal spray (used to treat dry nose). Observation of Resident #3's medications on hand in the resident's room on 06/21/23 at 9:35am revealed: -Resident #3's medications were in pill bottles and in medication bubble packs in various locations in her room. -There were medications in the top drawer of the night stand beside her bed. -There were medications in a plastic drawer container on the night stand. -There were medications in a plastic basket on top of the plastic drawer container. -Observed medications included vitamin B complex, lisinopril, mirtazapine, gabapentin, amlodipine, -Other observed medications included Ibuprofen 400mg, docusate sodium 100mg, acetaminophen 650mg, and vitamin D3 125mcg (5000 IU). Observation of Resident #3's medications on hand in the resident's room on 06/21/23 at 2:50pm revealed: -There were medications in a plastic shoe box container on a stand against the wall of Resident #3's room. -There were additional medications in Resident #3's night stand. -Observed medications included meclizine and sodium chloride nasal spray -Other observed medications included polyethylene glycol 3350 powder, Systane eye	D 377		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 377	Continued From page 26 drops, 24-hour allergy relief 180mg. Observation of Resident #3 on 06/21/23 at 2:49pm: -Resident #3 was in the dining area attending an activity. -Resident #3's room door was opened and there was medication on top of her night stand which was visible from the door. Interview with Resident #3 on 06/21/23 at 9:40am revealed: -She had not shared her room with another resident since her roommate left about a month ago. -She had been self-administering her medication since she was admitted to the facility in March 2023. -She kept medications in her night stand, and on top of her night stand. -She did not lock any of her medications up and did not lock her bedroom door when she left her room. Interview with the Special Care Unit Coordinator (SCUC) on 06/22/23 at 8:15am revealed: -She assisted on the assisted living side of the facility when needed and reviewed Resident #3's medications upon admission. -Resident #3's medications should have been locked in her closet in her room. -Residents had keys to their closets. -She did not know Resident #3's medications were not kept in a lockable space in her room. Interview with a MA supervisor on 06/22/23 at 9:06am revealed: -She had seen Resident #3 preparing her medications in a medication pillbox and self-administering her eye drops.	D 377		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	06/23/2023

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D 377	Continued From page 27 -She knew self-administered medications should have been kept in a lockable space. -She did not know Resident #3 medications were not kept in lockable storage. Interview with a second MA supervisor on 06/22/23 at 10:44am revealed: -She knew self-administered medications should be kept in a locked space. -She knew Resident #3's medications were not in a locked storage space. -She went to the store a month ago to try to find Resident #3 a locked box for her medications, but the one she found was too heavy for Resident #3 to lift. -She planned to go back to the store to look for a locked box, but she just had not. Interview with the Administrator on 06/23/23 at 10:33am revealed: -Usually, residents who self-administered their medications kept their medication in a locked box in their closet. -She did not know Resident #3's medications were not in a locked box. -Resident #3's family member stated upon admission that she had a locked box, but she did not go to Resident #3's room to check to see if the locked box was in the facility. -The MA supervisors were responsible for ensuring Resident #3's medications were secured in a lockable space.	D 377		