STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073018	A. BUILDING: _____ B. WING _____	R 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CANTERBURY HOUSE	1284 LEASBURG ROAD ROXBORO, NC 27573

(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 Person County Department of Social Services conducted an annual an follow-up survey on 06/28/23 to 06/29/23.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
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, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) related to a medication for bone health. The findings are: Review of Resident #1's current FL2 dated 05/02/23 revealed: -Diagnoses included dementia, headaches, seizure disorder, Vitamin B12 deficiency and osteopenia. -There was an order for alendronate (used to prevent osteoporosis) 70mg once weekly on Fridays. Review of Resident #1's May 2023 electronic medication administration record (eMAR) revealed:	D 358	Canterbury House shall ensure that the preparation and administration of medications and treatments by staff are according to Provider's orders, which are kept in the Resident's record, facility's policies and procedures, and rules in Section .1004. Executive Director (ED) in-serviced staff on Resident Rights. 7/6/23 ED, Assistant ED (AED), and Resident Care Coordinator (RCC) in-serviced Med Techs with a medication administration review, including cart audits, processing of new orders, order processing system, documentation, and proper chain of custody with narcotics. 7/6/23 Med Techs will give all medications according to the 6 rights of medication administration. They will ensure proper Provider notification with missed and /or refused doses per facility protocol, as well as ensuring required documentation has occurred. RCC will follow-up by reviewing the electronic facility documentation daily to ensure this has been completed. 8/13/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Meraldine Yancey — TITLE: Administrator — (X6) DATE: 8/9/23

Reviewed and acknowledged on 08/21/23. P.D.

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D 358	Continued From page 1 -There was an entry for alendronate 70mg once weekly scheduled on Fridays at 6:30am. -Alendronate 70mg was documented as administered on 05/05/23, 05/12/23, 05/19/23, and 05/26/23 at 6:30am. Review of Resident #1's eMAR from 06/01/23 to 06/29/23 revealed: -There was an entry for alendronate 70mg once weekly scheduled on Fridays at 6:30am. -Alendronate 70mg was documented as administered on 06/02/23, 06/09/23, 06/16/23, and 06/23/23 at 6:30am. Review of Resident#1's medications on hand on 06/29/23 revealed: -Resident #1's alendronate 70mg was dispensed in a single medication card. -Resident #1 had two medication cards of alendronate 70mg. -There were four alendronate 70mg tablets dispensed on 05/05/23; one tablet was available for administration in the card. -There were four alendronate 70mg tablets dispensed on 06/02/23; four tablets were available for administration in the card. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/29/23 at 1:21pm revealed: -Resident #1 had a current order for alendronate 70mg once weekly scheduled every Friday. -Resident #1's alendronate was on a cycle fill and was dispensed on a single card and was not included in the multidose package with her other medications. -On 05/05/23 and 06/02/23, four tablets of Resident #1's alendronate 70mg were dispensed. -Alendronate was used to increase bone strength and promote healthy bones.	D 358	MAR to cart audits will be completed weekly by the Med Techs per facility schedule, and will be reviewed by the RCC or Designee to ensure follow-up has occurred. RCC will complete a weekly QA cart audit to verify the condition and compliance of the med cart. Cart Audits will be reviewed by ED to ensure completion and follow through.	8/13/23 8/13/23

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D 358	Continued From page 2 -When alendronate was not administered as ordered the resident was at an increased risk for decreased bone strength, brittle bones, and decreased overall bone health; unhealthy bones put the resident at risk for injury. Interview with the Resident Care Coordinator on 06/29/23 at 1:30pm revealed: -The medication aides (MAs) were responsible for administering the residents their medications and auditing the medication carts when they worked. -She used the audits completed by the MAs to spot audit their work and to review the eMARs. -She usually conducted audits two times a week, but she had fallen behind due to other responsibilities over that past few weeks. -She looked at dispense dates, the eMAR and counted the medication available to determine if the medication was administered as ordered. -When a resident had extra medication available for administration, she would review the eMAR to determine why there was extra medication available. -When a medication is not properly administered it was considered a mediation error. -If a medication error was discovered because it had not been correctly administered, she immediately notified the resident's primary care provider (PCP) and documented the instructions from the PCP. -She also completed the facility's medication error report. -She had not audited Resident #1's medications during her weekly audits; the MAs should have discovered Resident #1's extra alendronate. Interview with the Administrator on 06/29/23 at 4:15pm revealed: -The MAs conducted daily audits on the	D 358		

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D 358	Continued From page 3 medication carts on every shift: the audits were documented on a form. -She and the RCC reviewed the audits and signed off on them. -If there was medication that was not administered the MAs would find it during a medication cart audit. -Resident #1's alendronate 70mg should have been found during the audits. -The MAs should have been comparing Resident #1's eMAR to the medication and the medication in the medication cart to the eMAR. -Resident #1's alendronate was on a separate card and should have been compared against the eMAR. -A medication error report would have been completed and the PCP notified. -There should not have been extra medication on the medication cart because it should have been administered correctly. Attempted telephone interview with Resident #1's PCP on 06/29/23 at 2:00pm was unsuccessful. Attempted telephone interview with the third shift MA on 06/29/23 at 1:27pm were unsuccessful. Based on record reviews, interviews, and observations Resident #1 was not interviewable.	D 358		