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
	HAL001148	A. BUILDING: _____ B. WING _____	R 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(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 a follow-up survey on September 19-20, 2023.	(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 310)	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interview, the facility failed to ensure therapeutic diets were served as ordered for 2 of 3 sampled residents (#6 and #7) with pureed diet orders. The findings are: 1. Review of Resident #6's current FL-2 dated 09/220/23 revealed: -Diagnoses included Alzheimer's disease, idiopathic epilepsy, and elevated blood pressure. -There was an order for a pureed diet. Review of Resident #6's diet order dated 09/20/23 revealed: -Resident #6 was ordered a pureed diet. -The pureed diet was noted as designed to provided foods of a smooth, soft consistency, like fluffy whipped potatoes. Review of the resident diet list posted in the kitchen on 09/19/23 at 8:12pm revealed Resident #6 was ordered a pureed diet. Observation of the lunch meal on 09/19/23 at 12:41pm revealed:	(D 310)	Alamance House shall ensure that all therapeutic diets, including nutritional supplements and thickened liquids, are served as ordered by the Resident's Physician. Executive Director (ED) in-serviced Dietary Cooks and Business Office Coordinator (BOC) on special diets, dietary needs of the Residents, as well as preparation and service of the offered diets. 9/21/23 Care Managers and Dietary Manager (DM) will continue to in-service Cooks and clinical staff on the therapeutic diets offered in the facility, as well as which Residents are on therapeutic diets. 11/4/23 Executive Director (ED)/ DM will ensure all newly hired cooks, and any staff that will help in the kitchen, are trained to understand the "Special Diet Instructions" found in the recipes for therapeutic diets, as well as the importance of ensuring Residents receive the correct diet per MD orders. 11/4/23	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer J. Evans — TITLE: Executive Director — (X6) DATE: 11/8/23

Reviewed & Acknowledged
W Edwards
11/10/23

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{D 310}	Continued From page 1 -Resident #6 was served pork chop, potatoes, collard greens and corn. -The collard greens appeared chopped. -The corn appeared "creamed" with whole pieces of corn. -There was no biscuit served. -Resident #8 consumed 100 % of the collard greens and corn. -Resident #8 had no coughing during the meal. Review of the puree therapeutic diet menu for lunch on 09/19/23 revealed the meal consisted of pured pork, mashed potatoes, pureed vegetables (no corn and no peas), pureed collards (no bacon), pureed roll and pureed mandrarin oranges. Interview with the personal care aide (PCA) on 09/19/23 at 2:33pm revealed: -She served Resident #8 his pureed diet for lunch today. -The kitchen staff plate the food and pass the plates to the PCA staff. -The kitchen staff told the PCAs what type of diet was on the plate and the PCA would serve the plate to the appropriate residents. -She knew which resident received which type of diet. -She knew Resident #8 was on a pureed diet. -She did not know what foods were to be served with the pureed diets. -She did not know corn was not to be served with the pureed diets. -Residents who received pureed diets received the same food as the residents who received a regular diet, except it was the texture of "baby food" or a little thicker. Interview with the Primary Care Provider (PCP) on 09/20/23 at 10:23am revealed:	(D 310)	Care Managers will ensure clinical staff are aware of residents that are on therapeutic diets, and what the diets are. Newly hired clinical staff will be oriented to understand the therapeutic diets in the facility. DM and Care Managers will monitor in the kitchen, and in the dining rooms to ensure accuracy. ED/ or Designee will randomly observe mealtimes to ensure staff are following proper procedure, as well as inspecting to ensure diets are prepared and served appropriately. Any noted concerns will be addressed with the DM/ Cook on duty/ or Care Manager immediately.	11/4/23 11/4/23 11/4/23

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{D 310}	Continued From page 2 -Resident #8 had an order for a pureed diet. -Resident #8 recently returned from the hospital with a pureed diet order. -She ordered Speech Therapy (ST) for Resident #8 since he returned from the hospital with an order for pureed diet. -She expected Resident #8 to be served a pureed diet as ordered until the ST evaluation was completed and the diet advanced. Refer to interviews with the cook on 09/19/23 at 1:06pm and 4:29pm. Refer to interview with the Business Office Manager (BOM) on 09/19/23 at 4:33pm. Refer to interview with the Administrator on 09/19/23 at 4:55pm. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. 2. Review of Resident #7's current FL-2 dated 02/20/23 revealed: -Diagnoses included cerebral palsy, gastroesophageal reflux disease (GERD), hypertension, and history of transient ischemic attack. -There was nothing listed for her diet order. Review of Resident #7's diet order dated 02/20/23 revealed: -Resident #6 was ordered a pureed diet. -The pureed diet was noted as designed to provided foods of a smooth, soft consistency, like fluffy whipped potatoes. Review of the resident diet list posted in the kitchen on 09/19/23 at 8:12pm revealed Resident	{D 310}		

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(D 310)	Continued From page 3 #7 was ordered a mechanical soft chopped meat only diet. Observation of the lunch meal on 09/19/23 at 12:15pm revealed: -Resident #7 was served chopped pork without gravy, a roll, mashed potatoes, corn, collard greens and a beverage. -Resident #7 ate 100 % of her meal. Review of the puree therapeutic diet menu for lunch on 09/19/23 revealed the meal consisted of pureed pork, mashed potatoes, pureed vegetables (no corn and no peas), pureed collards (no bacon), pureed roll and pureed mandarin oranges. Telephone interview with Resident #7's primary care provider (PCP) on 09/20/23 at 10:05am revealed: -Resident #7 did not have teeth. -She was ordered a pureed diet. -She would have to be evaluated by speech therapy to be upgraded. -She expected the facility to follow the diet order for Resident #7 because she could be at risk for aspiration if the therapeutic diet and menu were not followed. Interview with Resident #7 on 09/20/23 at 8:44am revealed: -She had been on a pureed diet once. -She thought she had been upgraded to a mechanical soft diet at the hospital. -She had not had any problems eating the mechanical soft diet. Refer to interviews with the cook on 09/19/23 at 1:06pm and 4:29pm.	(D 310)		

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(D 310)	Continued From page 4 Refer to interview with the Business Office Manager (BOM) on 09/19/23 at 4:33pm. Refer to interview with the Administrator on 09/19/23 at 4:55pm. --- Interviews with the cook on 09/19/23 at 1:06pm and 4:29pm revealed: -He plated the food and the personal care aides told him the residents' diets. -He looked at the therapeutic diet menu before he served the meal. -Different staff pureed the food for the lunch meal -He was told by other staff to chop the protein foods like the pork and then put them into the blender with some water and blend to a baby food consistency. Interview with the Business Office Manager (BOM) on 09/19/23 at 4:33pm revealed: -She was trying to help in the kitchen and pureed the food on the menu. -She pureed the pork, the collard greens and the corn for the lunch meal. -She placed the items in the blender and pureed them separately with some water until they "looked good". -She wanted the pureed food to be "scoop-able and squishy". -No one had shown her or told her how to puree food. -She did not know about the therapeutic diet menu until today, 09/19/23 after lunch; the cook showed it to her. Interview with the Administrator on 09/19/23 at 4:55pm revealed: -The cooks were trained while working by staff from their corporate office.	(D 310)		

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{D 310}	Continued From page 5 -She expected the staff to follow the therapeutic diet menu because it told them exactly what to serve for each diet. -She usually rounded in the kitchen and the dining rooms during meal service at least once daily. -She had seen two pureed meals lunch and they looked correct to her; she had not looked at the therapeutic menu for lunch. -If the staff had followed the therapeutic menu there would not have been any errors.	{D 310}		
{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 8 residents (#8) observed during the morning medication pass including errors with the administration of 2 supplements. The findings are: The medication error rate was 5.88% as evidenced by the observation of 2 errors out of 34 opportunities during the 8:00am medication pass on 09/20/23.	{D 358}	Alamance House shall ensure that the preparation and administration of medications and treatments by staff are according to Providers' orders, which are maintained in the Resident's record; the facility's policies and procedures; and the rule area .1004(a). ED/ Care Managers in-serviced Med Techs on proper Med Admin techniques including: 6 Rights of med administration, completing 3 checks prior to administering, med errors, and documentation. Care Managers will ensure accuracy when processing and approving orders, making sure to follow all directions given. When orders are discontinued, Care Managers will remove the medication from the cart upon verifying the order. If the	9/21/23 11/7/23 11/4/23

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(D 358)	Continued From page 6 Review of the facility medication administration policy revealed: -Prior to administration of any medication, the resident's electronic medication administration record (eMAR) should be compared with the medication label. -If the label and eMAR are different, the physician's orders were to be checked. -When a medication in a multi-dose pack was discontinued, a "change of direction/discontinued" sticker was to be placed on the multi-dose packaging beside the medication name. -When it was time to administer medication, the medication aide (MA) would check the description identifying numbers and letters on the pill and with a witness, remove the pill from the multi-dose package. Review of Resident #8's FL-2 dated 09/12/23 revealed diagnoses included chronic kidney disease stage 3 and vitamin B 12 deficiency. 1. Review of Resident #8's signed physician order dated 08/08/23 revealed there was an order for vitamin B 12 1000mcg daily. Review of Resident #8's signed physician order dated 09/05/23 revealed there was an order to discontinue vitamin B 12. Observation of the morning medication pass on 09/20/23 at 7:44am revealed: -The medication aide (MA) opened the second drawer on the medication cart. -The MA reached into the medication cart and perforated the multi-dose pack for the 8:00 morning pass for 09/20/23 without removing the weekly multi-dose pack from the medication cart. -The MA compared the list of medications on the back of the multi-dose pack with the electronic	(D 358)	discontinued medication is located within a multi-dose unit, the Care Manager will write "discontinued" beside the name and photo of the medication, or will affix a "change of direction/ discontinue" sticker, to alert Med Techs to dispose of medication. Med Techs will complete MAR to cart audits per facility schedule to ensure availability and accuracy of medications on medication carts. The audits will be reviewed by the Care Managers upon completion for compliance, and to ensure accurate and adequate medications are on hand at all times. Care Managers will complete cart audits weekly for overall QA of the medication carts to ensure the cart is stocked with appropriate and accurate medications. Care Managers will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate medication administration. Completed chart audits will be reviewed by the ED for compliance. Care Managers will pull Medication Compliance Reports daily to ensure meds are administered per MD orders. Reports will be reviewed with the ED during management meeting daily	11/4/23 11/4/23 11/4/23 11/4/23

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(D 358)	Continued From page 7 medication administration record (eMAR). -The MA opened the multi-dose pack and placed 10 pills into a medication cup and administered the 10 pills, including a vitamin B 12 1000mcg, to Resident #8. Review of Resident #8's September 2023 eMAR revealed: -There was an entry for vitamin B 12 with a scheduled administration time of 8:00am. -There was no documentation vitamin B 12 was administered at 8:00am. -There was documentation vitamin B 12 was discontinued on 09/07/23. Observation of Resident #8's medication on hand on 09/20/23 at 7:44am revealed there was a vitamin B 12 tablet in the 8:00am multi-dose pack. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/20/23 at 9:13am revealed: -The pharmacy received an order on 09/07/23 to discontinue vitamin B 12. -The pharmacy entered the discontinued order into the eMAR on 09/07/23, removing the medication from the active medication list. -The medication would not appear on the eMAR when the medication aide (MA) was administering medications. -The vitamin B 12 was still in the multi-dose pack due to the packaging schedule. -The MA was responsible for removing the medication that was discontinued from the multi-dose pack. Interview with the MA on 09/20/23 at 9:36am revealed: -She compared the medications listed on the	(D 358)	for compliance. Any noted areas of concern will have follow-up as appropriate, including MD notifications, clarifications, and any interventions needed.	

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(D 368)	Continued From page 8 back of the multi-dose pack with the medications listed on the eMAR. -She administered the 10 pills in the multi-dose pack to Resident #8, including vitamin B 12. -She confirmed all the medications in the multi-dose pack were on the eMAR. -She did not know vitamin B 12 had been discontinued. -A discontinued sticker should have been placed on the weekly multi-dose pack. -She thought the vitamin B 12 was on the eMAR -She did not notice the vitamin B 12 was not on the eMAR. -She did not notice someone had hand-written "discontinued" by vitamin B 12 on the weekly multi-dose pack. -She did not pull the weekly multi-dose pack from the medication cart; if she had, she would have seen the hand-written entry that the vitamin B 12 had been discontinued. -She should have removed the vitamin B 12 from the multi-dose pack since it had been discontinued. Telephone interview with Resident #8's Primary Care Provider (PCP) on 09/20/23 at 10:18am revealed: -She discontinued the vitamin B 12 on 09/05/23. -Resident #8 had an elevated B 12 level. -She expected the MA to follow orders as written. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Refer to the interview with the Special Care Coordinator on 09/20/23 at 9:49pm. Refer to the interview with the Administrator on 09/20/23 at 10:01am.	(D 368)		

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(D 358)	Continued From page 9 2. Review of Resident #8's signed physician order dated 08/17/23 revealed there was an order for a multivitamin with iron daily. Review of Resident #8's signed physician order dated 09/05/23 revealed there was an order to discontinue the multivitamin with iron. Observation of the morning medication pass on 09/20/23 at 7:44am revealed: -The medication aide (MA) opened the second drawer on the medication cart. -The MA reached into the medication cart and perforated the multi-dose pack for the 8:00 morning pass for 09/20/23 without removing the weekly multi-dose pack from the medication cart. -The MA compared the list of medications on the back of the multi-dose pack with the electronic medication administration record (eMAR). -The MA opened the multi-dose pack and placed 10 pills into a medication cup and administered the 10 pills, including a multivitamin with iron, to Resident #8. Review of Resident #8's September 2023 eMAR revealed: -There was an entry for a multivitamin with iron with a scheduled administration time of 8:00am. -There was no documentation multivitamin with iron was administered at 8:00am. -There was documentation multivitamin with iron was discontinued on 09/07/23. Observation of Resident #8's medication on hand on 09/20/23 at 7:44am revealed there was a multivitamin with iron tablet in the 8:00am multi-dose pack. Telephone interview with the Pharmacist at the	(D 358)		

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(D 358)	Continued From page 10 facility's contracted pharmacy on 09/20/23 at 9:13am revealed: -The pharmacy received an order on 09/07/23 to discontinue the multivitamin with iron. -The pharmacy entered the discontinued order into the eMAR on 09/07/23, removing the medication from the active medication list. -The medication would not appear on the eMAR when the medication aide (MA) was administering medications. -The multivitamin with iron was still in the multi-dose pack due to the packaging schedule. -The MA was responsible for removing the medication that was discontinued from the multi-dose pack. Interview with the MA on 09/20/23 at 9:36am revealed: -She compared the medications listed on the back of the multi-dose pack with the medications listed on the eMAR. -She administered the 10 pills in the multi-dose pack to Resident #8, including the multivitamin with iron. -She confirmed all the medications in the multi-dose pack were on the eMAR. -She did not know the multivitamin with iron had been discontinued. -A discontinued sticker should have been placed on the weekly multi-dose pack. -She thought the multivitamin with iron was on the eMAR -She did not notice the multivitamin with iron was not on the eMAR. -She did not notice someone had hand-written "discontinued" by the multivitamin with iron" entry on the weekly multi-dose pack. -She did not pull the weekly multi-dose pack from the medication cart; if she had, she would have seen the hand-written entry that the multivitamin	(D 358)		

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{D 358}	Continued From page 11 with iron had been discontinued. -She should have removed the multivitamin with iron from the multi-dose pack since it had been discontinued. Telephone interview with Resident #8's Primary Care Provider (PCP) on 09/20/23 at 10:18am revealed: -She discontinued the multivitamin with iron on 09/05/23. -She expected the MA to follow orders as written. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Refer to the interview with the Special Care Coordinator on 09/20/23 at 9:49pm. Refer to the interview with the Administrator on 09/20/23 at 10:01am. Interview with the Special Care Coordinator (SCC) on 09/20/23 at 9:49pm revealed: -She was responsible for faxing discontinued orders to the pharmacy. -She faxed the discontinued orders to the pharmacy on 09/05/23. -The pharmacy entered the discontinued order for the multivitamin with iron on the eMAR. -A discontinued sticker would be placed on the weekly multi-dose pack and the medication aide (MA) would remove the discontinued medication from the multi-dose pack. -The MA should use the scanner and scan the multi-dose pack. -The scanner would identify if a medication in the multi-dose pack was discontinued and would alert the MA by a "pop-up" on the computer screen.	{D 358}		

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{D 358}	Continued From page 12 Interview with the Administrator on 09/20/23 at 10:01am revealed: -She expected the MAs to use the scanner to scan the multi-dose pack. -The scanner would alert the MA if there was a medication in the multi-dose pack that had been discontinued. -She was concerned that residents were being administered medications that had been discontinued.	{D 358}		
{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, record reviews and interviews, the facility failed to ensure 1 of 1 sampled residents (Resident #3) had a physician's order to self-administer an arthritis gel and a dry mouth oral rinse. The findings are:	{D 375}	Alamance House shall permit residents who are competent and physically able to self administer their medications if they have a Physician/ Provider's order which will be stored in the resident's medical record; and specific instructions for administration of prescription medication are printed on the medication label. ED/ Care Managers in-serviced Med Techs on proper Med Admin techniques including: 6 Rights of med administration, completing 3 checks prior to administering, med errors, and documentation. Care Managers will maintain an updated list of residents that self-administer their medications. This list will be stored in a secure location that the Med Techs will be able to easily review, while maintaining HIPPA compliance. This will allow staff to be able to spot check for safe medication storage when going into resident rooms for care.	9/21/23 11/7/23 11/4/23

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	HAL001148	A. BUILDING: _____ B. WING _____	R 09/20/2023

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(D 375)	Continued From page 13 Review of the facility's Resident Self-Management medications policy revealed: -Any resident who desires to self-manage and administer his/her medications must successfully complete the Self-Administration assessment completed by the Resident Care Coordinator (RCC) or designee. -Once the resident has satisfactorily passed the evaluation, the RCC or designee will ensure there was a physician's order in place that indicated the resident is able to self-administer his/her medications and the specific instructions for the use of the medications were printed on the medication label. Review of Resident #3's current FL-2 dated 06/12/23 revealed: -Diagnoses included dementia, osteoporosis, chronic cough and hypertension. -There was no order for Resident #3 for self-administration of medications. Review of Resident #3's signed Physician Order Sheet dated 06/12/23 revealed: -There was no order for aspercreme, an arthritis gel for the relief of pain and stiffness. -There was no order for biotene, a moisturizing oral rinse. -There was no order for Resident #3 to self-administer medications. Observation of Resident #3's bathroom during the morning tour on 09/19/20 at 8:53am revealed: -There was a 3.75 oz, half used tube of aspercreme on the storage cubicle shelf. -There was a 2 fl. oz, half used container of biotene on the shelf.	(D 375)	Care Managers will ensure the Area Clinical Director is promptly notified when a provider order is received for a resident to self-administer their medications. ACD will complete the self -administer assessment on residents that wish to keep and administer their own medications. This assessment will ensure the resident is competent and can safely administer and store their own meds. This assessment will be repeated quarterly or more frequently if needed due to a change in resident condition. The ACD will discuss the results of the assessment with the ED and Care Managers upon completion. Care Managers will ensure medication label has clear instructions for administration written out on any prescriptions kept at the resident bedside. Care Managers will also ensure resident understands the importance of storing medications securely for safety at all times. ED/Care Managers will make facility rounds no less than twice daily, and will spot check for safe storage of bedside medications during rounding process.	11/4/23 11/4/23 11/4/23 11/4/23

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(D 375)	Continued From page 14 Observation of Resident #3's bathroom on 09/20/20 at 8:00am revealed: -There was a 3.75 oz, half used tube of aspercreme on the storage cubicle shelf. -There was a 2 fl. oz, half used container of biotene on the shelf. -The aspercreme and biotene containers were placed on the shelf. but had been moved to the back of the cubicle. Interview with Resident #3 on 09/20/23 at 9:19am revealed: -She used the aspercreme to lessen the pain in her shoulders and arms. -When she started to ache, she had the aspercreme close by and could apply it to her shoulders as needed. -Her mouth was always dry, and she frequently used the biotene to help moisten it. - She had used the aspercreme and biotene at home, brought the medication with her when she was admitted to the facility (05/22/22) and used them ever since. -She frequently went shopping with her family and would purchase the aspercreme and biotene herself and bring them back to the facility in her shopping bag. -She did not have a self-administration order for the use of medications; she could buy them over the counter (OTC). -She kept the medications in sight on the bathroom shelf for convenience. -Staff come and go into my room to assist her and administer medications. -No one told her she needed to have a self-administration order, or the medications needed to be stored in the medication cart. Interview with a medication aide (MA) on 09/20/23 at 9:50am revealed:	(D 375)		

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(D 375)	Continued From page 15 -Medications were usually administered to Resident #3 in her room. -She had not seen the aspercreme or biotene on the bathroom shelf in Resident #3's room. -She did not know how long the aspercreme and biotene had been kept in Resident #3's room. -She did know the medication was in Resident #3's room or she would have removed it and reported it to the Resident Care Coordinator (RCC). Interview with a pharmacist with the facility's contracted pharmacy on 09/20/23 at 10:40am revealed: -The pharmacy did not have an order for aspercreme 3.75 oz for Resident #3. -The pharmacy did not have an order for biotene 2 fl oz dry mouth oral rinse for Resident #3. -The pharmacy did not have an order for Resident #3 to self-administer medications. Interview with the Resident Care Coordinator (RCC) on 09/20/23 at 10:10am revealed: -All medications should be kept in the medication cart unless the resident had self-administration order. - When a MA or other staff find medications in a resident's room they were to remove the medications and bring them to her to check to determine why the medications were in the room. -If a resident wanted to self-administer their medications, they would need to complete an assessment and obtain an order from their (PCP). Interview with the Administrator on 09/20/23 at 10:15am revealed: -All medications should have a physician's order and label if coming from outside the facility. - All medications should be locked in the	(D 375)		

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(D 375)	Continued From page 16 medication cart unless the resident has been given an order for self-medication in their room. Attempted telephone interview with Resident #3's primary care provider (PCP) on 09/20/23 at 9:30am was unsuccessful.	(D 375)		
(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 to ensure residents medications were stored in a safe and secure manner for 1 of 1 sampled resident (Resident #3) who self-administered medications. The findings are:	(D 377)	Alamance House shall ensure that medications that are self-administered and stored in a Resident's room are stored in a safe and secure manner according to the facility's policies and procedures. Care Managers will maintain an updated list of residents that self-administer their medications. This list will be stored in a secure location that the Med Techs will be able to easily review, while maintaining HIPPA compliance. This will allow staff to be able to spot check for safe medication storage when going into resident rooms for care. 11/4/23 Care Managers will ensure medication label has clear instructions for administration written out on any prescriptions kept at the resident bedside. Care Managers will also ensure resident understands the importance of storing medications securely for safety at all times. 11/4/23 ED/Care Managers will make facility rounds no less than twice daily, and will spot check for safe storage of 11/4/23	

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(D 377)	Continued From page 17 Review of the facility's Medication Storage policy for residents revealed: -Medications would be stored in a manner that ensures the maintence of both the integrity of the medication and the safety of all residents residing in the community. -All medications, including over the counter (OTC) were always kept in locked storage Review of Resident #3's current FL-2 dated 06/12/23 revealed: -Diagnoses included dementia, osteoporosis, chronic cough and hypertension. -There was no order for Resident #3 for self-administration of medications. Observation of Resident #3's bathroom during the morning tour on 09/19/20 at 8:53am revealed: -There was a 3.75 oz, half used tube of aspercreme on the storage cubicle shelf. -There was a 2 fl. oz, half used container of biotene on the shelf. Observation of Resident #3's bathroom on 09/20/20 at 8:00am revealed: -There was a 3.75 oz, half used tube of aspercreme on the storage cubicle shelf. -There was a 2 fl. oz, half used container of biotene on the shelf. -The aspercreme and biotene containers were placed on the shelf. but had been moved to the back of the cubicle. Interview with Resident #3 on 09/20/23 at 9:19am revealed: -She used the aspercreme to lessen the pain in her shoulders and arms. -When she started to ache, she had the aspercreme close by and could apply it to her shoulders as needed.	(D 377)	bedside medications during rounding process.	

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(D 377)	Continued From page 18 -Her mouth was always dry, and she frequently used the biotene to help moisten it. -She frequently went shopping with her family, purchased the aspercreme and biotene herself and brought them back to the facility in her shopping bag. -No staff asked if she had any medications in her shopping bag. -She did not know to tell ataff she had medications in her shopping bag. -She kept the medications in sight on the bathroom shelf for convenience. -MA taff came and went into my room administering her medications. She did not know she needed a self-administration order to have medications in her room. She did not have a self-administration order for the use of medications. -No MAtold her she needed to have a self-administration order, or the medications needed to be stored in the medication cart. Interview with a medication aide (MA) on 09/20/23 at 9:50am revealed: -Medications were usually administered to Resident #3 in her room. -Resident #3's medications were kept on the cart except when she took them out to be administered or audited. -She had not seen the aspercreme or biotene on the bathroom shelf in Resident #3's room until now. -She did not usually look around the room when she was focusing on the resident and the medication pass. -The aspercreme and the biotene should have been stored in the medication cart drawer and brought to Resident #3 to be applied. -She did not know how long the aspercreme and	(D 377)		

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(D 377)	Continued From page 19 biotene had been kept in Resident #3's room. -She did not know the medications were in Resident #3's room or she would have removed them and reported it to the Resident Care Coordinator (RCC). Interview with the RCC on 09/20/23 at 10:12am revealed: -All residents medications must be kept locked in the medication cart unless it was being administered by the MA or by a resident given a self-administration order, by her PCP, and securely keep in their room. -MA's were to remove any medications found in a resident's room and lock them in the medication cart. medications and take them to her to lock on the cart. -If a resident wanted to keep medications in their room, they would need to complete an assessment and obtain a self-administration order from their physician. -She was not aware Resident #3 had been storing aspercreme and biotene in her room. She expected staff to be more aware of residents procuring and administering medications without an order and was not stored in a safe and secured manner. Interview with the Administrator 0 09/2023 at 10:15am revealed: --MAs and primary care aides (PCA) made rounds in residents' rooms 2 times a week at a minimum check for any unsecured medications in the resident's rooms. -She was not aware Resident #3 was keeping medications on an open, unsecured shelf in her bathroom. -Resident #3 did not have a self-administration order from her PCP to have unsecured	(D 377)		

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(D 377)	Continued From page 20 medications in her room. -She was not aware Resident #3 was keeping medications on an open, unsecured shelf in her bathroom. -Resident #3 often went shopping with family and would return to the facility carrying a shopping bag. - She was not aware of how long Resident #3 had been storing unsecured medication in Resident #3's room. -She expected all staff to be more aware of residents storing medications in an unsafe and unsecured manner.	(D 377)		

Edwards, Wanda A

From: Edwards, Wanda A
Sent: Thursday, November 2, 2023 11:40 AM
To: 'director@burlingtonseniors.com'
Subject: Alamance House 2023-10-09 SODBL 1WK712
Attachments: Alamance House 2023-10-9 SODBL 1WK712.pdf; Alamance House 2023-09-20 SOD 1WK712.pdf

Dear Ms. Evans,

Thank you for contacting me about the difficulty in receiving your letter and statement of deficiencies by e-mail. Please see the attached SODBL and SOD for the survey.

Please write your signiture, title, and the date at the bottom of page #1 and check to see your correction dates for each rule area is notated on the right side with your text. I will read the document and add my signature if no questions.

Thank you for your patience. If you have any questions please let me know.

Thank you,
Wanda

Wanda A. Edwards, BS, BSN, RN
Nurse Consultant
Division of Health Service Regulation, Adult Care Licensure Section
NC Department of Health and Human Services

Office: 919-817-4382
Fax: 919-733 9379
wanda.edwards@dhhs.nc.gov

801 Biggs Drive, Brown Building
2708 Mail Service Center
Raleigh, NC 27699-2708

Edwards, Wanda A

From: Alamance House, ED - Jennifer Evans <director@burlingtonseniors.com>
Sent: Wednesday, November 8, 2023 3:20 PM
To: Edwards, Wanda A
Cc: Roxanne Sills; Janet Hughes; Rakishia Peterson; Reka Green
Subject: [External] SOD/POC Alamance House
Attachments: Sharp Copier_20231108_145745.pdf

Good Afternoon Ms. Edwards,
Attached you will find the Plan of Correction for our follow up survey as requested.
Thank you for your assistance.

Best,
Jennifer Evans

From: noreply@burlingtonseniors.com <noreply@burlingtonseniors.com> on behalf of Sharp Copier <noreply@burlingtonseniors.com>
Sent: Wednesday, November 8, 2023 2:57 PM
To: Alamance House, ED - Jennifer Evans <director@burlingtonseniors.com>
Subject: Scanned image from Alamance House

Reply to: Sharp Copier <noreply@burlingtonseniors.com>
Device Name: Alamance House
Device Model: MX-M3570
Location: Alamance House

File Format: PDF MMR(G4)
Resolution: 200dpi x 200dpi

Attached file is scanned image in PDF format.
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