STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039016	A. BUILDING: _____ B. WING _____	R 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE HOUSE	200 COVENTRY DRIVE OXFORD, NC 27565

(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 folllow-up survey and complaint investigation on November 14 and 15, 2023.	{D 000}	Response to the cited deficiencies does not constitute an admission or agreement by the facility of the truth of the facts alleged or 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, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) for stool softener and a laxative. The findings are: Review of Resident #1's current FL-2 dated 08/02/23 revealed diagnoses included Alzheimer's, hypernatremia and acute kidney injury. a. Review of Resident #1's current FL-2 dated 08/02/23 revealed an order for docusate sodium (used to soften stools) 50mg/5ml administer 10ml once daily at bedtime. Review of Resident #1's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for docusate sodium	{D 358}	D358 a, 1,2 RCC will print EMAR compliance report daily to review for accurate and compliant medication administration. Report will be reviewed in management meeting daily with the Executive Director, and any noted concerns will have immediate follow-up. Reports that have needed follow up will be signed off by both the ED and the RC. Ongoing. ACD will complete random Med Tech observations during med passes to ensure at least 2 observations per month are completed. This will check compliance with giving medications correctly. Weekly cart audits will be completed by RCC/Med Techs to check for the QA compliance of the medication cart. Follow up will be reviewed with the ED. Ongoing.	Ongoing 1/03/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 1/8/24

Reviewed and Acknowledged
Dana Edwards
1/8/2024

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director | 1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 1	{D 358}		

50mg/5mL administer 10mL once daily at bedtime.
-Docusate was documented as administered 30 of 30 opportunities.

Review of Resident #1's October 2023 eMAR revealed:
-There was an entry for docusate sodium 50mg/5mL administer 10mL once daily at bedtime.
-Docusate was documented as administered 31 of 31 opportunities.

Review of Resident #1's November 2023 eMAR from 11/01/23 to 11/14/23 revealed:
-There was an entry for docusate sodium 50mg/5mL administer 10mL once daily at bedtime.
-Docusate was documented as administered 13 of 13 opportunities.

Observation of medication on hand for Resident #1 on 11/14/23 at 3:15pm revealed:
-There were two 16-ounce bottles of docusate sodium 50mg/5mL; both bottles were full.
-There was one bottle with a dispense date of 09/16/23 and had a handwritten open date of 11/16/23 on the bottle.
-There was a second bottle with a dispense date of 10/28/23 and a handwritten open date of 10/15/23.
-There were two full bottles of docusate sodium available for administration.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 11/14/23 at 3:49pm revealed:
-Resident #1 had a current order for docusate sodium 50mg/5mL 10mL once daily at bedtime.
-Sixteen ounces of docusate sodium on 07/27/23,

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{D 358}	Continued From page 2	{D 358}		

09/16/23 and 10/28/23; a 47-day supply was in each bottle.
-The facility would have to request a refill for the docusate sodium because it was not on a cycle fill.
-Docusate sodium was a stool softener and if not administered as ordered the resident could have harder stools, have difficulty having a bowel movement and possibly have constipation.

Telephone interview with Resident #1's primary care provider (PCP) on 11/15/23 at 1:36pm revealed:
-Resident #1 was ordered docusate sodium to soften her stools because it was reported to her that the resident had hard stools and hemorrhoids.
-She had not been able to examine Resident #1's hemorrhoids because the resident refused to let her examine her bottom.
-If Resident #1 was constipated or had hard stools it would indicate she was not administered her stool softener as ordered.
-It was important to routinely and consistently administer Resident #1 her docusate sodium to prevent constipation.

Interview with a personal care aide on 11/15/23 at 11:45am revealed:
-Resident #1 had a problem with hemorrhoids once but it had been a while ago.
-Sometimes Resident #1 would get compacted and have hard stools; last night, 11/14/23, her stools where hard.
-She told a medication aide (MA) and she gave her a laxative that helped soften her stools.
-Resident #1's stools were softer when she was regularly administered a stool softener.

Interview with a medication aide (MA) on 11/15/23

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{D 358}	Continued From page 3	{D 358}		

at 11:16am revealed:
-Resident #1 complained her docusate sodium burned her throat when so she mixed it into her iced tea.
-She administered Resident#1 her docusate in the evening.
-She would hold the docusate if Resident #1's stools were loose and document on the MAR.
-Resident #1 had regular bowel movements.
-Resident #1 had hemorrhoids but they did not give her trouble if she was administered the docusate sodium.
-Resident #1's bowel movements were typically soft, and she did not struggle or strain to push when she was toileted.

Refer to interview with the Resident Care Coordinator (RCC) on 11/1/23 at 2:53pm.

Refer to interview with the Administrator on 1/15/23 at 2:43pm revealed:

Based on observations, interviews, and record reviews Resident #1 was not interviewable.

b. Review of Resident #1's physicians' order dated 09/07/23 revealed an order for polyethylene glycol (used to treat constipation) 17gm in 4 to 8 ounces of fluid once daily.

Review of Resident #1's September 2023 electronic medication administration record (eMAR) from 09/11/23 to 09/30/23 revealed:
-There was an entry for polyethylene glycol 17gm mix one capful into 4 to 8 ounces of fluid once daily scheduled at 9:00am.
-Resident #1's polyethylene glycol was documented as administered 19 of 19 opportunities.

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{D 358}	Continued From page 4	{D 358}		

Review of Resident #1's October 2023 eMAR revealed:
-There was an entry for polyethylene glycol 17gm mix one capful into 4 to 8 ounces of fluid once daily scheduled at 9:00am.
-Resident #1's polyethylene glycol was documented as administered 31 of 31 opportunities.

Review of Resident #1's November 2023 eMAR from 11/01/23 to 11/14/23 revealed:
-There was an entry for polyethylene glycol 17gm mix one capful into 4 to 8 ounces of fluid once daily scheduled at 9:00am.
-Resident #1's polyethylene glycol was documented as administered 14 of 14 opportunities.

Observation of medication on hand for Resident #1 on 11/14/23 at 3:15pm revealed:
-There was a was half full bottle of polyethylene glycol 17gm available for administration with a dispense date of 09/07/23.
-There was a handwritten open date of 09/08/23 on the bottle.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 11/14/23 at 4:28pm revealed:
-Resident #1 had a current order for polyethylene glycol 17gm mix one capful into 4 to 8 ounces of fluid once daily.
-A thirty-day supply of polyethylene glycol was dispensed on 09/07/23.
-The facility would have to request a refill for the polyethylene glycol because it was not on a cycle fill.
- polyethylene glycol was used to treat or prevent constipation and if not administered as ordered the resident would possibly have constipation.

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{D 358}	Continued From page 5	{D 358}		

Telephone interview with Resident #1's primary care provider (PCP) on 11/15/23 at 1:36pm revealed:
- Resident #1was ordered polyethylene glycol because she had been told the resident was constipated.
-If Resident #1 was still constipated then it would indicate that she was not getting the polyethylene glycol as ordered on a routine schedule.
-There had been no reports to her of Resident #1 having any constipation since she was ordered the polyethylene glycol.
-She expected the facility to administer Resident #1 her medications as ordered.

Interview with a medication aide (MA) on 11/15/23 at 11:16am revealed:
-She administered Resident#1 her polyethylene glycol in the mornings.
-She would hold the polyethylene glycol if Resident #1 experienced runny bowel movements and document on the MAR.
-Resident #1 had regular bowel movements lately.
-Resident #1's had regular bowel movements.

Refer to interview with the Resident Care Coordinator (RCC) on 11/1/23 at 2:53pm.

Refer to interview with the Administrator on 1/15/23 at 2:43pm revealed:

Based on observations, interviews, and record reviews Resident #1 was not interviewable.

Interview with the Resident Care Coordinator (RCC) on 11/1/23 at 2:53pm revealed:
-She was not aware Resident #1 had a history of hemorrhoids or constipation.

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{D 358}	Continued From page 6	{D 358}		

-She was new to her position and had not had the chance to do a medication cart or eMAR audit.
-If Resident #1 had multiple full bottles of a scheduled medication that had been dispensed over thirty days ago it would appear her medication was not being administered as scheduled.

Interview with the Administrator on 1/15/23 at 2:43pm revealed:
-The RCC was new and had not conducted a medication cart audit.
-The medication aides (MAs) were supposed to conduct daily medication cart audits and catch expired medications, open dates on medications and clean the carts.
-If Resident #1 had unused medication available then it looked like the MAs were not administering medications per the order and just signing the MAR.
-He expected the MAs to administer the residents' medications and not sign on the MAR until they did.

Edwards, Wanda A

From: Four Oaks Senior Living, ED - James Frank <director@fouroaksseniors.com>
Sent: Monday, January 8, 2024 2:26 PM
To: Edwards, Wanda A
Cc: Granville House, BOC- Shannon Ward; mikew@carolinacommercialnc.com
Subject: [External] POC for Statement of Deficiencies
Attachments: Granville House Statement of Deficiencies.pdf

Good afternoon, Wanda

I've attached a signed copy of the Statement of deficiencies with the POC included.

James Franks |Traveling Executive Director| ALG Senior | C: (252) 772-5653 director@fouroaksseniors.com