STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043029	A. BUILDING: _____ B. WING _____	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE ASSISTED LIVING	431 JUNNY ROAD ANGIER, NC 27501

(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 conduced an annual and follow-up survey from 01/10/24 to 01/11/24.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by:	D 254		

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D 254	Continued From page 1 Based on interviews and record reviews, the facility failed to ensure an annual assessment and care plan was completed for 2 of 3 residents sampled (#1 and #2). The findings are: 1.Review of Resident #1's current FL-2 dated 04/24/23 revealed diagnoses included Parkinson's disease, epilepsy, Alzheimer's disease, hypertension, and chronic obstructive pulmonary disease. Review of Resident #1's Resident Register revealed he was admitted to the facility on 02/27/18. Review of Resident #1's record on 01/10/23 revealed: -The last annual assessment and care plan was completed on 03/02/22. -There was no documentation of a current annual assessment and care plan. Review of Resident #1's requested annual assessment and care plan for the year 2023 on 01/11/24 at 8:29am revealed the facility provided an assessment and care plan dated 03/02/22. Refer to interview with the Administrator in Training (AIT) on 01/11/24. Refer to telephone interview with the Administrator on 01/11/24 at 10:02am. 2. Review of Resident #2's current FL-2 dated 04/24/23 revealed diagnoses included hypertension, dysphagia, and chronic kidney disease.	D 254		

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D 254	Continued From page 2 Review of Resident #2's Resident Register revealed he was admitted to the facility on 11/13/17. Review of Resident #2's record on 01/10/23 revealed: -The last annual assessment and care plan was completed on 04/13/22. -There was no documentation of a current annual assessment and care plan. Review of Resident #2's requested annual assessment and care plan for the year 2023 on 01/11/24 at 8:29am revealed the facility provided an assessment and care plan dated 04/13/22. Refer to interview with the Administrator in Training (AIT) on 01/11/24. Refer to telephone interview with the Administrator on 01/11/24 at 10:02am. _____ Interview with the Administrator in Training (AIT) on 01/11/24 at 8:29am revealed: -She started working with the facility in April 2023. -She audited the residents' record in April 2023, and looked to ensure there were care plans in the records. -She did not make a note of which residents had care plans that were due when she completed her audit in April 2023. -She noticed the annual care plans were due at different times of the year. -She was responsible for ensuring the care plans were completed annually. -She was not aware Resident #1 and Resident #2 had overdue care plans. Telephone interview with the Administrator on	D 254		

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D 254	Continued From page 3 01/11/24 at 10:02am revealed: -The AIT and the Resident Care Coordinator (RCC) were responsible for ensuring the care plans for residents in the facility were completed. -She and her management staff reviewed the residents' records monthly to ensure annual care plans had been completed. -She was not aware Resident #1 and Resident #2 did not have their annual care plans completed. -She thought someone removed the annual care plans from Resident #1 and Resident #2's records.	D 254		
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 to 2 of 3 residents with orders for medications used to treat pain (#2, #3) and edema (#3). The findings are: 1. Review of the Resident #3's FL-2 dated 10/26/23 revealed: -Diagnoses included dementia, hypertension, anxiety, and depressive disorder.	D 358		

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-There was an order for aspirin 81mg tablet. (Aspirin is used to treat pain and reduce the risk of heart attack).
-There was an order for furosemide 20mg tablet. (Furosemide is used to treat edema and swelling. The brand name is Lasix).

a. Review of Resident #3's signed physician's orders dated 11/21/23 revealed an order to discontinue aspirin.

Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Aspirin 81mg tablet, 1 tablet every day scheduled for 8:00am.
-Aspirin 81mg tablet was documented as administered from 11/22/23 to 11/30/23.

Review of Resident #3's December 2023 eMAR revealed:
-There was an entry for Aspirin 81mg tablet, 1 tablet every day scheduled for 8:00am.
-Aspirin 81mg tablet was documented as administered from 12/01/23 to 12/31/23.

Review of Resident #3's January 2024 eMAR revealed:
-There was an entry for Aspirin 81mg tablet, 1 tablet every day scheduled for 8:00am.
-Aspirin 81mg tablet was documented as administered from 01/01/24 to 01/11/24.

Observation of Resident #3's medications on hand on 01/11/24 at 9:15am revealed there was a pack labeled Aspirin 81mg, 1 tablet every day in the medication cart, with 8 tablets remaining from a quantity of 30.

b. Review of Resident #3's signed physician's

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orders dated 11/21/23 revealed an order to discontinue Lasix.

Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Furosemide 20mg tablet, ½ tablet every day scheduled for 8:00am.
-The Furosemide 20mg tablet was documented as administered from 11/22/23 to 11/30/23.

Review of Resident #3's December 2023 eMAR revealed:
-There was an entry for Furosemide 20mg tablet, ½ tablet every day scheduled for 8:00am.
-Furosemide 20mg tablet was documented as administered from 12/01/23 to 12/31/23.

Review of Resident #3's January 2024 eMAR revealed:
-There was an entry for Furosemide 20mg tablet, ½ tablet every day scheduled for 8:00am.
-Furosemide 20mg tablet was documented as administered from 01/01/24 to 01/11/24.

Observation of Resident #3's medications on hand on 01/11/24 at 9:15am revealed there was a pack labeled Furosemide 20mg tablet, ½ tablet every day in the medication cart, with 6 tablets remaining from a quantity of 15.

Interview with the Administrator in training (AIT) on 01/11/24 at 8:29am revealed she was not aware Resident #3 had discontinued medication orders.

Telephone interview with the Administrator on 01/11/24 at 10:02am revealed Resident #3's discontinued medication orders were not reviewed and verified by the facility.

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D 358	Continued From page 6 Attempted telephone interview with the PCP on 01/11/24 at 9:19am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to interview with a Medication Aide on 01/11/24 at 7:46am. Refer to interview with the Administrator in training (AIT) on 01/11/24 at 8:29am. Refer to telephone interview with the Administrator on 01/11/24 at 10:02am. 2. Review of Resident #2's current FL-2 dated 04/24/23 revealed diagnoses included hypertension, dysphagia, and chronic kidney disease. Review of Resident #2's electronically signed physician's orders dated 10/24/23 revealed an order for acetaminophen 325mg, take 2 tablets every 8 hours as needed for pain. Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 6:00am. -Acetaminophen 325mg tablet was documented as administered from 11/01/23 to 11/30/23. -There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 2:00pm. -Acetaminophen 325mg tablet was documented as administered from 11/01/23 to 11/30/23.	D 358		

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D 358	Continued From page 7 -There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 10:00pm. -Acetaminophen 325mg tablet was documented as administered from 11/01/23 to 11/04/23, 11/06/23, 11/08/23 to 11/09/23, 11/11/23 to 11/20/23, and 11/22/23 to 11/30/23. Review of Resident #2's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 6:00am. -Acetaminophen 325mg tablet was documented as administered from 12/01/23 to 12/31/23. -There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 2:00pm. -Acetaminophen 325mg tablet was documented as administered from 12/01/23 to 12/31/23. -There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 10:00pm. -Acetaminophen 325mg tablet was documented as administered from 12/02/23 to 12/26/23 and 12/28/23 to 12/31/23. Review of Resident #2's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 6:00am. -Acetaminophen 325mg tablet was documented as administered from 01/01/24 to 01/10/24. -There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 2:00pm. -Acetaminophen 325mg tablet was documented	D 358		

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as administered from 01/01/24 to 01/09/24.
-There was an entry for Acetaminophen 325mg tablet, 2 tablets every 8 hours daily scheduled for 10:00pm.
-Acetaminophen 325mg tablet was documented as administered from 01/01/24 to 01/03/24 and 01/05/24 to 01/09/24.

Observation of Resident #2's medications on hand on 01/11/24 at 9:15am revealed there was a pack labeled Acetaminophen 325mg tablet, 2 tablets every 8 hours every day in the medication cart.

Interview with the Administrator in training (AIT) on 01/11/24 at 10:15am revealed she was not aware Resident #2's Acetaminophen 325mg tablet medication order was as needed and put into the eMAR system as scheduled.

Telephone interview with the Administrator on 01/11/24 at 10:02am revealed Resident #2's medication order was not reviewed and verified by the facility.

Attempted telephone interview with the PCP on 01/11/24 at 9:19am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

Refer to interview with a Medication Aide on 01/11/24 at 7:46am.

Refer to interview with the Administrator in training (AIT) on 01/11/24 at 8:29am.

Refer to telephone interview with the Administrator on 01/11/24 at 10:02am.

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D 358	Continued From page 9 Interview with a Medication Aide on 01/11/24 at 7:46am revealed: -The Primary Care Provider (PCP) sent medication orders electronically to the pharmacy. -The pharmacy was responsible for putting discontinued medication orders in the eMAR system. -The MAs were responsible for approving the discontinued medication order in the eMAR system. -Once the medication order was approved, the MAs were responsible for removing the medication from the medication cart. Interview with the Administrator in training (AIT) on 01/11/24 at 8:29am revealed: -The PCP sent medication orders electronically to the pharmacy. -When the facility received progress notes from the PCP with new orders, she was responsible for faxing the medication orders to the pharmacy. -The pharmacy was responsible for putting discontinued medication orders in the eMAR system. -The MAs were responsible for removing the medication from the medication cart. -She reviewed medication orders monthly to ensure they were complete, matched the eMAR, and were in or removed from the medication cart. Telephone interview with the Administrator on 01/11/24 at 10:02am revealed: -The Resident Care Coordinator (RCC) and the AIT were responsible for reviewing the PCP's progress notes and new orders. -The MAs were responsible for ensuring the discontinued medication orders went to the pharmacy and were removed from the medication	D 358		

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D 358	Continued From page 10 cart. -The RCC and the AIT were responsible for verifying the orders were faxed to the pharmacy and removed from the eMAR.	D 358		