STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL005013	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS ASSISTED LIVING & MEMORY CARE	182 CHATTYROB LANE WEST JEFFERSON, NC 28694

(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 an annual survey on December 03, 2024-December 04, 2024.	D 000		
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 record reviews and interviews, the facility failed to ensure physician's orders were implemented for 1 of 5 sampled residents related to an order for blood tests (#5). The findings are: Review of Resident #5's current FL2 dated 04/04/24 revealed diagnoses included heart failure, paroxysmal atrial fibrillation (fast irregular heart rhythm) and hypokalemia (low potassium level in the blood). Review of Resident #5's primary care provider's (PCP) order dated 09/20/24 revealed: -There was an order to start potassium 40meq, one tablet daily. -There was an order to start magnesium oxide 400mg, one tablet daily. -Staff were to encourage foods rich in potassium and magnesium. -Resident #5 was to have a basic metabolic panel	D 276		

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D 276	Continued From page 1 (BMP) (a blood test that measures substances in the blood, including potassium) and magnesium level checked in one week (09/27/24). Review of Resident #5's record revealed there were no BMP and magnesium blood level results for 09/27/24. Interview with a medication aide (MA) on 12/04/24 at 2:14pm revealed: -She faxed all new resident orders to the pharmacy when she received them. -After faxing the order to the pharmacy, she placed a copy of the order in the 'New Orders' notebook at the front desk. -A second copy of the order was kept by the fax machine along with the fax confirmation. -She was not aware of any bloodwork orders for Resident #5 for 09/27/24. Interview with the facility's Registered Nurse (RN) on 12/04/24 at 2:01pm revealed: -The MAs were responsible for faxing new orders to the pharmacy. -The MAs were responsible to make a copy of new orders and place them in the 'New Orders' notebook at the front desk. -The MAs were responsible for placing the original order in the resident's chart. -The previous Resident Care Coordinator (RCC) usually placed a copy of all bloodwork orders in her box. -She completed all resident blood draws for the facility. -The order for Resident #5's BMP and magnesium level that was to be done on 09/27/24 was missed and not completed. Interview with the Administrator on 12/04/24 at 2:22pm revealed:	D 276		

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D 276	Continued From page 2 -Resident #5's PCP was not available for a telephone interview. -The RCC and the Special Care Unit Coordinator (SCC) were responsible to review all orders in the 'New Order" notebook on their units. -The RCC was responsible for ensuring Resident #5's order for BMP and magnesium level on 09/27/24 was given to the facility's RN. -The facility's RN was responsible for completing all blood draws as ordered. -She was not aware Resident #5 did not have her bloodwork drawn as ordered on 09/27/24.	D 276		