STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085012	A. BUILDING: _____ B. WING _____	R 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND LIVING CENTER I	1290 DENNY ROAD KING, NC 27021

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 12/31/24.	D 000		
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 3 sampled residents (#1) who had orders for a cholesterol medication. The findings are: Review of Resident #1's current FL2 dated 03/27/24 revealed: -Diagnoses included schizoaffective disorder, hyperlipidemia, hypertension, and hypothyroidism. -There was an order for pravastatin (used to lower high cholesterol levels) 80mg 1 tablet at bedtime. Review of Resident #1's amended history and physical note from primary care provider (PCP) dated 10/02/24 revealed: -Resident #1 was discharged on 10/02/24 from the local hospital with an order for pravastatin	D 358		

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20mg twice daily.
-There was an order from Resident #1's PCP to continue pravastatin 80mg 1 tablet at bedtime.

A request was made on 10/02/24 for the discharge summary from Resident #1's hospital visit dated 10/02/24 but was not provided prior to exit on 12/31/24.

Review of Resident #1's October 2024 paper medication administration record (MAR) from 10/01/24 through 10/31/24 revealed:
-There was an entry for pravastatin 80mg 1 tablet at bedtime.
-There was documentation pravastatin was administered for 31 of 31 opportunities from 10/01/24 through 10/31/24.

Review of Resident #1's November 2024 paper MAR from 11/01/24 through 11/30/24 revealed:
-There was no entry for pravastatin 80mg 1 tablet at bedtime.
-There was no documentation pravastatin was administered for 30 of 30 opportunities from 11/01/24 through 11/30/24.

Review of Resident #1's December 2024 paper MAR for 12/01/24 through 12/30/24 revealed:
-There was no entry for pravastatin 80mg 1 tablet at bedtime.
-There was not documentation pravastatin was administered for 30 of 30 opportunities from 12/01/24 through 12/30/24.

Observation of Resident #1's medication-on-hand on 12/31/24 at 2:00pm revealed pravastatin was not available for administration.

Interview with Resident #1 on 12/31/24 at 2:30pm revealed:

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-He was not aware what medications the medication aides (MA) administered him daily.
-He had not experienced any issues related to his cholesterol or heart within the last several months.

Telephone interview with a representative from the facility's contracted pharmacy on 12/31/24 at 3:25pm revealed:
-Resident #1 did not have an active order for either pravastatin 80mg I tablet at bedtime or for pravastatin 20mg 1 tablet twice daily.
-The pharmacy last dispensed pravastatin 80mg 1 tablet at bedtime on 09/11/24 for a quantity of 238 tablets.
-The facility was responsible to send discharge summaries and new orders to the pharmacy.
-The pharmacy received Resident #1's discharge summary dated 10/02/24 but had not received communication from the facility staff for direction related to order clarification for pravastatin after the pharmacy completed 3 follow-up attempts.

Telephone interview with Resident #1's PCP on 12/31/24 at 3:10pm revealed:
-She expected the facility to communicate with her for Resident #1's medication changes from other medical providers and from discharge summaries from the local hospital.
-She expected the facility to administer Resident #1's pravastatin according to her orders and expected communication from the facility staff for any order changes or clarification.
-She expected a possible outcome for Resident #1 to have increased blood cholesterol if the facility did not administer the pravastatin as ordered.

Interview with a MA on 12/31/24 at 1:30pm revealed:

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D 358	Continued From page 3 -The MAs, the Resident Care Coordinator (RCC), and the Manager were responsible to review the discharge summaries when residents returned from a hospital visit. -The MAs, the RCC, and the Manager were responsible to review PCP progress notes for medication orders and medication changes. -The MAs, the RCC, and the Manager were responsible to review the MAR to ensure entries for medications were correct. -The MAs, the RCC, and the Manager were responsible to fax the new orders from medical providers and the hospital to the pharmacy. -She was not aware of the discharge summary order to change Resident #1's pravastatin medication and she was not aware of the PCP's progress note. -She was not aware pravastatin was not on the November and December 2024 MARs and had not been administered to Resident #1. Interview with a second MA on 12/31/24 at 2:40pm revealed: -The MAs, the RCC, and the Manager were responsible to review the discharge summaries when residents returned from a hospital visit. -The MAs, the RCC, and the Manager were responsible to review PCP progress notes for medication orders and medication changes. -The MAs, the RCC, and the Manager were responsible to review the MAR to ensure entries for medications were correct. -The MAs, the RCC, and the Manager were responsible to fax the new orders from medical providers and the hospital to the pharmacy. -She was not aware of the discharge summary order to change Resident #1's pravastatin medication and she was not aware of the PCP's progress note. -She was not aware pravastatin was not on the	D 358		

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November and December 2024 MARs and had not been administered to Resident #1.

Interview with the RCC on 12/31/24 at 4:05pm revealed:
-She, the Manager, and the MAs were responsible to review the discharge summaries when residents returned from a hospital visit.
-She, the Manager, and the MAs were responsible to fax the new orders from medical providers and the hospital to the pharmacy.
-She was not aware the pharmacy had followed-up with the facility several times about the discharge summary from 10/02/24 for Resident #1 with the medication changes.
-MAs were responsible to place the after-visit summaries in the PCP's folder at the facility for the PCP to review on upcoming visit to the residents.
-She and the Manager were responsible to audit the MAR to ensure medications were administered as order by the physician.
-She was not aware the pravastatin was not being administered as it must have been overlooked.

Interview with the Administrator on 12/31/24 at 2:55pm revealed:
-She was not aware of the orders for pravastatin for Resident #1 from the 10/02/24 local hospital discharge summary.
-She did not know Resident #1 missed doses of pravastatin from 11/01/24 through 12/30/24.
-She and the RCC were responsible to review the PCP's progress notes and the discharge summaries when residents returned from a hospital visit.
-She, the RCC, and the MAs were responsible to fax the new orders from medical providers and the hospital to the pharmacy.
-She, the RCC, and the MAs were responsible to

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D 358	Continued From page 5 audit the MARS monthly to avoid medications not being administered to the residents. -She expected MAs to administer Resident #1's medications as ordered by the physician.	D 358		