

PRINTED: 01/06/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL085012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/31/2024
NAME OF PROVIDER OR SUPPLIER GRACELAND LIVING CENTER I		STREET ADDRESS, CITY, STATE, ZIP CODE 1290 DENNY ROAD KING, NC 27021		
(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)	(X6) COMPLETE DATE
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	Director / RCC All MAPs will be audited by 2/15/25. MAPs will be audited monthly ongoing.	2/15/25

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

G31W11

If continuation sheet 1 of 6

Reviewed and Acknowledge by S.A. on 01/30/25

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GRACELAND LIVING CENTER I

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D 358	Continued From page 1 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:	D 358		

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D 358	Continued From page 2 -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 1 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:	D 358		

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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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D 358	Continued From page 4 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	D 358		

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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		