

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL081001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2025
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139		
(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 and the Rutherford County Department of Social Services conducted a follow up survey on 03/11/25.	{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: FOLLOW UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interview, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled resident (#2) related to a medication for a mood disorder. The findings are: Review of Resident #2's current FL2 dated 10/12/24 revealed diagnoses included dementia. Review of a physician's order for Resident #2 dated 02/19/25 revealed divalproex (used to treat mood disorder) 125mg, 2 capsules (250mg) twice daily.	{D 358}		

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

TITLE

(X6) DATE

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{D 358}	Continued From page 1 Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for divalproex 125mg take 2 capsules (250mg) twice daily at 8:00am and 8:00pm to start on 02/21/25. -There was documentation the divalproex was not administered 02/21/25 - 02/28/25 due to "medication not delivered". Observation of Resident #2's medication available for administration on 03/11/25 at 9:52am revealed there was one bottle labeled divalproex 125mg take 2 capsules twice daily and 120 capsules were dispensed on 02/24/25. Interview with the medication aide on 03/11/25 at 9:51am revealed: -She informed her supervisor there was not any divalproex to administer to Resident #1 in February 2025. -The procedure was to push the refill button on the eMAR if a medication was not available or telephone the pharmacy. -She did not telephone the pharmacy because she thought Resident #1's guardian brought the medications to the facility. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/11/25 at 9:47am revealed: -They received an electronic order for Resident #2 for divalproex 125mg 2 capsules twice daily on 02/19/25. -They were informed by facility staff on 02/20/25 to enter the order into the eMAR but not to deliver the medication unless the facility requested it. -He thought that Resident #2 might use a different pharmacy to dispense her medications.	{D 358}		

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{D 358}	Continued From page 2 Telephone interview with a pharmacist at a local pharmacy on 03/11/25 at 10:35am revealed: -The pharmacy received an electronic order on 02/24/25 for Resident #1 for divalproex 125mg 2 capsules twice daily. -Resident #2's guardian picked up the medication on 02/25/25. Telephone interview with Resident #2's guardian on 03/11/25 at 10:20am revealed: -Resident #2's medication was dispensed from a pharmacy other than the facility's contracted pharmacy. -She had no way of knowing if the resident was out of medications or when new prescriptions were ordered. -The facility knew that they were to send all prescriptions to the Resident #2's designated pharmacy and she would ensure the medications were delivered to the facility. -The facility sent the order to the wrong pharmacy in error. Telephone interview with Resident #2's Mental Health Provider (MHP) on 03/11/25 at 10:40am revealed: -Resident #2 was prescribed divalproex for mood stabilization. -Not receiving the divalproex as ordered may cause mood fluctuations. Interview with the Resident Care Coordinator (RCC) on 03/11/25 at 9:55am revealed: -MAs were trained to push the refill button on the eMAR or inform him and he would telephone the pharmacy if a medication was not available for administration. -Resident #2's guardian refused to have the facility's contracted pharmacy dispense her	{D 358}			

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{D 358}	Continued From page 3 medications and wanted to manage the medications herself with a different pharmacy . -He notified the guardian when the resident needed refills or newly prescribed medications and she was responsible to get the medications to the facility. Interview with the Administrator on 03/11/25 at 10:06am revealed: -Resident #2's guardian would not give consent for the facility to order medications for Resident #2. -The guardian had a different pharmacy she preferred to use. -She was not aware Resident #2 did not have any divalproex medications available 02/19/25 - 02/28/25. -She would have used the facility's back up pharmacy and the facility would have paid for the medication if staff informed her.	{D 358}		