

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

DEVOTED ASSISTED LIVING

5767 HWY 135
STONEVILLE, NC 27048

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 02/18/25.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 3 of 3 fixtures (2 sinks and 1 shower) used by the residents. The findings are: Observation of the facility during the initial tour on 02/18/25 from 8:45am to 9:30am revealed: -The facility was a one-story structure. -The facility had a census of 15 residents. Observation of the hot water temperature at the bathroom sink in the hallway on 02/18/25 at 9:18am revealed the hot water temperature was 123 degrees F. Observation of the hot water temperature at the	D 113		
			Immediately changed hot water temperature.	2/18/25

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

TITLE

(X6) DATE

Marlene Harrison

Administrator 3/9/25

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D 113	Continued From page 1 second bathroom sink in the hallway on 02/18/25 at 9:20am revealed the hot water temperature was 124 degrees F. Observation of the hot water temperature at the bathroom shower in the hallway on 02/18/25 at 9:23am was 121 degrees F. Interview with a resident on 02/18/25 at 10:05am revealed: -He had never been burned by the hot water when he washed his hands or took a shower. -If the water was too hot, he knew how to turn down the water temperature. Interview with a second resident on 02/18/25 at 10:09am revealed: -He knew how to adjust the water temperature to prevent getting burned. -He had never been burned by hot water in the bathroom. Interview with a third resident on 02/18/25 at 10:14am revealed -He did not think the water was too hot when taking a shower. -If the water was too hot for him, he would turn up the water temperature. On 02/18/25 at 1:50pm, an ice water slurry was used to check the surveyor's thermometer with a reading of 32 degrees F registered on the thermometer. Recheck of the first bathroom sink in the hallway on 02/18/25 at 10:45am revealed the hot water temperature was 107 degrees F. Recheck of the second bathroom sink in the hallway on 02/18/25 at 3:30pm revealed the hot	D 113	after changing temp of 2/18/25 hot water temp was between 106-107 in one bathroom. The other bathroom was around 100-101. The kitchen staff will check the hot water temperature monthly. The kitchen manager will ensure it is one correctly.	

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D 113	Continued From page 2 water temperature was 100 degrees F. Recheck of the bathroom shower in the hallway on 02/18/25 at 3:32pm revealed the hot water temperature was 100 degrees F. Interview with the medication aide (MA) on 02/18/25 at 3:55pm revealed: -She was not aware the hot water temperatures were required to range between 100-116 degrees F. -No resident had complained or reported to her hot water temperatures were elevated. -The Administrator was responsible for checking the water temperatures each month. Interview with the Manager on 02/18/25 at 4:05pm revealed: -She was aware hot water temperatures were required to range between 100-116 degrees F. -She had no knowledge of a resident being burned by the elevated water temperatures. -The Administrator was responsible for checking the water temperatures. Interview with the Administrator on 02/18/25 at 9:20am revealed: -She was not aware the hot water from the fixtures in the common bathroom sink and shower were too high. -She was aware hot water temperatures were required to range between 100-116 degrees F. -She was responsible for checking the water temperatures each month. -She was not sure if the water temperatures were checked for the month of February 2025. -She did not keep a log that recorded monthly water temperatures.	D 113	administrator trained staff on how to check the hot water temp and how and where to record the information	2/19/25 2/21/25

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D 358	Continued From page 3	D 358		
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, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#3) with an order for an antibiotic. The findings are: Review of Resident #3's current FL-2 dated 09/27/24 revealed diagnoses included hypertension, type 2 diabetes, and depression. Review of Resident #3's hospital after visit summary (AVS) medication list dated 12/29/24 revealed: -There was an order for cefdinir (an antibiotic used to treat infection) 300mg take 2 capsules (600mg) daily for ten days. -The prescription for cefdinir was sent to a pharmacy and was available to be picked up. Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed: -There was no entry for cefdinir 300mg. -There was no documentation cefdinir 300mg	D 358		

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D 358	Continued From page 4 was administered from 12/29/24 to 12/31/24. Review of Resident #3's January 2025 eMAR revealed: -There was no entry for cefdinir 300mg. -There was no documentation cefdinir 300mg was administered from 01/01/25 to 01/31/25. Review of Resident #3's February 2025 eMAR revealed: -There was no entry for cefdinir 300mg. -There was no documentation cefdinir 300mg was administered from 02/01/25 to 02/18/25. Observation of Resident #3's medications on hand on 02/18/25 at 3:41pm revealed there was no cefdinir 300mg on the medication cart. Telephone interview with a pharmacist from the pharmacy on 02/18/25 at 4:20pm revealed: -There was an order on file for Resident #3 for cefdinir 300mg take two capsules daily for ten days. -Resident #3's cefdinir prescription was never picked up at the pharmacy and was never dispensed. Attempted telephone interview with the provider who prescribed Resident #3's cefdinir on 02/18/25 at 4:10pm unsuccessful. Interview with Resident #3 on 02/18/25 at 3:50pm revealed she thought she remembered being administered an antibiotic after her hospital visit in December 2024. Interview with a medication aide (MA)/Manager on 02/18/25 at 4:27pm revealed: -She did not know about Resident #3's cefdinir order from December 2024.	D 358			

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D 358	Continued From page 5 -She thought Resident #3 was administered an antibiotic in December 2024 but did not know if it was cefdinir. -She or the other Manager normally reviewed the residents' hospital AVS to check for new medication orders. Interview with the Manager on 12/18/24 at 4:30pm revealed: -She or the other Manager normally picked up residents from the hospital once they were discharged. -Sometimes when she picked up residents from the hospital, their AVS was not available. -She did not know about Resident #3's cefdinir order from December 2024. -She reviewed the residents' hospital AVS if they were in her review box and faxed orders to the pharmacy if there were prescriptions. -She did not know Resident #3's cefdinir prescription was not picked up from the pharmacy. -She completed medication cart audits monthly and compared medication on the medication cart to the residents' physician orders. Interview with the Administrator on 02/18/24 at 4:40pm revealed: -She did not know Resident #3 had an order for cefdinir 300mg take two capsules daily for ten days from December 2024. -One of the two Managers normally picked up residents from the hospital once the residents were discharged back to the facility. -She told the Managers to look at the hospital AVS whenever they picked up a resident from the hospital. -Audits were completed on the 10th day of each month and compared the medications on the cart to the residents' eMARs.	D 358	Talked to the managers 2/18/25 about checking the discharge paperwork when they pick up residents. Explained if a medication has been sent to another pharmacy other than the one the facility uses then they can contact our pharmacy and have them call the pharmacy the medication was sent to and have them to get it sent to them. If this cannot be done then they will have to go to the	

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D 358	Continued From page 6 -She did not know Resident #3's cefdinir prescription was not picked up from the pharmacy. -She expected MAs to follow the rules and regulations of medication administration as well as follow facility policy and procedures. -MAs were responsible to administer medications as ordered.	D 358	pharmacy the medication was sent to and pick it up. Facility managers will ensure all protocols are met. administrator will oversee facility managers to make sure they are doing it correct. this will be done monthly.		