STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

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D 000	Initial Comments The Adult Care Licensure Section and the Lincoln County Department of Social Services conducted an annual and a complaint investigation on 11/02/21 to 11/05/21 with an exit via telephone on 11/05/21.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, B, and C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired 06/01/20. -There was no documentation a HCPR check was completed upon hire. Review of Staff A's HCPR check dated 11/03/21 revealed there were no substantiated findings. Refer to the interview with the Executive Director (ED) on 11/03/21 at 1:55pm. Refer to the Telephone interview with the	D 137		

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D 137	Continued From page 1 Administrator on 11/04/21 at 12:15pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired 03/30/20. -There was no documentation a HCPR check was completed upon hire. Review of Staff B's HCPR check dated 11/03/21 revealed there were no substantiated findings. Refer to the interview with the Executive Director (ED) on 11/03/21 at 1:55pm. Refer to the Telephone interview with the Administrator on 11/04/21 at 12:15pm. 3. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired 06/30/21. -There was no documentation a HCPR check was completed upon hire. Review of Staff C's HCPR check dated 11/03/21 revealed there were no substantiated findings. Refer to the interview with the Executive Director (ED) on 11/03/21 at 1:55pm. Refer to the Telephone interview with the Administrator on 11/04/21 at 12:15pm. _____ Interview with the Executive Director (ED) on 11/03/21 at 1:55pm revealed: -She was not aware of the required HCPR checks upon hire. -She thought the criminal background checks were the same as the HCPR checks. -The Business Office Manager (BOM) would have been responsible for completing the HCPR	D 137		

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D 137	Continued From page 2 checks had she been directed to do them. Telephone interview with the Administrator on 11/04/21 at 12:15pm revealed: -She was not aware that the HCPR check were not completed on newly hired staff. -She thought the HCPR checks were completed by a third party when completing the criminal background checks on new staff. -The BOM was responsible for notifying a third party that completed the HCPR checks.	D 137		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition,	D 255		

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	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

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D 255	Continued From page 3 or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 1 of 5 sampled residents (#5) who had a need for memory care for closer supervision due to frequent falls and increase in sun-downing behaviors. The findings are: Review of Resident #5's current FL2 dated 09/21/21 revealed: -Diagnoses included dementia, poorly controlled type II diabetes mellitus, hyperlipidemia, Hypertension, prostate cancer, vitamin B12 deficiency, and memory impairment. -The Special Care Unit (SCU) was documented as the recommended level of care. -Resident #5 was oriented and was documented	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 255	Continued From page 4	D 255		

as ambulatory, with no assistive device checked.

Review of Resident #5's virtual physician's progress note dated 09/03/21 revealed:
-Resident #5 had a history of frequent falls.
-He was oriented to self, date, month, and year but unable to state if he could make complex decisions.
-He refused to use a walker.
-Physician noted an FL2 will be completed for assisted living with memory care.

Review of Elopement Risk Review tool completed on 09/22/21 revealed Resident #5 had a diagnosis of dementia with a need for redirection and gets up during the night thinking it is time for a meal or time to go out.

There was no documentation of a subsequent assessment or care plan after 09/22/21 reflecting Resident #5's increased staff dependency for unsteady gait and increased need for sun-downing behaviors.

Review of the Licensed Health Professional Support (LHPS) evaluation completed on 10/13/21 revealed:
-Resident #5 had episodes of exit seeking and wanting to go home.
-Resident #5 was independent with transfers but was unsteady and a fall risk.
-Staff needed to assist with transfers for safety.
-Resident #5 had 3 documented falls since admission to the facility on 09/18/21.
-He ambulated independently with an unsteady gait and did not always use a rollator.
-He required cueing and redirection for these tasks.

Review of Resident #5's physician consultation

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D 255	Continued From page 5	D 255		

notes dated 10/18/2021 revealed:
-Resident #5 had an unwitnessed fall in his bedroom with complaint of left hip pain and when standing up his blood pressure dropped to 90/64.
-He was losing his balance often when walking and seems to be more confused as well.
-He had dementia without behavioral disturbance, unspecified dementia type
-Fall precautions were discussed, including slow transitions when moving from lying to sitting and from sitting to standing.

Record Review of the nurse's notes for September and October 2021 for Resident #5 revealed:
-Resident #5's power of attorney (POA) came to the facility on 09/21/21 with concerns of Resident #5 residing on the assisted living side and stated they are wanting to move him to the Special Care Unit (SCU) due to his wandering behavior.
-Resident #5's POA believed he could get out of the facility doors and walk to his home which is within walking distance of the facility.
-Staff provided redirection for Resident #5 displaying exit seeking behaviors and returned him back to his room on 09/24/21.
-Staff provided redirection for Resident #5 back to his room and other activities after his attempts to go into other resident's rooms 09/30/21 and 10/04/21.
-Resident# 5 had documented falls on 10/10/21, 10/11/21, 10/15/21, 10/18/21, and 10/28/21.
-Staff provided redirection for Resident #5 back to his room displayed agitation and pacing halls on 10/16/21 and 10/20/21.

Record Review of facility incident reports for Resident #5 revealed:
-On 09/19/21, he had a witnessed fall walking with his cane and lost his balance, hit his head

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D 255	Continued From page 6	D 255		

and was sent to hospital by emergency medical services (EMS).
-On 10/18/21, he had an unwitnessed fall in his room and advised staff his left hip was hurting and was sent to the hospital by EMS for evaluation.
-On 10/28/21, he had a witnessed fall, lost his balance and fell against the doorway, hit his head and was sent to the hospital by EMS for evaluation.

Telephone interview with Resident #5's family member on 11/03/21 at 3:26pm revealed:
-Resident #5's primary care physician recommended Resident #5 be moved to memory care unit due to frequent falls, agitation, and confusion in the evening.
-Resident #5 was currently residing in the assisted living unit instead of memory care because family was in in the process of trying guardianship or power of attorney in place to make decisions for him.
-Resident #5 has told his family he refused to go to live in the memory care unit.

Interview with a medication aide (MA) on 11/03/21 at 11:20am revealed:
-Resident #5 resides in the assisted living unit, not in memory care.
-She did not know why Resident #5 did not reside in the memory care unit.
-Resident #5 was evaluated by facility physician in September 2021 and his FL2 was changed from assisted living to memory care.
-The facility's Nurse Practitioner (NP) came to the facility two weeks ago to do her bi-weekly visit.
-The NP asked why Resident #5 was not in the memory care unit and reiterated Resident #5 was supposed to be in memory care
-Resident #5 was able to ambulate independently

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D 255	Continued From page 7	D 255		

but was unsteady and forgets to use his rollator.
-He was independent with bathing and dressing.
-He frequently walked up and down the halls and had frequent falls in the hallway.

Interview with a second MA on 11/03/21 at 3:59pm revealed:
-Resident #5 would walk up and down the halls and open the doors to other resident's rooms without their permission and look at them.
-Resident #5 would talk a lot about a town nearby but he mumbled when he spoke so it would be hard to understand what he was saying.

Telephone interview with Resident #5's primary care physician on 11/03/21 at 3:00 pm revealed Resident #5's FL2 was updated on 09/21/21 to increase the resident's level of care to the memory care unit for closer supervision needed due to increased falls and sun-downing behaviors.

Telephone interview with Resident #5's NP on 11/04/21 at 8:59 am revealed:
-She evaluated the resident on 10/15/21 for an initial assessment in the assisted living unit of the facility.
-Resident #5 was oriented but was having trouble remembering his history, difficulty with his balance, and his judgement and insight were impaired.
-The facility should be following all physician orders from Resident #5's primary care physician until she was able to complete an initial assessment.

Telephone interview with the Administrator on 11/03/21 at 3:50pm revealed:
-When Resident #5 first moved in, he seemed to pace a lot up and down the hall and would talk

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D 255	Continued From page 8 about looking for his wife. -Resident #5 had several falls since being admitted. -She remembered having a conversation with the family about their desire to not have Resident #5 in the SCU. -She did not know Resident #5's FL2 dated 09/21/21 indicated an increased level of care from assisted living to SCU.	D 255		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (#1, #2) related to not administering a medication to decrease fluid (#1) and administering a pain medication that had been discontinued (#2), and 1 of 6 residents (#6) observed on the medication pass, related to 6 medications not available to administer to the resident, including a medication to treat thyroid disease, depression, heart disease, constipation, improve bone health, and a vitamin supplement.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 9 The findings are: Review of the facility's Medication Administration Policy dated 06/22/21 revealed: -Licensed nurse or appropriate staff must refer to the Medication Administration Record (MAR) to obtain correct medication, time, dosage, and route of administration as ordered by the physician for each individual resident. -If a medication was not given or the resident refused the medication, staff should give a detailed explanation of the missed/refused dose on the MAR. 1. The medication error rate was 20% as evidenced by the observation of 6 errors out of 30 opportunities during the 12:00pm medication pass on 11/02/21. Review of Resident #6's current FL2 dated 09/13/21 revealed diagnoses included atrial fibrillation, Parkinson's Disease, and diabetes. a. Review of Resident #6's current FL2 dated 09/13/21 revealed a physician's order for levothyroxine (used to treat thyroid disease) 100mcg take 1 tablet daily. Review of Resident #6's record revealed a signed physician's order dated 10/15/21 to increase levothyroxine to 125mcg take 1 tablet daily. Review of Resident #6's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for levothyroxine 125mcg take 1 tablet every day scheduled to administer daily at 9:00am. -Levothyroxine 125mcg was documented as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 10	D 358		

administered on 11/01/21 but was documented as a "late entry."
-Levothyroxine 125mcg was not documented as administered on 11/02/21, but there was no documentation explaining why the dose was not administered.
-Levothyroxine 125mcg was not documented as administered on 11/03/21 because medication was not available.

Observation of the 12:00pm medication pass on 11/02/21 at 11:30am revealed the levothyroxine 125mcg was not available to administer to Resident #6.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/03/21 at 2:54pm revealed:
-The pharmacy had a signed physician's order for Resident #6 dated 10/15/21 for levothyroxine 125mcg take 1 tablet daily.
-The physician's order for levothyroxine was "profiled" because the pharmacy did not dispense medications to Resident #6.
-The pharmacy had the physician's order so the medication would appear on Resident #6's eMAR.

Telephone interview with a representative from Resident #6's pharmacy on 11/03/21 at 10:18am revealed:
-The pharmacy dispensed 90 tablets (90-day supply) of levothyroxine 100mcg take 1 tablet daily to Resident #6 on 05/28/21.
-The pharmacy did not have a physician's order for levothyroxine 125mcg dated 10/15/21 for Resident #6.

Observation of medications on hand for Resident #6 on 11/03/21 at 2:00pm revealed the

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D 358	Continued From page 11 levothyroxine 125mcg was not available to administer to Resident #6. Interview with a medication aide (MA) on 11/03/21 at 2:06pm revealed: -Resident #6 did not use the facility's contracted pharmacy. -About two weeks ago, she had pulled Resident #6's medications from the medication cart that were getting low and called Resident #6's pharmacy for refills. -She did not know why the medication refills were not delivered to the facility. -She did not follow up to find out why the medications were not delivered. -She realized the levothyroxine was not available to administer during the morning medication pass (11/03/21), but she did not have time to call the pharmacy to find out why the medication was not delivered. -She had administered levothyroxine 100mcg to Resident #6 until no levothyroxine was available to administer. -Resident #6 was out of levothyroxine for at least 2 to 3 days. -She did not know the dose of levothyroxine was increased to 125mcg. Telephone interview with a registered nurse from Resident #6's Nurse Practitioner's (NP) office on 11/05/21 at 9:40am revealed: -Resident #6's levothyroxine was increased at her last appointment because her thyroid labs were not in the normal range. -The levothyroxine should be restarted immediately. -Resident #6's hypothyroidism was uncontrolled and she needed to take the levothyroxine daily to prevent hyperglycemia, increased irritability, and increased sweating.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 12 Attempted interview with Resident #6 on 11/03/21 at 2:35pm and 11/03/21 at 4:45pm was not successful. Refer to interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am. Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:14pm. b. Review of Resident #6's current FL2 dated 09/13/21 revealed a physician's order Vitamin D3 (supplement used to promote bone health) 1000 IU take 1 tablet daily. Review of Resident #6's record revealed a signed physician's order dated 10/15/21 to increase Vitamin D3 1000IU to 2 tablets daily. Review of Resident #6's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Vitamin D3 1000IU take 2 tablets daily scheduled to be administered at 9:00am. -Vitamin D3 was documented as administered on 11/01/21 but was documented as a "late entry." -Vitamin D3 was not documented as administered on 11/02/21, but there was no documentation explaining why the dose was not administered. -Vitamin D3 was not documented as administered on 11/03/21 because medication was not available. Observation of the 12:00pm medication pass on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 13 11/02/21 at 11:30am revealed Vitamin D3 1000IU was not available to administer to Resident #6. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/03/21 at 2:54pm revealed: -The pharmacy had a signed physician's order for Resident #6 dated 10/15/21 for Vitamin D3 1000IU take 2 tablets daily. -The physician's order for Vitamin D3 was "profiled" because the pharmacy did not dispense medications to Resident #6. -The pharmacy had entered the physician's order so the medication would appear on Resident #6's eMAR. Telephone interview with a representative from Resident #6's pharmacy on 11/03/21 at 10:18am revealed: -The pharmacy had last dispensed 30 tablets (30-day supply) of Vitamin D3 1000IU to Resident #6 on 09/06/21. -They did not have a physician's order to increase the Vitamin D3 1000IU to 2 tablets daily. Observation of medications on hand for Resident #6 on 11/03/21 at 2:00pm revealed Vitamin D3 was not available to administer to Resident #6. Interview with a medication aide (MA) on 11/03/21 at 2:06pm revealed: -Resident #6 did not use the facility's contracted pharmacy. -About two weeks ago, she had pulled Resident #6's medications from the medication cart that were getting low and called Resident #6's pharmacy for refills. -She did not know why the medication refills were not delivered to the facility. -She did not follow up to find out why the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 14	D 358		

medications were not delivered.
-She realized Resident #6 was out of several medications during the morning medication pass (11/03/21), but she did not have time to call the pharmacy to find out why the medications were not delivered.
-She did not know Resident #6's Vitamin D3 dose was increased.
-She was not sure how long Resident #6 was out of her Vitamin D3.

Telephone interview with a registered nurse from Resident #6's Nurse Practitioner's (NP) office on 11/05/21 at 9:40am revealed:
-Resident #6's Vitamin D3 dose was recently increased because the resident was ambulating more often since she was in the assisted living facility.
-The physician wanted to increase the dose to promote bone health, specifically increasing bone density.
-Resident #6 was at risk for increased fatigue or a bone fracture if Vitamin D3 levels were not maintained and she had a fall.

Attempted interview with Resident #6 on 11/03/21 at 2:35pm and 11/03/21 at 4:45pm was not successful.

Refer to interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am.

Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm.

Refer to the telephone interview with the Administrator on 11/04/21 at 12:14pm.

c. Review of Resident #6's current FL2 dated 09/13/21 revealed a physician's order carvedilol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 15 3.125mg (used to treat heart arrhythmia and high blood pressure) take 1 tablet twice daily. Review of Resident #6's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for carvedilol 3.125mg take 1 tablet twice daily scheduled to be administered at 9:00am and 9:00pm. -Carvedilol was documented as administered at 9:00am and 9:00pm on 11/01/21. -Carvedilol was not documented as administered on 11/02/21 at 9:00am, but there was no documentation explaining why the dose was not administered. -Carvedilol was documented as administered on 11/02/21 at 9:00pm. -Carvedilol was not documented as administered on 11/03/21 at 9:00am because medication was not available. Observation of the 12:00pm medication pass on 11/02/21 at 11:30am revealed carvedilol 3.125mg was not available to be administered to Resident #6. Interview with a medication aide (MA) on 11/03/21 at 2:06pm revealed: -Resident #6 did not use the facility's contracted pharmacy. -About two weeks ago, she had pulled Resident #6's medications from the medication cart that were getting low and called Resident #6's pharmacy for refills. -She did not know why the medication refills were not delivered to the facility. -She did not follow up to find out why the medications were not delivered. -She realized Resident #6 was out of several	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 16	D 358		

medications during the morning medication pass (11/03/21), but she did not have time to call the pharmacy to find out why the medications were not delivered.

Telephone interview with a representative from Resident #6's pharmacy on 11/03/21 at 10:18am revealed:
-The pharmacy had last dispensed 90 tablets (45-day supply) of carvedilol 3.125mg take 1 tablet twice daily to Resident #6 on 06/15/21.
-The facility had called the pharmacy the previous week (week of 10/25/21) requesting a refill.
-The pharmacy technician told the facility the medication order was out of refills and the pharmacy had faxed the provider.
-The pharmacy did not have a new prescription for carvedilol with additional refills.

Telephone interview with a registered nurse from Resident #6's Nurse Practitioner's (NP) office on 11/05/21 at 9:40am revealed:
-Resident #6 was at an increased risk for high blood pressure especially if the facility was not closely monitoring her blood pressure.
-High blood pressure could lead to the resident having a stroke.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/05/21 at 9:30am revealed:
-Resident #6 was prescribed the carvedilol to treat atrial fibrillation.
-Resident #6 was at an increased risk for her heart to be out of rhythm if she was not administered the carvedilol.

Attempted interview with Resident #6 on 11/03/21 at 2:35pm and 11/03/21 at 4:45pm was not successful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

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D 358	Continued From page 17 Refer to interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am. Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:14pm. d. Review of Resident #6's current FL2 dated 09/13/21 revealed a physician's order citalopram (used to treat depression and anxiety) 20mg take 1 tablet daily. Review of Resident #6's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for citalopram 20mg take 1 tablet daily scheduled to be administered at 9:00am daily. -Citalopram was not documented as administered from 11/01/21 to 11/03/21. -There was no reason documented on 11/01/21 and 11/02/21 explaining why citalopram was not administered. -It was documented on 11/03/21 at 9:00am the citalopram was not available. Observation of the 12:00pm medication pass on 11/02/21 at 11:30am revealed citalopram 20mg was not available to be administered to Resident #6. Interview with a medication aide (MA) on 11/03/21 at 2:06pm revealed: -Resident #6 did not use the facility's contracted pharmacy. -About two weeks ago, she had pulled Resident #6's medications from the medication cart that	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 18	D 358		

were getting low and called Resident #6's pharmacy for refills.
-She did not know why the medication refills were not delivered to the facility.
-She did not follow up to find out why the medications were not delivered.
-She realized Resident #6 was out of several medications during the morning medication pass (11/03/21), but she did not have time to call the pharmacy to find out why the medications were not delivered.

Telephone interview with a representative from Resident #6's pharmacy on 11/03/21 at 10:18am revealed:
-The pharmacy had last dispensed 90 tablets (90-day supply) of citalopram 20mg take 1 tablet daily to Resident #6 on 05/28/21.
-The facility had called the pharmacy the previous week (week of 10/25/21) requesting a refill.
-The pharmacy technician told the facility the medication order was out of refills and the pharmacy had faxed the provider.
-The pharmacy did not have a new prescription for carvedilol with additional refills.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/05/21 at 9:30am revealed:
-Resident #6 was prescribed citalopram to treat depression.
-Resident #6 was at risk for having symptoms of depression, including suicidal ideations and increased anxiety.

Telephone interview with a registered nurse from Resident #6's Nurse Practitioner's (NP) office on 11/05/21 at 9:40am revealed:
-It was dangerous for Resident #6 to stop taking the citalopram without tapering.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 19	D 358		

-Resident #6 was at an increased risk for anxiety and withdrawal symptoms for not tapering the dose before stopping the medication.
-Resident #6 was at risk for having behaviors and depression if she was not administered the citalopram.
-She expected the staff at the facility to make sure Resident #6 was administered her medications.

Attempted interview with Resident #6 on 11/03/21 at 2:35pm and 11/03/21 at 4:45pm was not successful.

Refer to interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am.

Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm.

Refer to the telephone interview with the Administrator on 11/04/21 at 12:14pm.

e. Review of Resident #6's current FL2 dated 09/13/21 revealed a physician's order for docusate (used to treat constipation) 100mg take 1 tablet daily.

Review of Resident #6's November 2021 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for docusate 100mg take 1 tablet daily scheduled to be administered at 9:00am.
-Docusate was not documented as administered from 11/01/21 to 11/03/21.
-There was no reason documented on 11/01/21 and 11/02/21 explaining why docusate was not administered.
-It was documented on 11/03/21 at 9:00am that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 20 docusate was not available. Observation of the 12:00pm medication pass on 11/02/21 at 11:30am revealed docusate 100mg was not available to be administered to Resident #6. Interview with a medication aide (MA) on 11/03/21 at 2:06pm revealed: -Resident #6 did not use the facility's contracted pharmacy. -About two weeks ago, she had pulled Resident #6's medications from the medication cart that were getting low and called Resident #6's pharmacy for refills. -She did not know why the medication refills were not delivered to the facility. -She did not follow up to find out why the medications were not delivered. -She realized Resident #6 was out of several medications during the morning medication pass (11/03/21), but she did not have time to call the pharmacy to find out why the medications were not delivered. Telephone interview with a representative from Resident #6's pharmacy on 11/03/21 at 10:18am revealed: -The pharmacy had last dispensed 30 tablets of docusate 100mg take 1 tablet daily to Resident #6 on 09/16/21. -The facility had called the pharmacy the previous week (week of 10/25/21) requesting a refill. -The pharmacy technician told the facility the medication order was out of refills and the pharmacy had faxed the provider. -The pharmacy did not have a new prescription for carvedilol with additional refills. Telephone interview with a registered nurse from	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 21	D 358		

Resident #6's Nurse Practitioner's (NP) office on 11/05/21 at 9:40am revealed Resident #6 was at risk increased discomfort from constipation if she was not administered the docusate as prescribed.

Attempted interview with Resident #6 on 11/03/21 at 2:35pm and 11/03/21 at 4:45pm was not successful.

Refer to interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am.

Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm.

Refer to the telephone interview with the Administrator on 11/04/21 at 12:14pm.

f. Review of Resident #6's current FL2 dated 09/13/21 revealed a physician's order for Vitamin B12 (a vitamin supplement) 500mcg take 1 tablet daily.

Review of Resident #6's November 2021 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Vitamin B12 500mcg take 1 tablet daily scheduled to be administered at 9:00am.
-Vitamin B12 was not documented as administered from 11/01/21 to 11/03/21.
-There was no reason documented on 11/01/21 and 11/02/21 explaining why Vitamin B12 was not administered.
-It was documented on 11/03/21 at 9:00am that Vitamin B12 was not available.

Observation of the 12:00pm medication pass on 11/02/21 at 11:30am revealed Vitamin B12 was not available to be administered to Resident #6.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 22 Interview with a medication aide (MA) on 11/03/21 at 2:06pm revealed: -Resident #6 did not use the facility's contracted pharmacy. -About two weeks ago, she had pulled Resident #6's medications from the medication cart that were getting low and called Resident #6's pharmacy for refills. -She did not know why the medication refills were not delivered to the facility. -She did not follow up to find out why the medications were not delivered. -She realized Resident #6 was out of several medications during the morning medication pass (11/03/21), but she did not have time to call the pharmacy to find out why the medications were not delivered. Telephone interview with a representative from Resident #6's pharmacy on 11/03/21 at 10:18am revealed: -The pharmacy had last dispensed 30 tablets (30-day supply) of Vitamin B12 take 1 tablet daily to Resident #6 on 09/20/21. -The facility had called the pharmacy the previous week (week of 10/25/21) requesting a refill. -The pharmacy technician told the facility the medication order was out of refills and the pharmacy had faxed the provider. -The pharmacy did not have a new prescription for carvedilol with additional refills. Telephone interview with a registered nurse from Resident #6's Nurse Practitioner's (NP) office on 11/05/21 at 9:40am revealed Resident #6 should restart the supplement immediately to maintain appropriate levels and prevent feeling fatigue. Attempted interview with Resident #6 on 11/03/21	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 23	D 358		

at 2:35pm and 11/03/21 at 4:45pm was not successful.

Refer to interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am.

Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm.

Refer to the telephone interview with the Administrator on 11/04/21 at 12:14pm.

2. Review of Resident #1's current FL2 dated 07/09/21 revealed:
-Diagnoses included coronary artery disease, chronic kidney disease, and a history of coronary artery bypass graft (a surgical procedure used to treat coronary artery disease).
-There was an order for furosemide (used to treat fluid retention in congestive heart failure) 10mg twice daily.

Review of a physician's progress note for Resident #1 dated 09/08/21 revealed:
-Resident #1 had a history of congestive heart failure (CHF) (a chronic condition in which the heart does not pump blood as well as it should).
-There was an order to discontinue furosemide 10mg twice daily and start furosemide 10mg daily as needed for systolic blood pressure (SBP) greater than 120.

Review of Resident #1's electronic Medication Administration Record (eMAR) for 09/09/21 - 09/30/21 revealed:
-There was an entry for twice daily blood pressure readings at 8:00am and 8:00pm.
-There was documentation of SBP readings that ranged from 123-197 for 34 out of 43 blood pressure readings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 24 -There was an entry for furosemide take 10mg once daily as needed for SBP greater than 120. -There was no documentation the furosemide 10mg had been administered. Review of Resident #1's eMAR for October 2021 revealed: -There was an entry for twice daily blood pressure readings at 8:00am and 8:00pm. -There was documentation of SBP readings that ranged from 121-193 for 55 out of 61 blood pressure readings. -There was an entry for furosemide take 10mg once daily as needed for SBP greater than 120. -There was no documentation the furosemide 10mg had been administered. Review of Resident #1's eMAR for 11/01/21 revealed: -There was an entry for twice daily blood pressure readings at 8:00am and 8:00pm. -There was documentation of SBP readings of 139 and 167 for two blood pressure readings -There was an entry for furosemide take 10mg once daily as needed for SBP greater than 120. -There was no documentation the furosemide 10mg had been administered. Telephone interview with a medication aide (MA) on 11/02/21 at 3:36pm revealed she had not administered the furosemide 10mg to Resident #1 when the SBP was greater than 120 because she had not seen it on the eMAR. Telephone interview with a second MA on 11/02/21 at 3:47pm revealed she had not administered the furosemide 10mg to Resident #1 when the SBP was greater than 120. Observation of Resident #1's medications on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 25	D 358		

hand on 11/02/21 at 3:27pm revealed:
-There was one bubble pack labeled furosemide 20mg take ½ tablet (10mg) twice daily with 46 ½ tablets remaining.
-Printed on a sticker on the bubble pack was "directions changed refer to chart".

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/02/21 at 4:47pm revealed:
-She had changed the furosemide 10mg from twice daily to as needed because Resident #1's blood pressure readings had been low.
-Resident #1 needed the furosemide 10mg for SBP greater than 120 because he was at risk of CHF exacerbation (occurs when there is an increase in or worsening of heart failure symptoms).
-She expected the facility to administer the medications as ordered.

Interview with the Resident Care Coordinator (RCC) on 11/02/21 at 4:01pm revealed:
-She did not know why the MAs were not administering the furosemide to Resident #1.
-They should be administering medications as ordered.
-The MAs were trained by a nurse on administering medications.

Interview with the Executive Director (ED) on 11/02/21 at 4:20pm revealed:
-The MAs should be administering the furosemide as ordered.
-The MAs were trained on medication administration by a nurse.

Based on observations, interviews, and record review Resident #1 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 26	D 358		

Refer to interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am.

Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm.

Refer to the telephone interview with the Administrator on 11/04/21 at 12:14pm.

3. Review of Resident #2's current FL2 dated 10/04/21 revealed diagnoses included right femur fracture.

Review of physician's orders for Resident #2 revealed:
-Acetaminophen (pain reliever) 325mg, 2 tablets twice daily, dated 07/29/21.
-Change acetaminophen to 500mg twice daily, dated 09/30/21.
-Discontinue acetaminophen and start hydrocodone 5mg/acetaminophen 325mg (pain reliever) every six hours as needed for pain, dated 10/05/21.
-Change hydrocodone 5mg/acetaminophen 325mg to 1 tablet every six hours scheduled, dated 10/19/21.

Review of Resident #1's electronic Medication Administration Record (eMAR) for 10/05/21 - 10/31/21 revealed:
-There was an entry for acetaminophen 500mg twice daily with administration times of 8:00am and 8:00pm.
-There was documentation the acetaminophen 500mg had been administered on 10/05/21 - 10/31/21 at 8:00am and 8:00pm.

Review of Resident #1's eMAR for 11/01/21 - 11/02/21 revealed:
-There was an entry for acetaminophen 500mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 27	D 358		

twice daily with administration times of 8:00am and 8:00pm.
-There was documentation the acetaminophen 500mg had been administered on 11/01/21 and 11/02/21 at 8:00am and 8:00pm.

Interview with the Resident Care Coordinator (RCC) on 11/03/21 at 10:33am revealed:
-Medication orders were faxed to the pharmacy and initialed at the bottom of the order.
-The pharmacy entered the new orders into the eMAR system.
-The supervisors were responsible for verifying the new orders, by comparing with the original order, on the eMAR, and would then initial at the bottom of the order.
-She had initialed that she had verified the new order.
-She had "overlooked it".

Telephone interview with a representative from the facility's contracted pharmacy on 11/03/21 at 10:52am revealed:
-The pharmacy had received the faxed order from the facility to discontinue the acetaminophen 500mg on 10/05/21.
-The RCC had notified the pharmacy that only a previous order for acetaminophen 325mg was to be discontinued and the current acetaminophen 500mg was to continue.

Telephone interview with the Hospice physician's nurse on 11/03/21 at 11:09am revealed:
-All acetaminophen orders should have been discontinued as Resident #1 had an order for scheduled hydrocodone 5mg/acetaminophen 325mg.
-The facility should be administering medications as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 358	Continued From page 28 Based on observations, interviews, and record review it was determined that Resident #2 was not interviewable. Refer to interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am. Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:14pm. _____ Interview with the Resident Care Coordinator (RCC) on 11/02/21 at 11:30am revealed: -The facility had a medication aide (MA) call in for first shift and she was filling in for her. -She did not know why medications were not available to administer to several residents. -The MAs were responsible for reordering medications for the residents when the medications were getting low. Interview with the Executive Director (ED) on 11/02/21 at 3:05pm revealed: -The Supervisor or MA was responsible for reordering medications when there were 6 doses remaining in the medication cart. -The MA, Supervisor, or the RCC was responsible for approving the physician's orders from the pharmacy to appear on the eMAR. -The order should not be approved until the MA, Supervisor, or RCC has compared the order entered by the pharmacy to the order from the physician. -She did not know all medications were not available in the medication cart to be administered to the residents. Telephone interview with the Administrator on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

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D 358	Continued From page 29 11/04/21 at 12:14pm revealed: -The MAs were responsible for sending refill request to the pharmacy and calling the pharmacy to make sure they received the request. -The MAs were responsible for telling the RCC if there was a problem getting the pharmacy to refill a medication. -The MAs or RCC was responsible for contacting the provider or pharmacy to make sure medications were available. -The MAs were responsible for comparing the medication card to the directions on the eMAR and should have noticed any medication changes for a resident. _____ The facility failed to ensure medications were administered as ordered by a licensed prescribing provider for 1 of 6 residents (Resident #6) observed during the 12:00pm medication pass on 11/02/21 related to 6 medications not being available in the facility to administer to a resident (#6), including a medication used to treat hypothyroidism increasing the risk for anxiety and irritability, a supplement to promote bone health increasing the risk of a fracture with a fall, a medication used to treat atrial fibrillation and high blood pressure increasing the risk of an arrhythmia or stroke, an antidepressant that was stopped without tapering increasing the risk for suicidal ideations and anxiety, a medication used to treat constipation, and a supplement to prevent fatigue and 2 of 5 sampled residents (#1 and #2) which resulted in a resident (#1) not administered a medication used to treat fluid retention when systolic blood pressure was >120 increasing the risk of an congestive heart failure exacerbation, and Resident #2 receiving a pain medication that had been discontinued increasing the risk of a medication toxicity. This failure resulted in	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

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D 358	Continued From page 30 substantial risk of neglect and serious physical harm to the residents and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/03/21 for this violation. CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 5, 2021.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed or scheduled times for 3 of 3 sampled residents (#1, #2, #3) in the Special Care Unit (SCU) during the morning medication pass on 11/02/21 resulting in several medications with multiple administration times being administered too close to the next scheduled administration times. The findings are:	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 364	Continued From page 31 Interview with the Resident Care Coordinator on 11/02/21 at 11:30am revealed: -The medication aide (MA) had called out of work this morning and she was responsible for passing medications. -She was still administering medications that were scheduled for the 8:00am medication pass. -The Supervisor/MA that worked on third shift had never completed a morning medication pass and was a "little" behind administering medications when she got to work around 9:00am. -She started administering medications on the assisted living side of the facility when she got work. -She still had 3 residents on the assisted living to administer their morning medications and all the residents in the Special Care Unit (SCU). Review of the facility census dated 11/02/21 revealed there were 18 residents in the SCU. 1. Review of Resident #1's current FL2 dated 07/09/21 revealed diagnoses included atrial fibrillation, coronary artery disease, and history of coronary artery bypass graft. Review of Resident #1's electronic Medication Administration Record (eMAR) for 11/02/21 revealed: -There was an entry for acetaminophen (pain reliever) 500mg twice daily with administration times of 8:00am and 8:00pm and documentation of administration at 8:00am and 8:00pm. -There was an entry for aspirin (blood thinner) 81mg daily with administration times of 8:00am and documentation of administration at 8:00am. -There was an entry for carvedilol (treats heart failure) 12.5mg twice daily with administration times of 8:00am and 8:00pm and documentation	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

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D 364	Continued From page 32	D 364		

of administration at 8:00am and 8:00pm.
-There was an entry for doxazosin mesylate (treats urinary retention) 2mg daily with an administration time of 8:00am and documentation of administration at 8:00am.
-There was an entry for Eliquis (blood thinner) 2.5mg twice daily with administration times of 8:00am and 8:00pm and documentation of administration at 8:00am and 8:00pm.
-There was an entry Oysco 500mg + D 200mg (vitamin supplement) daily with an administration time of 8:00am and documentation of administration at 8:00am.
-There was an entry for Vitamin B-12 (vitamin supplement) 100mcg daily with an administration time of 8:00am and documentation of administration at 8:00am.

Review of Resident #1's medication time variance report for 11/02/21 revealed the 8:00am dose of acetaminophen, aspirin, carvedilol, doxazosin mesylate, Eliquis, Oysco + D, and Vitamin B-12 had been administered at 2:51pm on 11/02/21.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/04/21 at 12:05pm revealed administering the 8:00am dose of carvedilol at 2:51pm and then administering the 8:00pm dose put Resident #1 at risk of low blood pressure, low heart rate, and poor balance.

Based on observations, interviews, and record review it was determined that Resident #1 was not interviewable.

Refer to the telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/02/21 at 4:37pm.

Refer to the telephone interview with a MA on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 364	Continued From page 33 11/02/21 at 3:36pm. Refer to the telephone interview with a second MA on 11/02/21 at 3:47pm. Refer to the interview with a third MA on 11/03/21 at 2:06pm. Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:15pm. 2. Review of Resident #2's current FL2 dated 10/04/21 revealed diagnoses included hypertension and right femur fracture. Review of Review of Resident #2's electronic Medication Administration Record (eMAR) for 11/02/21 revealed: -There was an entry for acetaminophen 500mg twice daily with administration times of 8:00am and 8:00pm and documentation of administration at 8:00am and 8:00pm. -There was an entry for captopril 25mg twice daily with administration times of 8:00am and 8:00pm and documentation of administration at 8:00am and 8:00pm. -There was an entry for donepezil 10mg daily with an administration time of 8:00am and documentation of administration at 8:00am. -There was an entry for hydrocodone 5mg/acetaminophen 325mg every six hours with administration times of 6:00am, 12:00pm, 6:00pm, and 12:00am and there was documentation of administration at 6:00am, 12:00pm, and 6:00pm. -There was an entry for omeprazole 20mg twice daily with administration times of 8:00am and	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 364	Continued From page 34	D 364		

8:00pm with documentation of administration at 8:00am and 8:00pm.
-There was an entry for sertraline 100mg daily with an administration time of 8:00am with documentation of administration at 8:00am.
-There was an entry for sertraline 12.5mg daily with an administration time of 8:00am with documentation of administration at 8:00am.
-There was an entry for valproic acid 250mg twice daily with administration times of 8:00am and 8:00pm with documentation of administration at 8:00am and 8:00pm.

Review of Resident #2's medication time variance report for 11/02/21 revealed:
-The 8:00am dose of acetaminophen had been administered at 3:28pm.
-The 8:00am dose of captopril, donepezil, omeprazole, sertraline, and valproic acid had been administered at 3:29pm.
-The 12:00pm dose of hydrocodone/acetaminophen had been administered at 3:29pm.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/04/21 at 12:05pm revealed:
-Resident #2 receiving the 8:00am dose of captopril at 3:29pm and again at 8:00pm put her at increased risk of low blood pressure.
-Resident #2 receiving the 12:00pm dose of hydrocodone/acetaminophen at 3:29pm and again at 6:00pm put her at risk of increased sedation.

Based on observation, interviews, and record reviews it was determined Resident #2 was not interviewable.

Refer to the telephone interview with the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 364	Continued From page 35 contracted Nurse Practitioner (NP) on 11/02/21 at 4:37pm. Refer to the telephone interview with a MA on 11/02/21 at 3:36pm. Refer to the telephone interview with a second MA on 11/02/21 at 3:47pm. Refer to the interview with a third MA on 11/03/21 at 2:06pm. Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:15pm. 3. Review of Resident #3's current FL2 dated 06/18/21 revealed: -Diagnoses included dementia with behaviors and hypoxia. -There was a physician's order for acetaminophen, allopurinol, amlodipine, aspirin, carvedilol, docusate, memantine, quetiapine, and sertraline. Review of Resident #3's electronic Medication Administration Record (eMAR) for 11/02/21 revealed: -There was a computer-generated entry for acetaminophen (used to treat mild pain) 325mg take 2 tablets three times daily scheduled to be administered at 8:00am, 2:00pm, and 8:00pm and documented as administered at 8:00am, 2:00pm, and 8:00pm. -There was a computer-generated entry for allopurinol (used to treat gout) 300mg take 1 tablet daily scheduled and documented as administered at 8:00am.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 364	Continued From page 36 -There was a computer-generated entry for amlodipine 5mg (used to treat high blood pressure) take 1 tablet daily scheduled and documented as administered at 8:00am. -There was a computer-generated entry for aspirin (blood thinner) 325mg 1 tablet daily scheduled and documented as administered at 8:00am. -There was a computer-generated entry for carvedilol (used to treat heart arrhythmia and high blood pressure) 3.125mg 1 tablet daily scheduled and documented as administered at 8:00am and 5:00pm. -There was a computer-generated entry for docusate (used to treat constipation) 100mg 1 tablet daily scheduled and documented as administered at 8:00am. -There was a computer-generated entry for memantine (used to treat dementia) 5mg take 1 tablet twice daily scheduled and documented as administered at 8:00am and 8:00pm. -There was a computer-generated entry for quetiapine (used to treat behaviors) 50mg take 1 & ½ tablets twice daily scheduled and documented as administered at 8:00am and 8:00pm. -There was a computer-generated entry for sertraline (used to treat depression and anxiety) 100mg 1 tablet daily scheduled and documented as administered at 8:00am. Review of Resident #3's medication time variance report for 11/02/21 revealed: -The 8:00am dose of allopurinol, amlodipine, aspirin, carvedilol, docusate, memantine, quetiapine, and sertraline were administered at 2:42pm. -The 8:00am and 2:00pm dose of acetaminophen was administered at 2:42pm. -The 5:00pm dose of carvedilol was administered	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 364	Continued From page 37 at 4:14pm. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/04/21 at 11:15am revealed: -Resident #3 was at risk for a low heart rate, low blood pressure, and poor balance from getting both doses of carvedilol within 90 minutes. -It was important for the facility to administer each resident's medication when it was scheduled. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. Refer to the telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/02/21 at 4:37pm. Refer to the telephone interview with a MA on 11/02/21 at 3:36pm. Refer to the telephone interview with a second MA on 11/02/21 at 3:47pm. Refer to the interview with a third MA on 11/03/21 at 2:06pm. Refer to the interview with the Executive Director (ED) on 11/02/21 at 3:05pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:15pm. _____ Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/02/21 at 4:37pm revealed: -She had not been notified by the facility of 8:00am being administered late. -Some medications were ordered twice daily and	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 364	Continued From page 38	D 364		

should not be given close together.
-She expected the medications to be administered as scheduled.

Telephone interview with a medication aide (MA) on 11/02/21 at 3:36pm revealed:
-Sometimes medications were administered late to the residents.
-There were too many residents and one MA had difficulty administering all the medications.

Telephone interview with a third MA on 11/02/21 at 3:47pm revealed sometimes the facility was short staffed and the MAs were busy doing other things and medications were administered late.

Interview with a third MA on 11/03/21 at 2:06pm revealed some of the MAs had not completed all required training and were "nervous" to complete a morning medication pass.

Interview with the Executive Director (ED) on 11/02/21 at 3:05pm revealed:
-A MA called out of work this morning (11/02/21) at 7:00am.
-The third shift supervisor/MA was responsible for administering medications to the residents on the assisted living side of the facility.
-The first shift MA was responsible for administering medications to the residents on the Special Care Unit (SCU) side of the facility.
-She did not know the third shift supervisor/MA did not pass any of the medications scheduled for the 8:00am medication pass.
-She had "assumed" the third shift supervisor/MA had started the 8:00am medication pass for the assisted living residents.

Telephone interview with the Administrator on 11/04/21 at 12:15pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

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D 364	Continued From page 39 -She was not aware staff had not administered the 8:00am until the afternoon of 11/02/21. -She knew there were two nurses in the facility at the time and one should have administered the 8:00am medications if a MA was not available. The facility failed to ensure medications were administered within one hour before or after the scheduled times for 3 of 3 sampled residents (#1, #2, and #3) in the Special Care Unit (SCU) during the morning medication pass. This failure resulted in Resident #1 and #3 receiving a blood pressure medication too close to the second dose placing the resident at increased risk of low blood pressure, low heart rate, and poor balance. The facility's failure to administer medications within one hour before or after the scheduled time was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/02/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2021.	D 364		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by:	D912		

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	HAL055009	A. BUILDING: _____ B. WING _____	11/05/2021

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D912	Continued From page 40 Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and stat laws and rules and regulations related to mediation administration and medication aide training. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (#1, #2) related to not administering a medication to decrease fluid (#1) and administering a pain medication that had been discontinued (#2), and 1 of 6 residents (#6) observed on the medication pass, related to 6 medications not available to administer to the resident, including a medication to treat thyroid disease, depression, heart disease, constipation, improve bone health, and a vitamin supplement [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed or scheduled times for 3 of 3 sampled residents (#1, #2, #3) in the Special Care Unit (SCU) during the morning medication pass on 11/02/21 resulting in several medications with multiple administration times being administered too close to the next scheduled administration times [Refer to Tag D0364 10A NCAC 13F .1004(g) Medication Administration (Type B Violation)]. 3. Based on interviews and record reviews, the	D912		

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D912	Continued From page 41 facility failed to ensure 3 of 3 sampled staff (A, B, and C) who administered medications had completed the state approved 5-hour and 10-hour medication aide training course as required [Refer to Tag D0935 G.S. 131D-4.5B(b)3 Adult care home medication aides; training and competency evaluation requirements (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program	D935		

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D935	Continued From page 42	D935		

developed by the Department that includes training and instruction in all of the following:
1. The key principles of medication administration.
2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (A, B, and C) who administered medications had completed the state approved 5-hour and 10-hour medication aide training course as required.

The findings are:

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A was hired as a medication aide (MA) on 10/12/21.
-Staff A had completed the MA written exam on 07/29/21.
-Staff A had completed the Medication Administration Clinical Skills Validation Checklist on 10/01/21.
-There was no documentation of a 5, 10, or 15 hours MA training course.

Review of a resident's October 2021 electronic Medication Administration Record (eMAR) revealed:

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D935	Continued From page 43 -There was an entry for blood pressure readings at 8:00am and 8:00pm. -There was an entry for furosemide (decreases fluid) 10mg daily as needed for systolic blood pressure (SBP) greater than 120. -There was documentation of SBP readings of 127 on 10/06/21 at 8:00am and 165 on 10/24/21 at 8:00pm. -There was no documentation Staff A had administered the furosemide. Attempted telephone interview with Staff A on 11/02/21 at 2:15pm was unsuccessful. Refer to the interview with the Executive Director (ED) on 11/03/21 at 1:55pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:15pm. Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation). 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired as a medication aide (MA) on 07/18/21. -Staff B had completed the MA written exam on 04/08/21. -Staff B had completed the Medication Administration Clinical Skills Validation Checklist on 05/03/21. -There was no documentation of the 5, 10, or 15 hours MA training course. Review of a resident's October 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for blood pressure readings at 8:00am.	D935		

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D935	Continued From page 44 -There was an entry for furosemide (decreases fluid) 10mg daily as needed for systolic blood pressure (SBP) greater than 120. -There was documentation of SBP readings at 8:00am ranging from 122 to 183 on 10/04/21, 10/07/21, 10/09/21 - 10/10/21, 10/12/21, 10/14/21 - 10/15/21, 10/18/21 - 10/19/21, 10/21/21, 10/24/21, and 10/27/21 - 10/28/21. -There was no documentation Staff B had administered the furosemide. Interview with Staff B on 11/02/21 at 2:05pm revealed: -She had not had any previous employment as a MA. -She had been trained to administer medications by the previous Special Care Coordinator (SCC). -She had not received the 5, 10, or 15 hours MA training course. Refer to the interview with the Executive Director (ED) on 11/03/21 at 1:55pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:15pm. Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation). 3. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired as a medication aide (MA) on 06/30/21. -Staff C had completed the MA written exam on 01/28/20. -Staff C had completed the Medication Administration Clinical Skills Validation Checklist on 10/09/21. -There was no documentation of the 5, 10, or 15 hours MA training course.	D935		

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D935	Continued From page 45 Review of a resident's October 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for blood pressure readings at 8:00am. -There was an entry for furosemide (decreases fluid) 10mg daily as needed for systolic blood pressure (SBP) greater than 120. -There was documentation of SBP readings at 8:00am ranging from 127 to 180 on 10/01/21 - 10/03/21, 10/05/21, 10/08/21, 10/11/21, 10/16/21 - 10/17/21, 10/20/21, and 10/25/21. -There was no documentation Staff C had administered the furosemide. Interview with Staff C on 11/02/21 at 2:15pm revealed: -She worked at the facility for two years. -She had not had any previous employment as a MA. -She thought she had completed the 15 hours MA training course but did not know where the paperwork was. Refer to the interview with the Executive Director (ED) on 11/03/21 at 1:55pm. Refer to the telephone interview with the Administrator on 11/04/21 at 12:15pm. Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation). _____ Interview with the Executive Director (ED) 11/03/21 at 1:55pm revealed she was not aware of the required 15 hours of medication aide training. Telephone interview with the Administrator on	D935		

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D935	Continued From page 46 11/04/21 at 12:15pm revealed: -She thought the MAs had received the 15 hours of training and the documentation was in their personnel records. -Staff should have audited the personnel records for all required documents. -The nurse from the facility's contracted pharmacy would have given the required training. _____ The facility failed to ensure 3 of 3 sampled medication aides (MAs) met the qualifications, 5, 10, or 15-hour MA training course, to administer medications to residents. Staff A, B, and C did not administer an as needed medication to a resident on multiple days. This failure resulted in medication errors and was detrimental to the health of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 11/03/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2021.	D935		