

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL041054</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/15/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CLAPP'S ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4558 PLEASANT GARDEN ROAD</b> <b>PLEASANT GARDEN, NC 27313</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments  The Adult Care Licensure Section and the Guilford County Department of Social Services conducted an annual and follow-up survey on 08/14/19 - 8/15/19.	D 000		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #1) related to Vitamin C.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 04/24/19 revealed:</p>	D 358		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 358	<p>Continued From page 1</p> <p>-Diagnoses included Diabetes Mellitus Type II with neuropathy, long term use of Insulin, cerebral infarction with left side hemiplegia, chronic kidney disease, chronic obstructive pulmonary disease, hypertension, major depressive disorder, and gastroesophageal reflux disorder.</p> <p>-There was an order for Vitamin C 250 mg daily.</p> <p>Review of Resident #1's July 2019 Medication Administration Record (MAR) revealed: -There was an entry for Vitamin C 250 mg daily scheduled at 8:00 am. -There was documentation Vitamin C was administered at 8:00 am daily from 07/01/19 through 07/31/19.</p> <p>Review of Resident #1's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for Vitamin C 250 mg daily scheduled at 8:00 am. -There was documentation Vitamin C was administered at 8:00 am daily from 08/01/19 through 08/14/19.</p> <p>Observation of Resident #1's medications on hand on 08/15/19 at 9:20 am revealed: -There was a bottle of Vitamin C 500 mg which was house stock (used for multiple residents) with a handwritten date of opened on 07/07/19. -There was no Vitamin C 250 mg available for administration for Resident #1.</p> <p>Interview with a Medication Aide (MA) on 08/15/19 at 11:15 am revealed: -She had opened a bottle of Vitamin C 500 mg on 07/07/19 and placed it on the medication cart. -There was no Vitamin C 250 mg available for administration for Resident #1. -She had routinely administered Vitamin C 500</p>	D 358		

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D 358	<p>Continued From page 2</p> <p>mg to Resident #1 with his other medications, including today (08/15/19). -It was her fault, she did not read the label correctly." -The previous bottle was for Vitamin C 250 mg. -All the MAs including herself, were responsible for ensuring the correct dosage of medications were administered.</p> <p>Interview with the Administrator on 08/15/19 at 11:25 am revealed: -She did not know Resident #1 had received the incorrect dosage of Vitamin C. -She assumed the resident had a blister pack which contained 250 mg tablets of Vitamin C because another resident had a blister pack which contained a 250 mg of Vitamin C. -The MA administering the medication was responsible for ensuring the medication dosage was correct. -When house stock was used, the MA would compare the MAR to the bottle of medication instead of a blister pack. -She expected all medication to be administered as ordered.</p> <p>Telephone interview with Resident #1's primary care physician (PCP) on 08/15/19 at 1:35 pm revealed: -He knew he had ordered Vitamin C 250 mg for Resident #1. -The PCP did not know Resident #1 was administered Vitamin C 500 mg and not 250 mg as ordered.</p>	D 358		