Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041077		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING:			
		B. WING		R 03/04/2020		
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
UILFOR	DHOUSE		TFIELD RD SBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 000	Initial Comments		D 000			
	-	sure Section conducted a survey on 03/03/20 and				
D 375	10A NCAC 13F .100 Medications	5(a) Self-Administration Of	D 375			
	Medications (a) An adult care how who are competent a self-administer their for requirements are me (1) the self-administer physician or other per prescribe medication documented in the re (2) specific instruction	medications if the following t: ation is ordered by a rson legally authorized to s in North Carolina and				
	interviews, the facility residents sampled (# self-administer medic medication, a pain m	ns, record reviews, and y failed to assure 1 of 5 (1) had physicians' orders to cations for an antacid edication, a fiber C supplement, and hair, skin				
	The findings are:					
	Review of Resident 7 06/19/19 revealed: -Diagnoses included anemia, and osteoar	Alzheimer's disease,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		HAL041077	B. WING		03	R 3/04/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
JUILFORI	DHOUSE					
		GREEN	SBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 375	Continued From page 1		D 375			
	-Resident #1 was intermittently confused.					
		for acetaminophen (used to				
	treat mild pain), Antacid tablets (used to treat					
	heartburn), vitamin C supplement (used to treat					
	immune or vitamin deficiency), fiber supplement					
	(used to treat constipation) and hair, skin, and					
	nails supplement with biotin (used to treat vitamin					
	deficiency).					
	-There was no order	for self-administration.				
	Review of Resident #1's record revealed:					
	-There was no documentation of a					
	"Self-Administration of Medication Assessment"					
	and no physician's order to self-administer					
	medications.					
	-There was no documentation specific to					
	residents who may keep any medication in their					
	room or on their pers	son.				
	Observation of Resident #1's room on 03/03/20 at					
	9:50am revealed:					
	-On the bathroom co	unter top were six				
	unidentified pills.	in a new dimension from the f				
		in a row directly in front of				
	the sink.	nd plump red gummies, two				
		ts and two oblong clear				
		bright tan substance in the				
	capsules.					
		of over-the-counter (OTC)				
		ng, a bottle of OTC antacid				
	calcium carbonate 1000mg tablets, vitamin C					
	1000mg, daily fiber 100% natural psyllium husk					
	fiber, and a bottle of hair, skin, and nails gummies					
	with biotin 2500mg.					
	-The medications and supplements did not have					
	a prescription label.					
	Interview with Reside	ent #1 on 03/03/20 at 9:55am				
	revealed:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041077		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		BENTH IOATION NOMBER.	A. BUILDING:			
		B. WING		R 03/04/2020		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	D HOUSE	5918 NE	TFIELD RD			
JUILFOR	DHOUSE	GREENS	BORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 375	Continued From page 2		D 375			
	-He had the medications and supplements since					
	he moved into the facility last summer. -No one at the facility had told him that he was					
	unable to have the medications.					
	-He took the acetaminophen and antacid					
	medications as needed.					
	-He took the supplements daily which was how he					
	prevented illnesses.					
	Interview with the medication aide (MA) on					
	03/04/20 at 10:50am revealed:					
	-She passed medications to Resident #1 daily on					
	the first shift.					
	-She did not know Resident #1 had medications					
	in his room.					
	-Resident #1 was protective of his room and did					
	not allow her to enter his room past the doorway					
	entrance to the room.					
	-She had never been in Resident #1's room and					
	was not aware he had medications and					
	supplements in his room.					
		sleep all night and even				
		e was in and out of his going				
	outside to smoke.					
		nt #1 had left his room staff				
	resident yelled and to	om but was caught and the old staff to stay out of his				
	room.					
	-If Resident #1's roor					
		plements she did not know				
	when it was searche search.	d or what staff initiated the				
	Interview with the Div	rector of Resident Care				
	Interview with the Director of Resident Care (DRC) on 03/04/20 at 11:20am revealed:					
	. ,					
	-Shortly after he started to work at the facility in December 2019, he searched all the residents'					
	rooms.					
		e identified medications and				
	supplements in Resi					
	alth Service Regulation					

STATE FORM

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041077			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 03/04/2020	
		HAL041077				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GUILFOR	D HOUSE		TFIELD RD SBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMP THE APPROPRIATE DAT	
D 375	 -He removed the item family member aware those items in his roc -In January 2020, he residents' rooms and and supplements in F -He removed the item #1's family member t to have medications a the resident did not h self-administer medic -The family told him t listen to him and whe Resident #1 purchase -He had not contacte Care Provider (PCP) resident to self-admin Telephone interview v Care Provider (PCP) revealed: She was not aware I self-administered me -As of this date, no of informed her that Res medications and sup -Based on previous e she felt the resident v self-administering suf -She felt facility shou administering medica supplements. 	hs and made the resident's the resident could not have again did a search of the identified more medications Resident #1's room. Ins and again told Resident he resident was not allowed and supplements because lave an order to cations. hat Resident #1 would not en he took the resident out ed the items for himself. d Resident #1's Primary to obtain an order for the hister medications. with Resident #1's Primary on 03/04/20 at 9:50am Resident #1 dications and supplements. ne at the facility had sident #1 self-administered plements. encounters with Resident #1 was capable of pplements. Id be responsible for	D 375			

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