STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

(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 conducted follow-up survey via desk review 06/23/20 through 06/26/20, 06/29/20 through 07/02/20 and 07/06/20, including Infection Control onsite visit conducted on 06/26/20.	{D 000}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement a physician order for the application of thrombo-embolic deterrent (TED) hose (used to prevent blood clots) for 1 of 4 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated 03/16/20 revealed diagnoses included Alzheimer's, hypertension, and depressive	D 276		

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disorder.

Review of a physician note dated 03/16/20 for Resident #5 revealed:
-The resident was seen for a three month follow up appointment and blood pressure check.
-Diagnoses included hypertension, edema, obesity hyperlipidemia, anemia, dementia, insomnia, hypokalemia, and gastro-esophageal reflux disease.
-There was a physician order for the resident to wear thrombo-embolic deterrent (TED) hose (used to manage peripheral edema and prevent blood clots) daily.

Review of Resident #5's electronic medication administration records (eMARs) for 03/2020, 04/2020, 05/2020, and 06/2020 revealed:
-There was a "fyi" (for your information) entry dated 02/06/20 printed to the eMARs to elevate feet as much as possible.
-There was no entry for TED hose application or removal daily.

Observation of Resident #5 on 06/26/2020 at 1:00pm revealed:
-She was sitting in a chair in her bedroom watching television.
-Her feet were positioned flat on the floor.
-She was wearing ankle socks and bedroom slippers.
-She was not wearing TED hose.

Interview with Resident #5 on 06/26/2020 at 1:00pm revealed her hands and feet were swollen.

Telephone interview with the responsible family member for Resident #5 on 06/29/20 at 2:00pm revealed:

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-Resident #5 was supposed to wear "support" hose.
-She had seen the resident wearing TED hose in the past which were a skin tone color.
-She had seen swelling in the resident's leg last week.
-The resident was having some swelling "off and on".
-The resident told the family member she was swollen when the family member visited her at the resident's room window last week.
-The resident required assistance to put her socks and shoes on.

Telephone interview with a personal care aide (PCA) on 06/29/20 at 3:38pm revealed:
-Resident #5 required assistance with dressing.
-The resident did not have any TED hose right now.
-The resident needed another pair of TED hose ordered.
-Sometimes the TED hose would rip.
-The last time she had probably worked with Resident #5 and saw the resident with TED hose was "a few weeks, could have been three weeks ago."
-Resident #5's TED hose was "a beige/tan color."

Telephone interview with a Medication Aide/Supervisor (MAS) on 06/29/20 at 4:10pm revealed:
-She worked as a MA mainly, and rarely got to work as a PCA.
-Resident #5 had swelling sometimes in her feet, ankles, and legs.
-When she saw the swelling, she instructed the resident to sit down and elevate her feet.
-The resident would "prop her feet up for a little while."
-The resident was not wearing TED hose right

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now.
-The resident was wearing them but had stopped.
-It had probably been about three weeks since the resident had worn the TED hose.
-The MAs were responsible to put on and remove the TED hose.
-She worked with Resident #5 at least 5 - 6 days a week and would have been the person to remove the TED hose.
-She reported (no date provided) to the Resident Care Coordinator (RCC) that Resident #5 was not wearing TED hose.
-Some of the swelling in the resident's ankles, feet, and legs was returning.
-The swelling varied.

Telephone interview with a second PCA on 06/29/20 at 5:55pm revealed:
-She was responsible for providing personal care to residents, including Resident #5.
-She worked with Resident #5 about 2 - 3 days per week.
-She had not seen any TED hose and had never removed any TED for Resident #5.
-The resident had never asked her about TED hose.
-Resident #5 wore socks with grips on the bottom to prevent slipping.
-The facility staff kept Resident #5's legs elevated.
-The resident had complained before about her legs hurting.
-Resident #5 had one foot that would not go in her shoe because of swelling.
-The swelling was varied.
-She had never mentioned to anyone that Resident #5's feet were swollen because the MAs were the staff who told her to keep the resident's feet elevated, and she figured the MAs knew about the swelling.

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D 276	Continued From page 4 Telephone interview with the Special Care Unit Coordinator (SCUC) on 06/30/20 at 1:25pm revealed: -Resident #5 did not have an order for TED hose because the order was "never renewed". -She did not know when the last order for TED hose was written for Resident #5. -She was not aware of the 03/16/20 order for Resident #5 to wear TED daily. -The order for TED hose did not populate on Resident #5's eMARs. -TED hose were ordered through the contracted pharmacy. -It "might" have been around March 2020 when she had last seen the resident wearing TED hose. -She had put TED hose on Resident #5 and could not remember a date but was probably March. -Resident #5's feet and legs stay puffy. -Resident #5's hand would get puffy. -The RCC was aware Resident #5 was not wearing TED hose because she had spoken to the RCC in February or March about the TED hose. -The pharmacy entered new physician orders to the eMARs. -The RCC was responsible to process and approve new physician orders. Telephone interview with the contracted pharmacy provider on 06/30/20 at 3:09pm revealed: -When the PCP wrote an order for TED hose the facility was responsible for sending measurements to the pharmacy to ensure correct size was sent for the resident. -The facility normally faxed the order to the pharmacy. -The pharmacy would send TED hose to the	D 276		

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facility.
-The family had the option to purchase TED hose over the counter.
-The pharmacy had not received Resident #5's measurements for TED hose.
-The pharmacy had not dispensed TED hose for Resident #5.

Telephone interview with the RCC on 07/01/20 at 11:00am revealed:
-Resident #5's TED hose were discontinued in 2018 or early 2019 after a hospitalization.
-She had overlooked the 03/16/20 order for Resident #5 to wear TED hose daily.
-She had been sending new orders to the pharmacy to be entered into the eMARs since August 2019.
-She could not provide an answer as to why the pharmacy did not have a copy of the 03/16/20 order for Resident #5 to wear TED hose daily.
-An order for TED hose application would show up on the eMAR.
-She tried to check new orders to see if the pharmacy had entered everything.
-She checked orders by comparing the current list of orders with the new FL-2.
-When a resident came back from the hospital she checked the list of medications to make sure changes were made in the facility's eMAR system.

Telephone interview with the Administrator on 07/01/20 at 2:10pm revealed:
-She did not know about Resident #5's TED hose.
-The RCC was responsible for implementing physician orders.
-The RCC faxed physician orders to the pharmacy.
-The pharmacy entered new orders into the eMAR system.

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D 276	Continued From page 6 -The RCC reviewed pending orders and approved the orders. -Since implementing the eMAR system, the facility did not perform end of the month review of medication administration records. -Every "couple of months" the facility reviewed the medications on hand to ensure there were no residents missing medications. -When the facility received an order for TED hose she expected the facility to get the TED hose and the resident should be wearing them. -She did not know Resident #5 was having any swelling in her ankles, feet, and legs. Telephone interview with the PCP on 07/01/20 at 4:00pm revealed: -Resident #5 was supposed to wear TED hose. -The resident usually did not have the TED hose on when she came to the PCP office. -She did not know if the resident was refusing to wear the TED hose. -She expected Resident #5 to wear the TED hose. -Resident #5 would swell a lot and the TED hose were to help with the swelling. -The resident had worn TED hose before. -When the resident was seen on 03/16/20, the resident had swelling less than 1+ edema and she wrote an order for the resident to wear TED hose daily.	D 276		
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:	D 358		

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D 358	Continued From page 7 (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 B Violation Based on record reviews, observations, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #4) related to discontinuing an anti-hypertensive medication without a physician's order. The findings are: Review of Resident #4's current FL2 dated 05/28/20 revealed: -Diagnoses included hypertension, type 2 diabetes mellitus, and schizophrenia. -Medication orders included Catapress/clonidine (used to lower high blood pressure) 0.2mg tablet twice daily. Review of Resident #4's hospital discharge summary report dated 05/28/20 revealed: -Discharge medications included clonidine HCL 0.2mg tablet take 2 times daily. -There was documentation on the hospital discharge summary report with special instructions "Continue taking this medication and follow the directions you see here." Review of Resident #4's May 2020 electronic Medication Administration Records (eMARs) revealed: -There was an entry for clonidine 0.2mg twice daily at 9:00am and 9:00pm.	D 358		

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-There was documentation clonidine 0.2mg was administered twice daily from 05/01/20 through 05/23/20.
-There was documentation Resident #4 was in the hospital from 05/24/20 through 05/28/20.
-There was no documentation clonidine 0.2mg was administered from 05/28/20 through 05/31/20.

Review of Resident #4's May 2020 blood pressures (BPs) revealed the following:
-On 05/05/20 at 11:00am, the BP was 160/110.
-On 05/12/20 at 11:00am, the BP was 160/72.
-On 05/19/20 at 11:00am, the BP was 140/100.

Review of Resident #4's June 2020 eMAR revealed:
-There was no entry for clonidine 0.2mg twice daily on the eMAR.
-There was no documentation clonidine 0.2mg twice daily was administered from 06/01/20 through 06/30/20.

Review of Resident #4's weekly BPs for June 2020 revealed the following:
-On 06/02/20 at 11:00am, the BP was 162/110.
-On 06/09/20 at 10:00am, the BP was 155/118.
-On 06/16/20 at 10:00am, the BP was 140/100.
-On 06/23/20 at 10:00am, the BP was 170/120.
-On 06/30/20 (time unknown), the BP was 160/100.

Telephone interview with a pharmacist at the facility's contract pharmacy on 06/30/20 at 12:12pm revealed:
-Clonidine 0.2mg tablet twice daily was ordered on Resident #4's FL2 dated 02/27/20.
-The pharmacy did not have an order that discontinued the medication.
-The pharmacy did not have any orders or FL2s

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D 358	Continued From page 9 dated 05/28/20. -The facility was supposed to send current medication orders to the pharmacy. -When the pharmacy received an order, the order was entered on the eMARs. -Someone at the facility had to approve the order before it became visible for facility staff to see on the eMAR. -The pharmacy did not have orders to discontinue clonidine 0.2mg. -If the medication was discontinued on the eMAR that was done by facility staff. -The MAs did not have access to change or delete medication orders in the eMAR system. -Clonidine 0.2mg twice daily was last dispensed on 05/18/20. Telephone interview with a medication aide (MA) on 06/30/20 at 1:15pm revealed: -She was responsible for administering medications based on what was on the eMAR. -Resident #4's clonidine 0.2mg was not currently on the eMAR. -Prior to Resident #4's hospitalization 05/24/20 through 05/28/20 the resident was administered clonidine 0.2mg tablets twice daily. -She guessed clonidine 0.2mg tablet had been stopped but she did not inquire about the medication because it was handled by the RCC. -It had been at least one month since she administered clonidine tablets to Resident #4. -The Resident Care Coordinator (RCC) was responsible for approving medication orders on the eMARs. -The pharmacy entered the orders on the eMARs. -When a resident received new or changed medication orders, including the FL2s, the RCC was responsible for faxing the orders to the pharmacy and approving the orders on the eMAR.	D 358		

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D 358	Continued From page 10 -If there was a question about a resident's medication order, the RCC was responsible for contacting the Primary Care Provider (PCP) to clarify the medication order. -She checked the medication cart during this phone call and Resident #4's clonidine 0.2mg tablets were not on the medication cart. -She was not concerned about Resident #4's BP and did consider the resident's BP high. Interview with Resident #4's PCP on 06/30/20 at 2:07pm revealed: -She did not know Resident #4 had been hospitalized in May 2020. -She did not know clonidine 0.2mg tablet twice daily had been stopped. -She ordered clonidine due to the resident's high blood pressure (BP). -On 02/27/20, she increased clonidine from 0.1mg tablet every eight hours to 0.2mg twice daily. -The facility did not contact her to inform they stopped the medication. -The facility staff should never stop a medication without first consulting the PCP. -If facility staff were unclear about a medication order, they should contact the PCP before stopping the medication. -She was "not surprised" the resident's BPs were high because the facility stopped the clonidine 0.2mg tablets twice daily. -She had not previously given the facility BP parameters for Resident #4 because the facility did not ask for parameters. -The facility did not make her aware of the resident's high BP. -Had she known about Resident #4's high BPs she would have ordered parameters or at least checked the resident's medications.	D 358		

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D 358	Continued From page 11 Telephone interview with a personal care aide (PCA) on 07/01/20 at 1:43pm revealed: -When she worked, she usually assisted Resident #4 with personal care needs. -The MA checked Resident #4's BP, so she did not know when the resident's BP was high. -Lately, Resident #4 had been saying she did not feel well almost every day.-Resident #4 told her when she was not feeling well. -She did not ask the resident what specifically made her not feel well. -It was the facility's protocol to notify the MA on duty when a resident complained of not feeling well. -She did not notify the MA when Resident #4 told her that she did not feel well because the resident complained about not feeling well everyday. -She had identified that Resident #4's health had declined since her hospitalization in May 2020 but had not told anyone. Telephone interview with Resident #4 on 07/01/20 at 1:53pm revealed: -"I don't feel too good," I feel weak and tired. -She had been feeling dizzy and weak for at least two weeks. -Specifically, her right arm and hand felt weak. -She usually told the PCA when she was not feeling well but nothing was done. -She had high blood pressure. -She took medication for BP but did not know the name of medication. -She was able to tell when her BP was high because she felt dizzy and weak. -She was feeling dizzy and weak today and almost every. -She had a fall last week because she was weak and dizzy. -The MA was aware because the MA helped her off the floor last week.	D 358		

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-She told the MA that she fell because she was weak and tired.
-The MA checked her BP but she did not tell the result.

Second telephone interview with the MA on 07/01/20 at 1:15pm revealed:
-Resident #4 had not complained to her about feeling faint or being dizzy but the resident did have a fall about a week ago complaining of weakness in her arm.
-She checked Resident #4's BP and documented the resident's BP was increased but she did not write down the BP results.
-She think that she gave the report about the fall and increased BP to the RCC, but she was not sure.
-She did not do an incident report because Resident #4 was not sent out to the hospital and the resident did not appear to be injured.
-Resident #4 often complained that her arm hurt but she thought it was related to a previous stroke, she had not considered the pain or weakness to be related to the resident's blood pressure being high or due to not taking the clonidine 0.2mg tablet twice daily.
-Resident #4 had a history of high blood pressure since she was admitted to the facility and was administered medications to control high blood pressure.
-Resident #4's BP was checked once a week.
-She did not consider Resident #4's current BPs to be high enough to be concerned.
-She considered high BP to be "160/90."
-She was unable to recall who told her "160/90" was high BP.

Interview with the Resident Care Coordinator (RCC) on 07/01/20 at 11:02am revealed:
-When Resident #4 returned from the hospital on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	R 07/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

(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 05/28/20 she was given a discharge medication list and a new FL2. -Both the discharge medication list and a new FL2 were signed by the hospital's discharging physician. -Review of the discharge medication list and a new FL2 dated 05/28/20 she saw that clonidine 0.2mg tablet twice daily was ordered on both documents. -She felt the hospital had made a mistake because there was a new order for 0.2mg clonidine patch every seven days added to the resident's medications. -Without consulting the resident's PCP she discontinued the administration of the clonidine 0.2mg tablet twice daily. -It was the facility's policy to contact the PCP before stopping a medication order, but she did not contact the PCP before she stopped clonidine 0.2mg tablet twice daily. -She had no reason as to why she stopped Resident #4's clonidine without contacting the resident's PCP. Telephone interview with the Administrator on 07/01/20 at 3:00pm revealed: -The facility's policy was no medication should be stopped without a physician's order. -The RCC should have contacted the PCP before she stopped Resident #4's clonidine 0.2mg tablet twice daily. -She did not look at the eMARs and did not know the clonidine tablet had been stopped. -The PCA should have informed the MA and/or the RCC how the resident was feeling. -The RCC was responsible for reviewing the BPs and reporting the BPs to the resident's PCP. _____ The facility failed to administer medications as ordered for Resident #4 related to discontinuing	D 358		

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D 358	Continued From page 14 clonidine without a discontinue order and not administering clonidine for four and half weeks resulting in Resident #4 having hypertension, dizziness, weakness and a fall. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 07/01/20 for this violation. _____ THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 20, 2020.	D 358		
{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: 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 state laws and rules and regulations as related to medication administration. The findings are: Based on record reviews, observations, and interviews, the facility failed to administer medications as ordered by a licensed prescribing	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	Continued From page 15 practitioner for 1 of 5 sampled residents (Resident #4) related to discontinuing an anti-hypertensive medication without a physician's order.[Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).].	{D912}		