_

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	10 M		(X3) DATE SURVEY COMPLETED	
	HAL092182	B. WING		R 10/29/2021	
NAME OF PROVIDER OR SUPP		ET ADDRESS, CITY, SI			
OLIVER HOUSE		WENDELL BOULE	WARD		
····		DELL, NC 27591			
PREFIX IEACH D	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL 'ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
(D 000) Initial Comme	nts	{D 000}	Response to cited deficienci constitute an admission or a	es do not greement	
			by the facility of the truth of t	he facts	
	e Licensure Section conducted a		alleged or the conclusions se	et forth in	
follow-up surv	ey on Oclober 28-29, 2021.		the Statement of Deficiencie	s or	
			Corrective Action Report; the	e Plan of	
	F.1004(a) Medication	{D 358}	Correction is prepared solely	as a	
Administration	1		matter of compliance with St	ate law.	
(A) 11010 (
	F .1004 Medication Administration				
	are home shall assure that the ad administration of medications,		Upon reopening, Oliver Hous	se will	
	nd non-prescription, and treatments		maintain compliance by ensu	Iring the	
	accordance with:		preparation and administration	on of	
	a licensed prescribing practitioner		medications and treatments	by staff	
which are mai	ntained in the resident's record; and		according to MD orders; facil	ity's	
	s Section and the facility's policies		policies and procedures; and	State	
and procedure			rules.		
	ot met as evidenced by:		RCC/SCC will run daily EMAR c	omoliance	
	ervations, interviews and record		reports to review for accuracy an	nd 12/13/21	
	cility failed to administer		medication administration compl	liance, as	
medications a	s ordered for 3 of 3 sampled	ļ	well as a daily review of any resi	dents on	
residents (Res	idents #1, #2 and #3) related to the		sliding scale insulin to ensure all	ordered	
administration	of medications used to treat		medications are in the facility. The	nis report	
vitamin deficie	ncy, dry nose, acid reflux, and an		will be discussed with the ED in meeting daily for follow-up.	management	
eye disease (F	Resident #1) and medications used		theeding daily for follow up:		
to treat diabete	es and fluid retention (Resident #3).		RCC/SCC will run electronic act	ivity report	
			daily to review that medications	have been _12/13/2	
The findings a	e.		administered accurately per MD	orders, and	
. A Baviour of P	esident #1's current FL-2 dated		any required follow-up has occu will be reviewed daily with the E	D.	
1. Review or n	led diagnoses included chronic				
obstructive put	monary disease (COPD),		MAR to Medication cart audits w	vill be	
concestive her	rt failure (CHF), and hypertension.		completed weekly by Med Tech	s per Facility 12/13/2	
3 DI 100			schedule and reviewed by the R to ensure follow-up has occurred		
a, Review of R	esident #1's current FL-2 dated		necessary. RCC/SCC will comp	lete a weekiv	
10/27/21 revea	led a medication order for		overall QA cart audit to verify the	e condition	
Preservision Al	REDS 2 (used to reduce the risk of		of the med cart, i.e. cleanliness,	availability	
progression of	moderate macular degeneration)		of meds, expired meds, disconti	nued meds,	
tab chew take of	ne tablet twice daily with meals.		etc. Cart audits will be signed of SCC and ED to verify completio	n.	
	<u>are e</u>			1214	
on of Health Service Regulati RATORY DIRECTOR'S OR PRO	NIDER/SUPPLIER REPRESENTATIVE'S SIGNAT	URE	A A A L.	(X6) DATE	
			11 11 Dr. har (1010) YA	artine WILARIO	

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Reviewed and Acknowledged-SS-12/17/21

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			(X3) DATE SL COMPLE		
		HAL092182	HAL092182 B. WING		R 10/29/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ET ADDRESS, CITY, STATE, ZIP CODE				
		4230 WE	NDELL BOULE	VARD			
OLIVER H	DUSE	WENDEL	L, NC 27591				
(X4) 1D	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO)N	(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	COMPLET	
(D 358)	orders revealed then	#1's previous physician e was an order daled ision AREDS 2 softgel	{D 358}	RCC/SCC will complete a minimu chart reviews weekly to audit for o accuracy, and ensure there are no orders. Chart reviews will be subr ED weekly upon completion for ve	completion, o missed nitted to the		
	Review of Resident a record revealed: -Preservision ARED3 and 08/05/21. -There were 42 caps	#1's pharmacy dispense S was dispensed on 07/27/21 ules dispensed on 08/05/21. r dispense dates for Resident		ED/RCC/SCC reeducated Med Te importance of following insulin or documentation; reasons to notify to call the PCP for Out of Range V Refresher on notifying RCC/SCC are out.	lers; proper PCP; when /ital Signs;	11/1/2	
	from 08/27/21 to 10/2	1's facility dispense record 29/21 revealed there were no Resident #1's Preservision					
1	medication administr revealed: -There was an entry is chew take one tablet scheduled for 7:30an 5:00pm.	for Preservision AREDS 2 twice daily with meals, n, 8:00am, 4:30pm, and					
	Preservision AREDS 08/09/21 at 8:00am a -There was documen unavailable on 08/10/ -There was documen	tation that Resident #1 was					
	08/17/21 at 8:00am a -There was documen Preservision AREDS 7:30am and 4:30pm, a 08/20/21 at 4:30pm, a 08/25/21 at 7:30am at	nd 5:00pm. tation of administration of 2 chew on 08/18/21 at 08/19/21 at 7:30am, ind from 08/21/21 to					

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If continuation sheet 2 of 28

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVE COMPLETED
				R •
	HAL092182	B. WING		10/29/20
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE	
OLIVER HOUSE	4230 W	ENDELL BOULEVA	RD	
	WENDE	LL, NC 27591	8 8	
PREFIX (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COM
(D 358) Continued From pa	ge 2	{D 358}		
-There was docume	intation that Resident #1 was			
	08/26/21 at 4:30pm.			
-There was docume	ntation of administration of			
	3 2 chew 08/26/21 at 7:30am,			
	31/21 at 7:30am and 4:30pm.			
Device of Device of				2
revealed:	#1's September 2021 eMAR			
	for Programinian AREDS 1			ĩ
	for Preservision AREDS 2 twice daily with meals,			
scheduled for 7:30ar				
	ntation of administration of			10 10
	2 chew from 09/01/21 to	1 1		
09/30/21 at 7:30am a				
				:
Review of Resident #	1's October 2021 eMAR			
revealed:				1
	or Preservision AREDS 2			1
	twice daily with meals,			1
scheduled for 7:30am				
	ation of administration of	1		1
	2 chew from 10/01/21 to			1
10/28/21 at 7:30am ar				,
	nt #1's medications on			
	26am revealed there was		15	1
no Preservision ARED				•
administration.	S available for			ı
administration.				
Intentiow with Residen	t #1 on 10/28/21 at 7:39am			
revealed she had recer				
mediantians, and she h	ad only received two pills			
yesterday, on 10/27/21				
yesterday, on Toizriz'				i
A second Interview with	Resident #1 on 10/29/21			1
at 1:20pm revealed:				Í
-She did not like the tas	te of the Preservision	1		
AREDS 2.				
-The medication aides (MA) began crushing the			
Preservision AREDS 2 a				
	······································			•

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TATEMENT OF C	EFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	100 March 100 Ma		CONSTRUCTION		ATE SURVEY DMPLETED
1 Biggs Dr	ive, Brown Build	no	8	2			R
	vice Center	HAL092182		B WING			10/29/2021
Rigisior Phovi	52688-37798er		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
0.000			4230 WEND	ELL BOULEV	/ARD		
<u>Ariste</u> r H DHG	book YouTul	<u>be</u> <u>LinkedIn</u>	WENDELL,	NC 27591			· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE	(X5) COMPLETI DATE
allcorrespond	ience to and from this	address is subject to the	North Carolina	Rublig Record	s Law and may be disclosed to thi I information, including confidentia	ird parties by an ar	uthorized State
iciàl. Unauthori	ized disclosure of juv	enile, health, legally privil	eged, or otherw	ise confidentia	I information, including confidentia notify the sender immediately and	l information relation	ng to an ongoin
200-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0			eu tris ernañ ir	cirol, picase	notify the serider inificulately and	delete all records i	or ons entait.
	he lhought she go	· · · · · · · · · · · · · · · · · · ·	ho mail				
		ed any notifications in t and no one at the facili					
		s regarding the Preser					
	REDS 2.						
Те	lephone interview	with a pharmacy techr	nician				
al	the facility's contra	acted pharmacy on 10/	29/21				
	9:27am revealed:						
-T	here was an order	dated 07/20/21 for					÷ •
	eservision AREDS						
		S 2 softgels was dispe	nsed	6			
- 100	1 07/20/21 and 08/0						
		efill request on 09/10/2		3			
		d a reply to the facility					
		em that a new order wa #1's Preservision ARE	22 - 21 222 -				
	요즘 집안 집에 집안 집안 집안 하는 것이 같이 있다. 이 것은 것이 같이 많이	order was needed was	상태가는 지금 문화되었어.				
	ere, no more refills		un¢ .				
	reservision AREDS						
	630141310117-11200	~~.					
Te	lephone interview	with a representative a	at the	8			
		pharmacy multi-dose					
		n 10/29/21 at 10:01am					
re	vealed:						
		ervision AREDS 2 was					10
dis	spensed on 08/05/2	21 and forty-two tablet	s were				К
	nt.						80
-A	refill request was	sent from the facility or	ו				
8. C		not refilled because of	a				
	ling issue.						1
-T	he billing departme	ent made a note that	uor				
		al insurance did not co					
	s medication.	ent indicated the reaso	n was				1
¦ ⊷ محمد ا	ne plining departitie	n AREDS 2 was an ov	er the				
	unter medication.						
							i
	he facility would ha	IVA FACAIVACI IWO		1			1

Division of Health Service Regulation STATE FORM

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5H2E13

If continuation sheet 4 of 28

Division of Health Service Re				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	HAL092182	B. WING		R 10/29/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY, S	STATE, ZIP CODE	
		IDELL BOUL		
OLIVER HOUSE	WENDELI	_, NC 27591		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETE
{D 358} Continued From pa	age 4	{D 358}		
another from the m	nulti-dose packaging section.			
Resident #1's prim on 10/29/21 at 10:2 -Resident #1's PCI	w with a representative at ary care physician (PCP) office 29am revealed: P was no longer with the revious orders could not be	:		
-The reason the or	ders could not be viewed was had began using a different	17 18		
electronic medical		1		
10/29/21 at 12:00p -Resident #1 did n AREDS 2 on the n -Resident #1's Pre in her multi-dose p began sending it ir -He did not know w Preservision AREI not available. -He did not recall t available after 09/0 -When administeri package was scar appeared on the c -If there was a me in the multi-dose p called, a refill requ was made aware. -He waited 2 to 3 o	ot have any Preservision nedication cart. servision AREDS 2 used to be backage and then the pharmacy in a separate package. why the MAs were signing for DS 2 when the medication was the medication not being D9/21. ing medications, the multi-dose med and the medications computer screen. dication that was not included backage, the pharmacy was lest was completed, or the RCC	· · · · · · · · · · · · · · · · · · ·		
revealed: -She expected the there was a medic	RCC on 10/29/21 at 3:14pm MAs to call the pharmacy if cation that appeared on the available for administration.	- - -		
EIVIAR Dut was un Division of Health Service Regulation		6899	5H2E13	If continuation sheet 5 of 2

STATE FORM

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING		R		
		HAL092182	B. WING		R 10/29/2021		
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DORESS, CITY, STATE	, ZIP CODE			
OLIVER H	DUSE		NDELL BOULEVAR	RD OF			
		WENDEL	L, NC 27591				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET		
{D 358}	Continued From page	ge 5	(D 358)				
	-If the MA told her a	bout the unavailable					
		e would notify pharmacy and					
	try to determine why	rit was not available for					
	administration.						
		Resident #1's Preservision					
		eceiving an email from the					
		ng Resident #1's Preservision					
		e with billing for a medication,					
	the pharmacy sent a notification that a medication was not covered by insurance.						
	-She did not recall receiving a notification						
	concerning billing fr #1's Preservision Al	om the pharmacy for Resident REDS 2.					
		t it was not covered, the					
		options available for the					
		the PCP choosing					
	another medication discussing with reside medication.	dent concerning paying for the			•		
		dministrator on 10/29/21 at					
1		e was not aware that					
		rvision AREDS 2 was last /21 and was not available for					
1	administration.						
	Refer to interview w	ith the RCC on 10/29/21 at			÷		
2	2:50pm.						
ł	Refer to interview w	ith the Area Director of			15		
	Clinical Services on	10/29/21 at 5:15pm.					
	Refer to interview wi	ith the Administrator on					
	10/29/21 at 5:39pm.						
:	h Doulous of Dealds	nt #1% ourrant El 2 datad			20		
8		nt #1's current FL-2 dated medication order for saline					
:		treat dry nose, allergies, or	1				

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5H2E13

If continuation sheet 6 of 28

7

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AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		HAL092182	B. WING		R
		11746052102	0.11110		10/29/2021
INAME OF PA	IOVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE	
OLIVER H	DUSE		ENDELL BOULEVA	RD	
(74)0	SILLI IADV SI		LL, NC 27591		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL
(D 358)	Continued From page	e 6	(D 358)		<u> </u>
	nasal congestion) ac nostril three times a c	lminisler one spray each day.			
	Review of Resident #	1's previous FL-2 dated			
	01/28/21 revealed the	ere was a medication order			
	for saline nasal spray	administer one sprav into			
	each nostril three tim	es a day.			
	Review of Resident #	1's pharmacy dispense			
1	record revealed one 4	14 milliliter bottle of saline			
1	nasal spray was dispe	ensed on 07/26/21.	1		
1	Review of Resident #	1's August 2021 electronic			
	medication administra		1		
ĩ	revealed:	20 -	i i		
		or saline nasal spray one			
	spray into each nostri				
	and 6:00pm.	10:00am, 2:00pm, 7:00pm,			
		ation of administration of			
		n 08/01/21 to 08/09/21 at			
	:00am, 2:00pm and 8				
-	There was document	ation that Resident #1 was			
	navailable on 08/10/2	teast the state of the state of the state			
	terreture and the second	ation of administration of			11
	and an a second s	08/10/21 at 2:00pm and			άζ.
	:00pm, from 08/11/21	to 08/17/21 at 8:00am,			
		ation of administration of			
		1 08/18/21 to 08/31/21 at			
	0:00am, 2:00pm, and				0
	oview of Desident 44	a Sentember 2024 eMAD			
	eview of Resident #1 vealed:	's September 2021 eMAR			
		r saline nasal spray one	1		ł
	ray into each nostril t				
sc	heduled at 10:00am,	, 2:00pm, and 7:00pm.			
		tion of administration of			1
		09/01/21 to 09/17/21 at			
	:00am, 2:00pm, and	7.00			

STATE FORM

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5H2E13

If continuation sheet 7 of 28

AND PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	WINDATE CHIMA
		IDENTIFICATION NUMBER	A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL092182	B. WING		R 10/29/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STATE		
OLIVER H	OUSE	4230 WE	INDELL BOULEVA	RD	
	·····	WENDE	LL, NC 27591		
IX4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	4 (×5)
TAG		CSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL
(D 358)	Continued From page	je 7	(D 358)		
	-There was docume	ntation that Resident #1's			
	saline nasal spray w	as discontinued on 09/18/21			
	at 2:00pm,				
	-There was docume	ntation of administration of			
	10:00am, 2:00pm, a	rom 09/19/21 to 09/29/21 at			
	-There was docume	ntation of refusal by Resident	1		
	#1 on 09/30/21 at 2:	00nm			
		nlation of administration of			
	saline nasal spray or	n 09/30/21 at 10.00am and			
	7:00pm.				
	Review of Resident :	#1's October 2021 eMAR			
	revealed:				
	-There was an entry	for saline nasal spray one			
	spray into each nost				
		am, 2:00pm, and 7:00pm. Intation of administration of			
		om 10/01/21 to 10/05/21 at			
		nd 7:00pm, on 10/07/21 at			
		nd 7:00pm, and 10/08/21 at			
	10:00am and 2:00pm				
		ntation of administration of			
		om 10/09/21 to 10/16/21 at			
		nd 7:00pm, on 10/17/21 at			
		n, and from 10/18/21 to , 2:00pm, and 7:00pm.			
		lation of administration of			
		om 10/26/21 to 10/28/21 at			
	0:00am, 2:00pm, an		1		
-	There was documen	tation of not administered on			
	0/06/21 at 10:00am,	And the second			·
		tation of refusal on 10/06/21			i .
		at 7:00pm, 10/17/21 at			2
	0:00pm, 10/25/21 at 7	7:00pm, and 10/29/21 at			֥
1 i	0.008111.				l.
Ċ	bservation of Reside	ent #1's medications on			
		:26am revealed there was	1		
1998	o bottle of saline nas				4

STATE FORM

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5H2E13

Il continuation sheet 8 of 28

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	Health Service Regu of DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
	borrigenon		A, BUILDING.		-	
		HAL092182	B. WING		R 10/29/2021	
NAME OF PR	OVIDER OR SUPPLIER	STREET AG	DRESS, CITY, STATE	, ZIP CODE		
		4230 WE	NDELL BOULEVA	RD		
OLIVER HO	JUSE	WENDEL	L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(XS) E Completi Ate date	
(D 358)	Continued From pag	je 8	(D 358)			
	administration.				· , 4	
	Interview with Resid	lent #1 on 10/29/21 at 1:20pm				
	revealed:	20 0.000 0.0000				
		e nasal spray but refused it				
	most of the time. -She did not have the	ne bottle of saline nasal spray				
	in her room.					
	Telephone interview	with a pharmacy technician				
		racted pharmacy on 10/29/21			1	
	at 9:27am revealed	: r dated 07/16/21 for saline				
		ray in each nostril three times				
	a day.	netse - rokene interderation enderstander present er interderation för att stradiske				
	-There were no refil 07/16/21.	lls on the order dated				
		faxed a refill request on				
	09/10/21 and the pl	harmacy faxed that there were				
		a new prescription was				
	needed. -One 44 milliliter bo	ttle of saline nasal spray was				
	dispensed on 07/26				<i>x</i>	
	Interview with a me	dication aide (MA) on				
	10/29/21 at 12:39pi					
	 He could not locale nasal spray. 	e Resident #1's bottle of saline			5 3 1	
	-The last date that I	he saw Resident #1's saline			1	
	nasal spray was 10	/25/21.			1	
		n was not available for locumented "on hold".				
	-However, there sh	ould be a hold order for the			1	
	medication to docu				2 ²¹	
		Resident Care Coordinator			k j	
	(RCC) on 10/29/21	at 3:14pm revealed:				
	-She was not awan	e that Resident #1's saline t available for administration.				
	-She expected staff	f to request a refill when a				

STATE FORM

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5H2E13

If continuation sheet 9 of 28

TATEMENT	Health Service Requ OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL092182	B. WING		R 10/29/2021
				. 3/0.0005	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		
OLIVER H	OUSE		ENDELL BOULEVA LL, NC 27591	KD	
(X4) (D	SUMMARY ST	ATEMENT OF DEFICIENCIES	· 1D .	PROVIDER'S PLAN OF CORRECTION	l (X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
(D 358}	Continued From pag	e 9	(D 358)		
	medication was not a	available.			E.
	eacher and independent and the state	problems sending a refill			
		could request a refill online.			1
		nmunicate with her if there			
	were any difficulties	obtaining a medication.			
		sues she did not know aboul			÷
	for medications.				1
	Interview with the Ac	Iministrator on 10/29/21 at			ļ
		e did not know Resident #1's			1
		ould not be located and was			
	not administered.				
	Refer to interview wi 2:50pm.	th the RCC on 10/29/21 at			
	Refer to interview wi Clinical Services on	th the Area Director of 10/29/21 at 5:15pm.			
	Refer to interview wi 10/29/21 at 5:39pm.	ith the Administrator on			
	c. Review of Reside	nt #1's current FL-2 dated			
		medication order for			
	Daily-Vite 400 mcg (used to treat or to prevent			
	vitamin deficiency) c	one tablet daily.			
	Review of Resident	#1's physician orders			
	revealed:				
		order to discontinue			
	. Resident #1's daily v	vitamin signed by Resident			
	#1's primary care pr	ovider (PCP) on 08/30/21. order for Resident #1's			
	Daily-vite.				
	1 3				Ì
	Review of Resident	#1's previous FL-2 dated			
	01/28/21 revealed th	nere was an order for nerals take one tablet daily.			
		#1's pharmacy dispense			
ision of He	aith Service Regulation	en en ante alla alla de la	6599 54	H2E13	If continuation sheet 10

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TATEMENT	Health Service Regu DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		X3) DATE SURVEY COMPLETED	
	CONTECTION		A BUILDING			
					R	
63		HAL092182	B WING		10/29/2021	
AME OF PR	OVIDER OR SUPPLIER	STREET	DORESS, CITY, STATE	ZIP CODE		
DLIVER HO		4230 WE	NDELL BOULEVAI	RD		
	JU3E	WENDE	LL, NC 27591		v —	
(X4) ID		TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(XS) COMPLETE	
PREFIX		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE DATE	
140			1	DEFICIENCY)	<u></u>	
(D 358)	Continued From pag	je 10	{D 358}			
	11. -	nty-eight tablets of Daily-Vile				
		09/09/21 and 09/30/21.				
	were dispensed on t	55,55721 and 55,55721				
	Review of Resident	#1's August 2021 electronic				
		ration record (eMAR)				
	revealed:					
		for multivitamin with minerals				
		, scheduled for 10:00am.				
	Souther and the State state of the state of	ntation of administration of nerals from 08/01/21 to			2	
	08/29/21 at 10:00an					
		for Daily-Vite 400 mcg tablet				
		, scheduled at 10:00am.				
		nlation of administration of				
	Daily-vite from 08/30	0/21 to 08/31/21 at 10:00am.				
	Review of Resident	#1's September 2021 eMAR				
	revealed:	noot electrica presarete transport en				
		for Daily-Vite 400 mcg tablet				
	take one tablet daily	, scheduled at 10:00am.				
		Intation of administration of				
	Daily-vite from 09/0	1/21 to 09/30/21 at 10:00am.				
	Review of Resident	#1's October 2021 eMAR				
	revealed:					
	-There was an entry	/ for Daily-Vite 400 mcg tablet			2	
	take one tablet daily	r, scheduled at 10:00am. entation of administration of				
	-There was docume Daily-Vite from 10/0	11/21 to 10/26/21 at 10:00am,				
	and 10/28/21 at 10:					
	-There was docume	entation of not administered			2	
	due "on hold" on 10				20	
	Observation of Per	Ident #1's medications on			e -	
	hand on 10/29/21 a				2	
	-There were Daily-\	/ite tablets available in			l	
	Resident #1's week	ly multi dose packet dated				
	10/28/21.				Ĩ	
	-There was a note w	written in green beside the			1	
	inicture of a Daliv-Vi	te tablet that the medication			i	

STATE FORM

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5H2E13

If continuation sheet 11 of 28

TATEMENT	Health Service Requerts DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER	A, BUILDING		COMPLETED	
			5 U.U.		R	
		HAL092182	B, WING		10/29/2021	
IAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE.	ZIP CODE		
DLIVER H	DUSE		NDELL BOULEVAR	D		
(X4) ID	SUMMARY SI	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	IN (X5)	
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	
(D 358)	Continued From pag	e 11	(D 358)			
	was discontinued.					
	-There were handwri	Iten instructions to remove				
	the tablet from the m	ulli-dose packet.	Ì			
	Interview with Reside	ent #1 on 10/28/21 at 7:39am				
	revealed she took a	vilamin, but she did not				
	receive it on 10/27/2	1.				
	Telephone interview with a pharmacy technician					
		acted pharmacy on 10/29/21				
	at 9:27am revealed:					
		order dated 08/24/21 for				
	Daily-Vite one tablet	ntinue order for Daily-Vite on				
	Resident #1's profile				10	
		d for multi-dose packaging				
		ew the dispense dates.				
		with a representative at the				
		nulti-dose packaging on				
	10/29/21 at 10:01am					
		e order for Resident #1's	×3			
	packaging.	placed in the multi-dose				
	-There was no disco	ntinue order in the system for			3	
	Daily-Vite.	d in the 10/28/21 multi-dose				
	package for Residen					
		Resident #1's multi-dose				
		21 and Daily-Vite would be in				
	the packages.				12	
		shift medication aide (MA) on				
	10/29/21 at 12:39pm				8	
		it #1's Daily-Vite was did not know when it was				
	discontinued, out ne	OID HOLKHOW WHEN IL WES			1	
		was discontinued, the				
21	Resident Care Coord	dinator (RCC) wrote			4	
		multi-dose package beside				

STATE FORM

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5H2E13

If continuation shoet 12 of 28

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NAD PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED R	
		HAL092182	8. WING	1(10/29/2021	
NAME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
OLIVER H	DUSE		NDELL BOULEVAR	RD		
			L, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
(D 358)	Continued From pa	ge 12	{D 358}			
	the discontinued me	edication entry	ì			
		posed to remove the	4			
		e multi-dose package before				2
	administering it to the					
		was discontinued and it still				
		AR, the MAs were supposed				
	to document discon	······································				
	-He documented Re	esident #1's Daily-Vite as				
		September 2021 and				
	October 2021 for da					
		hy he documented Resident				
	#1's Daily-Vite as a					i
		ponsible for administering				Ĩ
	Construction of the second	ered and documenting				
	accurately on the re	sident eMARs.				Î.
	Interview with the R	CC on 10/29/21 at 3:14pm				ł
	revealed:					i
		was discontinued, it took the			3	, I
		ng system one to two				
		e medication was removed.				
		nued beside the discontinued				1
	medication on the n	nulti-dose package when it				
	was not removed.					
	-She expected the I	MAs to document disconlinued				
	when a discontinue	d medication still appeared on				
i	the eMAR.					
		nued orders to the pharmacy,				•
	and she removed th	e medication from the eMAR.				50
		he MAs continued to				
	administer Daily-Vit					i i
1		he pharmacy did not have				1
,	Resident #1's disco	ntinued order for Daily-Vite.	1 1			1
	Interview with the Ad	dministrator on 10/29/21 at				12
	5:37pm revealed:	ann an				1
		ontinued medications to be				i
	removed from the m					1
		tesident #1 continued to				
	receive Daily-Vite af					L.

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5H2E13

If continuation sheet 13 of 28

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STATEMENT	Health Service Reg DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			A, BUILUING:		
		HAL092182	B. WING	R 10/29/2021	
NAME OF PR	OVIDER OR SUPPLIER	STREET	ADURESS, CITY, STATE	. ZIP CODE	
DLIVER H	DUSE	4230 WI	ENDELL BOULEVAI	RD	
		······································	LL, NC 27591		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST 8E PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
{D 358}	Continued From page	ge 13	(D 358)		
	Refer to interview w 2:50pm.	ith the RCC on 10/29/21 at			
		ith the Area Director of 10/29/21 at 5:15pm.			
	Refer to interview w 10/29/21 at 5:39pm	ith the Administrator on			:
	10/27/21 revealed a	ent #1's current FL-2 dated medication order for			:
	100 C	d release (DR) (used to treat reflux disease) 20mg one			
ł	01/28/21 revealed a	#1's previous FL-2 dated medication order for capsule take one capsule			
	record revealed:	#1's pharmacy dispense			
	dispensed on 09/24	eprazole 20mg were /21. er dispense dates for			
	omeprazole after 09				
	medication administ revealed:	#1's August 2021 electronic ration record (eMAR)			; {
	one capsule at bedi -There was docume	for omeprazole 20mg take ime, scheduled at 7:00pm. ntation of administration of			
	5	/01/21 to 08/31/21 at 7:00pm.			1
3	revealed: -There was an entry	#1's September 2021 eMAR for omeprazole 20mg take			
!	one capsule at bedti In Service Regulation	me, scheduled at 7:00pm.			

STATE FORM

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5H2E13

If continuation sheet 14 of 28

	OF DEFICIENCIES F CORRECTION	QUIATION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		HAL092182	B. WING	R 10/29/2021	
NAME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	. ZIP CODE	
OLIVER H	OUSE		ENDELL BOULEVA	RD	
			LL, NC 27591		<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLI
(D 358)	Continued From pa	age 14	(D 358)		
		nentation of administration of 09/01/21 to 09/30/21 at 7:00pm.			
	Review of Resider revealed:	nt #1's October 2021 eMAR			
	one capsule at be	ry for omeprazole 20mg take dtime, scheduled at 7:00pm.			
		nentation of administration of 10/01/21 to 10/28/21 at 7:00pm.			Ÿ
	hand on 10/29/21	sident #1's medications on at 8:26am revealed there was			-
	no omeprazole ava	ailable for administration.			
	Interview with Res revealed	ident #1 on 10/28/21 at 7:39am			a 2
	not receive on 10/2				2
		if she had missed other er times during the month of			
		with Resident #1 on 10/29/21			
	at 1:20pm revealed				
	omeprazole. -She thought she r night on 10/28/21.	eceived the omeprazole last			
		w with a pharmacy technician tracted pharmacy on 10/29/21 d:			
	-There was an ord omeprazole 20mg	er dated 8/24/21 for one capsule at bedtime. prazole 20mg was last			
	dispensed on 09/2				
8. 19	placed in multi-dos -Resident #1's ome				

STATE FORM

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5H2E13

If continuation sheet 15 of 28

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER HAL092182		A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED R
	HAL092182	B, WING	10/29/2021	
WAE OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
LIVER HOUSE	4230 WE	ENDELL BOULEVAI	לם	
		LL, NC 27591	· · · · · · · · · · · · · · · · · · ·	
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
(D 358) Continued From p	page 15	{D 358}		
omeprazole from	the facility.			
Interview with a s	econd shift medication aide			
	at 2:51pm revealed:			
	edication not available to	ļ		
	Id the Resident Care			
medication.	c) and tried to reorder the			ĩ
	give the medication before the			4
	it was delivered from the			
	the end of her shift. call administering Resident #1's			
omeprazole.	an aunimatering resident #13			5
Interview with the	RCC on 10/29/21 at 3:14pm			I
revealed:				10 50 24
	re that Resident #1's ast dispensed on 09/24/21.			1
-She did not know	Resident #1 had not received rom 10/25/21 to 10/28/21.			2
-She expected the	e MAs to document not given on			5
the eMAR and the given.	e reason a medication was not			
interview with the	Administrator on 10/29/21 at			
5:37pm revealed	she did not know Resident #1			· E
active states and the second states and the	omeprazole available for			ų.
administration.				9
Refer to interview 2:50pm.	with the RCC on 10/29/21 at			
				i I
	with the Area Director of on 10/29/21 at 5:15pm.			
Refer to Interview 10/29/21 at 5:39p	with the Administrator on m.			
2. Review of Resi 08/17/21 revealed	dent #2's current FL-2 dated diagnoses included dementia,			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL092182	B. WING	10/29/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
OLIVER H	OUSE	4230 WE	NDELL BOULEVA	RD	
			LL, NC 27591		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
(D 358)	Continued From page	ge 16	(D 358)		- Andre - Andre -
	hypertension hyper	lipidemia, transient ischemia			
	attacks, gout, pulmo				
	cerebrovascular acc				
	D				
		#2's physician orders			
	provided by the facil	nty revealed: r dated 08/20/21 for vitamin			*
		amin D3 deficiency) 50mcg			
	(2000 units) take on				
	· · · · · · · · · · · · · · · · · · ·	ntinue order dated 10/28/21			1
	for vitamin D 2000 u				25 21
	for vitamit b 2000 0	and dany.			
	Review of Resident	#2's cart audits for			1
	September 2021 rev	realed there was no vitamin			1
	D3 available on the 09/15/21, and 09/22	medication cart on 09/07/21, /21.			
	Review of Resident	#2's facility dispense record			Ì
		29/21 revealed there was no			ł
	vitamin D3 dispense				- [
	Review of Resident	#2's August 2021 electronic			
		ration record (eMAR)			1
	revealed:				
		for vitamin D3 50 mcg (2000			i
		t daily, scheduled at 8:00am.			1
	-There was docume	ntation of administration of			2
	vitamin D3 from 08/2	21/21 to 08/31/21 at 8:00am.			
		#2's September 2021 eMAR			
:	revealed:	for vitamin D3 50 mcg (2000			
		t daily, scheduled at 8:00am.			1
	-There was docume	ntation of administration of			
;	vitamin D3 from 09/0)1/21 to 09/30/21 at 8:00am.			
	Review of Resident	#2's October 2021 eMAR			l
,	revealed:				i
l	-There was an entry	for vitamin D3 50 mcg (2000			İ
	units) take one table	t daily, scheduled at 8:00am.	1		l l

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5H2E13

If continuation sheet 17 of 28

	OF DEFICIENCIES F CORRECTION	Ulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		HAL092182	B. WING		R 10/29/2021		
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	TADDRESS, CITY, STATE, ZIP CODE				
	OURE	4230 WE	NDELL BOULEVA	RD			
OLIVER H	0056	WENDE	LL, NC 27591				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
{D 358}	Continued From page	ge 17	(D 358)				
	-There was docume	entation of administration of					
		01/21 to 10/27/21 at 8:00am.			20 10		
	Observation of Resi	ident #2's medications on					
	hand on 10/29/21 a	t 8:19am revealed there was					
	no vitamin D availat	ole for administration.					
	* -1. 1. 1. 1						
	-	with a representative at					
		iry care provider's (PCP) it 12:59pm revealed:	1		22		
		e previous provider ordered					
	vitamin D3 for Resid				1		
	-She was not able to	o locate the order in their					
	electronic medical r	ecords because the office had					
		a new electronic records					
	system.	10/00/04			10.		
		10/28/21 requesting a copy der for Resident #2 and she			i		
		he could not locate it.			4		
					2		
	Telephone interview	with a pharmacy technician			6		
		acted pharmacy on 10/29/21			1		
	at 9:27am revealed:				'		
		n order dated 08/19/21 for			į		
		its daily that was keyed into					
	the system for multi	-dose packaging. the dispense dates for			1		
		ig because it was a separate					
	section of the pharn				1		
	-There was no disco	ontinue order for vitamin D3			,		
	on Resident #2's pro	ofile.					
	Telephone interview	with a representative at the			1		
		pharmacy multi-dose					
		n 10/29/21 at 10:01am			i		
	revealed:				1		
		t dispensed for Resident #2			i		
3	because it was on b						
		nin D3 was dispensed in the					
	multi-dose packages atth Service Regulation	S.	<u></u>		<u> </u>		

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5H2E13

If continuation sheet 18 of 28

TATEMENT	Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVE COMPLETED	
	t	HAL092182	B. WING		R 10/29/2021	
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
OLIVER HO	DUSE		NDELL BOULEVA	RD		
			LL, NC 27591			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COM THE APPROPRIATE E	(X5) MPLET DATE
(D 358)	Continued From pag	e 18	{D 358}			
	-The item number for	r Resident #2's vitamin D3				
	had been on back or					
		a monthly cycle fill report				
		residents' medications such				
	as a new order was	needed or out of stock.				
	-She would have ser	nt a note concerning Resident				
	#2's vitamin D3 when	n it was first out of stock to				
	make staff at the fac	ility aware.				
	-She did not have the	e exact date that she sent the				
	facility a note but Re	sident #2's vitamin D3 had			5	
	not been in stock for	at least 3 months.				
	-The facility sent a re	efill request on 08/20/21 and				
	the pharmacy told st	aff at the facility that it was on				
	back order.					
		ew prescription sent on			s	
	08/19/21 from Resid					
		let the facility know weekly				
		tamin D3 was on back order				
	because it was on th	e cycle fill request form.				
	Interview with a med	lication aide (MA) on				
	10/29/21 at 8:15am					
		of vitamin D3 on 10/28/21				
		e Special Care Coordinator			1	
	(SCC).	o 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
		C called the pharmacy			,	
	concerning Resident	#2's vitamin D3.			15	
		in D3 was in an individual			÷	
	packet and was not	in her multi-dose packaging.				
		CC on 10/29/21 at 12:48pm				
	revealed:					
	-The pharmacy faxed	d or emailed the facility when			×	
	there was an issue w	vith a resident's medication. uill-dose package delivery				
	-She received the mi	ecall any notes concerning			1	
3	Resident #2's vitami	n D3				
		bottle of vitamin D3 in the			}	
		room and they used it for				
		· · · · · · · · · · · · · · · · · · ·	6			
	Resident #2's vitamin				i	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING:	ONSTRUCTION		DATE SURVEY
		HAL092182	B. WING			R 10/29/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
OLIVER H	OUSE		NDELL BOULEVAI .L, NC 27591	RD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
(D 358)	Continued From pag	le 19	{D 358}			
	D3 were in the bottle used for Resident #2 vitamin D3. -She did not have th	ow many tablets of vitamin e, when the bottle began to be 2, or who bought the bottle of e empty bottle and she did s for Resident #2's vitamin				
	4:31pm revealed: -She reviewed the ca and October 2021. -She could not find a 2021. -She thought Reside audits indicated no v did not know the bott Resident #2. -She held the MAs re- medications as order					
з	5:37pm revealed she Resident #2 did not h available to administe	ave any vitamin D3 er.				
8		ns, record reviews, and ermined that Resident #2 e.				
	Refer to interview with 2:50pm.	h the RCC on 10/29/21 at				
31	Refer to interview with Clinical Services on 1	h the Area Director of 0/29/21 at 5:15pm.				
	Refer to interview with 10/29/21 at 5:39pm.	n the Administrator on				
3	3. Review of Residen	t #3's FL-2 dated 08/26/21				;

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If continuation sheet 20 of 28

Division of	Health Service Regu	lation			
comparison of the second state of the second state of the	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	DNSTRUCTION	(X3) DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER	A. BUILDING:		COMPLETED
					R
		UAL 002402	B. WING		10/29/2021
<u> </u>		HAL092182			10/29/2021
NAME OF PR	ROVIDER OR SUPPLIER	SIREETA	ODRESS, CITY, STATE	. ZIP CODE	
		4230 WE	NDELL BOULEVA	RD	
OLIVER H	OUSE		LL, NC 27591		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
· · · · ·		······	<u></u>		
{D 358}	Continued From pag	e 20	{D 358}		
	revealed diagnoses i	included high blood pressure,	k		1
		a, and coronary artery			0
	disease.	a, and coronary artory			
					53
	a. Review of Reside	nt #3's FL-2 dated 08/26/21			•
	revealed:				
		for fingerstick blood sugar			L.
	Contraction and Contraction and Contraction of the Contraction	e times a day and at bedtime.			
1		for insulin aspart (Novolog)			1
		used to lower elevated blood			2
ļ	-	subcutaneously (SQ) using a mes a day and at bedlime.			
	and a second	S result for administering the			
	sliding scale insulin	The second			
1	,				l.
	Review of Resident	#3's subsequent primary care			
	provider's (PCP) ord	er dated 08/31/21 revealed:			
		for Novolog inject 5 units SQ			i
	with meals.				1
		to continue Resident #3's			
	(1777)	meals and at bedtime. ions to add the 5 units of			
	Novolog to the Novo				
	mealtimes.	ing out on one of a			
	Review of Resident	#3's PCP's order dated			
		nere was an order for Novolog	} [
	inject 10 units SQ at	lunch.			
		101-0-1			l
1		#3's September 2021			l .
		n administration record			
	 (eMAR) revealed: There was an entry 	for Novolog Inject 5 units SQ			
		reduled for administration at			
	8:00am, 12:00pm, a				
8		ntation Resident #3 did not			į.
		six opportunities between			1
	09/02/21-09/20/21.				i
		S results on those six			ł
L	opportunities ranged	1 from 105-143.	1		l
Division of He	alth Service Regulation				

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TATEMENT	Health Service Region OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			A, BUILDING:		R
		HAL092162	B. WING	10/29/2021	
NAME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
OLIVER H	OUSE	4230 Wi	ENDELL BOULEVA	RD	
OLIVERT		WENDE	LL, NC 27591		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLET D THE APPROPRIATE DATE
(D 358)	Continued From page	ge 21	(D 358)		
		ntation Novolog was not se Resident #3's FSBS			:
	results were below t administration.	the parameters for			
	Review of Resident revealed:	#3's October 2021 eMAR			1
	-There was an entry	r for Novolog inject 10 units led for administration at			i I
		entation Resident #3 did not			
	10/01/21-10/25/21.	four opportunities between			
	occasions ranged fr	S results on those four om 96-142. entation Novolog was not			
		se Resident #3's FSBS			
	administration.				
	10/29/21 at 12:01pr	t shift medication aide (MA) on n revealed: #3 had orders for scheduled			
	insulin and SSI. -Novolog was a fast	eacting insulin and was			-
		ding to parameters. Coordinator (RCC) or to use the parameters when			Ì
	administering fast-a -If the order did not	cting insulin. say "do not hold," he used the			
	-He did not adminis	e administered insulin. ter the scheduled Novolog			
1	when Resident #3's parameters used for	FSBS results were below the r the SSI insulin.			
:	Telephone interview facility's contracted 12:58pm revealed:	with a pharmacist at the pharmacy on 10/29/21 at			
	-There was a differe insulin and SSI.	nce between scheduled			

Division of Health Service Regulation STATE FORM

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6899

5H2E13

If continuation sheet 22 of 28

STATEMENT	f Health Service Rep of Deficiencies F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SI COMPLE	
					R 10/29/2021	
	8	HAL092182	B. WING			
NAME OF PROVIDER OR SUPPLIER STREET		STREET A	DDRESS, CITY STATE		i ioizoizozi	
			NDELL BOULEVA			
OLIVER H	OUSE		L, NC 27591			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	۱D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRU DEFICIENCY)	E NTE	COMPLE
{D 358}	Continued From pa	age 22	{D 358}			
		was to be administered at the				
	ordered times.		1			
		not given based on the FSBS	1			
	results and the ord administration.	ered parameters for				
	aurumstration.					
	Interview with Resi	dent #3 on 10/29/21 at 1:28pm				
		t know the specifics of his				
	insulin orders.					
	Interview with the F	RCC on 10/29/21 at 2:50pm				
	revealed:					
		eduled Novolog insulin was to				
		dependent of the SSI				
	parameters.	ave known how to administer				
	scheduled insulin.	ave known now to administer				
		ived training on diabetes care				
	within the last six m	1975				
	-She reviewed the	eMARs whenever she had	}			
	time, but eMARs wi	ith insulin orders should have				
	been reviewed daily					
		ber the last time she				
	reviewed Resident	#3's emars. o be reeducated on	i I			
	administering sched					
	fataa isuu uith tha A	desirial-read as 10/20/21 at				
	5:39pm revealed:	dministrator on 10/29/21 at				
		sident #3 was supposed to be			1	8
		heduled Novolog insulin at the				
		endent of the parameters for				
	the SSI.				1	
		pe held if it was written as a			12	
	scheduled medicati				1	
		administering scheduled	1		3	
	insulin was commun in-service training in	nicated to the staff during the			R	
		ther individual training with				
	the Area Director of				1	
	In Service Regulation					

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5H2E13

If continuation sheet 23 of 28

Division o	f Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING.		COMPLETED
					R
		HAL092182	B. WING		10/29/2021
MANE OF D	ROVIDER OR SUPPLIER	·			10/23/2021
NAME OF PI	ROVIDER OR SUPPLIER		ODRESS, CITY, ST		
OLIVER H	OUSE		NDELL BOULE .L, NC 27591	VARD	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC) REGULATORY OR (Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETE
(D 358)	Continued From page	23	{D 358}		
	-The RCC was respo	nsible for the daily review of			
	insulin administration	-			
	-The RCC had not rep	ported any concerns with			
	insulin administration	to her.	1		ł
			1		
	RCP on 10/20/21 of 1	interview with Resident #3's			
	Refer to the interview	:58pm was unsuccessful. with the RCC on 10/29/21			
	at 2:50pm.	with the RCC off 10/29/21			
			1		
	Refer to interview will				
	Clinical Services on 1	0/29/21 at 5:15pm.	1		
	Pefer to intension will	h the Administrator on			
	10/29/21 at 5:39pm.	i ine Administrator on			
		t #3's FL-2 dated 08/26/21			e a
		n order to weigh the resident			
	daily.				
	Review of Resident #	3's subsequent primary care			
	provider's (PCP) orde	r dated 09/23/21 revealed	1		
	there was an order for	r furosemide (used to treat			2
ļ	fluid retention) 20mg (take one tablet daily as			
		ht gain of 3 pounds was			
	noted.				
	Review of Resident #	3's September 2021			1
	electronic medication	administration record			
	(eMAR) revealed:				
	-There was an entry for				
	one tablet daily as not	or furosemide 20mg take eded for weight gain of 3			
	pounds or more in a d	av.			
		ation Resident #3 had a			92 19
	weight gain of 6 pound	ds in one day.			
i	-There was no docum				2
	received furosemide a	is ordered.			
	Review of Resident #3	3's October 2021 eMAR			
Division of Hea	Ith Service Regulation		<u> </u>		<u> </u>

STATE FORM

5H2E13

6499

If continuation sheet 24 of 28

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Division of Health Service Rep Statement of Deficiencies and plan of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
	HAL092182	B. WING		R 10/29/2021	
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			
		ENDELL BOULEVA			
DLIVER HOUSE		LL, NC 27591	λD		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE COMPLE HE APPROPRIATE DATE	
(D 358) Continued From page	je 24	(D 358)			
	<u> </u>	,,			
revealed:					
-There was an entry					
	for furosemide 20mg take seded for weight gain of 3				
pounds or more in a					
-On two dates, there	and a second				
	eight gain of 3 pounds in one				
day.	reight gain of a position in one				
_	ntation Resident #3 had a				
weight gain of 4 pour					
	mentation Resident #3				
received furosemide					
Observation of Resid	lent #3's medication				
available for administ	tration on 10/29/21 at				
11:49am revealed:					
-There were 27 of 30	furosemide 20mg tablets in				
a punch card.					
-The label on the pun					
pharmacy dispansed	30 furosemide 20mg tablets				
on 09/23/21.				5	
Interview with the me	diantion aida (MA) on			²⁰	
10/29/21 at 12:01pm				3	
-He weighed Residen					
	he previous day's weight in				
the eMAR.	te previous days weight int	1			
	sident Care Coordinator			3	
	as a gain or loss of at least				
two pounds.				1	
	he PCP and then let the MA	1			
know if the PCP wante					
Furosemide.		1		, r	
	tot given without notifying				
the PCP.					
	administering furosemide	1			
to Resident #3.				n	
}					
Interview with Resident	#3 on 10/29/21 at 1:28pm				
revealed:		1			

Division of Health Service Regulation STATE FORM

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6599

5H2E13

If continuation sheet 25 of 28

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL092182	B. WING		R 10/29/2021	
AME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS. CITY, STATE	, ZIP CODE		
LIVER H	OUSE		NDELL BOULEVA	RD		
(X4)10	SUMMARY ST	ATEMENT OF DEFICIENCIES	LL, NC 27591	PROVIDER'S PLAN OF CORRECT		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 8E COMPLETE	
(D 358)	Continued From page 25		(D 358)			
	-Staff did not tell him how much he weighed each day.					
	-He did not know he had an order for a					
	medication used to treat fluid retention.					
	Interview with the RC revealed:	CC on 10/29/21 at 2:50pm				
	-She expected the MA to administer the					
	furosemide as ordered.					
	-The MA should have administered the				1	
	furosemide when Resident #3 had a weight gain of at least three pounds in one day.					
	-The eMAR system had a tab listing all					
	medications that were ordered to be administered					
	as needed.					
	-The MA should have known about Resident #3's					
	furosemide order.					
	-The MA was responsible for conducting weekly		!			
	cart audits and should have been familiar with Resident #3's medication orders.					
		ation orders. esident #3 had an order for				
	furosemide and adm					
	documenting on the					
		per the last time she audited				
	Resident #3's eMAR					
	Interview with the Ad 5:39pm revealed:	ministrator on 10/29/21 at			6 g	
	-Resident #3 should	have received the				
		e PCP said not to administer			3	
	it to him.					
	-The MA was respon	sible for weighing Resident				
		the previous day's weight.				
	-The MA was expect order.	ed to follow the medication				
		e furosemide but did not			i	
	document it.					
	-The MA needed furt	her individual training with				
	the Area Director of C		i			

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5H2E13

If continuation sheet 26 of 28

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION HAL092182		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED	
		B. WING	R 10/29/2021		
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STATE	ZIP CODE	
DLIVER H	OUSE			RD	
(NA) (D	SINHADY C		L, NC 27591		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLET
(D 358)	Continued From pag	je 26	{D 358}		
		e interview with Resident #3's 1:58pm was unsuccessful.			
	Refer to interview wi 2:50pm.	ith the RCC on 10/29/21 at			
		ith the Area Director of 10/29/21 al 5:15pm.			
	Refer to interview wi 10/29/21 at 5:39pm.	ith the Administrator on			
		CC on 10/29/21 at 2:50pm e she reviewed an eMAR eks ago.			
	Services on 10/29/2	ea Director of Clinical 1 at 5:15pm revealed:			
	-The training topics i	the MAs on 08/27/21. Included counting narcotics,			
	documentation, verb	ers, taking vital signs, al orders, ordering tside pharmacies, refused			
9	medications, and car -She also observed i administering medica	the MAs while they were			1
		n all the information they r medications accurately.			
15	5:39pm revealed:	Iministrator on 10/29/21 at			
	according to state ru accordance with the				ł
1	additional training to reviewed their skills.	f Clinical Services provided the MAs on 08/27/21 and			
ļ	-She did not review e -She expected the R				ĺ

Division of Health Service Regulation STATE FORM

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5H2E13

6899

If continuation sheet 27 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092182		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED R 10/29/2021	
		B. WING					
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			23/2021	
OLIVER H	OUSE		ENDELL BOULEVA				
			LL, NC 27591				
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION				
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		(X5) COMPLE	
	· · · · · · · · · · · · · · · · · · ·		140	DEFICIENCY	HE APPROPRIATE ()	DATE	
{D 358}	Continued From page 27		{D 358}	······································	<u> </u>		
		o report any medication					
	administration conce	erns to her.					
	-The MA was respon	sible for the accurate					
	administration of me	edications.				1	
	1						
	-						
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