STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050016	A. BUILDING: _____ B. WING _____	R-C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR ASSISTED LIVING	95 MORNINGSTAR LANE SYLVA, NC 28779

(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 a follow-up survey on 04/05/22.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: This rule area is still out of compliance, see State 2567 at Event ID # XG4011, dated 02/01/22. Based on observations, interviews, and record review, the facility failed to administer medications as ordered by the Primary Care Provider (PCP) for 1 of 5 sampled residents (Resident #5). The findings are: Review of Resident #4's current FL-2 dated 03/10/22 revealed: -Diagnoses included anxiety, paranoia, and post-traumatic stress disorder (PTSD). -There was an order for Depakote ER (medication used as a mood stabilizer) 250mg one tablet every morning. -There was an order for Depakote ER 500mg three tablets (1500mg total) every morning. Review of Resident #4's Psychiatric Initial Consult	{D 358}		

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{D 358}	Continued From page 1 dated 03/09/22 revealed an order for Depakote 250mg by mouth at 2:00pm daily in addition to morning dose for mood. Review of Resident #4's physician's orders dated 03/10/22 revealed an order for Depakote 250mg by mouth at "1400" daily for mood. Review of Resident #4's March 2022 electronic Medication Administration Record (eMAR) revealed: -An entry for Depakote ER 250mg one tab every morning at 8:00am. -An entry for Depakote ER 500 mg three tabs every morning at 8:00am. -There was no entry for Depakote 250mg at 2:00pm daily. -There was no documentation Depakote 250mg at 2:00pm daily was administered. Review of Resident #4's April 2022 electronic Medication Administration Record (eMAR) revealed: -An entry for Depakote ER 250mg one tab every morning. -An entry for Depakote ER 500 mg three tabs every morning. -There was no entry for Depakote 250mg at 2:00pm daily. -There was no documentation Depakote 250mg at 2:00pm daily was administered. Review of the facility's procedures for approving orders revealed: -A medication aide (MA) had signed off on an undated form that she had verified Depakote 250mg was available for administration at 2:00pm daily in the facility for Resident #4. -This verification included the medication was available in the facility for administration.	{D 358}		

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{D 358}	Continued From page 2 -The MA had also signed off that the administration time of 2:00pm daily had been verified and added to the eMAR to reflect the physician's order. Observations of Resident #4's medications on hand on 04/04/22 at 11:30am revealed: -There was a bubble pack of Depakote ER 250mg labeled with instructions to administer one tablet every morning. -There was a bubble pack of Depakote ER 500mg labeled with instructions to administer three tablets every morning. -There was not a bubble pack of Depakote 250mg labeled with instructions to administer one tablet at 2:00pm daily. Interview with a Medication Aide (MA) on 04/04/22 at 11:51am revealed: -Resident #4 only received Depakote 250mg in the morning. -She was not aware of medication orders for Resident #4 to receive an additional dose of Depakote 250mg at 2:00pm daily. Interview with a second MA on 04/04/22 at 11:57am revealed: -She had verified the Depakote 250mg at 1400 daily per the physician's order. -She had verified the administration time for the Depakote. -She was unable to state what time 1400 was. -She did not know 1400 was military time and was 2:00pm. -She was sure she had faxed the order to the pharmacy. -She did not know why the pharmacy had not put the order on the MAR. Interview with the Administrator on 04/04/22 at	{D 358}		

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{D 358}	Continued From page 3 1:17pm revealed: -When a new medication order was received, the MA was supposed to fax it to the pharmacy. -The MA should then document the date and his or her initials on the order to indicate the order was faxed to the pharmacy. -When medications were received from the pharmacy the MA was supposed to check it against the copy that was faxed to the pharmacy and the delivery sheet for verification. -The order for Depakote 250mg at 2:00pm was faxed to the pharmacy and the pharmacy sent back a fax on 03/10/22 requesting the facility clarify the order for Depakote 250mg at 2:00pm was in addition to the morning dose of Depakote ER 250mg and Depakote ER 500mg three tablets and, if so, was the 2:00pm dose of Depakote 250mg ER (extended release) or DR (delayed release). Telephone interview with a Pharmacist from the facility's contracted pharmacy on 04/04/22 at 2:15pm revealed: -On 03/10/22, a new order was received from the facility via fax for Resident #4 for Depakote 250mg at 2:00pm. -A fax was sent back to the facility on 03/10/22 requesting to clarify if the Depakote 250mg was in addition to the morning dose of Depakote ER 250mg and Depakote ER 500mg three tablets and, if so, was it supposed to be ER or DR. -When a response from the facility was not received on 03/10/22, they followed up with a telephone call on 03/11/22 and left a voice mail message requesting the clarification for the order. -On 03/31/22, the pharmacy received a telephone call from staff at the facility with verbal confirmation the Depakote 250mg dose at 2:00pm daily was in addition to the morning dose of Depakote ER 250mg and Depakote ER 500mg	{D 358}		

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{D 358}	Continued From page 4 three tablets. -The pharmacy never received confirmation on whether the Depakote 250mg dose at 2:00pm was extended release or delayed release. -Normal time for clarification of orders for the facility is usually 3 to 4 days, but no more than 7 days. Telephone interview with Resident #4's Primary Care Provider (PCP) on 04/04/22 at 2:22pm revealed: -She wrote the original order for Resident #4 for Depakote 250mg at 2:00pm daily on 03/10/22. -The facility staff faxed the orders to the pharmacy for Resident #4. -She received a request from facility staff on 03/22/22 that clarification of the order was needed. -She called the facility on 03/22/22 and clarified that the original order was for Depakote 250mg at 2:00pm daily was in addition to the morning dose and should be delayed release. -She was unable to recall who she spoke to at the facility. -She would neither confirm not deny Resident #4 should have been receiving the Depakote 250mg DR at 2:00pm as ordered on 03/10/22. A second interview with the Administrator on 04/04/22 at 3:08pm revealed: -The Resident Care Coordinator (RCC) was responsible for clarification of orders. -They currently did not have an RCC so she or the Administrative Assistant were responsible for assuring new medication orders were correct.	{D 358}		