STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Martin County Department of Social Services conducted a follow-up survey and complaint investigation on August 23, 2022 to August 24, 2022. The complaint investigations were initiated by the Martin County Department of Social Services on August 12, 2022 and August 19, 2022.	D 000	Responses to the cited defeciencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth. In the statement of defeciencies; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider was notified for 4 of 5 residents sampled including a resident with tooth pain (#3), a blood sugar below the ordered parameters (#5), a resident that did not have their medications available for administration (#4), and blood sugars that were not completed because of lack of testing supplies (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 11/01/22 revealed diagnoses included type 2 diabetes, fall risk, cervical degeneration, and clavicle fracture. Interview with Resident #3 on 08/23/22 at 3:00pm revealed: -She was experiencing tooth pain and swelling for a few weeks. -She notified the Resident Care Coordinator (RCC) of her tooth pain, but she could not recall	D 273	10A NCAC 13F .0902(b) Health Care The Executive Director (ED) and Care Coordinator (CC) have conducted audits on all current residents to ensure any unmet healthcare follow-up need will be met immediately. 8/26/2022 The ED and CC will review activity reporting to include new orders, medication administration, and electronic medication administration compliance reporting daily in stand-up and report andy abnormal findings to the Primary Care Provider(PCP). 8/25/2022 The CC will conduct weekly cart audits against the EMAR to the medication cart to ensure accuracy. 8/29/2022 The ED and CC will review resident parameters daily during stand-up to ensure any out of range have been reported to the PCP. 8/25/2022 In-service was completed on Health Care follow-up with all staff by Area Clincal Director, RN on 9/7/2022. 9/7/2022 Resident Rights training completed with all staff by Area Clinical Director, RN 9/7/2022. 9/7/2022	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Stefanie N Jeman ED TITLE (X6) DATE 9-10-4-2022

Reviewed and Acknowledged RJK 10/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 273	Continued From page 1 when she told her. -She was told by the RCC that she could not get an appointment with the dentist until December 2022, which was 3 months away and she could not stand the pain for that long. -Staff sometimes gave her Tylenol but she was on pain medication for chronic pain (Tylenol is a medication used to treat mild pain). -Tylenol did not relieve her tooth pain and she notified the RCC that the Tylenol was not effective. Interview with the RCC on 08/24/22 revealed: -She notified Resident #3's on call provider of the resident's tooth pain on 08/21/22 at 1:16pm via a cellular phone notification application. -The on-call provider told the RCC that the resident would be assessed on site 08/24/22 by the primary care provider (PCP) and that until then she could not receive any additional pain medication. -The PCP did not come to the facility on 08/24/22 for a routine visit and staff was not aware that the PCP would not be coming to the facility. -She did not reach out to the provider covering for the PCP to notify them that she was not seen by the PCP on 08/24/22. -It was her responsibility to notify the provider covering for Resident #3's PCP that the resident was experiencing tooth pain and needed to be evaluated by a provider. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -The staff was under the impression that Resident #3 would be seen by the PCP today (08/24/22) and they were not aware that she was not going to be in the facility on 08/24/22. -Staff should have notified her and she could have tried different dentist offices to get an	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 273	Continued From page 2	D 273		

appointment sooner.
-She was not aware that staff had not reached out to the on-call provider once they realized that the PCP was not coming to the facility today.
-She would have expected the RCC to reach out to the on-call provider to notify them of Resident #3's continued tooth pain.
-If she was aware of the resident's tooth pain, she could have asked the Area Clinical Director, who was a registered nurse and who was on-site 08/24/22, to assess the resident and call the on-call provider.

Telephone interview with Resident #3's PCP on 8/24/22 at 1:23pm revealed:
-She was on vacation this week (08/22/22 through 08/26/22) and the facility was being covered by another provider for the company.
-She was not aware of Resident #3's tooth pain.

Attempted telephone interview with the facility's contracted provider covering for Resident #3's PCP on 08/24/22 at 12:04pm and 1:17pm were unsuccessful.

2. Review of Resident #5's current FL-2 dated 04/27/22 revealed diagnoses included Type 2 diabetes mellitus.

Review of Resident #5's physician order sheet dated 08/22/22 revealed there was an order to check fingerstick blood sugar (FSBS) daily notify primary care provider (PCP) if FSBS less than 70 or greater than 250.

Review of Resident #5's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS daily and notify PCP if FSBS less than 70 or greater than

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 273	Continued From page 3 250 scheduled for 7:30am. -Resident #5's FSBS was documented as 41 on 07/19/22. Review of Resident #5's progress notes revealed there was no documentation that Resident #5's PCP had been notified of the FSBS of 41 on 07/19/22. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:47pm revealed: -MAs were expected to notify the PCP of FSBS as ordered and document that they notified the PCP. -There was a phone application that was used to communicate with PCPs and there was no documentation on the application that a MA had notified the PCP of Resident #5's FSBS of 41 on 07/19/22. -The MA who failed to report the FSBS of 41 was no longer employed at the facility. Interview with the Administrator on 08/24/22 at 3:45pm revealed she expected the MA to notify Resident #5's PCP of her FSBS of 41 as ordered. Interview with Resident #5's PCP on 08/24/22 at 1:23pm revealed: -She expected to be notified that Resident #5 had a FSBS below 70. -She did not recall being notified by the facility that Resident #5 had a FSBS of 41. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. 3. Review of Resident #4's current FL-2 dated 06/30/22 revealed: -Diagnoses included Alzheimer's disease,	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 273	Continued From page 4 hypertension, and lumbar disc degeneration. -There was an order for Neurontin 100mg twice a day (Neurontin is a medication used to treat nerve pain). -There was an order for Omeprazole 40mg daily (Omeprazole is a medication used to treat reflux disease). Review of Resident #4's Resident Register revealed an admission date of 07/18/22. Review of Resident #4's physician's clarification orders dated 07/18/22 revealed: -There was an order for Lisinopril 30mg daily (Lisinopril is a medication used to treat high blood pressure). -There was an order for Vitamin D3 125mcg daily (Vitamin D3 is a supplement used to treat Vitamin-D deficiency). -There was an order for Vitamin B12 1,000mcg daily (Vitamin B12 is a supplement used to treat Vitamin-B deficiency). -There was an order for Nitrofurantoin 100mg daily (Nitrofurantoin is a medication used to treat and/or prevent urinary tract infections). Review of Resident #4's August 2022 electronic medication record revealed: -There was an entry for Neurontin 100mg twice a day, scheduled for administration at 8:00am and 8:00pm. -Neurontin 100mg was not documented as administered on 07/20/22 at 8:00pm or 07/21/22 at 8:00am. -There was an entry for Omeprazole 40mg daily, scheduled for administration at 7:30am. -Omeprazole 40mg was not documented as administered on 07/21/22 at 7:30am. -There was an entry for Lisinopril 30mg daily, scheduled for administration at 8:00am.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 273	Continued From page 5 -Lisinopril 30mg was not documented as administered on 07/21/22 at 8:00am. -There was an entry for Vitamin D3 125mcg daily, scheduled for administration at 8:00am. -Vitamin D3 125mcg was not documented as administered on 07/21/22 at 8:00am. -There was an entry for Vitamin B12 1,000mcg daily, scheduled for administration at 8:00am. -Vitamin B12 1,000mcg was not documented as administered on 07/21/22 at 8:00am. -There was an entry for Nitrofurantoin 100mg daily, scheduled for administration at 8:00am. -Nitrofurantoin 100mg was not documented as administered on 07/21/22 at 8:00am. Telephone interview with Resident #4's family member on 08/24/22 at 1:09pm revealed: -The resident arrived at the facility on 07/18/22 with her medications. -Some of the resident's medications were nearing the last of the pills in the bottles but he was not sure which ones. -The resident now used the facility's pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/24/22 at 10:27am revealed: -They received admission orders for Resident #4 on 07/18/22 and they were entered into the resident's medication profile by the pharmacy on 07/18/22. -The pharmacy received a fax on 07/21/22 stating the resident was at the facility and needed her medications dispensed. -The pharmacy sent her medications to the facility the evening of 07/21/22. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:45pm revealed: -She was not aware that it was documented that	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 273	Continued From page 6 Resident #4 did not receive 6 of her medications on 07/21/22 and 1 of her medications on 07/20/22. -She would have expected staff to notify her and the primary care provider if the resident did not have medications available for administration. -If the medications were administered as ordered she would have expected it to be documented on the eMAR. Interview with the facility's Administrator on 08/24/22 at 3:45pm revealed: -Resident #4 came to the facility with medication. -She was not aware that it was documented that Resident #4 did not receive 6 of her medications on 07/21/22 and 1 of her medications on 07/20/22. -She would have expected staff to notify the RCC or her and the primary care provider if the resident did not have medications available for administration. -She would have expected staff to document notification to the PCP of the resident not receiving their medication. Review of Resident #4's facility progress notes on 07/20/22 and 07/22/22 revealed there was no documentation notifying the provider of the resident missing medications. Interview with Resident #4's primary care provider on 08/24/22 at 1:23pm revealed she expected to be notified if residents did not have medications available for administration. Based on observation, interviews, and record reviews, it was determined Resident #4 was not interviewable. 4. Review of Resident #1's current FL-2 dated	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 273	Continued From page 7 11/01/21 revealed: -Diagnoses included type 2 diabetes. -There was an order for finger stick blood sugars (FSBS) in the morning, with instructions to notify the primary care provider (PCP) for blood sugar less than 70 or greater than 250. Review of Resident #1's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS every morning, with instructions to notify the PCP for blood sugar less than 70 or greater than 250, scheduled for 6:30am. -There was no documentation of a FSBS being done on 07/12/22 at 6:30am or 07/13/22 at 6:30am, with reason stated as "no test strips". Attempted interview with the MA on 08/24/22 at 2:00pm was unsuccessful. Interview with Resident #1 on 08/23/22 at 2:50pm revealed the MAs checked her blood sugars in the morning and she could not remember if they checked it every morning. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:46pm revealed: -She was not aware that Resident #1 did not get her blood sugar checked on 07/12/22 and 07/13/22. -She expected the staff to notify her if there were no test strips available, but she was not aware of a time when there were no testing strips available for Resident #1. -She would have expected the PCP to be notified if they were not able to obtain a blood sugar for Resident #1. -The facility had extra glucometers and testing supplies available for use if a resident ran out of	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 273	Continued From page 8 supplies. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -It was the RCC's responsibility to ensure that diabetic supplies were available for FSBS monitoring. -She was not aware of a time that there was not test strips available for Resident #1. -She expected staff to notify her or the RCC and the PCP if they were not able to obtain a FSBS for Resident #1. Telephone interview with Resident #1's PCP on 08/24/22 at 1:23pm revealed: -She did not recall being notified that the facility was not able to check Resident #1's FSBS. -She would have expected the facility to notify her if they were not able to check Resident #1's FSBS as ordered. -Resident #1 did not have any parameters for insulin administration related to her FSBS.	D 273		
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: FOLLOW-UP TO TYPE A1 VIOLATION.	D 358	10A NCAC 13F .1004(a) Medication Administration The CC will utilize the "Order Processing System" to assure all medications are available. The CC will conduct weekly cart audits against the EMAR to the medication cart to ensure accuracy. The Area Clinical Director, RN has in-serviced all Medication staff on Medication Administration to include the six rights of medications, documentation and medication errors to include the "order Processing System." The Area Clinical Director, RN will conduct random Med Tech Observation med passes during on-site visits.	8/29/2022 8/29/2022 9/7/2022 9/7/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 9 The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#6, #7) observed during the medication pass including errors with a medication used to treat diabetes (#7) and an inhaled medication used to treat asthma (#6); and for 5 of 5 residents sampled for record review (#1, #2, #3, #4, #5) including an antibiotic used to treat infection (#2), medications used to treat nerve pain (#2, #4), a medication used to treat low blood sugar (#1, #5), medications used to treat schizophrenia (#3, #5), a medication used to treat pain (#3), a medication used to treat low potassium levels (#3, #5), a medication used to reduce extra fluid in the body (#3), a medication used to reduce the risk of urinary tract infection (#4), vitamins (#4), a medication used to treat high blood pressure (#4), and a medication used to lower cholesterol levels (#5). 1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 26 opportunities during the 8:00am medication pass on 08/23/22. a. Review of Resident #6's current FL-2 dated 01/22/22 revealed: -Diagnoses included vitamin D deficiency and hyponatremia (low sodium levels). -There was an order for Advair Diskus 250-50mcg, 1 puff by inhalation twice a day with instructions to complete the electronic medication	D 358	Community ED and CC will review Matrix Care Medication Reporting daily in stand up to ensure order clarification. Community will ensure that all medications and treatments are administered as ordered. Community Area Clinical Director and Regional Director of Operations(RDO) will review medication cart audits and pull Medication Administration Report from Matrix Reporting during on-site visits. The Area clinical Director, RN completed Resident Rights training with all staff on 9/7/2022.	8/25/2022 8/29/2022 8/29/2022 9/7/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 10 administration record (eMAR) with packaging information (Advair Diskus is a medication used to prevent symptoms of asthma and chronic obstructive pulmonary disease. The manufacturer recommendations include to rinse mouth out after administration). Observation of the 8:00am medication pass on 08/23/22 revealed: -The medication aide (MA) prepared morning medications for Resident #6, including an Advair Diskus. -The MA primed the Advair Diskus and handed it to Resident #6. -The resident inhaled the medication at 8:10am. -The resident handed back the Advair Diskus to the MA. -The MA did not offer the resident water to rinse his mouth. Review of Resident #6's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Advair Diskus 205-50mcg with instructions to inhale 1 puff and a reminder to rinse mouth and spit out after each use, scheduled for administration at 8:00am and 8:00pm. -Advair Diskus 250-50mcg was documented as administered on 08/24/22 at 8:00am. Observation of Resident #6's medications on hand revealed: -There was an Advair Diskus with printed instructions on the box to inhale 1 puff twice a day and reminder to rinse after each use and date when opened. -There was an additional yellow pre-printed sticker from the pharmacy that said "rinse mouth after each use".	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 11 Interview with Resident #6 on 08/23/22 at 3:00pm revealed: -The resident did not recall if he rinsed his mouth out after using his Advair Diskus but he usually took that inhaler before he swallowed his other medications. -He did not have any sores in his mouth. Interview with the MA on 08/23/22 at 1:25pm revealed: -Resident #6 often refused to rinse his mouth after taking his Advair Diskus. -She should have followed the medication instructions on the eMAR and medication label that stated to rinse mouth after inhaling. -She did not offer Resident #6 water to rinse his mouth out after using his Advair. Interview with the Resident Care Coordinator (RCC) on 08/23/22 at 1:40pm revealed: -She expected the MA to administer medications as ordering including Resident #6. -The MA should have offered Resident #6 water to rinse his mouth out after use. Interview with the Administrator on 08/23/22 at 1:55pm revealed she expected staff to administer medications as ordered and to review the reminders on the eMAR and medication label that state to rinse mouth after use. Telephone interview with Resident #6's primary care-provider (PCP) on 08/24/22 at 1:23pm revealed: -She expected the MAs to offer Resident #6 water to rinse his mouth out after Advair Diskus administration. -It was important for Resident #6 to rinse out his mouth so that he did not get thrush which is a	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 12 type of infection that can occur with inhaled medications. b. Review of Resident #7's current FL-2 dated 02/14/22 revealed diagnoses include diabetes mellitus. Review of Resident #7's physician orders dated 07/19/22 revealed there was an order for Tresiba FlexTouch pen, administer 25 units daily (Tresiba is long-acting insulin used to manage symptoms of diabetes). Observation of the 8:00am medication pass on 08/23/22 revealed: -The medication aide prepared Resident #7's Tresiba FlexTouch pen by dialing up the dosage to 25 units at 8:19am. -She then removed the cap of the Tresiba FlexTouch pen and attached a needle. -The MA administered 25-units of Tresiba FlexTouch Pen insulin into Resident #1's left upper arm at 8:21am. -The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle and that the resident received the full dose of insulin. Review of the prescribing information from the Tresiba FlexTouch pen manufacturer revealed: -After the needle was attached, a safety test should have been performed. -The safety test is performed by dialing a test dose of 2 units. -Press the injection button and check to see that insulin comes out of the needle. Review of Resident #7's August 2022 electronic medication administration record (eMAR)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 revealed: -There was an entry for Tresiba FlexTouch pen with instructions to inject 25 units daily, scheduled for administration at 8:00am. -Tresiba FlexTouch pen 25 units was documented as administered in the left upper arm on 08/23/22 at 8:00am. Interview with Resident #7 on 08/23/22 at 3:12pm revealed she was a diabetic and the MAs administered her insulin after preparing it at the medication cart. Interview with the MA on 08/23/22 at 1:20pm revealed: -She was trained with the insulin pens to prime the pen before dialing the number of units administered to ensure that the resident received all of the insulin. -She normally primed the Tresiba FlexTouch pen but was nervous today and forgot to prime the insulin pen. Interview with the Resident Care Coordinator (RCC) on 08/23/22 at 1:40pm revealed she expected MAs to prime Resident #7's insulin pen as trained in order for the resident to receive the full amount of insulin ordered. Interview with the Administrator on 08/23/22 at 1:55pm revealed she expected MAs to administer Resident #7's medications according to manufacturer's guidelines and prime the insulin pen as-trained. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/24/22 at 10:27am revealed it was important for insulin pens such as Tresiba to be primed so that residents receive the full ordered dose of units.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 14 Telephone interview with Resident #7's primary care provider (PCP) on 08/24/22 at 1:23pm revealed: -She expected the MAs to administer Resident #7's Tresiba FlexTouch pen per the manufacturers guidelines. -If an insulin pen was not primed according to the manufacturer's directions the resident may not receive the full ordered dose which could cause elevated blood sugars. 2. Review of Resident #2's current FL-2 dated 04/19/22 revealed he had diagnoses included chronic urinary tract infection (UTI) and peripheral neuropathy (Peripheral neuropathy is weakness, numbness, and pain cause by nerve damage). a. Review of Resident #2's hospital discharge instructions dated 08/21/22 revealed: -He was seen in the emergency department (ED) on 08/21/22 and diagnosed with dehydration and UTI. -He received a prescription for Cipro 500mg take 1 tablet every 12 hours for 7 days. (Cipro is an antibiotic used to treat UTIs.) Review of Resident #2's August 2022 electronic medication administration record (eMAR) on 08/23/22 revealed: -There was an entry for Cipro 500mg every 12 hours for 7 days to be administered at 8:00am and 8:00pm. -Cipro 500mg was documented as "on hold" at 8:00am on 08/22/22 and 08/23/22. -The 8:00pm dose of Cipro 500mg on 08/23/22 was documented as "X" with no explanation. Interview of Resident #2 on 08/24/22 at 10:55am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 15 -He was sent to the ED on 08/21/22 because he was confused. -He was diagnosed with a UTI at the ED and received intravenous (IV) antibiotics while there. -He was prescribed Cipro for his UTI, and he thought the facility was administering the Cipro to him. Observation of Resident #2's medications on hand on 08/24/22 at 1:55pm revealed: -There was no Cipro on the medication cart for Resident #2. -The medication aide (MA) went into another room and brought out a bag from the pharmacy that was stapled shut. -The MA opened the bag which contained a bottle of Cipro showing there were 14 pills of Cipro 500mg dispensed for Resident #2 on 08/24/22. Interview with a MA on 08/24/22 at 1:57pm revealed: -The facility had just received Resident #2's Cipro from the pharmacy. -Resident #2 had not been administered Cipro yet because the Resident Care Coordinator (RCC) had to approve the medication before it could be placed on the medication cart. Interview with the RCC on 08/24/22 at 2:47pm revealed: -Resident #2 did not get his medications from the facility's contracted pharmacy and used another pharmacy. -A MA faxed Resident #2's prescription for Cipro to his pharmacy on 08/22/22. -A MA called the pharmacy on 08/23/22 and the Cipro had not been dispensed yet. -There was no documentation that the MA had called the pharmacy. -The MA should have documented that she called	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 16 the pharmacy to see if Resident #2's Cipro had been dispensed. -The RCC called the pharmacy on the morning of 08/24/22 and the Cipro had been dispensed. -Someone from the facility picked up Resident #2's Cipro from the pharmacy on 08/24/22. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -Resident #2 received a paper prescription for the Cipro in his ED discharge packet. -The prescription should have been taken to the pharmacy by someone at the facility on 08/22/22. -If the prescription was taken to the pharmacy and was not filled the same day, someone should have made her aware. Telephone interview with a pharmacist at Resident #2's pharmacy on 08/24/22 at 4:31pm revealed: -Someone from the facility called and spoke to him on the morning of 08/24/22 about Resident #2's prescription for Cipro. -He made them aware that the pharmacy had not received a prescription for Cipro for Resident #2. -After speaking with someone from the facility on the phone, a prescription for Resident #2's Cipro was brought to the pharmacy on 08/24/22. -Resident #2's prescription for Cipro was dispensed at 9:33am on 08/24/22 and was picked up at 1:39pm on 08/24/22. Telephone interview with Resident #2's primary care provider (PCP) on 08/24/22 at 1:23pm revealed: -She expected Resident #2 to receive his Cipro within one day of it being prescribed. -A delay in getting the Cipro could cause Resident #2's UTI to worsen.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 17 b. Review of Resident #2's current FL-2 dated 04/19/22 revealed there was an order for Lyrica 75mg three times a day (Lyrica is used to treat pain caused by nerve damage). Review of Resident #2's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lyrica 75mg scheduled to be administered three times a day at 8:00am, 2:00pm, and 8:00pm. -Lyrica 75mg was documented as "on hold" at 8:00am on 07/17/22-07/25/22. -Lyrica 75mg was documented as "on hold" at 2:00pm on 07/17/22-07/24/22. -Lyrica 75mg was documented as "on hold" at 8:00pm on 07/16/22-07/24/22. -Resident #2 did not receive 26 consecutive scheduled doses of Lyrica 75mg in July 2022. Review of Resident #2's primary care provider (PCP) orders revealed there were no orders to hold Lyrica 75mg. Review of Resident #2's progress notes revealed: -On 07/16/22, a medication aide (MA) contacted Resident #2's on-call PCP at 8:30pm and made them aware Resident #2's 8:00pm dose of Lyrica was on hold. -On 07/17/22, a MA contacted Resident #2's PCP at 7:52pm and made her aware that Resident #2's 8:00pm dose of Lyrica was on hold. -On 07/19/22, a MA contacted Resident #2's PCP at 2:00pm and made her aware that Resident #2's Lyrica was on hold and he needed a new prescription for it. -On 07/21/22, a MA contacted Resident #2's PCP at 2:00pm and made her aware that Resident #2's Lyrica was on hold and he needed a new prescription for it.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 18 Interview with Resident #2 on 08/24/22 at 10:55am revealed: -As far as he knew he had not missed any doses of his Lyrica. -He did not recall having any increased neuropathy pain over the past two months. Interview with a MA on 08/24/22 at 1:57pm revealed: -Resident #2 did not get his medication from the facility's contracted pharmacy so someone at the facility picked his medications up from his pharmacy. -The transportation coordinator usually picked up Resident #2's medication from the pharmacy or a MA, the Administrator, or Resident Care Coordinator (RCC) would pick up the medication if the transportation coordinator was unavailable. -The MA would call Resident #2's pharmacy to get a refill 1 week before he ran out of his medication. -After ordering a refill for Resident #2, the MA would call and check to see if his medication was ready to be picked up from the pharmacy. -Sometimes the Administrator or RCC would call to see if Resident #2's medication was ready to be picked up from the pharmacy. -There was no one person designated to call the pharmacy and check on the status of Resident #2's medication refills. -Once facility staff verified that Resident #2's medications were ready to be picked up, someone from the facility would pick up his medication that same day. Interview with the transportation coordinator on 08/24/22 at 10:55am revealed: -She sometimes picked up Resident #2's medication from the pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 19 -A MA would let her know that Resident #2's medication needed to be picked up from the pharmacy and she would pick the medication up the same day she was made aware. Interview with the Resident Care Coordinator on 08/23/22 at 2:47pm revealed: -Resident #2 did not get his medications from the facility's contracted pharmacy and used another pharmacy. -The transportation coordinator usually picked up Resident #2's medication from the pharmacy but sometimes she, a MA, or the Administrator would pick up his medications. -A MA called to see if Resident #2's medications were ready to be picked up from the pharmacy. -Once Resident #2's medication was ready to be picked up from the pharmacy the MA should notify the transportation coordinator that the medication needed to be picked up from the pharmacy. -If Resident #2's PCP had been notified that he needed a new prescription for a medication and it had not been refilled within one day of the PCP being notified, she expected a MA to make her aware so she could call and follow up with the PCP. -She was not made aware by a MA that Resident #2 needed a new prescription for Lyrica and it had not been provided by the PCP. Interview with the Administrator on 08/23/22 at 3:45pm revealed: -If a MA had contacted Resident #2's PCP for a refill and the medication was not refilled she expected the MA to make her aware within 2 days of the medication not being refilled. -If she were notified by the MA that Resident #2's PCP had not refilled his prescription she would have contacted the PCP.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 20 -Sometimes she was able to contact the PCP easier than the MA could. -She was not aware that Resident #2 was out of Lyrica for several days. -Resident #2 did not get his medications from the facility's contracted pharmacy because his family requested to use another pharmacy. -The transportation coordinator, a MA, or other facility staff would pick up Resident #2's medication from the pharmacy. -She expected someone from the facility to pick up Resident #2's medication on the same day it was filled by the pharmacy. Telephone interview with a pharmacist at Resident #2's pharmacy on 08/23/22 at 3:05pm revealed: -Resident #2's prescription for Lyrica was received by the pharmacy at 12:17pm on 07/22/22. -Resident #2's prescription for Lyrica was dispensed at 12:59pm on 07/22/22. -Lyrica was a controlled substance so someone had to sign for it when it was picked up from the pharmacy. -A facility staff member signed for and picked up Resident #2's Lyrica on 07/26/22. Telephone interview with Resident #2's PCP on 08/24/22 at 1:23pm revealed: -Resident #2 was prescribed Lyrica for his neuropathy. -She had originally sent Resident #2's refill for Lyrica to the wrong pharmacy because she did not know he did not receive his medications from the facility's contracted pharmacy. -She was unaware that Resident #2 missed 26 consecutive doses of Lyrica. -Resident #2 could have experienced rebound neuropathy pain due to missing 26 consecutive	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 21 doses of Lyrica. c. Review of Resident #2's current FL-2 dated 04/19/22 revealed there was an order for azo cranberry daily (Azo cranberry is used to reduce the risk of UTI). Review of Resident #2's physician order dated 06/22/22 revealed: -There was an order to discontinue azo cranberry plus C 250-60mg daily. -There was an order to start azo cranberry 500mg daily. Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for azo cranberry plus vitamin C 250-60mg every day scheduled for administration at 8:00am. -There was a discontinue date of 06/19/22. -Azo cranberry 250-60mg was documented as administered 06/01/22-06/08/22. -Azo cranberry 250-60mg was documented as "on hold" 06/09/22-06/13/22. -Azo cranberry 250-60mg was documented as discontinued on 06/14/22-06/19/22. -There was no entry for azo cranberry 500mg on the June 2022 eMAR and there was no documentation of administration. -Azo cranberry was not administered for 22 consecutive days in June 2022. Review of Resident #2's primary care provider (PCP) orders revealed there were no orders to hold azo cranberry 250-60mg. Review of Resident #2's July 2022 eMAR revealed: -There was an entry for azo cranberry 250-60mg	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 22 once daily scheduled for administration at 8:00am. -There was a start date of 07/27/22. -Azo cranberry 250-60mg was not administered 07/01/22-07/26/22. -Azo cranberry 250-60mg was documented as administered 07/27/22-07/31/22. -Azo cranberry 500mg was not administered to Resident #2 26 consecutive days in July 2022. Observation of Resident #2's medications on hand on 08/23/22 revealed: -There was an opened bottle of azo cranberry 500mg on the medication cart. -There was no azo cranberry plus vitamin C 250-60mg on the medication cart. Interview with Resident #2 on 08/24/22 at 10:55am revealed: -He had been taking cranberry pills for a long time to help with UTIs. -As far as he knew he had not missed any doses of his cranberry pills. -He was diagnosed with a UTI on 08/21/22. -He was not sure when his last UTI was prior to 08/21/22 but it was at least several months ago. Interview with a medication aide (MA) on 08/24/22 at 1:57pm revealed: -When Resident #2 had 1 week of medication left, she would call the pharmacy for a refill. -Azo cranberry 500mg was on the medication cart so that is what Resident #2 had been receiving.	D 358		
	Interview with the Resident Care Coordinator on 08/24/22 at 2:47pm revealed: -If Resident #2 ran out of azo cranberry the MA should have ordered more for him and made the RCC aware if she could not obtain the medication.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 23 -She was not aware Resident #2 did not receive azo cranberry for 48 days. -She was responsible for making sure Resident #2's azo cranberry order was entered correctly on the eMAR. -She did not know why Resident #2's azo cranberry had a start date of 07/27/22 on the July 2022 eMAR. -Medication cart audits should be done weekly. -If medication cart audits were done correctly someone would probably have noticed that Resident #2 was not receiving azo cranberry as ordered. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -She expected a MA to make her aware that a resident was out of medication within 2 days of the resident running out of the medication. -The RCC was responsible for looking at PCP orders and making sure any medication changes were made on the eMAR. -She was not aware Resident #2 did not receive azo cranberry for 48 consecutive days. -Resident #2's entry for azo cranberry should not have been removed from the eMAR. -She expected Resident #2 to receive azo cranberry as ordered. Telephone interview with a pharmacist at Resident #2's pharmacy on 08/23/22 at 3:05pm revealed the pharmacy did not have dispensing information for Resident #2's azo cranberry because they did not have an order for it since it was an over the counter medication. Telephone interview with Resident #2's primary care provider (PCP) on 08/24/22 at 1:23pm revealed: -Resident #2 was prescribed azo cranberry to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 24 help prevent UTIs. -She was not aware Resident #2 did not receive azo cranberry for 48 consecutive days. -She expected Resident #2 to receive azo cranberry every day as ordered. -She was not aware of Resident #2 having any adverse effects from not receiving the azo cranberry. 3. Review of Resident #5's current FL-2 dated 04/27/22 revealed diagnoses included Type 2 diabetes, schizophrenia, bipolar disorder, and depressive disorder. a. Review of Resident #5's physician order sheet dated 06/22/22 revealed there was an order for glucose gel give 75gm for fingerstick blood sugar (FSBS) less than 70 recheck FSBS in 15 minutes and give another 75gm if FSBS is still less than 70. Review of Resident #5's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS daily, notify primary care provider if FSBS less than 70 or greater than 250 scheduled for 7:30. -On 07/19/22 Resident #5's FSBS was 41. -There was an entry for glucose gel give 75gm for FSBS less than 70 recheck FSBS in 15 minutes and give another 75gm if FSBS still less than 70. -There was no documentation that Resident #5 received glucose gel on 07/19/22 for a FSBS of 41. -There was no documentation that Resident #5's FSBS was rechecked on 07/19/22. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:47pm revealed: -She expected the MA to administer Resident	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 25 #5's glucose gel as ordered. -The MA who failed to administer the glucose gel to Resident #5 no longer worked at the facility. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -She expected the MA to administer glucose gel as ordered. -Resident #5's FSBS could have gone even lower because she did not receive the glucose gel for a BS of 41. Telephone interview with Resident #5's PCP on 08/24/22 at 1:23pm revealed: -She expected Resident #5's glucose gel to be administered as ordered. -Because Resident #5 did not receive glucose gel for a FSBS of 41, her blood sugar could have gone lower causing her to have to be transported to the hospital. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. b. Review of Resident #5's physician order sheet dated 06/22/22 revealed: -There was an order for Abilify 5mg once a day. (Abilify is used to treat schizophrenia). -There was an order for Abilify 2mg at bedtime. Review of a prescription order from Resident #5's mental health provider dated 07/13/22 revealed: -There was an order to discontinue Abilify 5mg and Abilify 2mg. -There was an order for Abilify 15mg once a day. Review of Resident #5's July 2022 electronic medication administration record (eMAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 26 -There was an entry for Abilify 5mg once a day scheduled for administration at 8:00am. -There was a discontinue date of 07/14/22. -Abilify 5mg was documented as administered every day from 07/01/22-07/14/22 except on 07/09/22, 07/11/22, and 07/13/22 where it was documented as refused. -There was an entry for Abilify 2mg at bedtime scheduled for administration at 8:00pm. -There was a discontinue date of 07/20/22. -Abilify 2mg was documented as administered every day from 07/01/22-07/19/22 except on 07/06/22-07/09/22, 07/11/22, 07/16/22, and 07/18/22 where it was documented as refused. -There was an entry for Abilify 15mg every day scheduled for administration at 8:00am. -There was a start date of 07/13/22. -Abilify 15mg was documented as administered 07/14/22-07/27/22 except on 07/14/22, 07/16/22, 07/18/22, 07/20/22, 07/24/22, 07/26/22, 07/28/22, and 07/29/22 were it was documented as refused and on 07/30/22-07/31/22 were it was documented that Resident #5 was in the hospital. -Resident #6 received 4 doses of Abilify 2mg after it was discontinued. -Resident #5 received both Abilify 2mg and Abilify 15mg on 07/15/22, 07/17/22, and 07/19/22. Interview with the Resident Care Coordinator on 08/24/22 at 2:47pm revealed: -When Resident #5's Abilify 2mg was discontinued by the primary care provider (PCP) it should have been taken off the eMAR by her or the lead medication aide (MA). -Resident #5 should not have received Abilify 2mg and Abilify 15mg at the same time. -Resident #5 could have received too much Abilify since she was taking 2mg and 15mg at the same time.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 27 Interview with the Administrator on 08/24/22 at 3:45pm revealed: -Resident #5's Abilify 2mg should have been discontinued on the eMAR the same day the order was received from the PCP. -The RCC was responsible for looking at PCP orders and making sure any medication changes were made on the eMAR. Telephone interview with Resident #5's PCP on 08/24/22 at 1:23pm revealed she expected all medications to be administered as ordered. Attempted telephone interview with Resident #5's mental health provider on 08/24/22 at 12:04pm and 1:17pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. c. Review of Resident #5's physician order sheet dated 06/22/22 revealed there was an order for atorvastatin 20mg at bedtime (Atorvastatin is used to lower cholesterol levels). Review of Resident #5's June 2022 electronic medication administration record revealed: -There was an entry for atorvastatin 20mg at bedtime scheduled for administration at 8:00pm. -The entry had a discontinue date of 06/28/22. -Atorvastatin 20mg was documented as administered 06/01/22-06/27/22. -Atorvastatin 20mg was documented as "X" on the eMAR for 06/28/22 with no explanation. -There was a second entry for atorvastatin 20mg at bedtime scheduled for administration at 8:00pm. -The second entry had a start date of 06/27/22. -Atorvastatin 20mg was documented as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 28 administered 06/29/22-06/30/22. -Atorvastatin 20mg was documented as "X" on the second entry for 06/28/22 with no explanation. -Resident #5 did not receive atorvastatin 20mg on 06/28/22. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:47pm revealed: -She was responsible for making sure medications were entered correctly on the eMAR. -She expected residents to receive all medications as ordered. -The "X" on the eMAR indicated that Resident #5 did not receive atorvastatin 20mg on 06/28/22 but she did not know why the "X" was on the eMAR or how it got there. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -She expected residents to receive all medications as ordered. -She did not know why there was a "X" on Resident #5's eMAR for atorvastatin 20mg on 06/28/22. Telephone interview with Resident #5's primary care provider (PCP) on 08/24/22 at 1:23pm revealed she expected Resident #5 to receive all medications as ordered. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.	D 358		
	d. Review of Resident #5's physician order sheet dated 06/22/22 revealed there was an order for potassium chloride extended release 20meq daily at 8:00am (Potassium chloride is used to supplement potassium levels).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 29 Review of Resident #5's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for potassium chloride 20meq daily scheduled for administration at 8:00am. -There was a discontinue date of 07/05/22. -There was a second entry for potassium chloride 20meq daily scheduled for administration at 8:00am. -There was a start date of 07/05/22. -Potassium chloride was documented as not administered on 07/09/22, 07/11/22, 07/13/22, 07/16/22, 07/18/22, 07/24/22, 07/26/22, 07/28/22, 07/29/22 where it was documented as refused, and 07/30/22-07/31/22 where it was documented that Resident #5 was in the hospital. -Potassium chloride 20meq was documented as "X" on the second entry for 07/06/22 with no explanation. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:47pm revealed: -She was responsible for making sure medications were entered correctly on the eMAR. -She expected residents to receive all medications as ordered. -The "X" on the eMAR indicated that Resident #5 did not receive potassium chloride on 07/06/22 but she did not know why the "X" was on the eMAR or how it got there. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -She expected residents to receive all medications as ordered. -She did not know why there was a "X" on Resident #5's eMAR for potassium chloride 20meq on 07/06/22.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 30 Telephone interview with Resident #5's primary care provider (PCP) on 08/24/22 at 1:23pm revealed she expected Resident #5 to receive all medications as ordered. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. 4. Review of Resident #1's current FL-2 dated 02/14/22 revealed: -Diagnoses included diabetes mellitus. -There was an order for fingerstick blood sugars (FSBS) twice a day. -There was an order for Glutose-15 gel, administer 15gm for blood sugar less than 70 and recheck in 15 minutes and give another 15gm if blood sugar is still less than 70 (Glutose is dextrose given to increase blood sugar). Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS twice a day, scheduled at 7:30am and 7:30pm. -There was an entry scheduled for Glutose-15 gel with instructions to administer 15gm for blood sugar less than 70 and recheck in 15 minutes and give another 15gm if blood sugar is still less than 70. -Resident #1's FSBS on 06/08/22 at 7:30am was documented as 58. -There was no documentation that Glutose-15 gel was administered on 06/08/22 at 7:30am and there was no documentation of a FSBS rechecked after 15 minutes. -Resident #1's FSBS on 06/12/22 at 7:30am was documented as 51. -There was no documentation that Glutose-15 gel was administered on 06/12/22 at 7:30am and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 31 there was no documentation of a FSBS rechecked after 15 minutes. Review of Resident #1's facility progress notes 06/12/22 at 5:45am revealed she was sent to the emergency room for low blood sugar. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for FSBS twice a day, scheduled at 7:30am and 7:30pm. -There was an entry scheduled for Glutose-15 gel with instructions to give 15gm administer 15gm for blood sugar less than 70 and recheck in 15 minutes and give another 15gm if blood sugar is still less than 70. -Resident #1's FSBS on 08/04/22 at 7:30am was documented as 62. -There was no documentation that Glutose-15 gel was administered on 08/04/22 at 7:30am and there was no documentation of a FSBS rechecked after 15 minutes. -Resident #1's FSBS on 08/22/22 at 7:30am was documented as 'low'. -There was no documentation that Glutose-15 gel was administered on 08/22/22 at 7:30am and there was no documentation of a FSBS rechecked after 15 minutes. -Resident #1's FSBS on 08/22/22 at 7:30pm was documented as 'low'. -There was no documentation that Glutose-15 gel was administered on 08/22/22 at 7:30pm and there was no documentation of a FSBS rechecked after 15 minutes. Interview with a medication aide (MA) on 08/24/22 at 9:48am revealed the MAs were to follow the orders and administer Glutose-15 when Resident #1's blood sugar was less than the ordered parameters ordered to help get the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 32 residents blood sugar higher. Interview with the Resident Care Coordinator (RCC) on 8/24/22 at 2:46pm revealed she was not aware of the 2 times in June of 2022 and 3 times in August of 2022 where the MAs did not follow orders to administer Glutose-15 to Resident #1 for FSBS less than 70. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -She expected staff to follow medication orders including administering Glutose-15 for a blood sugar less than 70 as ordered. -She expected Resident #1 to receive Glutose-15 when her blood sugar was low so that the medication could help rapidly increase her blood sugar. 5. Review of Resident #3's FL-2 dated 11/01/21 revealed diagnoses included type 2 diabetes mellitus, cervical degeneration and clavicle fracture. a. Review of Resident #3's physician orders dated 06/22/22 revealed there was an order for Risperdal 37.5mg injection intramuscularly every two weeks (Risperdal is a medication used to symptoms of schizophrenia and bipolar disorder). Review of Resident #3's psychiatry progress note dated 08/08/22 revealed Resident #3 was on Risperdal every two weeks for schizoaffective disorder. Review of Resident #3's treatment record revealed: -She was administered Risperdal 37.5mg by a home health agency registered nurse on 08/15/22.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 33 -There was no documentation of Risperdal 37.5mg being administered on 06/29/22. -She was administered Risperdal 37.5mg by a home health agency registered nurse on 07/07/22. Interview with the Administrator on 08/24/22 at 3:15pm revealed: -She was not aware that the resident missed the Risperdal dose that should have been given on 06/29/22. -The Resident Care Coordinator and the Administrator were responsible for ensuring that residents receive their medications as ordered even if it was administered by a third-party. -There was no audit process in place to ensure that Resident #3 received her Risperdal every 2 weeks. -The facility depended on the home health agency to schedule medication administration as ordered. Attempted telephone interview with Resident #3's mental health provider on 08/24/22 at 12:04pm and 1:17pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. b. Review of Resident #3's physician orders dated 06/22/22 revealed there was an order for Oxycodone-Acetaminophen 5-325mg, take one tablet three times a day, hold for sedation (Oxycodone is a medication used to treat moderate to severe pain). Review of Resident #3 July 2022 electronic medication administration record (eMAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 34 -There was an entry for Oxycodone-Acetaminophen 5-325mg, 1 tablet three times a day, scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Oxycodone-Acetaminophen 5-325mg was documented as not given for reason 'on hold' 07/19/22 at 8:00am, 2:00pm, and 8:00pm. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:45pm revealed: -She was not aware that Resident #3 missed her scheduled pain medication for chronic pain for 3 consecutive doses in July. -Staff should have notified her so that she could have called the pharmacy to expedite the medication or use the facility's back-up pharmacy to obtain the medication. -MAs are responsible for requesting refills for medications from the pharmacy. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. c. Review of Resident #3's current FL-2 dated 11/01/21 revealed There was an order for Potassium Chloride 20mEq daily (Potassium Chloride is a medication used to supplement potassium). Review of Resident #3's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Potassium Chloride 20mEq daily, scheduled for administration at 8:00am. -Potassium Chloride was documented as not administered from 06/11/22 to 06/15/22 with a reason stated 'on hold'.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 35 Interview with a medication aide (MA) on 08/24/22 at 9:45am revealed: -Resident #3 was out of Potassium Chloride in the middle of June 2022 and staff had sent a request to pharmacy. -Staff notified the physician that the resident was out of her potassium and they were waiting on pharmacy refill. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/24/22 at 10:27am revealed the received a request from the facility for Resident #3's Potassium Chloride 20mEq on 06/15/22 and dispensed the medication that same day (06/15/22). Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:46pm revealed: -She was not aware that Resident #3 missed 6 doses of Potassium Chloride. -The MAs should have notified her if they were having difficulty obtaining medications from the pharmacy. -Resident #3 should not have missed her medications. Telephone interview with Resident #3's PCP on 08/24/22 at 1:23pm revealed: -Staff notified her when Resident #3 missed her Potassium Chloride dose in June 2022. -She was told that the facility was having issues with their pharmacy. -She expected medications to be available for the resident including Resident #3's Potassium Chloride. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	180 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 36 d. Review of Resident #3's current FL-2 dated 11/01/21 revealed there was an order for Lasix 20mg daily (Lasix is diuretic medication used to help remove fluid). Review of Resident #3's physician orders dated 06/22/22 revealed there was an order to discontinue Lasix 20mg. Review of Resident #3's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lasix 20mg daily, scheduled for administration at 8:00am. -Lasix 20mg was documented as administered 06/01/22 to 06/24/22. -Resident #3 received 2 doses of Lasix after it was discontinued by the primary care provider (PCP). Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:46pm revealed: -She was not aware that the PCP discontinued Resident #3's Lasix until 06/24/22 and then she discontinued it off of the eMAR. -The provider does not always notify them when she changed or discontinued the medication. Telephone interview with Resident #3's PCP on 08/24/22 at 1:23pm revealed she expected her medication orders to be followed as written. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. 6. Review of Resident #4's current FL-2 dated 06/30/22 revealed: -Diagnoses included Alzheimer's disease, hypertension, and lumbar disc degeneration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 37 -There was an order for Neurontin 100mg twice a day (Neurontin is a medication used to treat nerve pain). -There was an order for Omeprazole 40mg daily (Omeprazole is a medication used to treat reflux disease). Review of Resident #4's Resident Register reveals an admission date of 07/18/22. Review of Resident #4's physician's clarification orders dated 07/18/22 revealed: -There was an order for Lisinopril 30mg daily (Lisinopril is a medication used to treat high blood pressure). -There was an order for Vitamin D3 125mcg daily (Vitamin D3 is a supplement used to treat Vitamin-D deficiency). -There was an order for Vitamin B12 1,000mcg daily (Vitamin B12 is a supplement used to treat Vitamin-B deficiency). -There was an order for Nitrofurantoin 100mg daily (Nitrofurantoin is a medication used to treat and/or prevent urinary tract infections). Review of Resident #4's August 2022 electronic medication record revealed: -There was an entry for Neurontin 100mg twice a day, scheduled for administration at 8:00am and 8:00pm. -Neurontin 100mg was not documented as administered on 07/20/22 at 8:00pm or 07/21/22 at 8:00am. -There was an entry for Omeprazole 40mg daily, scheduled for administration at 7:30am. -Omeprazole 40mg was not documented as administered on 07/21/22 at 7:30am. -There was an entry for Lisinopril 30mg daily, scheduled for administration at 8:00am. -Lisinopril 30mg was not documented as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 38 administered on 07/21/22 at 8:00am. -There was an entry for Vitamin D3 125mcg daily, scheduled for administration at 8:00am. -Vitamin D3 125mcg was not documented as administered on 07/21/22 at 8:00am. -There was an entry for Vitamin B12 1,000mcg daily, scheduled for administration at 8:00am. -Vitamin B12 1,000mcg was not documented as administered on 07/21/22 at 8:00am. -There was an entry for Nitrofurantoin 100mg daily, scheduled for administration at 8:00am. -Nitrofurantoin 100mg was not documented as administered on 07/21/22 at 8:00am. Telephone interview with Resident #4's family member on 08/24/22 at 1:09pm revealed: -The resident arrived at the facility on 07/18/22 with her medications. -Some of the resident's medications were nearing the last of the pills in the bottles but he was not sure which ones. -The resident now used the facility's pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/24/22 at 10:27am revealed: -They received admission orders for Resident #4 on 07/18/22 and they were entered into the resident's medication profile by the pharmacy on 07/18/22. -The pharmacy received a fax on 07/21/22 stating the resident was at the facility and needed her medications dispensed. -The pharmacy sent her medications to the facility the evening of 07/21/22. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:45pm revealed: -She was not aware that it was documented that Resident #4 d'd not receive 6 of her medications	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 39 on 07/21/22 and 1 of her medications on 07/20/22. -She would have expected staff to notify her and the primary care provider if the resident did not have medications available for administration. -If the medications were administered as ordered she would have expected it to be documented on the eMAR. Interview with the facility's Administrator on 08/24/22 at 3:45pm revealed: -Resident #4 came to the facility with medication. -She was not aware that it was documented that Resident #4 did not receive 6 of her medications on 07/21/22 and 1 of her medications on 07/20/22. -She would have expected staff to notify the RCC or her and the primary care provider if the resident did not have medications available for administration so that they could facilitate getting the resident her medications. Interview with Resident #4's primary care provider on 08/24/22 at 1:23pm revealed she expected residents to have their medications available for administration. Based on observations, interviews and record reviews, it was determined that Resident #4 was not interviewable. The facility failed to administer medications as ordered for 2 of 4 residents observed during the medication pass resulting in a 7% medication error rate with 2 errors out of 26 opportunities resulting in the potential risk of Resident #6 developing thrush from not rinsing his mouth after his inhaled medication and Resident #7 not receiving her full dose of insulin because the insulin pen was not primed correctly. There was a	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 40 3-day delay in Resident #2 receiving an antibiotic for a urinary tract infection putting the resident at risk for a worsening infection. Resident #2 did not receive 26 consecutive doses of a medication used to treat nerve pain putting the resident at risk for breakthrough nerve pain. Resident #1 and #5 did not receive a medication to treat a low blood sugar putting the resident at risk for an even lower blood sugar and resulting in Resident #1 having a hospital visit for low blood sugar. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/24/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 8, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;	D 367	10A NCAC 13F .1004(j) Medication Administration Community will ensure the Electronic Medication Record are accurate and include all required informatiion according to rules and regulations set forth. The ED and CC have conducted cart audits against the electronic medication records for all current residents including both a review of the accuracy of the EMAR and audit of the EMAR against the medication cart. The CC will conduct weekly cart audits against the EMAR to the medication cart to ensure accuracy. The Area Clinical Director has in-serviced all Medication Staff on Medication Administration to include the six rights to medication administration, documentation and med errors.	8/29/2022 9/1/2022 8/29/2022 9/7/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 41 (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medication administration records were complete and accurate for 3 of 5 residents sampled including omitted medications (#2, #4), duplicate documentation for medications (#4), inaccurate charting of medication dosages (#5), and incorrect medication name and dosage listed (#2). The findings are: 1. Review of Resident #4's current FL-2 dated 06/30/22 revealed diagnoses included Alzheimer's disease, hypertension and degeneration of lumbar disc. a. Review of Resident #4's facility progress notes dated 08/09/22 at 9:56pm revealed: -The medication aide (MA) notified the on-call physician that the resident was complaining of indigestion. -The MA administered Mylanta 30mL as directed by the provider (Mylanta is a medication used to treat indigestion). Review of Resident #4's August 2022 electronic medication administration record (eMAR) revealed: -There was no entry for Mylanta 30mL.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 42 -There was no documentation of Mylanta 30mL administered on 08/09/22. Interview with a MA on 08/23/22 at 1:20pm revealed: -If you called the primary care provider (PCP) or on-call physician for a medication order you should document the medication on the eMAR. -If the medication was a new medication and not on the eMAR then you should document the medication administration on a paper medication administration record (MAR) in the chart. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:46pm revealed: -The lead MA, the RCC, and the Administrator were able to enter orders and approve them on the eMAR for administration. -If the order was received after hours, she expected the MA to document administration of the medication on a paper medication administration record. -There was no documentation of Mylanta being administered to Resident #4. -Resident #4 did not have standing orders that included Mylanta signed by the PCP. Interview with the Administrator on 08/24/22 at 3:45pm revealed she expected Resident #4's eMAR to accurately reflect medications administered including Mylanta on 08/09/22. Based on observations, interviews and record reviews, it was determined that Resident #4 was not interviewable. b. Review of Resident #4's physician's orders dated 07/17/22 revealed there was an order for Nitrofurantoin 100mg once daily (Nitrofurantoin is medication used to prevent urinary tract	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 43 Infections). Review of Resident #4's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Nitrofurantoin 100mg once a day, scheduled for administration at 8:00am. -Nitrofurantoin 100mg was documented as administered on 08/21/22 at 8:00am. -There was a second entry for Nitrofurantoin 100mg once a day, scheduled for administration at 8:00am. -Nitrofurantoin 100mg was documented as administered on the second entry on 08/21/22 at 8:00am. -There was duplicate documentation of Nitrofurantoin on 08/21/22. Interview with a medication aide (MA) on 08/23/22 at 1:20pm revealed: -There should not be duplicate administration of medications on the eMAR. -If there were two entries for a medication, staff should notify the lead MA so the medication could be removed. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:46pm revealed there should be no duplicate entries on the eMAR Refer to Interview with a MA on 08/23/22 at 1:20pm. Refer to Interview with the RCC on 08/24/22 at 2:46pm. Refer to Interview with the Administrator on 08/24/22 at 3:45pm.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 44 Based on observations, interviews and record reviews, it was determined that Resident #4 was not interviewable. 2. Review of Resident #5's current FL-2 dated 04/27/22 revealed diagnoses included Type 2 diabetes mellitus. Review of Resident #5's physician order sheet dated 06/22/22 revealed: -There was an order to check fingerstick blood sugar (FSBS) daily. -There was an order for Lantus 34 units daily at 7:30am before breakfast hold if FSBS less than 150. (Lantus is used to treat diabetes.) Review of Resident #5's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS daily scheduled for 7:30am. -Resident #5's FSBS was 180 on 06/03/22. -Resident #5's FSBS was 155 on 06/13/22. -There was an entry for Lantus inject 34 units daily at 7:30am before breakfast hold if FSBS less than 150. -Lantus 180 units was documented as administered on 06/03/22. -Lantus 155 units was documented as administered on 06/13/22. Review of Resident #5's July 2022 eMAR revealed: -There was an entry to check FSBS daily scheduled at 7:30am. -Resident #5's FSBS was 224 on 07/04/22. -There was an entry for Lantus inject 34 units daily at 7:30am before breakfast hold if BS less than 150. -Lantus 224 units was documented as	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 45 administered on 07/04/22. Interview with a medication aide (MA) on 08/24/22 at 1:57pm revealed: -The correct dosage of Lantus should be entered on the eMAR. -FSBS should be entered in the correct place on the eMAR. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:47pm revealed: -MAs were expected to document the correct dosage of Lantus on the eMAR. -MAs were expected to document FSBS in the correct location on the eMAR. -On 06/13/22 she incorrectly documented that Resident #5 received 155 units of Lantus. -She put Resident #5's FSBS in the wrong place on the eMAR. -It was important that the Lantus dosage be entered correctly on the eMAR so one could be sure that Resident #5 received the correct dose of Lantus. Interview with the Administrator on 08/24/22 at 3:45pm revealed she expected MAs to read the eMARs carefully and document accurately. Refer to interview with a MA on 08/23/22 at 1:20pm. Refer to interview with the RCC on 08/24/22 at 2:46pm.	D 367		
	Refer to interview with the Administrator on 08/24/22 at 3:45pm. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 46 3. Review of Resident #2's current FL-2 dated 04/19/22 revealed: -Diagnoses included chronic urinary tract infection (UTI). -There was an order for azo cranberry 1 tablet daily. (Azo cranberry is a medication used to reduce the risk of UTI.) Review of Resident #2's physician order dated 06/22/22 revealed: -There was an order to discontinue azo cranberry plus C 250-60mg daily. -There was an order to start azo cranberry 500mg daily. Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for azo cranberry plus vitamin C 250-60mg daily scheduled at 8:00am. -There was a discontinue date of 06/19/22. -Azo cranberry plus vitamin C 250-60mg was documented as administered from 06/01/22-06/08/22. -Azo cranberry plus vitamin C 250-60mg was documented as on hold 06/09/22-06/13/22 and as discontinued 06/14/22-06/19/22. -There was no entry for azo cranberry 500mg daily. Review of Resident #2's July 2022 eMAR revealed: -There was an entry for azo cranberry plus vitamin C 250-60mg once a day scheduled for 8:00am. -There was a start date of 07/27/22. -Azo cranberry plus vitamin C 250-60mg was documented as administered 07/27/22-07/31/22. -There was no entry for azo cranberry 500mg	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 47 daily. Review of Resident #2's August 2022 eMAR revealed: -There was an entry for azo cranberry plus vitamin C 250-60mg daily scheduled for administration at 8:00am. -Azo cranberry vitamin C 250-60mg was documented as administered 08/01/22-08/23/22. -There was no entry for azo cranberry 500mg daily. Observation of Resident #2's medications on hand on 08/23/22 revealed: -There was a bottle of azo cranberry 500mg. -There was no bottle of azo cranberry plus vitamin C 250-60mg. Interview with Resident #2 on 08/24/22 at 10:55am revealed he had been taking cranberry pills for a long time to help with UTIs. Interview with a medication aide (MA) on 08/23/22 at 1:58pm revealed azo cranberry 500mg was on the medication cart so that was what Resident #2 had been receiving. Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:47pm revealed: -She was not aware that azo cranberry 500mg did not get entered onto Resident #2's June 2022 eMAR. -She was not aware that Resident #2's July 2022 and August 2022 eMARs had azo cranberry plus vitamin C 250-60mg entered on them instead of azo cranberry 500mg. -She was responsible for entering Resident #2's azo cranberry orders onto the eMAR and the correct name and dosage should be on the eMAR.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 48 -She did not know why she entered a start date of 07/27/22 for the azo cranberry on Resident #2's July 2022 eMAR. Interview with the Administrator on 08/24/22 at 3:45pm revealed: -The RCC was responsible for looking at PCP orders and making sure any medication changes were made on the eMAR. -She expected Resident #2's azo cranberry dosage to be entered correctly on the eMAR. -Resident #2's azo cranberry 500mg should have been entered on the June 2022 eMAR when it was ordered. -Resident #2's azo cranberry 500mg should have been entered on the July 2022 and August 2022 eMAR instead of azo cranberry plus vitamin C 250-60mg. -Resident #2's azo cranberry should not have a start date of 07/27/22 on the July 2022 eMAR but should have started on 07/01/22. Telephone interview with a pharmacist at Resident #2's pharmacy on 08/23/22 at 3:05pm revealed the pharmacy did not have dispensing information for Resident #2's azo cranberry 500mg because they did not have an order for it since it was an over the counter medication. Refer to interview with a MA on 08/23/22 at 1:20pm. Refer to interview with the RCC on 08/24/22 at 2:46pm. Refer to interview with the Administrator on 08/24/22 at 3:45pm. Interview with a (MA) on 08/23/22 at 1:20pm revealed it was expected to document accurately	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058011	A. BUILDING: _____ B. WING _____	R-C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892

(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 367	Continued From page 49 on the electronic medication administration record (eMAR). Interview with the Resident Care Coordinator (RCC) on 08/24/22 at 2:46pm revealed: -Staff was expected to document accurately on the eMAR. -Currently there was no audit process in place to review eMAR accurately. Interview with the Administrator on 08/24/22 at 3:45pm revealed she expected staff to document accurately on the eMAR.	D 367		
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 observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#6, #7) observed during the medication pass including errors with a medication used to treat	D912	G.S. 131D-21(2) Declaration of Residents' Rights Community will ensure that every resident will receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. All Medication Staff has been In-serviced on Medication administration in accordance to the rules and regulations set forth and in compliance with federal and state laws by the Area Clinical Director,RN. ED has contacted the State Ombudsman to set up Resident Rights training with all staff.	8/25/2022 9/7/2022 9/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION
	HAL058011	A. BUILDING: _____ B. WING _____

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	08/24
WILLIAMSTON HOUSE	160 SANTREE DRIVE WILLIAMSTON, NC 27892	

(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
D912	Continued From page 50 diabetes (#7) and an inhaled medication used to treat asthma (#8); and for 5 of 5 residents sampled for record review (#1, #2, #3, #4, #5) including an antibiotic used to treat infection (#2), medications used to treat nerve pain (#2, #4), a medication used to treat low blood sugar (#1, #5), medications used to treat schizophrenia (#3, #5), a medication used to treat pain (#3), a medication used to treat low potassium levels (#3, #5), a medication used to reduce extra fluid in the body (#3), a medication used to reduce the risk of urinary tract infection (#4), vitamins (#4), a medication used to treat high blood pressure (#4), and a medication used to lower cholesterol levels (#5). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		