Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021009	A. BUILDING: _____ B. WING _____	C 08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON HOUSE	323 MEDICAL ARTS DRIVE EDENTON, NC 27932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on August 16, 2022 to August 17, 2022.	D 000	Responses to the cited deficiencies 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 Deficiencies; the plan of correction is prepared solely as a matter of compliance.	Type text he
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews, the facility failed to ensure the rights of all residents related to missing articles of clothing in the laundry. The findings are: Interview with a resident on 08/17/22 at 9:25am revealed: -There was a laundry aide that did the resident's laundry. -There was a washer and dryer that the residents could use to do their own laundry, but the washer was not working properly, so the laundry aide did the residents laundry. -She had a pair of denim slacks, a hooded sweatshirt, and an undergarment go missing in the laundry, but she did not recall when it went missing. -She did not mention it to the facility's management, only to the laundry aide. -The items were never located. Interview with a second resident on 08/17/22 at 9:10am revealed: -He had 2 pairs of pants that went missing about 2 weeks ago.	D 338	10A NCAC 13F .0909 Resident Rights The Executive Director (ED) has reached out for an in-service for staff with the Ombudsman for Resident Rights training, awaiting scheduled date. The ED and Care Coordinator (CC) along with other management and staff have placed names in all residents clothing throughout community. Any new admits will also have names placed in their personal clothing upon admission. Complaints of missing personal items will be discussed daily in stand-up with follow up by ED and CC. ED will provide an in-serivce on Resident Rights with all staff on 9/21/2022 and documentation will be placed in the in-service training binder.	9/15/2022 9/6/2022 8/18/2022 9/21/2022

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Randy M. Griffin Sr TITLE Executive Director (X6) DATE 9/15/2022

STATE FORM 6899 HQ3M11 If continuation sheet 1 of 9

Randy M. Griffin Sr

Reviewed and Acknowledged _____ AVT 09.16.22

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D 338	Continued From page 1 -He told the Resident Care Coordinator (RCC) that his pants were missing, and she told him maybe they would show up. -He was still missing the 2 pairs of pants. Telephone interview with a resident's family member 08/16/22 at 2:05pm revealed: -The facility was responsible for washing their family member's clothing. -There were some articles of clothing that had gone missing, but he did not recall specifically what went missing and when. -He thought that it was common that articles of clothing went missing saying "that happens to everyone in there". Interview with a personal care aide (PCA) on 08/17/22 at 9:55am revealed: -There was a laundry aide that was responsible for doing resident's laundry and linen. -She completed the laundry on the 100 hallway on Monday, the 200 hallway on Wednesday, and the 300 hallway on Friday. -She was aware of a resident's shirt that went missing in the laundry but it was eventually located. -She was not aware of any other residents missing laundry items. Interview with a medication aide (MA) on 08/17/22 at 10:00am revealed: -The laundry aide did laundry one room at a time, so if there were two residents in a room their laundry would be done together. -She was not aware of any residents missing laundry items and she had not seen residents wearing each other's clothing. Interview with the RCC on 08/17/22 at 10:15am revealed:	D 338		

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D 338	Continued From page 2 -In the past if a resident's article of clothing went missing, the staff would attempt to locate the missing article of clothing. -If they were not able to find the missing article of clothing the facility would replace the item. -She was not aware of any clothing items currently missing from any of the residents. Interview with the Administrator on 08/17/22 at 10:25am revealed: -He was not aware of any clothing items currently missing from any of the residents. -The laundry aide puts the roommates clothing together in the wash so not to get items separated. -There was not a Maintenance Director at the facility, but they are working on installing the new washer this week for the residents that wash their clothing independently. Attempted interview with the laundry aide on 08/17/22 at 9:15am was unsuccessful.	D 338		
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: Based on observations, interviews, and record reviews, the facility failed to administer	D 358	10A NCAC 13 F .1004(a) Medication Administration Community ED and CC will review new orders daily in stand up to ensure order clarification. Community ED and CC will review Medication Administration utilizing Matrix Care reporting and weekly Medication Cart Audits during Stand-up meetings. The CC will conduct weekly cart audits against the EMAR to the medication cart to ensure accuracy. The ED has in-serviced all Medication Staff on Medication Administration to include the six rights to medications, doumentation and med errors.	8/19/2022 8/22/2022 8/22/2022 8/30/2022

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D 358	Continued From page 3	D 358		

medications as ordered for 2 of 3 residents (#5, #7) observed during the medication passes including errors with a medication for diabetes (#5) and a medication for glaucoma (#7); and for 1 of 5 residents sampled (#1) for record review including failing to administer a full course of an antibiotic.

The findings are:

1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 30 opportunities during the 8:00am medication pass on 08/16/22.

a. Review of Resident #5's current FL2 dated 06/20/22 revealed:
-Diagnoses included diabetes.
-There was an order for Metformin extended release 500mg twice daily with meals. (Metformin is used to control blood sugar.)

Observation of the 8:00am medication pass on 08/16/22 revealed the medication aide (MA) administered Metformin 500mg to Resident #5 at 8:38am.

Interview with Resident #5 on 08/16/22 at 11:20am revealed:
-He ate breakfast around 7:30am on 08/16/22.
-He usually received his morning medication sometime after he ate breakfast.
-He was not having any stomach pain, diarrhea, or nausea.
-He was not having any dizziness or increased thirst.

Review of Resident #5's August 2022 electronic medication administration record (eMAR) revealed there was an entry for Metformin

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D 358	Continued From page 4 extended release 500mg twice daily with meals to be administered at 8:00am and 5:00pm. Interview with the MA on 08/16/22 at 11:33am revealed: -Resident #5's Metformin was scheduled to be administered at 8:00am so she could administer it one hour before or one hour after the scheduled time. -If a medication was ordered to be given with meals then it should be administered when the resident was eating or right before they began eating. -Breakfast at the facility was served at 7:30am so Resident #5 should have eaten around that time. -It was important that Resident #5 receive his Metformin with meals because it could harm his stomach lining or cause his blood sugars to fluctuate if he did not receive the medication with a meal. Interview with the Resident Care Coordinator (RCC) on 08/16/22 at 11:52 am revealed: -If a medication was ordered to be administered with a meal it should be given right when the resident started eating. -If a medication was ordered to be administered with a meal then it should be scheduled on the eMAR for 7:30am, 12:00pm, and 5:30pm since that was when meals were served at the facility. -She would change the medication administration times for Resident #5's Metformin on the eMAR to coincide with mealtimes. -It was important for Resident #5 to receive his Metformin with meals as ordered because the medication helped to keep his blood sugar from going too high. Interview with the Administrator on 08/16/22 at 11:59am revealed he expected Resident #5's	D 358		

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D 358	Continued From page 5 Metformin to be given with a meal as ordered by the primary care provider (PCP). Interview with Resident #5's PCP on 08/17/22 at 11:06am revealed she expected Resident #5's Metformin to be administered with meals or no more than 30 to 40 minutes after eating his meal to help control his blood sugars. b. Review of Resident #7's current FL2 dated 01/31/22 revealed she had diagnoses of acute kidney failure and cerebrovascular disease. Review of Resident #7's physician order sheet dated 04/18/22 revealed there was an order for dorzolamide-timolol 22.3-6.8mg/ml instill 1 drop into the left eye every day. (Dorzolamide-timolol is used to treat increased pressure in the eye caused by glaucoma.) Review of Resident #7's August 2022 electronic medication administration record (eMAR) revealed there was an entry for dorzolamide-timolol drops 22.3-6.8mg/ml instill 1 drop into left eye every day scheduled to be administered at 8:00am. Observation of the 8:00am medication pass on 08/16/22 revealed the medication aide (MA) administered 1 drop of dorzolamide-timolol into Resident #7's left eye and 1 drop of dorzolamide-timolol into Resident #7's right eye at 8:14am. Interview with Resident #7 on 08/16/22 at 11:39am revealed: -She received her morning eye drops in her left eye. -She sometimes received the morning eye drops in her right eye.	D 358		

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D 358	Continued From page 6 -She received the eye drops in both her left and right eye on 08/16/22. -She was not having any blurred vision or pain in her right eye. Interview with the MA on 08/16/22 at 11:30am revealed: -Resident #7 was supposed to receive her eye drop in her left eye only. -She mistakenly gave her eye drop in both eyes on 08/16/22. -It was important that Resident #7 receive her eye drop in the proper eye because she did not want to harm the resident's eye. Interview with the Resident Care Coordinator (RCC) on 08/16/22 at 11:52am revealed: -She expected all medications to be administered as ordered by the primary care provider (PCP) because the PCP ordered medications a certain way for a reason. -Resident #7 receiving her eye drop in the wrong eye could affect her vision. Interview with the PCP on 08/17/22 at 11:06am revealed she expected Resident #7 to receive her eye drop only in her left eye as ordered. 2. Review of Resident #1's current FL-2 dated 01/10/22 revealed diagnoses included anemia, Alzheimer's disease and insomnia. Review of Resident #1's physician's orders dated 08/03/22 revealed there was an order for Keflex 500mg, twice a day for 7 days (Keflex is an antibiotic used to treat urinary tract infections). Review of Resident #1's August 2022 electronic medication administration record (eMAR) revealed"	D 358		

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D 358	Continued From page 7 -There was an entry for Keflex 250mg/5mL, with instructions to give 10mL, twice a day for 7 days and to discard the remainder after 7 days. -Keflex 500mg was documented as administered on 08/04/22 at 8:00pm, 08/05/22 at 8:00am and 8:00pm, 08/06/22 at 8:00pm, 08/07/22 at 8:00am and 8:00pm, 08/08/22 at 8:00am and 8:00pm, 08/09/22 at 8:00am and 8:00pm, and 08/10/22 at 8:00am and 8:00pm, for a total of 12 doses. -Keflex 500mg was documented as not given, with reason 'on hold' on 08/06/22 at 8:00am. -Keflex was documented as administered for 12 doses, when the order was for a total of 14 doses. Observation of Resident #1's medication on hand on 08/17/22 at 10:40am revealed there was no Keflex available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/17/22 at 9:05am revealed: -The pharmacy received the order for Keflex 500mg, twice a day for 7 days at 11:00pm on 08/03/22. -Keflex was dispensed on 08/04/22 and sent to the pharmacy the afternoon of 08/04/22. -It was important for the resident to receive the full course of antibiotics as ordered to ensure that the infection was treated and to prevent reoccurrence of the infection. Interview with a medication aide (MA) on 08/17/22 at 10:00am revealed: -Medications were placed on the eMAR by the pharmacy and approved by the Resident Care Coordinator (RCC). -If a medication was held, there should be a note documenting a reason why the medication was not administered.	D 358		

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D 358	Continued From page 8 -MAs were to administer medications by the eMAR. Interview with the RCC on 08/17/22 at 10:10am revealed: -She expected the MAs to administer Resident #1's antibiotic as ordered. -She was not aware that Resident #1 only received 12 of the 14 doses ordered of her antibiotic. -She was responsible for approving the order entered by the pharmacy for it to show up on the eMAR. -It was important that Resident #1 received all of her ordered antibiotics to treat her urinary tract infection. Interview with the Administrator on 08/17/22 at 10:25am revealed he expected medications to be administered as ordered by the primary care provider (PCP). Telephone interview with Resident #1's PCP on 08/17/22 at 11:06am revealed: -She expected Resident #1 to receive all ordered doses of the antibiotic to treat her urinary tract infection. -She was not aware that Resident #1 only received 12 doses instead of the 14 doses ordered. -It was important for the resident to receive the full course of antibiotics to ensure that the infection as treated and to prevent reoccurrence of the infection. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.	D 358		