Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			D. MAILEO		R-C	
		HAL034116	B. WING		11/0	9/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE AND MEMORY	CARE	SALISBURY RO SALEM, NC 2			
0/0.15	SLIMMADV ST.		· ·	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
		sure Section conducted a complaint investigation on ad November 9, 2022.				
D 358	10A NCAC 13F .1004 Administration	e(a) Medication	D 358			
	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 record reviews and interviews, the facility failed to ensure medications were administered as ordered for 2 of 6 sampled residents (Resident #3 and #5) with physician's orders to hold an antipsychotic medication, a medication to inhibit renal excretion (#3) and not administering an alpha-Adrienne agonist eye drop (#5).					
	The findings are:					
	06/29/22 revealed dia Alzheimer's dementia state 3 chronic kidney failure, hypertension, a. Review of Residen	with behavior disturbances, disease, congestive heart and stroke. t #3's current FL2 dated edication orders included an order twice daily (an				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (
		A. BUILDING: _	A. BUILDING:			
HAL034116		B. WING			R-C / 09/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		2609 OLI	SALISBURY R	OAD		
SALEM TI	ERRACE AND MEMORY	CARE WINSTO!	N SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	÷1	D 358			
	disorders).					
	summary report dated -Resident #3 was host through 11/07/22 due -Discharge medication hold olanzapine 5mg was seen by the primal Review of Resident # electronic Medication (eMAR) revealed: -There was an entry for daily scheduled for ac 9:00pmThere was document administered and not	spitalized from 11/02/22 kidney failure. n orders included orders to twice daily until the resident ary care provider (PCP).				
	Observation of Resident on 11/09/22 at 1-Olanzapine 5mg was administration.					
	quantity of 60 tablets	s filled on 10/07/22 and a were dispensed. s of olanzapine remaining.				
	facility's contracted pl 4:15pm revealed: -The pharmacy had F discharge summary d resident's current med -The pharmacy was a to be held until the red -The pharmacy had n	ated 11/07/22 that listed the				

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Division of Health Service Regulation

OTATEMENT OF DEFICIENCIES (VA) DROVIDED (OURDLIED OUR		()(0) MILITED E	CONSTRUCTION	(X3) DATE SURVEY		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	1, ,		
ANDIEAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED	
					R-C	
		HAL034116	B. WING		11/09/2022	
					100/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
SAI FM TI	ERRACE AND MEMORY	CARE 2609 OLI	SALISBURY R	OAD		
O/ (ZZ.III 11		WINSTO	N SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	
			+	,		
D 358	Continued From page	2	D 358			
	-The pharmacy last d	ispensed a quantity of 30				
	olanzapine on 10/07/					
	•	ninistering olanzapine they				
		edications on hand already.				
		ibed on the eMAR for staff				
	to hold olanzapine.					
	10 11014 0141124					
	Telephone interview v	vith Resident #3's family				
	member on 11/09/22					
	-Yesterday (11/08/22)	•				
	• ,	alled to ask if she was aware				
	of changes in Reside					
	_	at she was not aware of				
	Resident #3's medica					
		ther to contact the PCP and				
	did not make her awa					
	medication changes.	or any operand				
	···· ·					
	Interview with the me	dication aide (MA) on				
	11/09/22 at 10:51am	revealed:				
	-The RCC or anyone	else had made her aware to				
	hold Resident #3's old					
	-She administered ola	anzapine 5mg his morning				
		e eMAR and scheduled at				
	9:00am.					
	-When a resident retu	irned from the hospital, the				
	MA on duty was supp	•				
	discharge summary r	eport.				
		ew orders and discharge				
	medication list to the					
		identified that olanzapine				
		oted the change on the				
	medication.	-				
		ministrator on 11/09/22 at				
	3:53pm revealed:					
		dent #3's hospital discharge				
		list had instructions to hold				
	olanzapine 5mg.					
	-Although, the hospita	al medication list was signed				

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
			1	-			
					R-	·C	
		HAL034116	B. WING		11/0	9/2022	
NAME OF D		OTDEET AD	DDEGG OITY OTA	TE 710 000E			
NAME OF PI	ROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, STA	ATE, ZIP CODE			
SALEMITE	ERRACE AND MEMORY	CARE 2609 OLD	SALISBURY R	OAD			
OALLIN II	INVACE AND MEMORY	WINSTON	SALEM, NC 2	7127			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE	
				DEFICIENCY)			
D 050		_	D 050				
D 358	Continued From page	e 3	D 358				
	by the physician she	did not consider the					
		order because the hospital					
		•					
	-	ate prescription order to hold					
	olanzapine 5mg.						
		dout to the resident's PCP					
	about holding olanza						
	-She contacted the R	CC and was told by the					
	RCC that she (RCC)	had communicated with the					
	PCP and was awaitin	g a response.					
		y said she had reached out					
		ly member and asked the					
		ntact the PCP about holding					
	olanzapine.	itade the FOF about holding					
	·	contation the DCD had been					
		nentation the PCP had been					
	contacted regarding a	an order to hold olanzapine.					
	•	with the nurse at Resident					
	#3's PCP's office on 7	11/09/22 at 11:39am					
	revealed:						
	-No one from the faci	lity had contacted the PCP's					
	office prior to today, a	about one hour ago.					
	-The Administrator ca	illed and asked about					
	holding two of Reside	ent #3's medications, which					
	included olanzapine 5						
		sent the hospital discharge					
	summary to the PCP'						
	-						
		vare Resident #3 had been					
	discharged from the h	•					
		CP and he stated if the					
	hospital discharge ha						
	olanzapine 5mg until	Resident #3 was seen by					
	the PCP, then the fac	cility should hold the					
	medication and not a	dminister olanzapine 5mg.					
	Attempted telephone	interview with the Special					
		r (SCUC) on 11/09/22 at					
	4:16pm was unsucce	•					
	T. TOPITI WAS UITSUCCE	ooiui.					
	h Davious of Dooi-les	t #210 ourrent EL 2 deted					
		t #3's current FL2 dated					
	06/29/22 included an	order for probenecid 500mg	1				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
BENT OTHER CONTROL		A. BUILDING: _			
HAL034116		B. WING	R-C 11/09/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SALEM TI	ERRACE AND MEMORY	CARE	SALISBURY R		
		WINSTON	SALEM, NC 2		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 4	D 358		
	twice daily (used to tr	eat gout).			
	summary report medi revealed an order to l	3's hospital discharge cation list dated 11/07/22 hold probenecid 500mg esident was seen by the			
	revealed: -There was an entry f daily scheduled for ac 9:00pmThere was documen	3's November 2022 eMAR for probenecid 500mg twice dministration at 9:00am and tation probenecid 500mg 9:00am on 11/08/22; 9:00pm 00am on 11/09/22.			
	Observations of Resident #3's medications on hand at the facility on 11/09/22 at 11:40am revealed: -Probenecid 500mg was available for administrationProbenecid 500mg was filled on 09/29/22 and a				
	quantity of 60 tablets -There were 9 tablets	were dispensed. of probenecid remaining.			
	member on 11/09/22 -Yesterday (11/08/22) she was aware of chamedicationsShe told the RCC thamedications are told the RCC thanks are told the RCC did not ask she had made no corpcp.), the RCC called to ask if anges in Resident #3's at she was not aware of			
	Telephone interview v	vith a pharmacist at the			

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Division of Health Service Regulation

Division of Health Service Regulation							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMI	COMPLETED	
					R-C		
		HAL034116	B. WING		l l	/09/2022	
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AF	DDRESS, CITY, STA	TE ZID CODE			
NAME OF T	TOVIDEIT OIT SOI I EIEIT						
SALEM TE	RRACE AND MEMORY	CARE	O SALISBURY RO N SALEM, NC 2				
			N SALEW, NC 2				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION)		(X5) COMPLETE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH	HE APPROPRIATE	DATE	
				DEFICIENCY	()		
D 358	Continued From page	e 5	D 358				
	facility's contracted pl 4:15pm revealed:	harmacy on 11/08/22 at					
	-The pharmacy had F	Resident #3's hospital					
		dated 11/07/22 that listed the					
	resident's current med	dication orders.					
		aware probenecid 500mg					
	was to be held until the PCP.	ne resident was seen by the					
		not dispensed probenecid					
		urned to the facility from the					
	hospital.						
	•	ministering probenecid they					
	the resident went to the	edications on hand before					
		ribed on the eMAR for staff					
	to hold probenecid.						
		on 11/09/22 at 10:51am					
	revealed:						
	hold Resident #3's pre						
	-She administered pro	•					
	morning because it w scheduled at 9:00am.						
	-When a resident retu	ırned from the hospital, the					
	MA on duty was supp						
	discharge summary re						
		ew orders and discharge					
	medication list to the						
		identified that probenecid					
	medication.	oted the change on the					
	medication.						
	Interview with the sec 3:12pm revealed:	cond shift MA on 11/09/22 at					
	-She administered Re	esident #3's probenecid at					
	9:00pm yesterday.	obenecid 500mg because					
		entation on the eMAR to hold					

Division of Health Service Regulation

the medication.

STATE FORM 6899 44K311 If continuation sheet 6 of 11

Division of Health Service Regulation

Division of Health Service Regulation							
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
					D.0		
		1141 004440	B. WING		R-C		
		HAL034116			11/09/202	2	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE			
		2609 OLF	SALISBURY RO	OAD			
SALEM TE	ERRACE AND MEMORY	CARE	N SALEM, NC 27				
			T SALLIN, NO 21				
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) MPLETE	
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		ATE	
				DEFICIENCY)			
D 050			D 050				
D 358	Continued From page	∍ 6	D 358				
	-The RCC or MA had	not made her aware the					
	probenecid should be						
	probonicola chicala be	, mora.					
	Interview with Admini	istrator 11/09/22 at 3:53pm					
	revealed:	anate: 11,00,22 at 0.00p					
		ident #3's hospital discharge					
		list had instructions to hold					
	probenecid 500mg tw						
	· ·	r the instructions to be an					
	order because the ho						
	separate prescription						
	medication.	order to note the					
		d out to the resident's PCP to					
		500mg should be held.					
		CC and was told the RCC					
		vith the PCP and was waiting					
		Till the FCF and was waiting					
	a response.	···					
		y said she had reached out					
		ly member and asked the					
	family member to con						
		nentation the PCP had been					
	contacted regarding a	an order to hold probenecid.					
	Tolophono intonvious	with the pures at Posident					
	#3's PCP's office on 1	with the nurse at Resident					
		11/09/22 at 11.59am					
	revealed:	lity had contacted the DCD's					
		ility had contacted the PCP's					
	office prior to today, a	alled and asked about					
		ent #3's medications, one of					
		•					
		enecid 500mg twice daily. Sent the hospital discharge					
	_						
	summary to the PCP'						
		vare Resident #3 had been					
	discharged from the h	•					
		with the PCP and he stated if					
		e had instructions to hold					
		vice daily until Resident #3					
	∣ was seen by the PCP	P, then the facility should hold					

Division of Health Service Regulation

the medication and not administer probenecid.

STATE FORM 6899 44K311 If continuation sheet 7 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND I LAN	. John Lonois	.DERTH TO ATOM HOWDER.	A. BUILDING: _			
		HAL034116	B. WING		R-C 11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE AND MEMORY	CARE	SALISBURY R			
		WINSTON	SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 7	D 358			
		interview with the Special r (SCUC) on 11/09/22 at ssful.				
	Based on observation interviews, it was deternot interviewable.	n, record review and ermined Resident #3 was				
	 2. Review of Resident #5's current FL2 dated 09/07/22 revealed: -Diagnoses included glaucoma, multiple sclerosis, confusion, acute cystitis, impaired mobility, anxiety and hypertension. -Medication orders included an order for brimonidine 0.2% ophthalmic one drop in both eyes three times daily (used to treat glaucoma). 					
	(eMAR) revealed: -There was an entry f times daily scheduled 8:00am, 2:00pm and -There was documen	Administration Record for brimonidine 0.2% three I for administration at				
	hand at the facility on revealed: -Brimonidine 0.2% wa administration. -Brimonidine 0.2% wa	as available for as dispensed on 10/16/22. st full with at least ¾ of the				
		vith a pharmacist at the harmacy on 11/09/22 at				

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Division	of Health Service Regu	ilation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D WING		R-C
		HAL034116	B. WING		11/09/2022
NAME OF D		CIDET	ADDDECC CITY CTA	TE 310 CODE	
NAME OF PI	ROVIDER OR SUPPLIER	SIREEL	ADDRESS, CITY, STA	TE, ZIP CODE	
CALEMIT	ERRACE AND MEMORY	2609 OI	LD SALISBURY RO	DAD	
SALEW II	ERRACE AND WENIOR	WINSTO	ON SALEM, NC 27	7127	
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
D 358	Continued From page	e 8	D 358		
	D: :1: 0.00/	6 (60) 1 1 1			
		as first filled and dispensed			
	on 08/26/22 and on 1	0/17/22.			
	 One bottle of brimon 	idine 0.2% would last 17			
	days if administered a	as ordered.			
	-Resident #5's eye dr	rops were not automatically			
	•	d to call and request a refill			
	of the brimonidine 0.2	•			
	or the bilinormanic 0.2	£ 70.			
	14	45 44/00/00 -+ 0.00			
		ent #5 on 11/08/22 at 9:23am			
	revealed:				
		and was supposed to be			
	given three eye drops	s daily.			
	-She had noticed that	t she did not always get			
	three eye drops daily.				
		e MA why she did not get one			
		MA said they did not have			
	the eye drops at the f				
		ny the facility did not get her			
	eye drop.				
	-She did not know the	e specific name of her eye			
	drops.				
	-She knew that she n	eeded to eye drops to keep			
	from going blind.				
		eived three eye drops at			
	bedtime.	ou unos ojo unopo un			
		n eye drops in the morning.			
	•				
		if she received eye drops			
	every day at 2:00pm.				
		he did not get eye drops at			
	three times daily.				
	Interview with a first s	shift MA on 11/09/22 at			
	1:51pm revealed:				
		e for administering Resident			
		% eye drop at 8:00am and			
		o cyc drop at 0.00am and			
	2:00pm.	and the subscribes above the second second			
		explain why the resident had			
	so much brimonidine	eye drop solution remaining.			

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-If the MA did not administer the resident's eye drop there should be documentation why the

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Division of Health Service Regulation							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					R-C		
HAL034116		B. WING		11/09/2022			
		HAL034116			11/09/2022		
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
241 514 55		2609 OL	D SALISBURY R	OAD			
SALEMIE	ERRACE AND MEMORY	CARE WINSTO	ON SALEM, NC 2	7127			
(X4) ID	SUMMARY ST.	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)		
PREFIX	(EACH DEFICIENC)	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE		
				DEFICIENCY)			
D 358	Continued From page	e 9	D 358				
	medication was not a	ıdministered.					
		L. L. 15 BAA 44 (00/00 of					
		ond shift MA on 11/09/22 at					
	3:53pm revealed:	and the same drama as					
		esident #5's eye drops as					
	documented on the e -She was unable to re						
		administered, or the resident					
	refused the eye drop.						
	·	n of the brimonidine 0.2%					
		ago, when she checked					
		ations there was an extra					
	bottle of eye drops.	AUDIS HICIO WAS AIT CAUA					
		eye drops with the oldest					
	date.	cyc drops with the sidest					
		rent bottle of brimonidine.					
		one botto of brinnermanie.					
	Interview with the Adr	ministrator on 11/09/22 at					
	4:51pm revealed:						
	•	explain why there was so					
	much brimonidine 0.2	· ·					
		onsible for medication cart					
	· ·	ly checked for medications					
		ordered; they were not					
	looking at medication	ns to see if a medication was					
		sure the medication was					
	administered as order	red.					
		cations to be administered as					
ordered.							
		<u> </u>					
	Interview with Reside						
	` ′	1/09/22 at 11:43am revealed:					
		vere glaucoma and was					
	ordered three eye dro	ops, which included					
	brimonidine 0.2%.						
		issue administering the					
	medication, they shoເ						
	-She expected the me	edication to be administered					

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as ordered.

-Resident #5 would know if she did not get the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						R-C	
		HAL034116	B. WING		I	/09/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
SALEM TE	ERRACE AND MEMORY	CARF	D SALISBURY RO				
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	N SALEM, NC 27	PROVIDER'S PLAN OF CORI	RECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 358	Continued From page	e 10	D 358				
D 358	eye dropsIf the resident said sidrops, then she was i	the was not getting the eye not getting the eye drops. With the Resident Care in 11/09/22 at 4:17pm was	D 358				

Division of Health Service Regulation

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