STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	R-C 11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE AND MEMORY CARE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on November 8, 2022 and November 9, 2022.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: 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: 1. Review of Resident #3's current FL2 dated 06/29/22 revealed diagnoses included Alzheimer's dementia with behavior disturbances, state 3 chronic kidney disease, congestive heart failure, hypertension, and stroke. a. Review of Resident #3's current FL2 dated 06/29/22 revealed medication orders included an order for olanzapine 5mg twice daily (an antipsychotic used to treat mental mood	D 358		

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D 358	Continued From page 1 disorders). Review of Resident #3's hospital discharge summary report dated 11/07/22 revealed: -Resident #3 was hospitalized from 11/02/22 through 11/07/22 due kidney failure. -Discharge medication orders included orders to hold olanzapine 5mg twice daily until the resident was seen by the primary care provider (PCP). Review of Resident #3's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for olanzapine 5mg twice daily scheduled for administration at 9:00am and 9:00pm. -There was documentation olanzapine 5mg was administered and not held as ordered at 9:00am on 11/08/22; 9:00pm on 11/08/22; and at 9:00am on 11/09/22. Observation of Resident #3's medications on hand on 11/09/22 at 11:40am revealed: -Olanzapine 5mg was available for administration. -Olanzapine 5mg was filled on 10/07/22 and a quantity of 60 tablets were dispensed. -There were 19 tablets of olanzapine remaining. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/08/22 at 4:15pm revealed: -The pharmacy had Resident #3's hospital discharge summary dated 11/07/22 that listed the resident's current medication orders. -The pharmacy was aware olanzapine 5mg was to be held until the resident was seen by the PCP. -The pharmacy had not dispensed olanzapine since Resident #3 returned to the facility from the hospital.	D 358		

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-The pharmacy last dispensed a quantity of 30 olanzapine on 10/07/22.
-If the facility was administering olanzapine they must have had the medications on hand already.
-They had not transcribed on the eMAR for staff to hold olanzapine.

Telephone interview with Resident #3's family member on 11/09/22 at 3:16pm revealed:
-Yesterday (11/08/22), the Resident Care Coordinator (RCC) called to ask if she was aware of changes in Resident #3's medications.
-She told the RCC that she was not aware of Resident #3's medication changes.
-The RCC did not ask her to contact the PCP and did not make her aware of any specific medication changes.

Interview with the medication aide (MA) on 11/09/22 at 10:51am revealed:
-The RCC or anyone else had made her aware to hold Resident #3's olanzapine.
-She administered olanzapine 5mg his morning because it was on the eMAR and scheduled at 9:00am.
-When a resident returned from the hospital, the MA on duty was supposed to review the discharge summary report.
-The MA was to fax new orders and discharge medication list to the pharmacy.
-The MA should have identified that olanzapine was to be held and noted the change on the medication.

Interview with the Administrator on 11/09/22 at 3:53pm revealed:
-She was aware Resident #3's hospital discharge summary medication list had instructions to hold olanzapine 5mg.
-Although, the hospital medication list was signed

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by the physician she did not consider the instructions to be an order because the hospital did not write a separate prescription order to hold olanzapine 5mg.
-She had not reached out to the resident's PCP about holding olanzapine.
-She contacted the RCC and was told by the RCC that she (RCC) had communicated with the PCP and was awaiting a response.
-The RCC additionally said she had reached out to Resident #3's family member and asked the family member to contact the PCP about holding olanzapine.
-There was no documentation the PCP had been contacted regarding an order to hold olanzapine.

Telephone interview with the nurse at Resident #3's PCP's office on 11/09/22 at 11:39am revealed:
-No one from the facility had contacted the PCP's office prior to today, about one hour ago.
-The Administrator called and asked about holding two of Resident #3's medications, which included olanzapine 5mg twice daily.
-The facility had not sent the hospital discharge summary to the PCP's office.
-The PCP was not aware Resident #3 had been discharged from the hospital.
-She contacted the PCP and he stated if the hospital discharge had instructions to hold olanzapine 5mg until Resident #3 was seen by the PCP, then the facility should hold the medication and not administer olanzapine 5mg.

Attempted telephone interview with the Special Care Unit Coordinator (SCUC) on 11/09/22 at 4:16pm was unsuccessful.

b. Review of Resident #3's current FL2 dated 06/29/22 included an order for probenecid 500mg

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twice daily (used to treat gout).

Review of Resident #3's hospital discharge summary report medication list dated 11/07/22 revealed an order to hold probenecid 500mg twice daily until the resident was seen by the PCP.

Review of Resident #3's November 2022 eMAR revealed:
-There was an entry for probenecid 500mg twice daily scheduled for administration at 9:00am and 9:00pm.
-There was documentation probenecid 500mg was administered at 9:00am on 11/08/22; 9:00pm on 11/08/22 and at 9:00am 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 administration.
-Probenecid 500mg was filled on 09/29/22 and a quantity of 60 tablets were dispensed.
-There were 9 tablets of probenecid remaining.

Telephone interview with Resident #3's family member on 11/09/22 at 3:16pm revealed:
-Yesterday (11/08/22), the RCC called to ask if she was aware of changes in Resident #3's medications.
-She told the RCC that she was not aware of Resident #3's medication changes.
-The RCC did not ask her to contact the PCP, she had made no contact with Resident #3's PCP.
-The RCC did not make her aware of any specific medication changes.

Telephone interview with a pharmacist at the

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facility's contracted pharmacy on 11/08/22 at 4:15pm revealed:
-The pharmacy had Resident #3's hospital discharge summary dated 11/07/22 that listed the resident's current medication orders.
-The pharmacy was aware probenecid 500mg was to be held until the resident was seen by the PCP.
-The pharmacy had not dispensed probenecid since Resident #3 returned to the facility from the hospital.
-If the facility was administering probenecid they must have had the medications on hand before the resident went to the hospital.
-They had not transcribed on the eMAR for staff to hold probenecid.

Interview with the MA on 11/09/22 at 10:51am revealed:
-The RCC or anyone else had made her aware to hold Resident #3's probenecid.
-She administered probenecid 500mg his morning because it was on the eMAR and scheduled at 9:00am.
-When a resident returned from the hospital, the MA on duty was supposed to review the discharge summary report.
-The MA was to fax new orders and discharge medication list to the pharmacy.
-The MA should have identified that probenecid was to be held and noted the change on the medication.

Interview with the second shift MA on 11/09/22 at 3:12pm revealed:
-She administered Resident #3's probenecid at 9:00pm yesterday.
-She administered probenecid 500mg because there was no documentation on the eMAR to hold the medication.

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D 358	Continued From page 6 -The RCC or MA had not made her aware the probenecid should be held. Interview with Administrator 11/09/22 at 3:53pm revealed: -She was aware Resident #3's hospital discharge summary medication list had instructions to hold probenecid 500mg twice daily. -She did not consider the instructions to be an order because the hospital did not write a separate prescription order to hold the medication. -She had not reached out to the resident's PCP to inquire if probenecid 500mg should be held. -She contacted the RCC and was told the RCC had communicated with the PCP and was waiting a response. -The RCC additionally said she had reached out to Resident #3's family member and asked the family member to contact the PCP. -There was no documentation the PCP had been contacted regarding an order to hold probenecid. Telephone interview with the nurse at Resident #3's PCP's office on 11/09/22 at 11:39am revealed: -No one from the facility had contacted the PCP's office prior to today, about one hour ago. -The Administrator called and asked about holding two of Resident #3's medications, one of which included probenecid 500mg twice daily. -The facility had not sent the hospital discharge summary to the PCP's office. -The PCP was not aware Resident #3 had been discharged from the hospital. -She communicated with the PCP and he stated if the hospital discharge had instructions to hold probenecid 500mg twice daily until Resident #3 was seen by the PCP, then the facility should hold the medication and not administer probenecid.	D 358		

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D 358	Continued From page 7 Attempted telephone interview with the Special Care Unit Coordinator (SCUC) on 11/09/22 at 4:16pm was unsuccessful. Based on observation, record review and interviews, it was determined Resident #3 was not interviewable. 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). Review of Resident #5's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for brimonidine 0.2% three times daily scheduled for administration at 8:00am, 2:00pm and 8:00pm. -There was documentation brimonidine 0.2% was administered three times daily from 11/01/22 through 11/09/22. Observation of Resident #5's medications on hand at the facility on 11/09/22 at 2:00pm revealed: -Brimonidine 0.2% was available for administration. -Brimonidine 0.2% was dispensed on 10/16/22. -The bottle was almost full with at least ¾ of the solution remaining in the bottle. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/09/22 at 2:07pm revealed:	D 358		

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-Brimonidine 0.2% was first filled and dispensed on 08/26/22 and on 10/17/22.
-One bottle of brimonidine 0.2% would last 17 days if administered as ordered.
-Resident #5's eye drops were not automatically refilled; the facility had to call and request a refill of the brimonidine 0.2%.

Interview with Resident #5 on 11/08/22 at 9:23am revealed:
-She had glaucoma and was supposed to be given three eye drops daily.
-She had noticed that she did not always get three eye drops daily.
-When she asked the MA why she did not get one of her eyes drops the MA said they did not have the eye drops at the facility.
-She did not know why the facility did not get her eye drop.
-She did not know the specific name of her eye drops.
-She knew that she needed to eye drops to keep from going blind.
-She sometimes received three eye drops at bedtime.
-The had never gotten eye drops in the morning.
-She could not recall if she received eye drops every day at 2:00pm.
-She was sure that she did not get eye drops at three times daily.

Interview with a first shift MA on 11/09/22 at 1:51pm revealed:
-She was responsible for administering Resident #5's brimonidine 0.2% eye drop at 8:00am and 2:00pm.
-She was unable to explain why the resident had so much brimonidine eye drop solution remaining.
-If the MA did not administer the resident's eye drop there should be documentation why the

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medication was not administered.

Interview with a second shift MA on 11/09/22 at 3:53pm revealed:
-She administered Resident #5's eye drops as documented on the eMAR.
-She was unable to recall a reason the medication was not administered, or the resident refused the eye drop.
-The reason so much of the brimonidine 0.2% was left a few weeks ago, when she checked Resident #5's medications there was an extra bottle of eye drops.
-She disposed of the eye drops with the oldest date.
-She opened the current bottle of brimonidine.

Interview with the Administrator on 11/09/22 at 4:51pm revealed:
-She was unable to explain why there was so much brimonidine 0.2% left.
-The MAs were responsible for medication cart audits, but they mainly checked for medications that needed to be reordered; they were not looking at medications to see if a medication was lasting too long to ensure the medication was administered as ordered.
-She expected medications to be administered as ordered.

Interview with Resident #5's Primary Care Provider (PCP) on 11/09/22 at 11:43am revealed:
-Resident #5 had severe glaucoma and was ordered three eye drops, which included brimonidine 0.2%.
-If the facility had an issue administering the medication, they should let her know.
-She expected the medication to be administered as ordered.
-Resident #5 would know if she did not get the

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D 358	Continued From page 10 eye drops. -If the resident said she was not getting the eye drops, then she was not getting the eye drops. Attempted interview with the Resident Care Coordinator (RCC) on 11/09/22 at 4:17pm was unsuccessful.	D 358		