PRINTED: 11/17/2022

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING HAL034116 11/09/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE AND MEMORY CARE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Initial Comments D 000 The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on November 8, 2022 and November 9, 2022. D 358 10A NCAC 13F .1004(a) Medication D 358 Administration All new provider orders will be faxed upon receipt. 10A NCAC 13F .1004 Medication Administration Once faxed, all orders will be (a) An adult care home shall assure that the reviewed and necessary action preparation and administration of medications, prescription and non-prescription, and treatments will be taken by RCC for order 11/24/2022 by staff are in accordance with: approval in eMAR system. (1) orders by a licensed prescribing practitioner Administrator will meet with RCC which are maintained in the resident's record; and every morning to review any new (2) rules in this Section and the facility's policies and procedures. orders to ensure necessary follow up is completed and This Rule is not met as evidenced by: documentation is accurate. Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered for 2 of 6 sampled Staff in-service to educate staff residents (Resident #3 and #5) with physician's 11/30/2022 on order process to be orders to hold an antipsychotic medication, a completed medication to inhibit renal excretion (#3) and not administering an alpha-Adrienne agonist eye drop (#5).MedAide refresher training to be 12/7/2022 completed with all MedAides The findings are: Review of Resident #3's current FL2 dated 06/29/22 revealed diagnoses included RN and RCC will complete full Alzheimer's dementia with behavior disturbances, carts audits weekly 11/30/2022 state 3 chronic kidney disease, congestive heart Administrator will review cart failure, hypertension, and stroke. audits weekly 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

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

BUU

Administrator

(X6) DATE /22

STATE FORM

Reviewed and acknowledged 12/21/22

44K311

If continuation sheet 1 of 11

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL034116	B. WING			R-C 09/2022
NAME OF D	BOLED OD SLIDSLES				1.17	USIZUZZ
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE			
SALEM T	ERRACE AND MEMORY	CARE	SALISBURY ROA			
2411.45			SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	1	D 358			
	disorders).					
	summary report dated -Resident #3 was hos through 11/07/22 due -Discharge medication hold olanzapine 5mg was seen by the prime Review of Resident # electronic Medication (eMAR) revealed: -There was an entry for daily scheduled for accompany scheduled for accompany scheduled for accompany scheduled and not on 11/08/22; 9:00pm on 11/09/22.	kidney failure. In orders included orders to twice daily until the resident ary care provider (PCP). 3's November 2022 Administration Record for olanzapine 5mg twice dministration at 9:00am and station olanzapine 5mg was held as ordered at 9:00am on 11/08/22; and at 9:00am				
	hand on 11/09/22 at 1 Olanzapine 5mg was administration.	s available for				
	quantity of 60 tablets	were dispensed. ts of olanzapine remaining.				
	facility's contracted placed: 4:15pm revealed: -The pharmacy had Formacy had F	lated 11/07/22 that listed the				
	since Resident #3 ret hospital.	urned to the facility from the				

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PRINTED: 11/17/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R-C B. WING ____ HAL034116 11/09/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE AND MEMORY CARE WINSTON SALEM, NC 27127 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 2 D 358 -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

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medication.

3:53pm revealed:

olanzapine 5mg.

was to be held and noted the change on the

Interview with the Administrator on 11/09/22 at

-She was aware Resident #3's hospital discharge

summary medication list had instructions to hold

-Although, the hospital medication list was signed

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Date TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Date Date TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Date Date Date Deficiency	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 3 by the physician she did not consider the instructions to be an order because the hospital						R-C	
SALEM TERRACE AND MEMORY CARE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 3 by the physician she did not consider the instructions to be an order because the hospital			HAL034116	B. WING		11/09/2	022
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 3 by the physician she did not consider the instructions to be an order because the hospital	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 3 by the physician she did not consider the instructions to be an order because the hospital	SALEM T	ERRACE AND MEMORY	CARE				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 3 by the physician she did not consider the instructions to be an order because the hospital	(X4) ID	SUMMARY ST				TION	(X5)
by the physician she did not consider the instructions to be an order because the hospital				PREFIX	CROSS-REFERENCED TO THE APPRO		COMPLETE
instructions to be an order because the hospital	D 358	Continued From page	3	D 358			
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		by the physician she instructions to be an olid not write a separal olanzapine 5mg. -She had not reached about holding olanzapineShe contacted the RRCC that she (RCC) PCP and was awaitin -The RCC additionally to Resident #3's familifamily member to conclanzapineThere was no docume contacted regarding at Telephone interview with #3's PCP's office on revealed: -No one from the faci office prior to today, at The Administrator catholding two of Reside included olanzapine summary to the PCP's -The PCP was not away discharged from the PCP's -The PCP was not away discharged from the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP, then the factor and not accomply a summary to the PCP's -The PCP was not as a summary to the PCP's -The PCP was not as a summary to the PCP's -The PCP was not as a summary to the PCP's -The PCP was not as a summary to the PCP's -The PCP was not as a summary to the PCP's -The PCP was not as a summary to the PCP's -The PCP was not as a summary to the PCP's -The	did not consider the order because the hospital ate prescription order to hold do out to the resident's PCP pine. CC and was told by the had communicated with the garesponse. It is said she had reached out and the pCP about holding the had communicated with the garesponse. It is said she had reached out and the pCP about holding the had contact the pCP had been an order to hold olanzapine. With the nurse at Resident 11/09/22 at 11:39am It is had contacted the pCP's about one hour ago. It is medications, which forms twice daily. It is medications, which forms twice daily. It is medications to hold the dinstructions to hold Resident #3 was seen by it is should hold the dminister olanzapine 5mg. Interview with the Special of (SCUC) on 11/09/22 at 11/09/24 at 11/0	D 358			

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PRINTED: 11/17/2022 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: R-C B. WING _____ 11/09/2022 HAL034116 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE AND MEMORY CARE WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 Continued From page 4 D 358 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 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

PCP.

medication changes.

Resident #3's medication changes.

-The RCC did not ask her to contact the PCP,

-The RCC did not make her aware of any specific

she had made no contact with Resident #3's

Telephone interview with a pharmacist at the

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FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: R-C B. WING 11/09/2022 HAL034116 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2609 OLD SALISBURY ROAD SALEM TERRACE AND MEMORY CARE WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 5 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

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the medication.

there was no documentation on the eMAR to hold

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Division of	of Health Service Regu	ulation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			/C DOILDING:			_
		HAL034116	B. WING		11/0	9/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
		2609 OL	D SALISBURY RO	AD		
SALEM TE	ERRACE AND MEMORY	WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pag	e 6	D 358			
	-The PCC or MA had	not made her aware the				
	probenecid should be					
	Interview with Admin	istrator 11/09/22 at 3:53pm				
	revealed:					
	-She was aware Resident #3's hospital discharge					
	summary medication list had instructions to hold					
	-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					
		500mg should be held.				
		RCC and was told the RCC with the PCP and was waiting				
	a response.	viul the FOF and was waiting				
		ly said she had reached out				
		ily member and asked the				
	family member to co					
		mentation the PCP had been an order to hold probenecid.				
	contacted regarding	an order to noid probenecia.				
	Telephone interview	with the nurse at Resident				
	#3's PCP's office on	11/09/22 at 11:39am				
	revealed:	ilit a band contracted the DCD's				
		ility had contacted the PCP's				
	office prior to today,	alled and asked about				
		ent #3's medications, one of				
		enecid 500mg twice daily.				
		sent the hospital discharge				
	summary to the PCP					
		ware Resident #3 had been				
	discharged from the					
		with the PCP and he stated if e had instructions to hold				

probenecid 500mg twice daily until Resident #3

the medication and not administer probenecid.

was seen by the PCP, then the facility should hold

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
			R-C
	HAL034116	B. WING	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)	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 7	D 358		
	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 hypertensionMedication 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 8:00pmThere 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 administrationBrimonidine 0.2% was dispensed on 10/16/22The 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:			

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2:00pm.

eye drop.

from going blind.

every day at 2:00pm.

three times daily.

1:51pm revealed:

drops.

bedtime.

-She did not know why the facility did not get her

-She did not know the specific name of her eye

-She knew that she needed to eye drops to keep

-The had never gotten eye drops in the morning.

-She could not recall if she received eye drops

-She was sure that she did not get eye drops at

-She was responsible for administering Resident

#5's brimonidine 0.2% eye drop at 8:00am and

-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

Interview with a first shift MA on 11/09/22 at

-She sometimes received three eye drops at

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R-C B. WING ____ HAL034116 11/09/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE AND MEMORY CARE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) ID COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 358 Continued From page 9 D 358 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.

as ordered.

-She expected the medication to be administered

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

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R-C B. WING _____ 11/09/2022 HAL034116 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2609 OLD SALISBURY ROAD SALEM TERRACE AND MEMORY CARE WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 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.

Division of Health Service Regulation STATE FORM