STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER STANDARD ASSISTED LIVING	596 NEAL RD REIDSVILLE, NC 27320

(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
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on July 25, 2023.	{C 000}		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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 refer 2 of 3 sampled residents (#1 and #2) who were diabetics and needed their toenails trimmed, to a podiatrist. The findings are: 1. Review of Resident #1's current FL-2 dated 01/27/23 revealed diagnoses included diabetes Type 2, and peripheral neuropathy. Review of Resident #1's care plan dated 01/27/23 revealed Resident #1 was totally dependent on bathing, dressing, and grooming/personal hygiene. Review of the report of health services from Resident #1's podiatrist provider revealed: -Resident #1 was seen on 01/12/23. -Resident #1 had 9 toenails trimmed and 1 lesion trimmed. -Resident #1 was to follow up in 3 months. Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation form dated 05/10/23 revealed: -Resident #1's last podiatry visit was 01/12/23. -Resident #1's toenails were trimmed.	C 246		

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	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

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C 246	Continued From page 1 -Resident #1 had calluses on the soles of her feet with hyperpigmented skin. Observation of Resident #1's toenails on 07/25/23 8:17am revealed: -The first toenail on her left foot was broken and jagged and was thick, brownish/gray, and rippled in appearance. -The second toenail on her left foot was approximately one-eighth of an inch from the top of her toes and had curled over the end of the toe. -The third and fourth toenails were both broken and jagged with sharp edges. -The resident did not have a fifth toe. -On her left foot she had two small, callused areas on the side of the fourth toe. -All 5 toenails on her right foot were broken and jagged with sharp edges. -On her right foot she had a large, callused area on the bottom of the foot below her first toe. Interview with Resident #1 on 07/25/23 8:17am revealed: -Her toenails needed to be cut; she did not recall when her toenails had last been cut. -She did not know if she had an appointment to get her toenails cut. -She was diabetic. -A doctor used to come to the facility and cut her toenails, but she had not seen him in a long time. Second interview with Resident #1 on 07/25/23 12:05pm revealed: -When she went a long time without her toenails being cut it hurt to walk. -Her toenails were so long that toenails broke off; the toes would hurt for a couple of days but then would feel better because the toenail would not be pressing against the end of the shoes.	C 246		

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	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

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C 246	Continued From page 2 -She had not told anyone her toenails needed to be cut, but the staff could see the toenails needed to be cut. Attempted telephone interview with the previous podiatrist on 07/25/23 at 1:00pm was unsuccessful. Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/25/23 at 2:14pm was unsuccessful. Refer to telephone interview with the LHPS nurse on 07/25/23 at 1:58pm. Refer to telephone interview with the receptionist at the podiatry office on 07/25/23 at 4:03pm. Refer to the interview with the medication aide (MA) on 07/25/23 at 4:07pm. Refer to telephone interview with the Administrator on 07/25/23 at 5:26pm. 2. Review of Resident #2's current FL-2 dated 01/27/23 revealed diagnoses included dementia, schizoaffective disease, anxiety, bipolar disorder, and depression. Review of Resident #2's care plan dated 01/27/23 revealed Resident #2 required limited assistance with bathing, and extensive assistance with grooming/personal hygiene and was totally dependent on dressing. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation form dated 05/10/23 revealed: -Resident #2 was diabetic. -Resident #2's toenails needed to be trimmed.	C 246		

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	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 246	Continued From page 3 -Resident #2 had calluses to bilateral feet on her heels and toes. -Resident #2 was seen by podiatry on 01/12/23. Review of the report of health services from Resident #2's podiatrist provider revealed: -The podiatrist saw resident #2 on 01/12/23. -Resident #2's toenails were trimmed. -Resident #2 was to follow up in 3 months. Observation of Resident #2's toenails on 07/25/23 8:17am revealed: -The toenails on both of her feet extended past the end of her toes between one-eighth and one-fourth inches. The second toenail on her right foot was curled toward the big toe and was pushing into the right side of the end of the toe. -Her feet were dry and scaly. Interview with Resident #2 on 07/25/23 8:17am revealed: -Her toenails needed to be cut; she did not recall when her toenails had last been cut. -She did not know if she had an appointment to get her toenails cut. -She was diabetic. Second interview with Resident #2 on 07/25/23 12:01pm revealed: -Her feet hurt, and walking was painful because her toenails hit the end of the shoe. -She needed to go to the doctor and have her toenails cut. -She had not told anyone her toenails needed to be cut. Attempted telephone interview with the previous podiatrist on 07/25/23 at 1:00pm was unsuccessful.	C 246		

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C 246	Continued From page 4 Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/25/23 at 2:14pm was unsuccessful. Refer to telephone interview with the LHPS nurse on 07/25/23 at 1:58pm. Refer to telephone interview with the receptionist at the podiatry office on 07/25/23 at 4:03pm. Refer to the interview with the medication aide (MA) on 07/25/23 at 4:07pm. (What is MA?) Refer to telephone interview with the Administrator on 07/25/23 at 5:26pm. _____ Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 07/25/23 at 1:58pm revealed: -Diabetic residents were expected to receive foot care. -The concern would be if the residents' toenails were long, they could cut themselves with their toenails. -Diabetics' feet were very sensitive and were hard to heal if there were any injuries to the foot. Telephone interview with a receptionist at the podiatry office on 07/25/23 at 4:03pm revealed: -On 07/18/23, they received a call to schedule two diabetic residents' appointments to see the podiatrist. -The appointments were scheduled for 08/02/23. Interview with the Medication Aide (MA) on 07/25/23 at 4:07pm revealed: -She and another [named] MA were both trying to find a podiatrist for the residents to see. -They tried to contact the previous podiatrist and	C 246		

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	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

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HIGHER STANDARD ASSISTED LIVING	596 NEAL RD REIDSVILLE, NC 27320

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C 246	Continued From page 5 were told the podiatrist was no longer going to facilities for podiatry care; she did not recall when she was told this. -She made the appointment for the residents to see a podiatrist on 08/02/23; she did not recall when she made the appointments. -They called a lot of different podiatrist's offices to find one who would see the residents; she did not recall who she called, "whoever popped up on goggle." Telephone interview with the Administrator on 07/25/23 at 5:26pm revealed: -They had tried to reach the previous podiatrist after the facility's last survey (04/28/23). -Someone from the previous podiatry office finally called him back and stated they would not be going back to the facility; he did not recall when. -It was a collective effort between himself and a [named] MA to locate a podiatrist for the residents. -Diabetic foot care could only be done by a podiatrist, or he would have taken them to a salon for a pedicure. -"It was not like he did not want the foot care to be done."	C 246		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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.	{C 330}		

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	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER STANDARD ASSISTED LIVING	596 NEAL RD REIDSVILLE, NC 27320

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{C 330}	Continued From page 6 This Rule is not met as evidenced by: FOLLOW UP TO A TYPE B VIOLATION Based on these findings, the previous Type B violation was not abated. Based on observations, record reviews, and interviews, the facility failed to ensure medication was administered as ordered for 2 of 3 sampled residents (#1, #2) related to two medications for constipation (#1); an antipsychotic medication (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 01/27/23 revealed diagnoses included diabetes Type 2, peripheral neuropathy, and schizophrenia. a. Review of Resident #1's after-visit summary dated 07/13/23 revealed: -Resident #1 was seen at the gastrointestinal (GI) clinic for constipation. -There was an order to start Benefiber (dietary fiber supplement) one tablespoon with each meal, three times per day to help with constipation. -An upper endoscopy and colonoscopy would be scheduled for further evaluation. Review of Resident #1's medication administration record (MAR) for July 2023 from 07/01/23-07/25/23 revealed: -There was no entry for Benefiber to take one tablespoon with each meal three times per day. -There was no documentation Benefiber had been administered from 07/13/23-07/25/23. Observation of Resident #1's medications on	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER STANDARD ASSISTED LIVING	596 NEAL RD REIDSVILLE, NC 27320

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{C 330}	Continued From page 7	{C 330}		

hand on 07/25/23 at 9:53am revealed there was no Benefiber available to be administered.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/25/23 at 1:14pm revealed:
-Benefiber had not been dispensed for Resident #1.
-The pharmacy had not received an order for Benefiber for Resident #1 dated 07/13/23.
-Upon further review, he located a fax from the facility yesterday, 07/24/23, with a handwritten note from a provider dated 04/18/23 with a recommendation to use Benefiber three times daily with meals and increase water intake.
-The hand-written note appeared to be a recommendation but not an actual order.
-No one had called to discuss Benefiber for Resident #1.
-He would have expected the medication aide (MA) to call if Benefiber was not received.
-The MA could have faxed the after-visit summary and or called to see why the Benefiber had not been dispensed.
-Benefiber was used to treat constipation and without the medication Resident #1 may not get relief from the constipation.

Interview with Resident #1 on 07/25/23 at 3:35pm revealed:
-She had a lot of problems with constipation.
-She had been to the emergency department (ED) earlier this year (she did not recall the date) for constipation.
-She had been to the GI clinic recently (she did not recall the date) because of constipation.
-Her stomach hurt a lot and she was having problems with having a bowel movement (BM).
-She had a BM on 07/24/23.
-The provider at the GI clinic told her she needed

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	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER STANDARD ASSISTED LIVING	596 NEAL RD REIDSVILLE, NC 27320

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{C 330}	Continued From page 8	{C 330}		

more fiber.
-The provider told her to eat foods high in fiber like nuts and green vegetables and to drink more water.
-The provider told her she was going to order something for her, but she did not know what it was.
-The provider told her she was going to order a colonoscopy.

Interview with the MA on 07/25/23 at 4:07pm revealed:
-She reviewed after-visit summaries and if there were orders she would fax them to the pharmacy.
-She had reviewed Resident #1's after visit summary dated 07/13/23.
-She did not fax Resident #1's after-visit summary dated 07/13/23 to the pharmacy because the resident was already on the medication listed for constipation, and it was being administered.
-She did not know Benefiber and MiraLAX (a laxative) were two different medications.
-Resident #1 had complained of her stomach hurting yesterday, 07/24/23, before bed.
-Resident #1 had complaints of constipation, not all the time, just "off and on."
-When Resident #1 complained of her stomach hurting, she took that as the resident was constipated.

Interview with the Administrator on 07/25/23 at 5:26pm revealed:
-The MA was responsible for faxing the after-visit summary to the pharmacy with new orders.
-He also tried to tell the staff who attended the appointment with the resident to tell the provider to send the prescription directly to the pharmacy but that did not always happen.
-He was aware Resident #1 had complained of constipation.

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	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

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{C 330}	Continued From page 9 -Resident #1 did not like to take the fiber powder. -He thought the fiber powder and MiraLAX were the same as it helped one go to the bathroom. -He was concerned "the ball had been dropped" and the resident did not get the help she needed. Attempted telephone interview with the provider at the GI clinic on 07/25/23 at 4:13pm was unsuccessful. b. Review of Resident #1's signed physician's orders dated 01/27/23 revealed an order for Enulose (used to treat constipation)10gm/15ml take 30mls twice a day. Review of Resident #1's medication administration record (MAR) for May, June, and July 2023 revealed: -There was no entry for Enulose 30mls twice daily. -There was no documentation of administration for Enulose on the May, June, and July 2023 MARs. Observation of Resident #1's medications on hand on 07/25/23 at 9:53am revealed there was no Enulose available to be administered. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/25/23 at 1:14pm revealed: -He did not see Enulose as an active order for Resident #1. -The original order for Resident #1's Enulose was received on 02/28/22 for Enulose 30mls twice daily. -On 03/02/22, they received an order to discontinue the Enulose after a 4-day regimen. -He had not received any other orders for Resident #1's Enulose.	{C 330}		

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	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER STANDARD ASSISTED LIVING	596 NEAL RD REIDSVILLE, NC 27320

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{C 330}	Continued From page 10	{C 330}		

-The pharmacy printed off the physician's orders based on the resident's current MAR.
-Resident #1's signed physician's orders dated 01/27/23 were profiled because they had not needed any new orders.
-He did not review the signed physician's orders to see that Enulose had been reprinted on the physician's orders generated from the pharmacy and signed by the provider.
-He considered the signed physician's order for Enulose as an order, but he thought it had been printed in error and was not a current order.
-The facility staff should have clarified if Resident #1's Enulose was a current order or not.

Interview with Resident #1 on 07/25/23 at 3:35pm revealed:
-She did not know what Enulose was, but she recalled having to drink a medication that "tasted really bad and made her throw up."
-She did not recall when she last took "that" medication and only currently took MiraLAX that she had to drink.

Interview with the medication aide (MA) on 07/25/23 at 4:07pm revealed:
-She did not know anything about an order for Resident #1's Enulose.
-She did not look at Resident #1's signed physician's order, a [named] MA was responsible for those orders and the FL-2.

Interview with the Administrator on 07/25/23 at 5:26pm revealed:
-He and the [named] MA made sure FL2s, and signed physician's orders were updated.
-A couple of days before the resident's appointment, they would request the pharmacy to print out the physician's orders.
-He did not review the physician's orders as he

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(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
{C 330}	Continued From page 11	{C 330}		

assumed they were current and correct based on the resident's current MAR.
-The Pharmacist told him the medication list sent was off of the resident's current MAR.
-He did not know there was an order for Resident #1's Enulose on the current signed physician's orders.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/25/23 at 2:14pm was unsuccessful.

Attempted telephone interviews with the [named] MA on 07/25/23 at 5:02pm and 5:25pm were unsuccessful.

2. Review of Resident #2's current FL-2 dated 01/27/23 revealed:
-Diagnoses included dementia, schizoaffective disease, anxiety, bipolar disorder, and depression.
-There was an order for Haloperidol (an antipsychotic medication) 5mg to administer one and one-half tablets (7.5mg) in the mornings and one tablet (5mg) in the evenings.

Review of Resident #2's medication administration record (MAR) for July 2023 from 07/01/23-07/25/23 revealed:
-There was an entry for Haloperidol 5mg administer one and one-half tablets (7.5mg) scheduled at 8:00am and 1 tablet (5mg) scheduled at 8:00pm.
-There was documentation Haloperidol 7.5mg was administered at 8:00am and 5mg at 8:00pm from 07/01/23-07/24/23.

Observation of Resident #2's medication on hand on 07/25/23 at 9:11am revealed:
-There was a multi-dose pack labeled as 8:00pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER STANDARD ASSISTED LIVING	596 NEAL RD REIDSVILLE, NC 27320

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{C 330}	Continued From page 12	{C 330}		

with a dispensed date of 07/11/23 and a start date of 07/20/23.
-The multi-dose package contained one and one-half tablets of Haloperidol 5mg to equal 7.5mg to be administered at 8:00pm.
-Haloperidol 7.5mg had been administered for 07/20/23-07/24/23 at 8:00pm.
-Haloperidol 7.5mg was available to be administered from 07/25/23-08/19/23 at 8:00pm.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/25/23 at 1:14pm revealed:
-Resident #2's current order was Haloperidol 5mg take one and one-half tablets in the morning and one tablet in the evening.
-When the multi-dose packages were dispensed to the facility, the facility staff were responsible for making sure the medication contained within the package was correct by matching it with the current MAR.
-Based on the dispensing information he could see 45 tablets of Haloperidol 7.5mg had been dispensed in both the 8:00am and 8:00pm packages for the medication dispensed on 07/11/23 with a start date of 07/23/23.
-It appeared the medication had been packaged correctly on the previous dispensing for June 2023; he did not know why the system had entered 7.5mg for the evening dose for this dispensing on 07/11/23.
-If there was a discrepancy, the MA should contact the pharmacy and they would have dispensed a corrected multidose package.
-Haloperidol was used for mood stabilization and if Resident #2 was administered the higher dosage the resident could become over-sedated.

Interview with Resident #2 on 07/25/23 at 4:05pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHER STANDARD ASSISTED LIVING	596 NEAL RD REIDSVILLE, NC 27320

(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
{C 330}	Continued From page 13 -She took whatever medications the MA gave her and did not look at what she was taking. -In the mornings she felt "real sleepy." -She usually would take her morning medications and had to go back to bed for about an hour because she felt so tired. -She had felt this way for "about 6 months." Interview with the MA on 07/25/23 at 4:07pm revealed: -When the cycled medications were delivered to the facility, she would make sure the medications delivered matched the resident's current MAR. -She checked off the medications on the MAR and underlined the medication on the multidose package to show she had matched the two together. -She had looked at Resident #2's multidose package for the 8:00pm medications. -She referenced the front of the multidose package Haloperidol 5mg was listed and Haloperidol 5mg was also listed on the MAR. -She had not counted the pills within the multidose package; she did not know that she needed to. -She had not noticed the one-half tablet in the multidose package. -She did not look at the back of the multidose package to see the list of the medications contained in the multidose package. -She had not seen Haloperidol 5mg listed as one tablet and a second line with Haloperidol one-half tablet on the back of the multidose package for the 8:00pm administration. Interview with the Administrator on 07/25/23 at 5:26pm revealed: -The MA was responsible for making sure the medications listed on the MAR matched up to the medications sent to the facility.	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017061	A. BUILDING: _____ B. WING _____	R 07/25/2023

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(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
{C 330}	Continued From page 14 -He expected the MAs to look at the front and back of the multidose package, including looking at the description of the tablets and making sure the colors matched. -He would have expected the MA to catch the extra one-half tablet in the 8:00pm multidose package. Attempted telephone interview with Resident #2's mental health provider on 07/25/23 at 5:02pm was unsuccessful. _____ The facility failed to ensure medications were administered as ordered for a resident who had a history of constipation and had been seen in the emergency department on 04/24/23 for constipation and was seen by a provider at a gastrointestinal clinic on 07/13/23 for ongoing complaints of constipation and did not receive a medication prescribed after the appointment and continued to experience stomach pains and difficulty with elimination and also had an order for another medication used to treat constipation that was not received (#1); and a resident who was administered the wrong dose of an antipsychotic medication which could cause an increase in sedation and who had felt "very sleepy" in the mornings (#2). This failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/25/23 for this violation.	{C 330}		