STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002003	A. BUILDING: _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLORSVILLE HOUSE	350 SCHOOL DRIVE TAYLORSVILLE, NC 28681

(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 and the Alexander County Department of Social Services conducted an anuual survey on August 15, 2023 through August 16, 2023.	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 interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #3) related to a medication used to lower the risk of heart attack or stroke, a medication used to treat Alzheimer's disease and administered a medication to treat allergy symptoms. The findings are: Review of Resident #3's current FL2 dated 07/17/23 revealed: -Diagnoses of dementia. -Recommended level of care was special care unit (SCU). -He was intermittently disoriented. Review of Resident #3's Resident Register dated 07/13/23 revealed: -Resident #3's admission date was 07/13/23.	D 358		

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D 358	Continued From page 1 -Resident #3 was documented as having significant memory loss and needed to be directed. Review of Resident #3's physician's orders dated 07/17/23 revealed: -There was an order for aspirin (used to lower the risk of heart attack or stroke) 325mg by mouth daily. -There was an order for donepezil (used to treat Alzheimer's disease) 10mg by mouth at bedtime. Review of Resident #3's July electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 325mg by mouth daily documented as administered. -There was an entry for donepezil 10mg by mouth at bedtime documented as administered. Review of Resident #3's August eMAR revealed: -There was an entry for aspirin 325mg by mouth daily documented as administered. -There was an entry for donepezil 10mg by mouth at bedtime documented as administered. Observation of Resident #3's medications on hand on 08/16/23 at 11:39am revealed: -There was a medication multi-dose pack of aspirin 81mg by mouth daily. -There was a medication multi-dose pack of donepezil 5mg by mouth at bedtime. -There was a medication multi-dose pack of loratadine (used to treat allergy symptoms) 10mg by mouth every morning. Review of Resident #3's Physician Orders revealed there was no order for loratadine 10mg by mouth every morning.	D 358		

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D 358	Continued From page 2	D 358		

Interview with a medication aide (MA) on 08/16/23 at 11:45am revealed:
-She knew Resident #3 had the incorrect dose of donepezil.
-She faxed a physician order to the pharmacy on 08/12/23 for donepezil 10mg by mouth at bedtime but did not follow up with the pharmacy.
-She did not know Resident #3 had a physician order for aspirin 325mg by mouth daily.
-She did not know Resident #3 did not have a physician order for loratadine.
-She had administered the medications in the multi-dose pack.
-She did not compare the medications on the medication cart to the eMAR but knew she was supposed to.

Review of the MA daily communication log dated 08/11/23 revealed documentation of Resident #3 needing donepezil 10mg with the facility only having 5mg.

Review of the MA daily communication log dated 08/12/23 revealed documentation the MA faxed a physician order to Resident # 3's pharmacy to fix and fill his donepezil and she would follow up.

Review of the MA daily communication log dated 08/13/23 revealed Resident #3 needed a new prescription for his donepezil and that the Special Care Unit Coordinator (SCC) was notified.

Telephone interview with the facility's contracted pharmacy on 07/16/23 at 12:00pm revealed:
-There was no documentation of the facility sending any orders to the pharmacy.
-There was an order for aspirin 81mg by mouth daily was received on 01/09/23 from Resident #3's Primary Care Provider (PCP) and dispensed to the facility on 08/02/23 with a start date of

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D 358	Continued From page 3	D 358		

08/08/23.
-There was an order for donepezil 5mg, by mouth at bedtime was received on 03/26/23 from Resident #3's PCP and dispensed to the facility on 08/02/23 with a start date of 08/08/23.
-There was an order for loratadine 10mg by mouth every morning was received on 01/09/23 from Resident #3's PCP and dispensed to the facility on 08/02/23 with a start date of 08/08/23.
-The pharmacy did not have any documentation of the facility sending any physician orders.
-The pharmacy had been made aware that Resident #3 was residing at the facility.

Interview with Resident #3's PCP on 08/16/23 at 12:51pm revealed:
-She did know Resident #3 had been receiving the incorrect dose of donepezil.
-She did not know Resident #3 had been receiving the incorrect dose of aspirin.
-She did not know Resident #3 was being administered loratadine.
-She was notified on 08/12/23 that Resident #3 needed a prescription for donepezil 10mg.
-There was no harm in resident receiving lower doses of the donepezil or aspirin.
-Daily loratadine was not recommended due to Resident #3's age and could cause more confusion and possible falls.

Interview with the SCC on 08/16/23 at 2:45pm revealed:
-She did know Resident #3 had been receiving the incorrect dose of donepezil.
-She did not know Resident #3 had been receiving the incorrect dose of aspirin.
-She did not know Resident #3 was being administered loratadine without a Physician's Order.
-The MAs were responsible for completing daily

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D 358	Continued From page 4	D 358		

medication cart and eMAR audits by auditing two residents per shift.
-She was responsible for reviewing the audits weekly.
-The MAs were responsible for notifying her and the PCP of any medication issues.
-She was notified that Resident #3 had the incorrect does of donepezil on 08/12/23.
-She faxed Resident #3's physician orders to the pharmacy on 08/12/23 but did not follow up with the pharmacy.

Review of the daily medication cart audit list on 08/16/23 revealed:
-Resident #3's room was documented as empty on 08/14/23.
-There was no documentation that a medication cart audit had been completed on Resident #3.

Interview with the Administrator on 08/16/23 at 12:43pm revealed:
-She did know Resident #3 had been receiving the incorrect dose of donepezil.
-She did not know Resident #3 had been receiving the incorrect dose of aspirin.
-She did not know Resident #3 was being administered loratadine without a Physician's Order.
-She worked as a MA that week and admitted she did not compare the medications to the eMAR prior to administering them to the Resident.
-She expected the MAs to notify the SCC and the PCP of any medication issues or concerns and to document it.
-She expected the MAs to document any issues on the daily medication cart audit form.
-She expected the SCC to follow up on any medication issues.