

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/14/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NEW GRACESON MANOR ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 GWYNN DRIVE REIDSVILLE, NC 27320</b>
--	--

(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 an annual survey on 09/14/23.	C 000		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care  10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record;	C 375		

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/14/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NEW GRACESON MANOR ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 GWYNN DRIVE REIDSVILLE, NC 27320</b>
--	--

(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 375	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly pharmaceutical reviews were completed for 2 of 3 sampled residents (#1 and #3).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 06/30/22 revealed diagnoses included schizophrenia, diabetes, hypertension, hypothyroidism, and Parkinson's disease.</p> <p>Review of Resident #1's pharmacy reviews revealed: -There was a completed pharmacy review dated 03/23/21. -There were no subsequent pharmacy reviews available for review.</p> <p>Interview with the Administrator/Owner on 09/14/23 at 11:12am revealed she was aware that Resident #1 did not have quarterly pharmacy reviews completed because she had so many other things to do to run the facility, and she had overlooked calling the pharmacy to request their medication review service.</p> <p>Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/14/23 at 11:45am.</p> <p>Refer to the interview with the Administrator/Owner on 09/14/23 at 11:15am.</p> <p>2. Review of Resident #3's current FL2 dated 05/25/23 revealed diagnoses included atrial fibrillation, peripheral neuropathy, history of pulmonary embolism and deep vein thrombosis.</p>	C 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/14/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NEW GRACESON MANOR ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 GWYNN DRIVE REIDSVILLE, NC 27320</b>
--	--

(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 375	<p>Continued From page 2</p> <p>Review of Resident #3's Resident Register revealed an admission date of 09/18/18.</p> <p>Review of Resident #3's pharmacy reviews revealed: -There was a completed pharmacy review dated 03/18/21. -There were no subsequent medication reviews available.</p> <p>Interview with the Administrator/Owner on 09/14/23 at 11:13am revealed she was aware that Resident #3 did not have quarterly pharmacy reviews completed, because she had so many other things to do to run the facility, and she had overlooked calling the pharmacy to request their medication review service.</p> <p>Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/14/23 at 11:45am.</p> <p>Refer to the interview with the Administrator/Owner on 09/14/23 at 11:15am.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 09/14/23 at 11:45am revealed: -The pharmacy was contracted for dispensing medications to the facility. -The pharmacy offered the service of completing medication reviews for facilities if they requested the service. -They did not complete quarterly pharmacy medication reviews for the facility because it had not been requested.</p> <p>Interview with the Administrator/Owner on 09/14/23 at 11:15am revealed:</p>	C 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/14/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NEW GRACESON MANOR ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>116 GWYNN DRIVE REIDSVILLE, NC 27320</b>
--	--

(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 375	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>-She was responsible for ensuring each resident had a quarterly pharmacy review.</li> <li>-She had not done an audit of the resident records in a year, and during the audits she had been checking that the residents were current with having pharmacy reviews completed.</li> <li>-She had been busy with other tasks for the facility and had forgotten to contact the pharmacy to request they do pharmacy medication reviews for the residents at the facility.</li> <li>-She had previously contracted the services of a nurse to complete the pharmacy reviews.</li> <li>-She did not currently have a nurse or pharmacy completing medication reviews for all the residents at the facility.</li> </ul>	C 375		