STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 Edgecombe Department of Social Services conducted a follow-up survey and complaint investigation on August 29, 2023 through August 30, 2023.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .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 ensure health care referral and follow up for 2 of 5 sampled residents (#2, #5) including failing to notify an eye care provider of a resident not receiving a prescription eye drop to treat chronic dry eye syndrome (#2) and failing to notify a prescribing practitioner that a resident refused diagnostic test (lab) orders (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 07/13/23 revealed diagnoses included Alzheimer's disease, breast cancer, cerebrovascular disease, and chronic kidney disease. Review of Resident #2's eye care provider visit note dated 08/09/23 revealed: -The resident was diagnosed with dry eye syndrome of bilateral lacrimal (tear) glands in both eyes. -The resident was educated on the chronic nature	D 273		

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D 273	Continued From page 1	D 273		

of the diagnosis.
-The resident was to restart Restasis eye drops twice a day in both eyes (indefinitely) while pulsing (pulse-dosing is used to regain control of dry eye symptoms) Prednisolone Acetate 1% twice a day in both eyes for 30 days. (Restasis is used to increase tear production in a type of chronic dry eye that causes decreased tear production due to inflammation. Prednisolone Acetate is used to treat eye inflammation.)
-The eye care provider would consider punctal occlusion (pressing finger near the inside corner of the eye for 2 minutes after instilling the eye drop to ensure penetration of the eye drop) as a future treatment option.
-The resident would continue to be monitored very closely for any changes.
-The resident was to return to the eye care provider if signs or symptoms returned or worsened.

Review of Resident #2's eye care provider orders dated 08/09/23 revealed:
-There was an order for Restasis 0.05% instill 1 drop in both eyes twice a day.
-There was an order for Prednisolone Acetate 1% instill 1 drop in both eyes twice a day for 30 days.

Review of Resident #2's medication communication from the facility's contracted pharmacy dated 08/10/23 revealed:
-The pharmacy was unable to send out Restasis 0.05% eye drops due to a billing issue.
-Prior authorization was required and had been initiated.

Review of Resident #2's verbal order by the primary care provider (PCP) dated 08/24/23 revealed an order to discontinue Restasis.

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	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

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D 273	Continued From page 2 Review of Resident #2's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Restasis 0.05% eye drops, instill 1 drop in both eyes twice daily. -There was a start date of 08/12/23 and an end date of 08/25/23 for the Restasis eye drops. -There was one dose of Restasis eye drops initialed as administered at 8:00am on 08/25/23. -There was an "x" marked in all other daily entries for the Restasis with no documentation of a reason for the missed doses. -There was an entry for Prednisolone Acetate 1% eye drops, instill 1 drop in both eyes twice daily 5 minutes prior to Restasis for 30 days. -Prednisolone Acetate 1% eye drops were documented as administered twice daily from 08/11/23 (8:00pm) - 08/29/23 (8:00am). Review of Resident #2's facility progress notes for August 2023 revealed: -There was a note dated 08/21/23 at 9:13pm indicating the facility staff contacted the contracted pharmacy provider about Restasis and they were still waiting on prior authorization. -There was no documentation the resident's eye care provider was notified the resident did not receive Restasis as ordered or that the PCP discontinued the Restasis. Interview with a medication aide (MA) on 08/30/23 at 12:24pm revealed: -Resident #2 did not have any Restasis eye drops on hand because the insurance needed prior authorization. -Resident #2 had not received any Restasis eye drops because there was none available. -She did not know if the resident's eye care provider was aware the resident did not receive the medication.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 3 Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 2:19pm revealed: -Resident #2's PCP discontinued the Restasis eye drops because the insurance would not pay for them. -She thought she contacted Resident #2's eye care provider but she was not sure when and there was no documentation of the contact. Attempted telephone interview with Resident #2's PCP on 08/30/23 at 3:24pm was unsuccessful. Telephone interview with a technician at Resident #2's eye care provider's office on 08/30/23 at 4:37pm revealed: -They were not made aware that Resident #2 was not receiving Restasis as ordered by the eye care provider. -If they had been made aware, the eye care provider could have potentially changed the order to a different medication to help the resident's dry eye symptoms. Based on observations, interviews, and record reviews, Resident #2 was not interviewable. 2. Review of Resident #5 current FL-2 dated 05/04/23 revealed diagnoses included hypertension, dementia, degenerative joint disease, chronic kidney disease, chronic hip pain, and vitamin D insufficiency. Review of Resident #5's Resident Register revealed an admission date of 05/09/23. Review of Resident #5's primary care provider (PCP) visit progress note dated 07/13/23 revealed: -The progress note was electronically signed by	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

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D 273	Continued From page 4	D 273		

the PCP on 07/30/23, and stamped that it was scanned and faxed to the facility on 07/31/23.
-There were lab orders for Complete Blood Count (CBC) with differential, Comprehensive Metabolic Panel (CMP), Lipid Panel, Hemoglobin A1C, Thyroid Stimulating Immunoglobulins, Magnesium, Vitamin D+ Metabolites, Vitamin B12 and Folate.

Review of a daily lab draw log dated 08/03/23 revealed Resident #5 refused for her labs to be drawn that were ordered July 2023.

Review of Resident #5's records revealed there was no documentation Resident #5's PCP was notified of the refusal.

Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 2:19pm revealed:
-She and the Administrator were responsible for reviewing progress notes and ensuring orders were implemented.
-She did not know if the PCP was notified that Resident #5 refused the July 2023 lab draw as ordered.

Interview with the Administrator on 08/30/23 at 1:02pm revealed:
-The RCC was responsible for reviewing orders on progress notes and making sure the orders were implemented.
-If the PCP was notified of resident refusal, it should be noted in the progress notes or via the telemedic system.
-She expected the PCP to be notified of resident refusals and for it to be documented.

Telephone interview with Resident #5's primary care provider (PCP) on 08/30/23 at 9:40am revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 5 -She was aware of Resident #5's refusal for labs drawn in June 2023. -She did not recall being notified Resident #5 refused labs being drawn that were ordered in July 2023. -She expected to be notified when the resident refused orders. Based on observation, record reviews and interviews, it was determined Resident #5 was not interviewable.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to implement an order for blood pressure parameters for 1 of 5 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated 05/04/23 revealed diagnoses included hypertension, dementia, degenerative joint disease, chronic kidney disease, chronic hip pain, and vitamin D insufficiency. Review of Resident #5's Resident Register	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

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D 276	Continued From page 6 revealed an admission date of 05/09/23. Review of Resident #5's primary care provider (PCP) visit progress note dated 07/13/23 revealed: -The PCP visited Resident #5 at the facility on 07/13/23. -The progress note of the visit was electronically signed by the PCP on 07/30/23, and stamped that it was scanned and faxed to the facility on 07/31/23. -There were instructions to continue to monitor blood pressure (BP) per facility protocol. -There were instructions to notify the provider for systolic blood pressure (SBP) less than 90 or greater than 180 or diastolic blood pressure (DBP) less than 60 or greater than 100. Review of Resident #5's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check vital signs monthly between 7:00am and 3:00pm on the 15th of the month. -There was documentation the BP was 134/69 on 07/15/23. Review of Resident #5's August 2023 eMAR revealed: -There was an entry to check vital signs monthly between 7:00am and 3:00pm on the 15th of the month. -There was documentation the BP was not taken on 08/15/23 due to refusal. Interview with the facility's contracted pharmacist on 08/30/23 at 9:28am revealed: -The pharmacist did not enter BP parameters for a resident unless it was connected to a medication.	D 276		

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D 276	Continued From page 7 -The facility was responsible for entering BP parameters on the eMAR for parameters not connected to a medication. Interview with a medication aide (MA) on 08/30/23 at 9:53am. -She was not aware of there being parameters for Resident #5's BP. -Resident #5's vital signs, which included BP, were taken once a month and entered on the eMAR. -There were no instructions on the eMAR to notify the provider for systolic blood pressure (SBP) less than 90 or greater than 180 or diastolic blood pressure (DBP) less than 60 or greater than 100. -If BP parameters were outside of the ordered parameters, she would not know to contact the PCP. Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 12:19pm revealed: -The facility's protocol was to monitor residents' vital signs monthly unless otherwise ordered. -She or the Administrator were responsible for reviewing provider progress notes and ensuring orders were implemented. -She was not aware Resident #5 had BP parameters. -Had she known there were BP parameters she would have entered the parameters on the eMAR. Interview with the Administrator on 08/30/23 at 1:02pm revealed: -The facility's protocol was to monitor residents' vital signs monthly. -The RCC was responsible for reviewing provider progress notes and making sure orders were implemented.	D 276		

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	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

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D 276	Continued From page 8 -She was not aware Resident #5 had BP parameters since her vital signs were taken only monthly. Interview with Resident #5's PCP on 08/30/23 at 9:40am revealed: -She ordered BP parameters for Resident #5 since she was on a blood pressure medication. -She expected the BP parameters to be placed on the eMAR for guidance to the MAs as to when to notify her. -If the BP was low, it could cause falls and if the BP was high it could cause a stroke. Based on observations, records reviews, and interviews, it was determined Resident #5 was not interviewable.	D 276		
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: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

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D 358	Continued From page 9	D 358		

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#6, #7) observed during the medication pass including errors with a diuretic for fluid retention and swelling (#6), antibiotics for infection, a blood thinner used to treat and prevent blood clots, a diabetes medication used to lower blood sugar, a medication for overactive bladder, and a vitamin supplement (#7).

The findings are:

The medication error rate was 21% as evidenced by 7 errors out of 33 opportunities during the 8:00am medication pass on 08/30/23.

1. Review of Resident #7's current FL-2 dated 02/14/23 revealed diagnoses included coronary artery disease, diabetes mellitus, congestive heart failure, essential hypertension, atrial fibrillation, stage 3 chronic kidney disease, overactive bladder, and chronic pain syndrome.

a. Review of Resident #7's current FL-2 dated 02/14/23 revealed an order for Eliquis 2.5mg 1 tablet twice a day. (Eliquis is a blood thinner used to treat and prevent blood clots and stroke in people with atrial fibrillation.)

Review of Resident #7's verbal order by the primary care provider (PCP) dated 07/14/23 revealed an order to hold Eliquis for the following dates, 07/14/23 - 07/21/23 due to billing issues with e-script (electronic prescription).

Review of Resident #7's physician's order sheet dated 07/31/23 revealed an order for Eliquis 2.5mg take 1 tablet twice daily.

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	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

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D 358	Continued From page 10	D 358		

Review of Resident #7's physician's orders revealed no other orders to hold the Eliquis.

Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Eliquis 2.5mg take 1 tablet twice daily scheduled for 8:00am and 8:00pm.
-Eliquis 2.5mg was documented as administered from 08/01/23 - 08/22/23 except on 08/21/23 at 8:00am the resident was out of the facility.
-Eliquis 2.5mg was documented as not administered from 08/23/23 (8:00am) - 08/29/23 (8:00am) due to waiting on pharmacy/refused.
-Eliquis 2.5mg was documented as not administered on 08/29/23 at 8:00pm due to the resident being out of the facility.

Observation of the 8:00am medication pass on 08/30/23 revealed:
-The medication aide (MA) retrieved Resident #7's morning medications from a multi-dose pack (MDP) dispensed by an outside pharmacy provider.
-Eliquis 2.5mg was not included in the MDP or listed on the label of the MDP.
-Eliquis 2.5mg was not administered as ordered when the resident received her other morning medications during the 8:00am medication pass on 08/30/23.

Interview with the MA on 08/30/23 at 8:53am revealed there was no Eliquis available to administer to Resident #7 due to issues with the resident's insurance.

Interviews with the Resident Care Coordinator (RCC) on 08/30/23 at 9:32am and 10:13am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 11	D 358		

-Resident #7 refused to pay for the Eliquis because it cost over $500.
-They had just set up a 90-day supply with 1 refill that would now cost the resident $30.
-She was not sure when the Eliquis would be delivered to the facility.
-If the resident would go to her cardiology provider, she could get some samples of Eliquis.

Telephone interview with a pharmacy technician at Resident #7's pharmacy provider on 08/30/23 at 3:35pm revealed:
-There was no order to hold or discontinue Resident #7's Eliquis.
-Resident #7's copay for Eliquis when they entered it through the electronic system to the insurance company was $514 on 07/18/23, so it was not dispensed.
-They ran it back through the electronic system on 07/21/23 and the copay was $24.
-They dispensed and delivered 60 Eliquis 2.5mg tablets to the facility on 07/21/23 for Resident #7.
-She last spoke with someone at the facility (could not recall who) about Resident #7's Eliquis about 3 or 4 weeks ago.
-The facility staff (could not recall who) said they would try to find a better way to get the resident's Eliquis.
-The pharmacy tried to enter the Eliquis through the electronic system yesterday, 08/29/23, but the transaction was canceled because there were no refills now.

Telephone interview with a nurse at Resident #7's PCP's office on 08/31/23 at 1:48pm revealed:
-She thought the resident took Eliquis for atrial fibrillation to prevent blood clots.
-The facility notified their office last Thursday, 08/24/23, that the resident's insurance would not cover the Eliquis and it was going to cost the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

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D 358	Continued From page 12	D 358		

resident $500 or $600.
-The resident was not refusing to take the Eliquis; she just could not afford to pay for it.
-She tried to call the facility back that day on 08/24/23, but was unable to reach anyone.
-Their office was closed on Friday, 08/25/23.
-She left a note for the PCP on Monday, 08/28/23, because she was not at work that day.
-On 08/29/23, they were going to refer the resident to an anti-coagulant (blood thinner) clinic but during the process, the resident said she could get the medication through a mail order pharmacy for $30.
-The process for mail order was started but it would take 7 days to get the medication.
-On 08/29/23, they called the resident's cardiology provider to get samples of the Eliquis until the mail ordered medication could be received.
-The facility was notified on 08/30/23 that they could pick up the samples of Eliquis from the cardiology provider's office and the resident did not have to pick up the samples herself.
-If Eliquis was not administered, there was a potential of the resident having blood clots.

Attempted telephone interview with Resident #7's cardiology provider on 08/30/23 at 4:49pm was unsuccessful.

Interview with Resident #7 on 08/30/23 at 2:56pm revealed:
-She thought she was receiving Eliquis.
-She thought her insurance paid for it but she was not sure.
-Someone (could not recall who) had talked with her about paying for Eliquis but she did not want to pay for it because it was so expensive.
-She thought she took Eliquis to help prevent stroke.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 13 b. Review of Resident #7's physician's orders revealed there was no order for Keflex 250mg in the resident's record. (Keflex is an antibiotic used to treat and prevent infections.) Observation of the 8:00am medication pass on 08/30/23 revealed: -The medication aide (MA) retrieved Resident #7's morning medications from a multi-dose pack (MDP) dispensed by an outside pharmacy provider. -The MDP contained one Keflex 250mg capsule in the MDP labeled for "morning" medications. -The MA took the Keflex 250mg capsule out of the MDP prior to pouring the medications in the MDP into a plastic medication cup and put the Keflex in a separate plastic cup. Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed there was no entry for Keflex 250mg and none was documented as administered. Interviews with the MA on 08/30/23 at 8:56am and 9:23am revealed: -She had removed and discarded the Keflex 250mg capsule in Resident #7's MDP for the past few days because it was not on the eMAR. -She did not administer Keflex 250mg today, or the last few days to Resident #7. -She could not recall how long Keflex 250mg capsules had been included in the MDP. -When asked if she had reported the discrepancy with Resident #7's Keflex 250mg, she answered they (referring to medication staff at the facility) had been working on the resident's orders. -She was unable to give any other details about the Keflex 250mg capsules.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 14 Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 9:08am revealed: -Resident #7 would take herself to appointments and go to her pharmacy provider and take prescriptions that the facility may not receive copies of. -She was not aware the resident had Keflex 250mg capsules in the MDP and it was not listed on the eMAR. -The resident's outside pharmacy did not enter any orders into the eMAR system because the eMARs were provided by the facility's contracted pharmacy. -The facility's contracted pharmacy would have entered the order into the eMAR system if the facility had an order and faxed it to them. -She would contact the resident's outside pharmacy provider to see if they could fax the order for Resident #7's Keflex 250mg. Review of Resident #7's electronic prescription (e-script) dated 04/13/23 and faxed by the resident's outside pharmacy provider to the facility on 08/30/23 revealed: -There was an order for Keflex 250mg with directions to take 1 capsule daily for 5 days. -The quantity to be dispensed was 30 capsules (a 30-day supply). -The section on the prescription for refills indicated 5 additional refills. -The e-script was signed by the resident's primary care provider (PCP). Review of Resident #7's record revealed no documentation the order for Keflex 250mg had been clarified to determine if it was to be administered for 5 days or as a routine daily medication. Telephone interview with a pharmacy technician	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 15	D 358		

at Resident #7's pharmacy provider on 08/30/23 at 3:35pm revealed:
-About 2 or 3 months ago, they ran out of refills for Resident #7's Keflex 250mg capsules so they contacted the PCP and were given a verbal order to continue the Keflex 250mg daily for urinary tract infections (UTIs).
-The pharmacy continued to dispense Keflex 250mg in the MDPs for Resident #7.
-Their pharmacy did not have anything to do with entering any orders into the facility's eMAR system.
-Keflex 250mg capsules were last dispensed in the MDP dated 08/02/23 with 24 capsules.

Telephone interview with a nurse at Resident #7's PCP's office on 08/31/23 at 1:48pm revealed:
-Resident #7 was supposed to receive Keflex 250mg daily for prophylactic treatment to help prevent UTIs.
-The facility did not contact the PCP's office prior to 08/30/23 to clarify the order.
-Not receiving the Keflex 250mg daily could have potentially contributed to the resident having the current UTI but it may not be a direct cause.

Interview with Resident #7 on 08/30/23 at 2:56pm revealed:
-She did not remember if she took an antibiotic daily, prior to going to the hospital ER on 08/29/23.
-She was weak and tired, and her mind was "messed up" so she went to the hospital ER last night, 08/29/23.
-She was diagnosed with a UTI.

c. Review of the facility's policy and procedure for medication administration of a new order dated September 2021 revealed:
-The policy was to provide consistency and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 16	D 358		

mutual understanding between the facility and the pharmacy regarding how soon new medication orders should be started.
-Administration for any medication order for a systemic antibiotic shall be started no later than 9:00am of the following day unless the order is designated by the physician as urgent.
-All efforts should be made to start antibiotics at the next scheduled dose.

Review of Resident #7's emergency room (ER) after visit summary (AVS) dated 08/29/23 revealed:
-The reason for visit was chest pain.
-The resident was diagnosed with urinary tract infection (UTI) without hematuria (blood in urine), malaise (general feeling of discomfort), and shortness of breath.
-There were instructions in bold print on the first page of the AVS to pick up Keflex at the resident's pharmacy.
-Documentation on the AVS indicated the resident was administered Keflex (no strength or route noted) in the ER at 6:33pm on 08/29/23.
-Changes in the medication list was documented as Keflex 500mg take 2 capsule 3 times a day for 10 days. (Keflex is an antibiotic used to treat infections.)

Review of Resident #7's electronic prescription (e-script) faxed by the resident's outside pharmacy provider dated 08/29/23 revealed:
-There was an order for Keflex 500mg with directions to take 1 capsule 3 times a day for 10 days.
-The quantity to be dispensed was 30 capsules (a 10-day supply).
-There were no additional refills.
-The e-script was signed by a hospital provider.
-The e-script was received electronically by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 17	D 358		

Resident #7's outside pharmacy provider on 08/29/23 at 8:13pm.

Observation of the 8:00am medication pass on 08/30/23 revealed:
-The medication aide (MA) retrieved Resident #7's morning medications from a multi-dose pack (MDP) dispensed by an outside pharmacy provider.
-The MDP did not contain Keflex 500mg and there was no other supply of Keflex 500mg available for administration to the resident.
-Keflex 500mg was not administered to the resident as ordered.

Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed there was no entry for Keflex 500mg and none was documented as administered.

Interview with the Area Clinical Director / Registered Nurse (ACD/RN) on 08/30/23 at 10:13am revealed:
-Resident #7's order for Keflex 500mg was at the resident's pharmacy.
-The resident's pharmacy would be sending the Keflex 500mg capsules today, 08/30/23; the medication was out for delivery.
-The resident would get at least one dose of the antibiotic tonight, 08/30/23.

Telephone interview with a pharmacy technician at Resident #7's pharmacy provider on 08/30/23 at 3:35pm revealed:
-The pharmacy received a new prescription from the local hospital ER yesterday, 08/29/23, at 8:12pm.
-The pharmacy closed at 7:00pm and opened at 9:00am.
-The order for Keflex 500mg capsules was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 18	D 358		

dispensed sometime after they opened that morning at 9:00am and delivered in the routine delivery to the facility today at 1:47pm.
-There were no instructions by the facility to deliver the medication sooner.
-No one from the facility came to the pharmacy to pick up the Keflex 500mg capsules for Resident #7 on 08/30/23.

Interview with the Administrator on 08/30/23 at 4:00pm revealed:
-She thought the facility's policy was to get medications in 24 hours of the order.
-They had a copy of the hospital ER AVS when Resident #7 returned from the ER on the night of 08/29/23.
-They did not have a copy of the signed order for Keflex 500mg when the resident returned to the facility from the hospital ER on 08/29/23.
-When asked about the instructions on the AVS to pick up the Keflex at the pharmacy; she thought they needed to clarify the order since they did not have a copy of it.

Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 4:09pm revealed:
-Resident #7 returned to the facility from the local ER on 08/29/23 around 9:30pm.
-The facility contacted the resident's PCP today and was told the pharmacy had a copy of the Keflex 500mg order.
-She called the resident's pharmacy that morning around 9:00am and they said the Keflex was out for delivery.

Interview with Resident #7 on 08/30/23 at 2:56pm revealed:
-She was weak and tired, and her mind was "messed up" so she went to the hospital ER last night, 08/29/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 19	D 358		

-She was diagnosed with a UTI.
-She was administered an antibiotic at the hospital ER last night, but she was not sure if she had received any antibiotics since she had returned to the facility.

Telephone interview with a nurse at Resident #7's primary care provider's (PCP's) office on 08/31/23 at 1:48pm revealed:
-Resident #7 had a history of recurrent UTIs.
-It was best practice to start an antibiotic as soon as possible to treat the infection and prevent it from getting worse.

d. Review of Resident #7's verbal order by the primary care provider (PCP) dated 06/26/23 revealed an order to increase Oxybutynin to 10mg daily. (Oxybutynin is used to treat overactive bladder / bladder spasms.)

Review of Resident #7's physician's order sheet dated 07/31/23 revealed an order for Oxybutynin extended release (ER) 10mg take 1 tablet once daily.

Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxybutynin ER 10mg take 1 tablet once daily scheduled for 8:00am.
-Oxybutynin ER 10mg was documented as administered from 08/01/23 - 08/29/23 except on 08/21/23 when the resident was out of the facility.
-There was no entry for Oxybutynin ER 5mg and none documented was administered.

Observation of the 8:00am medication pass on 08/30/23 revealed:
-Resident #7's medications were packaged in a multi-dose pack (MDP) labeled for "morning" and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 20	D 358		

dated 08/30/23.
-The medication aide (MA) prepared and administered morning medications to Resident #7 which included one Oxybutynin ER 5mg tablet instead of Oxybutynin ER 10mg as ordered.

Observation of Resident #7's medications on hand on 08/30/23 at 8:44am revealed:
-The resident's medications were dispensed in a MDP dated 08/03/23 by an outside pharmacy provider.
-Oxybutynin ER 5mg take 1 tablet once daily was included in the list of medications and instructions on the top of the MDP card.
-There was one Oxybutynin ER 5mg tablet included in each of the MDPs labeled for morning.

Interview with the MA on 08/30/23 at 2:36pm revealed:
-She administered Oxybutynin ER 5mg to Resident #7 that morning because it was included in the MDP.
-She did not notice the strength of Oxybutynin ER in the MDP did not match the strength of Oxybutynin ER 10mg listed on the eMAR.
-Resident #7's medications were dispensed by an outside pharmacy, so she was not sure why the there was a discrepancy with the resident's Oxybutynin ER.

Telephone interview with a pharmacy technician at Resident #7's outside pharmacy provider on 08/30/23 at 3:35pm revealed:
-They only had an order for Oxybutynin ER 5mg tablets.
-They did not receive an order to increase the Oxybutynin ER to 10mg.

Interview with the Resident Care Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 21	D 358		

(RCC) on 08/30/23 at 1:00pm revealed:
-The MAs were supposed to compare the medication labels with the medications on the eMAR.
-The MA should notify her if there was a discrepancy with the medication label and the eMAR.

Attempted telephone interview with Resident #7's urology provider on 08/30/23 at 4:54pm was unsuccessful.

Interview with Resident #7 on 08/30/23 at 2:56pm revealed:
-She had bladder spasms and she received medication to help with it.
-She had seen her urology provider about 2 weeks ago.
-She was not sure what dosage she received but she thought it had been increased at some point.

e. Review of Resident #7's current FL-2 dated 02/14/23 revealed an order for Januvia 100mg 1 tablet daily. (Januvia is used to lower blood sugar levels in type 2 diabetes mellitus.)

Review of Resident #7's physician's order dated 08/11/23 revealed an order for Januvia 50mg take 1 tablet once daily.

Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Januvia 50mg take 1 tablet once daily scheduled at 8:00am.
-Januvia 50mg was documented as administered from 08/13/23 - 08/29/23 except on 08/21/23 when the resident was out of the facility.

Observation of the 8:00am medication pass on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 22 08/30/23 revealed: -The medication aide (MA) retrieved Resident #7's morning medications from a multi-dose pack (MDP) dispensed by an outside pharmacy provider. -The MA put the medications in the MDP into a plastic medication cup. -The MA pulled a bubble card with Januvia 50mg from the medication cart and put one Januvia 50mg tablet in the plastic medication cup with the other medications for Resident #7. -The MA had questions about some of the medications in the MDP and the eMAR not matching. -The MA took the medications in the plastic medication cup to the office to ask the Resident Care Coordinator (RCC) for assistance. -The RCC contacted the resident's outside pharmacy provider via telephone to assist the MA with clarification of orders. -The Area Clinical Director / Registered Nurse (ACD/RN) obtained orders from the outside pharmacy and went through the medications in the cup with the RCC to determine what needed to be administered. -The MA had gone back to the hallway to administer medications to other residents while awaiting further instructions from the RCC. -The RCC took a cup of pills to the MA to be administered to Resident #7. -The MA did not inquire about the results of the clarifications or verify the medications in the cup. -At 10:34am, the MA took the cup of medications to Resident #7's room to administer the medications. -There were 10 and ½ pills in the cup, but Januvia 50mg was not included in the cup. -Surveyor intervened and asked the MA to step back to the medication cart. -The MA was asked to count the pills and to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 23 indicate what medications were in the cup. Interview with the MA on 08/30/23 at 10:34am revealed: -She was unsure which medications were in the cup that the RCC handed her to administer to Resident #7. -She counted 10 and ½ pills but she thought there was supposed to be 11 and ½ pills in the medication cup. -She needed to take the medication cup back to the office to verify what was in the cup and what clarifications were received. Observation of the office on 08/30/23 at 10:36am revealed: -The ACD/RN found the Januvia 50mg tablet in the trash can beside the RCC's desk. -The ACD/RN reviewed all medications in the cup with the MA and instructed the MA to get another Januvia 50mg tablet from the resident's supply in the cart and administer it to the resident. Interview with the ACD/RN on 08/30/23 at 10:36am revealed: -The Januvia tablet must have been put in the trash can inadvertently when they were clarifying the medications earlier. -There was an order for Resident #7 to receive Januvia 50mg and it should have been in the medication cup with the resident's other morning medications. Observation of the medication pass on 08/30/23 at 10:45am revealed the MA prepared and administered one Januvia 50mg tablet to Resident #7 when she received her other morning medications, after being prompted by surveyor.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 24 Telephone interview with a nurse at Resident #7's primary care provider's (PCP's) office on 08/31/23 at 1:48pm revealed: -Resident #7 should receive Januvia daily for diabetes. -The resident needed the Januvia to help control her blood sugar. f. Review of Resident #7's current FL-2 dated 02/14/23 revealed there was no order for Vitamin B12. (Vitamin B12 is a supplement used to treat and prevent Vitamin B12 deficiency.) Review of Resident #7's physician's orders revealed no order for Vitamin B12. Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed there was no entry for Vitamin B12 and none was documented as administered. Observation of the 8:00am medication pass on 08/30/23 revealed: -The medication aide (MA) retrieved Resident #7's morning medications from a multi-dose pack (MDP) dispensed by an outside pharmacy provider. -The MDP label indicated there was one Vitamin B12 ER 1000mcg tablet in the MDP with instructions to administer 1 tablet every morning. -There was no physical description of the Vitamin B12 ER 1000mcg tablet on the MDP label. -The MA took the medications in the plastic medication cup to the office to ask the Resident Care Coordinator (RCC) for assistance. -The RCC contacted the resident's outside pharmacy provider via telephone to assist the MA with clarification of orders. -The Area Clinical Director / Registered Nurse (ACD/RN) obtained orders from the outside	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 25	D 358		

pharmacy and went through the medications in the cup with the RCC to determine what needed to be administered.
-The MA had gone back to the hallway to administer medications to other residents while awaiting further instructions from the RCC.
-The RCC took a cup of pills to the MA to be administered to Resident #7.
-The MA did not inquire about the results of the clarifications or verify the medications in the cup.
-At 10:44am, the MA administered the medications, including one Vitamin B12 ER 1000mcg tablet.

Interview with the MA on 08/30/23 at 10:34am revealed:
-She was unsure which medications were in the cup that the RCC handed her to administer to Resident #7.
-She did not verify what was in the cup and what clarifications were received.

Telephone interview with a pharmacy technician at Resident #7's outside pharmacy provider on 08/30/23 at 3:35pm revealed:
-The facility did not have an order on file for the resident to receive Vitamin B12.
-The resident requested the Vitamin B12 tablets be added to the MDPs.
-They added the Vitamin B12 tablets to the MDP at the request of the resident since it was an over-the-counter (OTC) medication.
-Their pharmacy staff did not enter any orders into the facility's eMAR system.

Telephone interview with a nurse at Resident #7's primary care provider's (PCP's) office on 08/31/23 at 1:48pm revealed Resident #7 did not have an order for Vitamin B12 prior to request by the facility on 08/30/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 358	Continued From page 26 Interview with Resident #7 on 08/30/23 at 2:56pm revealed: -She was not sure if she took Vitamin B12. -She took what the MAs gave her. 2. Review of Resident #6's current FL-2 dated 08/17/23 revealed: -Diagnoses included hypertension, acute kidney failure, dementia, hyperlipidemia, and anemia. -There was an order for Furosemide 20mg take 1 tablet once daily for peripheral edema (swelling), hold for systolic blood pressure (SBP) less than (<) 100. (Furosemide is a diuretic used to treat fluid retention and swelling and it can lower blood pressure.) Review of Resident #6's verbal physician's order dated 08/25/23 at 3:30pm revealed an order to discontinue Furosemide 20mg once daily. Observation of the 8:00am medication pass on 08/30/23 revealed: -The medication aide (MA) pulled Resident #6's morning multi-dose pack (MDP) from the medication cart that was labeled Wednesday, 08/30/23, "morning". -There were 11 tablets/capsules in the MDP labeled as the morning medications for 08/30/23. -The MA administered the 11 medications to Resident #6 at 8:10am including one Furosemide 20mg tablet. Review of Resident #6's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Furosemide 20mg take 1 tablet once daily for peripheral edema, hold medication for SBP < 100 scheduled for 8:00am. -Furosemide 20mg was documented as	D 358		

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D 358	Continued From page 27	D 358		

administered from 08/01/23 - 08/25/23.
-There was documentation Furosemide 20mg was discontinued on 08/25/23 and none was documented as administered after 08/25/23.

Observation of Resident #6's medications on hand on 08/30/23 at 12:15pm revealed:
-The resident's medications were dispensed in a MDP dated 08/29/23.
-Furosemide 20mg take 1 tablet daily was included in the list of medications and instructions on the top of the MDP card.
-There was one Furosemide 20mg included in each of the MDPs labeled for morning.
-There was no markings on the MDP indicating any medication had been discontinued, including the Furosemide.

Interview with the MA on 08/30/23 at 12:17pm revealed:
-If a medication supplied in the MDP was discontinued, it was usually marked out on the MDP with a line and marked as discontinued.
-If a medication in the MDP was discontinued, the MAs were supposed to use the description on the MDP to identify and remove the discontinued medication.
-She did not see any medications marked as discontinued on Resident #6's MDP that morning.
-She usually worked second shift so she did not notice that Furosemide was not included on the eMAR that morning.
-The Furosemide should not have been administered to Resident #6.

Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 1:00pm revealed:
-Resident #6 used an outside pharmacy provider for dispensing her medications.
-The facility's contracted pharmacy was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 08/30/2023

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D 358	Continued From page 28	D 358		

responsible for entering orders into the eMAR system.
-When a medication was discontinued, the MAs, Supervisor, or herself were supposed to fax the order to both pharmacies, if the resident used an outside pharmacy.
-She and/or the Administrator had access to verify medication orders in the eMAR system.
-The order to discontinue Furosemide should have been faxed by the MAs to the outside dispensing pharmacy provider so the medication could have been removed from the packaging prior to being sent in the supply dated 08/29/23.
-If a medication supplied in a MDP was discontinued, the MAs were supposed to mark through the name of the medication on the MDP label and mark it as discontinued until the next supply was dispensed which should be correct.
-The facility's contracted pharmacy discontinued the Furosemide order in the eMAR system.
-The MAs were supposed to compare the medication labels with the medications on the eMAR.
-The MA should have noticed the Furosemide was not included on the current eMAR and the MA should have identified and removed the Furosemide and discarded it prior to administering medications to Resident #6 that morning.
-She would notify Resident #6's PCP of the medication error.

Attempted telephone interview with Resident #6's PCP on 08/30/23 at 3:24pm was unsuccessful.

Based on observations, interviews, and record review, it was determined that Resident #6 was not interviewable.

_____

The facility failed to administer medications as

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D 358	Continued From page 29 ordered to 2 of 3 residents observed during the medication pass on 08/30/23. Resident #7 missed 13 doses of Eliquis, a blood thinner, due to the medication being unavailable, putting the resident at risk of blood clots. Resident #7, who was diagnosed with a urinary tract infection (UTI) at the hospital emergency room on 08/29/23, was not administered a prophylactic antibiotic used to prevent UTIs putting the resident at risk of recurrent UTIs. There was a delay in starting an antibiotic for Resident #7's current UTI, putting the resident a risk of worsening symptoms. Resident #6 continued to receive a diuretic for swelling that lowers blood pressure for 4 days after it was discontinued on 08/25/23. The failure of the facility to administer medications as ordered resulted in substantial risk of physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/30/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2023.	D 358		