STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 conducted an annual, follow-up, and complaint investigation survey from 05/29/24 to 05/31/24 with an exit conference via telephone on 06/03/24.	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 observations, interviews, and record review, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#4) observed during the morning medication pass related to a potassium supplement, and a proton-pump inhibitor medications. The findings are: The medication error rate was 8% as evidenced by 2 errors out of 25 opportunities during the 8:00am medication pass on 05/30/24. Review of Resident #4's current FL2 dated 05/02/24 revealed diagnoses included Alzheimer's disease, Parkinson's disease, Type 2 diabetes and hypertension. Review of Resident #4 Resident Register revealed an admission date of 05/20/24.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 1 A Review of Resident #4's physician's encounter report dated 05/23/24 revealed an order for potassium chloride liquid 20 milliequivalents (mEq)/15mls take 15mls every,Tuesday, Wednesday, Thursday, Saturday and Sunday. (Potassium chloride liquid is as supplement used to treat low levels of potassium in the blood.) Observation of the 8:00am medication pass on 05/30/24 at 7:30am revealed: -The medication aide (MA) prepared 15ml of potassium chloride 20mEq/15ml a 473 ml manufacturer's packaged bottle. -The potassium chloride stock bottle was labeled for "Important Information" "Take this medication with plenty of water; Dissolve this medication completely in 4 to 8 ounces of cold water or juice. Drink slowly. -The MA approached Resident #4 to administer the 15mls of undiluted potassium chloride 20mEq/15ml liquid when the surveyor intervened to stop the MA. -The MA was informed of the precaution to dilute prior to administration displayed on the medication bottle. -The MA added 6 ounces of cold water, stirred the mixture and administered the diluted 15mls of potassium chloride 20mEq/15ml to Resident #4 at 8:15am. Observation of Resident #4's medications on hand on 05/30/24 at 7:40am revealed the resident had a partial bottle of potassium chloride 20mEq/15ml dispensed from an outside pharmacy provider (not the facility's contracted pharmacy). Review of Resident #4's May 2024 medication administration record (MAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 2	D 358		

-There was an entry for potassium chloride 10mEq/15ml oral solution take 15ml on Tuesday, Wednesday, Thursday, Saturday, and Sunday.
-Potassium chloride solution was scheduled for administration at 8:00am daily and documented as administered on 05/30/24 at 8:00am.

Interview with the MA on 05/30/24 at 7:45am revealed:
-Resident #4 was a recent admission to the facility.
-Resident #4 had a hard time swallowing pills and capsules whole.
-Resident #4 brought a supply of medications, including potassium chloride liquid with her upon admission.
-The MA was not familiar with Resident #4's medications and did not see the information label affixed to the side of the bottle of potassium chloride liquid.
-She was familiar with the facility's contracted pharmacy using brightly colored auxiliary labels to notify the MAs of any special instructions for administration.

Interview with Resident #4's primary care provider (PCP) on 05/30/24 at 10:15am revealed:
-She had seen Resident #4 on 05/23/24 as a new admission to the facility.
-Resident #4 had Parkinson's disease which affected her swallowing ability.
-She renewed Resident #4's medications, including potassium chloride liquid on 05/23/24.
-She would expect Resident #4's potassium chloride liquid to be administered according to the instructions on the medication bottle including diluting the medication before administering and thereby decreasing the possible stomach irritation from the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 3	D 358		

Based on observation, interview and record review, it was determined Resident #4 was not interviewable.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/30/24 at 9:50am.

Refer to the interview with the Administrator on 05/30/24 at 4:00pm.

B. Review of Resident #4's physician's encounter report dated 05/23/24 revealed an order for pantoprazole delayed release (DR) 40mg daily 30 minutes before breakfast. (Pantoprazole used used to decrease stomach acid secretion). (Delayed release tablets should be swallowed whole and not crushed or chewed.)

Observation of the 8:00am medication pass on 05/30/24 at 7:30am revealed:
-The MA prepared 5 solid dose oral medication (tablets and capsules), including one pantoprazole DR 40mg tablet for administration to Resident #4.
-The MA removed one capsule and placed the remaining tablets, including pantoprazole DR in a clear plastic sleeve and crushed the medications.
-The MA transferred the crushed medications from the plastic sleeve to a clear plastic souffle cup.
-The MA added one teaspoonful of apple sauce to the souffle cup and proceeded to the dining room where the resident was seated and waiting for breakfast.
-The MA administered the medications giving 2 small portions with a disposable plastic spoon.
-The resident drank approximately 4 ounces of water along with the medications.
-The MA documented administration on the resident's medication administration record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 4 (MAR). Observation of Resident #4's medications on hand on 05/30/24 at 7:40am revealed: -There was a partial bottle of pantoprazole 40mg DR dispensed from an outside pharmacy provider on 11/07/23 for 90 tablets. -The medication bottle had printed instruction to "swallow whole do not chew or crush" on the label beside the instructions for one tablet daily. Review of Resident #4's May 2024 MAR revealed: -There was an entry for pantoprazole 40mg DR take one tablet daily before breakfast. (There was no information regarding do not crush on the MAR). -The pantoprazole 40mg DR was scheduled for administration at 7:30am. -Pantoprazole 40mg DR was documented as administered on 05/30/24 at 7:30am. Interview with the MA on 05/30/24 at 7:45am revealed: -Resident #4 was a recent admission to the facility. -Resident #4 had a hard time swallowing pills and capsules whole. -Resident #4 had an order to crush medications. -She was familiar with the facility's contracted pharmacy using brightly colored auxiliary labels to notify the MAs of any special instructions for administration (Like do not crush). -Resident #4 brought a supply of medications, including pantoprazole 40mg DR from home when she was admitted last week (05/20/24). -The MA was not familiar with Resident #4's medications and overlooked the information label on the side of the bottle with instructions the medication should not be crushed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 5 Interview with Resident #4's primary care provider (PCP) on 05/30/24 at 10:15am revealed: -She had seen Resident #4 on 05/23/24 as a new admission to the facility. -Resident #4 had Parkinson's disease which affected her swallowing ability. -Resident #4 had difficulty swallowing whole tablets or capsules. -She authorized for Resident #4's medications to be crushed if the medications could be crushed. -She renewed Resident #4's medications, including pantoprazole 40mg DR. -She expected Resident #4's pantoprazole 40mg DR to be administered according to the instructions on the medication bottle and not crushed if the medication was labeled do not crush. Based on observation, interview and record review, it was determined Resident #4 was not interviewable. Refer to the interview with the Resident Care Coordinator (RCC) on 05/30/24 at 9:50am. Refer to the interview with the Administrator on 05/30/24 at 4:00pm. _____ Interview with the RCC on 05/30/24 at 9:50am revealed: -Resident #4 had been admitted recently to the facility. -Resident #4's medication packaging was different than the packaging from the facility's contracted pharmacy. -The MAs should read the label completely on medication containers when administering medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080019	A. BUILDING: _____ B. WING _____	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST OF CARE ASSISTED LIVING	234 NORTHDALE AVENUE KANNAPOLIS, NC 28081

(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 6 Interview with the Administrator on 05/30/24 at 4:00pm revealed: -MAs should be administering medications as ordered including following any label instruction regarding crushing, or diluting to ensure the medications were properly administered. -Resident #4 was recently admitted and the MAs were not accustomed to the packaging from the outside pharmacy provider.	D 358		