PRINTED: 09/01/2023 FORM APPROVED OMB NO. 0938-0391

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED |
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| | | 345420 | B. WING _ | | | C 07/06/2023 |
| | ROVIDER OR SUPPLIER | TER | | STREET ADDRESS, CITY, STATE 1987 HILTON ROAD BURLINGTON, NC 27217 | E, ZIP CODE | 0770072020 |
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| F 000 | INITIAL COMMENTS | 3 | F 0 | 000 | | |
| | to conduct a complation on 6/21/23. Additional on 6/22/23, 6/23/23 at team reentered the fon 7/6/23 to conduct and investigate anot survey exit date was The following intakes NC00202039, NC00 NC00203868, and NC00203868 results | s were investigated 202609, NC00202603, IC00204313. Intake ed in immediate jeopardy. | | | | |
| | CFR 483.45 at tag F | 684 at a scope and severity J 757at a scope and severity J 757 constituted Substandard | | | | |
| F 607 SS=D | Quality of Care. For tag F 684 immed 6-15-23 and was ren For tag F 757 immed 5-15-23 and was ren Develop/Implement ACFR(s): 483.12(b)(1) §483.12(b) The facili implement written possible \$483.12(b)(1) Prohibition | diate jeopardy began on noved on 7-3-23. diate jeopardy began on noved on 7-3-23. Abuse/Neglect Policies)-(5)(ii)(iii) ity must develop and olicies and procedures that: | F 6 | 007 | | 7/31/23 |
| ADODATOD | | tion of residents and | | TITLE | | (X6) DATE |

Electronically Signed 07/25/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | |
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| F 607 | to investigate any such §483.12(b)(3) Include paragraph §483.95, §483.12(b)(4) Establity QAPI program required §483.12(b)(5) Ensured occurring in federally facilities in accordance Act. The policies and but are not limited to \$483.12(b)(5)(ii) Postemployee rights, as of (3) of the Act. §483.12(b)(5)(iii) Progretaliation, as defined (2) of the Act. This REQUIREMENT by: Based on record rever pharmacist interview, facility failed to imples investigate and reportal legation that a residilegal drug (Ecstasy) facility. The facility als Administrator was imallegation. This was fastered in the control of the Administrator was imallegation. This was fastered in the control of the Administrator was in allegation. This was fastered in the control of the Administrator was in allegation. | esident property, sh policies and procedures ch allegations, and e training as required at sh coordination with the ed under §483.75. e reporting of crimes -funded long-term care ce with section 1150B of the d procedures must include the following elements. sting a conspicuous notice of defined at section 1150B(d) phibiting and preventing d at section 1150B(d)(1) and is not met as evidenced iew, staff interview, and physician interview the ment their abuse policy and t to the state agency an dent had been given an while residing at their so failed to assure the mediately notified of the for one (Resident # 1) of four | F 6 | The facility sets forth the following correction to remain in compliance federal and state regulations. The has taken or will take the actions in the plan of correction. The folloplan of correction constitutes the fallegation of compliance. All alleg deficiencies cited have been or will corrected by the date or dates ind | e with all e facility set forth swing facility□s ged II be |
| | included: | r abuse. The findings s policy for "Abuse/ Neglect/ | | F607-Develop/Implement Abuse/N Policies 1. Resident #1 was no longer a | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 607 | Investigations," date following instruction notification of an ab administrator was to the allegation. The | rime Reporting Requirements/ ed 1/23/20, revealed the as. Immediately upon ause allegation the b report to the state agency Administrator was to also | F 6 | 1 | of the facility. 2. All current residents have the potential to be affected by this same deficient practice. 3. On 7/18/2023, 100% of all documented service concerns were | | | |
| | report of the investig within five working of "Notify the Adult Pro- local Ombudsman, enforcement author and or/medical exart for any incident of p neglect, or misappro- | ate and file a complete written gation to the State Agency days. The policy also directed, otective Services agency, the and the appropriate local law ities (police, sheriff's office, miner as deemed appropriate) patient abuse, mistreatment, opriation of personal property a suspicion of a crime." | | t i i i i i i i i i i i i i i i i i i i | reviewed by the Regional Director of Clinical Services to ensure that none the criteria that required investigating/reporting to an outside agency for the past 30 days and to erthat the administrator was aware of a cossible incident or allegations that movestigation/reporting requirements to the total agency. There were no negation findings noted on review. On 7/26/23 the Director of Nursing ar | nsure ny net o an tive | | |
| | on 3/31/23 after bei debility and a thorac Additionally, the res hypertension, conge fibrillation, diabetes endocrine disorder) disease, urinary rete | nitially admitted to the facility ng hospitalized for general cic compression fracture. dident had diagnoses of estive heart failure, atrial , Addison's disease (an , gastroesophageal reflux ention, and panic attacks. | | \$ i i i | nursing leadership began in servicing staff on the facility shouse policy an procedure to follow when reporting an investigating abuse allegations. All allegations of abuse or neglect will shoroughly investigated regardless of resident status of current or dischaften the facility. All allegations will be immediately reported to the facility | id nd I be the irged | | |
| | the hospital on 4/18 she complained of revealed that on 4/1 done in the hospital drug screen report (Ecstasy). (Ecstasy Further review of hor Resident # 1 remain On Resident # 1's 4 | scharged from the facility to 1/23 upon her request when not feeling well. Tecords for Resident # 1 1/8/23 a urine drug screen was Emergency Department. The was positive for MDMA is an illegal stimulant drug). Despital records revealed ned hospitalized until 4/28/23. 1/28/23 hospital discharge on was made of the positive | | - r t t i 2 3 t t | administrator when received. The Director of Nursing or designee wereview all service concerns daily to exthat they do not include any allegation that meet criteria for nivestigation/reporting to outside age 4. The Director of Nursing/designee audit all service concerns daily x4 we then bi-weekly x2, then monthly thereafter. Findings will be reported the monthly QAPI committee. The Administrator is responsible for this port of correction. | nsure ns ncy. e will eks, o the | | |

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| F 607 | summary, the reside medical shock (wher enough blood). The suspected an adrenaresident's problem. The records, Resident # to a different facility to in from 3/31/23 until resident # 1's family phone on 6/21/23 at following. While hos Resident # 1 had test that when broken do A hospital Nurse Praabout the report. He facility about two were been discharged from had made it clear to (Assistant Director of been found in Reside had been discharged the facility, she had gever got back to him known to them. Review of a "service 5/4/23 at 4:00 PM re (Assistant Director of Worker had received 1's family on that dat being found in the reter the concern form do | coording to the discharge in thad been treated for in the body does not get obysician noted he all crisis had led to the According to hospital 1 was discharged on 4/28/23 than the one she had resided 4/18/23. If member was interviewed via 1:45 PM and reported the pitalized on 4/18/23, ted positive for a substance win was found to be Ecstasy. Citioner had talked to him had in turn talked to the eks after Resident # 1 had in the facility on 4/18/23. He the Social Worker and ADON of Nursing) that Ecstasy had ent # 1's system when she if from their facility and not gone to on 4/28/23. No one after he made the concern concern report" form, dated wealed the former ADON of Nursing) and the Social is a concern from Resident # is regarding the Ecstasy sident's urine at the hospital. In the that the resident had overdose related to which broke down to | F6 | 5. | Date of compliance: July 31, 202 | 3 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | | |
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| F 607 | concern form, there "obtained records fro currently at (another Nursing) and consul from (family membe notation on the form The facility's Social of/21/23 at 2:20 PM at When Resident # 1's them with the 5/4/23 already been at anomember was reporting substance found at the broke down to Ecstathospital records and the resident's family match the time where Resident # 1. The former ADON we 6/21/23 at 2:30 PM at Resident # 1's family incident to them whith hospital. He told here drug panel and foun was ecstasy when be clear on what hospit but thought it was the Resident # 1 had r | of "action taken" on the 5/4/23 was a notation that read, om hospital. She was facility). DON (Director of tant called with no answer rr)." There was no further about further follow up. Worker was interviewed on and reported the following. Is family member came to concern, Resident # 1 had ther facility. The family right there had been a she hospital in her body that was saying did not seem to read the facility had cared for the facility had cared for the facility had cared for the the resident was in the that the hospital had done and there was an ingredient that roken down. She was not alization he was referring to the hospitalization after sided at their facility. She had an out and notified the Director deninistrator on 6/21/23 at the had not been made aware as Resident # 1 had Ecstasy in the was transferred to the | F 6 | 07 | | | |

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| F 607 | Continued From pag | e 5 | F 607 | | | | |
| | Consultant were interest PM and reported the had told the DON absects asy was found in she was at the hospi understanding that the resident's last hospit family member had to They pulled her hospicated was last hospit another facility. They records and saw no resident's system. The member had confused Therefore, they had resident had tested pulled have occurred the state agency or since they thought the Interview with the faction 6/21/23 at 5:08 Pinformation. The high Metoprolol, can cause | ing (DON) and Nurse rviewed on 6/21/23 at 1:15 following. The former ADON out the family's concern that a Resident #1's system while tal. It was the DON's ne family was referring to the alization at the time the peen reporting it to them. Sitalization records, and the spitalized on 5/2/23 from a looked at the 5-2-23 hospital records of illegal drugs in the ney thought the family and them with another facility. The properties of the allegation to other agency per their policy the family was confused. Sility's Consultant Pharmacist M revealed the following on blood pressure medication, the a false positive result for the sy. According to the record, | | | | | |
| | Resident # 1 was red blood pressure while | ceiving Metoprolol for high at the facility. | | | | | |
| | 6/21/23 at 5:30 PM a lot of medications ca positive drug screen them. It was his med drug test yielded a fa usually gives a high | Director was interviewed on and reported the following. A n cross react to form a and Metoprolol was one of ical opinion that the urine alse positive result. Ecstasy to individuals. He had seen ay before her 4/18/23 facility | | | | | |

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| F 607 F 684 SS=J | of illicit drug use. Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment | d not present with symptoms are ndamental principle that nt and care provided to | F 607 | | 7/31/23 | |
| | assessment of a residental residents received accordance with professor practice, the comprehence plan, and the residents recomprehence plan, and the resident plan, and plants p | nensive person-centered sidents' choices. is not met as evidenced siew, staff interview, Nurse Practitioners' ian interview the facility are for a resident with a resident's valproic acid as decreased by a actitioner who believed it only stabilization and who was ion was being using for a was no communication ider before the change. The hospitalized, and intubated decrease. Prior to transport ent # 10's seizure was spond to intramuscular d lasted approximately 28 gency medical services ransport. This was for one ee sampled residents | | F684-Quality of Care 1. Resident #10 was in the hospital at time of the survey and not a current resident in the facility. 2. All residents on antiseizure medications are at risk of being affected by this deficient practice. All other residents receiving Valproic A and being followed by the Psychiatric were audited on 6/23/23 by the region director of clinical services, to determine there were other such discrepancies noted, such as change of indication for use or diagnosis. Any discrepancy found was reported to the attending physician and/or medical for immediate follow-up. The regional director of clinical service and/or DON will review all residents by 6/30/23 at the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director of clinical services and the direction of the medical director/attending physician (the same individual) to assure the appropriate less that the direction of the medical director of clinical services and the direction of the medical director of clinical services and the direction of | ed coid NP al ne if r o I NP | |

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| F 684 | without consulting will Immediate Jeopardy when the facility provallegation for immediate Jeopardy allegation for immediate Jeopardy and severity level of lipotential for more that immediate jeopardy) staff training and to a put in place are effect. The findings included Record review reveal initially admitted to the resident's diagnoses brain injury and compution disorder,) depression Resident #10's quarta assessment, dated 3 as severely cognitive assessed to need tot activities of daily livin | bic acid dosage was hiatric Nurse Practitioner th the health care providers. was removed on 7/3/23 ided an acceptable credible ate jeopardy removal. The t of compliance at a scope D (not actual harm with the an minimal harm that is not for the facility to complete ssure monitoring systems tive. I: led Resident # 10 was e facility on 3/21/21. The included in part traumatic blex partial epilepsy (seizure a, and anxiety. erly Minimum Data Set /16/23, coded the resident ly impaired. He was also | F | 684 | for anti-seizure medications are being monitored via lab including the mediatival Valproic Acid (Depakote), Carbamazepi (Tegretol), Phenytoin (Dilantin), Levetiracetam (Keppra), to assure there are no medications not be monitored appropriately, no delayed laid results, and no failures of the provider of center to monitor other residents on the anti-seizure medications. As of 6/28/23, the Chief Nursing Office the Medical Director/attending physicial the consulting pharmacy group, and the DON met to determine, agree upon and implement the following process for all current residents that receive Valproic Acid (Depakote), Carbamazepine (Tegretol), Phenytoin (Dilantin), Levetiracetam (Keppra) and other seizu medications will have labs to monitor these drug levels. " All of those receiving these medications will be subject to the following: "Lab monitoring once every three months for two months." Lab monitoring once every six months thereafter. | eing b or ese r, n, e d | |
| | both lacosamide and The last order for lac- and directed that the (milliliters) 10 mg (mi day. This remained a date of discharge. | led Resident # 10 received valproic acid for seizures. osamide was dated 5/12/23 resident receive 10 ml lligrams)/ml two times per s an active order up until his as related to Resident # 10's ion were as follows: | | | " Baseline lab will occur for new admissions, then at the notated schedulabove The consultant pharmacist will be involved at admission and monthly thereafter to identify anti-seizure medications and to determine if they are being monitored appropriately via the recommended labs at the recommended intervals noted above. The Chief Nursin Officer communicated with the pharma | re ed ng | |

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| F 684 | Continued From pag | e 8 | F 68 | 4 | | | |
| F 684 | From 5/2/23 until 5/1 ordered to receive 11 acid three times per 6 550 mg three times per 6 550 mg three times per 6 for 5/10/23 a valproic registered 108. (A the when the blood level range to be helpful b facility's lab report no valproic acid to be 50 On 5/10/23 at 2:38 P nursing note that she value regarding a val called it into Medical On 5/10/23 an order valproic acid dosage three times per day. (mg three times per day. (mg three times per deffect until 6/15/23. The valproic acid level be 5/15/23. The order w the Physician on 5/12 an active order up ur date of 6/19/23 with 10 There was no valproic 5/15/23 or a notation done. | 0/23, Resident # 10 was ml (250 mg/5ml) valproic day. (This would equate to per day) c acid level was done and erapeutic medication level is of the medication is in a per day | F 68 | consultant about this expectation 6/28/23. 3. After the meeting of the Chrofficer, Medical Director/attend physician, consulting pharmacy and DON, the nurse administration will be educated by the DON or director of clinical services on the by 6/30/23, to ensure all expect have been ordered on admission ongoing. This will be tracked vistracking policy outlined below a monitored for implementation of the process outlined below in the clinical meeting. The Chief Nurcommunicated with the pharmac consultant about this expectation 6/28/23. The Psychiatric NP was educated 6/27/23 by the Medical Director expectations for comprehensive record review, specifically revier indications of use and diagnosi anti-seizure medications and/or gradual dose reductions for psymedications which can also be seizures (ie. Valproic Acid) before commendations for changes. concerns on the medical impact and unrelated to mood and behalould be discussed and coord the provider (attending physicial medical NP) before changes ar recommended. Additionally, an medication such as Valproic Acid. | nief Nursing ing / group, tive team regional his process ted labs on and a the lab ind ingoing via he daily sing Officer acy on on ted on r on his e medical ew for s for //chotropic used for ore making Any it, related havior, inated with an and/or re y | | |
| | Psychiatric Nurse Probehaviors. The psych Resident # 10's valpro | actitioner (NP) related to | | can also be indicated for mood stabilization should be reviewed determine actual indication for to monitor lab values prior to | d closer to | | |

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| F 684 | Continued From pag | ne 9 | F6 | 384 | | | |
| | been high. | on because his level had 5 entered an order into the | | | recommending a decrease in dosage. The Medical Director is the attending physician for all residents at the facility Moving forward and related to this eve | | |
| | | chiatric NP for a lower | | | he will educate any current advanced | | |
| | | ic acid. The order was for 5 | | | practitioners (current NPs medical and | | |
| | , , | ee times per day. (This would | | | other consulting NPs), any future | | |
| | | ree times per day.) The order | | | attending physicians, advanced care | | |
| | | en that the valproic acid was | | | practitioners and internal consulting | | |
| | was used for seizure | viors. It did not mention that it | | | entities on comprehensive medical rev | | |
| | was used for seizure | e CONITOI. | | | and interdisciplinary provider discussion when consulting providers desire to ma | | |
| | On 6/15/23 Nurse # | 5 noted in a nursing note that | | | changes, and/or when the Medical NP | | |
| | | esident # 10's responsible | | | making changes to an anti-seizure | 10 | |
| | | c acid dosage had been | | | medication. The expectation is that lev | els | |
| | | to 5 ml. Nurse # 5 noted this | | | will be drawn, and a comprehensive | | |
| | was done following a | a visit from the psychiatric NP | | | review done before dosages are being | | |
| | and the valproic acid | I was given for behaviors. | | | changed for all providers involved. The |) | |
| | There was no notation | on that the medical physician | | | center DON knows who all current | | |
| | or medical Nurse Pra | actitioner were consulted. | | | providers are; she will be made aware the Administrator and/or Medical Direction | - | |
| | | PM Nurse # 4 noted in a | | | when new providers and consultant | | |
| | _ | sident # 10 had a grand mal | | | providers begin practicing at the facility | /. | |
| | seizure (a seizure wl | | | | She has ensured all current providers | | |
| | | violent muscle contractions), | | | have been educated by the Medical | u | |
| | | Medical NP responded, the | | | Director as of 6/29/23 and will ensure to | | |
| | _ | M (intramuscular) Ativan | | | new providers are communicated to th | е | |
| | | results. Nurse # 4 further came more intense and EMS | | | Medical Director for the need to | | |
| | | Services) was called to | | | education, tracked to completion, and maintain documentation of it onsite | | |
| | transfer the resident | • | | | moving forward. | | |
| | adioloi alo rodidont | to the hoopital. | | | The consultant pharmacist will be invo | lved | |
| | On 6/19/23 Medical | Nurse Practitioner # 2 | | | at admission and monthly thereafter to | | |
| | | sident # 10's record noting | | | identify antiseizure mediations and to | | |
| | | e had worsened although he | | | determine if they are being monitored | | |
| | | Ativan. She noted he had | | | appropriately via the recommended lat | os. | |
| | seized for about 28 r | minutes when EMS arrived. | | | Education began for nursing staff to | | |
| | According to hospita | I records Resident # 10 was | | | include licensed nurses and nursing assistants on | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BOILDI | NG _ | | , ا | C | |
| | | 345420 | B. WING | | | l | 06/2023 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | S ⁻ | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| AL ABAANI | SE HEALTH CARE CEN | TED | | 19 | 987 HILTON ROAD | | | |
| ALAWAN | CE HEALTH CARE CEN | IER | | В | SURLINGTON, NC 27217 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 684 | 6/19/23 and was into valproic acid level we subtherapeutic at 38 initial large dose of response) with intracemergency Department and Department in a post recovery after a seiz started to have leftwe concerning for possito hospital records, and a tracement obtained that same intensive Care Unit electroencephalogra capability of recording periods of time. Resident # 10 remains facility, the facility revalproic acid level to order for the 5/15/23 the valproic acid level 6/17/23. The lab rep 6/21/23 and reporter The valproic acid level The valproic acid L | ergency department on ubated. The resident's as determined to be and he was loaded (given an medication to obtain a quick venous valproic acid. The nent physician also noted rrived in the Emergency stictal state (a period of cure) and within two hours ard eye deviation that was ble seizure activity. According the Emergency Department d Resident #10 required a A larger hospital was insfer acceptance was day (6/19/23) to their for LTM EEG (long term uphic monitoring, which is the ing electrical brain activity over be a level. The lab report showed el had been drawn on our noted it was received on did to the facility on 6/22/23. Vel registered 21, which int's level was subtherapeutic | F | 684 | 6/27/23 by the Director of Nursing (DO Regional Director of Clinical Services, of member of nursing administration. Education included Nursing policy 2303 "Report of Consultation." Education included: " The physician may order a consultation with another physician or healthcare provider. " Nurse (DON, supervisor, unit manager, charge nurse or designee) should review the report of consultation or physician progress notes as applicable. These reports are provided to center nursing staff by the contracted provider at the time of the consultation. " The nurse will report findings to attending physician, Physician Assistar (PA) or Nurse Practitioner (NP). This will be reported verbally onsite or via phone cathe provider is not available onsite, at time of the review, as indicated for ordering implementation, changes to current orders or rejection of orders if not approved by the provider. " Implement orders as indicated and approved by the attending physician, For NP after review after review verbally. If the order was rejected, the nurse will communicate to the | or a 3, all if the | | |
| | | acy consultant was 23 at 12:22 PM and reported apeutic valproic acid level for | | | consulting entity and follow-up as need with the provider. | ed | | |

PRINTED: 09/01/2023 FORM APPROVED

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMR MC |). 0938-0391 _. | |
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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED | |
| | | 345420 | B. WING | | | | C | |
| NAME OF P | ROVIDER OR SUPPLIER | 0.10.120 | | | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 077 | 06/2023 | |
| NAME OF T | TOVIDEN ON SOI I LIEN | | | | 987 HILTON ROAD | | | |
| ALAMANO | E HEALTH CARE CENT | ER | | BURLINGTON, NC 27217 | | | | |
| (V4) ID | SLIMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
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| F 684 | Continued From page | s 11 | | 604 | | | | |
| 1 004 | · - | | F | 684 | | | | |
| | | be 50 to 100. The lab had | | | Any nursing staff member that did not | | | |
| | "" | 08 on 5/10/23 because it | | | receive education on 6/27/23 will recei | ve | | |
| | | ipper therapeutic range. | | | education by | | | |
| | , | hen serious adverse effects e to excessive medication in | | | the beginning of their next shift by the DON or designee. The Staff Developm | ont | | |
| | _ | ould be considered 175 or | | | Coordinator | CIIL | | |
| | | reviewed Resident # 10's | | | will be responsible for tracking staff that | ıt | | |
| | | d noted that his dosage had | | | still require education. Any staff that ha | | | |
| | | ng the lab value on 5/10/23. | | | not | | | |
| | | nistory of his levels going up | | | received education will not be allowed | to | | |
| | and down. It would ha | | | | work until education is received. All ne | wly | | |
| | recommendation that no changes be made in the | | | | hired licensed staff will be educated by | • | | |
| | dosage until a repeat | level be done given his | | | Staff Development Coordinator, DON, | or | | |
| | history, but the dosag | je had been already | | | a member of nursing administration on | | | |
| | changed before she | did her review. The valproic | | | this policy. | | | |
| | | nd been ordered on 6/15/23 | | | This education will be added to the | | | |
| | | was "historically" a very low | | | orientation process. Staff Developmen | t | | |
| | | 0, but she had not reviewed | | | was notified of this responsibility on | | | |
| | | /26/23 to have reported this. | | | 6/27/23. | | | |
| | _ | ty pharmacy consultant the | | | | | | |
| | | g monthly valproic acid | | | All consultation visits and associated | | | |
| | _ | nt that was appropriate, and | | | orders will be tracked by the DON or | | | |
| | on 5/26/23. | have any recommendation | | | Regional Director of Clinical Services to ensure that the | | | |
| | 011 3/20/23. | | | | policy/process was followed as outlined | 4 | | |
| | Medical Nurse Practit | tioner # 1 was interviewed | | | above. | 4 | | |
| | | I and reported the following. | | | 45070. | | | |
| | | provider when a facility | | | All reports of consultation from the | | | |
| | | /10/23 with the valproic acid | | | previous day and all new orders related | d to | | |
| | | 23. She had asked about any | | | consultations will | | | |
| | | sident had, and the nurse | | | be brought to and tracked in the daily | | | |
| | had told her that he h | | | | clinical meeting (M-F) and the weeken | b | | |
| | decreased his dosage | e by 1 ml during the three | | | supervisor will | | | |
| | | given. She had instructed the | | | review reports of consultation on | | | |
| | | el repeated in a month. It | | | Saturday/Sunday to ensure the proces | | | |
| | | nurse's responsibility to | | | has been followed. This process will be | egin | | |
| | | No one had told her that his | | | on 6/29/23. | | | |
| | level had been going | up and down. If this had | | | 4. The Director of Nursing or Region | al | | |

been shared with her, then she would have

Director of Clinical Services will audit all

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 345420 | B. WING _ | | | | C 06/2023 |
| | ROVIDER OR SUPPLIER | ER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON ROAD BURLINGTON, NC 27217 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 684 | regular provider the nombed by | generally covered the as interviewed on 6/23/23 at ad the following. She was not as to the order that had been proic acid level on 5/15/23. The Resident # 10's valproic ecreased on the date of ais out on 6/19/23 after he aric NP was interviewed on the date of ais out on 6/19/23 after he aric NP was interviewed on the date of ais out on 6/19/23 after he aric NP was interviewed on the depart of the following. The valproic acid was being arol. She thought it was only be attached a she saw Resident # 10 on this last valproic acid level as the had talked to the his but not with the medical cal NP. The weed on 6/23/23 at 12:30 following. She had entered a for the decrease in the tere the Psychiatric Nurse order but did not talk to the | F | 584 | consults daily x4 weeks, then 2x/week then weekly x4. All findings will be reported to the monthly QAPI committee. The administrator is responsible for this plan of correction. 5. Date of completion: July 31, 2023 | ee. | |
| | 1:40 PM, the DON re | rith the DON on 6/23/23 at ported the valproic acid was e control and was also | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | 345420 | B. WING _ | | | C 07/06/2023 | |
| NAME OF PROVIDER OR SUPPLIER ALAMANCE HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CO 1987 HILTON ROAD BURLINGTON, NC 27217 | • | 0.7.007.2020 | |
| (X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT | E PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 684 Continued From page 13 helping with some of the resident some of the resident some of the Nurse Practitioners or collaborated better about the for Resident # 10. Resident some dications. He could not satisfy of valproic acid and subtherate contribute to his seizure on 6 The Administrator was intervious for the Administrator and the Interpretation of the Administrator and the Interpretation of the Psychiatric Nurse Practitic checking with the medical profinitiated but not completed a some of the Administrator was inform the property on 6/26/23 at 7:19 For Administrator presented the form Jeopardy on 6/26/23 at 7:19 For Administrator presented the form of the Normal Plan. Identify those recipients who are likely to suffer, a serious a result of the noncompliance of the Normal Plan. Resident #10 was on Valproif for seizures. On 6/15/23 a control of the Normal Plan of t | r was interviewed on red the following. He buld have medication changes # 10 had a history of f seizure by that the lower dose peutic level did not 1/19/23. Sewed on 6/23/23 at Nursing. According Director of Nursing, Resident # 10's ad been changed by oner without by by oner without by one wi | F | 584 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345420 | B. WING | | | | C 06/2023 | |
| NAME OF PROVIDE | ER OR SUPPLIER | ER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON ROAD BURLINGTON, NC 27217 | | | 00/2023 | |
| (X4) ID PREFIX TAG | | | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| indice Psycused conformal | chiatric NP was not don't seizure contiduct a thorough remedical physician ree practitioner) were were not reviewed sician and/or his lage. The resident intubated on 6/19 date. I center staff did not | of for seizures. The of aware the medication was rol because she did not eview of the medical record. In and/or facility medical staff were not consulted, and wed with the attending NP before the change in seized and was hospitalized 20/23 and remains there as of of follow professional that Nursing Policy 2303, ansultation," related to as followed. Previously, this evider (in this case the functioning independently was conducted by the remedical NP, to approve, ammended orders prior to psychiatric NP was being intract provider, a ceiving Valproic Acid and Psychiatric NP were audited ional director of clinical erif there were other such such as change of indication Any discrepancy found was ling physician and/or | F | 584 | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | TIPLE CONSTRUCTION NG | | | LETED |
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| | | 345420 | B. WING _ | | | | 06/2023 |
| | ROVIDER OR SUPPLIER CE HEALTH CARE CENT | ER | • | STREET ADDRESS, CITY, STATE, ZIP COI 1987 HILTON ROAD BURLINGTON, NC 27217 | DE | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIAT | | (X5) COMPLETION DATE |
| F 684 | Levetiracetam (Kepp medications not being no delayed lab result provider or center to these anti-seizure medical Director/atte consulting pharmacy determine, agree upofollowing process for receive Valproic Acid (Tegretol), Phenytoin (Keppra) and other selabs to monitor these. "All of those receive subject to the follow two months. o Lab monitoring of thereafter. o Baseline lab will then at the notated selabs." The consultant provider of the selabs. | via lab including the Acid (Depakote), retol), Phenytoin (Dilantin), ra), to assure there are no g monitored appropriately, s, and no failures of the monitor other residents on edications. Alief Nursing Officer, the miding physician, the group, and the DON met to on and implement the all current residents that (Depakote), Carbamazepine (Dilantin), Levetiracetam eizure medications will have drug levels aving these medications will ewing: Another the months for the every six months Coccur for new admissions, chedule above tharmacist will be involved at | F6 | , | | | |
| | anti-seizure medicati are being monitored recommended labs a noted above. The C communicated with the about this expectation. After the meeting of the Medical Director/atte pharmacy group, and | t the recommended intervals hief Nursing Officer ne pharmacy consultant n on 6/28/23. he Chief Nursing Officer, nding physician, consulting | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
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| | | 345420 | B. WING | | C 07/06/2023 | | |
| | ROVIDER OR SUPPLIER | ITER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON ROAD BURLINGTON, NC 27217 | 1 07/06/2023 | | |
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| F 684 | or regional director process by 6/30/23, have been ordered This will be tracked outlined below, and ongoing via the prodaily clinical meetin communicated with about this expectati Specify the action the process or system of adverse outcome from the Medical Director comprehensive measurements of the medical impact, mood and behavior coordinated with the and/or medical NP) recommended. Active as Valproic Active and to monit recommending a dealth of the Medical Director of all residents at the and related to this earth of the medical Director of all residents at the and related to this earth of the medical Director of all residents at the and related to this earth of the medical Director of all residents at the and related to this earth of the medical Director of all residents at the and related to this earth of the medical Director of t | of clinical services on this to ensure all expected labs on admission and ongoing. via the lab tracking policy monitored for implementation cess outlined below in the g. The Chief Nursing Officer the pharmacy consultant on on 6/28/23. The entity will take to alter the failure to prevent a serious om occurring or recurring, and be completed. Was educated on 6/27/23 by or on his expectations for dical record review, or indications of use and eizure medications and/or for tions for psychotropic can also be used for seizures refore making or changes. Any concerns on related and unrelated to should be discussed and reprovider (attending physician before changes are relationally, any medication id, which can also be restabilization should be related to lab values prior to | F 68 | 34 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | I DENTIFICATION NUMBER: | | LE CONSTRUCTION | , , | (X3) DATE SURVEY COMPLETED | |
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| F 684 | attending physicians, and internal consultir medical review and it discussion when con make changes, and/or making changes to a The expectation is the comprehensive review being changed for all center DON knows with she will be made away and/or Medical Direct consultant providers facility. She has ensient have been educated 6/29/23, and will ensient to education, the medical to the need to education, the maintain documentate forward. The consultant pharmadmission and month anti-seizure mediation are being monitored recommended labs. Education began for licensed nurses and 6/27/23 by the Direct regional director of conforming administration included: The physician manother physician or Nurse (DON, su | ansulting NPs), any future advanced care practitioners in gentities on comprehensive interdisciplinary provider sulting providers desire to or when the Medical NP is in anti-seizure medication. It levels will be drawn and a widene before dosages are in providers involved. The who all current providers are; are by the Administrator for when new providers and begin practicing at the ured all current providers by the Medical Director as of the ured all current providers are. Medical Director for the acked to completion, and from of it onsite moving the macist will be involved at analy thereafter to identify in and to determine if they appropriately via the nursing assistants on or of Nursing (DON), linical services, or a member tion. Education included "Report of Consultation." | F 68 | 4 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345420 | B. WING | | | C 7/06/2023 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 1987 HILTON ROAD BURLINGTON, NC 27217 | | 7700/2023 | |
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| F 684 | as applicable. Thes center nursing staff be the time of the consulting the time of the consulting physician, Physician, Physician, Physician, Practitioner (NP). The onsite or via phone of available onsite, at the indicated for order in current orders or rejeapproved by the proving limit in the indicated for order in current orders or rejeapproved by the attendant order approved by the attendant order approved by the attendant order approved by the attendant or education on 6/27/23 beginning of their needucation on 6/27/23 beginning of their needucation will not be education will not be education is received will be educated by the Coordinator, DON or administration on this be added to the orient Development was not 6/27/23. All consultation visits be tracked by the DO clinical services to enwas followed as outlined as a consultation or the consultation of the province of the province of the consultation of the province of the consultation visits be tracked by the DO clinical services to enwas followed as outlined as a consultation of the province of the consultation visits be tracked by the DO clinical services to enwas followed as outlined as a consultation of the province of the consultation of the province | or physician progress notes e reports are provided to by the contracted provider at litation. Sport findings to attending Assistant (PA) or Nurse his will be reported verbally all if the provider is not he time of the review, as aplementation, changes to rection of orders if not hider. It is as indicated and/or anding physician, PA or NP hiew verbally. If the order was hill communicate to the follow-up as needed with the modern that did not receive the will receive education by the ext shift by the DON or Development Coordinator or tracking staff that still hiny staff that has not received allowed to work until and the staff Development a member of nursing spolicy. This education will | F 6 | 84 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345420 | B. WING _ | | _ | C 07/06/2023 |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION DATE |
| F 684 | orders related to consand tracked in the daithe weekend supervis consultation on Satur process has been foll begin on 6/29/23. Date of immediate ject Person responsible for the Administrator. The facility's credible Jeopardy removal wat 7/6/23. The validation was evand interviews to veri anti-seizure medicatic carbamazepine, pherhad lab work complet levels of the medication appropriately. An interview with the pharmacist confirmed newly admitted reside medications would have obtained and the level Multiple interviews we nurses to ensure the education was provid shift. The nurses con received in-service exprocess for reporting | sultations will be brought to ally clinical meeting (M-F) and sor will review reports of day/Sunday to ensure the owed. This process will be pardy removal is 7/3/23. For implementation the plan is allegation of Immediate is validated on 7/5/23 and be proceed by record reviews for all residents receiving for some sure their blood for swere monitored be a baseline drug level of the monitored appropriately. The proceedings which included the consultation, which included the consultation findings to the in (Medical NPs or MD) and for will reside these with one of these | F | 584 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345420 | B. WING | | | | C |
| NAME OF PROVIDER OF | | | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 987 HILTON ROAD BURLINGTON, NC 27217 | <u> </u> | 06/2023 |
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| An interconfirm complet to reconfirm complet to reconfirm (Medic response) F 756 Drug R CFR(s) \$483.4 \$483.4 must be licenses \$483.4 of the reconfirm facility' and the (i) Irreduced facility' and the (ii) Irreduced facility' and the (iii) Any during separate attending directors minimument and the | ned she was comprehenced a comprehenced and comprehenced was with the factal NPs and MI asible for review mended by a collementation of the collementation | ed with the Psychiatric NP cunseled on the need to ensive medical review prior hange in medication. cility's medical team D) indicated they would be ving and verifying all orders onsulting provider prior to f these orders. Firmed that Immediate ed on 7/3/23. W, Report Irregular, Act On (2)(4)(5) Immen Review. Lug regimen of each resident least once a month by a | | 756 | | | 7/31/23 |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | (X3) DATE COMPI | |
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| | | 345420 | B. WING _ | | | 07/0 |) 06/2023 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | 0770 | 30/2020 |
| 41 48441 | NE LIE AL TIL OADE OENT | | | 1987 HILTON ROAD | | | |
| ALAMANG | CE HEALTH CARE CENT | EK | | BURLINGTON, NC 27217 | | | |
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| F 756 | Continued From page resident's medical recirregularity has been action has been taked be no change in the rephysician should door the resident's medical §483.45(c)(5) The fact maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action. This REQUIREMENT by: Based on record reviconsultant interview to consultant failed to rephysician that 1) a rechad not been done as her monthly review air recommendation was changes be made with This was for 1 of 3 retheir seizure medicatifindings included. Record review reveal initially admitted to the discharged to the hose | cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in I record. Cility must develop and procedures for the monthly that include, but are not is for the different steps in its the pharmacist must take if its an irregularity that in to protect the resident. The is not met as evidenced is well and pharmacy the facility pharmacy prort to the medical is ident's valproic acid level is ordered at the time she did and 2) that her is that no further dosage thout a level being checked. Is idents reviewed related to on (Resident # 10). The | F 7 | DEFICIENCY) | e facility a eted. vill in-service egarding Reviews a s. This 7/28/202 be involve eafter to s to | ne are vice and | |
| | depression, and anxious Record review reveal both lacosamide and | r that causes seizures), | | appropriately via recommended When needed the consultant p will make the needed recomme and communicate them the me provider via the monthly pharm consultant report. The DON/designee will review | harmacis endations edical nacist | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| F 756 | (milliliters) 10 mg (mill day. This remained at date of discharge. Orders and lab result: valproic acid medication ordered to receive 11 acid three times per consistered 108. (Therefor seizures). On 5/10/23 at 2:38 Plance of the seizures of the seizure | resident receive 10 ml ligrams)/ml two times per s an active order up until his s related to Resident # 10's fon were as follows: 0/23, Resident # 10 was ml (250 mg/5ml) valproic lay. (This would equate to the er day). acid level was done and apeutic range is 50 to 100 M Nurse # 2 noted in the exceived a critical lab value locid level of 108 and called it reactitioner (NP) # 1. was given to decrease the to 10 ml (250 mg/5 ml) This would equate to 500 ay.) This order stayed in the order specifically noted for seizures. sian ordered Resident # 10's rechecked on the date of as electronically signed by //23. This order remained as till the resident 's discharge or revision of the order. | F | 756 | admission MRR/monthly MRR to assur that all residents current and admitted the facility with antiseizure medications have been reviewed by the consultant pharmacist and any recommendations made have been communicated to the medical practitioner and implemented timely once approved by the medical provider. 4. The DON/designee will review MR summaries weekly x4 weeks, then Bi-weekly x4 for all new admission and will review all monthly MRR summaries monthly x 3 months, to assure compliatis maintained. The DON/designee will take results of reviews to QA by the DON and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The Administrator who be responsible for any follow up on any recommendation from the QA Committee and additional training as indicated. 5. Date of completion: July 31, 2023 | to R S nce ed | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| F 756 | | | F7 | 756 | | |
| | Review of the facility' report, dated 5/27/23 name was on the list reviewed for the date and for which she had the time of the pharm review, Resident # 10 level drawn per the 5. The facility's pharmaci interviewed on 6/26/2 the following. A thera seizure control would flagged the value of 1 was higher than the utagged the value of 1 was higher than the utagged the value of 1 was higher than the utagged the value of 1 was higher than the utagged the value of 1 was higher than the utagged following the Changed following the Changed following the Changed following the Changed before she do and down. It would have commendation that dosage until a repeat history, but the dosage changed before she can she did not call it to the According to the pharmach thought that was she did not have any for the physician about level checks either. | s pharmacy consultant revealed Resident # 10's of residents she had s of 5/1/23 through 5/27/23, d no recommendations. At acist's drug regiment still had no valproic acid f11/23 order. by consultant was 3 at 12:22 PM and reported be to to 100. The lab had 08 on 5/10/23 because it pper therapeutic range. considered 175 or greater. d Resident # 10's record on at his dosage had been at lab value on 5/10/23. history of his levels going up ave been her no changes be made in the level be done given his e had already been lid her review and therefore, he attention of the physician. macy consultant the facility hly valproic acid levels and appropriate, and therefore recommendation on 5/26/23 at his valproic acid blood | | | | |
| F 757 SS=J | | e from Unnecessary Drugs -(6) | F7 | 757 | | 7/31/23 |
| | | ary Drugs-General. regimen must be free from An unnecessary drug is any | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345420 | B. WING | | | C 07/06/2023 | |
| | ROVIDER OR SUPPLIER | ER | • | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 987 HILTON ROAD BURLINGTON, NC 27217 | | |
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| F 757 | substitute of the substitute o | essive dose (including y); or cessive duration; or at adequate monitoring; or at adequate indications for its cresence of adverse indicate the dose should be ued; or embinations of the reasons (d)(1) through (5) of this is not met as evidenced iew and staff, Pharmacist, and Physician interviews the de effective monitoring of els and manage dose emedication (valproic acid). #10's valproic acid level was I is 50-100 mcg/mL). The re reported to the on-call a decrease in the daily e10's valproic acid. No orders resident's record that day ic acid level to be drawn. On the properties of the control of the | F | 757 | F757-Drug Regiment is Free from Unnecessary Drugs 1. The Regional Director of Clinical Services and/or DON will review all residents by 6/30/23 at the direction of medical director/attending physician (the same individual) to assure the appropriate levels for anti-seizure medications are being monitored via lab including the mediations Valproic Acid (Depakote), Carbamazepine (Tegretol), Phenytoin (Dilantin), Levetiracetam (Keppra), to assure there are no medications not be monitored appropriately, no delayed lat results, and no failures of the provider center to monitor other residents on the anti-seizure medications. | ne iate eing b or | |
| | medication blood lever changes for a seizure On 5/10/23 Resident 108 (therapeutic lever laboratory results were provider who ordered dosage of Resident # were entered into the for any repeat valproin 5/12/23 Resident #10 signed an order to repon 5/15/23. This order laboratory and remain resident's hospitalization. | els and manage dose e medication (valproic acid). #10's valproic acid level was I is 50-100 mcg/mL). The re reported to the on-call I a decrease in the daily 10's valproic acid. No orders resident's record that day ic acid level to be drawn. On I's Physician electronically peat the valproic acid level er was not received by the | | | Services and/or DON will review all residents by 6/30/23 at the direction of medical director/attending physician (the same individual) to assure the appropriate levels for anti-seizure medications are being monitored via lab including the mediations Valproic Acid (Depakote), Carbamazepine (Tegretol), Phenytoin (Dilantin), Levetiracetam (Keppra), to assure there are no medications not be monitored appropriately, no delayed lal results, and no failures of the provider of center to monitor other residents on the | eing b or ese | |

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| CENTERS FOR MEDICARE & MEDICA | | MEDICAID SERVICES | | | | OMB NO | <u>). 0938-0391</u> |
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| F 757 | Continued From page | 25 | | 757 | | | |
| 1 737 | | | | 151 | | | |
| | Practitioner (NP) rela | | | | the Medical Director/attending physicia | | |
| | | incorrectly that Resident # | | | the consulting pharmacy group, and the | | |
| | | s prescribed for mood | | | DON met to determine, agree upon ar | | |
| | stabilization and ordered a further reduction of the | | | | implement the following process for al current residents that receive Valproic | | |
| | valproic acid daily dosage. No monitoring of the resident's valproic acid level was ordered at the | | | | Acid (Depakote), Carbamazepine | | |
| | time of the visit. The lab successfully drew a | | | | (Tegretol), Phenytoin (Dilantin), | | |
| | valproic acid level on 6/17/23, and the result | | | | Levetiracetam (Keppra) and other seiz | rure | |
| | - | s subtherapeutic. The | | | medications will have labs to monitor | uio | |
| | subtherapeutic level | | | these drug levels. | | | |
| | facility until 6/22/23, a | | | All of those receiving these medicatio | ns | | |
| | documentation in the | | | will be subject to the following: | | | |
| | | to 6/22/23. On 6/19/23 | | | " Lab monitoring once every three | | |
| | Resident # 10 had a | grand mal seizure (a seizure | | | months for two months. | | |
| | where there is loss of | f consciousness and violent | | | " Lab monitoring once every six mo | nths | |
| | muscle contractions), | , which was documented not | | | thereafter. | | |
| | • | scular Ativan medication | | | " Baseline lab will occur for new | | |
| | | ately 28 minutes before | | | admissions, then at the notated sched | ule | |
| | | services arrived for care and | | | above | | |
| | 1 | 10 was transported to the | | | The consultant pharmacist will be |) | |
| | local hospital emerge | ency department and since the sinserted into the trachea for | | | involved at admission and monthly thereafter to identify anti-seizure | | |
| | ventilation). Upon Em | | | | medications and to determine if they a | ro | |
| | , . | # 10's valproic acid level | | | being monitored appropriately via the | ı G | |
| | was 39, which was su | | | | recommended labs at the recommend | ed | |
| | · · | ent physician determined | | | intervals noted above. The Chief Nurs | | |
| | , , | d LTM EEG (long term | | | Officer communicated with the pharma | | |
| | · · | ohic monitoring, which is the | | | consultant about this expectation on | • | |
| | | g electrical brain activity over | | | 6/28/23. | | |
| | | and Resident #10 was | | | " After the meeting of the Chief Nui | sing | |
| | transferred to the Inte | ensive Care Unit at a larger | | | Officer, Medical Director/attending | | |
| | hospital that same da | y. This was for 1 of 3 | | | physician, consulting pharmacy group | | |
| | sampled residents re | | | | and DON, the nurse administrative tea | | |
| | medications (Resider | nt #10). | | | will be educated by the DON or region | | |
| | | | | | director of clinical services on this pro- | | |
| | | began on 5/15/23 when the | | | by 6/30/23, to ensure all expected lab | 3 | |
| | - | cility did not obtain the physician ordered | | | have been ordered on admission and | | |
| | valproic acid level for | | | | ongoing. This will be tracked via the la | b | |
| | immediate jeopardy v | vas removed on 7/03/23 | | | tracking policy outlined below and | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| F 757 | 1 3 | | F 7 | 757 | | | |
| | acceptable credible a jeopardy removal. Th compliance at a lowe D to ensure monitorir | ided and implemented an illegation of immediate e facility remains out of r scope and severity level of of systems put into place omplete staff training. | | | monitored for implementation ongoing the process outlined below in the daily clinical meeting. The Chief Nursing Off communicated with the pharmacy consultant about this expectation on 6/28/23. | | |
| | The findings included: Record review revealed Resident # 10 was initially admitted to the facility on 3/21/21. The resident's diagnoses included in part traumatic brain injury and complex partial epilepsy (neurological disorder that causes seizures), depression, and anxiety. Resident #10's quarterly Minimum Data Set assessment, dated 3/16/23, coded the resident as severely cognitively impaired. He was also assessed to need total assistance with his activities of daily living, have no behaviors during the assessment period, and to have a seizure disorder. Record review revealed Resident # 10 received both lacosamide and valproic acid for seizures. The last order for lacosamide was dated 5/12/23 and directed that the resident receive 10 ml (milliliters) 10 mg (milligrams)/ml two times per day. This remained as an active order up until his date of discharge. From 5/2/23 until 5/10/23, Resident # 10 was ordered to receive 11 ml (250 mg/5ml) valproic acid three times per day. (This would equate to 550 mg three times per day). On 5/10/23 a valproic acid level was done and registered 108 mcg/mL. (A therapeutic | | | | 2. The Psychiatric NP will be educate by the Medical Director on his expectations for comprehensive medic record review, specifically review for indications of use and diagnosis for anti-seizure medications and/or for gradual dose reductions for psychotrop medications which can also be used fo seizures (ie. Valproic Acid) before mak recommendations for changes. Any concerns on the medical impact, relate and unrelated to mood and behavior, should be discussed and coordinated with provider (attending physician and/omedical NP) before changes are recommended. Additionally, any medication such as Valproic Acid, which | al r ing d vith | |
| | | | | | can also be indicated for mood stabilization should be reviewed closer determine actual indication for usage, a to monitor lab values prior to recommending a decrease in dosage. This will be done by 6/28/23. The Medical Director is the attending physician for all residents at the facility Moving forward and related to this even he will educate any current advanced of practitioners (current NPs medical and other consulting NPs), any future attending physicians, advanced care practitioners and internal consulting entities on comprehensive medical reviews | and nt, care | |

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| F 757 | Continued From page | e 27 | F | 757 | | | |
| | medication level is wh | hen the blood level of the | | | and interdisciplinary provider discussio | n | |
| | medication is in a ran | ige to be helpful but not | | | when consulting providers desire to ma | | |
| | dangerous. The facili | - | | | changes and/or when the Medical NP i | | |
| | | valproic acid to be 50 to 100 | | | making changes to an anti-seizure | | |
| | | eutic level for valproic acid | | | medication. The expectation is that leve | els | |
| | would be medication | blood levels below 50 | | | will be drawn, and a comprehensive | | |
| | mcg/ml. A toxic level | would indicate levels when | | | review done before dosages are being | | |
| | serious adverse effec | cts are brought about due to | | | changed for all providers involved. The | | |
| | excessive medication | n in a person's system). | | | center DON knows who all current | | |
| | | | | | providers are; she will be made aware | by | |
| | | M Nurse # 2 noted in a | | | the Administrator and/or Medical Direct | or | |
| | | had received a critical lab | | | when new providers and consultant | | |
| | | proic acid level of 108 and | | | providers begin practicing at the facility | - | |
| | called it into Medical | Nurse Practitioner (NP) # 1. | | | She has ensured all current providers | | |
| | | | | | have been educated by the Medical | | |
| | | order was given by Medical | | | Director as of 6/29/23 and will ensure t | | |
| | | ne valproic acid dosage to | | | new providers are communicated to the | 9 | |
| | | three times per day. (This | | | Medical Director for the need to | | |
| | | mg three times per day.) | | | education, tracked to completion, and | | |
| | _ | effect until 6/15/23. The | | | maintain documentation of it onsite | | |
| | | ed the valproic acid was for | | | moving forward. | | |
| | seizures. | | | | Education began for nursing staff to | | |
| | On 5/11/22 the Dhysi | sian ordered Resident # 10's | | | include licensed nurses and nursing | F | |
| | | cian ordered Resident # 10's rechecked on the date of | | | assistants on 6/27/23 by the Director o Nursing (DON) or designee. In the case | | |
| | l | | | | | 5 01 | |
| | | as electronically signed by 2/23. This order remained as | | | this deficient practice, the lab tracking process, from order/requisition to a tim | alv | |
| | | itil the resident's discharge | | | final result was not in place and was in | Ciy | |
| | | no revision of the order. | | | violation of our Laboratory Tracking Po | licy | |
| | There was no valproi | | | | 1702. | ПОУ | |
| | | in the record why it was not | | | Education included the policy and | | |
| | done. | and and the state of the state | | | protocols listed: - | | |
| | | | | | A licensed nurse will monitor and track | all | |
| | On 5/27/23 the facility | y Pharmacy Consultant | | | physician or physician extender ordere | | |
| | | ion Regimen Review and | | | laboratory tests and will ensure that lab | | |
| | • | commendations related to | | | tests are drawn as ordered and | | |
| | Resident # 10's medi | cations. | | | communicate results to the physician in | n a | |
| | | | | | timely manner. | | |
| | On 6/15/23 Resident | # 10 was seen by the | | | A. The Center will obtain lab services to |) | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | l ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| F 757 | Continued From page | e 28 | F 75 | 57 | | |
| | behaviors. The Psych Resident # 10's valpr mood stabilization, ar gradual dose reduction been high. On 6/15/23 Nurse # 5 Psychiatric NP into the dosage of the valproimal (250 mg/5ml) three equate to 250 mg three was specifically written being used for behave was used for seizure. On 6/15/23 Nurse # 5 had informed Resident the valproic acid from 10 ml to 5 ml in another medication for had. Nurse # 5 noted visit from the Psychia | oic acid was prescribed for and she was going to start a on because his level had be entered the order from the se computer for a lower coacid. The order was for 5 se times per day.) The order enter that the valproic acid was iors. It did not mention that it control. To noted in the record that she ent # 10's responsible party dosage had been dropped addition of increasing or behaviors the resident this was done following a tric NP and the valproic acid | | meet the needs of its patients. occurred to nurses, specifically the need for blood levels draw residents on seizure medicatic Dilantin, Valproic Acid and Kep B. Lab services will be provide ordered by the physician or prextender and the physician or will be notified of lab results in manner. C. When an order for a lab tereceived, for the current month nurse receiving the order will ab requisition form from the late The information will include: a. patient name and room numb. Test ordered. c. Date lab test is to be drawned. Medicare/Medicaid numbers. e. Other insurance information f. Name of the ordering physicing. Date of birth. h. Diagnosis related to the test. | y related to yn for ons, such as ppra. ed only when nysician extender a a timely st is h, a licensed complete a ab vendor. . s. n. cian | |
| | was given for behaviors. There was no notation that the Medical Physician or Medical Nurse Practitioner were consulted. | | | i. Any special instructions D. A licensed nurse receiving will document the information | g the order on the | |
| | PM and reported the the order written by the for the decrease in the talk to the Medical Pheractitioner. She thou | ewed on 6/23/23 at 12:30 following. She had entered he Psychiatric NP on 6/15/23 e valproic acid but did not hysician or the Medical Nurse light the Psychiatric NP had NP about the dose change. | | appropriate current month's la log located in the lab notebook labs will be recorded on the la log. The DON, Unit Manager or Nu Administration monitors the la log, to assure from order, to result, to communication to the | k. Routine b tracking ursing b tracking equisition, to | |
| | nursing noted the foll | M Nurse # 6 noted in a owing. The phlebotomist to draw the resident's lab oving his arm. The | | timely. The expectation is that routine/normal labs should be hours. Labs results not back ir should be reviewed and monit | all back in 24 n 24 hours | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | , , | (X3) DATE SURVEY COMPLETED | | |
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| F 757 | Continued From pag | e 29 | F 7 | 57 | | | | |
| | given a medication to blood draw could be noted the Medical NF According to a lab re was drawn on 6/17/2 On 6/19/23 at 12:48 nursing note that Resseizure, facility staff a responded, the reside (intramuscular) Ativa results. Nurse # 4 fur became more intense transfer the resident On 6/19/23 Medical Nentered a note in Resthe resident's seizure. | port, a valproic acid level 3. PM Nurse # 4 noted in a sident # 10 had a grand mal and the Medical NP # 2 ent was given IM n without any positive ther noted the seizure e and EMS was called to | | timeliness in the case that they expected to take more than 24 E. If the routine lab test order is the current month, the licensed document the appropriate informents the Lab Tracking Log indictype of lab test ordered and dat completed. The 11-7 shift licens or supervisor will check the Lab Form and the Culture & Sensitive Tracking Form nightly for lab we drawn in the morning. The appropriate in the Center designated location technician. F. Upon completion of the lab delicensed nurse will document the specimen was drawn on the applace to the lab to the lab Tracking Log. If the lab is upon the content of the lab is upon the lab of | not due in nurse will mation ating the e to be sed nurse Tracking vity Lab ork to be opriate e lab book placed in for the lab raw, a e date the propriate | | | |
| | According to hospital evaluated in the eme 6/19/23 and was intu valproic acid level was subtherapeutic at 39 initial large dose of mesponse) with intravemergency Department appearance overy after a seize started to have leftware concerning for possible to hospital records, the physician determined higher level of care. | records Resident # 10 was regency department on bated. The resident's as determined to be and he was loaded (given an nedication to obtain a quick enous valproic acid. The ent physician also noted rived in the Emergency cictal state (a period of cure) and within two hours and eye deviation that was pole seizure activity. According the Emergency Department of Resident #10 required a A larger hospital was refer acceptance was | | be drawn, the information will be communicated to the attending NP or PA for new orders, appromove the lab or any follow-up a depending on the need of the region of the results, a nurse will document the date the were received on the appropriate Tracking form. All routine lab reas Valproic acid, Dilantin and Keshould be back in 24 hours. All that are not back in 24 hours where expectation was 24 hours, should investigated for timeliness, follow the lab and report to physician further actions or orders needed H. Critical results will be called the physician or extender and docuindicated. The lab reports critical results reports critical results will be called the physician or extender and docuindicated. The lab reports critical results will be called the physician or extender and docuindicated. The lab reports critical results will be called the physician or extender and docuindicated. | physician, val to s needed esident. I licensed e results te Lab sults, such eppra level lab values nere the uld be w-up to for any d. to the mented as | | | |

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| ALAMANG | CE HEALTH CARE CENT | ER | | В | URLINGTON, NC 27217 | | |
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| F 757 | Continued From page | ≥ 30 | F 7 | 757 | | | |
| F 757 | obtained that same de Intensive Care Unit for electroencephalographic capability of recording long periods of time). Resident # 10 remains 6/26/23. Following Resident # facility, the facility recoval proic acid level that order for the 5/15/23 the valproic acid level 6/17/23. The lab reported The valproic acid level indicated the resident prior to his 6/19/23 set. The facility's Pharmac interviewed on 6/26/2 the following. A therat seizure control would flagged the value of 1 was higher than the uniterviewed set. | ay (6/19/23) to their or LTM EEG (long term othic monitoring, which is the g electrical brain activity over need hospitalized as of 10's discharge from the eleved from their lab the first at had been drawn since the level. The lab report showed I had been drawn on our noted it was received on to the facility on 6/22/23. The lab registered 21, which it's level was subtherapeutic electric. | F 7 | 757 | via phone to the charge nurse, and the charge nurse will report this verbally in person or via phone to the provider as soon as possible for follow-up, but not later than two hours after receiving the notification. I. Once the physician or extender has been notified of lab results, the nurse via document the date of notification and to method of notification in the appropriat space(s) on the appropriate Lab Track Log and place his/her initials in the nur initial column on the form. J. A licensed nurse will document any necessary information for follow up on 24- hour shift report. 3. Any nursing staff member that did receive education on 6/27/23 will receive education by the beginning of the next shift by the DON or designee. The Star Development Coordinator will be responsible for tracking staff that still require education. Any staff that has no received education will not be allowed work until education is received. All new hire licensed staff will be educated by the Staff Development Coordinator or designee on this policy. This education will be added to the orientation process staff Development was notified of this responsibility on 6/27/23. | lab vill he e ing se the not ve ff ot to w the | |
| | and down. It would hat recommendation that dosage until a repeat history, but the dosage changed before she of the facility Pharmacy been doing monthly were commended. | ave been her no changes be made in the level be done given his | | | 4. All lab orders will be tracked by the DON or designee to ensure that they a requisitioned, tracked for timely results reviewed by the attending physician, Nor PA daily and follow up as indicated. Each day (M-F) the lab tracking log allowith the previous day's new lab orders be brought to the clinical meeting by | re , IP ong | |

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| F 757 | She further reported to for valproic acid which 6/15/23 by the Psych very low dose for Res reviewed him again for reported this. Medical Nurse Praction 6/26/23 at 4:10 PN She was the on-call nurse called her on 5 level of 108 on 5/10/2 seizure activity the rehad told her that he had creased his dosage day and she had instillevel repeated in a minurse's responsibility one had told her that and down. If this had she would have instructonsult with the regul let them decide. The facility's Psychiam 6/23/23 at 1:25 PM and She did not think Resist the valproic acid for sit was only used for more behaviors. When she 6/15/23 she saw that had been critically hig dosage be decreased facility nurses about the Physician or the Med | commendation on 5/26/23. The decreased daily dosage had been ordered on liatric NP was "historically" a sident # 10, but she had not collowing 5/26/23 to have dident # 1 was interviewed of and reported the following. For order when a facility of 10/23 with the valproic acid with the his but not with the control of the following. The facility of 10/23 with the valproic acid with the his but not with the desire but the facility of 10/23 with the valproic acid with the facility of 10/23 with the valproic acid with the facility of 10/23 with the valproic acid with the facility nurse and none. She had with the facility nurse to have put the order in. No his level had been going up been shared with her, then facted the facility nurse to have put the next day and with the facility nurse to have put the facility nurse to have | F 7 | nursing administration from ereview for this process by the on Saturday/Sunday, the wee supervisor will complete the sprocess for each unit. The Director of Nursing will on weekly audits all lab orders reassure compliance. These authority thereafter or until substantial is achieved. All findings will be reported to QAPI committee. 5.Date of completion: July 31 | e DON, and ekend same omplete eccived to udits will be bi-weekly compliance | d e e x4 | |

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| F 757 | aware of any change given to draw Reside on 5/15/23. She was 10's valproic acid do 6/15/23. On 6/19/23 seizure, she found the been decreased. The Director of Nursion 6/23/23 at 11:00 / following. She though acid for 5/15/23 was medical record systes supposed to have be DON reported it was lab had not obtained valproic acid on 6/15 to get it that day. The the resident was more obtained on 6/17/23. During a follow up in 6/23/23 at 1:40 PM, syalproic acid was being the side of the s | ed the following. She was not as to the order that had been ent #10's valproic acid level also not aware Resident # sage had been decreased on after Resident # 10 had a see valproic acid dosage had and reported the sage had seen decreased on after Resident # 10 had a see valproic acid dosage had and reported the seen that the ordered lab for valproic an error in the electronic seen drawn on 6/15/23. The her understanding that the enough blood for the level was a seen drawn on 6/16/23 and wing too much. The lab was | F 75 | | | | |
| | 6/23/23 at 3:35 PM a 6/15/23 there had be acid level. The lab w unrelated lab which I Resident # 10. On 6/ from the facility to ha The lab tried to draw special-order lab, whunsuccessful in obta | rager was interviewed on and reported the following. On the en no order for a valproic as trying to draw another and had been ordered for 16/23 they had the first order to a valproic acid level done. It on 6/16/23 along with the ich they had been ining the previous day. On moved too much, and they | | | | | |

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| F 757 | lab. On 6/17/23 they the valproic acid lab a ran the valproic acid lab a they sent out the specialty lab usual complete and both reand the specialty lab on 6/22/23. The Chief Executive was interviewed on 6 reported the following copy of requisitions for requisition for Reside since the 5/10/23 leve 6/16/23. It was drawn was finalized on 6/17 day. They had sent the been drawn along with their cooperating lab automatically populate results are completed facility's electronic mesystem. It had been staff. At the initiation went over with the facility that labs would their electronic medicity that labs would the facility staff could system and see a residence. | proic acid lab or the specialty returned and drew both labs, and the specialty lab. They lab themselves that day was a routine lab for them. ecialty lab to their worked with. The results for ally took a few days to sults (the valproic acid level were released to the facility). Officer for the facility's lab (23/23 at 4:12 PM and g. They retained a scanned fom facilities. The first int # 10's valproic acid level, el had been done was a on 6/17/23 and the result (23 at 2:15 PM that same the specialty lab that had the the valproic acid level to to run. Lab results e electronically when all | F | 757 | | | | |

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| F 757 | Continued From pag | e 34 | F 7 | 57 | | | |
| | facility's Medical Dire 6/23/23 at 5:15 PM at felt the Nurse Practite collaborated better at for Resident # 10. Resident # 10. Resident # 10. The Administrator was 6:00 PM with the Dire to the Administrator at the facility had identification with the Psychiatric Nurse checking with the mainitiated but not commoditated but | about the medication changes desident # 10 had a history of ardless of seizure sysician reported that 10 had a history of seizures in the could not say that the could not say that the could and subtherapeutic attention to his seizure on 6/19/23. The could not seizure on 6/19/23 at ector of Nursing. According and the Director of Nursing, fied that Resident # 10's alosage had been changed by the Practitioner without edical provider and they had apleted a plan of correction. The could not say that the could not seizure on 6/19/23 at ector of 6/19/23 at ector of Nursing, fied that Resident # 10's alosage had been changed by the Practitioner without edical provider and they had apleted a plan of correction. The could not say that the could not seizure on 6/19/23 at ector of 6/19/23 at ector of Nursing, fied that Resident # 10's alosage had been changed by the Practitioner without edical provider and they had apleted a plan of correction. The could not say that the could not seizure on 6/19/23 at ector of 6/19/23 at ector of Nursing, fied that Resident # 10's alosage had been changed by the extension of field not seizure on 6/19/23 at ector of Nursing, fied that Resident # 10's alosage had been changed by the extension of field not seizure on 6/19/23 at ector of Nursing, fied that Resident # 10's alosage had been changed by the extension of field not seizure on 6/19/23 at ector of Nursing, fied that Resident # 10's alosage had been changed by the ector of Nursing, fied that Resident # 10's alosage had been changed by the ector of Nursing, fied that Resident # 10's alosage had been changed by the ector of Nursing, fied that Resident # 10's alosage had been changed by the ector of Nursing, fied that Resident # 10's alosage had been changed by the ector of Nursing, fied that Resident # 10's alosage had been changed by the ector of Nursing, fied that Resident # 10's alosage had been changed by the ector of Nursing, fied that Resident # 10's alosage had been changed by the ector of Nursing, fied that Resident # 10's al | | | | | |

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| F 757 | normal range 50-10 result was called fro charge nurse. The of Medical NP who way via phone at the time from 11 mls three time times day, diagnosis investigation, the medical related to the cridecreased the medifollow-up lab orders stated she would have to determine the new constant of the constant of | letermined high at 108, 0 by the lab, and the high m the lab to the center charge reported it to the s not in the center, but on-call e, who changed the dosage nes a day to 10ml's three s epilepsy. Upon further edical NP who answered the itical lab stated she cation, but did not give . When asked why, she we left it to the provider onsite | F 7 | 757 | | | |
| | was not entered into | normal practice. This order the electronic health record, writing onto the lab requisition | | | | | |

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| Continued From pa | ge 36 | F 75 | 7 | | |
| shortly after midnight requisitioned lab for repeated. The night requisitioned lab for 6/15/23 for next lab unrelated lab that won 6/16/23. The lab to let them know the lab, due to the buggested that he nalbwork. This was determined that patient-center approached the draw the lab the The lab was success was sub-therapeutic | at to state an unrelated 6/15/23 needed to be the shift nurse added the Valproic Acid (ordered on day) to the carbon copy of the as scheduled to be repeated or called the facility on 6/16/23, by would be unable to draw the scheduled to be resident and deeded Ativan prior to his discussed with the IDT, and it an alternative non-medicinal bach could be used to attempt the next lab day, on 6/17/23 and that time, but the facility | | | | |
| importance, related serious medication of dose changes, and The Valproic Acid w resident had a seizu intubated in the inte the hospital at this time the hospital at this time. The regional director DON will review all direction of the medical physician (the same appropriate levels for are being monitored mediations Valproic Carbamazepine (Te | to lab tracking, monitoring of for seizures at the time of timely follow up on lab results. as not monitored. The are, was hospitalized, and rim on 6/19/23 and remains at time. For of clinical services and/or residents by 6/30/23 at the ical director/attending individual) to assure the per anti-seizure medications I via lab including the Acid (Depakote), gretol), Phenytoin (Dilantin), | | | | |
| | OVIDER OR SUPPLIER E HEALTH CARE CEN SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page The facility lab calle shortly after midnighty requisitioned lab for repeated. The nighty requisitioned lab for 6/15/23 for next lab unrelated lab that won 6/16/23. The lab to let them know the lab, due to the busy suggested that he night lab was determined that patient-center approte the draw the lab the The lab was success was sub-therapeutic did not receive the resident had a seizu intubated in the inte the hospital at this time. The regional director DON will review all indirection of the media appropriate levels for are being monitored mediations Valproic Carbamazepine (Te | 345420 | OVIDER OR SUPPLIER E HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 The facility lab called the center on 6/16/23 shortly after midnight to state an unrelated requisitioned lab for 6/15/23 needed to be repeated. The night shift nurse added the requisitioned lab for Valproic Acid (ordered on 6/15/23 for next lab day) to the carbon copy of the unrelated lab that was scheduled to be repeated on 6/16/23. The lab called the facility on 6/16/23, to let them know they would be unable to draw the lab, due to the behaviors of the resident and suggested that he needed Ativan prior to his labwork. This was discussed with the IDT, and it was determined that an alternative non-medicinal patient-center approach could be used to attempt the draw the lab the next lab day, on 6/17/23. The lab was successfully drawn on 6/17/23 and was sub-therapeutic at that time, but the facility did not receive the results until 6/22. The facility failed to follow procedures of critical importance, related to lab tracking, monitoring of serious medication for seizures at the time of dose changes, and timely follow up on lab results. The Valproic Acid was not monitored. The resident had a seizure, was hospitalized, and intubated in the interim on 6/19/23 and remains at the hospital at this time. The regional director of clinical services and/or DON will review all residents by 6/30/23 at the direction of the medical director/attending physician (the same individual) to assure the appropriate levels for anti-seizure medications are being monitored via lab including the mediations Valproic Acid (Depakote), Carbamazepine (Tegretol), Phenytoin (Dilantin), | OVIDER OR SUPPLIER E HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 The facility lab called the center on 6/16/23 shortly after midnight to state an unrelated requisitioned lab for 6/15/23 needed to be repeated. The night shift nurse added the requisitioned lab for Valproic Acid (ordered on 6/16/23. The lab called the facility on 6/15/23, to let them know they would be unable to draw the lab, due to the behaviors of the resident and suggested that he needed Ativan prior to his labwork. This was discussed with the IDT, and it was determined that an alternative non-medicinal patient-center approach could be used to attempt the draw the lab the next lab day) on 6/17/23 and was sub-therapeutic at that time, but the facility did not receive the results until 6/22. The facility failed to follow procedures of critical importance, related to lab tracking, monitoring of serious medication for seizures at the time of dose changes, and timely follow up on lab results. The Valproic Acid was not monitored. The resident had a seizure, was hospitalized, and intubated in the interim on 6/19/23 and remains at the hospital at this time. The regional director of clinical services and/or DON will review all residents by 6/30/23 at the direction of the medical director/attending physician (the same individual) to assure the appropriate levels for anti-seizure medications are being monitored via lab including the medications Valproic Acid (Depakote), Carbamazepine (Tegretol), Phenytoin (Dilantin), | |

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| F 757 | provider or center to these anti-seizure medical Director/atte consulting pharmacy determine, agree up following process for receive Valproic Acid (Tegretol), Phenytoir (Keppra) and other slabs to monitor these "All of those receive be subject to the follo o Lab monitoring of two months. O Lab monitoring of the follo o Lab monitoring of two months. O Lab monitoring of the follo o Lab monitoring of the following following the following follo | is, and no failures of the monitor other residents on edications. Inief Nursing Officer, the inding physician, the group, and the DON met to on and implement the all current residents that I (Depakote), Carbamazepine in (Dilantin), Levetiracetam elizure medications will have endry drug levels iving these medications will owing: once every three months for once every six months Indicate the commended intervals of the pharmacy consultant in on 6/28/23. In the Chief Nursing Officer, inding physician, consulting | F 75 | 57 | | |

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| F 757 | daily clinical meeting communicated with about this expectation. Specify the action the process or system for adverse outcome frowhen the action will. The Psychiatric NP will Medical Director on comprehensive med specifically review for | eess outlined below in the g. The Chief Nursing Officer the pharmacy consultant on on 6/28/23. e entity will take to alter the allure to prevent a serious om occurring or recurring, and be completed. will be educated by the his expectations for | F 757 | | |
| | gradual dose reduction medications which continued (ie. Valproic Acid) be recommendations for the medical impact, mood and behavior, coordinated with the and/or medical NP) recommended. Add such as Valproic Acidindicated for mood sometimes reviewed closer to do usage, and to monitor recommending a debe done by 6/28/23. | ions for psychotropic an also be used for seizures efore making or changes. Any concerns on related and unrelated to should be discussed and provider (attending physician before changes are ditionally, any medication d, which can also be tabilization should be etermine actual indication for | | | |
| | for all residents at the and related to this even current advanced camedical and other contending physicians and internal consulti | re facility. Moving forward vent, he will educate any are practitioners (current NPs consulting NPs), any future advanced care practitioners and entities on comprehensive interdisciplinary provider | | | |

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| F 757 | make changes, and/making changes to a The expectation is the comprehensive review being changed for all center DON knows with she will be made award and/or Medical Directon consultant providers facility. She has enshave been educated 6/29/23, and will ensure communicated to the need to education, to maintain documental forward. | sulting providers desire to or when the Medical NP is an anti-seizure medication. The who all current providers are; are by the Administrator tor when new providers and begin practicing at the tured all current providers by the Medical Director as of the new providers are the new providers are the new providers are the Medical Director for the acked to completion, and tion of it onsite moving | F 7 | 57 | | |
| | licensed nurses and 6/27/23 by the Direct designee. In the cast the lab tracking process a timely final result with violation of our Labor Education included to -A licensed nurse will physician or physicial laboratory tests and drawn as ordered and physician in a timely 1. The Center will obneeds of its patients. nurses, specifically relevels drawn for residence. | will ensure that lab tests are d communicate results to the manner. tain lab services to meet the Education occurred to elated to the need for blood | | | | |

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| ALAMANO | CE HEALTH CARE CENT | ER | | Е | BURLINGTON, NC 27217 | | |
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| F 757 | and the physician or exter results in a timely ma 3. When an order for current month, a licer order will complete a lab vendor. The inforr a. patient name and r b. Test ordered. c. Date lab test is to b d. Medicare/Medicaid e. Other insurance inf f. Name of the physic g. Date of birth. h. Diagnosis related t i. Any special instruct 4. A licensed nurse re document the informa current month's lab tracking le notebook. Routine lab lab tracking log. The DON Administration monito assure from order, to communication to the expectation is that all be back in 24 hours. hours should be revie timeliness in the case to take more than 24 5. If the routine lab te current month, the lice the appropriate inform Log indicating the typ | e provided only when bian or physician extender of the provided only when bian or physician extender on the will be notified of lab onner. a lab test is received, for the provider is timely. The routine/normal labs should Labs results not back in 24 owed and monitored for that they are not expected beted. The 11-7 shift licensed of the mation onto the Lab Tracking the of lab test ordered the control onto the Lab Tracking the of lab test ordered teed. The 11-7 shift licensed on the control onto the Lab Tracking the of lab test ordered teed. The 11-7 shift licensed the control of the control of the control onto the Lab Tracking the of lab test ordered teed. The 11-7 shift licensed the control of the control of the control of the control onto the Lab Tracking the of lab test ordered teed. The 11-7 shift licensed | F | 757 | | | |

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| F 757 | Continued From pag | | F 757 | , | | |
| | Tracking Form nightidrawn in the morning will be pulled from the completed if necessed designated location 6. Upon completion on urse will document drawn on the approprime lab is unable to be communicated to or PA for new orders any follow-up as need of the resident. 7. Upon receipt of lawill document the day on the appropriate Lab results, such as Keppra level should values that are not be expectation was 24 for timeliness, follow physician for any furneeded. 8. Critical results will extender and documents, and the charge verbally in person or soon as possible for 9. Once the physician notified of lab results date of notification and the rappropriate space(s). Tracking Log and planurse initial column of 10. A licensed nurse | g. The appropriate requisition le lab book (or lary) and placed in the Center for the lab technician. The lab draw, a licensed the date the specimen was briate Lab Tracking Log. If the drawn, the information will left the attending physician, NP or approval to move the lab or eded depending on the need left the results were received ab Tracking form. All routine left the results were received ab Tracking form. All routine left the results where the lab and left in 24 hours. All lab lack in 24 hours where the lab and report to the lab and report to the lab and report to the ractions or orders. The called to the physician or left das indicated. The lab lab lack in 24 hours where the lab lack in left in the lab lack in later than or extender has been so the nurse will document the lab lack in left in the lab lack in left in the lab lack in later than or extender has been so the lab lack in later than or extender has been so the lab lack in later than or extender has been so the lab lack in later than or extender has been so the lab lack in later than or extender has been so the lab lack in later than or extender has been so the lab lack in later than or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in or extender has been so the lab lack in later than in l | | | | |

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| F 757 | education on 6/27/23 beginning of the next designee. The Staff will be responsible for require education. A education will not be education is received will be educated by the Coordinator or designeducation will be add process. Staff Develor responsibility on 6/27 All lab orders will be designee to ensure the tracked for timely rest attending physician, as indicated. Each of along with the previous be brought to the clin administration from exprocess by the DON the weekend supervit process for each unit Date of immediate je Person responsible for the Administrator The facility's credible Jeopardy removal wa 7/6/23. The validation was e | mber that did not receive will receive education by the shift by the DON or Development Coordinator or tracking staff that still any staff that has not received allowed to work until d. All new hire licensed staff the Staff Development nee on this policy. This led to the orientation opment was notified of this 7/23. It tracked by the DON or that they are requisitioned, sults, reviewed by the NP or PA daily and follow-up lay (M-F) the lab tracking log us day's new lab orders will sical meeting by nursing each unit to review for this and on Saturday/Sunday, sor will complete the same | F7 | 757 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 757 | carbamazepine, phei had lab work comple levels of the medicat appropriately. An interview with the pharmacist confirmed newly admitted resid medications would have obtained and the level thereafter. Multiple interviews with the education was provided shift. The nurses confeceived in-service effacility's procedures approviding follow up, a results for all lab order (located in a lab note complete a comprehence of the commending and laterviews with the face (Medical NPs and Mil responsible for reviews). | ons (including valproic acid, nytoin, and levetiracetam) ted to ensure their blood ons were monitored facility's consultant deshe would recommend ents receiving such ave a baseline drug level elemonitored appropriately face conducted with licensed necessary in-service ed prior to working their insistently reported they ducation, which included the for tracking, monitoring, and communicating the ers utilizing a lab tracking log book at the Nursing Station). for which included the for tracking a lab tracking log book at the Nursing Station). for which included to ensive medical review prior hange in medication. | F 7 | 757 | | |
| F 760 SS=E | the implementation of The facility's Immedition of 7/3/23 was validated | f these orders. ate Jeopardy removal date | F 7 | 760 | | 7/31/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 760 | · · · · · · · · · · · · · · · · · | | F 7 | 60 | | | |
| | medication errors. This REQUIREMENT by: Based on interviews Regional Director of O Practitioner (NP) and record reviews, the faidentify the diagnosis antiseizure medicatio inadvertently disconticorrected to indicate resulting in a failure to doses of the antiseizure residents (Resident # of seizures. The findings included Resident #11 was ad 6/17/16 with a cumula included epilepsy and A review of the reside record (EMR) indicate order was written for Depakote Delayed Remouth twice daily. The this medication was be #11's bipolar disorder valproic acid and is u including the treatme disorder. | with the facility staff, Clinical Services, Nurse Medical Doctor (MD), and cility failed to correctly (indication) for the use of an n. This medication was nued when the order was t was used to treat seizures, o administer 6 consecutive are medication for 1 of 3 11) reviewed with a history : mitted to the facility on ative diagnosis which I bipolar disorder. ent's electronic medical and a 2/17/23 physician's | | F760-Residents are Free of Sign Med Errors 1. On 7/5/23 resident #11 had valproic acid level drawn and res reported on 7/5/23. The medical was notified, and no new orders 2. All residents that reside in the have the potential to be affected practice. On 7/21/21 all orders written for anti-seizure medications since 7/were reviewed for appropriatenes implementation in the electronic record. 3. On 7/5/23 the Chief Nursing re-educated the Regional Director Clinical Services on the following PCC order entry-Running/Reviewing Order Report to review all discontinued current orders. Appropriate review of Order during daily clinical meeting and up on questionable order change The DON or designee will review discontinued/edited orders for an medications daily during the daily meeting to determine reason for discontinuation or updating to as the action is appropriate. Any ide issues will be corrected and imm | a serum ults provider given. e facility by this 11/2023 ss and health Officer or of l. e-cap and re-cap following ss. y all ti-seizure y clinical sure that entified | | |
| | | l assessment dated 6/29/23. | | communicated to the medical pro 4. Monitoring will include week monitoring of all antiseizure med | ovider. ly | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | L IDENTIFICATION NUMBER | | ULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| F 760 | valproic acid was dra to be 53 microgram laboratory report ind for valproic acid used 100 ug/ml. Resident #11's June Medication Administrate and the received ordered up to 6/30/2 indicated while the redose of Depakote DI an evening dose of Duly 2023 MAR docureceive both his morn Depakote DR on 7/1 also showed Reside morning dose of Depresident missed a to 500 mg Depakote DI re-initiated on 7/3/23 On 7/3/23 at 1:49 PN received to administrate resident by mouth A Medication (Med) documented a med of 7/2/23 with Resident on the Medication En occurred when the dechanged by the Reg Services on 6/30/23 inadvertently omitted taken included re-en Resident #11's EMR | revealed his blood level of awn and reported on 6/30/23 per milliliter (ug/ml). The icated the therapeutic range d to treat seizures was 50 - 2023 and July 2023 ration Records (MARs) d Depakote DR twice daily as 3. However, the June MAR esident received his morning R, he was not administered Depakote DR. Resident #11's amented the resident failed to ning and evening doses of 1/23 and 7/2/23. The MAR not #11 failed to receive his bakote DR on 7/3/23. The tall of 6 consecutive doses of R before the medication was | F 76 | to assure that they are still action appropriate, monitoring will occur, x4, bi-weekly x2 and monthly the until substantial compliance is of Findings will be reported to the QAPI committee. The Administrates ponsible for this plan of correst. Date of completion: July 31 | ur weekly ereafter or btained. monthly rator is ection. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| F 760 | affect the resident. An interview was con with the Regional Diro During the interview, 6/30/23 she was worldiagnosis (or indication of Depakote DR. Shin the order's diagnosi intended to update the Director reported she discontinued the medital discontinued the interview, Resident #11 on 6/30 receiving 500 mg Dep When she returned to was no longer on the reported the concern re-ordered the medical NP #2 acknowledged history of seizures and antiseizure medication #11 could not recall with The NP stated she devalproic acid level dra resident did not like to An interview was con with the facility's Dire During the interview, was received to have | ducted on 7/5/23 at 4:47 PM ector of Clinical Services. the Director reported on king on an audit to verify the on) in Resident #11's EMR he recalled making a change his for the Depakote DR and he order. However, the must have unintentionally lication instead of updating 1, an interview was he Practitioner (NP) #2. the NP reported he was bakote DR at that time. The properties of the facility on 7/3/23, he | F 7 | 60 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | I ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| F 760 | A blood sample was on 7/5/23 at 4:45 PM 7/5/23 at 7:21 PM. To valproic acid blood let therapeutic range). An interview was conwith Resident #11. Do resident acknowledge seizures but stated he last experienced of the resident stated his ago." An interview was conwith the facility's Med Director reported to had not experienced stated, "Sure, it's not given." However, he another antiseizure migher dose of Depak missed doses. Instead appropriate to wait a resident's valproic acid. | collected from Resident #11 with the results reported on the lab results indicated his wel was 54 ug/ml (within the ducted on 7/6/23 at 2:10 PM uring the interview, the ed he had a history of e could not remember when the interview in the ed he had a history of e could not remember when the interview in the ed he had a history of e could not remember when the interview in the ed he had a history of e could not remember when the interview in the ed he had a history of e could not remember when the interview in the ed he had a history of e could not remember when the interview in the ed he had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when the interview in the ed had a history of e could not remember when | F7 | 760 | | |