PRINTED: 12/13/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245246	B. WING	D. WING		С	
		345316	D. WING _			11/1	5/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2275 RUIN CREEK ROAD HENDERSON, NC 27537	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
F 755 SS=D	11/11/2023 to 11/15/2 The following intake of NC00209408. One of in a deficiency. Pharmacy Srvcs/Production	f the two allegations resulted cedures/Pharmacist/Records	F	755			11/15/23
	drugs and biologicals them under an agree §483.70(g). The faci personnel to adminis	vide routine and emergency to its residents, or obtain ement described in lity may permit unlicensed					
	pharmaceutical servi that assure the accur dispensing, and adm	es. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and he needs of each resident.					
		Consultation. The facility in the services of a licensed					
		es consultation on all ion of pharmacy services in					
	\ , , , ,	ishes a system of records of on of all controlled drugs in able an accurate					
	§483.45(b)(3) Detern	nines that drug records are in					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE

Electronically Signed 11/20/2023

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.

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		345316	B. WING			C I1/15/2023
NAME OF P	ROVIDER OR SUPPLIER	1 11 1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/13/2023
				2275 RUIN CREEK ROAD		
SENIOR C	ITIZENS HOME			HENDERSON, NC 27537		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	Continued From page	e 1	F 75	5		
F 755	order and that an accis maintained and per This REQUIREMENT by: Based on record rever pharmacy director intinterview, and reside to provide medication hours for 1 (Resident for provision of medic Findings included: Resident #1 had curred which included Type Bipolar disorder, condisorder, status post post-traumatic stress. Documentation in the Physician orders listed by Nurse #2 at 12:57 the following medicated - Novolin (Insulin) 70. Suspension Pen 60 usubcutaneously ever diabetes. 15 units of subcutaneously if Rebreakfast. - Novolin (Insulin) 70. Suspension Pen 30 ususpension Pen 30 ususpens	count of all controlled drugs riodically reconciled. I is not met as evidenced riew, staff interview, staff interview, serview, physician assistant interview the facility failed as upon admission for 18 at #1) of 3 residents reviewed cation upon admission. Inulative diagnoses some of 2 diabetes, Hypertension, gestive heart failure, anxiety orthopedic surgery, and disorder. It electronic medical record of red as entered on 10/30/2023 PM for Resident #1 included cions: If all the properties of the properties	F 75	(1). How corrective action will be accomplished for resident(s) for have been affected: On 11/11/23, the Pharmacy delives to the facility were changed to etimes. The Pharmacy also changes facility to be a first facility on the have the medications delivered. (2). How the corrective action we accomplished for resident(s) has potential to be affected by the same eding to be addressed: All residents have the potential affected by this non-compliance result, the systemic changes state have been put into place to previous of affecting the residents. (3). What measures will be put if or systemic changes made to enthe identified issue does not residents. On 11/11/23, we instructed the first section will be put if the future:	very hours arlier ged our run to ill be ving the ame issue to be and as a ated below vent any nto place nsure that occur in	
	Diabetes Mellitus. - Aspirin in the form of	usly every evening for of an 81-milligram (mg) tablet daily as supplement.		to change our delivery times to and 5:00pm and made the facilit run on each delivery. (4). Indicated how the facility plants in the faci	ty the first	
	- Atorvastatin Calciur	m in the form of an 80-mg		monitor its performance to make solutions are achieved and sust		

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		345316	B. WING		C 11/15/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27537	11110/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 755	artery disease. - Empagliflozin in the by mouth once a day. - Prasugrel HCL in the taken by mouth one. - Carvedilol in the form daily for Hypertension. - Sertraline HCL in the taken by mouth one disorder. - Buspirone HCL in the taken by mouth one disorder. - Icosapent Ethyl in the taken by mouth artery disease. - Lamotrigine in the staken by mouth two.	th at bedtime for coronary e form of a 10 mg tablet taken y for Diabetes Mellitus. ne form of a 10 mg tablet time a day as supplement. rm of a 3.125-mg tablet twice	F 75	<u> </u>	of s are ications nitoring e or the uality on of n
	- Ranolazine extend 1000 mg tablet to be day for Hypertension	orm of a 100 mg capsule to wo times a day for pain. ed release in the form of a e taken by mouth two times a n. ius in the form of a capsule to			
	be taken by mouth the supplement.				

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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 755	- Alprazolam in the taken by mouth ever anxiety. - Nitroglycerin Sublitablet to be taken so needed for chest paup to 3 0.4 mg table. - Levofloxacin in the administered by modays for amputation. - Metronidazole in the administered by days for antiinfection. - Oxycodone HCL in the administered by needed for pain. Documentation in a 10/30/2023 written Resident #1 arrived 2:00 PM. Nurse #1 was intention.	form of a 0.5 mg table to be ery 24 hours as needed for singual in the form of a 0.4 mg ublingually every 5 minutes as ain. Repeated every 5 minutes ets maximum. The form of a 500 mg tablet to be bouth one time a day for 10 mouth two times a day for 14 m. The form of a 5 mg tablet to mouth every 6 hours as In admission summary dated by Nurse #1 indicated at the facility at approximately	F 75			
	entered the medical discharge summary electronic medical r to the pharmacy on additionally reveale physician or the pharmedications for Resassumed the medical ready verified by in on the night shift.	aled that another nurse tions from the hospital of for Resident #1 to the record system for transmission 10/30/2023. Nurse #1 d she did not contact the armacy regarding the sident #1 because she reations for Resident #1 were the physician and would come. Nurse #1 confirmed she alter the tions for PM on 10/30/2023				

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F 755	in on that shift from the Nurse #2 was interviped. Nurse #2 reveal orders for medication discharge summary record system for Resecond nurse was to with the facility physicorders sent to the property orders and the property orders are sent to the property orders sent to the property	for Resident #1 did not come the pharmacy. I weed on 11/11/2023 at 3:53 led she entered the physician instraction from the hospital into the electronic medical esident #1. Nurse #2 stated a confirm the physician orders ician and then have the narmacy. I weed on 11/11/2023 at 6:28 med she worked from 11:00 or 7:00 AM on 10/31/2023. The following information ation orders for Resident #1. The dat the start of her nursing Resident #1 was admitted to moon and did not have any acility yet. Nurse #3 looked in a system and compared the from the hospital to orders to the electronic medical er #3 found no discrepancies of information on allergies.	F 7	55		
	Resident #1 received	d his ordered dose of Aspirin on received at 9:00 AM on				

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F 755	was interviewed on stated was made aw 10/31/2023 that Res medications delivered time as she was reviadmission. PA #1 stat that insulin was not a #1 revealed she wer blood sugar of Residmeans necessary if revealed she called medications for Residual medications to include the 10/31/2023. Nurse #4 of 10/31/2023. Nurse #6 10/31/2023 Residual medications to include she went to PA #1, vnotified her of the lace Resident #1. Nurse PA #1 to check the band it was within nor insulin administration Resident #1 did not the morning of 10/31.	tant (PA #1) for Resident #1 11/13/2023 at 1:29 PM. PA #1 vare on the morning of ident #1 did not have his ad from the pharmacy at that ewing his chart as a new ated her specific concern was available for Resident #1. PA at with Nurse #4 to check the lent #1 and find insulin by any insulin was required. PA #1 the pharmacy to order the dent #1 to be sent as soon where device the dent #1 still did not have his de insulin. Nurse #4 stated who was in the building, and ock of medications for #4 explained she went with allood sugar of Resident #1 armal limits, not requiring and Nurse #4 revealed require pain medication on 1/2023. ectronic medication	F 7:			
	"Medication not avail Documentation on the revealed Resident #	tered at 5:00 PM stated, lable from pharmacy." ne MAR for 10/31/2023 1 received his evening doses of Atorvastatin,				

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F 755	release, and Oxycode An interview was con 11/13/2023 at 2:28 P was working on the 7 11/01/2023 and was cart on the hall Resident confirmed the mornin available for Resident dose of insulin. An interview with the conducted on 11/11/2 policy, as explained to to enter the physiciar once on the MAR, the transmitted to the pha that the facility receiv medications from the approximately 2:00 P approximately 9:00 P revealed that the pha for the facility and the medications onsite in dispensing system. An interview was con Director for the facility 3:19 PM. The Pharm convey the following pharmacy records. To facility regarding the was received by the p 10/30/2023, after the the pharmacy. At 11: facility pharmacy records.	I, Icosapent Ethyl, alin, Ranolazine extended one. Iducted with Nurse #6 on M. Nurse #6 confirmed she 1:00 AM to 3:00 PM shift on assigned to the medication lent #1 resided. Nurse #6 ag medications were to include his morning Director of Nursing was 2:023 at 3:04 PM. The facility by the DON, was for a nurse of orders into the MAR and the orders were to be armacy. The DON revealed and two deliveries of pharmacy, one at 1:00 M. The DON further armacy was a new pharmacy of facility had no back up an automated medication Iducted with the Pharmacy by pharmacy on 11/11/2023 at acy Director was able to	F 7	55		

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F 755	on 10/31/2023. The was sent with the dr 10/31/2023. The drive for Resident #1 at 8 facility and the medical nurse #3 at that time had no explanation and elivered the medical facility. The Pharma was the expectation medications were not business of the pharma had no explanation were not business of the pharma was the expectation medications were not business of the pharma had been dications were of resident. The Pharma facility did not currer medication dispensions insulin as a backup. Documentation on a Status dated 10/31/2 was screened as cook Resident #1 was into 4:13 PM. Resident #1 and frustrating 2 day to the facility as he comedications were not #1 stated he "did not from not having his insulin, blut reiterated it was having his insulin, blut medication after he was able to "tolein the state of the part	when the pharmacy reopened first delivery of medications iver at 1:19 PM on ver delivered the medications 44 PM on 10/31/2023 to the cations were signed for by e. The Pharmacy Director for why the pharmacy driver ations for Resident #1 outside very times contracted by the cy Director explained that it of the pharmacy that if seded after the close of macy, the backup pharmacy by the facility so that otained by morning for the acy Director confirmed the atly have an automated and machine that contained for needed medications. Brief Interview for Mental 2023 revealed Resident #1 gnitively intact. Brief was a stressful vs when he was first admitted did not understand why his of available to him. Resident the suffer anything health wise medications available to him stressful worrying about not ood thinners, antibiotics, and resurgery. Resident #1 stated rate" the pain while he waited	F 7	55		
F 760 SS=D	for his medication to Residents are Free	arrive at the facility. of Significant Med Errors	F 7	60		11/15/23

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F 760	medication errors. This REQUIREMEN by: Based on record rev Physician Assistant i interview, Surgical P resident interview th antibiotic, diabetic, h and pain medication significant errors by medications for one reviewed for significa Antibiotic medication admission to the fac error for Resident #1 antiepileptic, and pa initially upon admiss required medications Resident #1. Findings included: 1.Documentation on summary dated 10/3	eure that its- ents are free of any significant T is not met as evidenced view, staff interview, nterview, Pharmacy Director hysician interview and e facility failed to provide ypertension, antiepileptic, as ordered resulting in omission of high alert (Resident #1) of one resident ent medication errors. Is were delayed after elity due to a transcription Diabetic, hypertension, in medication were omitted ion due to a delay obtaining from the pharmacy for a hospital discharge 0/2023 revealed Resident #1	F 760		e sue to d as
	for an amputation. T discharge summary diabetic infection of wound was cultured plan was to continue antibiotics Levaquin discharged to the fac infectious disease sp the same hospital di physician orders for	d to the facility post operation he problem list on the revealed Resident #1 had a his left foot. The surgical and grew out bacteria. The hat least 4 weeks of the and Flagyl when Resident #1 cility as discussed with the hecialist. Documentation on scharge summary revealed Levaquin in the form of a tablet administered by mouth		(3). What measures will be put into plat or systemic changes made to ensure the identified issue does not re-occur in the future: On 11/11/23 the Regional Nurse in-serviced the Director of Nursing, Nurse manager and staff nurses on the processor of verifying new admission or re-admission orders with the MD/PA/N immediately upon admission, place the orders into Point Click Care and	hat n rse ess

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			7 50.25.	_			
		345316	B. WING	B. WING		11/15/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SENIOR C	ITIZENS HOME				275 RUIN CREEK ROAD		
				Н	ENDERSON, NC 27537		
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F 760	Continued From page	9	F	760			
	every day and Flagyl in the form of a 500 mg				immediately order the medications. The	en	
		red by mouth twice a day.			utilizing our emergency backup kit for		
					immediate dispensing of medications		
	Resident #1 was adm				needed.		
		ulative diagnoses some of					
		tes mellitus, status post			On 11/11/23, the Regional Nurse		
		at toe and left forefoot, and			in-serviced the Director of Nursing, Nur	se	
	diabetic left foot infec	tion.			manger and nursing staff that the Pharmacy closes at 5:00pm and to call		
	Documentation in the	electronic medical record			the backup pharmacy for new admission		
		se #2 entered an order on			orders as well as any new medications		
		nt #1 to receive Levaquin in			ordered after 5:00pm.		
	the form of a 500 mg tablet by mouth one time				·		
	daily for 10 days with	a start date of 11/9/2023.			On 11/11/23, the Regional Nurse called the Director of Pharmacy and ordered a		
		e Medication Administration			Insulin E-kit for the facility. The Insulin		
	, ,	vember of 2023 revealed			E-Kit was received by the facility.		
	the first day the antibi	•			(4) 1 11 11 11 11 11 11 11		
		dent #1 was 11/9/2023, 10			(4). Indicated how the facility plans to	ho	
	days from 10/30/2023	3.			monitor its performance to make sure t solutions are achieved and sustained:	ne	
	Documentation in the	electronic medical record			The monitoring will be done by the		
		se #2 entered an order on			Director of Nursing or designee for eac	h	
		ent #1 to receive Flagyl in			new or re-admission admission. The		
	the form of a 500 mg	tablet by mouth two times a			Director of Nursing or designee will rev	iew	
	day for 14 days with a	a start date of 11/13/2023.			upon admission all new medications		
					orders in PCC to include start dates, st	ор	
		vey the documentation on			dates, and transcription accuracy. This		
		er 2023 revealed the first			monitoring will be done with each new admission for 4 months.		
		gyl was to be administered to PM on 11/13/2023, 14 days			admission for 4 months.		
	from 10/30/2023.	71 W 011 11/13/2023, 14 days			Any issues during monitoring will be		
					addressed immediately. The		
	An interview was con	ducted with Nurse #2 on			Administrator, Director of Nursing, or		
	11/13/2023 at 1:01 Pf	M. Nurse #2 indicated she			designee will report findings of the		
		ng in the orders for the			monitoring process to the facility Qualit	y	
		Levaquin and Flagyl to be			Assurance and Performance		
		pon admission of Resident irse #2 confirmed she made			Improvement Committee for any additional monitoring or modification of		

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F 760	Continued From page 10 an error and put the wrong start dates for the antibiotics for Resident #1.		F 760	this plan. The QAPI Committee of modify this plan to ensure the fac remains in substantial compliance	cility	
	Assistant (PA #1) or #1 confirmed she sa morning of 10/31/20 a new admission. Particle Levaquin and Flagy discharge summary to be administered to PA #1 noted Reside antibiotics in the hos administration by more confirmed the antibioshould have been so admission because for. PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics could have outcome on the hear in the left foot of Resident PA #1 revealed antibiotics reve	nducted with the Physician 11/13/2023 at 1:29 PM. PA aw Resident #1 on the 123 and reviewed his chart as A #1 confirmed the antibiotics I, according to the hospital I, were supposed to continue I when he arrived at the facility. Int #1 was on intravenous I spital but was to switch to I but he facility. PA #1 I otics Levaquin and Flagyl I tarted immediately upon I that was what the order was I delaying the provision of I we a potential effect or I ling process and the infection I sident #1 but, he had not I a systemic change since				
	Status dated 10/31/2 was screened as co Resident #1 was int 4:13 PM. Resident # anything health wise antibiotics available	Brief Interview for Mental 2023 revealed Resident #1 gnitively intact. erviewed on 11/11/2023 at #1 indicated he "did not suffer b" from not having his to him but revealed it was pout not having his antibiotics				
	amputation procedu #1 was interviewed	ian who performed the re on the left foot of Resident on 11/15/2023 at 9:08 AM. ian revealed the following				

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F 760	#1 during a follow up The open wound loc improved, and did n was not an ideal situ not continuing with he first admitted to the the facility provided wound VAC (vacuur #1 was always at a because he had dia uncontrolled blood of which included Ty Bipolar disorder, cordisorder, status postpost-traumatic stres Documentation in the Physician orders list by Nurse #2 at 12:5 some of the followin Novolin (Insulin) 70/Suspension Pen 60 subcutaneously eve diabetes. 15 units of subcutaneously if Rebreakfast. Novolin (Insulin) 70/Suspension Pen 30 injected subcutaneously injected sub	rgical Physician saw Resident of appointment on 11/14/2023. Sked good, was very much of show signs of infection. It leation regarding Resident #1 his antibiotics when he was facility but, more importantly good wound care with the in-assisted closure). Resident higher risk for infection of the same and had always had flucose levels. Cumulative diagnoses some are 2 diabetes, Hypertension, ingestive heart failure, anxiety orthopedic surgery, and is disorder. The electronic medical record of feed as entered on 10/30/2023 of PM for Resident #1 included	F 7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			C 11/15/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27537	'	11/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	daily for Hypertension Lamotrigine in the fortaken by mouth two artery disease. (Lam requires periodic momedication in the bloom pregabalin in the fortaken by mouth two Ranolazine extende 1000 mg tablet to be day for Hypertension Documentation in an 10/30/2023 written by Resident #1 arrived 2:00 PM. Nurse #1 was interv	orm of a 3.125-mg tablet twice on. form of a 200 mg tablet to be times a day for coronary notrigine is a medication that onitoring of levels of the bod.) form of a 100 mg capsule to be times a day for pain. In admission summary dated by Nurse #1 indicated at the facility at approximately iewed on 11/11/2023 at 5:03 med she worked from 7:00	F 7	760			
	that shift from the ph Nurse #2 was interv PM. Nurse #2 revea orders for medicatio discharge summary record system for Ri second nurse was to with the facility phys orders sent to the ph Review of the Medic (MAR) for October 2	iewed on 11/11/2023 at 3:53 led she entered the physician ns from the hospital into the electronic medical esident #1. Nurse #2 stated a confirm the physician orders ician and then have the					

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F 760	Continued From pag	ge 13 И to include his Novolin	F 7	60			
	insulin, Carvedilol, L Ranolazine.	amotrigine, Pregabalin, and					
	PM. Nurse #3 confir PM on 10/30/2023 to Nurse #3 conveyed regarding the medic Nurse #3 was inform shift on 10/30/2023 the facility that after medications in the fathe electronic record discharge summary that were entered in record system. Nurse except for the lack of Nurse #3 completed submitted the orders. Review of the MAR Resident #1 did not dose of Novolin insurance.	iewed on 11/11/2023 at 6:28 med she worked from 11:00 to 7:00 AM on 10/31/2023. The following information ation orders for Resident #1. The dat the start of her nursing Resident #1 was admitted to moon and did not have any acility yet. Nurse #3 looked in the system and compared the from the hospital to orders to the electronic medical the #3 found no discrepancies of information on allergies. If the allergy information and is to the pharmacy. for October 2023 revealed receive his ordered 7:30 AM ulin nor his 9:00 AM ordered zin, Carvedilol, Lamotrigine,					
	Pregabalin, and Rar The Physician Assis was interviewed on stated was made av 10/31/2023 that Res medications delivered time as she was rev admission. PA #1 st that insulin was not #1 revealed she well blood sugar of Resid means necessary if	tant (PA #1) for Resident #1 11/13/2023 at 1:29 PM. PA #1 vare on the morning of sident #1 did not have his ed from the pharmacy at that iewing his chart as a new ated her specific concern was available for Resident #1. PA nt with Nurse #4 to check the dent #1 and find insulin by any insulin was required. PA #1 the pharmacy to order the					

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		345316	B. WING			C 1/15/2023	
NAME OF PROVIDER OR SUPPLIER SENIOR CITIZENS HOME				STREET ADDRESS, CITY, STATE, ZIP CO. 2275 RUIN CREEK ROAD HENDERSON, NC 27537		1/15/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760	as possible. Nurse #4 was interviped, who worked the 10/31/2023. Nurse # of 10/31/2023 Resid medications to include she went to PA #1, who tified her of the lace Resident #1. Nurse in PA #1 to check the beand it was within nor insulin administration. Resident #1 did not the morning of 10/31. Documentation in eleadministration notes 10/31/2023 revealed insulin to be administration in the insulination on the insulination in the insulination i	ident #1 to be sent as soon iewed on 11/13/2023 at 12:25 27:00 Am to 3:00 PM shift on 44 stated that on the morning ent #1 still did not have his de insulin. Nurse #4 stated who was in the building, and ck of medications for #4 explained she went with blood sugar of Resident #1 rmal limits, not requiring h. Nurse #4 revealed require pain medication on 1/2023. ectronic medication for Resident #1 on I the evening dose of Novolin stered at 5:00 PM stated, lable from pharmacy."	F7	60			

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F 760	orders for Resident #1 were processed on 10/31/2023. The was sent with the of 10/31/2023. The dr for Resident #1 at 8 facility and the medicality and the medicality and the medicality. The Pharm was the expected defacility. The Pharm was the expectation medications were resident. The Pharm facility did not curre medication dispensing significant medication dispensing significant medication dispensing to enter the physicionce on the MAR, transmitted to the part that the facility recemedications from the approximately 2:00 approximately 9:00 revealed that the part of the facility and the facility	eceived a lot of physician if #1. The orders for Resident when the pharmacy reopened if first delivery of medications liver at 1:19 PM on iver delivered the medications 3:44 PM on 10/31/2023 to the dications were signed for by he. The Pharmacy Director for why the pharmacy driver cations for Resident #1 outside ivery times contracted by the acy Director explained that it h of the pharmacy that if heeded after the close of armacy, the backup pharmacy d by the facility so that obtained by morning for the macy Director confirmed the ently have an automated sing machine that contained ons such as insulin as a	F	760			

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F 760	change and an autor system for a back-up to be obtained from t significant medication. Documentation on a Status dated 10/31/2 was screened as cook Resident #1 was interested and frustrating 2 day to the facility as he d medications were no #1 stated he "did not from not having his in but reiterated it was a having his insulin, he medication after surgested.	mated medication dispensing of medications would need the pharmacy to prevent nerrors. Brief Interview for Mental 2023 revealed Resident #1 gnitively intact. Prviewed on 11/11/2023 at 1 stated it was a stressful s when he was first admitted id not understand why his t available to him. Resident suffer anything health wise nedications available to him stressful worrying about not eart medications, and pain gery. Resident #1 stated he	F7	760			