STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL005015	A. BUILDING: _____ B. WING _____	R 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST RIDGE	151 VILLAGE PARK DRIVE WEST JEFFERSON, NC 28694

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Ashe County Department of Social Services conducted an annual and follow-up survey on April 02, 2024 through April 03, 2024.	D 000		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of a controlled substance for 1 of 5 sampled residents (#4) who received a controlled substance for insomnia. The findings are: Review of Resident #4's current FL2 dated 09/13/23 revealed: -Diagnoses included major depression with anxiety, neuroleptic induced tardive dyskinesia, and cerebrovascular disease. -There was no documentation of a physician's order for zolpidem (used to treat insomnia) 5mg, take half of a tablet (2.5mg) by mouth at bedtime as needed. Review of Resident #4's Resident Register on 04/02/24 revealed he was admitted to the facility on 09/13/23.	D 392		

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D 392	Continued From page 1 Observation of Resident #4's medications on hand on 04/03/23 at 11:16am revealed: -There was a bubble pack medication card with a fill date of 07/15/23 for a quantity of 15 tables for zolpidem 5mg, take half of a tablet (2.5mg) at bedtime with a prescription number. -There was a total of 13 tablets remaining. Review of Resident #4's controlled substance count sheet (CSCS) on 04/03/24 at 11:16am revealed: -Resident #4's name, prescription number and zolpidem, take half of a tablet by mouth at bedtime as needed was handwritten on the CSCS. -There was no documentation that zolpidem had been administered. -There was documentation of 13 tablets received. Review of Resident #4's record on 04/03/24 revealed: -There was no physician order for zolpidem 5mg, take half of a tablet (2.5mg) by mouth at bedtime as needed. -There was no documentation of the facility receiving zolpidem 5mg, take half of a tablet (2.5mg) by mouth at bedtime as needed. Review of Resident #4's six months physicians orders dated 02/08/24 revealed there was no order for zolpidem 5mg, take half of a tablet (2.5mg) by mouth at bedtime as needed. Review of Resident #4's February electronic medication administration record (eMAR) on 04/03/24 revealed there was no entry for zolpidem 5mg, take half of a tablet (2.5mg) by mouth at bedtime as needed.	D 392		

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Review of Resident #4's March eMAR on 04/03/24 revealed there was no entry for zolpidem 5mg, take half of a tablet (2.5mg) by mouth at bedtime as needed.

Review of Resident #4's April eMAR on 04/03/24 revealed there was no entry for zolpidem 5mg, take half of a tablet (2.5mg) by mouth at bedtime as needed.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 04/03/24 at 11:30am revealed:
-Resident #4 did not have an active physician order for zolpidem 5mg, take half of a tablet (2.5mg) by mouth at bedtime as needed.
-The prescription number provided for the zolpidem had been dispensed to a different assisted living facility where the resident resided on 07/15/23.

Interview with Resident #4 on 04/03/24 at 2:30pm revealed he was not sure what medications he took but knew he took something at night to help him sleep.

Interview with a medication aide (MA) on 04/03/24 at 11:18am revealed:
-She worked as an MA during the day and had not given Resident #4 any of his nighttime medications.
-She did not know Resident #4 had zolpidem on the medication cart.
-There was no entry for zolpidem on Resident #4's eMAR.
-MAs were responsible for ensuring all medications on the medication cart had a physician's order prior to administering medications to residents.
-MAs were responsible for notifying residents

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Primary Care Providers (PCP) and/or the pharmacy if there was medication on the medication cart without an order.
-She was not aware of any medication cart audits.

Interview with a second MA on 04/03/24 at 12:20pm revealed:
-She was working when Resident #4 was admitted to the facility on 09/13/23.
-Resident #4 brought medications from the previous assisted living facility where he resided.
-She documented all the medications Resident #4 brought upon admission on the facility's external medication delivery log and faxed the documentation to the facility's contracted pharmacy.
-She had handwritten Resident #4's name, prescription number and zolpidem, take half of a tablet by mouth at bedtime as needed was handwritten on the CSCS on 09/13/23.
-She did not know Resident #4 did not have a physician's order for zolpidem.
-She did not verify that Resident #4 had a physician's order for zolpidem.

Interview with the Resident Care Coordinator (RCC) on 04/03/24 at 2:22pm revealed:
-She did not know Resident #4 had a controlled medication on the medication cart with no physician's order.
-Residents should not have any medications on the medication cart if there was no physician's order.
-She expected the MAs to compare medications on the medication cart to the eMAR and ensure there was a physician's order prior to administering medications to residents.
-She expected the MAs to call the Primary Care Provider (PCP) and/or pharmacy if there was a

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medication on the medication cart that did not have a physician's order.
-If there was a controlled medication in the facility that did not have a physician's order, she expected the MAs to send the controlled medication to the pharmacy to be destroyed.
-She and the facility nurse were responsible for completing weekly medication cart audits.
-She had not completed any medication cart audits in a very long time due to staffing issues.

Interview with the Administrator on 04/03/24 at 12:10pm and at 2:32pm revealed:
-She did not know Resident #4 had a controlled medication on the medication cart with no physician's order.
-Staff was expected to document all resident medications brought into the facility on an external medication delivery log.
-She expected the MAs to compare medications on the medication cart to the eMAR and ensure there was a physician's order prior to administering medications to residents.
-She expected the MAs to call the PCP and/or pharmacy if there was medication on the medication cart that did not have a physician's order.
-If there was a controlled medication in the facility that did not have a physician's order, she expected the MAs to send the controlled medication to the pharmacy to be destroyed.
-The RCC completed quarterly medication cart audits.
-There was not documentation of any medication cart audits available.
-The facility's contracted pharmacy completed medication cart audits twice a year.
-There was no documentation of any medication cart audits completed by the facility's contracted pharmacy available.

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D 392	Continued From page 5 Attempted telephone interview with Resident #4's PCP on 04/03/24 at 2:19pm was unsuccessful.	D 392		