

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060171	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2022
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NAME OF PROVIDER OR SUPPLIER BLISSFUL LIVING SENIOR CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8901 ROBINSON CHURCH ROAD CHARLOTTE, NC 28215
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(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
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on 06/09/22.	C 000		
C 342	<p>10A NCAC 13G .1004(j) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <ol style="list-style-type: none"> (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). <p>This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to accurately document administration of medications on the Medication Administration Record (MAR) for 1 of 1 resident (Resident #1).</p> <p>The findings are:</p>	C 342		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 342	<p>Continued From page 1</p> <p>Review of Resident #1's current FL2 dated 02/17/22 revealed: -Diagnoses included hypertension, dementia, and impairment of balance. -There was an order for antacid (a medication used to treat indigestion and heartburn), extra strength chewable, one tablet daily after dinner.</p> <p>Review of Resident #1's April, May, and June 2022 MARs revealed: -There was an entry for antacid, extra strength, 750mg, chew one tablet daily at 8:00am. -The scheduled 8:00am administration time had been handwritten to change the time to 6:00pm. -The entry was documented as administered at 6:00pm each day. -There was a second entry for antacid, extra strength, 750mg, chew and swallow one tablet once daily after dinner at 8:00am. -The second entry was documented as administered at 8:00am each day.</p> <p>Observation of medications on hand for Resident #1 on 06/09/22 revealed: -Resident #1's medications were dispensed in multi-dose bubble packaging. -There were two bubbles labeled "morning" and one bubble pack labeled "evening" for each day. -The antacid, extra strength, 750mg, was in the "evening" bubble for each day. -There was no antacid in the bubble packs labeled "morning".</p> <p>Interview with the Supervisor in Charge (SIC) on 06/09/22 at 12:25pm revealed: -She and the Administrator were responsible to administer Resident #1's medications. -She was trained to compare the medication label with the order on the MAR prior to administering medications.</p>	C 342		

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C 342	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Resident #1 received her antacid medication once daily, after dinner. -There was a duplicate entry on Resident #1's MAR for the antacid at 8:00am and 6:00pm.. -She was unsure why she signed the MAR for both entries and had not contacted the pharmacy to correct Resident #1's MAR. <p>Interview with the Administrator on 06/09/21 at 2:20pm revealed:</p> <ul style="list-style-type: none"> -He and the SIC were responsible to administer Resident #1's medications. -He had administered Resident #1's antacid to her after dinner. -He was unsure why he signed both antacid entries as administered at 8:00am and 6:00pm. -He was trained to compare the medication label with the MAR when administering medications. -He was unsure why he had not notified the pharmacy of the duplicate entry on Resident #1's MAR. -He expected resident MAR's to be accurate. 	C 342		