STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074047	A. BUILDING: _____ B. WING _____	R 05/07/2025

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NAVION OF GREENVILLE	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey from May 6, 2025 to May 7, 2025.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#4) related to failing to ensure an order for referral to mental health was completed. The findings are: Review of Resident #4's current FL-2 dated 10/25/24 revealed diagnoses included vascular dementia, anxiety, delusional disorder, unspecified intracranial hemorrhage and Parkinson's disease. Review of Resident #4's primary care provider (PCP) order dated 02/04/25 revealed there was an order for a referral to mental health for evaluation and management of somatic delusion disorder and insomnia. Review of Resident #4's observation note dated 02/18/25 revealed: -There was documentation Resident #4's PCP sent a mental health referral. -The Resident Care Coordinator (RCC) called the	D 273		

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local mental health provider and was told the referral coordinator was back logged for 3 months and new patient appointments were being made 6 months out.
-There was documentation the RCC was encouraged to call back in 1 month.
-There was no documentation an appointment was scheduled for Resident #4.

Review of Resident #4's record revealed there were no mental health provider notes or documentation of his contact with a mental health provider.

Interview with Resident #4 on 05/07/25 at 9:06am revealed:
-He had a history of traumatic brain injury.
-He had not seen a mental health provider.

Telephone interview with the Patient Administrative Support for the local mental health provider's office on 05/07/25 at 8:17am revealed:
-Resident #4 had a new patient appointment for 05/14/25 that was made on 05/06/25.
-New patient appointments were usually scheduled 3-6 months out but could be scheduled.
-When referrals were received by the practice, the practice would call the facility with an appointment.
-Referrals to the practice stayed in cue until an appointment was made.
-There was documentation the referral for Resident #4 was sent to the practice on 05/06/25.
-There had been no prior appointments made for Resident #4.

Interview with Resident #4's primary care provider (PCP) on 05/07/25 at 12:02pm revealed:
-She ordered behavioral health evaluation for

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Resident #4 to manage his insomnia and delusions at the request of the facility.
-She expected that an appointment should be scheduled within 2 weeks of ordering a referral even if it was several months out.
-She thought Resident #4 had been scheduled to see a behavioral health provider because she had not been informed of any trouble with scheduling the appointment.

Interview with the Resident Care Coordinator on 05/07/25 at 12:28pm revealed:
-The facility requested an order for Resident #4 to be evaluated by mental health because of his history of traumatic brain injury.
-It was her responsibility to ensure referrals were completed as ordered.
-She followed up on referrals if she had not received a call with an appointment date within 2 weeks following the order.
-She called the local mental health provider on 02/18/25 and was told appointments were 3 months out and there was no appointment scheduled for Resident #4.
-She did not know why an appointment was not made on 02/18/25.
-She was out of work from 02/27/25 to 04/16/25 and the Administrator was responsible for her duties while she was out.
-She did not follow-up on the referral when she returned to work and she did not think anyone had followed-up in her absence until 05/06/25.

Interview with the Administrator on 05/07/25 at 1:16pm revealed:
-Staff should have attempted more contact with Resident #4's mental health provider.
-She was responsible for the RCC's duties when she was out and the Resident #4's mental health referral was missed until 05/06/25.

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) for blood pressure checks. The findings are: Review of Resident #3's current FL-2 dated 11/12/24 revealed: -Diagnoses included hypertension and diastolic heart failure. -There was an order to check the resident's blood pressure three times a day, if blood pressure was greater than 140/85 resume medication, there were no medications listed to resume. -There was an order for Hydralazine 50mg, take one tablet twice a day (Hydralazine is a medication used to treat high blood pressure). -There was an order for Carvedilol 6.25mg, take one tablet twice a day with meals (Carvedilol is a medication used to treat high blood pressure and	D 344		

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D 344	Continued From page 4 heart failure). Review of a physician order for Resident #3 dated 02/25/25 revealed there was an order to check the resident's blood pressure three times a day, if blood pressure is greater than 140/85 resume medication. Review of a physician order for Resident #3 revealed: -The order was signed by a physician but was not dated. -There was a typed heading at the top of the physician order with "Active Orders as of 04/30/25." -There was a fax notification at the top left and right corner of the order dated 05/06/25 at 9:49am. -There was an order to discontinue the resident's blood pressure check three times a day and to resume medication if the resident's blood pressure was greater than 140/85. -There was a new order to check the resident's blood pressure three times a day, hold Hydralazine and Carvedilol if blood pressure is less than 140/85. Review of Resident #3's electronic medication administration record (eMAR) for March 2025 revealed: -There was an electronic entry to check the residents' blood pressure three times a day at 8:00am, 12:00pm, and 4:30pm, if blood pressure is greater than 140/85 resume medication. -There was an electronic entry for Carvedilol 6.25mg, take one tablet twice a day with meals at 8:00am and 5:00pm. -There was an electronic entry for Hydralazine 50mg, take one tablet twice a day at 8:00am and 8:00pm.	D 344		

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D 344	Continued From page 5 Review of Resident #3's eMAR for April 2025 revealed: -There was an electronic entry to check the residents' blood pressure three times a day at 8:00am, 12:00pm, and 4:30pm, if blood pressure is greater than 140/85 resume medication. -There was an electronic entry for Carvedilol 6.25mg, take one tablet twice a day with meals at 8:00am and 5:00pm. -There was an electronic entry for Hydralazine 50mg, take one tablet twice a day at 8:00am and 8:00pm. Review of Resident #3's eMAR for May 2025 revealed: -There was an electronic entry to check the residents' blood pressure three times a day at 8:00am, 12:00pm, and 4:30pm, if blood pressure is greater than 140/85 resume medication. -There was an electronic entry for Carvedilol 6.25mg, take one tablet twice a day with meals at 8:00am and 5:00pm. -There was an electronic entry for Hydralazine 50mg, take one tablet twice a day at 8:00am and 8:00pm. Interview with a medication aide (MA) on 05/06/25 at 2:15pm revealed: -She understood the physician order for Resident #3 to give medication if the resident's blood pressure was greater than 140/85 because she knew that Carvedilol and Hydralazine were medications for blood pressure. -When the resident's blood pressure was greater than 140/85 she administered the resident Carvedilol and Hydralazine. -The average person "off the street" would not have known what two blood pressure medications Resident #3 was taking.	D 344		

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D 344	Continued From page 6 -She assumed that the other MAs understood what two medications were blood pressure medications for Resident #3. -She thought that she had notified each MA which blood pressure medications Resident #3 was prescribed. -Approximately one month ago she asked the Resident Care Coordinator (RCC) if the order to take the resident's blood pressure three times a day and to resume medication if the resident's blood pressure was greater than 140/85 was a correct order. -She thought the RCC told her that the order was correct because the pharmacy had approved it. -If an order was not clear to her, she would contact the resident's primary care provider (PCP) to ask for a clarification order. -She should have reached out to the resident's PCP to ask for a clarification order. Interview with the RCC on 05/06/25 at 1:50pm revealed: -The physician order for Resident #3 to check the resident's blood pressure three times a day, if blood pressure is greater than 140/85 resume medication was not clear. -The MAs could be confused on what medications to resume since the resident's blood pressure medications were not listed in the order. -She could not recall a MA asking her if the order was correct. -She or the MAs should have notified the PCP to obtain a clarification order because the order was not clear. Interview with the Administrator on 05/07/25 at 1:16pm revealed: -The RCC or MAs should have contacted Resident #3's PCP to request clarification of the resident's blood pressure order.	D 344		

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D 344	Continued From page 7 -The blood pressure order for Resident #3 needed to have the medications listed that should be resumed and the order needed to have the systolic and diastolic parameters. -When an order was not clear to the RCC or the MAs they should notify the residents' PCP to request a clarification order. -Orders needed to be clear to ensure residents received the appropriate medication as ordered. Attempted telephone interview with Resident #3's PCP on 05/06/25 at 3:00pm was unsuccessful. Attempted interview with Resident #3 on 05/06/25 at 3:10pm was unsuccessful.	D 344		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure 1 of 5 residents (#5) were observed taking their medication. The findings are:	D 366		

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D 366	Continued From page 8 Review of Resident #2's current FL-2 dated 06/19/24 revealed: -Diagnoses included history of stroke and memory impairment. -She was intermittently disoriented. Observation of a medication aide (MA) on 05/06/25 at 8:41am revealed: -The MA brought Resident #2 a white cup with medications and a cup of water to the dining room table. -The MA left the white cup of medications with the resident and returned to the medication cart which was to the outside of the left entrance of the dining room. -At 8:42am the MA returned to Resident #2 and reminded her that she needed to take her medications, the MA then returned to the medication cart. -The resident picked up the white medication cup and appeared to take all her medications. Observation of Resident #2's bedroom on 05/06/25 at 10:14am revealed there was 1 round pink pill in a paper medication administration cup sitting on the counter beside the sink in her suite behind the door. Interview with Resident #2 on 05/06/25 at 10:14am revealed: -She brought the pill back with her from the dining room where she was administered medications. -She brought it to her room because she ran out of water to take all her medications with but forgot to take it when she got back to her room. -She did not know what the medication was. -The medication aide (MA) administered her medications to her and ensured she took them but there were so many people to administer medications to and the MA did not always stay	D 366		

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right with her.

Review of Resident #2's electronic medication administration record (eMAR) for May 2025 revealed:
-There were 11 medications electronically entered onto the eMAR scheduled to be administered at 8:00am including clopidogrel 75mg. (Clopidogrel is a medication used to prevent blood from clotting.)
-There was documentation 11 medications were administered at 8:00am on 05/06/25.

Observation of medications on hand for Resident #2 on 05/07/25 at 1:13pm revealed:
-There were 11 medications labeled to be administered at 8:00am.
-There was a medication dispensed as a round pink pill that was labeled as clopidogrel 75mg.

Telephone interview with the Registered Nurse (RN) for Resident #2's primary care provider (PCP) on 05/07/25 at 9:25am revealed:
-Resident #2 had a history of a stroke which left her with some cognitive deficits including her memory.
-Resident #2 needed to take her medications as prescribed because she had a history of a stroke and stents had been placed in her heart.
-Not taking clopidogrel as prescribed could lead to clots forming in the blood, increasing her risk for another stroke or heart attack.

Interview with the medication aide (MA) on 05/06/25 at 2:15pm revealed:
-She had found medication cups with pills left in resident rooms from the previous shift in the past.
-Medications were not supposed to be left with residents to take later and should never happen.
-She thought Resident #2 took all of her

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D 366	Continued From page 10 medications that were administered to her that morning and should have paid closer attention while administering medications. -She usually stayed with each resident when administering medications. -She was "peaking" at Resident #2 during the medication pass that morning in the dining room to ensure she took her medications. -She had to be wary when administering medications because some residents may forget to take them. Interview with the Administrator on 05/07/25 at 1:16pm revealed: -MAs should always stand and watch residents take their medications before documenting the administration and moving on to administer medications to another resident. -It was important to ensure medications were taken because MAs were documented they were taken and not taking a medication could greatly effect a resident's health or even lead to death.	D 366		