STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032020	A. BUILDING: _____ B. WING _____	R 01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM PARKWAY DURHAM, NC 27705

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on January 4-5, 2023.	D 000		
D 253	10A NCAC 13F .0801(a) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an initial assessment of each resident was completed within 72 hours of admission using the Resident Register document for 2 of 5 sampled residents (Resident #1 and Resident #2). The findings are: 1.Review of Resident #1's current FL-2 dated 10/22/22 revealed diagnoses of Alzheimer's disease, osteoarthritis of right knee, macular degeneration, irritable bowel syndrome, syncope, elevated blood pressure and irritable bowel syndrome. Record review for Resident #1 revealed: -There was an admission date of 02/10/22. -There was no initial assessment using the Resident Register for Resident #1. Attempted interview with Resident #1 on 01/04/22	D 253		

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at 10:40am was unsuccessful.

Refer to interview with the Administrator on 01/05/22 at 4:35pm.

2. Review of Resident #2's current FL-2 dated 02/09/22 revealed diagnoses of Alzheimer's disease, disorientation, celiac disease, migraine headaches and hearing loss.

Record review for Resident #2 revealed:
-There was an admission date of 09/24/21.
-There was no initial assessment using the Resident Register for Resident #2.

Attempted interview with Resident #2 on 01/04/22 at 9:20am was unsuccessful.

Refer to interview with the Administrator on 01/05/22 at 4:35pm.

Interview with the Administrator on 01/05/22 at 4:35pm revealed:
-The Administrator was responsible for meeting and assessing a new resident.
-An initial assessment was to be done, within 72 hours, using the Resident Register and was included in the admission documents to be brought back to the facility to be signed by the Administrator and scanned into the computer.
-She was currently the Acting Administrator and was not aware the initial assessments for Resident #1 and #2 were not in their records.
-The Administrator was responsible for ensuring the completed initial assessments were in the records for Resident #1 and Resident #2.

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D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications	D 375		

10A NCAC 13F .1005 Self -Administration Of Medications
(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:
(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and
(2) specific instructions for administration of prescription medications are printed on the medication label.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure 1 of 2 resident sampled (#4) had a physician's order to self-administer vitamins.

The findings are:

Review of the facility's self-administration of medication policy dated 03/20/05 revealed:
-The purpose of the policy was to provide guidelines to the interdisciplinary team on self-administration rights for residents and establish uniform guidelines concern the safe self-administration of drugs.
-The procedure included an assessment by the resident's Primary Care Provider (PCP) to determine if the resident was capable of safely administering medications to him or herself.

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-Next, the PCP would provide a signed and dated order for the self-administration of medications.
-A resident who was deemed appropriate to self-administer medications would receive medication education from the nursing staff.
-The PCP would document in the resident's care plan who was responsible for medication storage.
-The facility had to provide a secured compartment for the storage of medications.
-The nursing staff documented on the resident's medication administration record (MAR) after witnessing the resident self-administering medications.
-This policy was revised on 04/10/08.

1. Review of Resident #4's current FL-2 dated 12/07/22 revealed:
-Diagnoses included unspecified dementia without behavioral disturbances, major depressive disorder, vitamin D deficiency, and deficiency of other specified B group vitamins.
-There was no order to self-administer medications.

Review of Resident #4's record revealed there was no assessment to self-administer medications.

Review of Resident #4's care plan dated 12/08/22 revealed there was no documentation concerning Resident #4 self-administering medication.

a. Review of Resident #4's current FL-2 dated 12/07/22 revealed there was an order for vitamin B (used to prevent and treat vitamin B deficiency) 1000mcg daily.

Observation of Resident #4's dining room tablet on 01/04/23 at 10:15am revealed -There was one opened over the counter bottle of vitamin B12

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1000mcg tablets.

Review of Resident #4's December 2022 and January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin B12 1,000mcg one soft gel daily, scheduled for 9:00am.
-There was documentation of administration of vitamin B12 from 12/08/22 to 01/04/23.

Observation of Resident #4's medication on hand on 01/05/23 at 10:30 am revealed:
-There was a bottle of over the counter vitamin B12 containing 16 of 90 tablets.
-There was no documentation of the date the bottle was opened.

Interview with Resident #4 on 01/04/23 at 10:10am revealed:
-She had a bottle of vitamin B12 on her dining room table.
-She took the vitamin B12 occasionally.

Refer to the interview with Resident #4 on 01/04/23 at 10:10am.

Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) on 01/05/23 at 7:00pm.

Refer to the interview with a licensed practical nurse (LPN) on 01/05/23 at 4:46pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 01/05/23 at 5:52pm.

Refer to the interview with the Administrator on 01/05/23 at 6:50pm.

b. Review of Resident #4's current FL-2 dated

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12/07/22 revealed there was an order for multivitamin 50 plus tablet daily.

Observation of Resident #4's dining room tablet on 01/04/23 at 10:15am revealed there was an opened white bottle of 50 plus multi-vitamins with a few tablets.

Review of Resident #4's December 2022 and January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for multi-vitamin 50 plus tablet one table daily, scheduled for 9:00am.
-There was documentation of administration of multi-vitamin 50 plus from 12/08/22 to 01/04/23.

Observation of Resident #4's medication on hand on 01/05/23 at 10:30 am revealed there was one bubble package of multivitamins dispensed on 12/28/22 and containing 29 of 30 tablets.

Interview with Resident #4 on 01/04/23 at 10:10am revealed:
-She had a bottle of 50 plus multivitamins on her dining room table.
-She took the vitamins every other day or occasionally, but not daily.
-Her bottle of multi-vitamins was almost empty.

Refer to the interview with Resident #4 on 01/04/23 at 10:10am.

Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) on 01/05/23 at 7:00pm.

Refer to the interview with a licensed practical nurse (LPN) on 01/05/23 at 4:46pm.

Refer to the interview with the Resident Care

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Coordinator (RCC) on 01/05/23 at 5:52pm.

Refer to the interview with the Administrator on 01/05/23 at 6:50pm.

c. Review of Resident #4's current FL-2 dated 12/07/22 revealed there was no order for vitamin D3.

Observation of Resident #4's dining room tablet on 01/04/23 at 10:15am revealed there was one opened over the counter bottle of vitamin D3 125mcg with several tablets.

Interview with Resident #4 on 01/04/23 at 10:10am revealed:
-She had a bottle of vitamin D on her dining room table.
-She did not take the vitamin daily.

Refer to the interview with Resident #4 on 01/04/23 at 10:10am.

Refer to the telephone interview with Resident #4's Primary Care Provider (PCP) on 01/05/23 at 7:00pm.

Refer to the interview with a licensed practical nurse (LPN) on 01/05/23 at 4:46pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 01/05/23 at 5:52pm.

Refer to the interview with the Administrator on 01/05/23 at 6:50pm.

Interview with Resident #4 on 01/04/23 at 10:10am revealed:
-She kept medications in her room.
-She planned to begin taking the vitamins daily in

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hopes to do better for the new year.
-She had not told her PCP that she was self-administering vitamins.
-She was told by an "aide" yesterday, 01/03/23, that she was not supposed to have medications in her room.
-She thought all was well because the aide did not remove the medications.
-She purchased the vitamins.

Telephone interview with Resident #4's PCP on 01/05/23 at 7:00pm revealed:
-She had not written a self-administration of medications order for Resident #4.
-She last saw Resident #4 on 12/16/22 and there was no discussion concerning self-administering medications.

Interview with a licensed practical nurse (LPN) on 01/05/23 at 4:46pm revealed:
-She worked on the 100 hall of the Assisted Living unit during the second shift.
-She knew residents needed a self-administer of medications order in order to self-administer medications.
-She administered medications to Resident #4, and she did not know of a self-administration of medication order for Resident #4.
-She had not seen any medications in Resident #4's room.
-In the past, she had seen any medications in a resident room she removed the medications and looked to determine if the resident had an order to self-administer medications.
-She knew an assessment had to be completed to determine if a resident could self-administer medications.
-She did not know if Resident #4 had an assessment completed for self-administration of medications.

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Interview with the Resident Care Coordinator (RCC) on 01/05/23 at 5:52pm revealed:
-Resident #4 did not have a self-administer order for any medications.
-She did not know Resident #4 had vitamins in her room and was self-administering the vitamins.
-Residents needed an order from the physician to self-administer medications.
-The PCP also completed an assessment to determine if the resident was capable of self-administering medications.
-The nurse had to complete a quarterly assessment for residents with an order to self-administer medications.
-Resident #4 did not have an assessment for self-administering medications.
-She was responsible for obtaining a self-administration of medication order if needed for residents.
-She expected staff to notify her if medications were found in a resident room so that she could discuss the issue with the resident, family member and the PCP.

Interview with the Administrator on 01/05/23 at 6:50pm revealed:
-She did not know Resident #4 had vitamins in her room.
-Residents had to have an order to administer their own medication.
-She expected all staff to tell the RCC that Resident #4 had vitamins in her room.
-She held all staff responsible for notifying the RCC that a resident had medications in their room.

Attempted telephone interview with the facility's contract pharmacy on 01/05/23 at 7:05pm was unsuccessful.

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