

SEP 8 2015

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/31/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 916 S. MARIETTA STREET GASTONIA, NC 28054	<i>County: Gaston</i>
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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
{D 000}	Initial Comments	{D 000}		
{D 358}	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION.</p> <p>The Type B Violation was abated. Non-compliance continues.</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 2 of 5 sampled residents (#1 and #4).</p> <p>The findings are:</p> <p>A. Review of Resident #4's current FL2 dated 6/30/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of severe refractory seizure disorder, anxiety, schizophrenia, hypertension, and chronic obstructive pulmonary disease. - An admission date of 6/25/15. <p>1. Continued review of Resident #4's FL2 dated</p>	{D 358}	<p>Preparation and execution of this plan of correction in no way constitutes an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiency and plan of correction. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance.</p> <p>Rule/Statute Number: 10A NCAC 13F. 1004(a) Medication Administration.</p> <p>It is the intent of this facility to assure that preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <p>(1) Orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p>	<i>9/25/15</i>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>[Signature]</i>	<i>Executive Director</i>	<i>9/25/2015</i>

STATE FORM 6899 TFDU12 If continuation sheet 1 of 13

102-15 APPROVED

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NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 916 S. MARIETTA STREET GASTONIA, NC 28054
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{D 358}	<p>Continued From page 1</p> <p>6/30/15 revealed a medication order for Aricept 5mg, 1 tablet by mouth daily. (Aricept is a medication used to treat dementia.)</p> <p>Review of a hospital discharge summary dated 8/24/15 also included an order for Aricept 5mg daily.</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for July 2015 revealed:</p> <ul style="list-style-type: none"> - An entry for Donepezil 5mg (Generic Aricept), 1 tablet every night at bedtime with a scheduled administration time of 8pm. - The Donepezil 5mg had been circled and initialed as not given 8 times. - Six of those days, the 14th, 24th, 25th, 27th, 28th, and 29th, had a notation on the eMAR exception as "awaiting pharmacy." - The other 2 circled days were noted as "out of facility." <p>Review of Resident #4's eMAR for August 2015 revealed:</p> <ul style="list-style-type: none"> - An entry for Donepezil 5mg (Generic Aricept), 1 tablet every night at bedtime with a scheduled administration time of 8pm. - The Donepezil 5mg had been circled and initialed as not given 7 times. - Four of those days, the 10th, 25th, 26th, and 27th, had a notation on the eMAR exception as "awaiting pharmacy." - Two of the circled days, the 20th and 21st, were noted as "out of facility." - One day, the 7th was noted as "resident refused." <p>Observation of Resident #4's medications on hand at 3:15pm on 8/28/15 revealed no Donepezil 5mg available to administer.</p>	{D 358}	<p>(2) Rules in this Section and the facility's policies and procedures.</p> <p><u>1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice.</u></p> <p>Resident #4's Aricept was ordered but pharmacy failed to fill order. Pharmacy was contacted again. It was placed in cycle fill on 9/2/2015. Florastor is an expensive OTC medication. Resident was not willing to pay for it out of pocket. A discontinue order was received by the physician on 7/24/2015. Mucinex or Guaifenesin was discontinued on 9/16/2015 since the resident refused to pay out of pocket for this drug as well. The gap on 8/17/2015 8:00AM med was due to resident #4 being at the hospital and was documented on the exception list.</p> <p>Resident #1's physician was contacted to write a new prescription for Clonazepam as her current one had expired. This was a controlled drug and had to have a new written script and started back.</p>	9/25/15

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{D 358}	<p>Continued From page 2</p> <p>Interview with the Medication Aide (MA) on this med cart at 3:20pm on 8/28/15 revealed:</p> <ul style="list-style-type: none"> - The MA could order the medications directly from the laptop computer containing the eMAR. - She ordered Resident #4's Aricept at that time. - The MA stated the Aricept will come in tonight between 9am and 10pm. - She was not sure why Resident #4 was out of his Aricept. <p>Interview with a second Medication Aide (MA) on 8/31/15 at 2:02pm revealed:</p> <ul style="list-style-type: none"> - "Awaiting pharmacy" means, we don't have the medication available to administer. - When we don't have a medication, "we call the pharmacy and get it." <p>Interview with the Manager of the pharmacy of contract on 8/31/15 at 11:35am revealed:</p> <ul style="list-style-type: none"> - Resident #4 brought in his own medications when he was admitted to the facility. - Resident #4's medications were not put onto cycle fill on admission due to the fact he had his own medications. - The pharmacy has 24 hour a day service, 7 days a week. - If the facility was out of a medication they can call the pharmacist on call, and get the medication from a backup pharmacy. - The facility ordered Resident #4's medications, including Aricept, and "we did not put them on a cycle fill." - The Manager could not explain why Resident #4's medications were not put on cycle fill status. <p>Interview with the Pharmacist at the pharmacy of contract on 8/31/15 at 11:55am revealed:</p> <ul style="list-style-type: none"> - Resident #4's Aricept 5mg, 1 tablet daily, was dispensed on cycle fill on 7/14/15 for 7 tablets, 	{D 358}	<p><u>2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice:</u></p> <p>The Executive Director and Resident Care Director (RCD) met with Stanley Pharmacy on September 18, 2015 to implement new procedures. Moving forward all orders for new medications will be filled with a 5 day supply if awaiting Prior Authorization or if they are over the counter medications. This will give the facility time for the medication to either be approved by the resident's prescription coverage, replaced with a less expensive medication, or discontinued due to having to pay out of pocket. The Resident/Family Member will be responsible for paying the out of pocket costs should there be one.</p> <p>All newly admitted resident's medications brought in by family will be returned to the family and all meds for new admissions will be obtained by the facility's contracted pharmacy upon admission. The facility will only use meds as necessary until all new meds arrive in the facility.</p>	9/25/15

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{D 358}	<p>Continued From page 3</p> <p>7/29/15 for 7 tablets, and 8/28/15 for 6 tablets.</p> <ul style="list-style-type: none"> - The facility had to tell us when residents run out of their medications brought from home. - The cycle fill medications are routine medications, and a 7 day supply is sent automatically weekly. - The Pharmacist was not sure why Resident #4's Aricept wasn't sent routinely after it was started on cycle fill on 7/14/15. <p>Interview with Resident #4 on 8/31/15 at 2:40pm revealed:</p> <ul style="list-style-type: none"> - He believed he received his medications as ordered. - He was not aware of what his medications looked like. <p>2. Review of Resident #4's current FL2 revealed a medication order for Florastor 250mg, 1 tablet twice daily. (Florastor is a probiotic medication used to restore normal bacterial flora to the digestive tract, and it is used to treat a variety of conditions including antibiotic induced diarrhea.)</p> <p>Continued review of Resident #4's record revealed a discontinue order for Florastor dated 7/24/15.</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for July 2015 revealed:</p> <ul style="list-style-type: none"> - An entry for Florastor 250mg capsule, 1 twice daily, with scheduled administration times of 8am and 8pm. - The Florastor had been documented as administered twice daily except for the following: 7/4/15 8pm, out of facility, 7/14/15 8pm, not initialed as given, no reason noted. 7/15/15 8am and 8pm, not initialed, no reason 	{D 358}	<p>The tab "Awaiting Pharmacy" has been replaced with "Must contact RCD or Pharmacy with a phone number attached". A tab has been added to insert an additional note which will be keyed in to show the Med Tech making the call to the pharmacy and identifying who he/she spoke to.</p> <p><u>3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur.</u></p> <p>Staff in-service education was conducted with Med Techs to alert them the "Awaiting Pharmacy" tab has been removed from the eMAR system. If a medication is not found to be on the med cart, the Med Tech must call the pharmacy and identify who they spoke with. The RCD used a "Dummy" example as a teaching method on how to carry out this new procedure. All exceptions are being checked daily by the RCD and RCD assistant on the eMAR to ensure continued compliance.</p> <p><u>4) Facility's plan to monitor its performance so solutions are sustained, evaluated for</u></p>	9/25/15

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE OAKS ASSISTED LIVING **916 S. MARIETTA STREET**
GASTONIA, NC 28054

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noted.
7/16/15 8am and 8pm, out of facility.
7/17/15 8am, not initialed, in hospital.
7/17/15 8pm, initialed and circled as not given, "awaiting pharmacy" noted on the exception sheet of the eMAR.
7/18/15 8am and 8pm, initialed and circled as not given, "awaiting pharmacy" noted on the exception sheet of the eMAR.
7/19/15 8am and 8pm, initialed and circled as not given, "awaiting pharmacy" noted on the exception sheet of the eMAR.
7/20/15 8am and 8pm, initialed and circled as not given, "awaiting pharmacy" noted on the exception sheet of the eMAR.
7/21/15 8am, initialed and circled as not given, "awaiting pharmacy" noted on the exception sheet of the eMAR.
7/21/15 8pm, not initialed, in hospital.
7/22/15 8am, initialed and circled as not given, "awaiting pharmacy" noted on the exception sheet of the eMAR.
7/22/15 8pm, not initialed as given, no reason given.
7/23/15 8am and 8pm, initialed and circled as not given, "awaiting pharmacy" noted on the exception sheet of the eMAR.
7/24/15 8pm, initialed and circled as not given, "awaiting pharmacy" noted on the exception sheet of the eMAR.

Observation of Resident #4's medications on hand at 3:15pm on 8/28/15 revealed no Florastor.

Interview with the Manager of the pharmacy of contract on 8/31/15 at 11:35am revealed:
- Florastor was a very expensive over the counter (OTC) medication.
- "We don't get paid for OTC medications."
- "We try to send a few days supply of the OTC

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effectiveness, and integrated into the facility's QAPI process.

These measures are being monitored by the RCD and RCD assistant on a daily basis through the Quality Assurance program. The RCD will report on the measures implemented to the QA Committee which will monitor for effectiveness. The QA Committee will make further recommendations to adjust the measures as needed. The Executive Director is responsible to see that QA recommendations are acted upon in a timely manner.

9/25/15

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{D 358}	<p>Continued From page 5</p> <p>medication until the doctor can be called to change the order."</p> <ul style="list-style-type: none"> - The pharmacy has 24 hour a day service, 7 days a week. - If the facility was out of a medication they can call the pharmacist on call, and get the medication from a backup pharmacy. - The facility ordered Resident #4's medications, including Florastor, and "we did not put them on a cycle fill." <p>Interview with the Pharmacist at the pharmacy of contract on 8/31/15 at 11:55am revealed:</p> <ul style="list-style-type: none"> - Resident #4 brought his own medications into the facility from home when he was admitted to the facility. - Because Resident #4 had his own medications, the pharmacy did not setup his routine medications like Florastor on a cycle fill. - They had never dispensed any Florastor for Resident #4. - The Florastor was "profile only on the resident's record." - The Florastor was discontinued in their computer system on 7/27/15. <p>Interview with the Nurse Practitioner (NP) on 8/28/15 at 10:30am revealed:</p> <ul style="list-style-type: none"> - Resident #4 didn't need the Florastor. - "Many times patients are put on Florastor while they are taking antibiotics to prevent diarrhea." - Resident #4 hasn't had any diarrhea. <p>Interview with a Medication Aide (MA) on 8/31/15 at 2:02pm revealed:</p> <ul style="list-style-type: none"> - "Awaiting pharmacy" means, we don't have the medication available to administer. - When we don't have a medication, "we call the pharmacy and get it." 	{D 358}		

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{D 358}	<p>Continued From page 6</p> <p>Interview with Resident #4 on 8/31/15 at 2:40pm revealed: - He believed he received his medications as ordered. - He was not aware of what his medications looked like.</p> <p>3. Continued review of Resident #4's current FL2 dated 6/30/15 revealed a medication order for Mucinex 600mg, 1 tablet twice daily. (Mucinex is an over the counter [OTC] long acting expectorant used to thin mucous with upper respiratory infections and chronic obstructive pulmonary diseases.)</p> <p>Review of a hospital discharge summary dated 8/24/15 confirmed the Mucinex dose as 600mg, 1 twice daily.</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for July 2015 revealed: - An entry for Guaifenesin 600mg ER (generic Mucinex), 1 tablet twice daily, with scheduled administration times of 8am and 8pm. - On 7/29/15 at 8pm and 7/30/15 at 8am, the Guaifenesin was initialed and circled as not given, with a notation on the eMAR exception sheet, "awaiting pharmacy."</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for August 2015 revealed: - An entry for Guaifenesin 600mg ER, 1 tablet twice daily, with scheduled administration times of 8am and 8pm. - On 8/7/15 at 8am and 8/10/15 8pm, the Guaifenesin was initialed and circled as not given, with a notation on the eMAR exception sheet, "awaiting pharmacy."</p>	{D 358}		

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{D 358}	<p>Continued From page 7</p> <ul style="list-style-type: none"> - On 8/17/15 at 8am, there was a gap on the eMAR Guaifenesin entry with no initials and no explanation for the medication not documented as given. <p>Observation of Resident #4's medications on hand at 3:15pm on 8/28/15 revealed:</p> <ul style="list-style-type: none"> - Two bubble packs of Guaifenesin 600mg. - One had been dispensed on 8/25/15 and the other on 8/17/15. <p>Interview with the Manager of the pharmacy of contract on 8/31/15 at 11:35am revealed:</p> <ul style="list-style-type: none"> - Resident #4 brought in his own medications when he was admitted to the facility. - Resident #4's medications were not put onto cycle fill on admission due to the fact he had his own medications. - The pharmacy has 24 hour a day service, 7 days a week. - If the facility was out of a medication they can call the pharmacist on call, and get the medication from a backup pharmacy. - The facility ordered Resident #4's medications, including Mucinex, and "we did not put them on a cycle fill." - The Manager could not explain why Resident #4's medications were not put on cycle fill status. - "We don't get paid for OTC medications." - "We try to send a few days supply of the OTC medication until the doctor can be called to change the order." <p>Interview with the Pharmacist at the pharmacy of contract on 8/31/15 at 11:55am revealed:</p> <ul style="list-style-type: none"> - Resident #4 brought his own medications into the facility from home when he was admitted to the facility. - Because Resident #4 had his own medications, the pharmacy did not setup his routine 	{D 358}		

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{D 358}	<p>Continued From page 8</p> <p>medications like Mucinex on a cycle fill.</p> <ul style="list-style-type: none"> - The pharmacy had dispensed 14 tablets of Mucinex, a 7 day supply, on 8/19/15 and 8/25/15. <p>Interview with a Medication Aide (MA) on 8/31/15 at 2:02pm revealed:</p> <ul style="list-style-type: none"> - "Awaiting pharmacy" means, we don't have the medication available to administer. - When we don't have a medication, "we call the pharmacy and get it." <p>Interview with Resident #4 on 8/31/15 at 2:40pm revealed:</p> <ul style="list-style-type: none"> - He believed he received his medications as ordered. - He was not aware of what his medications looked like. <p>Refer to facility's policy and procedure for ordering medications.</p> <p>B. Review of Resident #1's current FL2 dated 8/28/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses which included schizophrenia, anxiety, depression and extrapyramidal symptoms (EPS). - A physician's order for Clonazepam (used to treat anxiety) 0.5mg twice daily. <p>Review of Resident #1's previous FL2 dated 7/1/15 revealed a physician's order for Clonazepam 0.5mg twice daily.</p> <p>Review of the Resident Register for Resident #1 revealed she was admitted to the facility on 2/4/13.</p> <p>Review of the Resident #1's electronic Medication Administration Record (eMAR) for August 2015 revealed:</p>	{D 358}		

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{D 358}	<p>Continued From page 9</p> <ul style="list-style-type: none"> - An entry for Clonazepam 0.5mg take one tablet twice daily. - An order origination date of 2/26/15 and a stop date of 8/26/15 at 2:00pm for Clonazepam 0.5mg. - Documentation of 53 doses administered from 8/1/15 to 8/26/15 at 8:00am. -Documentation was absent for 8/26/15 8:00pm dose, 8/27/15 8:00am dose, and 8/27/15 8:00pm dose. <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" for Resident #1's Clonazepam 0.5mg revealed:</p> <ul style="list-style-type: none"> - Clonazepam 0.5mg was documented as administered on 8/26/15 at 8pm. - Documentation was absent for administration for the 8:00am and 8:00pm doses on 8/27/15. <p>Further record review for Resident #1 revealed that the order for Clonazepam 0.5mg twice daily had not been discontinued by the physician.</p> <p>Interview with Resident #1 on 8/27/15 at 9:47am revealed:</p> <ul style="list-style-type: none"> - She received her medications on time. - She had never ran out of any medications. <p>Interview with a Medication Aide (MA) on 8/27/15 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -The order for Clonazepam had a stop date of 8/26/15 at 2:00pm. -Clonazepam was not showing up on the eMAR as an active medication. <p>Interview with the Resident Care Director's Assistant on 8/28/15 at 9:00am revealed:</p> <ul style="list-style-type: none"> -The order for Clonazepam 0.5mg twice daily should not have been discontinued. - The order was removed from the current eMAR 	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/31/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 916 S. MARIETTA STREET GASTONIA, NC 28054
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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
{D 358}	<p>Continued From page 10</p> <p>due to a stop date of 8/26/15 at 2pm.</p> <ul style="list-style-type: none"> - A new signed physician's order for Clonazepam was required in order to put it back on the eMAR. -The Psychiatric Physician's Assistant was on vacation this week and a new order for Clonazepam had not been received. <p>Interview with Resident #1 on 8/28/15 at 9:20am revealed:</p> <ul style="list-style-type: none"> - She was aware that she missed doses of her clonazepam. - "I feel happy and more awake." <p>Interview with Resident #1's Primary Care Provider (PCP) on 8/28/15 at 12:30pm revealed:</p> <ul style="list-style-type: none"> - She was notified by the facility of the missed doses of Clonazepam 0.5mg. - The Psychiatric Physician's Assistant normally prescribed the Clonazepam, but was on vacation this week. - She signed a new order dated 8/28/15 for Clonazepam 0.5mg twice daily. <p>Observation of Resident #1's Clonazepam 0.5mg on hand on 8/31/15 at 11:20am revealed:</p> <ul style="list-style-type: none"> - A bubble pack labeled Clonazepam 0.5mg, take one tablet twice daily. - A dispense date of 7/29/15 for a quantity of 60. - A total of 14 tablets remained in the pack. <p>Interview with the Pharmacist at the pharmacy of contract on 8/31/15 at 11:55am revealed 60 tablets of Clonazepam 0.5mg, a 30 day supply, were dispensed on 7/3/15 and 7/29/15 for Resident #1.</p> <p>Interview with a MA on 8/31/15 at 2:35pm revealed:</p> <ul style="list-style-type: none"> - When the last ordered dose of a medication is administered, the eMAR will flag the dose to alert 	{D 358}		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 916 S. MARIETTA STREET GASTONIA, NC 28054
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{D 358}	<p>Continued From page 11</p> <p>the MA's.</p> <ul style="list-style-type: none"> - New or changed medication orders come in on the fax in the medication room and the RCD or his assistant process them. - The new medication orders are placed in a book in the medication room and it is the responsibility of the MA's to double check the orders against the eMAR when the first dose is administered. - After new orders are checked by the MA's the original order is filed in the chart. <p>Interview with a MA on 8/31/15 at 3:20pm revealed:</p> <ul style="list-style-type: none"> - Resident #1 "seemed to be more energetic" when she missed the doses of Clonazepam. - The MA did not notice any negative behaviors from Resident #1 during that time. - The pharmacy sends a faxed request for the physicians to sign when new orders are needed for controlled substances. <p>Telephone interview with the Psychiatric Physician's Assistant on 8/31/15 at 4:06pm revealed:</p> <ul style="list-style-type: none"> - She did not believe that missing the 2 doses of Clonazepam 0.5mg on 8/27/15 had caused any harm to the resident. - She will write new orders when she returns to the facility on 9/3/15. - She was on vacation last week. <p>Refer to facility's policy and procedure for ordering medications.</p> <hr/> <p>Review of the facility's policy and procedure on ordering medications revealed:</p> <ul style="list-style-type: none"> - All medications are ordered through a centralized pharmacy (named pharmacy of 	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/31/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 916 S. MARIETTA STREET GASTONIA, NC 28054
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{D 358}	Continued From page 12 contract). The pharmacy delegates backup of medications by urgency and/or availability, i.e. (antibiotics.) - Medications are billed through a centralized pharmacy which residents have a signed agreement with. - Medications should be delivered in a timely manner.	{D 358}		



SEP 28 2015

916 SOUTH MARIETTA STREET • GASTONIA, NORTH CAROLINA 28054 • 704.864.3249

September 25, 2015

NCDHHS
Division of Health Service Regulation
Adult Care Licensure Section
12 Barbetta Drive
Asheville, NC 28806

Dear Sirs:

Please find attached the completed plan of correction for the recent survey conducted at Heritage Oaks Assisted Living on August 27, 28, and 31, 2015.

Please do not hesitate to contact me should you need additional information regarding this plan of correction dated September 25, 2015.

Sincerely,

A handwritten signature in cursive script that reads "Kim H. Harris".

Mr. Kim H. Harris
Administrator