STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-060170	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE AT HUNTERSVILLE	10200 HAMPTON PARK DRIVE HUNTERSVILLE, NC 28078

(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 an annual survey on 07/09/24 through 07/10/24.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 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: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure medications were administered within the ordered parameters for 1 of 5 residents related to a medication used to treat heart disease, high blood pressure, regulate heart rate and/or treat heart failure (#3). The findings are: Review of Resident #3's current FL-2 dated 05/15/24 revealed diagnoses included hypertension, chronic atrial fibrillation, congestive heart failure, and edema. Review of Resident #3's signed physician's orders dated 05/01/24 revealed: -There was an order for metoprolol extended release (ER) (a medication to treat high blood pressure, regulate heart rate) 25mg, one tablet daily, hold for heart rate (HR) less than 60. -There was an order for digoxin (a medication used to treat abnormal heart rhythm) 125mcg	D 358	Wellness Director to conduct training with med techs re: administration of medications with parameters RN consultant or designee to conduct weekly review of resident heart rate readings and administration of medications per parameters Welness Director or designee to review new orders weekly and conduct weekly review of medications administered with parameters RN consultant or designee to review med orders with parameters and resident MARs monthly	7/15/24 Starting 7/10/24 On-going x3 months Starting 7/10/24 On-going x3 months Starting 8/9/24 on-going monthly x3 months

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator/VP of Community Operations 8/8/24

Reviewed and Acknowledged by SSD 08/16/24
Sharon Dunton RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-060170	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE AT HUNTERSVILLE	10200 HAMPTON PARK DRIVE HUNTERSVILLE, NC 28078

(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	Continued From page 1	D 358		

tablet, one tablet daily, hold for pulse less than 60.

Review of Resident #3's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol ER 25mg, one tablet daily, hold for HR less than 60, scheduled at 8:00am.
-The entry for metoprolol ER 25mg had a field to document Resident #3's blood pressure.
-There was no field to document Resident #3's HR.
-There was an entry for digoxin 125mcg tablet, take one tablet daily, hold for pulse less than 60.
-There was a field to document Resident #3's pulse.
-Metoprolol ER 25mg was documented as administered on 05/09/24 at 8:00am.
-Resident #3's pulse on 05/09/24 at 8:00am was 47 as documented on the digoxin 125mg entry.
-Metoprolol ER 25mg was documented as administered on 05/10/24 at 8:00am.
-Resident #3's pulse on 05/10/24 at 8:00am was 50 as documented on the digoxin 125mg entry.
-Metoprolol ER 25mg was documented as administered on 05/11/24 at 8:00am.
-Resident #3's pulse on 05/11/24 at 8:00am was 52 as documented on the digoxin 125mg entry.
-Metoprolol ER 25mg was documented as administered on 05/12/24 at 8:00am.
-Resident #3's pulse on 05/12/24 at 8:00am was 52 as documented on the digoxin 125mg entry.

Review of Resident #3's June 2024 eMAR revealed:
-There was an entry for metoprolol ER 25mg, one tablet daily, hold for HR less than 60, scheduled at 8:00am.
-The entry for metoprolol ER 25mg had a field to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-060170	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE AT HUNTERSVILLE	10200 HAMPTON PARK DRIVE HUNTERSVILLE, NC 28078

(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	Continued From page 2	D 358		

document Resident #3's blood pressure.
-There was no field to document Resident #3's HR.
-Metoprolol ER 25mg was documented as administered on 06/09/24 at 8:00am.
-Resident #3's pulse on 06/09/24 at 8:00am was 59 as documented on the digoxin 125mg entry.

Interview with a medication aide (MA) on 07/10/24 at 9:28pm revealed:
-She had not administered the medications when the pulse was less than 60.
-She knew that metoprolol ER and digoxin were not to be administered to Resident #3 if his pulse was less than 60 as they are the same parameters listed on the eMar.
-Before administering any medications, she took Resident #3's blood pressure and pulse.

Interview with the facilities Registered Nurse on 07/10/24 at 9:34am revealed:
-The pharmacy entered orders into the eMAR system.
-The pharmacy entered a field for the blood pressure under the metoprolol entry, when they should have entered a field for the pulse in the eMAR system.
-The MAs should not have administered metoprolol ER to Resident #3's when his pulse was under 60.
-She was not responsible for completing audits.
-MAs were responsible for auditing the records for new orders to make sure they were on the eMAR but did not review for clarity.

Interview with the Health and Wellness Director (HWD) on 07/10/24 at 9:55am revealed:
-The pharmacy entered medication orders on the eMAR.
-A field for the HR or pulse should had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-060170	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE AT HUNTERSVILLE	10200 HAMPTON PARK DRIVE HUNTERSVILLE, NC 28078

(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	Continued From page 3	D 358		

placed on the eMAR for the metoprolol entry, not the blood pressure.
-The MA should have known the pulse was under 60 for the metoprolol ER because they held the digoxin for the same parameter.
-The metoprolol ER should not have been administered on 05/09/24, 05/10/24, 05/11/24, 05/12/24 and 06/09/24 and would be considered medication errors.
-The MAs reviewed new orders to make sure they were entered in the eMAR correctly and should have discovered the HR was not listed on the eMAR for the metoprolol ER 25mg.
-This was an error by pharmacy, the directions were correct, but they should had entered a field HR and not blood pressure checks.
-The HWD did complete cart audits but did not do record audits.
-The pharmacy did review the medications quarterly.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 07/10/24 at 1:15pm revealed:
-The facility sent physician orders to the pharmacy.
-A pharmacy technician entered the order on the eMAR, and it was reviewed by a pharmacist for accuracy.
-HR or pulse should have been listed on the eMAR under the metoprolol ER entry and not blood pressure, this was an error by the pharmacy.
-If Resident #3 was administered metoprolol ER and his pulse was low there could be several adverse effects including low pulse, tiredness/lethargy.

Interview with Resident #3 Primary Care Provider on 07/10/24 at 1:42pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-060170	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR RIDGE AT HUNTERSVILLE	10200 HAMPTON PARK DRIVE HUNTERSVILLE, NC 28078

(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	Continued From page 4 -Resident #3's heart rate typically ran low. -Resident #3 should not have gotten the metoprolol ER if his heart rate was less than 60. -Resident #3 could have experienced dizziness, falls with injury, or syncopal episodes (fainting, loss of consciousness caused by a drop in blood flow to the brain). Interview with the Administrator on 07/10/24 at 4:13pm revealed she would like the Corporate Resident Care Director to answer the questions pertaining to the non-compliance. Interview with the Corporate Resident Care Director on 07/10/24 at 4:13pm revealed: -The physician orders were reviewed for accuracy and sent to the pharmacy. -The pharmacy entered orders into the eMAR system. -The MAs were responsible to review and approve medication orders for accuracy on the eMAR system. -It was the expectation that the HWD or Resident Care Coordinator would review and audit the eMAR for accuracy to ensure there were no errors.	D 358		