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{D 000}	Initial Comments The Adult Care Licensure Section and the Hoke County Department of Social Services conducted a follow up survey and complaint investigation on October 13 - 15, 2015.	{D 000}		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure training on the care of residents with diabetes was provided to	D 164		

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unlicensed staff prior to the administration of insulin for 1 of 4 medication aides (Staff A) sampled.

The findings are:

Review of employee record for Staff A, Medication Aide revealed:
-Staff A was hired on 09/21/2015 as a Nurse Aide /Medication Aide.
-Staff A passed the written medication examination on 12/20/2012.
-A medication clinical skills competency validation checklist was completed on 10/05/2015.
-There was no documentation of training on the care of the diabetic resident in the employee record for Staff A.

Interview with Staff A on 10/13/2015 at 2:35pm revealed:
-Staff A had not had classroom or computer training on care of the diabetic resident since employed at the facility but had diabetic training on a previous job.
-Staff A had signed a lot of paperwork but did not know all of what she had signed.
-The Resident Care Director (RCD) had watched her draw up insulin and told her to change gloves between each resident.
-Staff A had administered insulin to Resident #4 the morning of 10/13/2015.
-Resident #4's insulin was administered per a sliding scale order.
-Staff A had been administering medications for "5 or 6 days".

Telephone interview with Staff A on 10/15/2015 at 11:40am revealed:
-Staff A had initialed the medication administration record for performing a finger stick

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D 164	Continued From page 2 blood sugar (FSBS) check on Resident #7 since employed at the facility. -Staff A had initialed the medication administration records for performing a finger stick blood sugar check and administering insulin to Resident #4 as recent as 10/13/2015. -Staff A could not recall specific dates of performing FSBS checks on Resident #7. -Staff A did not recall the facility providing training on basic facts about diabetes and care involved in the management of diabetes; insulin storage; treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; blood glucose monitoring and universal precautions; and sliding scale insulin administration. -Staff A knew from her previous job about sliding scale insulin administration. -Staff A had not been provided training by the facility on insulin action; mixing, measuring and injection techniques for insulin administration; and appropriate insulin administration times. -Staff A remembered another medication aide telling her about high and low blood sugars for Resident #6 and Staff A had never administered insulin to Resident #6. Review of the facility's policy titled "Medication Management Plan" revealed: -"Training of the care of residents with diabetes is provided prior to the administration of insulin." -"Training shall be provided by a registered nurse, registered pharmacist, or prescribing practitioner." -"Training should include: basic facts about diabetes; care involved in the management of diabetes: insulin action; insulin storage; mixing, measuring, and injection techniques for insulin administration; treatment and prevention of hypoglycemia and hyperglycemia, including signs	D 164		

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and symptoms; blood sugar monitoring; universal precautions; appropriate administration time; and sliding scale insulin administration."
-"Training shall consist of demonstration and hands-on supervised administration of insulin injections."
-"Prior to administering insulin to residents, unlicensed medicine staff must obtain certification from a licensed health professional that the staff member demonstrates sufficient skill and knowledge to safely administer injections. Certificates of completion shall be kept in staff member's personnel file."

Interview with Resident #6 on 10/15/2015 at 10:45am revealed:
-Resident #6 thought his FSBS was check "about every 2 hours."
-Resident #6 did not remember what "nurse" checked his FSBS.
-The "nurse" gave him insulin once a day.

Review of October 2015 Medication Administration Records for Resident #6 revealed:
-On 10/02/2015 at 7:30am, Staff A initialed the MAR for the FSBS performed and documented the FSBS results as 101.
-No insulin was documented as administered.

Interview with Resident #7 on 10/15/2015 at 12:05pm revealed:
-Resident #7's FSBS was checked daily by staff.
-Resident #7 could not remember names of staff who performed FSBS checks for her.
-Resident #7 was not requiring insulin to be administered anymore.

Review of October 2015 Medication Administration Records for Resident #7 revealed:
-On 10/09/2015, 10/10/2015, 10/12/2015, and

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10/13/2015 at 7:30am, Staff A initialed the MAR for the FSBS performed and documented the FSBS results ranging from 91 - 132.
-No insulin was documented as administered.

Interview with Resident #4 on 10/15/2015 at 3:15PM revealed:
- He did not know the names of the MA who checked his FSBS or administered insulin injection.
- His FSBS was checked by the MAs before breakfast, lunch, supper, and before bedtime.
- If his FSBS was not "high", the MAs would not administer insulin.
-On Tuesday (10/13/15) the MA administered insulin before lunch, and at bedtime.
- The MAs always wore gloves and used alcohol pads to clean area before finger sticks and administering insulin.

Review of the October 2015 Medication Administration Records for Resident #4 revealed:
-On 10/09/2015 at 7:30am, Staff A initialed and documented performing a FSBS of 104 for Resident #4.
-On 10/09/2015 at 11:30am, Staff A initialed and documented performing a FSBS of 84 for Resident #4.
-On 10/10/2015 at 7:30am, Staff A initialed and documented performing a FSBS of 111 for Resident #4.
-On 10/10/2015 at 11:30am, Staff A initialed and documented performing a FSBS of 151 for Resident #4 with administration of Humalog Insulin (a fast acting medication administered by subcutaneous injection used to lower blood sugar levels in diabetics) 2 units.
-On 10/12/2015 at 7:30am, Staff A initialed and documented performing a FSBS of 96 for Resident #4.

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-On 10/12/2015 at 11:30am, Staff A initialed and documented performing a FSBS of 144 for Resident #4.
-On 10/13/2015 at 7:30am, Staff A initialed and documented performing a FSBS of 112 for Resident #4.
-On 10/13/2015 at 11:30am, Staff A initialed and documented performing a FSBS of 170 for Resident #4 with administration of Humalog 2 units.

Interview with the Interim Executive Director (IED) on 10/14/2014 at 11:40am revealed:
-She did not know if Staff A had diabetic training since employment with the facility.
-The Business Office Manager (BOM) was supposed to ensure diabetic training had been completed within the past 12 months for Staff A prior to hire.
-Now that the facility had a nurse hired, the nurse would be responsible to ensure diabetic training was provided for medication aides.
-She thought if Staff A had diabetic training completed within the past 12 months with a previous employer, the staff was covered until it was offered at their facility which currently employed Staff A.

Interview with the Business Office Manager (BOM) on 10/14/2015 at 11:20am revealed:
-There was no documentation of diabetic training in Staff A's employee fie.
-The BOM thought she had the documentation for Staff A having completed diabetic training because the BOM had checked it off on the employee file check-off list.
-The BOM was not aware Staff A needed to have diabetic training provided by the facility and thought the diabetic training completed by Staff A's previous employer would meet the

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requirement as long as the training had been done within the past 12 months.

Interview with the IED on 10/15/15 at 4:55pm revealed:
-All MA's working in the facility received orientation and training on the "Medication Managment Plan" policy.
-All MA's receive an orientation packet containing the "Medication Management Plan" policy and sign for receipt of the policy.

The Interim Executive Director presented a certificate on 10/14/2015 for a diabetic care inservice dated 05/14/2015, which was prior to Staff A's hire date at the facility. A second certificate of completion for Staff A for a diabetic care inservice attended at the facility with a completion date of 09/25/2015 was presented on 10/15/2015. The certificate did not provide a name or credentials of a presenter.

{D 346} 10A NCAC 13F .1002(c) Medication Orders {D 346}

10A NCAC 13F .1002 Medication Orders
(c) The medication orders shall be complete and include the following:
(1) medication name;
(2) strength of medication;
(3) dosage of medication to be administered;
(4) oute of administration;
(5) specific directions of use, including frequency of administration; and
(6) if ordered on an as needed basis, a stated indication for use.

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This Rule is not met as evidenced by:
Based on observation, record reviews, and interviews, the facility failed to clarify and ensure medication orders were complete for 1 of 6 sampled residents (Resident #6) related to sliding scale insulin orders implemented without sliding scale blood sugar (BS) parameters.

The findings are:

Observation of medication pass on 10/14/15 revealed:
- Medication aide (MA) on the Safe Haven unit prepared and administered a subcutaneous injection of 2 units of Humulin insulin to Resident #6 at 11:30am in his right upper arm.
- The medication aide documented the insulin administration on the resident's October 2015 medication administration record (2 units of Humalog insulin for BS of 178).

Review of Resident #6's current FL-2 dated 9/18/15 revealed an order for Humalog sliding scale insulin (used to treat high blood sugar) with meals.

Review of a physician's order for Resident #6 dated 9/9/15 revealed:
- Accuchecks before meals and at bedtime.
- Sliding scale Humalog insulin for BS of 150 - 200 (administer 2 units of Humalog insulin); 201 - 250 (administer 5 units of Humalog insulin); 251 - 300 (administer 8 units of Humalog insulin); 301 - 350 (administer 11 units of Humalog insulin); 351 - 400 (administer 14 units of Humalog insulin); 401 - 450 (administer 17 units of Humalog insulin); notify physician if BS less than

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40 or greater than 450.

Interview with the 1st shift MA, assigned to the Safe Haven unit, on 10/14/15 at 12:05pm revealed:
- She administered the resident's sliding scale insulin according to the parameters on the MAR.
- She was not aware the resident's current FL-2 (dated 9/18/15) did not have orders for the sliding scale BS parameters.
- She would contact the resident's physician today for clarification orders.
- The resident's BS's were checked before each meal and at bedtime with sliding scale insulin coverage as needed.

Review of Resident #6's September 2015 and October 2015 MARs revealed:
- From 9/18/15 through 10/14/15, the resident's BS were documented each day at 7:30am, 11:30am, 4:30pm and 8:00pm.
- Humalog insulin was documented as administered 28 times (From 9/18/15 through 9/30/15) and 22 times (From 10/01/15 through 10/14/15).

Interview with the 1st shift MA, assigned to the Safe Haven unit, on 10/15/15 at 10:40am revealed:
- When the facility received a new FL-2 signed by a medical provider, the facility's resident care director (RCD) reviewed the FL-2.
- If an order needed clarification, the RCD informed the MA on duty and the MA followed up with obtaining clarification order from the medical provider.

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{D 346}	Continued From page 9 Interview with the facility's RCD on 10/15/15 at 11:00am revealed: - The facility received clarification orders for Resident #6's sliding scale insulin with parameters for administering insulin. - The order was missed when the current FL-2 was received by the facility. Review of a clarification order dated 10/14/15 revealed the sliding scale insulin parameters were the same as the 9/09/15 orders except to notify physician if BS less than 80 or greater than 450. Review of Resident #6's MARs for September 2015 and October 2015 revealed no documented BS's below 80 or above 450.	{D 346}		
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues.	{D 358}		

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TYPE B VIOLATION

Based on observations, record reviews, and interviews, the facility failed to administer prescription medications (Lidocaine 5% ointment, Tylenol, Artificial Tears gel formula) in accordance with orders by a licensed prescribing practitioner for 2 of 5 residents sampled (Residents #2 and #3).

The findings are:

1. Review of Resident #2's current FL-2 dated 07/20/15 revealed:
- Resident #2 was admitted to the facility on 07/22/15.
- Diagnoses included hypertension, hypercholesterolemia, chronic pain syndrome, spinal stenosis, rheumatoid arthritis, and osteoporosis.

Review of physician orders for Resident #2 revealed three medications were prescribed for pain:
A. An order dated 08/19/15 for Lidocaine 5% ointment, apply sparingly twice daily as needed for pain. (Lidocaine 5% ointment is an anesthetic, preventing nerves from sending painful impulses to the brain.)

B. An order dated 07/20/15 for Gabapentin 300 mg capsule, take 1 capsule by mouth twice daily. (Gabapentin is used to treat neuropathic pain.)
- An order dated 07/30/15 for Gabapentin 300 mg capsule, take 1 capsule by mouth three times daily.
- An order dated 10/04/15 for Gabapentin 300 mg capsule, take 2 capsules three times daily.
- An order dated 10/07/15 for Gabapentin 300 mg

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capsule, take 2 capsules in the morning, 2 capsules at 2PM, and 3 capsules at 8PM prn
- An order dated 10/08/15 for Gabapentin 300 mg capsule, take two tablets by mouth in AM and three tablets by mouth in PM.

C. An order dated 08/19/15 for Tylenol 325 mg tablets, take 2 tablets by mouth every 4 hours prn for fever, headache.
- An order dated 09/23/15 for Tylenol 325 mg tablets, take 1 tablet by mouth daily.

Interview with Resident #2 at 10:00AM on 10/15/15 revealed:
- She had chronic pain in her legs and feet.
- She now had to use a walker and wheelchair to ambulate due to her pain.
- She had to go to the hospital Emergency Room in August because the pain and swelling in her legs and feet was so bad.
- She had contacted her primary care physician to request Gabapentin dosage increases several times since she came to live at the facility. Gabapentin was the only medication that gave her any real relief from pain in her legs and feet.
- The Medication Aides (MAs) only gave her Tylenol for pain in her legs and feet. She had never taken Tylenol before for pain in her legs and feet, but that was the only medication the MAs offered to her when she complained of pain.
- She thought Tylenol was for treating headaches and fevers, it did not help very much with leg pain compared to Gabapentin.
- She did not differentiate from pain in her legs vs. her feet. She stated her legs and feet were attached, and both legs and both feet hurt at the same time.
- She had never received the Lidocaine 5% ointment from the facility's MAs, they never told her that her doctor prescribed it for her foot pain.

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She wanted to use it.
- She stated she may have used Lidocaine ointment in the past for leg and foot pain, she can't remember.

Review of the facility's 24 Hour Report for 08/05/15 revealed:
- The Lidocaine 5% ointment was received on 08/05/15 from the pharmacy, without an order for its use. Faxed [the physician] for order on 08/05/15. Medication in cabinet.

Review of the facility's 24 Hour Report for 08/07/15 revealed:
- Resident #2 was sent to the local hospital Emergency Room on second shift, and returned at 1:30am, no new [medication] orders.

Review of a fax transmission to the primary care physician dated 08/08/15 revealed:
- Resident #2 was sent out to the ER with complaints of pain and edema of the feet.
- Hospital discharge summary dated 08/07/15 was included, listing a diagnosis of peripheral edema, and recommendation for follow-up with the primary physician and continue current medications.

Continued review of the facility's 24 Hour Reports revealed:
- Resident #2 complained of not feeling good on 08/09/15.
- Resident #2 complained of leg pain on 08/13/15.

Review of a fax transmission from the facility's Resident Care Coordinator (RCC) to the primary care physician dated 08/22/15 revealed:
- Lidocaine ointment 5%, apply twice a day as needed for pain. To where? Please advise.

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The physician refaxed the 08/22/15 fax to the facility on 09/24/15, responding "Where does [the resident] complain of pain?"

Review of a fax transmission from the facility to the primary care physician dated 08/29/15 revealed:
- Resident #2 had a prn order for Tylenol 325 mg, and had been requesting this medication daily.
- Physician changed the order to daily Tylenol administration on 09/23/15.

A progress note by the RCC in the the Resident Record dated 10/03/15 stated Resident [#2] called on call nurse for [physician] and requested an increase on her Gabapentin. Med office faxed an order to change time and dosage.

A progress note by the RCC in the the Resident Record dated 10/04/15 stated Resident [#2] called on call nurse [at the physician's office] to change the time for her Gabapentin from TID to 2 pills po [by mouth] at 8AM and 2PM.

Interview with the RCC at 11:00AM on 10/15/15 revealed:
- Resident #2 wanted to manage her own medications, and frequently called her physician to request increased dosages of Gabapentin.
- Resident #2 did not want to use Tylenol for leg pain control, but the MAs gave it to her prn for pain control.
- MAs documented the Tylenol provided some pain relief on the back of the monthly Medication Administration Record (MAR).
- The RCC stated the physician's initial order on 08/19/15 for the Lidocaine 5% ointment was incomplete, as it did not specify where to apply the cream. His response on 8/24/15 did not say where to apply the cream, so they did not have a

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complete order. The facility could not apply the cream without a complete order.
- The RCC did not know who handwrote the following undated order on the August MAR: "Lidocaine ointment 5%, apply sparingly to feet twice daily as needed for pain, with an hour of administration of prn.
- The MARs for September 2015 and October 2015 printed by the pharmacy stated "Lidocaine Ointment 5% apply sparingly twice a day as needed prn, and someone added "to feet for pain". The RCC did not know who wrote the additional instructions on the order.
- The RCC stated MAs must have not offered Lidocaine 5% ointment to Resident #2 for leg and foot pain, because it was not transcribed on the MARs.

Observation in the Medication Room at 11:15AM on 10/15/15 revealed:
- Lidocaine 5% ointment was not available on the medication cart where Resident #2's other medications were stored.
- Lidocaine 5% ointment was not stored in the locked cabinets along with other back-up medications.
- The RCC stated MAs did not administer Lidocaine 5% ointment to Resident #2 for leg and foot pain, as it was not available in the facility.

Continued observation in the Medication Room at 11:45AM on 10/15/15 with the Resident Care Director (RCD) and the RCC revealed:
- The RCD located a sealed, unopened box containing Lidocaine 5% ointment in a bottom drawer of the medication cart.
- The RCD confirmed the Lidocaine 5% ointment was sent for Resident #2 in August 2015, per the pharmacy label on the box.

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Three telephone calls to the physician's office were made on 10/15/15. Neither the physician nor the physician's on call nurse were available for interview about use of pain medications by Resident #2, by the close of the survey.

2. Review of Resident #3's current FL-2 dated 06/30/2015 revealed
-Diagnoses included osteoarthritis, hypertension, depression, status post hip fracture, and insomnia.
-Resident #3 was admitted to the facility on 07/07/2015.

Review of physician orders for Resident #3 revealed:
-An order dated 10/07/2015 for Artificial Tears (eye moisturizer) gel formula every night to both eyes.
-An order dated 10/08/2015 to continue Artificial Tears gel formula.

Review of October 2015 Medication Administration Records for Resident #3 revealed:
-No transcription entry to the October 2015 MARS for Artificial Tears gel formula.
-No documentation of administration for Artificial Tears gel formula every night to both eyes for Resident #3.

Observation of Resident #3's medications on hand with the Resident Care Coordinator/Medication Aide (RCC/MA) on 10/14/2015 at 10:15am revealed an unopened pharmacy labeled 10ml bottle of Systane eye gel (eye moisturizer) with printed instructions to apply to both eyes every night and a pharmacy dispense date of 10/08/2015.

Interview with the Resident Care

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{D 358}	Continued From page 16 Coordinator/Medication Aide (RCC/MA)on 10/14/2015 at 10:20am revealed: -The RCC/MA did not see a transcription entry or documentation of administration to the October 2015 MARs for the Systane gel application every night. -The RCC/MA stated there would have to be an order for the medication for the pharmacy to have sent the medication to the facility. -The RCC/MA did not know if the Systane eye gel had just been delivered to the facility since the medication was not listed on the October 2015 MARs. -The Medication Aide (MA) on duty when the new order came to the facility was responsible for transcribing the order to the MARs. -The facility's system for transcribing new orders included use of a new order tracking sheet. The receiving MA was supposed to make two copies of the new order, place the original order in the resident's record and attach the second copy to the new order to the new order tracking sheet after faxing the order to the pharmacy and transcribing the order to the MARs. The third shift MA was responsible to review new order tracking sheets with the MAR and new order to assure the order had been processed correctly. The third shift MA was supposed to flag the MAR alerting staff that the medication had been received at the facility. Third shift MA completed the new order tracking sheet and forwarded the tracking sheet to the Resident Care Director (RCD) for signature. -The RCC/MA had not been able to locate a new order tracking sheet for the Artificial Tears gel formula. Interview with the Pharmacy Provider on 10/14/2015 at 10:50am revealed: -The pharmacy dispensed Systane gel drops to	{D 358}		

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the facility for the Artificial Tears gel formula on 10/08/2015.
-The pharmacy had not received a call from the facility questioning what was sent as a substitute for the Artificial Tears Gel drops.
-Resident #3 had a previous order for Artifcial Tears drops to her eyes every night but had been refusing the eye drops.

Interview with Resident #3 on 10/15/2015 at 4:15pm revealed:
-Sometimes her eyes felt "like I have something in my eyes".
-The MA "started using a lubricant on my eyes last night" and her "eyes feel better today".

____

The facility submitted the following Plan of Protection on 10/15/2015:
-The facility will inservice the Medication Aides within the next 24 hours on offering residents their as needed medications. The residents will be asked open ended questions for full understanding of the level of pain and medication needed.
-The Resident Care Director will monitor new order tracking and auditing of MARs daily to ensure proper administration of new and as needed orders.
-The Resident Care Director will be holding staff members accountable for not offering as needed medications appropriately. The Resident Care Director will be conducting periodic audits to ensure the policy is adhered to.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2015.

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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: TYPE B VIOLATION Based on observation, record reviews, and interviews, the facility failed to ensure the implementation of safe procedures for medication administration by the recording of medication administration by staff who did not administer the medications or observe the administration of medications. The findings are: Observation at 11:45 a.m. on 10/13/15 revealed: -The Interim Executive Director (IED) left the nurses' station in the Assisted Living (AL) part of the facilityand began walking down the hallway located to the right of the nurses station. -The IED had a clear, disposable cup in her hand. -The disposable cup had clear liquid and a disposable white drinking straw in it. -The IED arrived at Resident #1's room (room #106) and was heard stating "I was going to see if he wanted any water. I didn't know somebody else was in here" as she entered room 106.	D 366		

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-As the surveyor arrived at the entry door to room #106, the IED was observed at Resident #1's bedside holding the disposable cup while Resident #1 was drinking a sip of the clear liquid from the cup.
-The Registered Nurse (RN) from the contracted hospice agency was also at Resident #1's bedside.

Interview with Staff A, Medication Aide on 10/13/2015 at 11:45 a.m., who remained in the medication room at the medication cart revealed:
-Staff A had just prepared Dilaudid (a controlled drug used to treat pain) for administration to Resident #1, at the request of the IED.
-Staff A gave the Dilaudid to the IED to administer to Resident #1.
-The IED came into the medication room and asked Staff A if Resident #1 had been administered his prn (as needed) medication for pain.
-Staff A replied "no" to the IED.
-The IED asked Staff A if Staff A could "pull it" and Staff A replied "yes."
-The IED told Staff A that she (IED) would take the medication down to Resident #1.
-Staff A unlocked the controlled drug box, pulled the medication, put it in a clear plastic medicine cup, and handed it to the IED.
-Staff A had signed the narcotic control log when she pulled the Dilaudid and gave it to the IED to administer to Resident #1, but she had not signed Resident #1's MAR.
-Staff A did not know if Resident #1 took the Dilaudid and could not say Resident #1 took the Dilaudid because she (Staff A) was not in the Resident #1's room and did not observe Resident #1 take the medication.

Observation of Staff A, who remained in the

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medication room at the medication cart, on 10/13/2015 at 11:55 a.m. revealed Staff A documented administering the PRN Dilaudid on Resident #1's October 2015 MARs without conferring with the IED.

Interview with the contract hospice RN at 11:50 a.m. on 10/13/15 revealed:
-Resident #1 had scheduled and PRN (as needed) medication prescribed for pain.
-The hospice RN had not observed Resident #1 being administered any medication during the visit.

Review of Resident #1's current hospital generated FL-2 dated 6/18/15 revealed diagnoses included metastatic lung cancer, prostate cancer, and type 2 diabetes.

Observation and interview with Resident #1 at 11:55 a.m. on 10/13/15 revealed:
-Resident #1 was in supine position in a hospital bed.
-Resident #1 demonstrated increased work of breathing and his respirations were uneven.
-Resident #1 opened his eyes when spoken to.
-When asked "Are you hurting?," Resident #1 nodding his head to indicate "yes."
-Resident #1 did not know if he had received any pain medication that day (10/13/15).
-Resident #1 did not know if the IED had given him any medication that day (10/13/15).
-Resident #1 did not know if the IED had ever given him any medication.

Review of Resident #1's October 2015 MARs revealed:
-Entry for "Hydromorphone/Dilaudid 2 mg. Take 4 tabs (8 mg.) by mouth every 4 hours as needed for pain."

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D 366	Continued From page 21 -The MA documented administering Dilaudid to Resident #1 on 10/13/15 on the front side of MAR. -On the reverse side of page 3 of the MAR, the MA documented administering Dilaudid to Resident #1 at 11:45 a.m. on 10/13/15 "for pain." -The IED's initials and/or signature were not found on any section or page of Resident #1's October 2015 MARs. Review of the "Controlled Drug Record" for Resident #1's Dilaudid medication revealed: -The MA documented administering 4 Dilaudid tablets to Resident #1 at 11:45 a.m. on 10/13/15. -The IED's initials and/or signature were not found on the "Controlled Drug Record." Additional interview with Staff A at 12:07 p.m. on 10/13/15 revealed: -Staff A had been employed at the facility about 3 weeks. -Staff A had worked as a MA for 3 years at another facility. -Staff A had only been assigned to the medication carts "5 or 6 times" since hired at the facility. -Staff A had "not really" received any Medication Aide training since being hired. -Staff A had no knowledge of the facility's policies related to medication administration. -Staff A did not know if the facility had a specific policy on pulling medications and then giving the medication to another staff member to administer to a resident and had not received any training regarding pouring/dispensing medications and giving them to another staff member to administer. -Staff A had not pulled medications for any other resident and then given the medication to another staff member to administer. -Staff A recalled one additional occasion "maybe	D 366		

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one day last week" when the IED had asked her for Resident #1's PRN Dilaudid medication and Staff A gave the medication to the IED at that time to administer to Resident #1.
-On the two occasions Staff A had given Resident #1's medications to the IED to administer, Staff A had documented administering the medications to Resident #1's without observing Resident #1 take the medications.

Interview with the IED at 1:11 p.m. on 10/13/15 revealed:
-She had been in the position of IED since "the first week of August" 2015.
-The IED was not credentialed as a licensed health care professional.
-The IED had not completed Medication Aide training and was not a MA.
-The Resident Care Director (RCD), Resident Care Coordinator (RCC), and MAs are the only employees allowed to administer medications at the facility.
-It was facility policy that the person administering the medication was supposed to initial the MAR.
-It was facility procedure for the person administering a controlled substance to sign the narcotic log.
-"I did give [Resident's name] (Resident #1) his medication."
-The IED had been down to talk to Resident #1 earlier in the morning and "he was in pain."
-Resident #1 had asked for the PRN pain medication but "I don't know if he refused to take it for her [the MA]."
-The IED had asked the MA on duty if she had been able to give Resident #1 his PRN pain medication and the MA said she had not; "So I said I can take care of that for you."
-"I got his PRN medication and took it down and gave it to him."

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-The IED had not documented administering the PRN medication on Resident #1's MAR.
-The MA had documented administrating the medication on Resident #1 ' s MAR.
-Resident #1 "has taken a liking to me, so I can generally get him to take it or get him to drink. I generally go with the Med Tech and talk to him and ask him to take it."
-"I know one resident shouldn't get special treatment, but he is dying."
-The IED denied administering medication to Resident #1 on any other time; "the only time I actually handed him his pill was today."
-The IED denied administering medication to any other residents of the facility.

Review of the IED's personnel file revealed:
-The IED was hired 12/15/14.
-There was no documentation the IED held credentials as a licensed health care professional.
-There was no documentation the IED had completed Medication Aide training.

5 of 8 confidential staff interviews revealed:
-3 staff recalled being approached by the IED and refusing to give medication to the IED to administer.
-5 staff recalled the IED had administered medications and controlled substances to 4 named residents.
-Resident #1 was 1 of the 4 residents named in the confidential staff interviews.
-The IED was observed taking a cup with Resident #1's medication to his room [date withheld to maintain confidentiality of staff].
-"I don't think she [IED] is a med tech."
-The IED administered medication to "a lot of them [residents]."
-The IED administered medication to residents

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residing in the AL and the Safe Haven units of the facility.
-The IED administered medication "multiple times" to residents.
-The IED administered medications "twice" to residents during breakfast "to help out."
-The IED administered medications that "were made up in the cup for the patient already and she just gave them out. She didn't pop them or anything."
-When admininstering medications, staff were supposed to make sure the medication "went down"[the resident took the medication].
-It was facility procedure for the person who administered a controlled or PRN medication to sign the MAR and narcotic book as documentation the medication was administered to the resident.
-One staff member was not aware of any specific facility policy or procedure regarding one staff person pouring/dispensing a medication and giving it to another staff member to administer to a resident.
-"I was trained if you pull it, you pass it."

Confidential interviews with the 2 residents revealed:
-2 of the 4 residents named in the confidential staff interviews recalled being given medication by the IED.
-"Sometimes the IED gives medicine ...think the nurse gets outs what I need and [IED's named] just brings it."
-The MA stands at the medication cart and the IED brings the medication to the resident.

Review of the August, September, and October 2015 MARS of the 4 residents named in the confidential staff interviews revealed the IED had not documented (by initial or signature)

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administering any medications on the 4 resident's MARs.

Confidential interview with other facility residents' not named in the staff interviews throughout the survey revealed:
-3 additional residents recalled receiving their medications from the IED.
-One resident had received medication from the IED "once or twice."
-Another resident recalled being administered medications by the IED but could not recall the dates.
-Another resident referred to the IED as "the boss" and thought the IED had given them their medication.

Review of the August, September, and October 2015 MARs of the 3 additional residents who reported receiving medication from the IED revealed the IED had not documented (by initial or signature) administering any medications on the 2 resident's MARs.

Interview with the IED on 10/15/15 at 4:25 p.m. revealed:
-The IED did not know that name of the medication she had administered to Resident #1 on 10/13/15; "it's for pain."
-The IED was told by her supervisors to be "all over nursing" to "get it in order" [be involved to correct the identified problems].
-The IED had "tried to be up close and personal so I know what is going on."
-It was not unusual for the IED to stand at the medication cart with the MAs while the MAs are administering medications to residents.
-"I am standing and talking; while the MA pops the pill, I pour the water."
-The IED had given water and applesauce to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT WAYSIDE	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(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 366		D 366		

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residents' "before, while they are waiting, or after they are getting meds."
-The IED did not know why confidential staff and resident interviews had revealed the IED had administered medication to residents other than Resident #1.
- "I honestly don't know unless they see the two of us together and I give the water."
-The IED acknowledged administering medication to Resident #1 on one additional occasion "a week or so ago."
-The IED had not touched or popped the medications off of the card.
-"My thinking was that administering the med was putting it in the cup and not necessarily giving it to the resident and watching them take it."
-It was the facility expectation that the person pouring and administering a medication is supposed to sign the MAR after the resident takes the medication.
-The IED had not signed Resident #1's MARs.
-"I understand it is out of my scope to give medications."
-"It will not happen again."

Review of the facility policy "Medication Management Plan" revealed:
-"The recording of the administration of medication shall be by the staff person who administers the medication immediately following administration of the medication to the resident an (sic) observation of the resident actually taking the medication ..."
-"The MAR shall be accurate and include: the "name or initials of the person administering the medication or treatment."

Interview with the IED on 10/15/15 at 4:55 p.m. revealed:
-All MAs working in the facility received

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D 366	Continued From page 27 orientation and training on the "Medication Management Plan" policy. -All MAs received an orientation packet containing the "Medication Management Plan" policy and signed for receipt of the policy. ____________________ The facility submitted the following Plan of Protection on 10/13/2015: -All medication aides will be retrained within 72 hours on the proper administration of medication. -The Resident Care Director (RCD) will observe each new medication aide three times during the first 90 days of employment to ensure proper medication administration. -The RCD will ensure that no non licensed medication aide will participate in any of the medication administration process. -Each employee will be made aware of the NC qualifications for a medication aide to administer medication to a resident. -All non -certified employees will not be allowed to participate in medication administration process. -Training will begin immediately and each employee will be informed within the next 24 hours. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2015.	D 366		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and	{D912}		

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{D912}	Continued From page 28	{D912}		

regulations.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration, and adult care home medication aides training and competency evaluation requirements.

The findings are:

1. Based on observations, record reviews, and interviews, the facility failed to administer prescription medications in accordance with orders by a licensed prescribing practitioner for 2 of 5 residents sampled (#2 and #3) [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

2. Based on observation, record reviews, and interviews, the facility failed to ensure the implementation of safe procedures for medication administration by the recording of medication administration by staff who did not administer the medications or observe the administration of medications. [Refer to Tag D366 10A NCAC 13F .1004(i) Medication Administration (Type B Violation)].

3. Based on observation, interviews, and record review, the facility failed to assure 1 of 5 staff (Interim Executive Director) met the qualifications and requirements to perform medication aide duties and administer medications. [Refer to Tag D935 G.S. 131D 4.5B(b) Adult Care Home Med

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{D912}	Continued From page 29 Aide Training and Competency (Type B Violation)].	{D912}		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if	D935		

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applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observation, interviews, and record review, the facility failed to assure 1 of 5 staff (Interim Executive Director) met the qualifications and requirements to perform medication aide duties and administer medications.

The findings are:

Observations of the Interim Executive Director (IED) on 10/13/2015 at 11:45am revealed:
-The IED came out of the medication room with a clear plastic cup filled ¾ full of a clear liquid substance. There was a straw inside the cup of liquid. Staff B moved swiftly down the hall and into room 106.

Interview with Staff A, Medication Aide on 10/13/2015 at 11:45am, who remained in the medication room at the medication cart revealed:
-Staff A had just prepared Dilaudid (a controlled drug used to treat pain) for administration to Resident #1, at the request of the IED.
-Staff A gave the Dilaudid to the IED to administer to Resident #1.
-The IED came into the medication room and asked Staff A if Resident #1 had been

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D935	Continued From page 31 administered his prn (as needed) medication for pain. -Staff A replied "no" to the IED. -The IED asked Staff A if Staff A could "pull it" and Staff A replied "yes". -The IED told Staff A that she (IED) would take the medication down to Resident #1. -Staff A unlocked the controlled drug box, pulled the medication, put it in a clear plastic medicine cup, and handed it to the IED. -Staff A did not know if Resident #1 took the medicine and stated could not say he took the medicine because she (Staff A) was not in the room to witness it. Review of the IED's personnel file revealed: -The IED was hired 12/15/14. -The was no documentation the IED had completed Medication Aide training. -There was no documentation the IED had taken/passed the Medication Aide test. -There was no documentation the IED had completed diabetic or annual infection control training. -There was no documentation the IED had been validated by a licensed health professional to administer medications. -There was no documentation the IED had previously worked as a MA. Review of Resident #1's October 2015 MARs revealed: -Entry for "Hydromorphone/Dilaudid 2 mg. Take 4 tabs (8 mg.) by mouth every 4 hours as needed for pain." -The MA documented administering Dilaudid to Resident #1 at 11:45 a.m. on 10/13/15 "for pain." -The IED's initials and/or signature were not found on any section or page of Resident #1's MAR.	D935		

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Review of the "Controlled Drug Record" for Resident #1's Dilaudid medication revealed:
-The MA documented administering 4 Dilaudid tablets to Resident #1 at 11:45 a.m. om 10/13/15.
-The IED's initials and/or signature were not found on the "Controlled Drug Record."

Confidential staff interview revealed:
-3 staff members recalled the IED had administered medications and controlled substances to 4 named residents.
-Staff observed the MA who was working on the 100 and 200 halls prepare medication for Resident #1.
-Staff observed the IED take the cup with Resident #1's medication in his room (do not know the exact time).
- "I dont think she [IED] is a med tech".
-Resident #1 was 1 of the 4 residents named in the confidential staff interviews.
-The IED administered medication to "a lot of them" [residents].
-The IED administered medication to residents residing in the AL and the Safe Haven units of the facility.
-The IED administered medication "multiple times" to residents.
-The IED administered medications "twice" to residents during breakfast "to help out."
-The IED administered medications that "were made up in the cup for the patient already and she just gave them out. She didn't pop them or anything."

Three confidential resident interviews revealed:
-The IED brings medication to the residents.
-The Medication Aide stands at the medication cart and the IED brings the medication to the resident.

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-"Sometimes the IED gives medicine - think she does it under the nurse - think the nurse gets out what I need and [IED named] just bring it."
-The IED was helpful and she was "in charge".
-The IED had administered the resident medication, but the resident did not remember the dates.
Confidential interviews with the 2 residents named in the confidential staff interviews revealed both residents named in the confidential staff interviews recalled being given medication by the IED.

Confidential interview with 2 additional residents (not named in staff interviews) during the survey revealed:
-One resident had received medication from the IED "once or twice."
-Another resident referred to the IED as "the boss" and thought the IED had given them their medication

Additional interview with Staff A at 12:07 p.m. on 10/13/15 revealed Staff A recalled one additional occasion "maybe one day last week" when the IED had asked her for Resident #1's PRN Dilaudid medication and Staff A gave the medication to the IED at that time to administer to Resident #1.

Interview with the IED at 1:11 p.m. on 10/13/15 revealed:
-She had been in the position of IED since "the first week of August" 2015.
-The IED was not credentialed as a licensed health care professional.
-The IED had not completed Medication Aide training and was not a MA.

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-The Resident Care Director (RCD), Resident Care Coordinator (RCC), and MAs are the only employees allowed to administer medications at the facility.
-"I did give [Resident's name] (Resident #1) his medication."
-The IED had been down to talk to Resident #1 earlier in the morning and "he was in pain."
-Resident #1 had asked for the PRN pain medication but "I don't know if he refused to take it for her."
-The IED had asked the MA on duty if she had been able to give Resident #1 his PRN pain medication and the MA said she had not; "So I said I can take care of that for you."
-"I got his PRN medication and took it down and gave it to him."
-The IED had not documented administering the PRN medication on Resident #1's MAR.
-The MA had documented administrating the medication to Resident #1 on his MAR.
-Resident #1 "has taken a liking to me, so I can generally get him to take it or get him to drink. I generally go with the Med Tech and talk to him and ask him to take it."
-The IED denied administering medication to Resident #1 on any other time; "the only time I actually handed him his pill was today."
-The IED denied administering medication to other residents of the facility.
-"I know one resident shouldn't get special treatment, but he is dying."

Review of the "Progress Note" in Resident #1's record dated 10/13/15 at 11:45 signed by the RN/Area Director of Clinical Services revealed "Resident was given his PRN pain medication Dilaudid by a staff member that does not meet the qualifications to administer medications. Family and MD have been notified."

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Interview with the IED on 10/15/15 at 4:25 p.m. revealed:
-The IED did not know that name of the medication she had administered to Resident #1 on 10/13/15; "It's for pain."
-The IED was told to be "all over nursing" to "get it in order."
-The IED had "tried to be up close and personal so I know what is going on."
-It was not unusual for the IED to stand at the medication cart with the MAs while the MAs are administering medications to residents.
-"I am standing and talking; while the MA pops the pill, I pour the water."
-The IED had given water and applesauce to residents "before, while they are waiting, or after they are getting meds."
-The IED did not know why confidential staff and resident interviews revealed the IED had administered medication to residents other than Resident #1.
- "I honestly don't know unless they see the two of us together and I give the water."
-The IED had also administered medication to Resident #1 on another occasion "a week or so ago."
-The IED had not touched or popped the medications off of the card.
-"My thinking was that administering the med was putting it in the cup and not necessarily giving it to the resident and watching them take it."
-It was the facility expectation that the person dispensing and administering a medication is supposed to sign the MAR after the resident takes the medication.
-The IED had not signed Resident #1's MARs when she administered his medications.
-"I understand it is out of my scope to give

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medications."
-"It will not happen again."

Review of the facility's "Medication Management Plan" policy revealed:
-"All licensed nursing staff (RN/LPN), Registered Medication Aides, medication administration staff who are not licensed by the State must meet qualification requirements prior to administering medications to residents."
-"Staff who administer medication... shall provide documentation of successfully completing the clinical skills validation portion of the competency evaluation prior to the administration...of medications."

Interview with the IED on 10/15/15 at 4:55 p.m. revealed:
-All MAs working in the facility received orientation and training on the "Medication Management Plan" policy.
-All MAs received an orientation packet containing the "Medication Management Plan" policy and signed for receipt of the policy.

____
The facility submitted the following Plan of Protection on 10/13/2015:
-Ongoing training and development will be provided by the Regional/Corporate Team to ensure the Administrator fully understands her role.
-All staff will be trained on the role of the medication aide versus other team members.
-The Administrator/IED stated she would not be involved in the medication administration process.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2015.

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