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THE CROSSINGS AT WAYSIDE	**8398 FAYETTEVILLE ROAD RAEFORD, NC 28376**

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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 on 02/10/16 - 02/12/16.	{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: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in death, serious physical harm, abuse, neglect or exploitation. THIS IS A TYPE A1 VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 9 residents (#7, #8, #9) observed during the medication passes, including errors with insulin (#8) and prn (as needed) lubricant eye drops (#9) and a resident (#7) who received another resident's medications for heart/high blood pressure, depression, and tremors and 1 of 6 residents (#6) sampled for record review related to a resident (#6) who received another resident's	{D 358}		

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medications for heart/blood pressure, Alzheimer's disease, depression, lowering triglycerides, and calcium and vitamin supplements. The findings are:

1. The medication error rate was 47% as evidenced by the observation of 16 errors out of 34 opportunities during the 8:00 a.m./9:00 a.m. and 11:30 a.m./12:00 noon medication passes on 02/11/16.

A. Observation of the 9:00 a.m. medication pass on the Safe Haven side of the facility on 02/11/16 revealed:
- The medication aide administered medications to a resident at 9:11 a.m. and another resident at 9:26 a.m.
- The medication aide then pointed at a name printed on the bottom of a page of the medication administration record (MAR) and stated she was going to administer medications to Resident #6.
- The medication aide stated she had to check the resident's blood pressure.
- The medication aide walked to the common living room where multiple residents were sitting and took the blood pressure of a resident she identified as Resident #6.
- The resident's blood pressure was 106/59 and her pulse was 53.
- The medication aide then pulled 6 different medications, crushed the pills and put them in applesauce.
- She took the medication and walked to the common living room and again walked up to the same resident she identified as Resident #6 and called the resident by her first name.
- The resident responded by looking at the medication aide when the name was called.
- The medication aide then administered the medications at 9:43 a.m. to the resident she had

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identified as Resident #6.
- The medications administered included: Norvasc 10mg, Lisinopril 40mg, Hydralazine 25mg, and Toprol XL 50mg (all for heart/blood pressure); Primidone 50mg ½ tablet (for tremors/seizures); and Zoloft 100mg 1 and ½ tablets (an antidepressant).
- All medications administered, including Toprol XL, were crushed. (Toprol XL is an extended-release medication and should not be crushed.
- The medication aide returned to the medication cart and initialed the MARs indicating she had administered the medications to Resident #6.

Review of the February 2016 MARs on 02/11/16 at 1:10 p.m. revealed:
- There were resident photos located in plastic sleeves in front of each residents' MARs.
- The photo in front of the MARs for Resident #6 did not match the resident who was observed by surveyors to receive Resident #6's medications at 9:43 a.m.
- The photo had Resident #6's name written on it.
- There was a photo in front of Resident #7's MAR that matched the resident who was administered Resident #6's medications during the observed medication pass at 9:43 a.m.
- Resident #6 and Resident #7 had the same first name.

Observation and interview with the medication aide on 02/11/16 at 1:15 p.m. revealed:
- Surveyor asked the medication aide to take them to and identify Resident #6.
- She looked in the common living room and stated she did not see Resident #6.
- The medication aide walked all the way down the hall looking for Resident #6's name labeled

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{D 358}	Continued From page 3 outside the rooms but could not find it. - She had walked past it and saw it when she came back up the hall. - She knocked on the door but no one answered. - The medication aide then took her set of keys and started to unlock the door labeled with Resident #6's name. - A resident sitting in the common living room stood up and yelled that was her room and she did not want the medication aide to go in the room. - The resident who stood up (Resident #6) was not the same resident observed to get medications listed on the MAR for Resident #6 during the morning medication pass. - At that time, the medication aide realized the resident she thought was Resident #6 was not Resident #6 but actually Resident #7. - The medication aide stated she had worked at the facility for 2 weeks and she had trained with other medication aides. - She usually looked at the pictures of the residents in the MAR book to help identify the residents but she did not look at the pictures this morning. - She did not know why she did not look at the pictures this morning. - She stated, "I missed it." - She thought she got the residents confused because they had the same first name. - She stated prior to the surveyor's observing the medication pass, she had already given medications to Resident #6 that she now realized belonged to Resident #7. - She stated when the surveyor's observed her, she actually gave Resident #6's medications to Resident #7, thinking she was the other resident. - She knew which medications she could crush by watching the other medication aides that she trained with and she was not aware of a Do Not	{D 358}		

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Crush List.
- She did not realize Toprol XL should not be crushed.

Observation of Resident #7 with the medication aide on 02/11/16 at 1:25 p.m. revealed:
- Resident #7 was lying on her back on the bed with her eyes open.
- The resident was non-verbal when asked questions.
- The medication aide stated she would take her vital signs and notify the nurse.

Interview with the Administrator and Director of Clinical Services / Registered Nurse (RN) on 02/11/16 at 1:35 p.m. revealed:
- The RN would assess the residents immediately and get help accordingly.
- The medication aide was new and should use the photos in the MAR books to identify the residents.

Observation on 02/11/16 at 2:05 p.m. revealed emergency medical services (EMS) personnel came into the facility and went to Resident #7's room.

Interview with the Administrator on 02/11/16 at 2:10 p.m. revealed they were going to send Resident #7 to the hospital as a precaution.

Observation of the EMS personnel on 02/11/16 at 2:20 p.m. revealed:
- One of the EMS staff came out of Resident #7's room.
- He stated she would be an ICU (intensive care unit) patient.

Interview with the Director of Clinical Services / RN on 02/11/16 at 2:22 p.m. revealed:

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{D 358}	Continued From page 5 - She had checked Resident #7's vital signs prior to EMS arriving at the facility. - When she checked, the blood pressure was 96/60 and the pulse was 52. - When EMS checked the resident's blood pressure it was 70/50. - She saw a pulse ox of 98% on the EMS monitor and the pulse rate was 54. Review of Resident #7's weekly vital sign flow sheet for January and February 2016 revealed: - The resident's blood pressure ranged from 106/72 - 148/72. - The resident's pulse ranged from 60 - 84. Interview with the medication aide on 02/11/16 at 2:54 p.m. revealed: - She was being shadowed by another medication aide last week when she administered medications as part of her training. - This was the first time she had administered medications to the residents in the Safe Haven side of the facility on her own. Interview with the Director of Clinical Services / RN on 02/11/16 at 5:50 p.m. revealed: - She called the hospital to check on Resident #7. - The nurse at the hospital reported the last blood pressure check they did on Resident #7 was 111/43. - She would call back later with more information. Interview with the Director of Clinical Services / RN on 02/12/16 at 9:04 a.m. revealed: - She had contacted the hospital to check on Resident #7. - Hospital staff reported the resident was still in the emergency room. - The resident's blood pressure was now stable	{D 358}		

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at 106/53 and heart rate was currently 57.
- There were having trouble keeping the resident's heart rate up.
- The resident's heart rate had been fluctuating and dropping in the 30's.
- The resident was receiving intravenous medication to increase her heart rate.
- They planned to move the resident to the intensive care unit for acute monitoring.

Interview with a second medication aide on 02/12/16 at 11:10 a.m. revealed:
- She helped train the new medication aide who administered morning medications on 02/11/16.
- She always taught new staff to check the residents' photos in the MAR books when administering medications to help identify the residents.
- She worked with the new medication aide on the medication cart for 2 days.
- They worked together on the cart one day in the Safe Haven side of the facility and one day on the other side of the facility.
- When she observed during the training, the new medication aide used the photos during medication administration.
- All new medication aides are trained to use the photos to identify the right resident.
- Resident #7 was still in the hospital.

Review of Resident #7's current FL-2 dated 06/04/15 revealed:
- The resident's diagnoses included bradycardia (slow heart rate), anemia, urinary tract infection, mechanical fall, acute kidney injury, and Non-ST elevation myocardial infarction (heart attack).
- The resident was oriented to person but not oriented to place or time.
- The resident was noted to have wandering behavior.

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{D 358}	Continued From page 7 Review of Resident #7's current FL-2 dated 06/04/15 revealed: - There was an order for Norvasc 2.5mg daily. (Norvasc lowers blood pressure and heart rate.) - There was an order for Lexapro 5mg daily. (Lexapro is an antidepressant.) - There was an order for Folic Acid 0.5mg daily. (Folic Acid is a Vitamin B supplement.) - There was an order for Namenda 10mg twice daily. (Namenda is used to treat moderate to severe Alzheimer's disease.) - There was an order for Theragran-M 1 tablet daily. (Theragran-M is a multivitamin.) - There was an order for Vitamin D 400 units twice daily. (Vitamin D is a supplement used for low Vitamin D levels.) Review of physician's orders dated 11/12/15 for Resident #7 revealed: - There was an order for Aspirin 81mg once daily. (Aspirin may be used to prevent heart disease.) - There was an order for Calcium with Vitamin D 600/400 take 1 twice daily. (Calcium with Vitamin D is supplement used to prevent osteoporosis.) - There was an order for Fish Oil 1000mg twice daily. (Fish oil is used to lower triglycerides.) Observation of the 9:00 a.m. medication pass on 02/11/16 revealed: - Resident #7 did not receive 8 medications ordered by her physician including: Lexapro, Folic Acid, Namenda, Theragran-M, Vitamin D, Aspirin, Calcium with Vitamin D, and Fish Oil. - Resident #7 received Norvasc 10mg (belonged to Resident #6) instead of Norvasc 2.5mg as ordered for Resident #7. - Resident #7 received 5 medications in addition to the Norvasc 10mg that belonged to Resident	{D 358}		

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#6 including: Lisinopril, Toprol XL, Primidone, Zoloft, and Hydralazine.

Attempts to contact Resident #7's physician during the survey were unsuccessful.

B. Review of Resident #8's current FL-2 dated 01/22/16 revealed:
-The resident's diagnoses included iron deficiency anemia secondary to blood loss, esophageal varices with bleeding, gastrointestinal hemorrhage, repeated falls, and unspecified dorsalgia.

Review of a Physician's order for Resident #8 dated 01/24/16 revealed:
-There was a medication order for finger stick blood sugars (FSBS) before meals and at bedtime and to administer Humalog insulin according to the following scale: 200 - 249 = 2 units; 250 - 299 = 4 units; 300 - 349 = 6 units; 350 - 399 = 8 units; > or equal to 400 = 10 units; and call physician if blood sugar is < 70 or > 400. (Humalog is rapid-acting insulin used to lower blood sugar.)

Review of a Physician's order for Resident #8 dated 02/02/16 revealed:
- There was a medication order to change Humalog insulin to the Novolog Flex-Pen using the same sliding scale. (Humalog was not covered by the resident's insurance. Novolog is rapid-acting insulin use to lower blood sugar and the manufacturer recommends Novolog be given 5 to 10 minutes before eating a meal.)

[According to the Novolog FlexPen manufacturer, the pen should be primed before each injection. A dose of 2 units should be dialed up and hold the pen with the needle pointing up and tap reservoir

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gently to move air bubbles to the top of needle. Press the push button on the syringe as far as it will go until a drop of insulin appears the needle tip. This removes air bubbles and ensures the pen and needle are working properly. (Air bubbles displace the amount of insulin in the syringe and prevents the full dose from being administered.)]

[According to the Novolog FlexPen manufacturer, the needle of the Novolog FlexPen should be held in the skin for at least 6 seconds after the insulin injection to ensure the full dose of insulin has been administered.]

Observation during the 11:30 a.m. medication pass on 02/11/16 revealed:
- The medication aide checked Resident #8's blood sugar at 12:15 p.m. and it was 321.
- She noted the documentation log for insulin administration in the medication administration record (MAR) book had Humalog printed on it instead of Novolog and she went to clarify the documentation log.
- Novolog sliding scale was printed on the February 2016 MAR for Resident #8.
- The medication aide took Resident #8 to the dining room for lunch at 12:20 p.m. and the resident ate approximately 1/3 of her lunch prior to the medication aide returning to the dining room.
- The medication aide returned with the correct Novolog documentation log and took Resident #8 back to her room at 12:26 p.m. and resident went to the bathroom.
- The medication aide dialed up 6 units of insulin using the Novolog FlexPen and injected the insulin into the lower left abdominal quadrant of Resident #8 at 12:35 p.m. and immediately removed the needle from the resident's abdomen

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after the insulin injection.
- The needle of the Novolog FlexPen was not held in the skin for at least 6 seconds after the insulin was injected.
- The medication aide did not prime the Novolog pen with a 2 unit air shot prior to dialing up the 6 units Novolog ordered per sliding scale.
- Resident #8 was administered Novolog insulin 15 minutes after she had started eating instead of before the meal as ordered.
- Resident #8 was taken back to the dining room at 12:37 p.m. to finish her lunch.

Interview with the medication aide on 02/11/16 at 3:20 p.m. revealed:
- She had gotten busy changing out the documentation log for Resident #8.
- She really did not think about giving the Novolog insulin prior to the resident eating lunch today but she knew that the resident needed to eat with the insulin administration.
- She was unaware the order was to give the sliding scale prior to meals but she usually does give the resident her insulin prior to her eating or shortly after the resident starts eating.
- She recalled having insulin pen training at this facility during the summer of 2015.
- She did not remember being trained to use the 2 unit air shot to prime the needle prior to insulin pen administration.
- She was unaware that she needed to hold the needle in the skin for at least 6 seconds after she administered the insulin using the Novolog FlexPen.
- She had diabetes training at this facility but she was unsure of when this training occurred.

Interview with the Director of Clinical Services/Registered Nurse on 02/11/16 at 3:45 p.m. revealed:

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{D 358}	Continued From page 11 - She would review the sliding scale order for Resident #8 and make sure that the medication aides gave the sliding scale as ordered. - Diabetic training had been done on 01/06/16 by the Resident Care Coordinator and the observed medication aide was in that training. - Insulin pens had to be primed prior to insulin administration and the needle had to remain in the skin to complete the insulin administration - She was unaware that medication aides were not priming the insulin pens prior to insulin administration. - Staff had training on how to use the insulin pens but she was unsure if this was covered in the diabetes training done on 01/06/16. - She would make sure the medication aides were educated again on the administration of insulin using insulin pens. - She would work with the medication aides to make sure they understood the medication orders and that insulin was being administered at the correct times using the correct administration procedures. Interview with a second Medication Aide on 02/11/16 at 4:55 p.m. revealed: - She had gotten diabetes training at the facility within the last year. - She did not remember receiving any training on insulin administration using insulin pens at this facility. - She did not prime insulin pens prior to insulin administration. - She removed the needle from the resident's skin immediately after injecting the insulin. Interview with a third medication aide on 02/12/16 at 10:05 a.m. revealed: - She attended a training at 7:30 a.m. on 02/12/16 with the Director of Clinical Services/Registered	{D 358}		

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Nurse on the correct administration of insulin using the Novolog Pen.
- She did not know that insulin pens needed to be primed before insulin administration prior to this training.
- She had not been holding the needle in the skin for at least 6 seconds after insulin pen administration prior to this training.
- She planned to be more careful in reading the medication orders and reviewing the MARs to make sure she was administering medications as ordered for all residents.

Interview with Resident #8 on 02/12/16 at 1:20 p.m. revealed:
- Her blood sugar was usually checked 2-3 times a day.
- She usually got insulin either before she ate or staff would come get her shortly after she started eating.
- Medication aide held in the needle in her skin for a least a minute after administering her insulin but she did not say when this occurred.
- She hasn't noticed any problems with getting her insulin.

Interview with a family member of Resident #8 at 02/12/16 at 1:20 p.m. revealed:
- The resident is supposed to get her blood sugar checked 4 times a day.
- Sometimes the resident's memory was not good at recalling events.
- The resident has gotten her insulin both before she eats and sometimes after she has already started eating.
- He wasn't sure how long the medication aide held the needle in during the insulin administration.

Review of the February 2016 MARs revealed

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Resident #8's blood sugars ranged from 127 to 451.

C. Review of Resident #9's current FL-2 dated 02/03/16 revealed:
- The resident's diagnoses included abdominal pain, nausea, hypertension, schizophrenia, chronic hepatitis C, liver cancer, gastroesophageal reflux disease, hypothyroidism, hypercholesterolemia, and anxiety.

Review of physician's orders for Resident #9 dated 02/09/16 revealed:
- There was a medication order for Artificial Tears 1.4% solution instill 1 drop four times daily as needed (PRN) for dry, itchy eyes. (Artificial Tears is used as a lubricant to relieve dry, irritated eyes.)

Observation during the 12:00 p.m. medication pass on 02/11/16 revealed:
- The medication aide administered 1 drop of Artificial Tear 1.4% solution to each eye of Resident #9 at 12:47 p.m.
- The medication aide did not ask Resident #9 if he had any eye irritation prior to the administration of Artificial Tears.
- Resident #9 did not voice any complaints of eye irritation prior to the administration of Artificial Tears and he did not request any eye drops.
- Medication aide documented on the MAR the administration of the Artificial Tears for Resident #2 for 12:00 p.m.

Review of medications on hand revealed:
- The instructions on the label for the Artificial Tears was to administer 1 drop to each eye four times a day as needed for eye irritation.

Review of the February 2016 medical

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administration record (MAR) for Resident #9 revealed:
- There was computer generated entry for Artificial Tears 1 drop in affected eye(s) 4 times daily as needed for dry/itching eyes.
- Administration times were printed on the MAR at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.
- Artificial Tears were documented as administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. instead of PRN as ordered from 02/01/16 through 02/11/16.

Interview with the Medication Aide on 02/11/16 at 3:35 p.m. revealed:
- She was unaware the Artificial Tears were ordered as needed for Resident #9.
- She gave the Artificial Tears because of the times printed on the MAR for Resident #9.
- She did not notice the instructions on the MAR were for the Artificial Tears to be administered as needed.
- She had always administered the Artificial Tears 1 drop in each eye at the scheduled times.

Interview with Director of Clinical Services/Registered Nurse on 02/11/16 at 3:45 p.m. revealed:
- She was unaware the Artificial Tears were ordered as needed and the medication aides were giving this medication as a scheduled medication.
- The medication aides should be reading all of the MARs prior to administering any medication to the residents.
- The medication aides should go back and review the resident's record if they have any questions about the MARs and contact the Resident Care Coordinator or her if they still have questions or concerns regarding medication orders.

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- She would review the MAR for Resident #9 and clarify which eye(s) to administer the eye drops.

Interview with a second Medication Aide on 02/11/16 at 4:55 p.m. revealed:
- She was not aware the Artificial Tears were ordered as needed for Resident #9.
- She had administered the eye drops at the times printed on the MAR for Resident #9.
- Resident #9 had never complained of eye irritation or asked for the Artificial Tears to be administered.

Interview with Resident #9 on 02/12/16 at 1:30 p.m. revealed:
- He did not really need the Artificial Tears for his eyes.
- He only took the eye drops because the medication aides gave him the eye drops four times a day.
- The facility staff told him on 02/11/16 that the Artificial Tears were ordered as needed and that he would need to ask for the eye drops if he needed them from now on.

2. Review of Resident #6's current FL-2 dated 06/04/15 revealed:
- The diagnoses included severe dementia, hypertension, tremors, depression, and insomnia.
- The resident was constantly disoriented.
- There was an order for Toprol XL 50mg daily. (Toprol XL lowers blood pressure and heart rate.)
- There was an order for Lisinopril 40mg daily. (Lisinopril lowers blood pressure and heart rate.)
- There was an order for Norvasc 10mg daily. (Norvasc lowers blood pressure and heart rate.)
- There was an order for Hydralazine 25mg 3 times a day. (Hydralazine lowers blood pressure and heart rate.)

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- There was an order for Primidone 50mg ½ tablet daily. (Primidone is used to treat and prevent seizures but may also be used to treat tremors.)
- There was an order for Zoloft 100mg take 1 and ½ tablets (150mg) daily. (Zoloft is an antidepressant.)

Review of the February 2016 MARs on 02/11/16 at 1:10 p.m. revealed:
- There were resident photos located in plastic sleeves in front of each residents' MARs.
- The photo in front of the MARs for Resident #6 did not match the resident who was observed by surveyors to receive Resident #6's medications at 9:43 a.m.
- The photo had Resident #6's name written on it.
- There was a photo in front of Resident #7's MAR that matched the resident who was administered Resident #6's medications during the observed medication pass at 9:43 a.m.
- Resident #6 and Resident #7 had the same first name.

Observation and interview with the medication aide on 02/11/16 at 1:15 p.m. revealed:
- At that time, the medication aide realized the resident she thought was Resident #6 was not Resident #6 but actually Resident #7.
- She stated prior to the surveyor's observing the medication pass, she had already given Resident #6 medications that she now realized belonged to Resident #7.
- She stated when the surveyor's observed her she actually gave Resident #6's medications to Resident #7, thinking she was the other resident.

Interview with the Administrator and Director of Clinical Services / Registered Nurse (RN) on

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{D 358}	Continued From page 17 02/11/16 at 1:35 p.m. revealed: - The RN would assess the residents immediately and get help accordingly. - The medication aide was new and should use the photos in the MAR books to identify the residents. Interview with the Administrator on 02/11/16 at 2:10 p.m. revealed: - They checked Resident #6's blood pressure around 1:40 p.m. and it was 141/70 and her pulse was 64. - They contacted Resident #6's physician and they were supposed to monitor the resident. - The Resident Care Coordinator was going to relieve the medication aide and take over administering the medications. Review of Resident #6's blood pressure flow sheet revealed the resident's blood pressure ranged from 104/64 - 190/82 from 02/01/16 - 02/12/16. Observation and interview of Resident #6 on 02/11/16 at 5:00 p.m. revealed: - She was in the dining room eating supper. - She stated she was doing "okay" and "about the same". Interview with a medication aide / personal care aide on 02/11/16 at 5:00 p.m. revealed: - The staff had been monitoring Resident #6. - Resident #6 seemed okay but she was usually more talkative. - Resident #6 seemed more quiet than normal. Review of the February 2016 MAR revealed: - There were 9 medications prescribed to Resident #7 that were actually administered to Resident #6 on the morning of 02/11/16.	{D 358}		

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- Eight of the medications included: Lexapro 10mg (an antidepressant), Folic Acid (a Vitamin B supplement), Namenda (for Alzheimer's disease), Theragran-M (a multivitamin), Vitamin D (a supplement for low Vitamin D levels), Aspirin (for prevention of heart disease), Calcium with Vitamin D (supplement to prevent osteoporosis), and Fish Oil (lowers triglycerides).
- The ninth medication prescribed for Resident #7 was Norvasc 2.5mg but Resident #6 was prescribed Norvasc 10mg.
- Resident #6 did not receive 5 medications prescribed for her in addition to the Norvasc 10mg that she was ordered to receive.
- The other 5 medications that Resident #6 did not receive during the 9:00 a.m. medication pass on 02/11/16 included: Lisinopril 40mg, Toprol XL 50mg, Hydralazine 25mg (all for heart/blood pressure); Primidone (for tremors/seizures); and Zoloft (an antidepressant).

Observation and interview of Resident #6 on 02/12/16 at 11:17 a.m. revealed:
- She was sitting in the common living room.
- She was doing "okay".
- She was "about the same".
- She has good days and bad days.

Interview with a medication aide on 02/12/16 at 11:10 a.m. revealed:
- She helped train the new medication aide who administered morning medications on 02/11/16.
- She always taught new staff to check the residents' photos in the MAR books when administering medications to help identify the residents.
- She worked with the new medication aide on the medication cart for 2 days.
- They worked together on the cart one day in the Safe Haven side of the facility and one day on the

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other side of the facility.
- When she observed during the training, the new medication aide used the photos during medication administration.
- All new medication aides are trained to use the photos to identify the right resident.
- Resident #6 was "fine" this morning but the resident told the medication aide that she was tired.

Attempts to contact Resident #6's physician during the survey were unsuccessful.

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Review of the facility's plan of protection dated 02/11/16 revealed:
- Administrator or designee removed the medication aide from passing medications upon notification of the medication error.
- The medication aide will be retrained and observed for two medication passes prior to resuming medication aide duties.
- A "Do Not Crush" medication list was placed in front of the MAR books.
- They immediately sent resident (Resident #7) who was given the wrong medication to the emergency room for medical evaluation.
- Area Director of Clinical Services assessed other resident's (Resident #6) vital signs which were checked.
- Resident #6's primary care provider was contacted and they were advised to monitor for any change in condition.
- Administrator or designee will meet with all medication aides prior to their shift and accepting keys to the cart to clearly review the "Do Not Crush" medication list and ensure they are following the six rights of medication administration.
- They will begin an immediate in-service with all

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{D 358}	Continued From page 20 medication aides by the Area Director of Clinical Services and / or designee on insulin pens and insulin administration. - This in-service is to include the importance of actually verifying that the right medication is given to the right resident by use of a picture. - They will immediately begin a MAR to cart, MAR to chart audit completed by Administrator and / or designee. - Administrator will contact pharmacy for a pharmacy review. - Random chart audits will be conducted monthly and ongoing. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 13, 2016.	{D 358}		
{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 regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to medication administration. The findings are: Based on observation, interview, and record review, the facility failed to assure medications	{D912}		

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{D912}	Continued From page 21 were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 9 residents (#7, #8, #9) observed during the medication passes, including errors with insulin (#8) and prn (as needed) lubricant eye drops (#9) and a resident (#7) who received another resident's medications for heart/high blood pressure, depression, and tremors and 1 of 6 residents (#6) sampled for record review related to a resident (#6) who received another resident's medications for heart/blood pressure, Alzheimer's disease, depression, lowering triglycerides, and calcium and vitamin supplements. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A1 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	{D935}		

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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 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:
FOLLOW-UP TO TYPE B VIOLATION

The Type B Violation was abated.
Non-compliance continues.

Based on interviews and record reviews, the facility failed to assure 1 of 5 medication aides (Staff C) sampled who administered medications had passed the medication aide written exam within 60 days from the hire date. The findings are:

Review of Staff C's personnel file revealed:
- Staff C was hired on 05/05/15 as a medication

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aide / nursing aide.
- Staff C was listed on the N.C. Medication Aide Registry with an expiration date of 09/30/16.
- Staff C had completed the medication administration clinical skills checklist on 05/15/15.
- There was no documentation of Staff C passing the written medication aide exam.

Review of the December 2015 - February 2016 medication administration records (MARs) revealed:
- Staff C documented the administration of medications on 16 of 31 days in 12/2015.
- Staff C documented the administration of medications on 16 of 31 days in 01/2016.
- Staff C documented the administration of medications on 3 of 11 days in 2/2016.

Interview with the Administrator and the Business Office Manager on 02/12/16 at 1:55 p.m. revealed:
- They usually do a pre-employment checklist for all new employees.
- They thought the medication aide written exam was checked off in error for Staff C.
- Staff C had a form indicating she was listed on the Medication Aide Registry.
- They thought this form was mistaken as the confirmation of Staff C having passed the written medication aide exam.
- It was an oversight.
- They were trying to contact Staff C about the medication aide exam but had not heard back from Staff C yet.

Attempts to contact Staff C during the survey on 02/12/16 were unsuccessful.