Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **CARILLON ASSISTED LIVING OF KNIGHTDALE** | **2408 HODGE ROAD KNIGHTDALE, NC 27545** |

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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on June 5, 2018 through June 8, 2018 with an exit conference via telephone on June 11, 2018. | {D 000} | | |
| {D 358} | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 5 of 6 residents (#8, #9, #10, #11 and #12) observed during the medication pass; and 4 of 7 sampled residents (#3) with missed doses of pain medications resulting in the resident (#3) suffering severe pain due to multiple missed doses of pain medications, and 3 residents (#6, #7, #13) where their medications which included a narcotic were left in medications cups on the dining room table.<br><br>The findings are:<br><br>1. The medication error rate was 29% as evidenced by the observation of 10 errors out of | {D 358} | | |

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34 opportunities during the 8:00am and 9:00am medication passes on 06/06/18.

a. Review of Resident #13's current FL-2 dated 12/19/17 revealed:
-Diagnoses included dementia, depression, anxiety, left quadrant abdominal pain, peripheral arterial disease, hypertension, coronary artery disease, osteoporosis, kyphosis, and esophageal ulceration.
-There was an order for Miralax 17gm - 1 capful mixed with 6 ounces of liquid once daily (Miralax is used to treat constipation).

Observation of the morning medication pass on the assisted living unit of the facility on 6/06/18 at 8:00am revealed:
-The medication aide (MA) mixed 1 capful of Miralax in approximately 8 ounces of water in a cup for Resident #13.
-The MA took the cup containing the Miralax mixture to the dining room area where Resident #13 was sitting.
-The MA placed the cup with the Miralax mixture on right side of the table next Resident #13 and instructed Resident #13 to drink the mixture with her breakfast at 8:05am.
-The MA left the dining room without verifying Resident #13 took the Miralax mixed in the cup.
-Seven other residents were present in the dining room area for breakfast.
-No MAs (MAs) were present in the dining room.

Interview with the MA on 06/06/18 at 8:06am revealed:
-She normally left medications with residents if they were not ready to take the medications right away.
-She did not see any problem with leaving the Miralax mixture with "Resident #13 because she

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was going to drink water with her breakfast anyway".

Interview with Resident #13 on 06/06/18 at 8:07am revealed:
-The MA left what looked like water in a cup for her to drink with her breakfast on 06/06/18.
-The water tasted "funny" so Resident #13 didn't believe it was water in the cup the MA left for her on 06/06/18.
-"It's that medicine that made her go to the bathroom so much and she didn't like to take".
-She was not going to drink the medicine mixture.
-The MAs mixed "the bathroom medicine in her water" a lot, but Resident #13 was not able to specify how often or when this was done.

Interview with the Resident Care Coordinator (RCC) on 06/06/18 at 8:10am revealed:
-She was not aware the MA had left Miralax mixture at the dining room table for Resident #13 to take.
-The MAs were expected to watch the residents to make sure medications were administered.
-"The MA for Resident #13 was new and just probably forgot to make sure Resident #13 took the Miralax".
-The RCC would make sure Resident #13 took the Miralax mixture with her breakfast.
-The RCC would follow-up with the MA to make sure no other medications were left unattended with the residents.

Observation of the dining room on the assisted living unit of the facility on 06/06/18 at 8:17am revealed:
-The MA returned and removed the Miralax mixture from the table where Resident #13 was seated.
-One-fourth of the Miralax mixture remained in

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the cup.

Second interview with the MA on 06/06/18 at 8:20am revealed:
-She had just started working as a MA at the facility about 2 weeks ago.
-She did not think it was a problem leaving the Miralax with Resident #13 because it was just mixed with water and she had to give medications to other residents.
-She had been trained that medications were not to be left unattended with residents during medication administration.
-Resident #13 drank most of the medication that was mixed in the cup and the MA had removed the cup with medication from the dining room area.
-The MA documented on Resident #13's electronic medication administration record (eMAR) that she had administered Miralax to Resident #13 on 06/06/18.

Review of Resident #13's June 2018 eMAR revealed:
-There was an entry for Miralax 17gm and it was scheduled for administration at 8:00am.
-There was documentation of administration of Miralax to Resident #13 on 06/06/18 at 8:00am.

Interview with a second MA in the Special Care Unit on 06/06/18 at 9:15am revealed:
-She had been working at the facility since January 2018.
-It was part of the facility's medication administration policy that staff should observe residents taking their medications to ensure the medications were administered entirely to the right resident.

Interview with the Executive Director (ED) on

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06/06/18 at 3:20pm revealed:
-No MAs should be leaving any medications at the dining room table.
-The facility had a few new MAs who may need a little more training.
-The RCC usually worked with making sure the MAs were trained and she would follow-up with the RCC.

b. Review of Resident #8's current FL-2 dated 02/01/18 revealed:
-Diagnoses included Alzheimer's disease, essential hypertension, hyperthyroidism, and urinary tract infection.
-There were orders for Gabapentin 100mg 3 times a day and Acetaminophen 500mg 3 times a day
(Gabapentin is used to treat nerve pain and prevent seizures and Acetaminophen is used to treat mild to moderate pain.).

Review of a physician's order for Resident #8 dated 05/08/18 revealed a medication order for Lorazepam 0.5mg twice a day (Lorazepam is used to treat anxiety).

Review of Resident #8's June 2018 electronic administration record (eMAR) revealed:
-There was an entry for Acetaminophen 500mg 3 times a day and it was scheduled for 8:00am, 2:00pm, and 8:00pm.
-There was an entry for Gabapentin 100mg 3 times a day and it was scheduled for 8:00am, 2:00pm, and 8:00pm.
-There was an entry for Lorazepam 0.5mg 2 times daily and it was scheduled to be administered at 8:00am and 2:00pm.

Observation of the morning medication pass on the SCU on 06/06/18 revealed the MA

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administered Resident #8's Acetaminophen, Gabapentin, and Lorazepam at 9:17am, approximately 1 hour and 17 minutes past the scheduled time.

Review of the facility's medication off schedule report form dated 06/06/18 for Resident #8 revealed:
-The 8:00am doses of Acetaminophen, Gabapentin, and Lorazepam were documented as administered at 9:19am.
-The 8:00am doses of Acetaminophen, Gabapentin, and Lorazepam were administered 1 hour and 19 minutes after their scheduled times.

Review of the facility's orders administered report form dated 06/06/18 for Resident #8 revealed:
-The 2:00pm doses of Acetaminophen, Gabapentin, and Lorazepam were documented as administered at 1:12pm.
-The 8:00am and 2:00pm doses of Acetaminophen, Gabapentin, and Lorazepam were administered 3 hours and 53 minutes apart.

Based on observation, interview, and record review, it was determined Resident #8 was not interviewable.

Refer to interview with the medication aide (MA) in the SCU on 06/06/18 at 9:07am.

Refer to interview with the same MA who was passing medications on 06/06/18 at 9:35am.

Refer to interview with the RCC on 06/06/18 at 11:47am.

Refer to interview with the Executive Director (ED) on 06/06/18 at 3:20pm.

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c. Review of Resident #9's current FL-2 dated 08/29/17 revealed diagnoses included memory loss, hyperlipidemia, and early stage dementia.

Review of physician's orders for Resident #9 revealed:
-There was a medication order for Memantine 5mg 2 times daily dated 11/14/17 (Memantine is used to treat moderate to severe confusion (dementia).)
-There was a medication order for Divalproex DR 250mg 2 times daily dated 11/16/17 (Divalproex DR is used to treat seizure disorders, certain psychiatric conditions, and to prevent migraine headaches.).

Review of Resident #9's June 2018 eMAR revealed:
-There was an entry for Memantine 5mg 2 times daily and scheduled for 8:00am and 8:00pm.
-There was an entry for Divalproex DR 250mg 2 times daily and scheduled for 8:00am and 8:00pm.

Observation of the morning medication pass on the SCU on 06/06/18 revealed the MA administered Resident #9's Memantine and Divalproex at 9:29am, approximately 1 hour and 29 minutes past the scheduled time.

Review of the facility's medication off schedule report form dated 06/06/18 for Resident #9 revealed:
-The 8:00am doses of Memantine and Divalproex DR were documented as administered at 9:30am.
-The 8:00am doses of Memantine and Divalproex DR were administered 1 hour and 30 minutes after their scheduled times.

Based on observation, interview, and record

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review, it was determined Resident #9 was not interviewable.

Refer to interview with the medication aide (MA) in the SCU on 06/06/18 at 9:07am.

Refer to interview with the same MA who was passing medications on 06/06/18 at 9:35am.

Refer to interview with the RCC on 06/06/18 at 11:47am.

Refer to interview with the Executive Director (ED) on 06/06/18 at 3:20pm.

d. Review of Resident #10's current FL-2 dated 06/14/17 revealed:
-Diagnoses included dementia without behaviors, Alzheimer's disease, left femur fracture, presence of artificial left hip joint, insomnia, and history of malignant breast neoplasm.
-There was a physician's order for Vitamin D3 1000 units once daily (Vitamin D3 is a nutritional supplement.).

Review of Resident #10's June 2018 eMAR on 06/06/18 at 9:35am revealed:
-Vitamin D3 1000 units was scheduled once daily at 8:00am.
-There was no documentation that Vitamin D3 had been administered.

Observation of the morning medication pass on the SCU on 06/06/18 revealed the MA did not administer Resident #10's Vitamin D at 9:35am.

Observation of medications on hand for Resident #10 revealed on 06/06/18 at 9:34am there was no Vitamin D3 available on the medication cart for Resident #10.

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| {D 358} | Continued From page 8<br><br>Review of the facility's medication off schedule report form dated 06/06/18 for Resident #10 revealed Vitamin D3 was not documented as administered on 06/06/18 at 11:02am.<br><br>Interview with the same MA that was administering the medication pass on 06/06/18 at 9:35am revealed:<br>-She would contact the pharmacy to reorder Resident #10's Vitamin D3 for the medication cart.<br>-The Vitamin D3 should have been reordered when Resident #10 was down to a week supply.<br><br>Interview with RCC on 06/06/18 at 10:20am revealed:<br>-She did not know the Vitamin D3 was not available on the medication cart for Resident #10.<br>-The MAs were supposed to reorder the medication when a resident's medication supply was down to 7 to 10 days.<br>-She would contact the pharmacy to have the Vitamin D3 refilled as soon as possible.<br>-She would follow up with the medications aides to make sure medications were being reordered in a timely manner so residents did not run out of medications.<br><br>Review of physician's orders for Resident #10 revealed there was a medication order for Cetaphil moisturizing lotion apply 2 times daily to the face dated 01/23/2018. (Cetaphil is used to treat dry skin.)<br><br>Review of Resident #10's June 2018 eMAR revealed:<br>-There was an entry for Cetaphil moisturizing lotion apply 2 times daily to the face was scheduled for 8:00am and 8:00pm. | {D 358} | | |

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-There was documentation that the 8:00am dose of Cetaphil was administered.

Observation of the morning medication pass on the SCU on 06/06/18 revealed the MA administered Resident #10's Cetaphil lotion at 9:35am, approximately 1 hour and 35 minutes past the scheduled time.

Review of the facility's medication off schedule report form dated 06/06/18 for Resident #10 revealed the 8:00am dose of Cetaphil was documented as administered at 9:36am, approximately 1 hours and 36 minutes after its scheduled time.

Based on observation, interview, and record review, it was determined Resident #10 was not interviewable.

Refer to interview with the medication aide (MA) in the SCU on 06/06/18 at 9:07am.

Refer to interview with the same MA who was passing medications on 06/06/18 at 9:35am.

Refer to interview with the RCC on 06/06/18 at 11:47am.

Refer to interview with the Executive Director (ED) on 06/06/18 at 3:20pm.

e. Review of Resident #11's current FL-2 dated 09/11/17 revealed diagnoses included dementia with memory loss, depressive disorder, essential hypertension, hyperlipidemia, osteoporosis, carotid artery occlusion, cholecystectomy, and degenerative macular disease.

Review of physician's orders for Resident #11

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dated 11/30/17 revealed a medication order for Divalproex ER 500mg 2 times daily. (Divalproex ER is used to treat seizure disorders, certain psychiatric conditions, and to prevent migraine headaches.)

Review of Resident #11's June 2018 eMAR revealed:
-There was an entry for Divalproex ER 500mg 2 times daily and it was scheduled for 8:00am and 8:00pm.
-There was documentation Divalproex ER was administered at 8:00am.

Observation of the morning medication pass on the SCU on 06/06/18 revealed the MA administered Resident #11's Divalproex at 9:54am, approximately 1 hour and 54 minutes past the scheduled time.

Based on observation, interview, and record review, it was determined Resident #11 was not interviewable.

Refer to interview with the medication aide (MA) in the SCU on 06/06/18 at 9:07am.

Refer to interview with the same MA who was passing medications on 06/06/18 at 9:35am.

Refer to interview with the RCC on 06/06/18 at 11:47am.

Refer to interview with the Executive Director (ED) on 06/06/18 at 3:20pm.

f. Review of Resident #12's current FL-2 dated 01/02/18 revealed:
-Diagnoses included dementia, abnormality of gait and mobility, chronic pain, chronic sinusitis,

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diverticulitis of the small intestine, insomnia, gastroesophageal reflux, and hypertension.
-There was a physician's order for memantine 10mg - 2 times daily. (Memantine is used to treat moderate to severe confusion (dementia).)

Review of physician's orders for Resident #12 dated 02/26/18 revealed a medication order for Fanny cream apply to affected 4 times a day (Fanny cream is used prevent skin irritation and diaper rash.)

Review of Resident #12's June 2018 eMAR revealed:
-There was an entry for Memantine 10mg two times daily and it was scheduled for 8:00am and 8:00pm.
-Memantine 10mg was documented as administered at 8:00am.
-There was an entry for Fanny cream 4 times daily and scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Fanny cream was documented as administered at 8:00am.

Observation of the morning medication pass on the SCU on 06/06/18 revealed the MA administered Resident #12's Memantine and Fanny cream at 10:08am, approximately 2 hours and 8 minutes past the scheduled time.

Review of the facility's medication off schedule report form dated 06/06/18 for Resident #12 revealed:
-The 8:00am doses of Memantine and Fanny cream were documented as administered at 10:09am.
-The 8:00am doses of Memantine and Fanny cream were administered 2 hours and 9 minutes after their scheduled times.

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Review of the facility's orders administered report forms for Resident #12 dated 06/06/18 revealed the 12:00pm dose of Fanny cream was administered to Resident #12 at 11:17am by the same MA, approximate 1 hour and 9 minutes after 8:00am dose was given.

Based on observation, interview, and record review, it was determined Resident #12 was not interviewable.

Telephone interview with a nurse with Resident #12's physician's office on 06/07/18 at 10:30am revealed:
-No communication had been received from the facility regarding any late medication administration for Resident #12 on 06/06/18.
-She would follow-up with the physician for his expectations for the late medication administrations.

Refer to interview with the medication aide (MA) in the SCU on 06/06/18 at 9:07am.

Refer to interview with the same MA who was passing medications on 06/06/18 at 9:35am.

Refer to interview with the RCC on 06/06/18 at 11:47am.

Refer to interview with the Executive Director (ED) on 06/06/18 at 3:20pm.

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Interview with the medication aide (MA) in the SCU on 06/06/18 at 9:07am revealed:
-She was the only MA working in the SCU on 06/06/18.
-She was late administering 8:00am medications to the residents.

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-She was slow in administering medications because she was a new MA and she "wanted to be extra careful to administer the medications correctly to the residents".

Interview with the same MA who was passing medications on 06/06/18 at 9:35am revealed:
-She had been in medication aide training since March 2018 and she worked with another MA during medication administration.
-She was supposed to shadow with another MA on 06/06/18 but she ended up working the medication cart alone in the SCU.
-She was "afraid of making mistakes" with the medications which made her nervous and it took her longer to administer medications to the residents.

Interview with the RCC on 06/06/18 at 11:47am revealed:
-The RCC came to work between 8:00am - 8:30am and she saw the MA working the medication cart alone in the SCU.
-She did not know the MA had been administering the medications to the residents late on the morning of 06/06/18 in the SCU.
-She would be assisting the MA in the SCU for the remainder of the 7:00am -3:00pm shift on 06/06/18.
-It was expected for the MA to administer medications to the residents one hour before or one hour after their scheduled times.

Interview with the Executive Director (ED) on 06/06/18 at 3:20pm revealed:
-She had spoken with the RCC and they would be contacting the residents' physicians about the late medication administration in the SCU for 8:00am/9:00am medication passes.
-She was not aware there was any problems with

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| {D 358} | Continued From page 14<br>the MA or late medication administration for the morning of 06/06/18.<br>-The RCC was in charge of MAs and scheduling.<br>-It was expected that residents at the facility received their medications within one hour before or one hour after their scheduled times.<br><br>2. Review of Resident #3's current FL-2 dated 8/22/17 revealed:<br>-Diagnoses included reflex sympathetic dystrophy and chronic pain syndrome.<br>-There was an order for Oxycodone 30 mg every eight hours.<br>-There was an order for Oxycodone 80 mg every eight hours.<br><br>Interview with Resident #3 on 06/05/18 at 10:30 a.m. revealed:<br>-He had resided at the facility for about two years.<br>-He was supposed to get pain medication at midnight.<br>-The facility often ran out of his pain medications.<br>-He was last out of pain medicine for three days about two weeks ago.<br>-He was told the medication aide forgot to send the script to the doctor.<br>-He remembered going for three to five days without pain meds.<br>-He had complained to the Resident Care Coordinator (RCC) and several medication aides.<br>-He suffered from reflex sympathetic dystrophy that had progressed to his central nervous system and caused full body pain.<br>-His mind raced with worry that he would not get his pain medicine.<br>-He sometimes kept pills in his room for emergencies when the facility would run out of pain medication.<br>-He would save pain pills on days when he felt bettter to avoid going without them on days when | {D 358} | | |

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| {D 358} | Continued From page 15<br>the facility did not have the medicine.<br>-He was able to save pills because the medication aide (MA) did not watch him swallow his medicine.<br>-He did not have any pills in his room that day 06/05/18.<br><br>Review of Resident #3's Medication Administration Record (MAR) dated April 2018 revealed:<br>-There was an order for Oxycodone 30 mg one tab every eight hours scheduled at 5:00 a.m., 1:00 p.m., and 9:00 p.m.<br>-There was a note to contact the doctor when 15 doses remained.<br>-There was documentation Oxycodone 30 mg was not documented as administered from 9:00 p.m. on 04/20/18 through 9:00 pm. on 04/23/18.<br>-There was documentation on the back of the MAR dated 04/21/18-4/23/18 that the medication needed to be refilled.<br>-There was documentation on the back of the MAR dated 04/20/18 that the facility was awaiting delivery of the medication.<br>-There was documentation that Resident #3 was not administered ten consecutive doses of Oxycodone 30 mg<br><br>Review of the MAR dated May 2018 revealed:<br>-There was an order for Oxycodone 80 mg ER one tab every eight hours scheduled at 1:00 p.m., 9:00 a.m., and 5:00 p.m.<br>-There was documentation Oxycodone 80 mg ER was not documented as administered on 05/06/18 at 1:00 a.m. and 9:00 a.m.<br>-There was documentation on the back of the MAR dated 05/06/18 that the medication was out of stock and had been ordered.<br>-There was documentation Oxycodone 80 mg ER was not documented as administered on | {D 358} | | |

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| {D 358} | Continued From page 16<br>05/07/18 at 1:00 a.m.<br>-There was documentation Oxycodone 30 mg was not documented as administered on 05/09/18 at 1:00 p.m and 05/13/18 at 9:00 p.m.<br>-There was documentation on the back of the MAR dated 05/09/18 that the medication was being refilled.<br>-There was documentation that Resident #3 was not administered three doses of Oxycodone 80 mg and two doses of Oxycodone 30 mg<br><br>Review of the Medication Quality Assurance Log dated 05/08/18 revealed there was no Oxycodone 30 mg on hand and the medication had be reordered.<br><br>Observation of medications on hand on 06/08/18 at 9:51 a.m. revealed:<br>-There were 30 tablets of Oxycodone 30 mg on hand in the facility.<br>-There were 25 tablets of Oxycoodone 80 mg on hand in the facility.<br><br>Interview with the contracted pharmacy on 06/07/18 at 3:37 p.m. revealed:<br>-Oxycodone 30 mg tablets were dispensed on 04/04/18 for 45 tablets, on 04/24/18 for 45 tablets, and 05/09/18 for 45 tablets.<br>-Prescriptions for Oxycoodone 30 mg were received on 04/04/18, 04/24/18, and 05/09/18 the same days the medication was dispensed.<br>-Oxycodone 80 mg tablets were dispensed on 04/04/18 for 45 tablets, on 04/19/18 for 45 tablets, and on 05/07/18 for 45 tablets.<br>-Prescriptons for Oxycodone 80 mg were received on 04/04/18, 04/19/18, and 05/05/18 (Saturday).<br>-The pharmacy was closed on weekends but "the facility could have gotten the medicine from the back up pharmacy." | {D 358} | | |

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| {D 358} | Continued From page 17<br>-The pharmacy dispensed the medication when it reopened on Monday 05/07/18.<br><br>Review of Resident #3's physician orders revealed:<br>-There was an order for Oxycodone 30 mg (45 tablets) dated 04/03/18.<br>-There was an order for Oxycodone 30 mg (45 tabletsd) dated 04/23/18.<br>-There was a request for a reorder on both the Oxycodone 30 mg and 80 mg on 05/19/18.<br><br>Interview with a representative at Resident #3's primary care physician's office (PCP) on 06/07/18 at 4:13 p.m. revealed:<br>-The resident was last seen by the PCP on 04/13/18.<br>-Facility staff requested an order for the Oxycodone 30 mg on 04/23/18 and the PCP wrote the prescription that same day 04/23/18.<br>-The Oxycodone 30 mg was ordered on 05/09/18.<br>-The facility requested this prescription on 05/08/18.<br><br>Interview with a medication aide (MA) on 06/07/18 at 4:00 p.m. revealed:<br>-MAs were to order medications when half of the medication card was used.<br>-Due to the Oxycodone being a narcotic, a request had to be sent to the doctor for a hard prescription.<br>-It usually took a day or two to get prescription refills from the PCP.<br>-She tried to order Resident #3's pain medications well ahead of them running out because the resident became agitated when he was out of medicine due to being in pain.<br><br>Interview with the Resident Care Coordinator (RCC) on 06/07/18 at 4:35 p.m. revealed: | {D 358} | | |

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| {D 358} | Continued From page 18<br>-(MAs) were supposed to request refills on medications when the pills on the card reached the blue tab.<br>-This marked ten doses remaininng on the medication card.<br>-For controlled medications, the MA or the RCC should fax the PCP and request a hard prescription for the medicine.<br>-The faxed request form should be filed in the resident's record.<br>-She was aware Resident #3 had missed some doses in April due to his PCP being out of the office.<br>-They were able to contact the PCP while he was away and obtain the order for the resident.<br>-She could not locate any fax requests for Oxycodone reorders in April 2018 in Resident #3's record.<br><br>Interview with the Executive Director (ED) on 06/07/18 at 5:00 p.m. revealed:<br>-She had only been employed at the facility for a few weeks.<br>-She was not familiar with the facility's policy on ordering medications.<br>-She was not aware Resident #3 had missed ten consecutive doses of pain medication in April 2018 or additional doses in May 2018.<br>-She would speak with the RCC to determine what the policy was and how to prevent the issue in the future.<br><br>Interview with Resident #3 on 06/07/18 at 5:15 p.m. revealed:<br>-He remembered being out of his pain medicine for three days in April 2018.<br>-He recalled missing several doses in May 2018 as well, but he was not sure of the dates.<br>-He felt "horrible" during the time he missed doses in April 2018. | {D 358} | | |

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-He had been told by physicians that his case of sympathetic dystrophy was one of the worst cases.
-The condition now affected his entire nervous system.
-He suffered from full body pain and experienced over 200 cramps daily.
-He described his pain as "burning and stabbing."
-When he missed two doses he remembered how his mind raced and the pain flared.
-He rated his pain level as greater than ten.
-The pain associated with his condition had been described as more painful than cancer.

Interview with Resident #3's PCP on 06/08/18 at 8:10 a.m. revealed:
-Resident #3 suffered from complex regional pain syndrome also known as sympathetic reflex dystrophy.
-This condition was a neurological disorder that caused "chronic, intense, and severe pain."
-Complex regional pain syndrome was a "horrendous condition" and the pain would measure a 10 out of 10 or greater.
-The condition was very difficult to treat and Resident #3 had been seen in many pain clinics.
-The PCP had been out of the office in April of 2018 and asked to fax an order while out of town.
-He expected the facility to provide him with more notice, at least three days prior to the resident running out of medication.
-He was on call 24 hours a day including weekends and could do reorders after hours if needed.
-He only wrote narcotic prescriptions for two weeks at a time and the medication required a hard prescription.
-He did not remember being notified of Resident #3 missing any doses of his pain medication in May 2018.

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-When the resident got his pain medication as scheduled, he was usually comfortable.
-He would expect to be notified of any missed doses or issues with pain for Resident #3.

3. a. Review of Resident #6's current FL-2 dated 10/25/2017 revealed:
-Resident #6's diagnoses included Alzheimer's disease, acute encephalopathy, acute urinary tract infection (UTI), essential hypertension (HTN), chronic depression, hyperlipidemia, chronic hypokalemia, anemia and chronic kidney disease.
-An order for Amlodipine Besylate 5mg(used to treat high blood pressure and chest pain) and Fluoxetine 40 mg (used to treat depression).
-Resident #6 was sometimes disoriented.
-Resident #6's level of care was for the Special Care Unit (SCU).

Review of Resident #6's electronic Medication Record (eMAR) dated 06/2018 revealed there was an entry for Oxycodone/Acetaminophen 5-325mg take 2 tablets every 4 hours as needed for pain.

Review of Resident #6's controlled substance log dated 4/24/2018 revealed Oxycodone/Acetaminophen (a narcotic used for pain) 5-325mg was administered on 06/07/2018 at 8:09 am.

Observation of the SCU dining room on 06/07/2018 from 8:15am to 8:40am revealed:
- Approximately 20 residents were in the dining room area for breakfast.
-There was one medication aide (MA) in and out of dining room continually giving medication to other residents in the dining room.

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-Resident #6 was sitting with two other residents at a table with multiple pills in a medication cup near her plate on the right side of the table.
-The medications in Resident #6's cup were of various shapes, sizes and colors.
-Resident #6 left the dining room table and returned approximately 2-3 times while the medication cup was left on the dining room table.
-The MA returned to the dining room area and asked Resident #6 to take the medications in the cup after 25 minutes of the pills remaining in the medication cup left on the table by the MA beside Resident #6's plate.

Interview with the MA on 06/07/2018 at 3:20 pm revealed she had left "all of the morning medication" in a medicine cup at the tablet with Resident #6 during breakfast on 06/07/2018.

Interview with the RCC on 06/07/2018 at 3:45pm revealed:
-She did not know the MA had left medications in a medicine cup for Resident #6 and to take during breakfast on 06/07/2018.
-The MA was supposed to watch the resident take the medication and then document the medication in the computer as administered.

b. Review of Resident #7's current FL-2 dated 4/17/18 revealed:
-Diagnoses included Alzheimer's disease and impaired memory.
-An order for atorvastatin 40 mg (used to reduce the risk of heart attack and stroke).
-Resident #7 was sometimes disoriented.
-Resident #7's level of care was for the Special Care Unit (SCU).

Observation of the dining room on 06/07/2018 from 8:15am to 8:40am revealed:

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- Approximately 20 residents were in the dining room area for breakfast.
-There was one medication aide (MA) in and out of dining room continually giving medication to other residents in the dining room.
-Resident #7 was sitting with two other residents at a table with multiple pills in a medication cup left near her plate.
-The medications in Resident #7's cup were of various shapes, sizes and colors.
-The Resident Care Coordinator (RCC) went to Resident #7's table after 20 minutes after the observation of the pills remaining in the medication cup left on the table by the MA Resident #7 and asked Resident #7; "are you going to take your medicine".
-Resident#7 replied to the RCC "you know I take my medicine after I eat".
-Resident #7 did not take the medication and the RCC took the medication with her out of the dining room.

Interview with Resident #7 on 06/07/2018 at 9:05am revealed:
-"They bring my medications to the table or they bring it to my room and leave it and I usually take it".
-She was not sure how much time passed from when the MA left the medications with her and when the RCC came to the dining room to check on her.
-Resident #7 reported "they know I always take my medicine after I eat".

Interview with the MA on 06/07/2018 at 3:20 pm revealed she had left "all of the morning medication" in a medicine cup at the table with Resident #7 during breakfast on 06/07/2018.

Interview with the RCC on 06/07/2018 at 3:45pm

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| {D 358} | Continued From page 23<br>revealed:<br>-She walked up and found the medication cup with medicine on the table for Resident #7.<br>-She did not know the MA had left medications in a medicine cup for Resident #7 to take during breakfast on 06/07/2018.<br>-The MA was supposed to watch the resident take the medication and then document the medication in the computer as administered.<br>_______________________________<br>The facility failed to assure pain medications were administered as ordered resulting in multiple missed doses for one resident (#3)with a history of chronic pain resulting increased pain; failed to observe medication administration by leaving mixed medication unattended with one resident (#13) resulting in the resident not receiving the full dose and additional medication being administered past their scheduled administration times up to 2 hours and 9 minutes late for 5 residents (#8, #9, #10, #11, #12) in SCU. The failure of the facility to assure medications were administered as ordered resulted in substantial risk of serious neglect of the residents and constitutes a Type A2 Violation.<br>________________________<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/2018 for this violation.<br><br>CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOTE EXCEED JULY 12, 2018. | {D 358} | | |
| D 375 | 10A NCAC 13F .1005(a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications | D 375 | | |

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| D 375 | Continued From page 24 | D 375 | | |

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

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

Based on observations, record reviews, and interviews, the facility failed to assure 1 of 1 resident sampled (#2) who self-administered medications had physicians' orders to self-administer medications. The findings are:

Review of Resident #2's current FL-2 dated 5/15/2018 revealed diagnoses included dementia, diabetes type 2, gait instability and hypothyroidism.

Observation on 6/5/2018 at 3:20pm revealed:
-Resident #2 and family member (another resident) were sitting in their room in recliners.
-A small table was between the recliners and a bottle of medication with a pharmacy label was sitting on the table.

Review of the pharmacy label on the bottle of medication sitting on a table in Resident #2's room revealed:
-Instructions to administer Metoprolol 50mg (used

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| D 375 | Continued From page 25<br><br>to treat atrial fibrillation) one tablet 2 times a day.<br>-The medication was filled on 6/01/2018 and 60 tablets were dispensed.<br><br>Interview with Resident #2's family member on 6/6/2018 at 8:00am revealed:<br>-Resident #2 and the family mwmber have been residing at the facility since last May (2017).<br>-Resident #2 had a history of atrial fibrillation and a cardioversion procedure done in January 2018.<br>-The resident had an appointment with a cardiologist on 6/01/2018 and received a new medication order for Metoprolol.<br>-The resident was to return to the cardiologist on 6/08/2018 for a cardioversion procedure.<br>-The family member filled the new prescription at a local pharmacy and he had administered the medication 2 times a day to Resident #2 since 6/01/2018.<br>-The medication had been on the table since 6/01/2018 and the facility staff had not removed the bottle or questioned him about the medication.<br>-Staff came into the room several times during the day and evening to bring Resident's medications and to assist her with care and no one ever mentioned or questioned him about the bottle of medication.<br><br>Review of Resident #2's care plan dated 5/29/2018 revealed:<br>-The resident was sometimes forgetful and needed reminders.<br>-The resident required limited assistance with toileting, ambulation, bathing, dressing, and grooming.<br>-The resident required supervision with eating and transfers.<br>-There was no documentation regarding self-administration of medications. | D 375 | | |

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| D 375 | Continued From page 26 | D 375 | | |

Review of a Cardiology After Visit Summary report (from an office visit) dated 6/01/2018 revealed:
-Resident #2 was seen by a cardiologist on 6/01/2018 due to atrial fibrillation (irregular heartbeat) and high blood pressure.
-A referral was made for electrophysiology (EP) cardioversion.
-There was a new medication order for Metoprolol Tartrate, 50mg take 1 tablet 2 times a day.

Review of a pharmacy prescription information sheet (no date) revealed 60 tablets of Metoprolol Tartrate 50mg was dispensed to Resident #2.

Review of Resident #2's electronic medication administration record (eMAR) for June 2018 revealed no documentation of Metoprolol Tartrate on the eMAR.

Interview with Resident #2 on 6/6/2018 at 8:45am revealed:
-Her family member was out of the facility and she did not know when he would be back.
-The resident did not remember whether her morning medications had been administered to her.

Observation on 6/6/2018 at 8:50am revealed:
-Resident #2 was sitting in a chair in her room beside a table with the Metoprolol on the table.
-The resident's family member was not in the room.
-The resident picked the bottle up and attempted to open the bottle without success.

Interview with the Resident Care Coordinator (RCC) on 6/6/2018 at 11:55am revealed:
-She did not know Resident #2 had a bottle of

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| D 375 | Continued From page 27<br>medication in her room.<br>-She did not know the resident's family member transported her to a medical appointment on 6/01/2018.<br>-Medication should not have been stored in the resident's room because she did not have a medication self-administration order.<br>-She did not know the resident's family member was administering Metoprolol to her 2 times a day.<br>-Staff should have removed the bottle of medication from the resident's room and placed it in the locked medication cart.<br>-If the medication bottle was kept on the table in the room, staff should have seen the bottle and assured the bottle was removed.<br>-She would remove the bottle of medication from the resident's room, confirm the physician order, report the medication order to the pharmacy, and talk with her family member.<br>-The facility's policies and procedures for self-administration for medications included: the facility must obtain an order from the health care provider for residents who self-administer their medications; residents must keep all medications including over the counter medications in a locked secured area out of access or view of other residents; and a self-administration assessment would be completed and documented on the residents by the Resident Care Coordinator (RCC) or Resident Care Director (RCD) and made available to the physician.<br>-When residents were transported to medical appointmemts by family members, upon return to the facility, the family members were to leave all orders and visit documemtations with staff, usually the medication aides or RCC.<br><br>Observation of Resident #2's room on 6/6/2018 at | D 375 | | |

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| D 375 | Continued From page 28<br>12:15am revealed the bottle of Metoprolol was not in the room.<br><br>Interview with a 2nd shift personal care aide (PCA) on 6/6/2018 at 4:15pm revealed:<br>-She checked on Resident #2 about every 2 hours and the resident never verbalized any needs.<br>-She never observed a bottle of pills on the resident's table or anywhere in her room.<br>-The table always had a lot of items on top and she did not see any pills.<br><br>Interview with a 1st shift MA on 6/7/2018 at 8:55am revealed:<br>-She prepared the resident's morning medications, which included Metoprolol and the family member administered them to the resident.<br>-She did not remember seeing the medication in her room on the table beside her recliner this week.<br>-Medications were not allowed to be kept in the resident's room unless there was a medication self-administration order and Resident #2 did not have that order.<br><br>Interview with a second 1st shift MA on 6/7/2018 at 9:20am revealed:<br>-The MA worked on the assisted living (AL) unit and special care unit (SCU).<br>-When she worked on the AL unit she administered Resident #2's medication.<br>-She went in the resident's room in the morning to check her pulse.<br>-The MA worked on the AL unit on Monday, 6/4/2018 but did not remember seeing a medication bottle on the table beside the resident's recliner.<br>-The MA worked on the AL unit on Friday 6/01/2018 and when she checked the resident's | D 375 | | |

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pulse Friday morning, the family member informed her he was going to transport Resident #2 to a medical appointment to get her heart rate lowered because her heart rate was to high.
-She did not report the appointment to the RCC or other staff because she thought they knew about the appointment because the RCC kept up with the residents' appointments.

Interview with the RCC on 6/7/2018 at 10:35am revealed Resident #2's Metoprolol was placed in the medication cart and the prescription was sent to the facility's pharmacy to update the eMAR.

Interview with the Executive Director on 6/7/18 at 11:00am revealed:
-She did not know Resident #2 had a bottle of medication in her room.
-The ED was not aware the resident was seen by a cardiologist on 6/01/2018.
-When family transported/accompanied residents to medical appointments, the orders and all information sent back with the residents should be given to the RCC or the MAs.
-If a resident had a medication self-administration orders, all medications would be kept locked/secured in the room.

Interview with Resident #2's primary health care provider on 6/8/2018 at 10:00am revealed:
-There was not an order for self-administration of medications for the resident.
-The facility medication staff should be administering all of the resident's medications.

______________________________

The facility failed to assure a cardiac medication (for Resident #2) who had a diagnosis of dementia, was secured and not accessible to the resident and administered by the medication staff.

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| D 375 | Continued From page 30<br>This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation.<br>________________________________<br>The facility provided the following plan of protection in accordance with G. S. 131D-34 on 6/8/2018<br><br>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOTE EXCEED JULY 26, 2018. | D 375 | | |
| D 377 | 10A NCAC 13F .1006(a) Medication Storage<br><br>10a NCAC 13F .1006 Medication Storage<br>(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to assure that a residents' cardiac medication was stored in a safe and secure manner for 1 of 1 residents sampled (#2) who had dementia, was forgetful, and had access to the medication.<br>The findings are:<br><br>Observation on 6/5/2018 at 3:20pm revealed:<br>-Resident #2 and family member (another resident) were sitting in their room in recliners.<br>-A small table was between the recliners and a prescription bottle of medication was sitting on | D 377 | | |

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| D 377 | Continued From page 31<br>the table.<br><br>Review of the pharmacy label on the bottle of medication sitting on a table in Resident #2's room revealed instructions to administer Metoprolol 50mg (used to treat atrial fibrillation) one tablet 2 times a day.<br><br>Review of Resident #2's current FL-2 dated 5/15/2018 revealed:<br>- Diagnoses included dementia, diabetes type 2, gait instability and hypothyroidism.<br>-Medication orders included Diltiazem 240mg every day (used to treat hrpertension), Microzide 12.5mg every morning (used to treat hrpertension), Cozaar 50mg every day (used to treat hypertension), metoprolol 50mg 2 times a day (used to treat cardiac disease and hypertension) and Xarelto 20mg every day with evening meal (a blood thinner).<br><br>Interview with Resident #2's family member on 6/6/2018 at 8:00am revealed:<br>-Resident #2 and the family member have been living at the facility since last May (2017).<br>-The resident had an appointment with a cardiologist on 6/01/2018 and received a new medication order for Metoprolol.<br>-The family member filled the new prescription at a local pharmacy on 6/01/2018 and he has administered the medication 2 times a day to Resident #2 since 6/01/2018.<br>-The medication has been on the table since 6/01/2018 and the facility staff had not removed the bottle or questioned him about the medication.<br>-Staff came into the room several times during the day and evening to bring Resident's medications and to assist her with care and no one ever mentioned or questioned him about the | D 377 | | |

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| D 377 | Continued From page 32 | D 377 | | |

bottle of medication.

Review of Resident #2's care plan dated 5/29/2018 revealed:
-The resident was sometimes forgetful and needed reminders.
-The resident required limited assistance with toileting, ambulation, bathing, dressing, and grooming.
-The resident required supervision with eating and transfers.
-There was no documentation regarding self-administration of medications.

Interview with Resident #2 on 6/6/2018 at 8:45am revealed she did not remember whether her morning medications had been administered to her.

Observation of Resident #2's room on 6/6/2018 at 8:50am revealed:
-Resident #2 was sitting in a chair in her room beside a table with the Metoprolol on the table.
-The resident's family member was not in the room.
-The resident picked the bottle up without prompting and attempted to open the bottle without success.

Interview with the Resident Care Coordinator (RCC) on 6/6/2018 at 11:55am revealed:
-She did not know Resident #2 had a bottle of medication in her room.
-Medication should not be have been stored in the resident's room because she did not have a medication self-administration order.
-She was not aware the resident's family member was administering Metoprolol to her 2 times a day.
-Staff should have removed the bottle of

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medication from the resident's room and placed it in the locked medication cart.
-If the medication bottle was kept on the table in the room, staff should have seen the bottle and assured the bottle was removed.
-She would remove the bottle of medication from the resident's room, confirm the physician order, report the medication order to the pharmacy, and talk with the family member.
- The facility's policies and procedures for self-administration for medications included: the facility must obtain an order from the health care provider for residents who self-administer their medications; residents must keep all medications including over the counter medications in a locked secured area out of access or view of other residents; and a self-administration assessment would be completed and documented on the residents by the Resident Care Coordinator (RCC) or Resident Care Director (RCD) and made available to the physician.

Observation on 6/6/2018 at 12:15am revealed the bottle of Metoprolol was not in the room.

Interview with a1st shift MA on 6/7/2018 at 8:55am revealed:
-She prepared the resident's morning medications, which included Metoprolol and the family member administered them to the resident.
-She did not remember seeing the medication in her room on the table beside her recliner this week.
-Medications were not allowed to be kept in the resident's room unless there was a medication self-administration order, then the medications would be in a locked area/box.
-Resident #2 did not have a self-administration order.

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| D 377 | Continued From page 34 | D 377 | | |

Interview with the RCC on 6/7/2018 at 10:35am revealed Resident #2's Metoprolol was placed in the medication cart and the prescription was sent to the facility's pharmacy to update the electronic MAR.

Interview with the Executive Director on 6/7/18 at 11:00am revealed:
-She did not know Resident #2 had a bottle of medication in her room.
-The ED was not aware the resident was seen by a cardiologist on 6/01/2018.
-When family transported/accompanied residents to medical appointments, the orders and all information sent back with the residents should be given to the RCC or the MAs.
-If a resident had a medication self-administration orders, all medications would be kept locked/secured in the room.

Interview with Resident #2's primary health care provider on 6/8/2018 at 10:00am revealed:
-There was not an order for self-administration of medications for the resident.
-The facility medication staff should be administering all of the resident's medications.

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The facility failed to assure a cardiac medication (ordered for a resident (Resident #2) who had a diagnosis of dementia, left in her room and accessible to the resident) was kept in a secured area. This failure was detrimental to the health and safety of the resident and constitutes a Type B violation.

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The facility provided the following plan of

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| D 377 | Continued From page 35<br>protection in accordance with G. S. 131D-34 on 6/8/2018<br><br>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOTE EXCEED JULY 26, 2018. | D 377 | | |
| {D912} | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration, self administration of medications, medication storage, and medication aide training.<br><br>The findings are:<br><br>1. Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 5 of 6 residents (#8, #9, #10, #11 and #12) observed during the medication pass; and 4 of 7 sampled residents (#3) with missed doses of pain medications resulting in the resident (#3) suffering severe pain due to multiple missed doses of pain | {D912} | | |

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|---|---|
| **CARILLON ASSISTED LIVING OF KNIGHTDALE** | **2408 HODGE ROAD KNIGHTDALE, NC 27545** |

| (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 |
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| {D912} | Continued From page 36<br>medications, and 3 residents (#6, #7, #13) where their medications which included a narcotic were left in medications cups on the dining room table. [Refer to Tag 0358 10A NCAC 13F .1004 (a) Medication Administation (Type A2 Violation).]<br><br>2. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 1 resident sampled (#2) who self-administered medications had physicians' orders to self-administer medications. [Refer to Tag 0375 10A NCAC 13F .1005 (a) Self-Administation of Medication (Type B Violation).]<br><br>3. Based on interviews and record reviews, the facility failed to assure 3 of 5 medication aides sampled (Staffs A,B and C) completed medication clinical skills validation (Staff A and C) and passed the written medication examanation (Staff B) before administering medication to residents. [Refer to Tag 935 GS 131D-34 Medication Aide Training and Competencey (Type B Violation).]<br><br>4.Based on observations, record reviews, and interviews, the facility failed to assure that a residents' cardiac medication was stored in a safe and secure manner for 1 of 1 residents sampled (#2) who had dementia, was forgetful, and had access to the medication. [Refer to Tag 0377 10A NCAC 13F .1005 (a) Medication Storage (Type B Violation).] | {D912} | | |
| D935 | G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency<br><br>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. | D935 | | |

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(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 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.

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

Based on interviews and record reviews, the facility failed to assure 3 of 5 medication aides sampled (Staffs A,B and C) completed medication clinical skills validation (Staff A and C) and passed the written medication examanation (Staff B) before administering medication to residents. The findings are:

1. Review of Staff A, medication aide (MA), personnel record revealed:
-Staff A's hire date was 01/02/2018.
-Staff A had a certificate of completion for the State-approved Medication Administration 15-Hour Training Course for Adult Care Homes completed on 03/14/2018.
-Staff A passed the state Medication Aide (MA) examination on 05/31/2018.
-The completed "Medication Administration Clinical Skills Validation Checklist" was dated 06/06/2018.
-Staff A completed Diabetic Care training on 03/13/2018.

Interview with Staff A on 06/06/2018 at 9:15am revealed
-She was training as a medication aide (MA) to work the medication cart.
-She had passed the state medication aide exam on 05/31/2018.
-She was scheduled to complete her medication skills checklist with the nurse on the afternoon of 06/06/2018.

Observation of the medication pass for the

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Special Care Unit (SCU) on 06/06/2018 from 9:15am - 10:15am revealed Staff A was the only MA working 2 medication carts in the SCU.

Review of June 2018 electronic medication administration records (eMARs) revealed Staff A had documented administration of medications on 06/06/2018.

Interview with the Resident Care Coordinator (RCC) on 06/06/2018 at 11:29am revealed:
-She was in charge of the medication aides and their medication aide training.
-The facility was short on the medication aides and was in the process of training new medication aides.
-The Staff A was still in training and was not supposed to be working the medication cart alone.
-Staff A had passed the medication aide test and the class work as a medication aide, but Staff A still needed to be checked off by the nurse.
-Staff A was still supposed to be "buddy training" with another medication aide.
-The RCC came to work between 8:00am - 8:30am and Staff A was working the medication cart alone in the SCU.
-The RCC did not remove Staff A from the medication cart in the SCU.

Interview with the Executive Director (ED) on 06/06/2018 at 11:35am revealed:
-She was not aware of where Staff A was in the process of completing her training.
-She would have to check with the RCC to verify Staff A's status.
-Staff A should not be administering medications alone if she has not completed her medication skills checklists.

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Interview with Staff A on 06/08/2018 at 10:35am revealed:
-She was not supposed to be working the medication cart alone on 06/06/2018 because she had not completed her medication clinical skills checklists.
-She was scheduled for medication clinical skills check-off for the afternoon of 06/06/2018.
-She was supposed still to be training on the medication cart with another MA but no other MA showed up on the 7:00am-3:00pm shift 06/06/2018 so she started administering the medications.
-She completed her skills checklists with the nurse consultant with medication administration and Staff A did a fingerstick on the assisted living unit during her medication skills check-off with the nurse consultant.
-Staff A did not perform any insulin injections during her skills check-off with the nurse consultant.
-Staff A was not sure if it was either because the nurse consultant did not need to see it or the nurse consultant would come back and see the demonstration later.

Interview with facility nurse consultant on 06/08/2018 at 3:45pm revealed:
-She performed the LHPS reviews and medication clinical skills checklists at the facility.
-She did not complete the medication clinical skills checklists for Staff A until 06/06/2018.
-She did not know why Staff A was working the medication cart in the SCU on 06/06/2018 prior to completing the skills checklists.
-Staff A demonstrated using a demo insulin pen how to administer insulin for her medication clinical skills check-off.

Second interview with the facility nurse consultant

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on 06/11/2018 at 8:02am revealed:
-She used an old discarded insulin pen with Staff A to demonstrate how to administer insulin correctly.
-She believed Staff A had done a returned demonstration for insulin injection in the classroom setting.

Second interview with the RCC on 06/11/2018 at 2:20pm revealed:
-Staff A had been scheduled for additional MA training to shadow with another MA to become more familiar with administering medications independently.

Refer to interview with the Executive Director (ED) on 06/06/2018 at 11:40am.

2. Review of Staff B, personal care aide (PCA), personnel record revealed:
-Staff B's hire date was 10/10/2016.
-Staff B had a certificate of completion for the State-approved Medication Administration 15-Hour Training Course for Adult Care Homes completed on 12/08/2017.
-Staff B failed the state Medication Aide (MA) test on 05/31/2018.
-The "Medication Administration Clinical Skills Validation Checklist" was completed on 01/08/2018.

Interview with the RCC on 6/08/2018 at 12:03pm revealed:
-Staff B failed the state medication aide test 4 times in 4 or 5 months. The last date she failed was on 5/17/2018.
-Staff B was taken "off the cart" before she took and failed the last test on 5/17/2018.
-On 6/4/2018, Staff B was scheduled to work as a personal care aide (PCA) but worked on a

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medication cart, administering medications to residents due to the facility did not have enough MAs. But new MAs were being trained.

Interview with the ED on 6/8/2018 at 12:20pm revealed:
-She was not aware Staff B was not qualified to pass medications.
-Staff B should not be passing medications if she failed the medication aide test multiple times.

Refer to interview with the Executive Director (ED) on 06/06/2018 at 11:40am.

3. Review of a personnel record for Staff C (medication aide) on 06/08/18 at 12:05pm revealed:
-Staff C's hire date was 03/20/18.
-Staff C had a certificate of completion for the State-approved Medication Administration 15-Hour Training Course for Adult Care Homes completed on 04/13/18.
-Staff C successfully passed the written medication administration exam on 05/31/18.
-No "Medication Administration Clinical Skills Validation Checklist" form was found in Staff C's personnel record.

Interview with Staff C on 06/5/18 at 10:40am revealed she was training as a new MA to work the medication cart.

Interview with the Resident Care Coordinator (RCC) on 06/06/18 at 8:30am revealed:
-"Staff C probably needs some more training" and the RCC would be working with Staff C on the medication cart for the remainder of the 7:00am - 3:00pm shift on 06/06/18.
-She would check Staff C's personnel record to

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ensure what medication aide training had been completed.

Review of June 2018 electronic medication administration records (eMARs) revealed Staff C had administered medications on 06/06/18.

Telephone interview with Staff C on 06/07/18 at 4:30pm revealed:
-She had started working as a personal care aide at the facility in March 2018 and then she started training to become a MA in April 2018.
-She completed the 15 hours medication aide class in April 2018 and she had been shadowing with other medication aides while they worked the medication cart for about 2 weeks.
-She passed the state medication aide test on 05/31/18, but she had never completed her medication clinical skills checklist.
-She was waiting for the RCC to schedule for her medication clinical skills checklist to be done by the nurse consultant.
-She worked the medication cart on 06/06/2018 because the facility was short on medication aides.
-"I told the RCC on 06/07/18 that I would not be working the medication cart any more until I was checked off for my medication clinical skills".

Second interview with the RCC on 06/08/18 at 11:45am revealed she did not know why Staff C was working the medication cart on 06/06/2018 because Staff C had not completed the medication clinical skills checklist.

Interview with the Executive Director (ED) on 06/08/18 at 12:15pm revealed:
-The RCC was in charge of keeping up with training of the MAs.
-She did not know that Staff C had not completed

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| D935 | Continued From page 44<br>her medication clinical skills checklist prior to working the medication cart alone on 06/06/18.<br>-"There seemed to be a problem with the facility's system in making sure the MAs were qualified before they worked alone on the medication cart and they would have to work on trying to correct that".<br><br>Review of a Medication Administration Clinical Skills Checklist revealed a completed checklist dated 06/04/18 with Staff C's signature and the facility nurse consultant's signature was received was provided by the facility on 06/08/18 at 2:45pm.<br><br>Interview with facility nurse consultant on 06/08/18 at 3:45pm revealed:<br>-She performed the LHPS reviews and medication clinical skills checklists at the facility.<br>-She had not completed the medication clinical skills checklist for Staff C on 06/04/18 because there was not enough time to complete the checklist.<br>-Staff C had completed the classwork for medication aide training but no clinical skills checklists.<br>-She did leave copies of blank medication clinical skills checklists and other training forms, printed with her signature, locked in a file cabinet in the facility's country kitchen.<br>-She expected the other staff at the facility had access to this file cabinet since it was in the facility.<br><br>Second interview with the facility nurse consultant on 06/11/18 at 8:02am revealed:<br>-She verified she did not complete a medication clinical skills checklist for Staff C because she "did not trust that Staff C was capable of passing medications safely independently". | D935 | | |

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-She did not leave any copies of blank checklists for staff qualifications or training, printed with her signature, locked in any cabinets at the facility.
-She did not know how her signature was obtained for Staff C's checklist dated 06/04/18 because she did not complete it.

Second interview with RCC on 06/11/18 at 2:20pm revealed:
-The nurse consultant called her on the morning of 06/11/2018 regarding Staff C.
-Staff C would continue shadowing with MAs on the medication cart.
-Staff C would continue with additional MA training until it could be determined she was safe to administer medications and completed the medication clinical skills checklist.

Refer to interview with the Executive Director (ED) on 06/06/18 at 11:40am.

_______________________

Interview with the Executive Director (ED) on 06/06/18 at 11:40am revealed:
-The RCC was in charge of the training for the medication aide training.
-It was the company policy that all new medication aides had to complete the 15 hour medication aide training class and pass the state medication aide exam.
-The company tried to have new medication aides to shadow with trained medication aides for about a week or two weeks and then the facility nurse consultant checks off the new medication aides for the medication clinical skills checklists.
-After the medication aides complete the skills checklists with the facility nurse consultant, then the medication aide can work the medication cart alone.

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| D935 | Continued From page 46<br>[Refer to Tag 0358 10A NCAC 13F .1004 (a) Medication Administation (Type A2 Violation).]<br>__________________________<br>The facility failed to assure 3 new medication aides (A,B,C) had completed the Medication Administration Clinical Skills Checklist and 1 new medication aide (B) had successful passed the written medication administration exam test prior to administering medications, resulting in residents in receiving medication late and medications being administered to residents unwitnessed. The facility's failure to have qualified medication aides administering medications was detrimental to the health, safety, and welfare of all residents and constitutes a Type B Violation.<br>__________________________<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/18 for this violation.<br>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOTE EXCEED JULY 26, 2018. | D935 | | |