STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053028	A. BUILDING: _____ B. WING _____	R 12/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on December 11-12 and 16, 2019.	{D 000}		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff A) had a criminal background check completed prior to hire. The findings are: Review of Staff A, personal care aide (PCA)'s personnel record revealed: -Staff A was hired on 09/30/19. -There was no documentation of a criminal background check or consent for a criminal background check. Interview with Staff A on 12/12/19 at 11:45 am revealed she had a criminal background check completed prior to hire. The Administrator Assistant (AA) was not available for interview on 12/12/19. Interview with the Administrator on 12/12/19 at 4:07 pm revealed: -She could not find documentation for the criminal background check for Staff A.	D 139		

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D 139	Continued From page 1 -A criminal background check for Staff A was completed on 12/11/19. -The AA was responsible for the completion of the criminal background check for Staff A. -This was an oversight of the criminal background check for Staff A. -She was responsible for making sure all staff criminal background checks were completed prior to hire. -She would audit the staff records monthly.	D 139		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication aides observed 2 of 2 residents take their medications related to leaving medications in the residents' rooms (Resident #1 and #3). The findings are: 1. Review of Resident #3's current FL-2 dated	D 366		

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D 366	Continued From page 2 11/17/19 revealed: -Diagnoses included abdominal pain, cellulitis, hypomagnesemia, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), abdominal pain, diabetes mellitus, chronic pain hypercholesterolemia, normocytic anemia, sinus tachycardia, dementia, tobacco use, hypokalemia and history of lung cancer. -There were no physician orders to self-administer medications. Observation on 12/11/19 between 9:30 am and 9:40 am revealed: -Resident #3 was standing at the front desk. -The resident had a paper medication cup in her hand which contained several tablets. -There were no staff present. -Resident #3 poured the medications in her right hand and took them. Interview with Resident #3 on 12/11/19 at 9:40 am revealed: -The medication aide (MA) left her morning medications in her room around 8:30 am on 12/11/19. -The MA usually left her medications on the bedside table. -She did not have an order to self-administer her medications. Observation of the Electronic Medication Administrator Records (e-MARs) for December 2019 for Resident #3 on 12/11/19 at 11:30 am revealed the 8:00 am medications had been signed off. Interview with a MA on 12/11/19 at 3:15 pm revealed: -She did not give 8:00 am medications to Resident #3 on 12/11/19.	D 366		

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D 366	Continued From page 3 -Her initials were on the e-MAR, but another MA had given Resident #3 her medications on 12/11/19 at 8:00 am. -The MA was in training, and she was not allowed to sign off on the e-MARs. -The MA should have watched Resident #3 take her medications before she left the room. Interview with a second MA on 12/12/19 at 11:45 am revealed: -She gave medications to Resident #3 on 12/11/19 at 8:00 am. -She left the medications on the beside table on 12/11/19 at 7:15 am. -Resident #3 asked her to leave the medications on her bedside table. -Resident #3 was very difficult to give medications. -She was supposed to observe Resident #3 take her medications before she left the room. -This was the first time she left medications on a resident's bedside table. Interview with the Administrator on 12/12/19 at 3:40 pm revealed: -She did not know a MA left Resident #3's medications on the bedside table on 12/11/19 at the 8:00 am medication pass. -The MA should not have left the medications on the bedside table. -Resident #3 did not have a self-administer order for medications. -The MA who gave medications to Resident #3 on 12/11/19 at 8:00 am should have observed the resident take her medications. -The MA should have signed the e-MAR after she administer the medications to the resident. -All MAs should observe residents take their medications unless residents have an order to self-administer their medications.	D 366		

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D 366	Continued From page 4 -She would do a MA training on 12/13/19 on how to administer medications to the residents. 2. Review of Resident #1's current FL-2 dated 12/10/19 revealed: -Diagnoses included heart failure, chronic obstructive pulmonary disease, hypertension transient ischemic attacks, insomnia and anxiety. -There was no physician's order for Resident #1 to self administer her medications. Observation on 12/11/19 at 12:15 pm revealed: -Resident #1 was in her room, seated in a chair, beside the bedside table. -On the bedside table was a plastic medication cup, containing 3 medications. -Inside the cup was one round yellow tablet, one oval white tablet and one blue capsule. Review of Resident #1's physician orders revealed: -There was an order dated 12/10/19 for Clonidine HCL 0.1 mg. (antihypertensive used to treat high blood pressure; yellow tablet) to be administered at 8:00 am, 2:00 pm, and 8:00 pm. -There was an order dated 12/10/19 for Dicyclomine 10 mg. (reduces symptoms of stomach and intestinal cramping; blue capsule) to be administered at 8:00 am, 2:00 pm, and 7:00 pm. -There was an order dated 12/10/19 for Hydrocodone-Acetaminophen 5-325 mg. (narcotic used to treat pain; white tablet) to be administered at 8:00 am, 2:00 pm, and 8:00 pm. Interview with Resident #1 on 12/12/19 at 12:15 pm revealed: -The medication aide (MA) came into her room between 7:30 am and 8:00 am that morning to administer her medications.	D 366		

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-The MA placed 2 medication cups on her over bed table and told her "here are your meds (medications)" and left the room.
-The MA did not stay to watch her take her morning medications.
-One of the cups was for her 8:00 am scheduled medications which she had taken that morning and the second cup contained her 2:00 pm scheduled medications.
- "She resided at the facility for 3 years and she knew her medications; the MA trusted her to take her medications at their scheduled times."
-The MA would sometimes bring both the morning and afternoon medications to her room for her to take later.
-The MA was very busy today; she was given 2 cups of medications, one for the morning medications and the second one for the afternoon medications.
-She did not have a physician's order to self administer her medications.

Interview with the MA on 12/12/19 at 2:45 pm revealed:
-She checked the residents' medications and the orders, placed the resident's medications into the medication cups, and went to the residents' rooms and administered medications to the residents.
-Some residents could not hold their cup of water when taking their medications; she had to stand beside the resident and assist holding the water and make sure all the medications were swallowed.
-She was very busy that morning; she had to administer all of the residents' medication by herself.
-During the 8:00 am medication pass, the MA placed Resident #1's medications in her room.
-Resident #1 did not need assistance to take her

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medications.
-Resident #1 told the MA she wanted to take her medications later; the MA left to continue the medication pass.
-Resident #1 did not have a physician's order to administer her medications.

Interview with Resident #1 on 12/12/19 at 3:05 pm revealed Resident #1 administered the Clonidine HCL 0.1 mg., Dicyclomine 10 mg. and Hydrocodone-Acetaminophen 5-325 mg to herself at 2:30 pm.

Review of the December 2019 electronic medication administration record (e-MAR) for Resident #1 revealed Clonidine HCL 0.1 mg., Dicyclomine 10 mg. and Hydrocodone-acetaminophen 5-325 mg were initialed as having been administered at 8:00 am and 2:00 pm by the MA.

Interview with the Administrator on 12/12/19 at 3:37 pm revealed:
-The MAs were trained to watch the residents swallow all their medications unless they had a self-administration order.
-The MAs should not assume a resident would take their medications if left in their room; they should watch the resident take the medication.
-She was not aware Resident #1's 8:00 am and 2:00 pm medications were placed in the resident's room for the resident to self-administer.
-Resident #1 did not have a self-administer order from her physician.