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D 000	Initial Comments The Adult Care Licensure Section completed an annual survey from August 31, 2021 to September 02, 2021.	D 000		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 medication aides (Staff A) and 2 of 3 personal care aides (Staffs C, E and F) had been competency validated for licensed health professional support (LHPS) tasks by return demonstration including applying compression stockings, obtaining fingerstick blood sugar checks, and transferring residents who needed assistance. The findings are: 1. Review of Staff A's medication aide (MA) personnel record revealed: -She was hired on 07/05/21. -There was no documentation Staff A's completed	D 161		

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a LHPS competency validation checklist.

Review of a resident's electronic medication administration record (eMAR) for August 2021 revealed:
-Staff A documentation of compression hose 3 days.
-Staff A documented obtaining fingerstick blood sugar checks 3 days.

Interview with Staff A on 09/02/21 at 1:10pm revealed:
-She did not remember any specific training for LHPS task such as helping with transfers and applying compression stockings.
-She would help residents transfer from their chairs.
-She would apply or remove compression stockings for residents that required them.

The Health and Wellness Director (HWD) was not available for interview from 08/31/21 to 09/02/21.

Refer to the interview with the Area Nurse Manager (ANM) on 09/02/21 at 12:30pm.

Refer to the interview with the Administrator on 09/01/21 at 3:00pm.

Refer to the interview with the BOM on 09/02/21 at 4:45pm.

2. Review of Staff C's, personal care aide (PCA) personnel record revealed:
-Staff C was hired on 04/05/21.
-There was no documentation Staff C's completed a LHPS competency validation checklist since she was hired.

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Telephone interview with Staff C on 09/02/21 at 11:55am revealed:
-She routinely worked third shift (11:00pm to 7:00am).
-She did not remember any specific training for LHPS task such as helping with transfers and applying compression stockings.
-She did not remember any staff doing a type of check off that required any return demonstration since she had been hired.
-She helped residents transfer to and from their wheelchairs.

The Health and Wellness Director (HWD) was not available for interview from 08/31/21 to 09/02/21.

Refer to the interview with the Area Nurse Manager (ANM) on 09/02/21 at 12:30pm.

Refer to the interview with the Administrator on 09/01/21 at 3:00pm.

Refer to the interview with the BOM on 09/02/21 at 4:45pm.

3. Review of Staff E's, personal care aide (PCA) personnel record revealed:
-Staff E was hired on 04/25/21.
-There was no documentation Staff E's completed a LHPS competency validation checklist since she was hired.

Telephone interview with Staff E on 09/02/21 at 12:50pm revealed:
-She routinely worked different shifts, first and third shifts.
-She completed certified nursing assistant training prior to coming to the facility.
-She did not remember any specific training for

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LHPS task such as helping with transfers.
-She provided care such as transferring residents from the bed to wheelchairs.

The Health and Wellness Director (HWD) was not available for interview from 08/31/21 to 09/02/21.

Refer to the interview with the Area Nurse Manager (ANM) on 09/02/21 at 12:30pm.

Refer to the interview with the Administrator on 09/01/21 at 3:00pm.

Refer to the interview with the BOM on 09/02/21 at 4:45pm.

4. Review of Staff F's, personal care aide (PCA) personnel record revealed:
-Staff F was hired on 03/25/21.
-There was no documentation Staff F's completed a LHPS competency validation checklist since she was hire.

Interview with Staff F on 09/02/21 at 4:20pm revealed:
-She routinely worked evening shifts.
-She did not remember nursing staff doing any type of check off that required any return demonstration since she had been hired.
-She helped residents transfer to and from their wheelchairs for residents needing 2 person assist.

The Health and Wellness Director (HWD) was not available for interview from 08/31/21 to 09/02/21.

Refer to the interview with the Area Nurse Manager (ANM) on 09/02/21 at 12:30pm.

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Refer to the interview with the Administrator on 09/01/21 at 3:00pm.

Refer to the interview with the BOM on 09/02/21 at 4:45pm.
____
Interview with the ANM on 09/02/21 at 12:30pm revealed:
-The HWD was responsible to ensure staff were competency validated for tasks including LHPS checklist.
-Staff providing care to residents should be LHPS validated upon hire before providing care to the residents.
-The HWD provided documentation for completed LHPS to the Business Office Manager for record keeping.
-The ANM was assisting with ensuring staff completed validations while the HWD was out of work.

Interview with the Administrator on 09/01/21 at 3:00pm revealed:
-The BOM was responsible for maintaining the staff records in the BOM office.
-The HWD was responsible for ensuring all staff were checked of for competency requirements, had documentation for the requirements of the various positions or were assisted with scheduling and validating completion of requirements.
-The ANM was assisting with ensuring staff completed validations while the HWD was out of work.

Interview with the BOM on 09/02/21 at 4:45pm revealed:
-He became the BOM in the middle of February 2021.

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D 161	Continued From page 5 -He had not audited staff records for completeness and documentation for required staff qualifications. -There was not a check off list for staff requirements that he was aware of or could locate. -The HWD was responsible to ensure were in compliance with staff requirements.	D 161		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to provide supervision for 1 of 5 sampled residents (Resident #4) resulting in multiple falls and scrapped knee. The findings are: Review of the facility's Falls Management policy revealed: -A falls risk evaluation was completed at the time of move-in. -Falls were recorded in the facility's computer system. -A post fall evaluation was completed after a resident had a fall. -Individualized interventions were considered and the evaluation was a part of the resident record.	D 270		

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Review of Resident #4's current FL2 dated 05/06/21 revealed:
-Diagnoses of Alzheimer's disease.
-Resident #4 was non-ambulatory and constantly disorientated.

Review of Resident #4's Care Plan dated 03/18/21 revealed the resident was totally dependent on staff for eating, toileting, ambulation, bathing, dressing, grooming and transferring.

Review of Resident #4's Licensed Health Professional Support evaluation dated 07/02/21 revealed:
-Resident #4 was totally dependent on staff for all Activities of Daily Living (ADL).
-Resident #4 was unable to stand independently and was a two-person transfer.

Review of Resident #4's falls risk evaluation form dated 03/27/19 revealed:
-A resident was considered a "Level 3 fall risk" if there were one or more level 3 question responses with "yes" checked.
-Resident #4 was considered a "Level 3" fall risk with a "yes" response checked to the following:
-Resident #4 had problems ambulating and transferring.
-Resident #4 appeared unsteady when ambulating.
-Resident #4 had a history of cognitive decline.

Review of Resident #4's progress note dated 01/18/21 at 11:12pm, revealed "Resident #4 was found on the floor."
-Resident #4 was put on safety checks.
-There were no documentation safety checks were completed on the progress note.

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Review of Resident #4's physician notification form dated 01/18/21 revealed Resident #4 had a fall and "suffered a scrape to her left knee."

Review of the post-fall report dated 01/18/21 revealed:
-At 10:00pm, Resident #4 was found lying on the floor near her bed.
-The medication aide (MA) documented Resident #4 received a scrape to her left knee.
-The post-fall evaluation was initiated but not completed, the status was showing "error."

There was no documentation Resident #4's service plan was reviewed for adjustments according to the falls policy.

Review of Resident #4's computerized clinical assessment worksheet revealed the post-fall evaluation status was "errors." It could not be determined exactly what the errors were related to.

There was no documentation of increased supervision to prevent Resident #4 from falling.

Telephone interview with a second shift MA on 09/02/21 at 11:42am revealed:
-On 01/18/21, he found Resident #4 on the floor near her bed.
-He thought maybe Resident #4 was asleep in the bed and fell from the bed, but he was not sure.
-Resident #4's fall resulted in a scrape to the resident's knee and required first-aid treatment.
-He documented Resident #4 was put on safety checks, but he did not document the safety checks were completed.
-Safety checks were done for three days following a resident's fall.
-The first day safety checks were done every 30

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minutes, up to 24 hours.
-The second day safety checks were every hour for 24 hours.
-The third day safety checks were done every two hours, which was the facility's regular protocol for checking on residents.
-Last year (2020), there was a system of documenting when he completed safety checks, but the Health and Wellness Director (HWD) told him that he could no longer document the safety checks because there was no order for safety checks.
-Because there was no order, safety checks stopped being done after a resident had a fall.
-There was no system for increased supervision put in place for Resident #4's falls.
-When he worked, Resident #4 was provided every two hours for incontinent care as well as the other residents.

Review of Resident #4's progress note dated 05/03/21 at 9:48pm revealed "Resident #4 was found on the floor bedside her bed, no injuries."

Review of Resident #4's physician notification form dated 05/03/21 revealed Resident #4 was found on the floor by the bedside, no apparent injuries.

Review of the post-fall evaluation dated 05/03/21 revealed:
-Resident #4 fell at 3:00pm.
-The fall was near the resident's bed.
-The cause of the fall was unknown.

Review of Resident #4's computerized clinical assessment worksheet revealed the post-fall evaluation was incomplete and "still in progress."

There was no documentation of increased

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supervision to prevent Resident #4 from falling.

The MA who completed the post-fall evaluation was not available for interview on 09/02/21.

Review of Resident #4's progress note revealed on 08/13/21 at 9:37pm, "Resident #4 was found lying on the floor in her room, no apparent injuries."

Review of Resident #4's physician notification form dated 08/13/21 revealed Resident #4 was found lying on the floor by her bedside with no apparent harm/injuries.

Review of Resident #4's post-fall evaluation dated 08/13/21 revealed:
-At 10:00pm, Resident #4 was found lying on the floor bedside her bed.
-Resident #4 was lying on left side and had no apparent injuries.
-
-The post-fall evaluation was initiated but not completed. The status showed "in-progress."

There was no documentation of increased supervision to prevent Resident #4 from falling.

Interview with the MA on 09/02/21 at 11:42am revealed:
-The post-fall report was showing "in-progress" because it was partly completed.
-He completed his section of the post-fall report but the HWD had to complete the remaining of the report.
-Following the fall on 08/13/21, no instructions or orders had been given to supervise Resident #4 more frequently, than the required every two hours for incontinent care.

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Review of Resident #4's progress notes revealed:
-On 05/18/21 at 8:39pm, "Resident #4 was found on the floor, no injuries." There was no documentation a post-fall evaluation was completed on Resident #4 as required by the facility's policy. There was no documentation of increased supervision to prevent Resident #4 from falling.
-On 06/18/21 at 14:31pm, "Resident #4 was found on the floor in her room." There was no documentation a post-fall evaluation was completed on Resident #4 as required by the facility's policy. There was no documentation of increased supervision to prevent Resident #4 from falling.

Based on Resident #4's progress notes, post-fall reports and notification to the physician, Resident #4 had 5 falls (one January 2021, two in may 2021, one June 2021 and one in August 2021). One of the falls resulted in a scrape to the resident's knee. There was no documentation of increased supervision to prevent Resident #4 from falling.

Interview with the MA on 09/02/21 at 11:42am revealed:
-Resident #4's falls occurred because the resident attempted to stand and walk.
-Resident #4 had dementia and forgot that she was totally dependent on staff for ambulation and transferring.
-If Resident #4 tried to stand without staff assistance she would fall to the floor.
-It was common for Resident #4 to have frequent falls because she wanted to stand and walk.
-Resident #4 was checked every two hours according to the facility's incontinent policy.
-There was no system of monitoring or checking on Resident #4 more frequently, then the required

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every two hours for incontinent care.

Interview with Resident #4's guardian on 09/01/21 at 4:18pm revealed:
-Resident #4 had about 5 falls since the beginning of the year, 2021.
-Resident #4 had a history of falling because she did not remember that she could no longer walk.
-Last year (unable to recall exact date) she asked the facility about putting a mattress on the floor because the majority of Resident #4's falls happened when the resident was getting out of bed.
-The facility told her that a mattress on the floor was a fire hazard and not allowed.
-The facility told her they would put pillows on the floor so when Resident #4 fell out of bed she did not get hurt.
-She had not been at the facility to observe if pillows were being used.
-The facility had not talked with her about implementing measures to increase supervision to prevent Resident #4's falls.

Interview with the Administrator on 09/01/21 at 10:20pm.
-Most of Resident #4's falls happened on the second shift so she instructed staff to keep Resident #4 up longer, because when the resident was put to bed, she would try to get up out of the bed.
-Staff were also instructed to keep Resident #4 more engaged in an activity at 6:30pm, and not to put Resident #4 down for naps.
-She instructed staff to not send the resident to bed early, like 7:00pm, but to try to keep the resident up to 10:00pm, so she would sleep all night.

Based on observation, record review and

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D 270	Continued From page 12 interviews it was determined Resident #4 was not interviewable. The HWD was not available for interview on 09/02/21.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#3) who had orders for finger stick blood sugar (FSBS) checks with parameters. The findings are: Review of Resident #3's current FL2 dated 08/17/21 revealed diagnoses included dementia, hyponatremia, B12 deficiency, urinary retention, and pain. Review of Resident #3's Primary Care Physician's (PCP) consultation notes dated 08/19/21 revealed: -He had a diagnosis of type 2 diabetes mellitus without complication and without long-term current use of insulin. -He suffered from diabetes and was currently on glipizide and metformin. -The PCP would order fasting blood sugars for close monitoring. -There was an order to check FSBS in the morning and notify the PCP if FSBS was less	D 273		

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than 60 or more than 500.

Review of Resident #3's electronic Medication Administration Record (eMAR) for August 2021 revealed:
-There was an entry to check fasting blood sugar in the morning for type 2 diabetes and notify the physician if FSBS was less than 60 or greater than 500.
-There was documentation Resident #3's FSBS was checked from 08/24/21 through 08/31/21, but there was no documentation of any FSBS readings.

Review of Resident #3's Progress Notes for August 2021 revealed:
-On 08/23/21, there was documentation of a new order for FSBS to be checked in the morning.
-On 08/24/21, there was documentation Resident #3's FSBS was 286.
-On 08/31/21, there was documentation Resident #3's FSBS was 98.
-There was no other documentation of Resident #3's FSBS in August 2021.

Interview with a representative from the contracted pharmacy on 08/31/21 at 11:38am revealed:
-There was an order for Resident #3 to check FSBS in the morning and contact the physician for FSBS less than 60 or greater than 500.
-The order for FSBS was faxed to the pharmacy on 08/23/21 and the pharmacy entered the order on the eMAR on 08/23/21.

Interview with the Resident #3's family member on 08/31/21 at 11:50am revealed:
-Resident #3 was diabetic.
-Resident #3 received FSBS checks, but she was not sure how many times a day.

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Interview with Resident #3's PCP on 08/31/21 at 1:10pm revealed:
-Resident #3 was hospitalized prior to being admitted into the facility.
-She wrote an order for FSBS for Resident #3 because his family wanted his FSBS to be checked.
-She was only going to leave the order for FSBS in place for 2 weeks and then discontinue the order.
-Resident #3 was not on insulin and really did not need to have his FSBS checked.

Interview with a medication aide (MA) on 08/31/21 at 3:37pm revealed:
-MAs were able to enter orders on the eMAR, but the Health and Wellness Coordinator (HWC) or the Health and Wellness Director (HWD) usually entered the orders.
-FSBS were usually documented on the eMAR, but MAs could also document FSBS in the progress notes.
-Any MA also could have added an entry for FSBS to the eMAR.
-She documented on the eMAR Resident #3's FSBS was checked on 08/28/21, but she did not document the FSBS reading for 08/28/21.
-She did not remember what Resident #3's FSBS reading was on 08/28/21.
-She did not know why there was not a space to document FSBS readings on the eMAR or why FSBS were not documented daily for Resident #3.
-She had not contacted the physician regarding FSBS and did not know if any other MA had contacted the physician for FSBS reading less than 60 or above 500.

Interview with the HWC on 08/31/21 at 3:50pm

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revealed:
-She was new to working at the facility and was still in training.
-She did not know there was not an entry to document FSBS readings for Resident #3 on the eMAR or that his FSBS had not been recorded daily.
-FSBS readings should have been documented on the eMAR and parameters should have been followed as ordered by the physician.

Interview with a MA on 09/01/21 at 10:00am revealed:
-She noticed there was no space to document FSBS readings on the eMAR, she did not know who was responsible for entering FSBS readings on the eMAR.
-She did not ask how or where to document, and no one instructed her how to document the FSBS for Resident #3.
-She documented FSBS for Resident #3 in his progress notes on 08/24/21, 08/31/21, and 09/01/21.
-She did not know why FSBS readings were not documented for Resident #3 daily and she did not know if Resident #3's PCP needed to be contacted due to FSBS being less than 60 or above 500.

Interview with Resident #3's PCP on 09/01/21 at 5:00pm revealed:
-She did not know there was no documentation of Resident #3's FSBS readings.
-She expected staff to check and record Resident #3's FSBS daily and to contact her with any FSBS less than 60 or more than 500.
-She had not been contacted by staff at the facility regarding Resident #3's FSBS.

Interview with the Administrator on 08/31/21 at

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D 273	Continued From page 16 4:14pm revealed: -She did not know there was no space on the eMAR for documentation of FSBS readings for Resident #3. -FSBS should have been documented on the eMAR or in the progress notes. -She did not know if Resident #3's PCP needed to be contacted for FSBS less than 60 or greater than 500. -A space to document FSBS readings could have been entered on the eMAR by the HWC, HWD or by any MA approved by the HWC, HWD or a second MA. The HWD was not available for interview from 08/31/21 through 09/02/21.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record review, and interviews the facility failed to clarify medication	D 344		

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orders for 1 of 5 residents sampled (#4) who had orders for acid reflux medication and an order for routine pain medication.

The findings are:

a. Review of Resident #4's current FL2 dated 05/06/21 revealed:
-Diagnoses of Alzheimer's disease.
-Medication orders did not include pantoprazole 40mg once daily.

Review of Resident #4's record revealed a hospital discharge summary dated 08/01/21 with orders for pantoprazole 40mg once daily (used to treat gastroesophageal reflux).

Review of Resident #4's June, July and August 2021 electronic medication administration record (eMAR) revealed there was no entry for pantoprazole 40mg once daily.

Observation of Resident #4's medications on hand on 09/01/21 at 1:50pm revealed:
-Pantoprazole 40mg once daily was available for administration.
-There were three unused cards of pantoprazole 40mg.
-Each medication card had visible hand writing that spelled "PRN" in the top left corner of the medication card.
-One card was filled on 06/10/21 and 28 tablets were dispensed, there were 28 tablets remaining.
-A second card was filled on 07/08/2 and 28 tablets were dispensed, there were 28 tablets remaining.
-A third card was filled on 08/04/21 and 28 tablets were dispensed, there were 28 tablets remaining.

Telephone interview with a representative from

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the facility's contracted pharmacy on 09/01/21 at 3:00pm revealed:
-The pharmacy received a refill order for pantoprazole 40mg on 06/03/21.
-Pantoprazole 40mg was initially ordered from a hospital discharge summary report dated 08/01/21.
-Pantoprazole 40mg once daily was on cycle fill and 28 tablets were scheduled to be dispensed every month.
-There had been no orders to discontinue pantoprazole 40mg, so the pharmacy dispensed the medication as ordered.
-Resident #4's current medication orders should be sent to the pharmacy.
-The last FL2 received by the pharmacy was dated 03/19/19.
-If the pharmacy received the current FL2 and it did not include pantoprazole 40mg the pharmacy would have requested to have the medication clarified.

Interview with the medication aide (MA) on 09/01/21 at 3:22pm revealed:
-It was her understanding Resident #4 currently was not administered any medications.
-She did not realize Resident #4's pantoprazole 40mg was ordered once daily and was sure the medication was not administered.
-She did not read the medication card and was aware the administration instructions were to administer the medication daily.
-She had not contacted the resident's Primary Care Provider (PCP) to clarify the order.
-The MA that wrote "PRN" (as needed) on the pantoprazole medication card should have put a change sticker on the medication and called the doctor to clarify the order.

Interview with Resident #4's PCP on 09/01/21 at

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11:12am revealed:
-She visited the facility weekly but did not look at medications.
-She did not recall ordering pantoprazole 40mg once daily.
-The medication may have been ordered from the resident's last hospital visit.
-She expected all medications to be administered as ordered.
-If the facility was not sure about administering the pantoprazole they should have contacted her.

Interview with the Administrator on 09/02/21 at 5:13pm revealed:
-If the MA was not administering a medication, she should let the HWD know and the HWD should contact the resident's PCP or find out why the medication was not administered.
-The HWD did medication cart audits monthly to identify medications not used and expired.
-During the cart audit the HWD should have identified Resident #4's pantoprazole was marked as PRN but was not ordered PRN.
-The HWD should have contacted the resident's PCP and clarified the order for the pantoprazole.

Based on observation, record review and interview it was determined Resident #4 was not interviewable.

The HWD was not available for interview on 09/02/21.

b. Review of Resident #4's current FL2 dated 05/06/21 revealed an order for tylenol 325mg 2 tablets (650mg) every 8 hours as needed for pain. There was no order for tylenol 325mg 2 tablets (650mg) every 8 hours as needed (PRN) for pain.

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Review of Resident #4's record revealed a hospital discharge summary dated 08/01/20 with orders for tylenol 325mg 2 tablets (650mg) twice daily (used to treat pain).

Review of Resident #4's June, July and August 2021 eMAR revealed there was no entry for tylenol 325mg 2 tablets (650mg) twice daily on the MAR.

Observation of Resident #4's medications on hand on 09/01/21 at 1:52pm revealed:
-Tylenol 325mg 2 tablets (650mg) was available for administration.
-There were six unused cards of tylenol 650mg with instructions to administer the medication twice daily.
-There was two partially used cards of tylenol 650mg with instructions to administer the medication twice daily.
-There was hand-writing in the top left corner of each medication cards of tylenol for "PRN".
-One card had a fill date of 02/18/21 and 56 tablets were dispensed. There were 12 tablets remaining.
-Two cards with a fill date of 05/13/21 and 56 tablets per card were dispensed. One card had 56 tablets remaining. The second card had 22 tablets remaining.
-Two cards with a fill date of 06/10/21 and 56 tablets were dispensed per each card. One card 56 tablets remaining. The second card had 48 tablets remaining. There was no documentation on the eMAR the medication was administered.
-Two cards with a fill date of 07/08/21 and 56 tablets were dispensed per each card, there were 112 tablets remaining.
-Two cards with a fill date of 08/05/21 and 56 tablets were dispensed per each card, there were 112 tablets remaining.

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Review of Resident #4's record revealed there was no documentation clarifying the order for tylenol 650mg twice daily or notifying the PCP that tylenol 650mg twice daily was not administered.

Telephone interview with a representative from the facility's contracted pharmacy on 09/01/21 at 3:00pm revealed:
-The pharmacy received an order dated 08/01/21 for tylenol 325mg 2 tablets (650mg) twice daily.
-Tylenol 325mg 2 tablets (650mg) were cycle filled and dispensed every month.
-The pharmacy contacted the facility on 08/01/20 to clarify the tylenol 650mg twice daily because Resident #4 already had an order for tylenol 650mg every 8 hours as needed for pain. There no response from the facility regarding the pharmacy's request to clarify the tylenol 650mg twice daily, so the pharmacy continued to dispense the medication.
-There had been no orders discontinuing tylenol 650mg twice daily, so the medication was dispensed monthly.

Interview with Resident #4's primary care provider (PCP) on 09/01/21 at 11:12am revealed:
-She did not order tylenol 650mg twice daily.
-The medication may have been ordered when the resident went to the hospital.
-The facility should clarify the order instead of not administering the medication.
-Resident #4 did not complain a lot of pain and did not know why the hospital ordered tylenol 650mg twice daily.

Interview with the Administrator on 09/02/21 at 5:13pm revealed:
-The HWD did a cart audit monthly and should

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D 344	Continued From page 22 have identified Resident #4's tylenol 650mg was ordered twice daily but some parked "PRN" on the medication card. -The HWD should have contacted the resident's PCP to clarify the order for tylenol instead of not administering the medication. Based on observation, record review and interview it was determined Resident #4 was not interviewable. The HWD was not available for interview on 09/02/21.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, records and interviews the facility failed to ensure medications were administered as ordered by the prescribing physician for 1 of 5 sample residents (Resident #5) with orders for an antidepressant medication. The findings are: Review of Resident #5's current FL2 dated 06/07/21 revealed diagnoses included Alzheimer's dementia.	D 358		

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Review of Resident #5's record revealed an order dated 06/21/21 for citalopram 20mg once daily (used to treat major depression).

Review of Resident #5's June 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for citalopram 20mg once daily scheduled for administration at 9:00am.
-There was documentation citalopram 20mg was first administered 06/21/21 at 9:00.
-There was documentation citalopram 20mg once daily was administered every day from 06/22/21 through 06/30/21 as ordered.
-There was no documentation the resident refused citalopram 20mg or the medication was not administered.

Review of Resident #5's July 2021 eMAR revealed:
-There was an entry for citalopram 20mg once daily scheduled for administration at 9:00am.
-There was documentation citalopram 20mg once daily was administered every day from 07/01/21 through 07/31/21 as ordered.
-There was no documentation the resident refused citalopram 20mg or the medication was not administered.

Review of Resident #5's August 2021 eMAR revealed:
-There was an entry for citalopram 20mg once daily scheduled for administration at 9:00am.
-There was documentation citalopram 20mg once daily was administered every day from 08/01/21 through 08/31/21 as ordered.
-There was no documentation the resident refused citalopram 20mg or the medication was not administered.

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Observation of Resident #5's medications on hand revealed:
-Citalopram 20mg was available for administration.
-There were three cards of citalopram 20mg.
-Citalopram 20mg was filled on 06/21/21 for a quantity of 30 tablets. There were 16 tablets remaining.
-Citalopram 20mg was filled on 07/08/21 for a quantity of 28 tablets, there were 10 tablets remaining.
-Citalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remaining.

According to review of eMAR documentation and dispensed dates, there was an overage of 26 citalopram 20mg tablets, there should only have been 13 tablets remaining.

Interview with Resident #5's guardian on 09/02/21 at 9:00am revealed:
-Resident #5 was admitted to the facility on 06/09/21.
-When Resident #5 was admitted she had not been ordered citalopram.
-Citalopram 20mg once daily was ordered one to two weeks after the resident was admitted to the facility.

Interview with the medication aide (MA) on 09/01/21 at 3:22pm revealed:
-The new medications were not put on the medication cart until 09/06/21.
-The MA was pulling medications from both cards of citalopram, which was why there were so many citalopram 20mg tablets left.
-She also thought that maybe Resident #5 came to the facility with citalopram 20mg but was not

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sure.

Interview with the MA on 09/02/21 at 9:25am revealed:
-Resident #5 sometimes refused her citalopram, which may account for the overage.
-The past four days the resident refused the medication when she worked.
-She had not notified the PCP but planned to do so today.
-When the resident refused there should be documentation on the MAR that showed the date of the refusal and the MA that attempted to administer the medication.
-She was sure the overage of citalopram 20mg was because Resident #5 had refused the medication, and the MA was clicking off as if the medication was administered, instead of going back to the eMAR and showing the medication was refused.

Interview with Resident #5's primary care provider (PCP) on 09/02/21 at 10:11am revealed:
-She had last seen Resident #5 on 08/13/21 and adjusted another medication.
-She was in the facility weekly and was not made aware the resident was not being administered the citalopram 20mg.
-No one told her anything about the resident refusing the medication.
-Resident #5 had depression and did not like to come out of her room.
-If the medication was not given for whatever reason the facility should notify her to clarify how the medication should be administered.
-In order for the medication to be effective she expected the medication to be administered as ordered.

Based on observation, record review and

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D 358	Continued From page 26 interview it was determined Resident #5 was not interviewable. The HWD was not available for interview on 09/02/21. Interview with the Administrator on 09/02/21 at 5:13pm revealed: -The HWD was responsible for doing monthly cart audits. -The HWD should have identified Resident #5 had an overage of citalopram 20mg and questioned why. -If the resident was refusing the medication there should be documentation related to medication refusal. -The HWD should be notified when a medication was not administered.	D 358		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	D934		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARY	7870 CHAPEL HILL ROAD CARY, NC 27513

(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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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) who were employed as medication aides had completed the state approved annual infection control training.

The findings are:

Review of Staff B's, medication aide personnel record revealed:
-Staff B was hired on 12/21/16.
-There was documentation Staff B's last state approved infection control training was completed on 07/25/19.
-There was no documentation of completion of the state approved infection control training since 07/25/19 available for review in Staff B's personnel record.

Telephone interview with Staff B on 09/02/21 at 11:50am revealed:
-He had completed the state approved infection control training several times.
-He did not remember participating in an infection control training recently.
-The Business Office Manager (BOM) had been keeping all of his infection control training certificates.

Interview with the Administrator on 09/01/21 at 3:00pm revealed:
-The BOM was responsible for maintaining the staff records in the BOM office.
-The Health and Wellness Director (HWD) was responsible for ensuring all staff were checked off for competency requirements, had documentation for the requirements of the various positions or were assisted with scheduling and validating completion of requirements including infection

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D934	Continued From page 28 control training. Interview with the BOM on 09/02/21 at 4:45pm revealed: -He became the BOM in the middle of February 2021. -He had not audited staff records for completeness and documentation for required staff qualifications. -There was not a check off list for staff requirements that he was aware of or could locate. -The HWD was responsible to ensure MAs received infection control training annually. The HWD was unavailable for interview from 08/31/21 to 09/02/21.	D934		
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	D935		

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applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
(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:
Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff who administered medications had completed a Medication Clinical Skills Competency Validation (Staff A), and had successfully passed the written medication aide examination (Staff D).

The findings are:

1. Review of Staff D's, personal care aide (PCA)/medication aide (MA) personnel record revealed:
-Staff D was hired on 10/06/20.
-Staff D completed the Medication Clinical Skills Competency Validation on 05/07/21 and completed the 15-hour medication administration

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training course on 04/27/21.
-There was no documentation Staff D passed the written medication aide exam.

Review of 2 residents' June 2021, July 2021 and August 2021 electronic Medication Administration Record (eMAR) revealed:
-Staff D documented the administration of medications 10 days in June 2021.
-Staff D documented the administration of medications 13 days in July 2021.
-Staff D documented the administration of medications 9 days in August 2021.

Attempted interviews with Staff D on 09/01/21 and 09/02/21 at 11:30am were unsuccessful.

Interview with the Administrator on 09/01/21 at 3:00pm revealed:
-The Business Office Manager (BOM) was responsible for maintaining the staff records in the BOM office.
-The Health and Wellness Director (HWD) was responsible for ensuring all staff were checked of for competency requirements, had documentation for the requirements of the various positions or were assisted with scheduling and validating completion of requirements including MA training and competency validations.
-The HWD was responsible to ensure the medication aides met the training requirements and passed the written MA examination in order to pass medications.
-The BOM and HWD should assist each other to ensure the facility was compliant with staff requirements.
-MAs were responsible to schedule, take and proved documentation of successful passing of the written MA exam within the 60 day restriction if they did not have documentation of previously

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passing the exam.

Interview with the BOM on 09/02/21 at 4:45pm revealed:
-He became the BOM in the middle of February 2021.
-He had not audited staff records for completeness and documentation for required staff qualifications.
-There was not a check off list for staff requirements that he was aware of or could locate.
-The MAs were informed upon hire and completion of the Medication Clinical Skills Competency Validation by the facility HWD of the requirement to schedule and successfully pass the written MA examination within 60 days of hire as a MA.
-The HWD was responsible to ensure MAs passing medications were in compliance with staff requirements.
-The Area Nurse Manager (ANM) was assisting with ensuring staff completed validations while the HWD was out of work.

The HWD was unavailable for interview from 08/31/21 to 09/02/21.

2. Review of Staff A's, medication aide (MA) personnel record revealed:
-Staff A was hired on 07/05/21.
-Staff A passed the written MA exam on 09/26/13.
-Staff A had an incomplete Medication Clinical Skills Competency Validation partially completed on 07/22/21.

Observation of medication administration on 09/02/21 at 7:30am revealed Staff A administered 5 medications to a resident.

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Review of 2 residents' August 2021 electronic Medication Administration Record (eMAR) revealed Staff A documented the administration of medications 15 days in August 2021.

Interview with the Area Nurse Manager (ANM) on 09/02/21 at 12:30pm revealed:
-MAs routinely have training at a designated facility not this facility.
-The MA should have returned from the off-site training with a partially completed Medication Clinical Skills Competency Validation completed by the training nurse.
-The nurse at the MA's assigned facility would be responsible to complete the Medication Clinical Skills Competency Validation to include the validations for the particular facility and sign off for the MA.
-Staff A's Medication Clinical Skills Competency Validation had not been completed by the current facility nurse.

Interview with Staff A on 09/02/21 at 1:10pm revealed:
-She had the Medication Clinical Skills Competency Validation partially completed on 07/22/21 at another facility as part of her orientation.
-She did not know she should have the remaining items on the Medication Clinical Skills Competency Validation completed by the nurse in current facility.
-She had not had additional competencies validated by the facility nurse.

Interview with the Administrator on 09/01/21 at 3:00pm revealed:
-The Business Office Manager (BOM) was responsible for maintaining the staff records in the BOM office.

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-The Health and Wellness Director (HWD) was responsible for ensuring all staff were checked of for competency requirements, had documentation for the requirements of the various positions or were assisted with scheduling and validating completion of requirements including MA training and competencies.

Interview with the BOM on 09/02/21 at 4:45pm revealed:
-He became the BOM in the middle of February 2021.
-He had not audited staff records for completeness and documentation for required staff qualifications.
-There was not a check off list for staff requirements that he was aware of or could locate.
-The HWD was responsible to ensure MAs passing medications were in compliance with staff requirements.
-The Area Nurse Manager (ANM) was assisting with ensuring staff completed validations while the HWD was out of work.

The HWD was unavailable for interview from 08/31/21 to 09/02/21.