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
	HAL026054	A. BUILDING: _____ B. WING _____	R 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on October 13 and 14, 2021.	D 000		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure activities were provided to promote active involvement by all residents. The findings are: Review of the activity calendar fo October 2021 revealed: -Morning coffee was scheduled for 31 out of 31 days at 8:30am. -Diners club was scheduled for 31 out of 31 days at 11:30am. Review of the activity calendar for 10/13/21 revealed: -Morning coffee was scheduled at 8:30am. -Exercise was scheduled for 9:15am.	D 315	10/15/21 10/15/2021 Administrator and Activity Director reviewed current Calendar activities and made changes to ensure activities comply with state regulations. Administrator/Designee will review calendar monthly/as needed for resident participation to ensure all activities are designed to promote active involvement with residents, families, and community.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rochelle Mallette | TITLE: administrator | (X6) DATE: 12/6/21

Reviewed and acknowledged 3 December 2021

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D 315	Continued From page 1 -Fancy nails was scheduled for 10:00am. -Therapy was scheduled for 1:00pm. -One on one and ball toss was scheduled for 2:00pm. Observation of the facility on 10/13/21 at 8:30am revealed: -Some residents were in the dining room for breakfast. -Some residents were lined up in the hallways. -There were no activities offered. Observation of the activity/television room on 10/13/21 at 9:15am revealed: -There were 16 residents in the television room. -No activities were offered. Observation of the activity/television room and hallways on 10/13/21 at 10:00am revealed: -There were several residents in the activity/television room. -There were residents in the hallways. -No activities were offered. Observation of the facility on 10/13/21 at 11:30am revealed: -Residents were lining up for lunch in the hallways. -No activities were offered. Observation of the facility on 10/13/21 at 2:00pm revealed: -There were several residents in the hallways. -No activities were offered. Interview with the Activity Director on 10/14/21 at 11:33am revealed: -She was responsible for completing the activity calendar. -She was responsible for providing all activities	D 315		

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D 315	Continued From page 2 for the residents. -Exercise on 10/13/21 was provided outside in the courtyard at 10:00am instead of 9:15am. -Ball toss scheduled on 10/13/21 at 2:00pm was incorporated in exercise at 10:00am outside in the courtyard. -Fancy nails was not provided on 10/13/21. -Diners club activity scheduled for 11:30am on 10/13/21 was when the residents had lunch. -Therapy on 10/13/21 at 1:00pm was when residents participated in provider ordered rehabilitative therapy. -Morning coffee scheduled on 10/13/21 at 8:00am was when residents gathered for breakfast. -She thought she could incorporate resident ordered therapy as a resident activity because the residents were actively participating. -She thought she could incorporate resident breakfast and lunch as a resident activity because all the residents were grouped together and socializing at those times. Interview with the former Administrator on 10/14/21 at 5:50pm revealed she did not know the AD was including breakfast, lunch, and rehabilitative therapy as a form of resident activity.	D 315		
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.	D 358		

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D 358	Continued From page 3 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered by a licensing/prescribed practitioner for 1 of 2 residents (#6) observed during the medication passes. The findings are: The medication error rate was 12% as evidence by the observation of 3 errors out of 25 opportunities during the 8:00am medication pass on 10/13/21 and 7:00am medication pass on 10/14/21. Review of Resident #6's current FL-2 dated 04/07/21 revealed diagnoses included diabetes mellitus, arthritis, and dementia. Review of Resident #6's standing orders dated 10/05/21 revealed there was an order to crush oral medications if not contraindicated. Observation of the medication cart on 10/14/21 at 5:45pm revealed there was not a do not crush medication list on the 100-hall medication cart. a. Review of Resident #5's current FL-2 dated 04/07/21 revealed there was an order for Hydrochlorothiazide (used treat hypertension and fluid retention) 12.5mg one capsule daily. Review of Resident #6's current physician's order sheet dated 10/11/21 revealed there was an order for Hydrochlorothiazide 12.5mg one capsule daily. Review of Resident #6's October 2016 electronic	D 358	10/14/21 Administrator/RCC notified pharmacy and PCP for medications that cannot be crushed regarding resident #6. One on one in-service was done by Administrator on 10/14/2021 with all Medication Aides to ensure they are aware of: • Proper hand hygiene when dispensing medication • Policies and procedures for medications that cannot be crushed(crush med list placed on each med cart) • Procedures to follow for residents that have medications that need to be crushed (to notify RCC/Administrator with all medications who will contact PCP for medication administration guidance) • Ensuring 3 checks are done along with reading EMAR to properly ensure all medications are given properly See attachment #3	

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D 358	Continued From page 4 medication administration record (eMAR) revealed: -There was an entry for Hydrochlorothiazide 12.5mg take one capsule daily to be administered at 8:00am. -There was documentation Hydrochlorothiazide 12.5mg was administered at 8:00am at 10/13/21. Observation of the medication aide (MA) on 10/13/21 from 9:15am - 9:35am revealed: -The MA removed the Hydrochlorothiazide capsule from the bubble pack and placed it medication cup with other medications. -The MA poured the medications containing the Hydrochlorothiazide capsule into a crush envelope. -The MA crushed the Hydrochlorothiazide capsule with other medications. -The Hydrochlorothiazide capsule broke apart and the capsule did not crush. -The MA mixed the Hydrochlorothiazide capsule in pudding and administered to Resident #6. Interview with the MA on 10/13/21 from 12:00pm - 12:15pm revealed: -He always crushed Resident #6's Hydrochlorothiazide. -He did not know capsules were not to be crushed. -He had never received education from the facility to not crush capsules. -There was no do not crush medication list on the medication cart. -He had never seen a do not crush medication list since starting six years ago. -He had never been trained regarding do not crush medications. -He was told when first hired Resident #6 required all her medications crushed for administration. He did not know who told him.	D 358	11-9-21 10/14/2021 Staff A was pulled from medication cart and was not able to pass any medication until a validation was done by a LHPS nurse. A LHPS medication administration validation was done for staff A on 10/17/2021. Medication administration course was done by a LHPS nurse on 11/9/2021 with all medication aides. See attachment 1 & 2	

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D 358	Continued From page 5 -Resident #6's medications were crushed because she had difficulty swallowing. -The medication administration process was to read the eMAR for the resident name, time, and dose to be administered. He would not read anything else on the eMAR. -The eMAR did not contain any other information other than when a medication order had expired. -He would pull the medication bubble pack and verify the resident name and time of administration on the pharmacy label. He would not read anything else on the pharmacy label. -He would administer the mediation to the resident after following those steps. Interview with the Administrator on 10/13/21 at 12:36pm revealed: -She did not expect the MA to crush a capsule. -She expected the MA's to read the eMAR and pharmacy labels for specific instructions such as do not crush. -There was no do not crush medication list on the medication cart for MA's to refer to. Interview with Resident #6's Primary Care Provider on 10/14/21 at 2:35pm revealed: -Hydrochlorothiazide was a diuretic and could cause low blood pressure. -She did not expect capsules to be crushed. -Capsules were to be broken apart and the medication sprinkled in pudding or apple sauce for administration. -She was not concerned Resident #6 would have a negative outcome from administering a crushed Hydrochlorothiazide capsule to the resident. Refer to interview with the Administrator on 10/13/21 at 12:36pm. Based on observations, interviews, and record	D 358		

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D 358	Continued From page 6 reviews Resident #6 was not interviewable. b. Review of Resident #6's current FL-2 dated 04/07/21 revealed there was an order for Nifedipine (used to treat hypertension) 30mg Extended Release (ER) one tablet daily. Review of Resident #6's current physician's order sheet dated 10/11/21 revealed there was an order for Nifedipine 30 mg ER one tablet daily, do not crush. Review of Resident #6's October 2016 eMAR revealed: -There was an entry for Nifedipine 30mg ER one tablet daily, do not crush to be administered at 8:00am. -There was documentation Nifedipine 30mg was administered on 10/13/21 at 8:00am. Observation of a medication aide (MA) on 10/13/21 from 9:15am - 9:35am revealed: -The MA removed the Nifedipine ER tablet from the bubble pack and placed it medication cup with other medications. -The MA poured the medications containing the Nifedipine ER tablet into a "crush" envelope. -The MA crushed the Nifedipine ER tablet with other medications. -The MA was prompted to review the do not crush order in Resident #6's eMAR. -The MA did not respond. -The MA mixed the Nifedipine ER tablet in pudding and administered to Resident #6. Interview with the MA on 10/13/21 from 12:00pm - 12:15pm revealed: -He did not remember reading Resident #6's Nifedipine's "do not crush" instructions on the pharmacy label.	D 358		

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D 358	Continued From page 7 -He did not see the do not crush Nifedipine instructions on Resident #6's eMAR during the 8:00am medication pass today, 10/13/21. -He had always crushed Resident #6's Nifedipine. -There was no do not crush medication list on the medication cart. -He had never seen a do not crush medication list since starting six years ago. -He had never been trained regarding do not crush medications. -He was told when first hired Resident #6 required all her medications crushed for administration. He did not know who told him. -Resident #6's medications were crushed because she had difficulty swallowing. -The medication administration process was to read the eMAR for the resident name, time, and dose to be administered. He would not read anything else on the eMAR. -The eMAR did not contain any other information other than when a medication order had expired. -He would pull the medication bubble pack and verify the resident name and time of administration on the pharmacy label. He would not read anything else on the pharmacy label. -He would administer the medication to the resident after following those steps. Interview with the Administrator on 10/13/21 at 12:36pm revealed: -She expected the MA's to read the eMAR and pharmacy labels for specific instructions such as do not crush. -There was no do not crush medication list on the medication cart for MA's to refer to. Telephone interview with Resident #'s Primary Care Provider (PCP) on 10/13/21 at 2:45pm revealed: -Nifedipine was not to be crushed because it was	D 358		

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D 358	Continued From page 8	D 358		

an ER medication.
-Crushing Nifedipine would cause Resident #6 to receive all the medication at once instead of gradually over a period.
-Administering crushed Nifedipine ER to Resident #6 could cause the resident's blood pressure to lower suddenly causing syncope.
-She did.not think Resident #6 would experience syncope because her blood pressure was normally high.
-She has ordered blood pressure checks twice daily for two weeks for Resident #6 to monitor her for low blood pressure.

Refer to interview with the Administrator on 10/13/21 at 12:36pm.

Based on observations, interviews, and record reviews Resident #6 was not interviewable.

c. Review of Resident #6's current physician's order sheet dated 10/11/21 revealed there was an order for Tylenol (used to treat pain) 650mg three times daily (TID).

Observation of the medication cart for 100-hall on 10/14/21 at 2:40pm revealed there was approximately 100 tablets of Tylenol 325mg of house stock on the cart.

Review of Resident #6's October 2016 eMAR revealed:
-There was an entry for Tylenol 325mg take two tablets (650mg) TID at 8:00am, 2:00pm, and 8:00pm.
-There was documentation Tylenol 650mg was administered on 10/13/21 at 8:00am.

Observation of the medication aide (MA) on 10/13/21 from 9:15am - 9:35am revealed the MA

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D 358	Continued From page 9 did not administer Tylenol 650mg to Resident #6. Interview with the MA on 10/13/21 at 9:35am revealed he had administered all 7:00am and 8:00am medications to Resident #6 that were due today, 10/13/21. Second interview with the MA on 10/13/21 from 12:00pm - 12:15pm revealed he did not think he administered Tylenol to Resident #6 during the 8:00am medication pass today, 10/13/21. -There was no reason why. Interview with the Administrator on 10/13/21 at 12:36pm revealed: -She expected Resident #6's Tylenol to have been administered per order. -She did not expect a medication to be documented in the eMAR as administered if not. -She expected three checks to be performed when administering medications to ensure there were no medication errors made. -She expected the MA to have compared the eMAR to the pharmacy label, compared the pharmacy label to the eMAR then pop the medication from the bubble pack, administered the medications to the resident, then compared the pharmacy label to the eMAR when returning the bubble packs to the medication cart drawer. Telephone interview with Resident #'s PCP on 10/13/21 at 2:45pm revealed: -She expected Tylenol to be administered as ordered. -Tylenol was ordered for Resident #6 to treat mild shoulder and neck pain. -She was not concerned with Resident #6 missing one dose of Tylenol. Refer to interview with the Administrator on	D 358		

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D 358	Continued From page 10 10/13/21 at 12:36pm . Based on observations, interviews, and record reviews Resident #6 was not interviewable. Interview with the Administrator on 10/13/21 at 12:36pm revealed: -She expected three checks to be performed when administering medications to ensure there were no medication errors made. -She expected the MA to have compared the eMAR to the pharmacy label, compared the pharmacy label to the eMAR then removed the medication from the bubble pack, administered the medications to the resident, then compared the pharmacy label to the eMAR when returning the bubble packs to the medication cart drawer.	D 358	Administrator/Designee will do a medication med pass review once a month with each Medication Aid to ensure they are properly administering medications according to policies and procedures x3 and then quarterly.	continues
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by:	D 612		

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D 612	Continued From page 11 Based on observation, interviews and record reviews the facility failed to ensure recommendations and guidance established by the Centers for Disease Control and Prevention (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to the screening of visitors for COVID-19 signs and symptoms. The findings are: Review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 09/10/21 revealed: -Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has symptoms of COVID-19, a positive viral test for SARS-CoV-2, or who meets criteria for quarantine so that they can be properly managed. -Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report symptoms of COVID-19 before entering the facility. -A strong infection control program is critical to protect both residents and healthcare personnel. Review of the NCDHHS guidelines dated 05/05/21 revealed: -Everyone who enters a healthcare facility shall be screened for signs and symptoms of COVID-19 by temperature checks, screening questions and observations of signs and symptoms. -Establish a process to ensure visitors entering the facility are assessed for symptoms of COVID-19 and temperatures are checked.	D 612	10/20/2021 Administrator in serviced all staff of visitor screening process. Facility screening policy is posted in common employee areas and in each sign in book. Office Manager will review screening log three times a week to ensure all screening areas are being addressed. Administrator/Designee will review screening logs once monthly or as needed. Administrator/Designee will in service staff at hire and as needed for updates and changes.	10/20/21

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D 612	Continued From page 12 Review of the facility's COVID-19 policy revealed visitors will be screened for fever and other COVID-19 symptoms. Review of the facilities training agenda for Infection Control Policies and Updates provided by the Administrator on 10/14/21 revealed: -Staff were educated to screen all visitors before entering the facility. -The training document was not dated. Review of the facility's Guidance for Infection Prevention and Control Program (IPCP) dated 10/29/20 revealed: -The facility will update and implement the IPCP consistent with the Centers for Disease Control (CDC) guidelines. -There would be a procedure for screening facility visitors. -There would be criteria for restricting visitors who exhibit signs of illness. Review of the visitor sign in sheet from 10/01/21 - 10/13/21 revealed: -There was no documentation temperatures had been assessed for 14 out of 83 visits. -There was no documentation that symptoms of COVID-19 were assessed for 9 out of 83 visits. -There was no documentation of recent travel outside the country or COVID-19 exposure had been assessed for 14 out of 83 visits. -There was incomplete documentation for 37 out of 83 visits for COVID-19 screening.. Observation of the facility on 10/13/21 at 8:15am revealed: -There was a thermometer on the wall and visitors sign in sheet on a table to the right of the door upon entrance to the facility.	D 612		

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	NAL026054	A. BUILDING: _____ B. WING _____	R 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 13 -The visitors sign in sheet contained documentation asking if positive for COVID-19 symptoms, travel outside the country or exposure to COVID-19, and temperature. Observation of the facility on 10/13/21 at 9:00am revealed: -A health care provider was allowed entrance through the front door of the facility by the office manger (OM). -COVID-19 screening or a temperature check were not performed prior to entry. -There was a thermometer on the wall and visitors sign in sheet on a table to the right of the door upon entrance to the facility. -The OM walked away without screening the healthcare providers temperature, asking COVID-19 screening questions, or prompting to perform a temperature self-assessment and completing the visitor sign in sheet. -The healthcare provider performed a temperature self-assessment using the wall thermometer and completed the visitor sign in sheet which contained COVID-19 screening questions. -The OM did not review the healthcare providers temperature or COVID-19 screening questions. Interview with the OM on 10/13/21 at 9:10am. -Visitors were to have their temperatures taken and asked COVID-19 screening questions by any staff before entering the facility. -Healthcare providers could screen their temperatures and complete the COVID-19 screening questions independently. -Today, the healthcare provider knew to screen her temperature and complete the COVID-19 screening questions in the visitors sign in sheet because she visited the facility twice a week. -The OM knew the healthcare provider did not	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	R 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 14 have a temperature today because she heard the wall thermometer speak "normal temperature" when the healthcare provider screened her temperature. -She was confident the healthcare provider would not have entered the facility if she had signs/symptoms of COVID-19. Observation of the facility on 10/14/21 at 7:00am revealed: -A personal care aide (PCA) allowed surveyors entrance in the facility through the locked front door. -There was a thermometer on the wall and visitors sign in sheet on a table to the right of the door upon entrance to the facility. -The PCA instructed surveyors to obtain temperatures and complete the visitor sign in sheet located on the table. -The PCA walked away without screening temperatures, asking COVID-19 screening questions, or reviewing the visitor sign in sheet completed by surveyors. Interview with the PCA on 10/14/21 at 7:15am revealed: -She would allow visitors in the facility, tell them to assess their temperature and to complete the COVID-19 screening questions documented in the visitor sign in sheet. -The wall thermometer would alert "normal temperature" or "hi temperature" when visitors assessed their temperatures. -She would hear the thermometer alert as she walked away. -The Administrator educated her about 3 months ago to screen visitors for signs and symptoms of COVID-19 before allowing their entrance in the facility. -She did not screen surveyors for signs or	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026034	A. BUILDING: _____ B. WING _____	R 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 15 symptoms of COVID-19 before allowing entrance in the facility today, 10/14/21, because she was in a hurry. Interview with the Administrator on 10/14/21 at 7:37am revealed: -There was not one specific person assigned the responsibility of allowing visitors in the facility. -Any staff who opened the door could screen visitors in the facility. -Before visitors were allowed entrance in the facility, the staff who answered the door would ask the visitors if they had signs/symptoms of COVID-19 and screen their temperature. -Visitors who had signs/symptoms of COVID-19 or a temperature of 99.9 degrees were not allowed entrance in the facility. -Visitors who did not have signs/symptoms of COVID-19 were allowed in the facility and instructed to complete the visitors log. -The visitors log contained documentation asking if they had signs/symptoms of COVID-19, exposure, travel, and temperature. Attempted interview with the healthcare provider on 10/13/21 at 9:30am was unsuccessful.	D 612		
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	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	R 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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
D935	Continued From page 16 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 staff sampled (A) who administered medications had completed the medication administration clinical skills validation checklist prior to administering medications and had completed the state-approved 5-hour and 10-hour medication	D935	10/18/21 Staff A completed the 5-hour Medication Aide training course 6/19/2015, had a Medication Administration validation by a LHPS nurse on 10/17/2021, and a 10-hour Medication Administration Training Course on 10/18/2021. Business Office Manager/Administrator/Designee will conduct biannual personal records. See attachment 4 (3 pages)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	R 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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
D935	Continued From page 17 aide training courses as required (A). The findings are: Review of Staff A's personnel record revealed: -There was no hire date documented for Staff A. -There was no Medication Administration Clinical Skills Validation Checklist for Staff A. -There was no 5, 10, or 15-hour MA training courses completed for Staff A. -Staff A completed the MA written exam on 05/12/15. Review of resident's August - October 2021 electronic medication administration records (eMARs) on 10/14/21 revealed: -Staff A administered medications on 6 of 31 days from 08/01/21 - 08/31/21. -Staff A administered medications on 16 of 30 days from 09/01/21 - 09/30/21. -Staff A administered medications on 10 of 13 days from 10/01/21 - 10/31/20. Observation of the 8:00am medication pass on 10/13/21 revealed: -Staff A made 3 medication errors with one resident during the medication pass. -Staff A did not administer the resident's Tylenol (for pain) as ordered. -Staff A crushed the resident's Nifedipine Extended Release (for high blood pressure slowly released over a period of time) tablet for administration. -Staff A crushed the resident's Hydrochlorothiazide (a diuretic) capsule for administration. Interview with Staff A on 10/14/21 at 5:45pm revealed: -He was hired in 2014 or 2015 as a personal care	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	R 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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
D935	Continued From page 18 aide (PCA). -He advanced to a MA sometime in 2016. -He completed the MA 15-hour class sometime in 2016. -He began working as a MA as needed sometime in 2018 but did not work during that time. -He returned working full time as a MA in March 2019. -He completed the MA Clinical Skills Validation Checklist in 2016 and 2019. Interview with the Administrator on 10/14/21 at 5:50pm revealed: -Human Resources (HR) staff, the Administrator, and the Business Office Manager (BOM) were responsible to ensure the MA 5, 10, 15-hour training course was completed prior to functioning as a MA in the facility. -HR staff, the Administrator, and the BOM were responsible to ensure the MA Clinical Skills Validation Checklist was completed prior to working as a MA in the facility. -She was not working as the Administrator when Staff A was hired 10/06/14. -She thought Staff A's facility medication continuing education classes completed on 06/11/15 counted as the MA 5, 10, 15-hour training course. -She did not know when the MA Clinical Skills Validation Checklist was supposed to be completed. -Staff A had completed the MA Clinical Skills Validation Checklist. -She did not know when Staff A completed the MA Clinical Skills Validation Checklist. -She could not locate Staff A's MA Clinical Skills Validation Checklist.	D935		

attachment # 1

The unlicensed staff must (without prompting or error) demonstrate the following skills or tasks in accordance with the guidelines on the attachments with 100% accuracy to a registered nurse or pharmacist. Competency validation by the registered nurse or pharmacist is to be in accordance with their occupational licensing laws. Items that are (*) must be checked off only by a registered nurse. **Instructor – Refer to attachment on instructions and guidelines for completing this checklist prior to beginning observation of skills or tasks. (Latest revision of guidelines for checklist is dated 10/05)**

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs More Training	Inst. Initials/ Signature
1. Basic Medication Administration Information and Medical Terminology (Refer to attachment)				
A. Matched common medical abbreviations with their meaning	10/17/04	SPS		
B. Listed/Described common dosage forms of medications and routes of administration		SPS		
C. Listed the 6 rights of medication administration		SPS		
D. Described what constitutes a medication error and actions to take when a medication error is made or detected		SPS		
E. Described resident's rights regarding medications, i.e., refusal, privacy, respect		SPS		
F. Defined medication "allergy"		SPS		
G. Demonstrated the use medication resources or references		SPS		
2. Medication Orders (Refer to attachment)				
A. Listed or Recognized the components of a complete medication order		SPS		
B. Transcribed orders onto the MAR 1. Used proper abbreviations 2. Calculated stop dates correctly 3. Transcribed PRN orders appropriately 4. Copied orders completely and legibly and/or checked computer sheets against orders and applied to the MAR 5. Discontinued orders properly		SPS		
C. Described responsibility in relation to telephone orders		SPS		
D. Described responsibility in relation to admission and readmission orders and FL-2		SPS		
E. Described or Demonstrated the process for ordering medications and receiving medications from pharmacy		SPS		
F. Identified required information on the medication label		SPS		
3. Demonstrated appropriate technique to obtain and record the following: (Refer to Attachment)				
A. * Blood Pressure		SPS		
B. * Temperature		SPS		
C. * Pulse		SPS		
D. * Respirations		SPS		
E. Fingersticks/Glucose Monitoring (Only required to be validated if the employee will be performing this task.)	✓	SPS		

EMPLOYEE NAME: [redacted]

ADULT CARE HOME NAME: Fayetteville Manor

Medication Administration Clinical Skills Checklist

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs More Training	Inst. Initials/ Signature
4. If medications are prepared in advance, procedures, including documentation, are in accordance with regulation 10A NCAC 13F/13G .1004. (Refer to Attachment)	N/A	N/A		
5. Administration of Medications (Refer to attachment)				
A. Identified resident	10/17/24	SPS		
B. Gathered appropriate equipment and keeps equipment clean		SPS		
C. MAR utilized when medications are administered and also when medications are prepared or poured (if prepouring is allowed)		SPS		
D. Read the label 3 times; Label is checked against order on MAR		SPS		
E. Used sanitary technique when pouring and preparing medications into appropriate container		SPS		
F. Offered sufficient fluids with medications		SPS		
G. Observed resident taking medications and assures all medications have been swallowed.		SPS		
6. Utilized Special Administration/Monitoring Techniques as indicated(vital signs, crush meds. check blood sugar, mix with food or liquid) (Refer to Attachment)		SPS		
7. Administered medications at appropriate time (Refer to attachment)		SPS		
8. Described methods used to monitor a resident's condition and reactions to medications and what to do when there appears to be a change in the resident's condition or health status (Refer to Attachment)		SPS		
9. Utilized appropriate hand-washing technique and infection control principles during medication pass (Refer to Attachment)		SPS		
10. Documentation of Medication Administration (Refer to Attachment)				
A. Initialed the MAR immediately after the medications are administered and prior to the administration of medications to another resident. Equivalent signature for initials is documented.		SPS		
B. Documented medications that are refused, held or not administered appropriately		SPS		
C. Administered and documented PRN medications appropriately		SPS		
D. Recorded information on other facility forms as required	✓	SPS		
E. Wrote a note in the resident's record when indicated		SPS		

EMPLOYEE NAME: [redacted]

ADULT CARE HOME NAME: Fayetteville Manor

Rev 10/05

Medication Administration Clinical Skills Checklist

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
11. Completion of Medication Pass (Refer to Attachment)				
A. Stored medications properly	10/17/04	SPS		
B. Disposed of contaminated or refused medications		SPS		
C. Rechecked MARs to make sure all medications had been given and documented		SPS		
12. Medication Storage (Refer to Attachment)				
A. Maintained security of medications during medication administration		SPS		
B. Stored controlled substances appropriately and counted and signed controlled substances per facility policy		SPS		
C. Assured medication room/cart/cabinet is locked when not in use		SPS		
13. Administered medications using appropriate technique for dosage form/route & administered accurate amount: (Refer to Attachment)				
A. Oral tablets and capsules		SPS		
B. Oral liquids		SPS		
C. Sublingual medications		SPS		
D. Oral Inhalers		SPS		
E. Eye drops and ointments		SPS		
F. Ear drops		SPS		
G. Nose drops		SPS		
H. Nasal Sprays/Inhalers		SPS		
I. Transdermal medications/Patches		SPS		
J. Topical (creams and ointments; not dressing changes)		SPS		
K. *Clean dressings		SPS		
L. * Nebulizers		SPS		
M. * Suppositories 1. Rectal 2. Vaginal		SPS		
N. * Enemas		SPS		
O. * Injections 1. Insulin** 2. Other subcutaneous medications		SPS		
P. * Gastrostomy Tube	—	SPS	—	

EMPLOYEE NAME: [redacted]

ADULT CARE HOME NAME: Fayetteville Manor

Medication Administration Clinical Skills Checklist

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
Section 14: Other Tasks/Skills				
A. Self-Administration of medications	10/17/07	SPS		
B. Received orientation to facility's policy and procedures for medication administration	See File	SPS		

EMPLOYEE NAME _____

EMPLOYEE SIGNATURE & DATE: _____

ADULT CARE HOME NAME: Fayetteville Manor

The employee at the above named facility has demonstrated competency validation in the areas as indicated on this checklist. The instructions/guidelines were used to determine the employee's competency.

INSTRUCTOR'S NAME, SIGNATURE, TITLE AND DATE:
SOUTHERN PHARMACY SERVICES (SPS)

INSTRUCTOR'S NAME, SIGNATURE, TITLE AND DATE:
[redacted] 10/17/07 [redacted]

(If more than one instructor completes the checklist, the initials of each instructor is to documented by the instructor's signature and title. The section for comments may be used if additional space needed.)

COMMENTS

Continue to learn policy and procedures and follow them. Continue to ask questions if policies are unfamiliar with you.

****It is facility/employee responsibility to complete the 5 hour class and to complete the 10 hour class and complete state test within 60 days. This RN has only validated competency on this date and did not verify 5 or 10 hour state mandated training. *****

Fayetteville Manor

Attachment 2

Training Description	Medication Administration
Purpose	Review
Date and Duration	11/09/2021

*Please Print

Name	Position	Initials
[redacted]	Med Tech	[redacted]
	med tech	
	medtech	
	medtech	
	med tech	
	medtech	
	Administrator/medtech	
	RE /medtech	

Facilitator Name: [redacted]

attachment #3 10.14.91

Inservice

patches on/off (separate order)
giving PRN medications & clicking off
passing medications within policy 1hr before
1hr after
hand hygiene when dispensing medications
policy for crushed meds | Notify RCC who will notify PCP
ensuring 3 checks are done along w/ reading
to ensure all medications are given

done by: L Wallette L Wallette

attachment 4 (3 pages)

FELS & ASSOCIATES, INC.
CULTURE AND LEARNING MANAGEMENT

Certificate of Continuing Education

is herby granted to:

[redacted]

For successfully completing

MEDAD10-01	MEDICATION AIDE
MEDAD10-02	LEGAL & ETHICAL RESPONSIBILITIES
MEDAD10-03	OVERVIEW OF MEDICATION ADMIN
MEDAD10-04	MEDICATION ORDERS & MAR
MEDAD10-05	MEDICATION ADMIN RECORD 1

5 HOURS
CEU Granted

Brett Fels

Brett Fels Ph.D.ABD, President
Fels & Associates, Inc.

6/19/15

Date Granted

North Carolina Department of Health and Human Service
Division of Health Service Regulation
Adult Care Licensure Section
2708 Mail Service Center
Raleigh, North Carolina 27699-2708
Phone: 919-855-3765
Fax: 919-733-9379

ADULT CARE HOME CONTINUING EDUCATION COURSE/PROGRAM

APPLICATION FOR CONTINUING EDUCATION PROGRAM APPROVAL

1. Fels & Associates, Inc. Corporate Learning Partners

Name of Program Sponsor (Organization or individual which may or may not be same as instructor)

2. Contact Person __Les Kafel M.Ed._Phone__910 763-6755__Fax_910-223-6924

3. E-mail address: support@felsandassociates.com

4. Wilmington, NC 28401 New Hanover County 1210 South Sixteenth St.
   Street City State Zip County

5. Course/Program Topic: **5-10-Hour Medication Administration Program**

6. Number of Instruction/Classroom Hours) Med Tech Required Instruction.-Fee-NA

7. Name(s) of Instructor(s)_Computer Based Instruction/ DHHS State Program

8. Attach the Following:

   a. Learning objectives
   b. Content outline with time schedule - show time allotted to each program topic
   c. List of any media aids planned
   d. Instructor Resume
   e. Sample CE Certificate to be isued to participants with name of program sponsor and space for recording participant's name. ED hours completed and instructior's signature and titile of person verifying participation if a conference or no instructio on site, video presentation, teleconference, etc. or signature of representivie of program sponsor if self-study.

Signature of applying applicant: *Brent G. Fels PhD Ed.S.* *President* *8-25-2012*

Mail-to:

Adult-Care-Licensure-Section
2708-Mail Service Center
Raleigh, NC 27699-2708
Phone: 919-855-3765
Fax: 919733-9379

Submit one completed application for each proposed course/program. Please notify this office of any proposed changes in the thours, content or instructiors or if the course/ program is no longer offered.

FELS & ASSOCIATES, INC.
CULTURE AND LEARNING MANAGEMENT

Certificate of Continuing Education

is herby granted to:

[redacted]

For successfully completing

Medication Administration: 10-Hour Training Course
For Adult Care Homes

Course

10 CEU Credits

CEU

Brett Fels

Brett Fels Ph.D and, President
Fels & Associates, Inc.

10/18/2021

Date Granted

Washington, Bynithia T

From: Sheka Mallette <lmallette.fm@hotmail.com>
Sent: Friday, November 19, 2021 4:04 PM
To: Washington, Bynithia T; lewis.clewis@dhhs.nc.gov; tina.nielson@dhhs.nc.gov; Torrey Locklear
Subject: RE: [External] state survey
Attachments: statesurvey.pdf

Thank you and sorry about you.

Have a beautiful day

Leshekia Mallette
Administrator
Fayetteville Alzheimer's & Dementia Care
Phone: 910-488-4821
Fax: 910-488-5269
www.fayettevillecare.com

From: Washington, Bynithia T
Sent: Friday, November 19, 2021 3:59 PM
To: 'Sheka Mallette'; lewis.clewis@dhhs.nc.gov; tina.nielson@dhhs.nc.gov; Torrey Locklear
Subject: RE: [External] state survey

Hello Shekia,

I did not receive an attachment with your email.

Kindly,
Bynithia

From: Sheka Mallette <lmallette.fm@hotmail.com>
Sent: Friday, November 19, 2021 3:57 PM
To: Washington, Bynithia T <Bynithia.Washington@dhhs.nc.gov>; lewis.clewis@dhhs.nc.gov; tina.nielson@dhhs.nc.gov; Torrey Locklear <tlocklear.fm@hotmail.com>
Subject: [External] state survey

Hello Survey Team,

I have attached a copy of the completed plan of correction from 10/14/2021. I have also put a copy of this in the mail. Please let me know if you have any questions.

Have a beautiful day

Leshekia Mallette
Administrator
Fayetteville Alzheimer's & Dementia Care
Phone: 910-488-4821
Fax: 910-488-5269
www.fayettevillecare.com

Washington, Bynithia T

From: Sheka Mallette <lmallette.fm@hotmail.com>
Sent: Friday, December 3, 2021 2:51 PM
To: Washington, Bynithia T
Subject: [External] requested information
Attachments: doc01138320211203140257.pdf

Hello Ms. Washington,

I have attached the first page with the signature only. Thank you and Happy Holidays!

Have a beautiful day,

Leshekia Mallette
Resident Care Director
Fayetteville Alzheimer's & Dementia Care
Phone: 910-488-4821
Fax: 910-488-5269
lmallette.fm@hotmail.com

From: fayettevillemanor5069@gmail.com <fayettevillemanor5069@gmail.com>
Sent: Friday, December 3, 2021 2:03 PM
To: lmallette.fm@hotmail.com <lmallette.fm@hotmail.com>
Subject:

ECOSYS M2640idw
[00:17:c8:38:9f:97]
