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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on 05/10/22- 05/13/22. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 04/12/22.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a locked area was in place for hazardous personal care items for residents in the Special Care Unit (SCU). Observation of resident rooms during a tour of the SCU on 05/10/22 between 9:15am and 2:30pm revealed: -Rooms 415, 419 and 422, were unlocked with doors open and easily accessible to the hallway. -In room 422, body lotion containing alcohol, two uncapped razors, and shampoo was visible and	D 056		

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easily accessible in an unlocked cabinet in the bathroom.
-In room 415, several bottles of body lotion, body wash, mouthwash, nail polish remover, and therapeutic foot cream was visible and easily accessible in an unlocked cabinet in the bathroom, and a resident was observed lying on the bed.
-In room 419, barrier cream and body wash containing alcohol was visible and easily accessible in an unlocked cabinet in the bathroom.
-Residents were observed walking up and down the hallways, opening doors leading into residents' rooms and entering these rooms.
-A resident was observed removing orange juice from the medication cart and drinking it.

Observation of resident rooms on 05/11/22 between 9:10am and 3:00pm on the SCU revealed:
-Rooms 415, 419 and 422, were unlocked with doors open and easily accessible to the hallway.
-In room 422, body lotion containing alcohol, two uncapped razors, and shampoo were visible and easily accessible in an unlocked cabinet in the bathroom.
-In room 415, several bottles of body lotion, body wash, mouthwash, nail polish remover, and therapeutic foot cream was visible and easily accessible in an unlocked cabinet in the bathroom.
-In room 419, barrier cream and body wash containing alcohol was visible and easily accessible in an unlocked cabinet in the bathroom.
-Residents were observed walking up and down the hallway, opening doors leading into residents' rooms and entering these rooms.
-A resident was observed walking out of a

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resident's room that was not her room.

Observation of resident rooms on 05/12/22 between 10:00am and 3:30pm on the SCU revealed:
-Rooms 415 and 422 were unlocked with doors open and easily accessible to the hallway and room 419 was unlocked with the door partially open and easily accessible to the hallway.
-In room 422, body lotion containing alcohol, two uncapped razors and shampoo were visible and easily accessible in an unlocked cabinet in the bathroom.
-In room 415, several bottles of body lotion, body wash, mouthwash, nail polish remover, and therapeutic foot cream was visible and easily accessible in an unlocked cabinet in the bathroom.
-In room 419, barrier cream and body wash containing alcohol was visible and easily accessible in an unlocked cabinet in the bathroom.

Review of the Material Safety Data Sheets (MSDS) for personal care products, moisture barrier ointments and nail care products on the items left unsecured on 05/10/22, 05/11/22 and 05/12/22 revealed:
-Ingestion of an alcohol-based mouthwash or lotion could lead to alcohol toxicity or altered mental status and had warning labels.
-The shampoos and lotions could cause nausea, vomiting, diarrhea, serious eye damage and gastrointestinal injury if ingested and all had warning labels.
-The barrier cream and nail care products were labeled with external use only, could cause acute toxicity and had warning labels.

Interview with a housekeeper on 05/12/22 at

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11:20am revealed:
-Housekeeping was not trained on what residents could keep in their rooms.
-She did not check the rooms for personal items because that was not her job.
-She kept the housekeeping cart always locked.
-She saw residents going in and out of rooms daily, taking and moving things.

Interview with a personal care aide (PCA) on 05/12/22 at 11:30am revealed:
-She was never told what personal items needed to be locked up on the SCU.
-There was a resident who went in and out of other resident rooms, picked things up, moved things and ate food if it was left in the rooms.
-If she saw razors, she would move them up on a higher shelf so residents could not reach them.

Interview with the Special Care Coordinator (SCC) on 05/12/22 at 11:45am revealed:
-Staff were trained on what residents could have in their room.
-Razors and toiletries should be kept on the top shelves.
-She did not know what staff were trained on now because we have someone coming in and doing prn (whenever needed) training.
-The MAs check the rooms at times when they passed medications.

Interview with a Medication Aide (MA) on 05/13/22 at 11:30am revealed:
-She went into the rooms only if the resident was in bed and they needed their medications.
-She was never told what items had to be locked up and there was no place to lock them.
-She did not know who was responsible for locking up hazard items, probably the SCC.

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D 056	Continued From page 4 Interview with the Administer on 05/13/22 at 2:20pm revealed: -He did not know how often the rooms should be checked for hazards. -A supervisor should be overseeing the rooms being checked. -He had not informed family members on what could be brought into the SCU.	D 056		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration.	D 164		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled Medication Aides (Staff A and Staff C), who administered insulin and obtained finger stick blood sugars for residents, completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-There was a hire date of 02/21/22.
-There was no documentation Staff A had completed training of diabetic residents.

Review of resident's March 2022 eMAR revealed Staff A documented the administration of sliding scale insulin to a resident on 03/21/22, 03/23/22, 03/27/22 and 03/28/22.

Review of resident's April 2022 eMAR revealed Staff A documented the administration of sliding scale insulin to a resident on 04/04/22.

Telephone interview with Staff A on 05/11/22 at 8:48am revealed:
-She was hired by the facility at the end of February 2022 as a personal care aide (PCA) and MA.
-She had not taken the North Carolina Medication Aide exam.
-She had not received any training related to medication administration by a facility Registered Nurse, Pharmacist or any other licensed healthcare professional.
-On or about 04/01/22 she had received

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medication administration training from other MAs and the Business Office Manager (BOM).
-On 04/04/22, she was scheduled to administer medications at the facility, no additional MA's were available to assist her.

Refer to interview with the Resident Care Coordinator (RCC) on 05/13/22 at 8:30am.

Refer to interview with the Administrator on 05/13/22 at 2:04pm.

2. Review of Staff C's, medication aide (MA), personnel record revealed:
-There was a hire date of 10/02/21.
-There was no documentation Staff C had completed training of diabetic residents.

Review of resident's March 2022 eMAR revealed Staff C documented the administration of sliding scale insulin to a resident on 03/01/22, 03/05/22, 03/06/22, 03/10/22, 03/15/22, 03/16/22, 03/23/22, 03/24/22, 03/28/22, 03/29/22 and 03/30/22.

Review of resident's April 2022 eMAR revealed Staff C documented the administration of sliding scale insulin to a resident on 04/02/22, 04/07/22, 04/11/22, 04/16/22, 04/20/22, 04/22/22 and 04/25/22.

Telephone interview with Staff C on 05/03/22 at 2:35pm revealed:
-She was employed by the facility as a personal care aide (PCA) and was promoted to MA in February 2022.
-In February 2022, she received medication administration training from the BOM and the former Special Care Coordinator (SCC) with no additional training by a licensed healthcare professional.

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-She did not know what medication administration training the former SCC had prior to training her.
-She was scheduled to take the North Carolina Medication Aide exam on 05/08/22.
-In February 2022, she started to administer residents' medications independently.

Refer to interview with the Resident Care Coordinator (RCC) on 05/13/22 at 8:30am.

Refer to interview with the Administrator on 05/13/22 at 2:04pm

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Interview with the RCC on 05/13/22 at 8:30am revealed:
-The RCC worked with the Special Care Unit Coordinator (SCC) and Administrator to ensure staff received the appropriate training for their position.
-The Corporate Registered Nurse (RN) was responsible for providing diabetic training for the staff.
-The Administrator was responsible for notifying the Corporate RN to schedule required training for staff.
-She knew MAs should have training on the care of diabetic residents before administering insulin injections.
-The RCC and SCC are responsible for maintaining staff training.

Interview with the Administrator on 05/13/22 at 2:04pm revealed:
-The Corporate RN is responsible for providing diabetic training for the staff.
-He and the RCC, SCC and Business Office Manager are responsible for contacting the Corporate RN to schedule required training.
-He expected diabetic training be completed prior to staff administrating insulin or checking blood

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sugars.
-The RCC and SCC are responsible for maintaining staff training.

D 273 10A NCAC 13F .0902(b) Health Care D 273

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:
TYPE A1 VIOLATION

Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 2 of 7 sampled residents (#1, and #7) related to not receiving a blood thinning medication for a month (March 2022) increasing the risk for blood clots and signs of bleeding in April 2022 (#1) and missed doses of a medication to treat fluid retention, a medication for mood, a medication to treat anxiety and a vitamin supplement (#7).

The findings are:

1. Review of Resident #1's FL2 dated 09/28/21 revealed diagnoses included coronary artery disease and hypertension.

Review of Resident #1's hospital discharge summary dated 11/05/21 revealed:
-Resident #1 was hospitalized with a pulmonary embolism (blood clot in the lung).
-Discharge medications included apixaban 5mg (a medication to thin blood and prevent blood clots); take 10mg twice daily for six days and then

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take 5mg twice daily beginning 11/12/21.

a. Review of Resident #1's Primary Care Provider's (PCP) visit note dated 03/28/22 revealed:
-Resident #1's rivaroxaban was discontinued.
-Resident #1 was prescribed warfarin (a medication to decrease blood clotting) 5mg one tablet daily.
-An INR blood test was to be done in one week and monthly thereafter.

Review of the PCP's order for Resident #1 dated 03/29/22 revealed:
-Warfarin 5mg one tablet daily was prescribed for Resident #1.
-Resident #1 was to have an INR blood test in one week.

Review of Resident #1's March electronic medication administration record (eMAR) revealed:
-There was an entry for rivaroxaban 10mg daily.
-There was no entry for warfarin 5mg, one tablet daily.

Review of Resident #1's April 2022 eMAR revealed:
-There was an entry for rivaroxaban 10mg daily with a discontinue date of 04/12/22.
-There was an entry for warfarin one tablet four times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was no dosage indicated for the warfarin entry.
-The entry was documented as administered 14 instances from 04/12/22 to 04/15/22, 19 instances from 04/18/22 to 04/22/22, and 4 instances on 04/25/22.

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Review of Resident #1's INR results revealed:
-Her INR result dated 04/15/22 revealed the INR was 8.91 (therapeutic range 2.0-3.0) which was critically high, and was reported to Resident #1's PCP's office.
-Her INR result dated 04/19/22 revealed the INR was high, greater than 10 and was reported to the facility.
-Her INR result dated 04/26/22 revealed the INR was high, greater than 10.

Review of Resident #1 PCP's order dated 04/15/22 revealed:
-Resident #1's INR was 8.91.
-Warfarin was to be held until further notice.
-A stat (urgent) INR was to be done on Monday (04/18/22).
-Facility staff were to make sure patient was not taking rivaroxaban as it was discontinued on 03/29/22.

Review of Resident #1's PCP's visit note dated 04/25/22 revealed:
-Resident #1 had an elevated INR close to 10.
-Her warfarin was placed on hold.
-Resident #1 was to be monitored for blood in her stool, fatigue, dizziness, shortness of breath and chest pain.

Review of Resident #1's PCP's order dated 04/26/22 revealed:
-"Please continue to hold Coumadin" (warfarin).
-"Please make sure medication has not been given".
-The INR was to be rechecked on 04/29/22.

Review of Resident #1's April 2022 nursing progress notes revealed:
-There was no documentation the PCP was notified of the high INR results.

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-There was no documentation Resident #1 was monitored for bleeding.

Interview with a personal care aide (PCA) on 05/13/22 at 10:07am revealed:
-Resident #1 was bleeding for about a week before she was sent to the hospital.
-She first witnessed blood on the resident's arm on 04/18/22.
-She reported it to the Business Office Manager (BOM) who was previously the facility's lead MA, and was told to report it to the Special Care Coordinator (SCC) because the RCC was off.
-She was not sure who the SCC reported the bleeding to.
-On 04/20/22, she witnessed blood on Resident's #1's buttocks and in her brief.
-She reported this to the SCC who looked at the resident's buttocks.
-The SCC stated because she could not identify the source of bleeding, she could not send the resident to the hospital because the hospital would just send her back to the facility.
-The SCC stated the resident was probably picking at her arm and wiping the blood on her bottom.
-She had to change the resident's brief 2-3 times that shift, along with her clothes and bedding, due to the bleeding.
-She asked the SCC to look at resident at least two separate times and she argued with her about where the blood was coming from.
-On 04/26/22, she reported to the MA Resident #1 was bleeding and the MA sent her to the hospital immediately.

Interview with a MA on 5/11/22 at 4:10pm revealed:
-She could not recall the date but observed Resident #1's brief soaked with urine and it was

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brown in color.
-Resident #1 did not have any wounds but there was blood on her sheets.
-She reported it to the Resident Care Coordinator (RCC).
-She was told by the RCC not to send the resident to the hospital and that she would call the nurse and have the resident evaluated.

Telephone interview with MA on 05/03/22 at 2:35pm revealed:
-On 04/26/22, she was notified by a PCA that Resident #1 had blood in her brief and on her bed.
-On 04/26/22, she called 911 and had Resident #1 sent to the emergency department for evaluation due to bleeding from her nose, mouth, and brief with no known cause.

Review of Resident #1's hospital discharge summary dated 05/04/22 revealed:
-Resident #1 was hospitalized from 04/26/22 to 05/04/22 for gastrointestinal bleeding.
-Resident #1's International Normalized Ratio (INR) blood test result (a test that measures the time for blood to clot) was greater than 13.1, higher than the therapeutic level (2.0-3.0).
-Resident #1 received 2 units of blood.

Interview with the SCC on 05/13/22 at 10:30am revealed:
-A staff member informed her of blood in Resident #1's bed but she could not recall what staff member or when it was.
-She observed the spot and it was dark red, dry and looked as though it had been there awhile.
-The staff member came to her a second time regarding another spot, but she could not recall if she looked at the second spot.
-She did not send Resident #1 to the hospital and

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did not notify the resident's PCP because she could not identify where the blood was coming from.
-She was not sure if she knew Resident #1 was on a blood thinning medication because the resident was not on her unit.
-She would have notified the RCC and Resident #1's PCP if she was able to identify the source of the bleeding.

Interview with the RCC on 05/12/22 at 9:15am revealed:
-She could not recall the date but was called to Resident #1's room by another staff member because the resident was wet and there were blood spots on her sheet.
-The resident was very wet and had an abrasion on her bottom and she felt the spots of blood were related to the wetness and the abrasion.
-She felt no treatment or follow up was necessary and the resident just needed to be kept dry.
-She did not report the bleeding to Resident #1's PCP.
-She had placed Resident #1's warfarin on hold on two occasions but could not recall the dates.
-She could not recall how long she put the medication on hold but thought she had a restart date.
-She did not know how to put a medication on hold indefinitely because she had never done it.

Telephone interview with Resident #1's PCP on 05/11/22 at 4:19pm revealed:
-Resident #1 was prescribed anticoagulant medications because she was previously diagnosed with bilateral pulmonary emboli.
-Anticoagulant medications increased the risk of bleeding.
-He was not notified or aware Resident #1 was getting her anticoagulant medication four times a

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day instead of once daily as prescribed.
-Each time he was notified of high INR results, he gave an order to hold Resident #1's warfarin.
-He did not give any orders for Resident#1's warfarin to restart.
-Possible outcomes of taking higher than prescribed doses of anticoagulant medications included internal bleeding and death.

Interview with the Administrator on 05/13/22 at 2:05pm revealed:
-A couple PCAs mentioned Resident #1's bleeding to the SCC but she could not determine where the bleeding originated.
-He expected a resident's PCP to be notified if any resident was bleeding.

b. Review of Resident #1's signed PCP's orders dated 02/04/22 revealed an order for apixaban 5mg one tablet twice daily.

Review of Resident #1's PCP's visit note dated 03/01/22 revealed:
-There was an addendum to the note stating Resident #1's family would like an alternative anticoagulant medication.
-An order for rivaroxaban (a medication to decrease blood clotting) 10mg one tablet daily was sent to the facility.

Review of the PCP's order for Resident #1 dated 03/01/22 revealed:
-The apixaban was discontinued.
-Resident #1 was prescribed rivaroxaban 10mg one tablet daily.

Review of Resident #1's March 2022 eMAR revealed:
-There was an entry for rivaroxaban 10mg one tablet daily.

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-The rivaroxaban entry had a start date of 03/03/22 and a discontinue date of 04/12/22.
-The rivaroxaban was documented as administered 11 instances from 03/03/22 to 03/31/22.
-There were 18 instances the rivaroxaban was documented with a code "09" indicating the medication was not administered and to see the nurse's notes.

Review of Resident #1's April 2022 eMAR revealed:
-There was an entry for rivaroxaban 10mg one tablet daily with a discontinue date of 04/12/22.
-The rivaroxaban was documented as administered 4 times from 04/01/22 to 04/11/22, and discontinued on 04/12/22.
-There were 7 instances the rivaroxaban was documented with a code "09" indicating the medication was not administered and to see the nurse's notes.

Review of Resident #1's nursing progress notes from 03/03/22 to 04/11/22 revealed:
-There were 22 instances the rivaroxaban was not administered because it had not been received or was on order.
-On 03/23/22, the medication aide (MA) spoke with a family member and was informed the rivaroxaban was too expensive and the family wanted to speak with Resident #1's PCP about an alternative medication. The note indicated the MA would notify the PCP on 03/24/22 when he visited the facility.
-There were two instances, on 04/04/22 and 04/05/22, when there was no documented reason why the medication was not administered.
-The progress note dated 04/08/22 stated the medication was discontinued.
-There was no documentation the PCP was

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notified the rivaroxaban was not administered as ordered.

Telephone interview with a pharmacist from Resident #1's pharmacy on 05/11/22 at 8:45am revealed:
-The pharmacy filled Resident #1's prescriptions and family members picked them up.
-They received an order for rivaroxaban 10mg one tablet daily on 03/04/22.
-The prescription was not filled because the family had not come to pick it up.

Telephone interview with Resident #1's family member on 05/12/22 at 11:52am revealed:
-She picked up Resident #1's medications from the pharmacy and delivered them to the facility.
-She had not picked up the rivaroxaban medication because of cost.
-She thought the resident was still getting her previous anticoagulant medication while waiting to get the warfarin (a medication to decrease blood clotting) order in place.
-The facility had not informed her of any times the resident did not receive anticoagulant medication.
-Facility staff gave her the impression on multiple occasions they had medications available if residents ran out of their medication, such as borrowing medications from another resident who was on the same medication and dosage.

Interview with a MA on 05/13/22 at 11:30am revealed:
-She would call the pharmacy on day 2 if a resident's medication was not available for administration.
-Depending on the medication, she might contact the resident's PCP.
-She notified the RCC when a resident's medication was not available.

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Interview with the RCC on 05/12/22 at 9:15am revealed:
-She started working for the facility about seven weeks ago and her responsibility was to staff the building.
-She was told the previous day (05/11/22) it was her responsibility to follow up with the pharmacy and the resident's PCP if a medication was not administered.
-MAs were trained if a medication was not available to administer, they were to document it on the eMAR and provide a reason why the medication was not given.
-The MAs were to follow up with the pharmacy and the provider when a medication was not available for administration.
-She did not think there was a report that could be run each morning to see what medications were not administered to residents.

Telephone interview with Resident #1's PCP on 05/11/22 at 4:19pm revealed:
-Resident #1 was prescribed anticoagulant medications because she was previously diagnosed with bilateral pulmonary emboli (blood clots in the lungs).
-On 03/01/22, he discontinued Resident #1's apixaban and started rivaroxaban at the request of the family.
-He was not aware the rivaroxaban had not been picked up from the pharmacy.
-He was not notified Resident #1's rivaroxaban was not administered as ordered.
-Possible outcomes of not receiving a anticoagulant medication as ordered included respiratory failure and death from a pulmonary embolism.

Interview with the Administrator on 05/13/22 at

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2:05pm revealed:
-He expected the MA or the RCC to notify the resident's PCP after the first missed dose of a medication.
-Medication carts were to be audited weekly by the night shift MA to ensure medications were available for administration.
-He was not sure if the medication cart audits were being completed.

2. Review of Resident #7's current FL2 dated 08/07/21 revealed diagnosis that included frank hematuria.

a. Review of Resident #7's Primary Care Provider's (PCP) order dated 04/14/22 revealed an order for furosemide (used to treat fluid retention) 40mg, take two tablets daily.

Review of Resident #7's May 2022 electronic Medication Administration Record (eMAR) from 05/01/22 to 05/13/22 revealed:
-There was an entry for furosemide 40mg, two tablets to be administered daily at 8:00am.
-On 05/01/22 and 05/04/22, furosemide 40mg, two tablets were documented as not administered.
-On 05/09/22 to 05/13/22, furosemide 40mg, two tablets were documented as not administered.
-Furosemide was not documented as administered 7 of 13 opportunities in May 2022 due to medication not available.

Observation of Resident #7's medication available for administration on 05/11/22, 05/12/22 and 05/13/22 revealed there was no furosemide 40mg tablets available for administration.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at

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12:45pm revealed possible outcomes of not receiving furosemide included fluid buildup, swelling and increase in blood pressure.

b. Review of Resident #7's PCP order dated 02/01/22 revealed an order for nifedipine ER (used to treat high blood pressure) osmotic release tablet 60mg, 1 tablet twice daily.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for nifedipine 60mg to be administered daily at 8:00am and 8:00pm.
-On 05/01/22 and 05/02/22, nifedipine 60mg was documented as not administered.
-On 05/04/22 to 05/06/22, nifedipine 60mg was administered once daily.
-On 05/09/22, nifedipine 60mg was administered once daily.
-On 05/10/22 to 05/13/22, nifedipine 60mg was documented as not administered.
-Nifedipine was not documented as administered 16 of 25 opportunities in May 2022 due to medication not available.

Observation of Resident #7's medication available for administration on 05/11/22, 05/12/22 and 05/13/22 revealed there was no nifedipine 60mg tablets available for administration.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed possible outcomes of not receiving nifedipine included heart rate and blood pressure issues.

c. Review of Resident #7's PCP order dated 02/01/22 revealed an order for aripiprazole (used to treat mood) 2mg daily.

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Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for aripiprazole 2 mg, to be administered daily at 9:00am.
-On 05/09/22, aripiprazole 2mg was documented as not administered.
-On 05/09/22 to 05/13/22, aripiprazole 2mg was documented as not administered.
-Aripiprazole was not documented as administered 4 of 13 opportunities in May 2022 due to medication not available.

Observation of Resident #7's medication available for administration on 05/11/22, 05/12/22 and 05/13/22 revealed there was no aripiprazole 2mg tablets available for administration.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed possible outcomes of not receiving nifedipine included heart rate and blood pressures issues.

d. Review of Resident #7's PCP order dated 02/01/22 revealed an order for clonazepam (used to treat anxiety) 0.5mg, 1 tablet twice daily.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for clonazepam 0.5mg to be administered daily at 9:00am and 4:00pm.
-On 05/09/22 to 05/13/22, clonazepam 0.5mg was documented as not administered.
-Clonazepam 0.5mg was not administered 9 of 25 opportunities in May 2022 due to medication not available.

Observation of Resident #7's medication available for administration on 05/11/22, 05/12/22 and 05/13/22 revealed there was no clonazepam

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0.5mg tablets available for administration.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed possible outcomes of not receiving clonazepam included anxiety or seizures.

e. Review of Resident #7's PCP order dated 02/01/22 revealed an order for fluvoxamine (used to treat depression) 100mg daily.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for fluvoxamine 100mg daily at 9:00am
-On 05/09/22, fluvoxamine 100mg was documented as not administered.
-On 05/11/22 to 05/13/22, fluvoxamine 100mg was documented as not administered.
-Fluvoxamine 100mg was not administered 4 of 13 opportunities in May 2022 due to medication not available.

Observation of Resident #7's medication available for administration on 05/11/22, 05/12/22 and 05/13/22 revealed there was no fluvoxamine 100mg tablets available for administration.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed possible outcomes of not receiving fluvoxamine included depression, behaviors and anxiety.

f. Review of Resident #7's PCP's order dated 02/01/22 revealed an order for Metoprolol (used to treat high blood pressure) 25mg daily.

Review of Resident #7's May 2022 eMAR from

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05/01/22 to 05/13/22 revealed:
-There was an entry for metoprolol tartrate 25mg to be administered daily at 9:00am.
-On 05/11/22 to 05/13/22, metoprolol 25mg was documented as not administered.
-Metoprolol 25mg was not administered 4 of 13 opportunities in May 2022 due to medication not available.

Observation of Resident #7's medication available for administration on 05/11/22, 05/12/22 and 05/13/22 revealed there was no metoprolol 25mg tablets available for administration.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed possible outcomes of not receiving metoprolol included heart rate and blood pressure issues.

g. Review of Resident #7's PCP order dated 02/01/22 revealed an order for Vitamin D (used as a supplement) 50mcg 1 daily.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for Vitamin D 50mcg to be administered daily at 9:00am.
-on 05/04/22 Vitamin D 50mcg was documented as not administered.
-On 05/09/22 Vitamin D 50 mcg was documented as not administered.
-On 05/11/22 to 05/13/22, Vitamin D 50mcg was documented as not administered.
-Vitamin D 50mcg was not administered 5 of 13 opportunities in May 2022 due to medication not available.

Observation of Resident #7's medication available for administration on 05/11/22, 05/12/22

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and 05/13/22 revealed there was no Vitamin D 50mcg tablets available for administration.

Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed no signed refill orders for the residents missed medications.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed possible outcomes of not receiving Vitamin D included bone loss, osteoporosis and fractures over time.

Interview with the RCC on 05/12/22 at 9:14am revealed:
-The MA was responsible for refills of medications.
-The process was to refill the medications 3-5 days prior to the medications running out.
-She did not know Resident #7 was not getting her medications as ordered.
-There was no documentation the MA's notified the PCP of Resident #7's missed medication.
-MAs were trained if a medication was not available to administer, they were to document it on the eMAR and provide a reason why the medication was not given.
-The MAs were to follow up with the pharmacy and the provider when a medication was not available for administration.

Interview with the MA on 05/11/22 at 8:50am revealed:
-If the medication was not on the cart, she checked to make sure the refill was completed on the eMAR and expected the medication to be in that night.
-If the medication did not come in during the night, she would make the RCC or the Special

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Care Coordinator (SCC) aware the next morning.
-She said the RCC or SCC made the PCP aware when medications were not available for residents.

Interview with the Administer on 05/13/22 at 11:30am and 05/13/22 at 2:20pm revealed:
-He expected the PCP to be made aware when medications were not administered to the residents.
-He was unaware Resident #7 had no signed refill orders for seven medications.
-He expected the RCC and SCC to coordinate who would be making the PCP aware when medications were not available.
-Medication carts were to be audited weekly by the night shift MA to ensure medications were available for administration.
-He was not sure if the medication cart audits were being completed.
-He started running reports 2-3 weeks ago but did not feel he was capturing everything he should be on the reports.
-The facility consultant had begun working with him on what reports he should be getting.

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The facility failed to contact the physician for a resident with physician orders to monitor for signs of bleeding due to being on an anticoagulant medication and having critically high lab results, with an INR of greater than 10, who had signs of bleeding in her undergarments and bed and was not sent to the hospital until six days later when she was bleeding from her nose, mouth and in her brief, whereby requiring hospitalization for 8 days for gastrointestinal bleeding and received two units of blood. This failure resulted in serious physical harm and constitutes a Type A1 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/12/22 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 11, 2022.

D 276 10A NCAC 13F .0902(c)(3-4) Health Care D 276

10A NCAC 13F .0902 Health Care
(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on interviews, and record reviews, the facility failed to implement physician's orders for 1 of 6 sampled residents (Resident #8) regarding a medication to treat inflammation.

The findings are:

Review of Resident #8's FL2 dated 03/04/21 revealed diagnoses included diverticulitis (inflammation or infection in the colon) and muscle weakness.

Review of Resident #8's Primary Care Provider's (PCP)'s visit note dated 05/02/22 revealed:
-The resident had a moist cough.

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-She had a chest x-ray that showed left lower lobe pneumonia.
-He prescribed a Z-Pak (azithromycin, an antibiotic) and prednisone (a medication to decrease inflammation) 20mg one tablet daily.

Review of Resident #8's May 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for azithromycin 250mg two tablets on 05/04/22.
-There was an entry for azithromycin 250mg one tablet daily from 05/05/22 to 05/07/22.
-There was no entry for prednisone.

Interview with a medication aide (MA) on 05/11/22 at 4:55pm revealed:
-Resident #8 left with family that morning (05/11/22) for a leave of absence.
-Resident #8 took the medications she would need while she was away with her today (05/11/22).
-She documented the medications given to the resident on a "Leave of Absence Medication Release Form".
-She did not administer Resident #8's morning medications today (05/11/22) because the resident left before the morning medication pass.

Review of Resident #8's Leave of Absence Medication Release Form dated 05/11/22 revealed prednisone 20mg seven tablets were released to the resident.

Telephone interview with a representative from the facility's contracted pharmacy on 05/12/22 at 1:10pm revealed:
-They received an order for prednisone 20mg one tablet daily for seven days for Resident #8 on 05/03/22.

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-Prednisone 20mg, seven tablets were dispensed on 05/03/22.

Interview with the Resident Care Coordinator (RCC) on 05/12/22 at 9:15am revealed:
-She started working for the facility about seven weeks ago and was still learning the eMAR system.
-The Special Care Coordinator (SCC) helped her enter the Z-Pak order because she knew the eMAR system better.
-Both she and the SCC overlooked the order for the prednisone, and it did not get entered in the system.
-A new system put in place at the end of April 2022 to have a second staff member view new orders in the eMAR system for accuracy did not work and she was unsure why.
-The MA that received the prednisone from the pharmacy was responsible to compare the medication label with the order in the eMAR system, but she was not sure why it was not done.

Interview with the Administrator on 05/13/22 at 2:05pm revealed:
The MAs, RCC, and SCC were all responsible to enter new orders into the eMAR system when the order was received.
-The MAs were responsible to compare the label of new medications with the order in the eMAR system when the medication arrived from the pharmacy.
-Medication carts were to be audited weekly by the night shift MA, comparing the medications available to the resident's eMAR.
-He was not sure if the medications audits were being completed and completed accurately.

Attempted telephone interview with Resident #8's

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PCP on 05/13/22 at 12:14pm was unsuccessful.

D 358 10A NCAC 13F .1004(a) Medication Administration D 358

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:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 6 residents (#7) observed during the medication pass including errors with two medications to treat hypertension, a medication to treat depression, a medication to treat fluid retention, a medication to treat mood, a medication to treat anxiety and a supplement; and for 2 of 6 residents (#1 and #2) sampled for record review including errors with a medication to decrease blood clotting (#1), and medication to treat panic disorders and decrease anxiety (#2).

The findings are:

The medication error rate was 21% as evidenced by the observation of 7 errors out of 33 opportunities during the 9:00am medication passes on 05/10/22 on the Special Care Unit (SCU) and the 8:00am medication pass on 05/11/22 on the Assisted Living Unit.

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1. Review of Resident #1's FL2 dated 09/28/21 revealed diagnoses included coronary artery disease and hypertension.

Review of Resident #1's hospital discharge summary dated 11/05/21 revealed:
-Resident #1 was hospitalized with a pulmonary embolism (blood clot in the lung).
-Discharge medications included apixaban 5mg (a medication to decrease blood clotting); take 10mg twice daily for six days and then take 5mg twice daily beginning 11/12/21.

Review of Resident #1's signed Primary Care Provider's (PCP) orders dated 02/04/22 revealed an order for apixaban 5mg one tablet twice daily.

Review of Resident #1's PCP's visit note dated 03/01/22 revealed:
-There was an addendum to the note stating Resident #1's family would like an alternative anticoagulant (a medication to decrease blood clotting) medication.
-An order for rivaroxaban (a medication to decrease blood clotting) 10mg one tablet daily was sent to the facility.

Review of the PCP's order for Resident #1 dated 03/01/22 revealed:
-The apixaban was discontinued.
-Rivaroxaban 10mg one tablet daily was prescribed for Resident #1.

Review of Resident #1's PCP's visit note dated 03/28/22 revealed:
-The rivaroxaban was discontinued.
-Resident #1 was prescribed warfarin (a medication to decrease blood clotting) 5mg one tablet daily.

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-An International Normalized Ratio (INR) blood test (a test that measures the time for blood to clot) was to be done in one week and monthly thereafter.

Review of the PCP's order for Resident #1 dated 03/29/22 revealed:
-The rivaroxaban was discontinued.
-Warfarin 5mg one tablet daily was prescribed for Resident #1.
-Resident #1's was to have an INR blood test in one week.

Review of Resident #1's INR results dated 04/07/22 revealed an INR of 1.92 (therapeutic range 2.0-3.0).

Review of Resident #1's PCP's visit note dated 04/11/22 revealed:
-Rivaroxaban was discontinued.
-Warfarin 5mg one tablet daily was prescribed.
-Resident was to have an INR blood test in one week and monthly thereafter.

Review of Resident #1's INR results dated 04/15/22 revealed the INR was 8.91 which was critically high.

Review of Resident #1 PCP's order dated 04/15/22 revealed:
-Resident #1's INR was 8.91.
-Warfarin was to be held until further notice.
-A stat (urgent) INR was to be done on Monday (04/18/22).
-"Please make sure patient is not taking Xarelto" (rivaroxaban).
-Rivaroxaban was discontinued on 03/29/22.

Review of Resident #1's INR results dated 04/19/22 revealed the INR was high, greater than

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10.

Review of Resident #1's PCP's visit note dated 04/25/22 revealed:
-Resident #1 had an elevated INR close to 10.
-The lab result was a potential lab error.
-Warfarin had been placed on hold.
-The INR was to be repeated that day (04/25/22).
-Resident #1 was to be monitored for blood in her stool, fatigue, dizziness, shortness of breath and chest pain.

Review of Resident #1's INR results dated 04/26/22 revealed the INR was high, greater than 10.

Review of Resident #1's PCP's order dated 04/26/22 revealed:
-"Please continue to hold Coumadin" (warfarin).
-"Please make sure medication has not been given".
-The INR was to be rechecked on 04/29/22.

Review of Resident #1's March 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for apixaban 5mg one tablet twice daily.
-The apixaban entry was discontinued on 03/02/22.
-There was an entry for rivaroxaban 10mg one tablet daily.
-The rivaroxaban entry had a start date of 03/03/22 and a discontinue date of 04/12/22.

Review of Resident #1's April 2022 eMAR revealed:
-There was an entry for rivaroxaban 10mg one tablet daily.
-The rivaroxaban entry had a discontinue date of

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04/12/22.
-The rivaroxaban was documented as administered 4 times from 04/01/22 to 04/11/22.
-There were 7 instances the rivaroxaban was documented with a code "09" indicating the medication was not administered and to see the nurse's notes.
-There was an entry for warfarin one tablet four times daily, at 8:00am, 12:00pm, 4:00pm and 8:00pm with a start date of 04/12/22.
-There was no dosage indicated for the warfarin entry.
-The warfarin entry was documented as administered from 14 instances from 04/12/22 to 04/15/22, 19 instances from 04/18/22 to 04/22/22, and 4 instances on 04/25/22.
-The warfarin entry was documented with a "H", indicating hold, 10 instances from 04/15/22 to 04/17/22 and 9 instances from 04/22/22 to 04/24/22.
-The warfarin entry on 04/26/22 at 8:00am was documented with code "06", indicating Resident #1 was hospitalized.

Observation of Resident #1's medications on 04/29/22 at 11:30pm revealed:
-There was a bottle labeled warfarin 5mg, take one tablet every day.
-The label indicated 60 tablets were dispensed on 03/29/22.
-There were 27 tablets remaining in the bottle.

Telephone interview with a MA on 05/03/22 at 2:35pm revealed:
-She was responsible for implementation of new medication orders into the facilities electronic filing system and transcribe physician's orders into residents eMAR.
-The facility did not have a process to ensure staff transcribed physician's orders into the eMAR

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accurately.
-On or about 04/11/22, she found an order for Resident #1 in the copier room to discontinue rivaroxaban medication and start warfarin 5mg medication dated 03/29/22.
-She did not know when or how Resident #1's warfarin 5mg medication order dated 03/29/22 had been placed in the copier room.
-On 04/11/22, she transcribed Resident #1's order dated 03/29/22 to discontinue rivaroxaban effective 04/11/22 and start Resident #1's warfarin 5mg on 04/12/22 on the eMAR.
-She may have added Resident #1's warfarin 5mg medication as 'qd' (once daily) or 'qid' (four times daily), she did not know the difference between the medication abbreviations.
-She did not recall notification to Resident #1's pharmacy to fill Resident #1's warfarin 5mg medication.
-She was aware Resident #1 was on blood thinner medications but did not know the names of blood thinner medications.
-On 04/26/22, she was notified by a personal care aide (PCA) that Resident #1 had blood in her brief and on her bed.
-On 04/26/22, she called 911 and had Resident #1 sent to the emergency department (ED) for evaluation due to bleeding from her nose and mouth with no known cause.

Telephone interview with a pharmacist from Resident #1's pharmacy on 05/11/22 at 8:45am revealed:
-The pharmacy dispensed Resident #1's prescriptions and family members picked them up.
-Warfarin 5mg, 60 tablets were dispensed for Resident #1 on 03/29/22.
-The medication was picked up from the pharmacy on 03/30/22.

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-The label indicated warfarin 5mg, one tablet daily was to be administered to Resident #1.

Telephone interview with a representative from the facility's contracted pharmacy on 05/11/22 at 9:12am revealed:
-Resident #1 used an outside pharmacy for her medications.
-If they received orders for Resident #1, they would profile or place the orders on her eMAR but would not send the medication to the facility.
-She thought facility staff could change orders placed on resident eMARs but if they did the pharmacy staff would not be able to see the changes.
-She was unable to retrieve Resident #1's profile because she was out of the facility for more than 14 days.

Telephone interview with Resident #1's Healthcare Power of Attorney (POA) on 04/29/22 at 1:50pm revealed:
-On 04/26/22, a nurse from the facility called Resident #1's family member to inform him the resident was sent to the ED because staff observed blood coming from her mouth and nose.
-Resident #1's blood was "very thin" and she had internal bleeding.

Telephone interview with Resident #1's POA on 05/11/22 at 1:20pm revealed staff at the facility did not administer Resident #1's blood thinning medication correctly and she was hospitalized with internal bleeding.

Telephone interview with Resident #1's PCP on 05/11/22 at 4:19pm revealed:
-Resident #1 was prescribed anticoagulant medications because she was previously

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diagnosed with bilateral pulmonary emboli.
-Resident #1's anticoagulant medication was changed to warfarin at the request of the family.
-Resident #1's warfarin dose would need to be regulated based on her INR blood test results.
-He wrote an order on 03/29/22 to discontinue Resident #1's rivaroxaban, start warfarin 5mg one tablet daily and check the resident's INR in one week.
-Resident #1 was seen by a colleague on 04/11/22 and his colleague did not see the warfarin order on Resident #1's eMAR.
-His colleague wrote the order again on 04/11/22 to discontinue Resident #1's rivaroxaban, start warfarin 5mg daily and check the resident's INR in one week and monthly thereafter.
-On 04/15/22 Resident #1's INR blood test result was high at 8.91.
-His colleague wrote an order on 04/15/22 to hold Resident #1's warfarin until further notice, get a STAT INR on Monday (04/18/22), and for the facility to make sure Resident #1 was not taking rivaroxaban.
-Resident #1 had high INR readings, greater than 10, on 04/18/22, 04/22/22, and 04/25/22 and after each lab result, he ordered Resident #1's warfarin to be held.
-He thought the INR results greater than 10 were inaccurate because he did not know Resident #1's warfarin was being administered QID (four times daily) instead of QD (once daily).
-He did not give any orders for Resident #1's warfarin to be restarted after it was put on hold.
-Resident #1 was sent to the hospital for internal bleeding.
-Possible outcomes of receiving a greater than prescribed dose of warfarin included internal bleeding and death.

Interview with the Resident Care Coordinator

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(RCC) on 05/12/22 at 9:15am revealed:
-The MAs were responsible to enter new orders into the eMAR system.
-Resident #1 received her medications from an outside pharmacy.
-When a new medication arrived at the facility, it was the MA's responsibility to compare the label on the medication to the order in the eMAR system to ensure they matched.
-MAs were trained to compare the medication label with the eMAR prior to administering a medication.
-She had placed Resident #1's warfarin on hold on two occasions but could not recall the dates.
-She was unsure if she entered a date for the hold on the warfarin to end.
-She could not recall how long she put the medication on hold but thought she had a restart date.
-She did not know how to put a medication on hold indefinitely because she had never done it.
-Prior to the medication error with Resident #1, on 04/12/22, there was not a system in place for a second staff member to review the order in the eMAR system for accuracy.

Interview with the Administrator on 05/13/22 at 2:05pm revealed:
-The MAs were responsible for putting new orders into the eMAR system.
-The RCC and the Special Care Unit Coordinator (SCC) were responsible for reviewing new orders on the eMAR for accuracy, but he was not sure if it was being done.
-The warfarin order for Resident #1 was a transcription error by the MA.
-The MAs were responsible to compare the label of new medications with the order in the eMAR system when the medication arrived at the facility.
-When the warfarin order was entered into the

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eMAR system, he did not think there was a second staff member reviewing orders for accuracy.

2. Review of Resident #2's current FL-2 dated 08/03/21 revealed:
-Diagnoses included coronary artery disease, hypertension, hyperlipidemia, history of cerebrovascular accident, recurrent urinary tract infections, chronic pain, glaucoma, and frail elderly.

Review of Resident #2's current care plan dated 08/12/21 revealed:
-Resident #2 was alert and able to make her needs known.
-Resident #2 utilized a rollator for ambulation.
-Resident #2 did not administer her own medications.
-Resident #2 was not prescribed medications for mental health or behaviors.

Review of Resident #2's facility progress notes revealed:
-On 04/04/22 at 8:26pm, staff documented Resident #2 was observed in her bedroom on the floor.
-Staff documented Resident #2 reported she had fallen without any injury.
-On 04/04/22 at 9:05pm, staff documented contacting Resident #2's physician to report a medication error.
-There was no information related to the type of medication administered to Resident #2 in error.
-Staff documented Resident #2's physician reported Resident #2 should get sleepy and to monitor Resident #2.
-There was no additional documentation related to the incident.

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Review of Resident #2's emergency department (ED) documentation dated 04/05/22 at 2:11am revealed:
-Resident #2 "was administered clonazepam tonight which is not a medication she takes, resident was drowsy and fell, hitting the back of her head."
-There was no additional information documented related to the time the clonazepam was administered in error.
-There was no additional information documented related to the dosage of clonazepam administered to Resident #2 in error.
-Resident #2 was stable and discharged to the facility on 04/05/22.

Review of Resident #2's current physician's orders dated 02/01/22 revealed no order for clonazepam (a medication used to treat seizures, panic disorders, and/or anxiety) medication.

Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed there was no entry for clonazepam.

Interview with Resident #2 on 04/12/22 at 12:00pm revealed:
-She utilized a rollator for ambulation.
-A medication aide (MA) administered the wrong medication to her in the afternoon on 04/04/22.
-After she was administered the wrong medication, she felt drowsy and unsteady on her feet and fell in her bedroom in the evening of 04/04/22.
-Resident #2 stated "my memory is failing but I am paranoid that staff are going to give me the wrong pill again."
-She was not aware of any other occasions of the wrong medication being administered to her.

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Observation of Resident #2 on 05/11/22 at 9:05am revealed:
-Resident #2 was in the hallway at a medication cart.
-A MA attempted to administer Resident #2's scheduled medications, and Resident #2 was resistant and stated, "Are you positive these are my right medications."
-A MA reassured Resident #2 the medications dispensed in a single serve medication cup were the correct medications prescribed by her physician.

Telephone interview with Resident #2's responsible party on 05/11/22 at 10:30am revealed:
-Resident #2 required staff to administer her medications.
-On 04/04/22 at 9:30pm the Administrator notified him that Resident #2 had been administered a medication, clonazepam in error.
-Resident #2 did not have a physician's order for clonazepam.
-He visited Resident #2 on 04/04/22 and was informed she fell that evening.
-Resident #2 was sent to the ED for evaluation after the fall.
-Resident #2 was evaluated at the ED on 04/04/22 with no physical injuries and discharged back to the facility on 04/05/22.
-Since the medication error, Resident #2 was fearful of the facility staff administering her medications.

Telephone interview with Resident #2's physician's assistant on 05/11/22 at 4:32pm revealed:
-Resident #2 was not prescribed clonazepam medication.
-Resident #2 required staff to administer her

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medications.
-He was notified by the facility in the evening of 04/04/22 related to a day shift MA administration of another resident's clonazepam 1mg medication to Resident #2 in error.
-On 04/04/22 he instructed facility staff to monitor Resident #2 for abnormal drowsiness.
-He was not aware Resident #2 had sustained a fall on 04/04/22 until 04/05/22.
-If Resident #2 had been administered clonazepam 1mg in error, it may cause grogginess and an unsteady gait.
-Resident #2's medication administration error on 04/04/22 could have contributed to Resident #2's fall on 04/04/22.
-Resident #2 had expressed anxiety with staff administration of her medications since 04/04/22.

Interview with a dayshift MA on 05/11/22 at 9:30am revealed:
-Resident #2 constantly questioned her medications since a medication administration incident occurred in early April 2022.
-Resident #2 required frequent reassurance by staff that her dispensed medications were accurate before she would take them by mouth.

Telephone interview with Staff A, a MA, on 05/11/22 at 8:48am revealed:
-She was hired by the facility at the end of February 2022 as a personal car aide (PCA) and MA.
-She had not taken the North Carolina Medication Aide exam.
-She had not received any training related to medication administration by a facility Registered Nurse, Pharmacist or any other licensed healthcare professional.
-On or about 04/01/22, she had received medication administration training from other MAs

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and the Business Office Manager (BOM).
-On 04/04/22, she was scheduled to administer medications at the facility, no additional MAs were available to assist her.
-On 04/04/22 between 2:00pm and 3:00pm, she was in the process of administering another residents' medications when Resident #2 requested a medication for pain.
-On 04/04/22 between 2:00pm and 3:00pm, she administered a Clonazepam 1mg tablet to Resident #2 in error.
-On 04/04/22 shortly after 7:00pm, the evening shift MA counted a controlled substance log and asked about one clonazepam 1mg tablet that was not accounted for.
-On 04/04/22, she and the nightshift MA counted controlled substance medications and reviewed the controlled substance log, and she notified the MA that she had accidentally administered another resident's clonazepam 1mg to Resident #2 in error.
-On 04/04/22, the evening MA notified the BOM of the error.
-On 04/04/22, the BOM instructed her to leave the facility and was terminated effective immediately due to the medication error.

Telephone interview with a nightshift MA on 05/10/22 at 5:26pm revealed:
-She was a night shift MA at the facility.
-On 04/04/22 at approximately 7:00pm - 7:30pm she reconciled controlled substance medications with the controlled substance log with the first shift MA and counted one clonazepam 1mg dose unaccounted for one resident.
-On 04/04/22, during controlled substance reconciliation, the first shift MA recognized that she had given Resident #2 a clonazepam 1mg in error.
-On 04/04/22, she contacted the BOM to notify

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her of the medication error and subsequently the dayshift MA was instructed to leave the facility and not return to the facility.
-On the evening of 04/04/22, she notified Resident #2's physician regarding the medication administration error, and he instructed her to monitor Resident #2 for drowsiness.
-On the evening of 04/04/22, after notification to Resident #2's physician related to the medication error, she checked on Resident #2 and found Resident #2 on the floor in her room.
-On 04/04/22, Resident #2 informed her that she felt unsteady while standing and fell.
-On 04/04/22, Resident #2 informed her that she did not sustain any injuries from the fall and requested staff assist her to bed for the night.
-Resident #2's responsible party visited her on 04/04/22 around 10:00pm and requested that Resident #2 be sent to the ED for evaluation due to the medication error and fall.

Interview with the BOM on 04/12/22 at 10:15am revealed:
-She had been a MA at the facility and recently promoted to BOM.
-Staff A was hired as a PCA and MA at the end of February 2022.
-Staff A was trained by the BOM on medication administration procedures on or about 04/01/22.
-Staff A also received training from other MAs at the facility before Staff A was allowed to administer medications independently.
-Staff A had not received any medication administration training from a RN, Pharmacist, or other licensed healthcare professional prior to administration of medications independently.
-On 04/04/22, Staff A was scheduled to work as the only dayshift MA.
-On 04/04/22, she was received a call from the nightshift MA related to the dayshift MA

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administration of one clonazepam 1mg to Resident #2 in error.
-On 04/04/22, she instructed the dayshift MA to leave the facility and not return to the facility.
-On 04/04/22, she instructed the nightshift MA to notify Resident #2's physician related to the medication error.
-She was not aware Resident #2 had sustained a fall prior to instructing the nightshift MA.
-On 04/04/22, she called the Administrator to inform him of Resident #2's medication administration error.
-The Administrator notified her that he would contact Resident #2's responsible party.

Interview with the Administrator on 04/12/22 at 10:30am revealed:
-The BOM notified him on the evening of 04/04/22 that Resident #2 was administered the wrong medication by the dayshift MA.
-The medication error was identified by the nightshift MA.
-Resident #2 was not prescribed clonazepam.
-On 04/04/22, he notified Resident #2's responsible party related to the medication administration error.
-On 04/04/22, Resident #2 had sustained an unwitnessed fall that evening without injury and did not want to be sent to the ED for evaluation.
-On 04/04/22, Resident #2's responsible party visited the facility and requested Resident #2 be sent to the ED due the medication administration error and subsequent fall.
-The dayshift MA that administered Resident #2's medication in error on 04/04/22 had received medication administration training from other facility MAs and the BOM a few days prior to 04/04/22.
-The dayshift MA that administered Resident #2's medication in error on 04/04/22 had not received

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any medication administration training from a RN, Pharmacist, or other licensed healthcare professional prior to administration of Resident #2's medications on 04/04/22 because he did not arrange a licensed healthcare professional to train the dayshift MA.
-He was responsible for ensuring a RN trained PCAs and MAs.
-The dayshift MA that administered Resident #2's medication in error on 04/04/22 was instructed not to return to the facility on 04/04/22.

3. Review of Resident #7's current FL2 dated 08/07/21 revealed diagnosis included frank hematuria.

a. Review of Resident #7's physician orders dated 04/14/22 revealed there was an order for furosemide 40 mg, 2 tablets (a medication used to treat fluid retention and swelling) to be administered daily.

Observation of the medication pass on 05/11/22 at 8:50am revealed:
-The medication aide (MA) prepared 7 oral medications for Resident #7.
-Furosemide was not administered to Resident #7.

Observation of Resident #7's medications available for administration on 05/11/22 at 8:50am revealed furosemide was not available for administration.

Review of Resident #7's May 2022 electronic Medication Administration Record (eMAR) from 05/01/22 to 05/13/22 revealed:
-There was an entry for furosemide 40mg, 2 tablets to be administered daily at 8:00am.
-Outside pharmacy provided an order on

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D 358	Continued From page 45 04/14/22 for Furosemide 40mg, 2 tablets to be administered daily. -Furosemide was not documented as administered 7 of 13 opportunities due to medication was unavailable. Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time furosemide was dispensed for Resident #7 from their pharmacy was 10/09/21 for 30 tablets. Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed: -The pharmacy had no signed refill orders for Resident #7's furosemide. -The pharmacy was unaware Resident #7 had gone without furosemide. -Possible outcomes of not receiving furosemide included fluid buildup and increase in blood pressure. b. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for nifedipine ER Osmotic Release Tablet 60 mg (used to treat high blood pressure), to be administered 2 times daily. Observation of the medication pass on 05/11/22 at 8:50am revealed: -The MA prepared 7 oral medications for Resident #7. -Nifedipine was not documented as administered to Resident #7. Observation of Resident #7's medications available for administration on 05/11/22 at 8:50am revealed nifedipine was not available for administration.	D 358		

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Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for nifedipine 60 mg to be administered twice daily at 8:00am and 8:00pm.
-Nifedipine was not documented as administered 16 of 25 opportunities due to medication was unavailable.

Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time nifedipine was dispensed for Resident #7 from their pharmacy was 03/09/22 for 60 tablets.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed:
-The pharmacy had no signed refill orders for Resident #7's nifedipine.
-The pharmacy was unaware Resident #7 had gone without nifedipine.
-Possible outcomes of not receiving nifedipine included heart rate and blood pressure issues.

c. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for aripiprazole 2mg. (to treat mood disorder) to be given daily in the morning.

Observation of the medication pass on 05/11/22 at 8:50am revealed:
-The MA prepared 7 oral medications for Resident #7.
-Aripiprazole was not administered to Resident #7.

Observation of Resident #7's medications available for administration on 05/11/22 at 8:50am revealed aripiprazole was not available

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for administration.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for aripiprazole 2 mg to be administered daily at 8:00am.
-Aripiprazole was not documented as administered 4 of 13 opportunities due to medication was unavailable.

Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time aripiprazole was dispensed for Resident #7 from their pharmacy was 03/09/22 for 30 tablets.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed:
-The pharmacy had no signed refill orders for Resident #7's aripiprazole.
-The pharmacy was unaware Resident #7 had gone without aripiprazole.
-Possible outcomes of not receiving aripiprazole could lead to behavioral issues.

d. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for clonazepam 0.5 mg, (used to treat anxiety), to be administered twice daily.

Observation of the medication pass on 05/11/22 at 8:50am revealed:
-The MA prepared 7 oral medications for Resident #7.
-Clonazepam was not administered to Resident #7.

Observation of Resident #7's medications available for administration on 05/11/22 at

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8:50am revealed clonazepam was not available for administration.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for clonazepam 0.5 mg, to be administered twice daily at 9:00am and 4:00pm.
-Clonazepam was not documented as administered 9 of 25 opportunities due to medication was unavailable.

Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time clonazepam was dispensed for Resident #7 from their pharmacy was 02/05/22 for 60 tablets.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed:
-The pharmacy had no signed refill orders for Resident #7's clonazepam.
-The pharmacy was unaware Resident #7 had gone without clonazepam.
-Possible outcomes of not receiving clonazepam included anxiety or seizures.

e. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for fluvoxamine 100 mg (used to treat depression), to be administered daily in the morning.

Observation of the medication pass on 05/11/22 at 8:50am revealed:
-The MA prepared 7 oral medications for Resident #7.
-Fluvoxamine was not administered to Resident #7.

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Observation of Resident #7's medications available for administration on 05/11/22 at 8:50am revealed fluvoxamine was not available for administration.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for fluvoxamine 100 mg to be administered once daily at 9:00am.
-Fluvoxamine was not documented as administered 4 of 13 opportunities due to medication was unavailable.

Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time fluvoxamine was dispensed for Resident #7 from their pharmacy was 02/11/22 for 30 tablets.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed:
-The pharmacy had no signed refill orders for Resident #7's fluvoxamine.
-The pharmacy was unaware Resident #7 had gone without fluvoxamine.
-Possible outcomes of not receiving fluvoxamine included depression, behaviors and anxiety.

f. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for metoprolol tartrate 25 mg (used to treat high blood pressure), to be administered daily.

Observation of the medication pass on 05/11/22 at 8:50am revealed:
-The MA prepared 7 oral medications for Resident #7.
-Metoprolol was not administered to Resident #7.

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Observation of Resident #7's medications available for administration on 05/11/22 at 8:50am revealed metoprolol was not available for administration.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for metoprolol 25 mg to be administered daily at 9:00am.
-Metoprolol was not documented as administered 4 of 13 opportunities due to medication was unavailable.

Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time metoprolol was dispensed for Resident #7 from their pharmacy was 03/10/22 for 30 tablets.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed:
-The pharmacy had no signed refill orders for Resident #7's metoprolol.
-The pharmacy was unaware Resident #7 had gone without metoprolol.
-Possible outcomes of not receiving metoprolol included heart rate and blood pressure issues.

g. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for Vitamin D Capsule 50 mcg, (a supplement), to be administered in the morning daily.

Observation of the medication pass on 05/11/22 at 8:50am revealed:
-The MA prepared 7 oral medications for Resident #7.
-Vitamin D was not administered to Resident #7.

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Observation of Resident #7's medications available for administration on 05/11/22 at 8:50am revealed Vitamin D was not available for administration.

Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed:
-There was an entry for Vitamin D 50 mcg, to be administered daily at 9:00am.
-Vitamin D was not documented as administered 5 of 13 opportunities due to medication was unavailable.

Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time Vitamin D was dispensed for Resident #7 from their pharmacy was 03/09/22 for 30 tablets.

Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed:
-The pharmacy had no signed refill orders for Resident #7's Vitamin D.
-The pharmacy was unaware Resident #7 had gone without Vitamin D.
-Possible outcomes of not receiving Vitamin D included bone loss, osteoporosis and fractures over time.

Interview with the MA on 05/11/22 at 8:50am revealed:
-When medications were not available, she documented it on the electronic progress notes (eprogress notes).
-She did not know who was responsible for reviewing eprogress notes.
-She requested refills on the eMAR.
-She knew how to do a refill but did not know why the medications were not on the cart.

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-She made the Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC) aware if the medication was not on the cart before it ran out.

Interview with the second MA on 05/13/22 at 11:30am revealed:
-She received training on what needed to be done to eliminate medication errors last week.
-If the medication was not on the cart, she checked to make sure the refill was completed on the eMAR and expected the medication to be in that night.
-If the medication did not come in during the night, she would make the RCC or the SCC aware the next morning the medication was not available for administration.
-She gave the medications to Resident #7 during the morning medication pass and realized the resident did not have many of her medications.
-She made the RCC aware of the issue after her morning medication pass on 05/13/22.

Interview with the RCC on 05/12/22 at 9:14am revealed:
-The MA was responsible to do the refills on all medications.
-She was not aware Resident #7 needed signed refill orders at the pharmacy.
-She did not know Resident #7 was not getting her medications as ordered.
-No auditing was done until 2-3 weeks ago when training was done on medication errors.
-The RCC and the SCC reviewed all new orders since training began.

Interview with the Administrator on 05/13/22 at 11:30am and 05/13/22 at 2:20pm revealed:
-He expected the primary care provider (PCP) to be made aware when medications were not

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administered to the residents.
-He was not aware there were no signed refill orders on file at the pharmacy for Resident #7.
-He was not aware Resident #7 was not receiving 7 of her medications.
-Medication carts were to be audited weekly by the night shift MA to ensure medications were available for administration.
-He was not sure if the medication cart audits were being completed.
-Training took place on 05/07/22 for medication errors and medication refills.

Attempted telephone interview with the Resident #7s PCP on 05/13/22 at 12:14pm was unsuccessful.

____

The facility failed to ensure medications were administered as ordered for 2 of 6 residents sampled for record review, one who received a greater than prescribed dose of blood thinning medication and was hospitalized with internal bleeding (Resident #1), a resident who received another resident's medication for anxiety and panic disorder and was sent to the hospital after receiving the medication because she fell, hitting her head and 1 of 6 residents during the medication pass, who did not receive two medications to lower blood pressure, a medication to treat fluid retention, and a medication to treat depression (Resident #7). The facility's failure resulted in serious neglect and constitutes a Type A1 Violation.

____

The facility provided a plan of protection on 05/10/22 in accordance with G.S. 131D-34 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED June 9, 2022.

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10A NCAC 13F .1004 Medication Administration
(j) The resident's medication administration record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medication administration records were complete and accurate for 1 of 7 residents sampled related to a medication to decrease blood clotting (Resident #1).

The findings are:

Review of Resident #1's FL2 dated 09/28/21 revealed diagnoses included coronary artery disease and hypertension.

Review of Resident #1's hospital discharge

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summary dated 11/05/21 revealed:
-Resident #1 was hospitalized with a pulmonary embolism (blood clot in the lung).
-Discharge medications included apixaban 5mg (a medication to decrease blood clotting); take 10mg twice daily for six days and then take 5mg twice daily beginning 11/12/21.

Review of Resident #1's signed Primary Care Provider's (PCP) orders dated 02/04/22 revealed an order for apixaban 5mg one tablet twice daily.

Review of Resident #1's PCP's visit note dated 03/01/22 revealed:
-There was an addendum to the note stating Resident #1's family would like an alternative anticoagulant (a medication to decrease blood clotting) medication.
-An order for rivaroxaban (a medication to decrease blood clotting) 10mg one tablet daily was sent to the facility.

Review of the PCP's order for Resident #1 dated 03/01/22 revealed:
-The apixaban was discontinued.
-Rivaroxaban 10mg one tablet daily was prescribed for Resident #1.

Review of Resident #1's March 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for apixaban 5mg one tablet twice daily.
-The apixaban entry was discontinued on 03/02/22.
-There was an entry for rivaroxaban 10mg one tablet daily at 9:00am.
-The rivaroxaban entry had a start date of 03/03/22.
-The rivaroxaban was documented as

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administered 11 instances from 03/03/22 to 03/31/22.
-There were 18 instances the rivaroxaban was documented with code "09" indicating the medication was not administered and to see the nurse's notes.

Review of Resident #1's April 2022 eMAR revealed:
-There was an entry for rivaroxaban 10mg one tablet daily at 9:00am.
-The rivaroxaban entry had a discontinue date of 04/12/22.
-The rivaroxaban was documented as administered 4 times from 04/01/22 to 04/11/22.
-There were 7 instances the rivaroxaban was documented with a code "09" indicating the medication was not administered and to see the nurse's notes.

Review of Resident #1's nursing progress notes from 03/03/22 to 04/11/22 revealed:
-There were 22 instances the rivaroxaban was not administered because it had not been received or was on order.
-On 03/23/22, the medication aide (MA) spoke with a family member and was informed the rivaroxaban was too expensive and the family wanted to speak with Resident #1's PCP about an alternative medication.
-The note on 03/23/22 indicated the MA would notify the PCP on 03/24/22 when he visited the facility.
-On 04/04/22 and 04/05/22, there were two instances when there was no documented reason why the medication was not administered.
-On 04/08/22, the medication was discontinued.

Telephone interview with a pharmacist from Resident #1's pharmacy on 05/11/22 at 8:45am

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revealed:
-The pharmacy filled Resident #1's prescriptions and family members picked them up.
-They received an order for rivaroxaban 10mg one tablet daily on 03/04/22.
-The prescription was not filled because the family had not come to pick it up.

Telephone interview with Resident #1's family member on 05/12/22 at 11:52am revealed:
-She picked up Resident #1's medications from the pharmacy and delivered them to the facility.
-She had not picked up the rivaroxaban medication because it was too expensive.
-She thought the resident was still getting her previous anticoagulant medication while waiting to get an order for warfarin (a medication to decrease blood clotting) in place.

Interview with a MA on 05/11/22 at 4:20pm revealed:
-If she was not able to administer a medication she documented "09", indicating to see nurses' notes, on the resident's eMAR and documented the reason in the nurse's notes.
-If the medication needed to be reordered she would fax the reorder to the pharmacy.
-She notified the Resident Care Coordinator (RCC), Special Care Coordinator (SCC), or Business Office Manager (BOM) when a resident's medication was not available.

Interview with the RCC on 05/12/22 at 9:15am revealed:
-MAs were trained on medication administration and documentation by the previous Health and Wellness Director (HWD).
-The previous HWD continued to train MAs when needed.
-MAs were trained to accurately document

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D 367	Continued From page 58 administration of medications or any exceptions into the resident's eMAR. -The instances when Resident #1's eMAR indicated the rivaroxaban was administered were transcription errors since the medication was not dispensed. -She did not think there was a report that could be run each morning to see what medications were not administered to residents. Interview with the Administrator on 05/13/22 at 2:05pm revealed: -He expected the MAs to accurately document medication administration and any exceptions on the residents' eMAR. -If a medication was not available to administer, he expected the MA to follow up with the pharmacy and notify the RCC or SCC. -He expected the MA or the RCC to notify the resident's PCP after the first missed dose of a medication.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: The facility failed to ensure notification to the county department of social services of any accidents or incidents which required referral for	D 451		

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emergency medical evaluation, hospitalization, or medical treatment other than first aide for 4 of 5 sampled residents (Resident #1,#2,#5, & #6) within 48 hours.

The findings are:

1. Review of Resident #1's current FL-2 dated 09/28/21 revealed diagnoses included coronary artery disease, hypertension, depression, osteoarthritis, lower extremity edema, chronic renal disease, dysphagia, and constipation.

Review of Resident #1's facility progress notes revealed documentation related to Resident #1 being sent to the emergency department (ED) on 04/26/22 due to bleeding from an unknown source.

Review of Resident #1's record revealed no incident report for Resident #1's referral for ED evaluation on 04/26/22.

Telephone interview with Staff C on 05/03/22 at 2:35pm revealed:
-On 04/26/22, she was notified by a personal care aide (PCA) that Resident #1 had blood in her brief and on her bed.
-On 04/26/22, she called 911 and had Resident #1 sent to the ED for evaluation due to bleeding from her nose, mouth, and brief with no known cause.
-She did not know who was responsible for completing an incident report when a resident was referred to the ED for evaluation.

Refer to interview with the Resident Care Coordinator (RCC) on 05/12/22 at 9:15am.

Refer to interview with the Special Care

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Coordinator (SCC) on 05/13/22 at 1:30pm.

Refer to interview with the Administrator on 05/13/22 at 3:30pm.

2. Review of Resident #2's current FL-2 dated 08/03/21 revealed diagnoses included coronary artery disease, hypertension, hyperlipidemia, history of cerebra-vascular accident, recurrent urinary tract infections, chronic pain, glaucoma, and frail elderly.

Review of Resident #2's facility progress notes revealed:
-On 04/04/22 at 8:26pm, staff documented Resident #2 was observed in her bedroom on the floor.
-Staff documented Resident #2 reported she had fallen without any injury.
-On 04/04/22 at 9:05 pm, staff documented contacting Resident #2's physician to report a medication error.
-There was no information related to the type of medication administered to Resident #2 in error.
-Staff documented Resident #2's physician reported Resident #2 should get sleepy and to monitor Resident #2.
-There was no additional documentation related to the incident.

Review of Resident #2's emergency department (ED) documentation dated 04/05/22 revealed:
-At 2:11am, was admitted after Resident #2 was administered clonazepam which was not a medication she takes, resident was drowsy and fell, hitting the back of her head.
-Resident #2 was stable and discharged back to the facility.

Review of Resident #2's record revealed no

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incident report for Resident #2's referral for ED evaluation on 04/04/22.

Interview with Resident #2 on 04/12/22 at 12:00pm revealed she was referred to the ED on 04/04/22 due to a medication error and subsequent fall which occurred that day.

Telephone interview with Resident #2's responsible party on 05/11/22 at 10:30am revealed:
-On 04/04/22 at 9:45pm he visited Resident #2 and was informed she had fallen that evening and was to be sent to the ED for evaluation.
-Resident #2 was evaluated at the ED on 04/04/22 with no physical injuries and discharged back to the facility.

Telephone interview with a nightshift medication aide (MA) on 05/10/22 at 5:26pm revealed:
-On the evening of 04/04/22, after identification of a medication administration error which involved Resident #2 and notification to Resident #2's physician, she checked on Resident #2 and found Resident #2 on the floor in her room.
-On 04/04/22, Resident #2 notified her that she felt unsteady while standing and fell.
-On 04/04/22, Resident #2 notified her that she did not sustain any injuries from the fall and requested staff assist her to bed for the night.
-On 04/04/22 at approximately 10:00pm, Resident #2's responsible party visited Resident #2 and requested she be sent to the ED related to the medication administration error and subsequent fall.
-She did not know who was responsible for completing an incident report for Resident #2 on 04/04/22.

Refer to interview with the RCC on 05/12/22 at

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9:15am.

Refer to interview with the SCC on 05/13/22 at 1:30pm.

Refer to interview with the Administrator on 05/13/22 between 2:00pm and 3:30pm.

3. Review of Resident #5's current FL-2 dated 10/20/21 revealed:
-Diagnoses included memory impairment, anxiety, depression, hypothyroidism, hypertension, Gilbert's Syndrome, steatosis of liver, and Alzheimer's Dementia.
-The documented recommended level of care was for the Special Care Unit.

Review of Resident #5's facility progress notes revealed:
-On 04/10/22 at 8:53pm staff documented Resident #5 was observed with a small knot and bruise over her right eye.
-On 04/11/22 at 2:24pm, staff documented Resident #5 was seen by her physician.
-On 05/05/22 at 7:47am, staff documented Resident #5 was observed on the floor in her bathroom complaining of hip pain and was sent to the ED for evaluation.

Review of Resident #5's ED documentation dated 04/11/22 revealed:
-At 3:04pm, Resident #5 was evaluated on 04/11/22 for a fall with a bruise on her forehead.
-Resident #5 was discharged back to the facility on 04/11/22.

Review of Resident #5's ED documentation dated 05/05/22 revealed:
-At 10:25am, Resident #5 was referred for ED evaluation due to an unwitnessed fall on

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05/05/22.
-Resident #5 was diagnosed with a left intertrochanteric fracture.
-Resident #5 was admitted to the hospital.

Review of Resident #5's facility incident report dated 05/05/22 revealed:
-At 7:27am, Resident #5's husband notified staff that Resident #5 had a fall in her bathroom.
-Resident #5 notified staff that she had sustained a fall and hit her head and her left hip was painful.
-Resident #5 was sent to ED for evaluation.

Review of Resident #5's record revealed no incident report for Resident #5's referral for ED evaluations on 04/11/22, and 05/05/22.

Refer to interview with the RCC on 05/12/22 at 9:15am.

Refer to interview with the SCC on 05/13/22 at 1:30pm.

Refer to interview with the Administrator on 05/13/22 between 2:00pm and 3:30pm.

4. Review of Resident #6's current FL-2 dated 10/21/21 revealed:
-Diagnoses included End-Stage Alzheimer's Disease, seizure disorder, hypothyroidism.
-The documented recommended level of care was for the Special Care Unit.

Review of Resident #6's facility progress notes revealed:
-On 04/27/22 at 12:52pm, staff documented Resident #6 was wandering into other residents' rooms and struck another resident in the face.
-On 04/28/22 at 6:34am, staff documented Resident #6 returned from the emergency

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department (ED) at approximately 12:30am.

Review of Resident #6's ED documentation dated 04/27/22 at 2:46pm revealed Resident #6 was evaluated for altered mental status.

Review of Resident #6's physician's routine visit summary dated 04/28/22 revealed Resident #6 was seen for follow-up evaluation due to hospitalization on 04/27/22 for behavioral issues.

Review of Resident #6's facility incident report dated 04/27/22 revealed:
-On 04/27/22 at 12:52pm, staff documented Resident #6 was wandering into other residents' rooms and struck another resident in the face.
-Resident #6 was sent to ED for evaluation.

Refer to interview with the RCC on 05/12/22 at 9:15am.

Refer to interview with the SCC on 05/13/22 at 1:30pm.

Refer to interview with the Administrator on 05/13/22 between 2:00pm and 3:30pm.

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Interview with the RCC on 05/12/22 at 9:15am revealed:
-The MAs were responsible for completing an incident report when a resident was sent to the ED for evaluation.
-She and the SCC were responsible for reviewing incident reports and notifying the Administrator.
-She was not sure when resident incident reports required notification to the county Department of Social Services (DSS).
-She was not sure which type of incidents, such as falls or a change in condition, required an incident report to be completed.

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(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 451	Continued From page 65 -The Administrator was responsible for submitting incident reports to the county DSS. Interview with the SCC on 05/13/22 at 1:30pm: -MA's were responsible for completing an incident report when a resident was sent to the ED for evaluation. -She and the RCC were responsible for reviewing incident reports and notifying the Administrator. -She was not sure when resident incident reports required notification to the county DSS. -She was not sure which type of incidents, such as falls or a change in condition, required an incident report to be completed. -The Administrator was responsible for submitting incident reports to the county DSS. Interview with the Administrator on 05/13/22 between 2:00pm and 3:30pm revealed: -MA's were responsible for completing a facility incident report when a resident was sent to the ED for evaluation. -The RCC or SCC were responsible for reviewing incident reports and notifying the Administrator. -The incident reports were not completed or he forgot to send them. -He expected staff to complete an incident reports for any resident requiring more than first aide. -He was responsible for submission of incident reports to the county DSS. -He was not aware incident reports required submission to the county DSS within 48 hours.	D 451		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit	D 463		

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D 463	Continued From page 66	D 463		

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In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit:
(1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served.
(2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit.
(3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled residents (Residents #5 and #6) residing in the Special Care Unit (SCU) had a pre-admission screening for appropriate placement.

The findings are:

1. Review of Resident #5's current FL2 dated 10/20/21 revealed:
-Diagnoses included memory impairment, anxiety, depression and Alzheimer's dementia.
-The recommended level of care was the SCU.

Review of Resident #5's record revealed there was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU.

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D 463	Continued From page 67	D 463		

Refer to interview with the Special Care Coordinator (SCC) on 05/13/22 at 10:15am.

Refer to interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm.

Refer to interview with the Administrator on 05/13/22 at 11:18am

2. Review of Resident #6's current FL2 dated 10/21/21 revealed:
-Diagnoses included end-stage Alzheimer Disease and seizure disorder.
-The resident was constantly disoriented with wandering behaviors.
-The resident needed personal care assistance with bathing, feeding and dressing.
-The resident's recommended level of care was the SCU.

Review of Resident #6's record revealed there was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU.

Refer to interview with the Special Care Coordinator (SCC) on 05/13/22 at 10:15am.

Refer to interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm.

Refer to interview with the Administrator on 05/13/22 at 11:18am

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Interview with the Special Care Coordinator (SCC) on 05/13/22 at 10:15am revealed:
-She started her position in February 2022 and has not been able to complete all of her training at this time.

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-She was not sure who was responsible for completing the SCU prescreening at this time.
-She started auditing resident records about 1 week ago but had not gotten to Resident #5's or Resident #6's record.
-She was not aware that they were missing the SCU prescreening evaluation.

Interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm revealed:
-The SCU prescreening forms could not be found for the 2 sampled residents.
-The prescreening should have been completed by the SCC on admission.
-The contracted electronic database for the facility provided a report that reveals what documents were missing from the resident records.
-The SCC was trained on how to access that report today (05/12/22).

Interview with the Administrator on 05/13/22 at 11:18am revealed:
-The facility recently started a contract with an electronic database system and had to scan in all paper documents.
-The SCU prescreening evaluations could not be located in the electronic database for Resident #5 or Resident #6.
-The previous SCC had a physical file folder with the resident's SCU prescreening evaluations but the folder could not be located.
-The SCC was responsible for ensuring that all residents in the SCU had a prescreening evaluation completed.
-The previous SCC kept a spreadsheet of documents required in the residents' records.
-He did not audit the residents' records.

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D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan	D 464		

10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan
In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following:
(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.
(2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure a Special Care Unit (SCU) Resident Profile and Care Plan was completed within 30 days of admission for 2 of 2 sampled residents (Residents #5 and #6).

The findings are:

1. Review of Resident #5's current FL2 dated 10/20/21 revealed:
-Diagnoses included memory impairment, anxiety, depression and Alzheimer's dementia.
-The recommended level of care was the SCU.

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D 464	Continued From page 70	D 464		

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Review of Resident #5's record revealed there was no documented SCU Resident Profile and Care Plan completed within 30 days of admission.

Refer to interview with SCU personal care aide on 05/13/22 at 12:30pm.

Refer to interview with SCU medication aide on 05/13/22 at 12:40pm.

Refer to interview with the Special Care Coordinator (SCC) on 05/13/22 at 10:15am.

Refer to interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm.

Refer to interview with the Administrator on 05/12/22 at 4:30pm and 05/13/22 at 11:18am

2. Review of Resident #6's current FL2 dated 10/21/21 revealed:
-Diagnoses included end-stage Alzheimer Disease and seizure disorder.
-The resident was constantly disoriented with wandering behaviors.
-The resident needed personal care assistance with bathing, feeding and dressing.
-The resident's recommended level of care was the SCU.

Review of Resident #6's record revealed there was no documented SCU Resident Profile and Care Plan completed within 30 days of admission.

Interview with the Regional Clinical Specialist on 05/11/22 at 10:00am revealed he was not able to find a care plan for Resident #6 so her Primary Care Provider (PCP) signed a new care plan for

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D 464	Continued From page 71	D 464		

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her this morning, (05/11/22).

Refer to interview with SCU personal care aide on 05/13/22 at 12:30pm.

Refer to interview with SCU medication aide on 05/13/22 at 12:40pm.

Refer to interview with the Special Care Coordinator (SCC) on 05/13/22 at 10:15am.

Refer to interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm.

Refer to interview with the Administrator on 05/12/22 at 4:30pm and 05/13/22 at 11:18am.

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Interview with SCU personal care aide on 05/13/22 at 12:30pm revealed:
-He received a verbal report from the medication aide (MA) regarding resident care needs.
-He did not know of any document the staff would refer to for resident care needs.
-He did not know what a resident profile or care plan was.

Interview with SCU MA on 05/13/22 at 12:40pm revealed:
-She did not know what document the staff would refer to for resident care needs.
-She stated standup meetings were held in the mornings to discuss any resident needs.
-Resident's behaviors are documented in the staff progress notes.
Interview with the Special Care Unit Coordinator (SCC) on 05/13/22 at 10:15am revealed:
-She started her position in February 2022.
-The Regional Clinical Specialist was currently training her on how to complete care plans.
-The previous Health and Wellness Director

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(HWD) and previous SCC came into the facility as needed to complete the care plans until she was fully trained.
-She started auditing residents' records about 1 week ago and was not aware that Resident #5 and Resident #6 did not have a completed care plan.
-She was not sure what document the staff would refer to direct the resident's care needs in absence of a completed care plan.
-She had not been trained on how to complete a SCU resident profile at this time.
-Resident's behaviors are currently documented in the staff progress notes.

Interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm revealed:
-The HWD was responsible for completing the care plan but she resigned in February 2022.
-The SCC or Resident Care Coordinator (RCC) were responsible for completing care plans until the HWD position was filled.
-The care plan and SCU resident profile were combined into one document by corporate.
-That document was expected to be completed upon admission as well as quarterly by the SCC or HWD.
-The current SCC was trained on how to complete a resident profile on 04/04/22 but she was still learning how to complete a care plan.

Interview with the Administrator on 05/12/22 at 4:30pm and 05/13/22 at 11:18am revealed:
-The HWD, SCC an RCC were responsible for completing resident's care plans.
-He was not aware that Resident #5 and Resident #6 did not have completed care plans.
-He thought the traveling HWD completed their care plans before she resigned in February 2022, but he was unable to locate the evaluations.

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D 464	Continued From page 73 -He was aware that the residents in the SCU required a resident profile and that it should be updated quarterly. -The SCC or HWD were responsible for completing the SCU resident profile and updating it quarterly. -The previous HWD and the previous SCC were uploading all of the facility's paper evaluations to the electronic database before they left in February 2022. -The SCU resident profiles could not be located for Resident #5 and Resident #6.	D 464		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, and in compliance with relevant federal and state laws and rules and regulations related to Medication Aide Training and Competency. The findings are: Based on interviews, and record reviews the facility failed to ensure 2 of 3 sampled staff (Staff A and C) who administered medications had completed the clinical skills checklist and 1 of 3 sampled staff (Staff A) had completed the Medication Aide Training prior to administering	D912		

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D912	Continued From page 74 medications. [Refer to Tag D935 10A NCAC 13F G.S. 131D-4.5B(b) Medication Aide Training and Competency (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to ensure all residents were free from neglect related to medication administration and health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 6 residents (#7) observed during the medication pass including errors with two medications to treat hypertension, a medication to treat depression, a medication to treat fluid retention, a medication to treat mood, a medication to treat anxiety and a supplement; and for 2 of 6 residents (#1 and #2) sampled for record review including errors with a medication to decrease blood clotting (#1), and medication to treat panic disorders and decrease anxiety (#2). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure referral and follow-up to	D914		

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D914	Continued From page 75 meet the routine and acute health care needs for 2 of 7 sampled residents (#1, and #7) related to not receiving a blood thinning medication and bleeding (#1) and missed doses of a medication to treat fluid retention, a medication for mood, a medication to treat anxiety and a vitamin supplement (#7). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and 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	D935		

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D935	Continued From page 76	D935		

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:
TYPE B VIOLATION

Based on interviews, and record reviews the facility failed to ensure 2 of 3 sampled staff (Staff A and C) who administered medications had completed the clinical skills checklist and 1 of 3 sampled staff (Staff A) had completed the Medication Aide Training prior to administering medications.

The findings are:

1.Review of Staff A's personnel record revealed:
-Staff A was hired on 02/21/22.
-She worked as a medication aide (MA).
-There was no documentation she completed the 5/10/15 hour MA training.
-There was no documentation she completed the medication clinical skills checklist competency validation.
-There was no documentation she passed the written MA exam.

Review of a resident's March 2022 electronic medication administration record (eMAR)

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revealed Staff A administered medications on 03/23/22, 03/26/22 and 03/27/22.

Review of a resident's April 2022 eMAR revealed Staff A administered medications on 04/04/22.

Review of a resident's May 2022 eMAR revealed Staff A did not administer medications in May 2022.

Telephone interview with Staff A on 05/11/22 at 8:48am revealed:
-She was hired by the facility at the end of February 2022 as a personal care aide (PCA) and MA.
-She had not taken the North Carolina Medication Aide exam.
-She had not received any training related to medication administration by a facility Registered Nurse (RN), Pharmacist or any other licensed healthcare professional.
-Around 04/01/22 she had received medication administration training from other MAs and the Business Office Manager (BOM).
-On 04/04/22, she administered medications at the facility, no additional MAs were available to assist her.

Refer to interview with the Resident Care Coordinator (RCC) on 05/12/22 at 9:14am.

Refer to interview with the Special Care Unit Coordinator (SCC) on 05/13/22 at 11:18am.

Refer to interview with the Business Office Manager (BOM) on 05/12/22 at 12:10pm.

Refer to telephone interview with the previous Health and Wellness Director (HWD), Registered Nurse (RN) on 05/12/22 at 11:27am and

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	HAL060166	A. BUILDING: ______ B. WING ______	05/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	**13600 S TRYON ST CHARLOTTE, NC 28278**

(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 78 11:40am. Refer to interview with Administrator on 05/13/22 at 2:10pm. 2. Review of Staff C's personnel record revealed: -Staff C was hired on 10/02/20. -She worked as a personal care aide (PCA) and a medication aide (MA). -There was documentation she completed the 15-hour MA training on 06/24/21. -There was no documentation she completed the medication clinical skills checklist competency validation. -There was no documentation that she passed the written MA exam. Review of a resident's March 2022 electronic medication administration record (eMAR) revealed Staff C administered medications on 03/01/22, 03/02/22, 03/05/22, 03/06/22, 03/09/22, 03/10/22, 03/14/22, 03/15/22, 03/16/22, 03/19/22, 03/20/22, 03/23/22, 03/24/22, 03/25/22, 03/28/22, 03/29/22 and 03/30/22. Review of a resident's April 2022 eMAR revealed Staff C administered medications on 04/02/22, 04/03/22, 04/07/22, 04/11/22, 04/12/22, 04/13/22, 04/15/22, 04/16/22, 04/17/22, 04/20/22, 04/21/22, 04/22/22, 04/25/22, 04/26/22, 04/27/22 and 04/30/22. Review of a resident's May 2022 eMAR revealed Staff C administered medications on 05/01/22. Telephone interview with Staff C on 05/03/22 at 2:35pm revealed: -She was hired by the facility as a PCA and was promoted to MA in February 2022. -In February 2022, she received medication	D935		

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administration training from the Business Office Manager (BOM) and the former Special Care Unit Coordinator (SCC) with no additional training by a licensed healthcare professional.
-She did not know what medication administration training the former SCC had prior to training her.
-She was scheduled to take the North Carolina Medication Aide exam on 05/08/22.
-In February 2022, she started to administer residents' medications independently.

Refer to interview with the Resident Care Coordinator (RCC) on 05/12/22 at 9:14am.

Refer to interview with the SCC on 05/13/22 at 11:18am.

Refer to interview with the BOM on 05/12/22 at 12:10pm.

Refer to telephone interview with the previous HWD RN on 05/12/22 at 11:27am and 11:40am.

Refer to interview with the Administrator on 05/13/22 at 2:10pm.

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Interview with the RCC on 05/12/22 at 9:14am revealed:
-The facility's previous HWD RN provided 15-hour MA training and the medication clinical skills checklist competency validation for MAs.
-The Administrator and BOM were responsible for setting up the training through the previous HWD RN.
-After the County initiated the complaint on 04/12/22, she was made aware that some of the MAs in the facility were not fully trained.
-Those MAs were taken off the medication cart and were not allowed to pass medications until they become fully trained.

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-The RCC did not audit staff records and was unsure how the untrained staff were identified.
-The BOM was responsible for ensuring that staff training was up to date.

Interview with the SCC on 05/13/22 at 11:18am revealed:
-The previous HWD RN was responsible for providing all the MA training.
-The BOM was responsible for ensuring that staff records were complete.

Interview with the BOM on 05/12/22 at 12:10pm revealed:
-She worked as a MA for the facility and transitioned into the BOM position in December 2021.
-The previous HWD RN left the facility in December 2021 and since that time the facility did not always have access to an RN that could provide the medication clinical skills checklist competency validation for MAs.
-The BOM knew that the medication clinical skills checklist competency validation was required before a MA could administer medication to residents.
-She was aware that Staff C did not have the medication clinical skills checklist competency validation completed prior to administering medications to residents alone because the facility needed staff.
-She was not sure if the Administrator was aware that Staff C was not fully trained prior to administering medications.
-She stored the personnel records in her office and was responsible for non-clinical documents such as criminal background checks, tuberculous testing and new hire paperwork.
-She trusted the RCC to ensure that the necessary clinical trainings were in the staff

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record and completed on time.
-She was responsible for ensuring staff records were complete, but she did not audit the staff records.

Telephone interview with the previous HWD RN on 05/12/22 at 11:27am and 11:40am revealed:
-She worked at the facility as the HWD from February 2020 until the end of December 2021.
-She remained available to the facility after leaving, for as needed training and RN support.
-At the end of April 2022, the Administrator contacted her to provide training on infection control, licensed health professional support (LHPS) and review of refilling medications.
-She had not been asked to provide 5/10/15-hour MA training since December 2021 but did provide medication clinical skills checklist competency validation to some MAs in mid-April 2022.
-She did not provide the medication clinical skills checklist competency validation to Staff A or Staff C.
-She was made aware of the required Medication Administration Skills Validation Form in April 2022 and had previously been using a different checklist to validate MAs' medication skills.

Interview with the Administrator on 05/13/22 at 2:10pm revealed:
-The BOM, RCC and SCC were responsible for scheduling new employee training with the previous HWD RN.
-He and the BOM were responsible for keeping up with deadlines for annual and other training.
-The BOM should have a spreadsheet to track the dates of required training for staff members.
-The RCC and SCC should have access to the spreadsheet and would be responsible for checking it then scheduling necessary training.
-Since the previous BOM left, the facility did not

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have a current spreadsheet to track staff training.
-He was aware that some MAs were administering medications before they were validated by the previous HWD RN.
-The facility was working on getting the MAs training up to date.

Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).

Refer to Tag D0164 10A NCAC 13F .0505 Training on Care of Diabetic Resident (Type SD Violation).

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The facility failed to ensure 3 of 3 sampled staff (Staff A, B and C) who administered medications had completed the clinical skills checklist and 1 of the 3 sampled staff (Staff A) had completed the Medication Aide Training prior to administering medications which increased the risk of medication errors for all of the residents who received assistance with medication administration. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on May 11, 2022 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25, 2022.