DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL 011-361**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/19/2022

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony at Reynolds Mountain	**41 Cobbler's Way, Asheville, NC 28804**

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D 358	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/18/22 – 10/19/22. 10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a medication prescribed by a licensed prescriber was administered as ordered for 1 of 5 sampled residents (#3) related to an antipsychotic medication. The findings are: Review of Resident #3's current FL2 dated 09/13/22 revealed: -Diagnoses included memory loss and depression. -Resident #3 was intermittently confused. Review of physician's orders for Resident #3 dated 07/28/22 revealed Seroquel (antipsychotic medication) 50mg every night. Review of Resident #3's electronic Medication Administration Record (eMAR) for 10/01/22 – 10/18/22 revealed:			

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	-There was an entry for Seroquel 50mg tablet every evening with an administration time of 8:00pm. -There was documentation the Seroquel 50mg was not administered on 10/11/22 – 10/17/22. -Resident #3 refused the Seroquel on 10/11/22 – 10/13/22, the Seroquel was not available for administration 10/14/22 – 10/16/22, and Resident #3 refused on 10/17/22. Observation of Resident #3's medications on hand for administration on 10/18/22 at 2:15pm revealed there was not any Seroquel available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/18/22 at 2:35pm revealed: -The pharmacy had received a faxed physician's order from the facility on 07/29/22 for Seroquel 50mg every evening. -A 30 day supple of Seroquel 50mg was delivered monthly to the facility. -On 10/03/22 the pharmacy had dispensed a bubble pack of Seroquel 50mg, 30 tablets, and delivered by courier the same night. -The bubble pack with the 30 tablets of Seroquel 50mg should have been started on 10/06/22. Interview with a medication aide (MA) on 10/18/22 at 3:30pm revealed: -She was not aware Resident #3 had been out of Seroquel. -She did not know why she had documented Resident #3 had refused the medication. -She knew that when a resident was out of a medication, she was to request a refill within the eMAR.			

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	Telephone interview with a second MA on 10/18/22 at 3:55pm revealed: -The Seroquel was not in the medication cart to administer on 10/16/22. -She had reported it missing to the next shift. -She had not telephoned the pharmacy or requested the refill within the eMAR because she had been trained that only the day shift MAs were to refill medications so that medication refills were not duplicated. -There was no way to check the eMAR if a medication had already been ordered. Interview with the Memory Care Director (MCD) on 10/19/22 at 10:00am revealed: -Medication cart audits were completed weekly by the third shift MA supervisor. -They were to check for missing medications at that time. -All MAs were able to reorder medications via the eMAR if there were a few left in the bubble pack, or telephone the pharmacy if the medication was completely out or missing. -The third shift MA supervisor was responsible for reviewing the eMARs for missed medications and bringing it to her attention. -The third shift MA supervisor did not reorder the Seroquel for Resident #3 or she had missed it. Interview with the Executive Director (ED) on 10/19/22 at 10:15am revealed: -The MAs on any shift had the ability to reorder medications by telephoning the pharmacy or refilling via the eMAR. -The MCD and the Health and Wellness Director (HWD) were responsible for reviewing the eMAR and regularly			

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	Reviewing the missed medications report. -Medications were delivered from the pharmacy on third shift. -The third shift MA supervisor would account for all medications and place them in the appropriate medication cart. Telephone interview with the hospice Nurse Practitioner (NP) for Resident #3 on 10/18/22 at 3:43pm revealed: -Resident #3 had been prescribed the Seroquel for agitation and resistance to care. -The resident was at risk of decreased safety awareness and an increase in agitation missing 7 doses of the Seroquel. Based on observations, interviews and record reviews, Resident #3 was not interviewable.			
D 935	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			

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	Applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NACA 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed 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: The findings are: Review of Staff A's (MA) personnel record revealed: -Staff A was hired on 08/24/21. -There was documentation of a MA test on 06/15/12. -There was no documentation of 15 hours of MA training. -There was no documentation verifying prior MA employment. Review of a resident's October 2022 electronic Medication Administration (eMAR) revealed there was documentation that Staff A had administered medications on 10/04/22, 10/11/22, and 10/12/22. Interview with the Health and Wellness Director (HWD) on 10/19/22 at 11:50am revealed: -She was responsible for ensuring the MAs completed			

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	the 15 hours of MA training. -She did not know Staff A had not completed the training. -She did not know who was responsible for auditing the personnel records for required training. Interview with the Business Office Manager (BOM) on 10/19/22 at 1:21pm revealed: -He never audited personnel records for required training. -The corporate clinical director audited the personnel records, but he was unsure how often. Interview with the Executive Director (ED) on 10/19/22 at 1:25pm revealed: -The BOM was responsible for auditing all personnel records for required training and documentation. -She did not know why Staff A's 15 hours of MA training was missing. Attempted telephone interview with Staff A on 10/19/22 at 1:15pm was unsuccessful.			

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