STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments Citation Text for Tag 0000, Regulation UZ74 The Adult Care Liscensure Section and the Warren County Department of Social Services conducted a follow-up survey on January 10, 2022 to January 12, 2022.	{D 000}		
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the kitchen and food storage areas including the refrigerators, dishwasher, and stove were kept clean and free of contamination. The findings are: Observation of the kitchen during the initial tour on 01/11/23 at 8:33am revealed: -There were two reach in refrigerators in the kitchen. -The door gasket on the first refrigerator was torn and was hanging down from the bottom and side of the door. -There was a sheet of aluminum foil on the bottom of the refrigerator; under the foil was a layer of dried red, brown and black liquid and food crumbs.	{D 282}		

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{D 282}	Continued From page 1 -There was a strainer located on the outside of the dishwasher. -The strainer was full of food; there were peas, carrots, pasta, chicken and other unidentifiable food items in the strainer. -The drainboard on the clean side of the dishwasher had standing water and food debris including carrots, rice, bread crumbs and small bits of chicken. -Clean dishes were in a dish rack on the drainboard. -The cast iron grates on the stove had a black build up on them and there were spills and drips under them. -The stainless steal backsplash on the stove had a brown and black build up and an accumulation of splatters and spills. -The side of the stove had a thick build up of brown and yellow grease that was stick to the touch. Review of the weekly and daily cleaning schedules posted in the kitchen dated 01/01/23 and 01/08/23 revealed: -The schedule was for one week at a time and the week was divided into days with a list of tasks for each day. -There were two blanks beside each cleaning task. -Every task had been signed off as completed and had a check beside the initials of the staff for the week of 01/01/23. -The cleaning task had been signed off as completed and had a check beside them for the days of Sunday, 01/08/23, to Tuesday, 01/10/23. -The cleaning task included cleaning the shelves in the refrigerator daily. -The stove was assigned to be cleaned on Wednesdays. -The strainer and the drain board on the	{D 282}		

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{D 282}	Continued From page 2 dishwasher were not included on the cleaning schedules. Interview with a kitchen staff on 01/11/23 at 10:53am revealed: -She only worked in the kitchen a few days a week. -She would walk around the kitchen in the morning when she set up. -If she noticed anything needed to be cleaned before she started working, she would clean it first. -The food debris and water would build up as she washed dishes; she usually cleaned the drain board off as she was washing dishes to remove the food and water. -She had stayed busy that morning, 01/11/23, and had not had a chance to clean the drain board. -The Kitchen Manager (KM) did all the deep cleaning in the kitchen. -She cleaned equipment as she saw it needed to be cleaned and she signed the cleaning schedule once she completed the cleaning task. Interview with the cook/KM on 01/11/23 at 9:36am revealed: -The gaskets to the refrigerators had been torn for a while. -Maintenance had worked on the gasket about two months ago and the gasket was back in place. -The gaskets did not stay in place very long and were separated again. -The foil in the bottom of the refrigerator was to help keep the bottom of the refrigerator clean and make it easier to clean up. -The foil was removed once a week on Wednesdays and the bottom of the refrigerator was scrubbed clean; new foil was placed on the bottom of the refrigerator after it was cleaned.	{D 282}		

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{D 282}	Continued From page 3	{D 282}		

-The bottom of the refrigerator was last cleaned on 01/04/23.
-The strainer on the outside of the dishwasher was to collect food from the dishwasher and was supposed to be cleaned out every evening.
-He did not check the strainer to see if it was clean when he came to work that morning, 01/11/23.
-The drain board where the clean dishes were placed after they were removed from the dishwasher was supposed to be clean after every meal to remove food debris and excess water.
-Rice had been on the menu the day before so he did not know why there was rice on the drain board; he thought it might not have been cleaned the night before.
-If the drain board was dirty it should have been cleaned before clean dishes were placed on it.
-The cast iron grates to the stove should have been removed and cleaned once a week.
-He had not had the chance to clean them in a couple of weeks because of his work schedule and the lack of staff.
-The back splash and the sides of the stove had been cleaned but the brown build-up did not come clean.
-The staff were supposed to clean the stove in the evening; including wiping off the grates, the back splash and the sides.
-There was a cleaning schedule posted in the kitchen; staff initialed the schedule once they completed a cleaning task.
-The cleaning task were not assigned to anyone; staff cleaned equipment when they saw it needed to be cleaned.
-He did not check the cleanliness of equipment behind the staff once they signed off on the cleaning schedule because he was pressed for time.
-He did a walk through the kitchen when he came

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{D 282}	Continued From page 4 in first thing in the morning; the kitchen and the equipment always looked clean. Interview with the Maintenance Director on 01/11/23 at 10:28am revealed: -An outside company had repaired the gaskets on the reach in refrigerators the week before. -The gasket must have come loose after the company repaired it. -The KM usually let him know when something was broken in the kitchen and needed to be repaired. Interview with the Administrator on 01/11/23 at 11:03am revealed: -She went into the kitchen every day during meal times. -She would check the cleanliness of the kitchen while she was in the kitchen. -She looked at the cleaning schedule for a reference when she checked the kitchen. -When she saw something that needed to be cleaned, she would tell who ever was working about it. -She knew the refrigerator was cleaned once a week, she did not notice the foil on the bottom of the refrigerator, so she did not know what was under it. -She had just noticed the torn gasket that morning, 01/11/23, and was going to inform the Maintenance Director about it. -She had not noticed the food strainer on the outside of the dishwasher when she was in the kitchen that morning, 01/11/23. -The food should have been cleaned out of the strainer the night before and not left-over night. -The drainboard on the dishwasher should be cleaned as it gathered water and food and sanitized after every meal. -The stove grates should be cleaned once a week	{D 282}		

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{D 282}	Continued From page 5 or more often if they needed it. -She expected the kitchen staff to complete the cleaning schedule and to clean as needed. -She expected the KM to monitor the sanitation in the kitchen and instruct the staff when they needed to do the cleaning. -The KM had come to her last week about some of the cleaning in the kitchen not being completed; they reviewed the cleaning schedule and discussed some changes to begin more deep cleaning.	{D 282}		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a therapeutic diet menu for 1 of 5 sampled residents (#2) with a diet order for a regular, chopped diet (#2). The findings are: Observation of the kitchen during the initial tour on 01/11/23 at 8:33am revealed: -There was a therapeutic diet menu available in the kitchen. -The therapeutic diet menu did not have a chopped diet menu available for the staff to reference.	D 296		

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D 296	Continued From page 6 Review of Resident #2's current FL2 dated 11/18/22 revealed: -Diagnoses included dementia, schizoaffective disorder and cerebrovascular accident. -There was an order for a regular diet. Review of Resident #2's signed physician's orders dated 12/16/22 revealed an order for a regular, chopped diet. Review of Resident #2's physician's signed diet order dated 11/04/22 revealed: -Resident #2 had an order for a regular, chopped diet. -A chopped diet was listed as cut or chop table food into small pieces. Interview with the cook on 01/11/23 at 12:20pm revealed: -She did not use the therapeutic diet menu as a guide when preparing meals. -The residents who had a chopped diet order just had their meats cut up and she did not need a therapeutic diet menu for that. Interview with the Kitchen Manager (KM) on 01/10/23 at 10:11am revealed: -He did not know there was not a chopped diet on the therapeutic diet menu. -He did not reference the menu for a chopped diet he knew what to cut up. -He only cut up the meats for residents on a chopped diet. Interview with the Resident Care Coordinator (RCC) for the special care unit (SCU) on 01/11/23 at 1:31pm revealed: -She gave the kitchen staff the list of residents and their diet orders.	D 296		

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D 296	Continued From page 7 -She was not aware there was not a therapeutic diet menu for a chopped diet. -Some residents had diet orders for just chopped meats, but some had a diet order for a chopped diet. Interview with the Administrator on 01/11/23 at 1:06pm revealed: -She knew the facility offered chopped meats for some residents. -She did not think there were any residents on a full chopped diet, only chopped meats. -She was not aware the diet orders the facility used listed a chopped diet with table food cut into small pieces. -There should have been a menu for a chopped diet if it was listed on the diet orders. -The kitchen staff should have been following the therapeutic diet menu for a chopped diet. -The kitchen staff had not told her they did not have a therapeutic diet menu for a chopped diet. -The kitchen staff or the KM should have informed her they needed a therapeutic diet menu for the chopped diet. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's Primary Care provider (PCP) on 01/11/23 at 12:21pm was unsuccessful	D 296		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	{D 358}		

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{D 358}	Continued From page 8	{D 358}		

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 medications were administered as ordered for 1 of 5 sampled residents (#5), related to a medication for mood disorders.

The findings are:

Review of Resident #5's current FL2 dated 05/12/22 revealed diagnoses included bipolar disorder.

Review of Resident #5's physician's orders dated 11/04/22 revealed:
-There was an order for asenapine 2.5mg one tablet under tongue every morning.
-There was an order for asenapine 5mg one tablet under tongue every evening.

Review of Resident #5's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for asenapine 2.5mg to be administered every morning with a scheduled administration time of 8:00am.
-There was documentation Resident #5 was administered asenapine 2.5mg 26 out of 30 days from 11/01/22 to 11/30/22.
-There were exceptions documented; the exceptions were Resident #5 refused the medication.

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	HAL093010	A. BUILDING: _____ B. WING _____	R 01/11/2023

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{D 358}	Continued From page 9 -There was an entry for asenapine 5mg to be administered every evening with a scheduled administration time of 5:00pm. -There was documentation Resident #5 was administered asenapine 5mg 25 out of 30 days from 11/01/22 to 11/30/22. -There were exceptions documented; the exceptions were Resident #5 refused the medication. Review of Resident #5's December 2022 eMAR revealed: -There was an entry for asenapine 2.5mg to be administered every morning with a scheduled administration time of 8:00am. -There was documentation Resident #5 was administered asenapine 2.5mg 15 out of 31 days from 12/01/22 to 12/31/22. -There were exceptions documented; the exceptions were Resident #5 refused the medication. -There was an entry for asenapine 5mg to be administered every evening with a scheduled administration time of 5:00pm. -There was documentation Resident #5 was administered asenapine 5mg 15 out of 30 days from 12/01/22 to 12/31/22. -There were exceptions documented; the exceptions were Resident #5 refused the medication. Review of Resident #5's January 2023 eMAR from 01/01/23 to 01/10/23 revealed: -There was an entry for asenapine 2.5mg to be administered every morning with a scheduled administration time of 8:00am. -There was documentation Resident #5 was administered asenapine 2.5mg 7 out of 10 days from 01/01/23 to 01/10/23. -There were exceptions documented; the	{D 358}		

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{D 358}	Continued From page 10	{D 358}		

exceptions were Resident #5 refused the medication.
-There was an entry for asenapine 5mg to be administered every evening with a scheduled administration time of 5:00pm.
-There was documentation Resident #5 was administered asenapine 5mg 3 out of 9 days from 01/01/23 to 01/09/23.
-There were exceptions documented; the exceptions were Resident #5 refused the medication.

Observation of Resident #5's medications on hand on 01/11/23 at 9:03pm revealed:
-There was a zip lock bag that contained 8 asenapine 5mg tablets in the top drawer of the medication cart with a dispense date of 09/28/22.
-The were no asenapine 2.5 mg tablets on the medication cart.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 01/11/23 at 9:30am revealed:
-Asenapine was an antipsychotic and mood stabilizer.
-The pharmacy had an order for asenapine 5mg every evening.
-The pharmacy dispensed 30 tablets of asenapine 5mg 04/29/22.
-The pharmacy did not have an order for asenapine 2.5mg every morning.
-The pharmacy had not dispensed asenapine 2.5mg for administration.
-The pharmacy received new orders through fax, e-script or phone.
-Resident #2 could have an increased in mood swings.

Interview with a Medication Aide (MA) on 01/11/23 at 11:15am revealed:

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	HAL093010	A. BUILDING: _____ B. WING _____	R 01/11/2023

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{D 358}	Continued From page 11 -She checked each medication against the eMAR before she prepared the medication for administration. -Resident #5 refused asenapine 2.5mg this morning during the 8:00am medication pass. -She did not prepare the medication for administration since Resident #5 said she did not want the medication. -She did not know asenapine 2.5mg was not on the medication cart since she did not prepare it for administration this morning. -She thought she had previously administered asenapine 2.5mg. -She did not know why there was documentation that asenapine 2.5mg had been administered if the pharmacy had not dispensed the medication. -She had not noticed Resident #5 with any mood swings, such as crying, being aggressive, or yelling. Interview with the Resident Care Coordinator (RCC) on 01/11/22 at 11:14am revealed: -The MAs should compare the medication in the medication cart to the medication listed on the eMAR. -Once the MAs was certain they had the correct medication, they should prepare the medication for administration by popping the pill in a medication cup. -After the medication had been prepared the MAs should click on the eMAR to note the medication was prepared for administration. -The MAs should click "complete" on the eMAR once the medication had been administered. -If the medication was not on the medication cart the MA should document "medication was not available for administration", call the pharmacy, and notify the RCC. -Resident #5 had not experienced any mood swings; she was very quiet, stayed in her room	{D 358}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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{D 358}	Continued From page 12 and walked outside. -She audited the medication carts for expired medications and discontinued medications every week but did not compare medications on the medication cart to the entries on the eMAR. -She expected the MAs to administer medications as ordered and to notify the pharmacy if medications were not available for administration. Interview with the Administrator on 01/11/22 at 1:28pm revealed: -The MAs were responsible for faxing new orders to the pharmacy. -The MAs should give the new orders to the RCC and the RCC would verify the medication arrived in the facility for administration. -The RCC should audit the medication carts weekly. -The RCC looked for expired and discontinued medications. -She audited one medication cart every few weeks. -She did not compare medications in the medication carts to the medications listed on the eMAR for administration. -She expected the MAs to administer medications as ordered. -She expected the MAs to call the pharmacy and let the RCC know if a medication was not in the facility. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Attempted telephone interview with Resident #2's Primary Care provider (PCP) on 01/11/23 at 12:21pm was unsuccessful	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D 375	Continued From page 13	D 375		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 1 resident sampled (#1) had a physician's order to self-administer an enzyme supplement for the digestion of milk and a mineral supplement. The findings are: 1. Review of Resident #1's current FL-2 dated 09/06/22 revealed: -Diagnoses included gastro-esophageal reflux disease, history of constipation, hyperlipidemia, depression, hypertension and history of alcohol dependence. -There was no order for the self-administration of medications. Review of Resident #1's care plan dated 05/12/22 revealed there was no documentation that	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 01/11/2023

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D 375	Continued From page 14 Resident #1 was assessed to administer any medications. a. Review of Resident #1's current FL-2 dated 09/06/22 revealed there was an order for Lactaid (used to aid in the digestion of milk and milk products) 3000 units take 3 tablets prior to eating cereal daily. Review of Resident #1's six-month primary care provider (PCP) orders dated 11/04/22 revealed there was no order for Lactaid. Interview with Resident #1 on 01/10/23 at 3:28pm revealed: -He did not drink cow's milk but used lactose free milk. -He had a container of lactose free milk in his personal refrigerator. -He did not remember having an order for Lactaid pill, but he had purchased some himself from the store. -When he did not have lactose free milk to drink, he used his generic Lactaid pills. -He had not told his PCP that he had or took the pills. -He stored the pills in his plastic drawer organizer. Observation of the fourth drawer of Resident #1's organizer drawer on 01/10/23 at 3:37pm revealed: -An opened bottle of generic Lactaid tablets was removed from the resident's drawer. -The pill bottle indicated 60 tablets were in an unopened bottle of generic Lactaid. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/10/22 at 4:36pm revealed: -Resident #1 had an order for Lactaid.	D 375		

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D 375	Continued From page 15 -On 08/29/22, the order for Lactaid was discontinued by Resident #1's PCP. Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 01/10/23 at 4:36pm. Refer to the interview a medication aide (MA) on 01/11/23 at 10:02am. Refer to the interview with the Resident Care Coordinator (RCC) on 01/11/23 at 10:22am. Refer to the interview with the Administrator on 01/11/23 at 12:45pm. b. Review of Resident #1's current FL-2 dated 09/06/22 revealed there was no order for zinc (used as a treatment for the common cold and enhanced wound healing). Review of Resident #1's physician orders dated 11/04/22 revealed there was no order for zinc. Interview with Resident #1 on 01/10/23 at 3:28pm revealed: -He wanted to show a bottle of medication that he took daily. -He had a bottle of zinc 50mg tablets stored in his plastic drawer organizer. -He took one tablet of zinc daily. -He had told his PCP that he took zinc daily and his PCP stated that was alright to take it. Observation of the fourth drawer of Resident #1's organizer on 01/10/22 at 3:37pm revealed: -An opened bottle of zinc 50mg tablets was removed from the drawer. -The pill bottle indicated 200 tablets were in an unopened bottle of zinc.	D 375		

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D 375	Continued From page 16 Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/10/22 at 4:36pm revealed Resident #1 did not have an order for zinc. Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 01/10/23 at 4:36pm. Refer to the interview a medication aide (MA) on 01/11/23 at 10:02am. Refer to the interview with the Resident Care Coordinator (RCC) on 01/11/23 at 10:22am. Refer to the interview with the Administrator on 01/11/23 at 12:45pm. _____ Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/10/22 at 4:36pm revealed Resident #1 did not have an order to self-administer medications. Interview with a medication aide (MA) on 01/11/23 at 10:02am revealed: -She did not know Resident #1 had medications in his room. -Resident #1 did not have an order to self-administer medications. -She administered all of Resident #1's medications. -If she saw medications in a resident's room she would remove the medications and explain to the resident that an order was needed to self-administer any medication. Interview with the Resident Care Coordinator (RCC) on 01/11/23 at 10:22am revealed: -She was told on 01/10/23 that Resident #1 had	D 375		

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D 375	Continued From page 17	D 375		

medications in his room.
-Resident #1 did not have any orders to self-administer medications.
-If the resident did not have an order, she would notify the physician and request an assessment to determine if the resident could self-administer medications.
-All staff were responsible for ensuring residents without an order to self-administer medications did not have medications in their rooms.
-When residents had an order to self-administer medications, residents administered their medication.
-If a resident did not have an order to self-administer medication, then there should be no medication in the resident's room.
-She expected staff to remove medications that were discovered in residents' rooms without an order to self-administer medications.
-She was responsible for ensuring residents who self-administered medications had a physician order and assessment.

Interview with the Administrator on 01/11/23 at 12:45pm revealed:
-She did not know Resident #1 had medications in his room to self-administer.
-Resident #1 went to church services and had an opportunity to purchase things that staff would not know about.
-Residents had to have an order to self-administer any medication kept in their room.
-The PCP completed an assessment for residents to determine if a resident could self-administer medications.
-She expected a personal care aide (PCA) to notify the MA if medications were seen in a resident's room.
-She expected a MA to notify the RCC if medications were seen in a residents room.

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D 375	Continued From page 18 -Any staff could notify her if medications were found in a resident's room. -The RCC was responsible for ensuring residents who wanted to self-administer medications had an assessment and physician's order. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 01/10/23 at 4:33pm was unsuccessful.	D 375		
{D 468}	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.	{D 468}		

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{D 468}	Continued From page 19 (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure 2 of 4 sampled staff (Staff A and Staff B) completed 6 hours of special care unit (SCU) training within the first week of employment who were assigned to perform duties in the SCU. 1. Review of staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 12/14/22. -There was no documentation Staff A completed 6 hours of Special Care Unit (SCU) orientation. Review of the facility's schedule for a two-weeks period from 12/31/22 to 01/13/23 revealed Staff A was assigned to the SCU for 10 of 14 night shifts. Interview with the Business Office Manager (BOM) on 01/11/23 at 12:15pm revealed: -She knew Staff A did not have the required SCU training. -Staff A had not attended training offered to staff last week because she worked on third shift. -She had reminded Staff A to complete her online training and told her she had 30 days to complete the training from her hire date. -She knew Staff A had no documentation of SCU training. -She knew Staff A was assigned to the SCU. Interview with the Administrator on 01/11/23 at 12:45pm revealed she did not know Staff A did not have documentation of the 6 hours of SCU training and orientation.	{D 468}		

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{D 468}	Continued From page 20 Attempted interview with Staff A on 01/11/23 at 12:40pm was unsuccessful. Refer to the interview with the Business Office Manager (BOM) on 01/11/23 at 12:15pm. Refer to interview with the Administrator on 01/11/23 at 12:45pm. 2. Review of Staff B's, personal care aide (PCA), personnel record revealed: -Staff B was hired on 01/04/23. -There was no documentation Staff B completed 6 hours of Special Care Unit (SCU) orientation. Review of the facility's schedule for a two weeks period from 12/31/22 to 01/13/23 revealed Staff B was assigned to the SCU for 7 of 14 second shifts. Interview with the Business Office Manager (BOM) on 01/11/23 at 12:15pm revealed: -She knew Staff B did not have the required SCU training because Staff B had just started her employment at the facility. -She knew Staff B did not have documentation of any SCU training. -Staff B told her she had begun her online training, but it was for other required areas of training. -She knew Staff B was assigned to the SCU. Interview with the Administrator on 01/11/23 at 12:45pm revealed she did not know Staff B did not have documentation of the 6 hours of SCU training and orientation. Attempted interview with Staff B on 01/11/23 at 12:41pm was unsuccessful.	{D 468}		

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{D 468}	Continued From page 21 Refer to the interview with the Business Office Manager (BOM) on 01/11/23 at 12:15pm. Refer to interview with the Administrator on 01/11/23 at 12:45pm. _____ Interview with the Business Office Manager (BOM) on 01/11/23 at 12:15pm revealed: -She did not know staff assigned to the SCU had to complete 6 hours of orientation on the nature and needs of the residents within the first week of employment. -She knew staff assigned to the SCU needed 20 hours of SCU training within 6 months of employment. -She was still learning her job duties. -She had completed some tasks related to the personnel records but was still in the process of doing other tasks. -She was responsible for ensuring staff assigned to the SCU had the required 6 hours of training within the first week of employment. Interview with the Administrator on 01/11/23 at 12:45pm revealed: -She did not remember that the 6-hour SCU orientation was needed the first week of employment to work in the SCU. -She was aware of some training currently being done for staff and taught by the pharmacy staff. -She was aware of the 20-hour training SCU staff needed to complete in the first 6 months of working in the SCU. -She did not know if SCU staff's personnel records had been audited for completeness. -She was responsible for ensuring SCU staff were offered the training required to work in the SCU and the documentation was placed in their personnel records.	{D 468}		

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