Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: ______ B. WING ______	R 12/07/2023

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow Up Survey on 12/06/23 to 12/07/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 2 sampled medication aides (Staff B and Staff C) who were administering medications had taken and completed the medication aide examination. The findings are: 1. Review of Staff B's, medication aide (MA) personnel record revealed: -Staff B hire date was 05/31/23. -There was documentation of a medication clinical skills competency validation checklist dated 09/18/23. -There was documentation of medication training of 5 hours dated 08/20/23 and 10 hours dated 08/27/23. -There was no documentation of Staff B	D 125		

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completing the medication aide exam.

Observation of the morning medication pass on 12/07/23 at 7:25am revealed:
-Staff C (MA) administered 8 pills and 2 eye drops to a resident located on the 100 hall.
-There was not a MA Supervisor present during the medication pass.

Attempted telephone interview with Staff B on 12/07/23 at 3:00pm was unsuccessful.

Interview with the Administrator on 12/07/23 at 3:21pm revealed:
-Staff B worked as a MA on the second shift.
-Staff B had not taken the medication aide exam because she was waiting on getting her identification card (ID).
-Staff B had passed medication without staff supervision.

2. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C's hire date was 05/05/23.
-There was documentation of a medication clinical skills competency validation checklist dated 09/18/23.
-There was documentation of medication training of 5 hours dated 08/20/23 and 10 hours dated 08/27/23.
-There was no documentation of Staff C completing the medication aide exam.

Telephone interview with Staff C on 12/07/23 at 10:34pm revealed:
-She worked as a MA on the third shift.
-She had taken the medication aide exam for the first time about two weeks ago by computer but could not remember the date of the exam.
-She took the medication exam for a second time

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D 125	Continued From page 2 but could not remember the date. -There was a malfunction with the computer during the test and the test was discontinued. -She had contacted the online exam administrator but had not received a response. -She would not provide an answer if she had passed medication without supervision. Interview with the Administrator on 12/07/23 at 3:31pm revealed: -Staff C was hired as a MA. -Staff C had attempted to take the medication aide exam twice but there was a discontinuation by the computer system. -She did not know if Staff C tried to contact the Raleigh Office to report an issue with the test exam. -Staff C had passed medication without staff supervision.	D 125		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed medication was administered to 1 of 5 sampled residents (#4) as ordered by the physician for enlarged prostate gland.	D 358		

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The findings are:

Review of Resident #4's current FL-2 dated 03/15/23 revealed:
-Diagnoses included dementia, psychosis, schizophrenia, hypertension and glaucoma.
-There was an order for Finasteride 5mg, 1 tablet by mouth every morning to treat enlarged prostate gland.

Review of Physician's orders dated 10/11/23 revealed:
-Diagnoses included benign prostatic hyperplasia without lower urinary and retention of urine.
-There was an order for Finasteride 5mg, 1 tablet by mouth once daily to treat enlarged prostate gland.

Review of Resident #4's October 2023 electronic medication administration record (eMAR) revealed Finasteride was documented as administered 5mg, 1 tablet by mouth daily from 10/01/23 through 10/31/23.

Review of Resident #4's November 2023 eMAR revealed Finasteride was documented as administered from 11/01/23 through 11/30/23.

Review of Resident #4's December 2023 eMAR revealed Finasteride was documented as administered from 12/01/23 through 12/06/23.

Observation of medications on hand on 12/07/23 at 12:00pm revealed:
-There was a bottle of Finasteride 5mg tablet on the medication cart with a pharmacy label that had a fill date of 03/02/23 with a quantity of 90 pills.
-The bottle of Finasteride on the cart with the fill

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date of 03/02/23 had 36 pills remaining.

Interview of a medication aide (MA) on 12/07/23 at 12:00pm and 3:20pm revealed:
-Resident #4 was administered Finasteride 5mg tablet every morning.
-There were no other bottles of Finasteride 5mg tablet on the medication cart or in the medication room.
-She did not look at the date on the medication bottle so she was not aware that the Finasteride bottle on the cart was filled on 03/02/23.
-She was unsure why the bottle of Finasteride on the cart was from 03/02/23.
-Resident #4's responsible person provided all medications.

Telephone interview of Resident #4's responsible person on 12/07/23 at 12:36pm and 3:30pm revealed:
-She picked Resident #4's medications up from a local pharmacy and provided it to the facility only when the facility staff notified her that the medication needed to be refilled.
-Finasteride was prescribed to Resident #4 for his prostate years ago.
-She was unsure if Resident #4 was still taking Finasteride.
-The facility staff have not asked for any refills on Finasteride "in a good while."
-She last had the Finasteride filled 03/02/23.

Telephone interview of the local Pharmacist on 12/07/23 at 2:50pm revealed:
-Resident #4 was prescribed Finasteride for his prostate.
-A 90 day supply of Finasteride was last filled on 03/02/23 and picked up on 03/05/23.
-90 pills of Finasteride was distributed and would have run out in June 2023.

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-There was one remaining refill after March 2023 that expired because it was never used.
-Failure to administer the Finasteride could have led to worsening prostate issues.

Interview of a second MA on 12/07/23 at 3:15pm revealed:
-He gave Resident #4's medications based on what he saw on the computer screen that included Finasteride and he gave all medications that he documented had been given.
-He was not aware the bottle of Finasteride on the cart was filled 03/02/23 because he did not look at the date.
-He did not know why the bottle of Finasteride on the medication cart was from 03/02/23.

Telephone interview of the primary care provider (PCP) on 12/07/23 at 2:20pm and 3:08pm revealed:
-Resident #4 had been prescribed Finasteride for his prostate prior to her becoming his PCP.
-Resident #4 should have still been administered Finasteride.
-Resident #4's responsible person provided his medications to the facility.
-She was unsure why the Finasteride had not been filled since 03/02/23.
-She expected facility staff to give the medication as ordered.
-Resident #4 could have experienced urinary retention as an adverse outcome of the medication not being administered.

Interview of the Administrator on 11/07/23 at 3:45pm revealed:
-She was not aware the Finasteride bottle on the medication cart was from 03/02/23.
-Resident #4's responsible person provided all his medications from an outside pharmacy.

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D 358	Continued From page 6 -She notified Resident #4's responsible person of the need for refills. -The last documentation of Resident #4's responsible person being notified of the need for a refill on Finasteride was 02/07/23 via text message. -A third shift MA completed cart audits once per week while other MAs had no responsibility to report the need for medication refills. -She was unsure when it was last reported to her that Resident #4 needed a refill of Finasteride. -There was no process in place to ensure Resident #4's medication refills were provided.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure there was a care coordinator for a freestanding special care unit (SCU) with a census of 53 residents for 8 hours per day 5 days per week. The findings are: Review of the facility's resident census report dated 12/06/23 revealed there were 53 residents in the SCU.	D 466		

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Review of the staff schedule for 12/06/23 to 12/07/23 revealed a personal care aide (PCA) was noted as the Resident Care Coordinator (RCC) in Training.

Observations on the SCU on 12/07/23 revealed there were 5 personal care aides (PCA) and 2 medication aides (MA) on duty for the first shift.

Interview with the PCA on 12/07/23 at 3:42pm revealed:
-She had been training as the RCC for about two months (exact dates not given).
-The Administrator had been providing the RCC training.
-She had not supervised the MAs but had supervised the PCAs as the RCC in Training.
-She performed job duties for setting up residents' appointments, making referrals and charting.
-She worked as the RCC in Training Monday through Friday at least 40 hours a week.
-She did not have MA experience or training.
-The Administrator was the Acting RCC.

Interview with the Administrator on 12/07/23 at 3:21pm revealed:
-The PCA had trained as the RCC for about two months (exact dates not given).
-The PCA had training in making and following up on appointments for the residents.
-The PCA had supervised the PCAs as the RCC in Training.
-The PCA worked 40 hours weekly as the RCC in Training.
-The PCA had not provided supervision to the MAs.
-The PCA did not have any medication aide training or experience.
-She did not know the qualifications for hiring a

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D 466	Continued From page 8 RCC. -She worked as the RCC at least 25-25 hours a week. -She assisted with transporting the residents when needed. -She worked as the Administrator at least 20 hours a week.	D 466		