STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and complaint investigation survey from 03/12/24 to 03/13/24.	D 000		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the documentation on the electronic medication administration record was recorded by the medication aide that administered the medication to 1 of 4 residents (#4) observed during the medication pass related to a medication used to treat hypothyroidism. The findings are: Review of Resident #4's current FL-2 dated 03/07/23 revealed diagnoses included hypertension, unspecified convulsions, hypothyroidism, vitamin D deficiency, and iron deficiency anemia. Review of Resident #4's physician order summary report dated 03/07/23 revealed an order for Levothyroxine 125mcg, 1 tablet once a day.	D 366	Medication administration documentation must occur accurately at time of administration, no pre documentation is allowed. If a resident communicates that a medication that was documented was not actually taken, the Med Tech must contact the RCC and prior shift Med Tech immediately, do not give the medication. The RCC and/or Med Tech must contact the physician upon discovery of medication error. Additional measures recommended by the physician must be completed as ordered. This may include contact of poison control, observation of resident vital signs and behaviors over a specific time frame, and other lab testing as ordered. Medication Administration Record Documentation training was conducted by pharmacy nurse on March 20, 2024 with med tech and RCCs. Training on documentation will be a part of the regular monthly med tech meetings. Med tech shift change communication log will be included in their reference binder and med tech will be trained to review shift change notes at the beginning of every shift. This will be implemented, and training completed by April 30, 2024. RCC will monitor that the shift changes notes have been utilized by med techs on a regularly. RCC will monitor to see if any medication errors, refusals, or other reasons medication was not received is documented in PCC. RCC will follow up with physician orders made due to any errors on a regular basis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lydia Vanderlaan 4-9-24

Reviewed and Acknowledged 04/22/24 Teresa A Hazel

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D 366	Continued From page 1 (Levothyroxine is a medication used to treat hypothyroidism). Observation of the 8:00am medication pass on 03/13/24 revealed Levothyroxine 125mcg, 1 tablet was administered to Resident #4 by the first shift medication aide (MA) at 7:25am. Review of Resident #4's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Levothyroxine 125mcg, 1 tablet once a day to be administered at 6:00am. -There was documentation the Levothyroxine 125mcg, 1 tablet was administered by the third shift MA on 03/13/24 at 6:00am. Interview with Resident #4 on 03/13/24 at 10:30am revealed: -He was not administered the Levothyroxine by the third shift MA. -He typically wanted to receive the Levothyroxine with his 8:00am medications. -He was administered the Levothyroxine by the first shift MA. Interview with the first shift MA on 03/13/24 at 9:30am revealed: -The administration of the Levothyroxine was signed off as administered by the third shift MA on the eMAR, but Resident #4 told her that he had not received his 6:00am Levothyroxine. -She administered Resident #4 the Levothyroxine with his 8:00am medications. -The resident was very aware of the medications he took, but she should have verified with the third shift MA that she did not administer the resident his Levothyroxine before administering the medication to the resident. -The third shift MA did not tell her that she had	D 366		

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D 366	Continued From page 2 not administered Resident #4's Levothyroxine. -She should go by what was documented on the eMAR and verify. Telephone interview with the third shift MA on 03/13/24 at 1:20pm revealed: -She did not administer Resident #4's Levothyroxine that was scheduled at 6:00am. -She signed off that the Levothyroxine was administered because the resident told her that he would take the medication, but he went to feed the cat and did not return to take the medication. -She did not tell the first shift MA that she did not administer the resident his medication even though she signed off on the eMAR that it was administered. -She did not make a notation in the eMAR that Resident #4's Levothyroxine was not administered. -She should have told the first shift MA that she had not administered the resident's Levothyroxine and documented on the eMAR that the medication had not been administered. Interview with the Resident Care Coordinator (RCC) on 03/13/24 at 9:40am revealed: -The first shift MA should have verified the administration of Resident #4's Levothyroxine with the third shift MA before administering the medication. -The third shift MA should have notified her that she had documented on the eMAR that the resident's Levothyroxine had been administered but was not administered so a notation could be made on the eMAR. Interview with the Administrator on 03/13/24 at 9:50am revealed: -Resident #4 was very astute and aware of the medications he was prescribed.	D 366		

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D 366	Continued From page 3 -However, the first shift MA should have verified with the third shift MA before administering the resident's Levothyroxine to ensure the resident did not receive a double dose. -If the third shift MA could not be notified, then the medication should not be administered and the primary care provider(PCP) contacted for further instructions. -What was documented on the eMAR should be followed or verified -Documentation of the administration of a medication on the eMAR should be by the MA administering the medication.	D 366	Resident incident occurs, incidents include, falls, aggressive behaviors, medication error, chocking, elopement, unknown injury, and pressure ulcer or skin changes. Incidents that are observed are reported to the Med Tech on shift. Med tech notifies provider, family, RCC and emergency services if needed. Med tech determines if send out is needed and then contacts physician, RCC, and OnCall phone. If the resident is on hospice, they are contacted for determination of send out. Med tech prepares paperwork for transfer. Paperwork includes face sheet, order summary, and code status.	
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: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of an incident resulting in injury requiring an emergency medical evaluation for 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 07/25/23 revealed diagnoses included depressive	D 451	Med tech is to fill out company incident report form and put a charting note in PCC. Incident report form includes description of incident, resident description, type of injury, ambulatory status, metal status, environmental information, predisposition of phycological and situation, witnesses if existing. Name, date and time family member and physician was notified is indicated on the form. Progress note needs to entered into PCC for incident. Completed report are to be placed in the communication box located in each med room. RCC collects communication from box daily and first thing Monday morning. Forms are reviewed by RCC and management section is completed. The resident is put on the provider list. Follow up based on hospital discharge if resident was sent out. RCC provides incident report to ED for review and reporting. ED reviews, initials, dates, scans and sends to county monitor. Report is then filed by building by month in RCC office.	

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D 451	Continued From page 4 disorder, hypertension, cerebral infarction, and gastrointestinal hemorrhage. Review of the on-duty Medication Aide's (MA) incident note for Resident #2 dated 12/18/23 revealed: -The resident had a fall getting out of the bed. -During the fall, the resident hit his rib on the corner of the nightstand. -The resident was in pain and after encouragement he decided to go to the hospital. Review of the Resident Care Coordinator's (RCC) incident note for Resident #2 dated 12/18/23 revealed: -The MA put a progress note in the electronic notes related to the fall. -The resident stood, lost his balance, and fell. -The resident was sent to the Emergency Room (ER) for observation. Review of the hospital's discharge instructions for Resident #2 dated 12/18/23 revealed: -The diagnosis was a rib contusion. (Also called a bruised rib). -The injuries were often a result of a fall. Interview with the RCC on 03/12/24 between 11:54am and 12:40pm revealed: -She started training with the facility as the RCC on 12/09/23. -The MA was responsible for completing the incident/ accident report for Resident #2's fall. -An incident/ accident report should have been completed for Resident #2. -After the incident/accident report was completed, it should have been given to the Administrator so it could have been sent to the county. -After reviewing documentation, she did not find an incident/ accident report was completed for	D 451	Measures to put in place: • Training on incident reports process to be complete, including process for send out outs and none send outs for example elopements. • Review all reasons for incident reports with med tech and communication of incidents immediately to on call phone. • Med tech must complete report by end of shift. If they have not, they will be called in to do so. • Med tech will receive disciplinary action and additional training if not completed by end of shift. • Person with on call phone will notify RCC and ED when an incident has been reported. • RCC will check PCC when completing the management section to verify if a progress note has been completed, if a note has not been completed, they will put one in • ED will verify that there is a note in PCC before scanning and sending to the county monitor. Monitoring: • Monitoring will be part of the regular process of incident reporting. RCC will enter notes and incident reports into PCC. • ED will monitor entries made into PCC and enter a progress note that the incident report was sent to the county DSS. This will be started in March 2024 and added to the ongoing process Training on med tech completion of incident Report will be completed by May 15, 2024.	

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D 451	Continued From page 5 Resident #2. Interview with the Special Care Coordinator (SCC) on 03/13/24 at 8:02am revealed: -The MA was responsible for completing the incident/ accident report for Resident #2. -She completed the incident note for Resident #2 dated 12/18/23 under the RCC's position. -She helped the sister facility at the time of the incident because the RCC was in training. -She was not sure why the incident/accident report was not completed for Resident #2. -She should have made sure the incident/accident report was done because it would have been her responsibility. Interview with the Administrator on 03/12/24 at 4:00pm revealed: -The MAs were to complete incident/ accident reports within 24 hours of an incident, for example, falls, when residents were sent to the ER, or had behaviors. -She would then send the incident/ accident report to the county. -The employee did not follow the proper protocol for completing an incident/ accident report for Resident #2. -The RCC should have followed up with the MA to ensure the incident/ accident report was completed and helped with completing it, if assistance was needed. Attempted telephone interview with the MA on duty on 12/18/23 on 3/13/124 at 9:05am was unsuccessful.	D 451		

Lisha Vandette, 4-9-24
Administrator