STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032144	A. BUILDING: _____ B. WING _____	R 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY LIVING AT OAK GROVE	3811 WAKE FOREST HIGHWAY DURHAM, NC 27703

(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
{C 000}	Initial Comments The Adult Care Licensure Section condutcted a follow up survey on 07/02/24.	{C 000}		
{C 166}	10A NCAC 13G .0503(a) Medication Administration Competency Evaluati 10A NCAC 13G .0503 Medication Administration Competency Evaluation (a) The competency evaluation for medication administration shall consist of a written examination and a clinical skills validation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) rules pertaining to medication administration in adult care facilities; and (10) the facility's medication administration policy and procedures.	{C 166}		

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{C 166}	Continued From page 1 This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff, who administered medications, had completed the 5, 10, or 15-hour state approved medication aide (MA) training course and successfully passed the written state medication administration examination. The findings are: Review of Staff A's, personal care aide (PCA), personnel record revealed: -Staff A was hired 12/31/15. -There was no documentation Staff A completed the 5, 10, or 15-hour state approved MA training course. -There was no documentation Staff A completed and passed the state written MA examination. -There was documentation Staff A completed the Medication Administration Competency Validation Clinical Skills Checklist on 06/10/23. Review of Staff A's staffing hours for July 2024 revealed he worked the 7:00pm to 7:00am shift on 07/01/24. Review of the staffing hours for May, June, and July 2024 revealed there was not a MA scheduled to work the 7:00pm to 7:00 am shifts when Staff A was not on duty. Review of residents' MAR for 07/01/24 revealed: -Staff A did not document that he administered medications to the residents. -There was no documentation medications were administered on the 7:00pm to 7:00am shift.	{C 166}		

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{C 166}	Continued From page 2 Interview with Staff A on 07/02/24 at 12:07pm revealed: -He worked the 7:00pm to 7:00am shift Monday through Friday. -He worked 07/01/24 and administered medications to the residents. -He administered medications to the residents when he worked in the facility. -He was not a MA. -He had not completed the state approved 5, 10, or 15-hour MA training course or taken the written MA examination. -He did not document that he administered mediations to the residents because he was not a MA. -A MA would document that medications were administered on the residents MAR's. -He thought it was okay for him to administer medications if there was a MA in the facility. Interview with a MA on 0/02/24 at 10:00am revealed: -She worked 7:00am to 7:00pm Monday through Friday. -She stayed overnight in the facility with Staff A. -Staff A administered medications to the residents on the 7:00pm to 7:00am shift. -She documented the medications were administered on the residents' MARs because Staff A was not a MA. -There was not a MA that was scheduled to work in the facility with Staff A. Interview with a resident on 07/02/24 at 1:40pm revealed: -Different staff gave him his medications at night. -Staff A was one of the staff that gave him his medications.	{C 166}		

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{C 166}	Continued From page 3 Interview with two other residents on 07/02/24 at 2:25pm revealed: -Staff A administered medications when he worked the night shift. -A MA was present in the facility when Staff A worked but did not administer the pm medications. Interview with the Administrator on 07/02/24 at 1:45pm revealed: -Staff A was not a MA and should not administer medications to the residents. -A MA that was live-in staff stayed over when her 7:00am to 7:00pm shift was over and administered medications to the residents. _____ The facility failed to ensure staff who worked as a medication aide and administered medications to residents completed and passed the written medication aide examination and completed the state approved 5, 10, or 15-hour state approved medication aide training course before administering medications resulting in possible medication errors. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/02/24 for this violation.	{C 166}		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:	{C 330}		

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{C 330}	Continued From page 4 (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, record review, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#1) related to an analgesic, a vitamin supplement, a laxative, and a sleep medication. The findings are: Review of Resident #1's current FL-2 dated 03/05/24 revealed diagnoses including multiple sclerosis and hypothyroidism. a. Review of Resident #1's current FL-2 dated 03/05/24 revealed there was an order for Tylenol 500mg 2 tablets three times a day. Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Tylenol 500mg 2 tablets three times a day. -There was documentation Tylenol 500mg 2 tablets was administered three times a day on 05/01/24 to 05/06/24, 05/12/24, and 05/19/24. -There was documentation Tylenol 500mg 2 tablets was administered twice a day on 05/11/24, 05/13/24, 05/18/24, and 05/26/24. -There was documentation Tylenol 500mg 2 tablets was administered once a day on 05/10/24 and 05/25/24. Review of Resident #1's June 2024 eMAR revealed: -There was an entry for Tylenol 500mg 2 tablets	{C 330}		

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three times a day.
-There was documentation Tylenol 500mg 2 tablets was administered three times a day on 06/02/24, 06/16/24 to 06/17/24, 06/23/24 to 06/24/24, and 06/30/24.
-There was documentation Tylenol 500mg 2 tablets was administered two times a day on 06/03/24, 06/08/24 to 06/09/24, 06/15/24, 06/22/24, and 06/29/24.

Review of Resident #1's July 2024 eMAR from 07/01/24 to 07/02/24 revealed:
-There was an entry for Tylenol 500mg 2 tablets three times a day.
-There was documentation Tylenol 500mg 2 tablets was administered three times a day on 07/01/24.

Observation of Resident #1's medications on hand on 07/02/24 at 10:24am revealed there was no Tylenol 500mg available to administer to the resident.

b. Review of Resident #1's current FL-2 dated 03/05/24 revealed there was an order for aspirin 81mg daily.

Review of Resident #1's May 2024 eMAR revealed:
-There was an entry for aspirin 81mg daily.
-Aspirin 81mg was documented as administered daily on 05/01/24 to 05/06/24, 05/12/24, 05/13/24, and 05/19/24, 05/26/24.

Review of Resident #1's June 2024 eMAR revealed:
-There was an entry for aspirin 81mg daily.
-Aspirin 81mg daily was documented as administered daily on 06/01/24 to 06/03/24, 06/09/24, 06/16/24 to 06/17/24, 06/23/24,

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{C 330}	Continued From page 6 06/24/24, and 06/30/24. Review of Resident #1's July 2024 eMAR for 07/01/24 to 07/02/24 revealed: -There was an entry for aspirin 81mg daily. -Aspirin 81mg was documented as administered daily on 07/01/24. Observation of Resident #1's medications on hand on 07/02/24 at 10:24am revealed there was no aspirin 81mg available to administer to the resident. c. Review of Resident #1's current FL-2 dated 03/05/24 revealed there was an order for vitamin d 1,000u daily. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for vitamin d3 1,000u daily. -Vitamin d 1,000u was documented as administered daily on 05/01/24 to 05/06/24, 05/12/24, 05/13/24, 05/19/24, and 05/26/24. Review of Resident #1's July 2024 eMAR for 07/01/24 to 07/02/24 revealed: -There was an entry for vitamin d3 1,000u daily. -Vitamin d 1,000 was documented as administered daily on 07/01/24. Observation of Resident #1's medications on hand on 07/02/24 at 10:24am revealed there was no vitamin d3 1,000u available to administer to the resident. d. Review of Resident #1's current FL-2 dated 03/05/24 revealed there was an order for senna 8.6-50mg twice a day. Review of Resident #1's May 2024 eMAR	{C 330}		

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{C 330}	Continued From page 7	{C 330}		

revealed:
-There was an entry for senexon-s 8.6-50mg 2 tablets twice a day.
-Senexon-s 8.6-50mg 2 tablets was documented as administered twice a day on 05/01/24 to 05/06/24, 05/13/24, 06/19/24, and 06/26/24.

Review of Resident #1's June 2024 eMAR revealed:
-There was an entry for senexon-s 8.6-50mg 2 tablets twice a day.
-Senexon-s 8.6-50mg 2 tablets was documented as administered twice a day on 06/01/24, 06/02/224, 06/09/2406/16/24, 06/17/24, 06/23/24, 06/24/24, and 06/30/24.
-Senexon-S 8.6-50mg 2 tablets was documented as administered once a day on 06/03/24, 06/08/24, 06/15/24, 06/22/24, and 06/29/24.

Review of Resident #1's July 2024 eMAR for 07/01/24 to 07/02/24 revealed:
-There was an entry for senexon-s 8.6-50mg 2 tablets twice a day.
-Senexon-s 8.6-50mg 2 tablets was documented as administered twice a day on 07/01/24.

Observation of Resident #1's medications on hand on 07/02/24 at 10:24am revealed there was no senexon-s 8.6-50mg available to administer to the resident.

e. Review of Resident #1's current FL-2 dated 03/05/24 revealed there was an order for melatonin 3mg at bedtime.

Review of Resident #1's May 2024 eMAR revealed:
-There was an entry for melatonin 3mg at bedtime.
-Melatonin was documented as administered at

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bedtime on 05/01/24 to 05/06/24, 05/11/24, 05/12/24, 05/18/24, 05/19/24, 05/25/24, 05/26/24, and 05/28/24 to 05/30/24.

Review of Resident #1's June 2024 eMAR revealed:
-There was an entry for melatonin 3mg at bedtime.
-Melatonin was documented as administered at bedtime on 06/01/24, 06/02/24, 06/08/24, 06/09/24, 06/15/24 to 06/17/24, 06/22/24 to 06/24/24, 06/29/24 and 06/30/24.

Review of Resident #1's July 2024 eMAR revealed for 07/01/24 to 07/02/24 revealed:
-There was an entry for melatonin 3mg at bedtime.
-Melatonin was documented as administered at bedtime on 07/01/24.

Observation of Resident #1's medications on hand on 07/02/24 at 10:24am revealed there was no melatonin 3mg available to administer to the resident.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/02/24 at 12:15pm revealed:
-Resident #1 had an order for Tylenol 500mg 2 tablets three times a day.
-Resident #1 had an order for aspirin 81mg daily.
-Resident #1 had an order for vitamin d3 1,000u daily.
-Resident #1 had an order for senna-s 8.6-50mg twice a day.
-Resident #1 had an order for melatonin 3mg at bedtime.
-The medications were over the counter medications.
-The pharmacy had not dispensed the

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{C 330}	Continued From page 9 over-the-counter medications for Resident #1 since March of 2024. -Resident #1 would not have any of the over-the-counter medications in the facility; the supply would have run out. -Resident #1 had a balance due to the pharmacy and they could not send the over-the-counter medications until some agreement was reached or the balance was paid. Interview with Resident #1 on 07/02/24 at 1:45pm revealed: -She had multiple sclerosis and did have pain in her leg, back, and knees. -Her pain level was an 8 now because she was seated on the picnic table that was not very comfortable. -She had patches the staff put on that helped with pain. -She did not have any problems with constipation. -She was sleeping okay; sometimes she slept all day, and it was harder to sleep through the night. Interview with the medication aide (MA) on 07/02/24 at 10:30am revealed: -Resident #1 did not have any of her over the counter medications at the facility to administer. -She was told Resident #1 had a balance due at the pharmacy and the medications could not be dispensed until the balance was paid. -She documented the medications were not available on the eMAR. -She was not sure why the other MA's documented the over the counter medications for Resident #1 were administered when they were not in the facility. -Resident #1 did not complain of pain to her. -She did not work over night. -She had not heard Resident #1 complain of trouble sleeping.	{C 330}		

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{C 330}	Continued From page 10 Telephone interview with the Administrator on 07/02/24 at 1:45pm revealed: -She was aware Resident #1 did not have her over the counter medications in the facility and had not received them. -Resident #1's primary care provider (PCP) was also aware Resident #1 had not received her over the counter medications. -The PCP was not willing to discontinue the over the counter medications. -Resident #1 had spoken to the pharmacy and said she would send money to them but had not. -She thought Resident #1 would rather spend her money on other things. -She did expect the residents to get their medications as ordered.	{C 330}		