STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 07/10/2024

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WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 000	Initial Comments The Adult Care Licensure Section and Hoke County Department of Social Services conducted a follow-up survey and complaint investigation on 07/9/24-07/10/24. Hoke County Department of Social Services initiated the complaint investigation on 07/02/24.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards including personal care products that were accessible to the residents living on the special care unit (SCU). The findings are: Review of the facility's policy and procedures; ingestion of harmful substance on the special care unit (SCU) dated 10/01/20 revealed: -It is the policy of the facility to prevent residents from coming into contact with substances that may be harmful to them if swallowed. -Harmful substances may consist of products containing alcohol such as mouthwash. -Any personal items used by the resident that may be harmful if swallowed will be kept in a locked drawer in the resident's room, when not	D 079	It shall always be the procedure of the community to be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards. 9/9/24 The community ARCC/AMCD Designee will come into the community daily and perform rounds to ensure that we are maintaining an environment that is free of hazards including personal care products that may be accessible to the residents living on the special care unit. 9/9/24 If items are discovered they 9/9/24	

Joyce Johnston 08/23/2024 JJ Reviewed and Acknowledged

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D 079	Continued From page 1 being used for personal care. -If harmful substances are found, they will be removed immediately and taken to a secure location. -The associate will report finding the harmful substance and an incident report will be written outlining outcome and how to mitigate the issue. -Associates will monitor resident apartments for any harmful substances while in the resident's rooms cleaning or giving personal care. Review of the facility's census report received on 07/09/24 revealed there were 27 residents on the SCU. Observation of the 300 hall and the 400 hall in the SCU on 07/09/24 from 8:32am -9:00am revealed: -At 8:32am, there were personal hygiene products in the shared bathroom for residents' room 303. -The personal care products included two in one body wash and moisturizer. -These products were sitting on the shelf in the bathroom. -At 8:33am, there were personal care hygiene products in the shared bathroom for residents' room 305. -The personal products included a bottle of shampoo, lotion, and two bottles of body wash. -These products were sitting on the shelf in the bathroom. -At 8:35am, there were personal care hygiene products in the shared bathroom and in the room on the chest of drawers for residents' room 302. -The personal care hygiene products on the bathroom shelf included a bottle of shampoo, body wash, body lotion and hair detangler. -The personal care hygiene products on the chest of drawers included mouthwash, petroleum jelly and body lotion.	D 079	removed immediately and placed in the designated resident bin 9/9/24 and locked in the supply closet. The community has inserviced all staff on checking all apartments daily during rounds for anything in the resident apartments that could be hazadous. 9/9/24	

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D 079	Continued From page 2 -At 8:37am, there were personal care hygiene products in the shared bathroom for residents' room 306. -The personal care hygiene products included body wash, dandruff shampoo and regular shampoo. -These products were sitting on the shelf in the bathroom. -At 8:38am there were personal care hygiene products in the bathroom for resident room 307. -The personal care hygiene products included hair body and face wash, body lotion and deodorant. -These products were sitting on the sink in the bathroom. -At 8:43am there was a bottle of body wash observed in the shower of the bathroom in room 402 -At 8:46am there was a bottle of body wash observed on the sink of the bathroom in room 409. -At 8:48am there was a tube of moisture barrier ointment observed on the shelf in the bathroom in room 401 -Warning labels on some of the personal care products included: keep out or reach of children expect under adult supervision, for external use only, if swallowed get medical help or call poison control center and avoid contact with eyes. Interview with a personal care aide (PCA) on 07/09/24 at 9:00am revealed: -The personal care products for residents in the SCU were usually put back in the locked clean linen closet after use. -She had gotten busy with the residents and forgot to put the personal care products back in the closet. A second observation of the 300 hall in the SCU	D 079		

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D 079	Continued From page 3 on 07/10/24 from 8:57am -9:05am revealed: -There were personal care hygiene products in the shared bedroom for residents' room 302. -The personal care hygiene products included mouthwash, petroleum jelly and body lotion. - These products were sitting on the chest of drawers in the bedroom. Interview with the Memory Care Director (MCD) on 07/10/24 at 9:06am revealed: -All personal hygiene items should be taken to the supply closet and put in each resident's individual bin after use. -The hospice company that came into the facility and provided personal care often asked for personal hygiene items and after use did not give them back to the facility staff. Interview with the Assistant Memory Care Director (AMCD) on 07/10/24 at 1:12pm revealed: -She performed daily checks of each room on the SCU to ensure there were no personal hygiene products left in the rooms -She did not get around to doing the check yesterday, because of being pulled to work on the medication cart. -She performed the checks once a day, usually around 9:15am. Interview with the facility executive director on 07/10/24 at 10:15am revealed: -The AMCD did everyday checks in the rooms on the SCU for personal care hygiene products. -If there were products found they were taken out of the room and put back into their individual bins in the locked supply closet. -She was not sure if the AMCD had time to do the checks yesterday. -The AMCD conducted these checks as personal hygiene products being left in the rooms on the	D 079		

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D 079	Continued From page 4 SCU had been an issue before. Telephone interview with the facility's primary care provider (PCP) on 07/10/2024 at 10:27am revealed: -She was concerned about the personal hygiene products being left accessible to the residents on the SCU. -The personal hygiene products should be locked away to ensure the products were used properly and not misused by the residents with memory impairment.	D 079		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 6 sampled staff (staff A) had a criminal background check completed prior to hire to ensure no findings were listed. The findings are: Review of Staff A's personnel record on 07/10/24 revealed: -Staff A was hired on 06/21/24. -Staff A was a medication aide. Interview with the Business Office Manager (BOM) on 07/10/24 at 10:30am revealed: -She knew that a criminal background check	D 139	It shall be the policy of the community to ensure that all staff have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file. 9/9/24 It shall be the responsibility of the Business office Manager/ Designee to ensure that all potential associates, new or rehired have criminal background checks completed prior to hire to ensure no findings are listed. 9/9/24 The Executive Director/ Designee	

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D 139	Continued From page 5 must be performed on all hired employees. -It was an oversight that the criminal background check was not performed on Staff A. -She was responsible for performing the criminal background check on all hired employees. Interview with the Administrator on 07/10/24 at 10:05am revealed: -It was the BOM's responsibility to perform the criminal background checks on all hired employees. -She did not know why the criminal background check was not performed on Staff A. -It was her responsibility to ensure that the BOM completed the criminal background check.	D 139	will complete a weekly and as needed check on personnel files, to ensure all associates have a criminal background check completed in accordance with GS 131D-40 and results available in the staff persons personnel file.	9/9/24
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 to ensure medications were administered as ordered to 2 of 4 residents (#5, #2) observed during the medication passes including errors with a medication used to treat mood disorders, a medication used to treat acid reflux disease, a medication used to treat psychiatric conditions (#5), and a medication used to treat seasonal allergies (#2).	D 358	It shall always be the procedure of the community to assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: orders by a licensed prescribing practitioner which are maintained in the residents record; and rules in this section and the community's policies and procedures. All med techs will be retrained on Medication Administration and be Medication Skills validated	9/9/24 9/9/24

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D 358	Continued From page 6 The findings are: The medication error rate was 15% as evidenced by 4 errors out of 26 opportunities during the 8:00am medication passes on 07/09/24. Review of Resident #5's current FL2 revealed diagnoses included Alzheimer's dementia with behavioral disturbance, hypertension, and vitamin B12 deficiency. a. Review of Resident #5's medication review report dated 05/20/24 revealed: -There was an order for "may crush appropriate medications". -There was an order for Depakote Delayed Release (DR) 125mg, give one tablet two times daily for mood, do not crush (Depakote DR is an extended-release medication used to treat mood disorders). Observation of the 8:00am medication pass on 07/09/24 from 8:18am to 8:33am revealed: -At 8:26am, the medication aide (MA) started preparing Resident #5's medications. -The MA placed 5 pills, including Depakote DR 125mg, in a plastic pouch and placed the pouch in a medication crushing device. -The MA crushed the medications in the pouch and emptied the medication into a plastic medication cup. -The MA mixed applesauce with the crushed medications and then added a whole capsule to the cup with the other medications mixed in applesauce. -The MA administered Resident #5's medications at 8:30am. Review of Resident #5's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Depakote DR 125mg, give one tablet two times a day for mood, do not	D 358	by our RN Consultant on 9/8/24 and 9/9/24. The RCD/MCD/Designee will complete a weekly med pass monitoring at different times, to ensure staff are passing medications according to state regulations and according to prescribing practitioners. 9/9/24 The ED/Designee will complete prn med pass monitoring to ensure that meds are administered according to the prescribing practitioner. 9/9/24	

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D 358	Continued From page 7 crush scheduled twice daily for 8:00am and 8:00pm. -Depakote DR 125mg was documented as administered at 8:00am from 07/01/24 to 07/09/24. -Depakote DR 125mg was documented as administered at 8:00pm from 07/01/24 to 07/08/24. b. Review of Resident #5's medication review report dated 05/20/24 revealed: -There was an order for "may crush appropriate medications". -There was an order for Zyprexa 5mg, give one tablet two times daily for mood, do not crush (Zyprexa is a medication used to treat psychiatric conditions). Observation of the 8:00am medication pass on 07/09/24 from 8:18am to 8:33am revealed: -At 8:26am, the medication aide (MA) started preparing Resident #5's medications. -The MA placed 5 pills, including Zyprexa 5mg, in a plastic pouch and placed the pouch in a medication crushing device. -The MA crushed the medications in the pouch and emptied the medication into a plastic medication cup. -The MA mixed applesauce with the crushed medications and then added a whole capsule to the cup with the other medications mixed in applesauce. -The MA administered Resident #5's medications at 8:30am. Review of Resident #5's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Zyprexa 5mg, give one tablet two times a day for mood, do not crush	D 358		

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D 358	Continued From page 8 scheduled twice daily for 8:00am and 8:00pm. -Zyprexa 5mg was documented as administered at 8:00am from 07/01/24 to 07/09/24. -Zyprexa 5mg was documented as administered at 8:00pm from 07/01/24 to 07/08/24. c. Review of Resident #5's medication review report dated 05/20/24 revealed: -There was an order for "may crush appropriate medications". -There was an order for Protonix 20mg, give one tablet one time a day for gastroesophageal reflux disease (GERD), do not crush (Protonix 20mg is a medication used to treat acid reflux and heartburn). Observation of the 8:00am medication pass on 07/09/24 from 8:18am to 8:33am revealed: -At 8:26am, the medication aide (MA) started preparing Resident #5's medications. -The MA placed 5 pills, including Protonix 20mg, in a plastic pouch and placed the pouch in a medication crushing device. -The MA crushed the medications in the pouch and emptied the medication into a plastic medication cup. -The MA mixed applesauce with the crushed medications and then added a whole capsule to the cup with the other medications mixed in applesauce. -The MA administered Resident #5's medications at 8:30am. Review of Resident #5's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Protonix 20mg, give one tablet one time a day for GERD, do not crush scheduled daily for 8:00am. -Protonix 20mg was documented as administered	D 358		

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D 358	Continued From page 9 at 8:00am from 07/01/24 to 07/09/24. Interview with a medication aide (MA) on 07/09/24 at 10:52am revealed: -There was a do not crush medication list in the front of the narcotic count book on each medication cart. -Medications that should not be crushed were indicated on the residents' eMAR. -Resident #5 had an order to crush his medications. -Resident #5 would not take his medication if the medication was not crushed. -She had noticed on Resident #5's eMAR there were instructions not to crush Depakote DR, Zyprexa, and Protonix. -She used the pill crusher this morning, 07/09/24, on Resident #5's medications to break the medications into smaller pieces so Resident #5 would take the medications. -Resident #5 would spit medications out if the medications were not crushed and placed in applesauce. -She had not notified the Memory Care Director (MCD) of Resident #5 spitting out medications. -She referred to the do not crush list if she thought she needed to refer to it. Interview with the Memory Care Director (MCD) on 07/09/24 at 2:35pm revealed: -Each medication cart had a do not crush list located in the front of the narcotic count book. -Medications that should not be crushed were indicated on the residents' eMAR. -She was aware Resident #5 had some difficulty swallowing medications. -Some of Resident #5's medications could be crushed because he had an order to crush his medications. -Resident #5's medications that could not be	D 358		

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D 358	Continued From page 10 crushed were indicated on the order on his eMAR. -She was not aware that Resident #5 had spit out medications previously. -MAs should inform her when a resident had difficulty taking medications so she could notify the resident's primary care provider (PCP). Interview with the Executive Director on 07/09/24 at 2:42pm revealed: -MAs had a list of medications that should not be crushed on each medication cart, located in the front of the narcotic count book. -Medications that should not be crushed were on each resident's eMAR. -Any medication that could not be crushed was indicated on the instructions on the eMAR. -The MA should not have crushed Resident #5's medications this morning, 07/09/24, if the eMAR indicated do not crush. -If a resident had difficulty swallowing or taking medications, the MA should notify the MCD. -The MCD would notify a resident's PCP if the resident had difficulty taking medications and request an alternative medication. Interview with a pharmacist from the facility's contracted pharmacy on 07/09/24 at 2:00pm revealed: -Depakote DR, Zyprexa, and Protonix should not be crushed. -Depakote DR was a delayed release medication and was formulated to release a little of the medication over time to keep Depakote levels consistent in the blood. -Zyprexa should not be crushed due to having a film coating, which kept the medication from having a bitter taste. -Protonix was a delayed release medication and if the medication was crushed, the medication may	D 358		

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D 358	Continued From page 11 not work as effectively. Interview with Resident #5's PCP on 07/10/24 at 10:21am revealed: -When medications were crushed and should not be, the medications were absorbed immediately instead over the course of several hours. -Depakote DR and Zyprexa could potentially cause some sedation if the medication was crushed. -Protonix may not work as effectively to reduce acid in the stomach if the medication was crushed. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. d. Review of Resident #2's current FL-2 dated 10/12/2024 revealed diagnoses included ruptured cerebral aneurysm, hydrocephalus, left thalamic infarct, hypertension, chronic kidney disease, bladder calculus, subarachnoid bleed, prostate cancer, and anemia. Review of Resident #2's current physician order sheet dated 03/15/24 revealed there was an order for Fluticasone Propionate Nasal Spray 50mcg (a medication used for allergies) give 2 sprays in both nostrils two times daily. Observation of the morning medication pass on 07/09/24 revealed Resident #2 was administered Fluticasone Propionate Nasal Spray 27.5mcg 2 sprays in both nostrils at 8:30am. Observation of Resident #2's medications on hand on 07/09/24 at 2:25pm revealed: -There was one bottle of Fluticasone Propionate Nasal Spray 27.5mcg on the medication cart.	D 358		

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D 358	Continued From page 12 -There was no Fluticasone Propionate Nasal Spray 50mcg on the medication cart. Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Fluticasone Propionate Nasal Spray 50mcg give 2 sprays in both nostrils two times daily at 8:00am and 4:00pm. -Fluticasone Propionate Nasal Spray 50mcg was documented as administered at 8:00am and 4:00pm on 06/07/24-06/30/24. Review of Resident #2's July 2024 eMAR revealed: -There was an entry for Fluticasone Propionate Nasal Spray 50mcg give 2 sprays in both nostrils two times daily at 8:00am and 4:00pm. -Fluticasone Propionate Nasal Spray 50mcg was documented as administered at 8:00am on 07/01/24-07/09/24. -Fluticasone Propionate Nasal Spray 50mcg was documented as administered at 4:00pm on 07/01/24-07/08/24. Telephone interview with the facility's contracted pharmacist on 07/10/24 at revealed: -The pharmacy had never received a prescription for Fluticasone Propionate Nasal Spray 50mcg give 2 sprays in both nostrils two times daily. -A prescription for Fluticasone Propionate Nasal Spray 27.5mcg give 2 sprays in both nostrils two times daily was received on 10/12/23. -Fluticasone Propionate Nasal Spray 27.5mcg was dispensed on 10/19/23, 12/7/24, 3/12/24, and 5/22/24. -Fluticasone Propionate Nasal Spray 27.5mcg contained 120 sprays that would last one month. Telephone interview with Resident #2's primary	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 07/10/2024

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D 358	Continued From page 13 care provider (PCP) on 07/10/24 at 10:35am revealed: - Fluticasone Propionate Nasal Spray was administered for allergies and runny nose. -Not having the full dose could lead to worsening allergies and allergy symptoms. Interview with a medication aide (MA) on 07/09/24 at 3:10pm revealed: -She did not know why the Fluticasone Propionate Nasal Spray 27.5mcg was a different dose from what was entered on the eMAR. -She did not compare the medication to the eMAR before administering. -She had been educated to compare the medication to the eMAR before administering. Interview with the Resident Care Director (RCD) on 07/10/24 at 10:15am revealed: -The MAs were supposed to compare the medication administered to the eMAR before administering. -The MAs had been educated on comparing the medication to the eMAR before administering. -The MA should have notified her that there was a discrepancy between the medication and the eMAR. Interview with the Administrator on 07/09/24 at 3:12pm revealed: -The MAs had been educated to compare the medication to the eMAR before administering the medication. -The medication should have been removed from the medication cart and replaced with the correct medication. -It was the RCD's responsibility to ensure that the correct medication was on the medication cart.	D 358		

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D 367	Continued From page 14	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#2) to include a medication for allergies. Review of Resident #2's current FL-2 dated 10/12/2024 revealed diagnoses included ruptured cerebral aneurysm, hydrocephalus, left thalamic infarct, hypertension, chronic kidney disease, bladder calculus, subarachnoid bleed, prostate cancer, and anemia.	D 367	It shall always be the procedure of the community to ensure the residents medication record is accurate and includes the following: residents name; name of medication or treatment order; strength and dosage or quantity of medication administered; instructions for administering the medication or treatment; reason or justification for the administration of medications or treatments as needed and documenting the effects on the resident; date and time of administration; documentation of any omission of medications or treatments and the reason for the omission, including refusals and name or initials of the person administering the medication or treatment. If initials are used a signature equivalent to those initials is to be documented and	9/9/24 9/9/24 9/9/24

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D 367	Continued From page 15 Review of Resident #2's current physician order sheet dated 03/15/24 revealed there was an order for Fluticasone Propionate Nasal Spray 50mcg (a medication used for allergies) give 2 sprays in both nostrils two times daily Observation of Resident #2's medications on hand on 07/09/24 at 2:25pm revealed: -There was one Fluticasone Propionate Nasal Spray 27.5mcg on the medication cart. -There was no Fluticasone Propionate Nasal Spray 50mcg on the medication cart. Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Fluticasone Propionate Nasal Spray 50mcg give 2 sprays in both nostrils two times daily at 8:00am and 4:00pm. -Fluticasone Propionate Nasal Spray 50mcg was documented as administered at 8:00am and 4:00pm on 06/07/24-06/30/24. Review of Resident #2's July 2024 eMAR revealed: -There was an entry for Fluticasone Propionate Nasal Spray 50mcg give 2 sprays in both nostrils two times daily at 8:00am and 4:00pm. -Fluticasone Propionate Nasal Spray 50mcg was documented as administered at 8:00am on 07/01/24-07/09/24. -Fluticasone Propionate Nasal Spray 50mcg was documented as administered at 4:00pm on 07/01/24-07/08/24. Telephone interview with the facility's contracted pharmacist on 07/10/24 at revealed: -The pharmacy had never received a prescription for Fluticasone Propionate Nasal Spray 50mcg give 2 sprays in both nostrils two times daily.	D 367	and maintained with the medication administration record. All med techs will be retrained on medication Administration 9/9/24 and be skills validated by our RN. consultant on 9/8/24 and 9/9/24. In addition to twice weekly medication cart audits, the RCD/MCD/ Designee will complete 9/9/24 a weekly med pass monitoring at different times, to ensure staff are passing medications according to accurate medication administration records. The lead med tech/Designee will complete weekly MAR 9/9/24 audits to ensure orders were put in according to orders, to ensure the accuracy of orders. The ED will complete prn checks of MARS to ensure the accuracy of orders against MARS.	

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D 367	Continued From page 16 -A prescription for Fluticasone Propionate Nasal Spray 27.5mcg give 2 sprays in both nostrils two times daily was received on 10/12/23. Review of the eMAR order details on 07/10/24 revealed that the Fluticasone Propionate Nasal Spray 50mcg give 2 sprays in both nostrils two times daily was entered onto the eMAR on 10/21/23 at 9:55am by a MA. Interview with a medication aide (MA) on 07/09/24 at 3:10pm revealed she did not know why Resident #2's Fluticasone Propionate Nasal Spray 27.5mcg was a different dose from what was entered on the eMAR. Interview with the Resident Care Director (RCD) on 07/10/24 at 10:15am revealed: -She, the Assistant Resident Care Director (ARCD), or the MAs, was responsible for entering new orders into the eMAR and faxing the orders to the pharmacy. -She was responsible for ensuring that all orders were entered correctly into the eMARs and sent to the pharmacy and the medication arrived at the facility and was correct. Interview with the Administrator on 07/09/24 at 3:12pm revealed it was the RCD's responsible to ensure that the orders were entered into the eMAR correctly, sent to pharmacy, and arrived at the facility within 24 hours.	D 367		