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
	FCL098036	A. BUILDING: _____ B. WING _____	R 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE HOME AT FOXCROFT	2413 FOXCROFT RD WILSON, NC 27893

(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 and the Wilson County Department of Social Services conducted an annual and follow-up survey on 02/07/25.	C 000		
C 173	10A NCAC 13G .0504 (d) Competency Validation For Licensed Health Pro 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (d) If a physician certifies that care can be provided to a resident in a family care home on a temporary basis in accordance with G.S. 131D-2.2(a), the facility shall ensure that the staff performing the care task(s) authorized by the physician are competent to perform the task(s) in accordance with Paragraphs (b) and (c) of this Rule. For the purpose of this Rule, "temporary basis" means a length of time as determined by the resident's physician to meet the care needs of the resident and prevent the resident's relocation from the family care home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure unlicensed staff were authorized by the physician and were competent to perform the administration of a medication by intramuscular (IM) injection for 1 of 1 residents	C 173	Unlicensed staff will not perform any tasks they are not qualified to perform! (i.e. IM injections) If a doctor's order is provided for staff to perform a certain task, documentation of appropriate training & return demonstration/ proof of competency will be completed. (RN will administer IM injections) training will be completed by RN and administrator will provide ongoing monitoring to ensure this rule is met.	2/8/25

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy R Rudgen RN — TITLE: Administrator — (X6) DATE: 3/4/25

Reviewed and acknowledged-MB 03/14/25

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(#3).

The findings are:

Review of Resident #3's current FL-2 dated 02/26/24 revealed:
-Diagnoses included chronic weakness and congestive heart failure.
-She was semi-ambulatory.
-She was intermittently disoriented.

Review of Resident #3's physician's order dated 02/26/24 revealed cyanocobalamin (vitamin B-12) 1000mcg was to be administered intramuscularly (IM) every 30 days. (Cyanocobalamin is a form of B12 vitamin that is used to treat and prevent B12 deficiency.(IM injection is a method of administering medication by injecting the medication directly into the muscle. Approved injection sites include the deltoid muscle [upper arm], vastus lateralis [thigh] and the gluteus medius [buttocks].)

Review of Resident #3's physician's order dated 03/07/24 revealed:
-It was okay for staff to administer vitamin B12 injections IM monthly and the last injection was administered on 03/07/24.
-There was no specification of which staff were authorized to administer the IM medication.

Review of Resident #3's electronic medication administration record (eMAR) for December 2024 revealed:
-There was a computerized entry for cyanocobalamin 1000mcg/1ml, 1ml to be injected intramuscularly every month.
-There was documentation a medication aide administered the injection on 12/07/24 at 10:00am.

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-The administration site was documented as stomach/abdomen.

Review of Resident #3's electronic medication administration record (eMAR) for January 2025 revealed:
-There was a computerized entry for cyanocobalamin 1000mcg/1ml, 1ml to be injected intramuscularly every month.
-There was documentation a medication aide administered the injection on 01/07/25 at 10:00am.
-The administration site was documented as left arm.

Review of Resident #3's electronic medication administration record (eMAR) for February 2025 revealed:
-There was a computerized entry for cyanocobalamin 1000mcg/1ml, 1ml to be injected intramuscularly (IM) every month.
-There was documentation cyanocobalamin 1000mcg/1ml, 1ml was not administered on 02/07/25 and was withheld per order.

Interview with Resident #3 on 02/07/25 at 5:10pm revealed:
-She had been receiving her B12 injection at the facility monthly but was going back to getting it administered at her PCP office.
-She did not know which staff had administered her injection.

Interview with a medication aide (MA) on 02/07/25 at 3:20pm revealed:
-She did not administer Resident #3's injection on 02/07/25 because Resident #3's family wanted her to go back to receiving the injection at the doctor's office because of cost.
-She had administered cyanocobalamin

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1000mcg/1ml, 1ml to Resident #3 in the past but did not remember when.
-She was taught by the Administrator how to administer the IM medication but there had been no return demonstration of IM administration.

Interview with a second MA on 02/07/25 at 4:39pm revealed:
-She had administered cyanocobalamin 1000mcg/1ml, 1ml to Resident #3 at least once.
-Pharmacy sent a syringe each month with the single dose vial that was dispensed for Resident #3.
-She would clean the top of the vial with an alcohol pad, insert the syringe into the vial and draw the medication into the syringe by pulling the plunger.
-She ensured there was no air in the syringe and checked to be sure the amount of medication in the syringe was 1ml before giving the injection.
-She would grab the deltoid muscle (upper arm), clean the skin with another alcohol pad and insert the needle of the syringe into the muscle.
-She would pull back the plunger of the syringe to check for any blood return and slowly inject the medication by depressing the plunger.
-She was taught how to administer the IM injection by the Administrator demonstrating how it was to be done when Resident #3 received her first shot at the facility but there was no return demonstration of giving IM injections.
-The Administrator had not observed her administer the IM injection to Resident #3.
-IM medications could be given in the upper arm or the thigh and were not to be administered into the stomach.

Telephone interview with Resident #3's family member on 02/07/25 at 3:44pm revealed:
-She did not remember when the facility began

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administering Resident #3's monthly IM injection but the injection was going back to being administered at Resident #3's primary care provider (PCP) office due to cost.
-She was not sure why Resident #3 was prescribed cyanocobalamin by injection.

Telephone interview with the lead pharmacy technician with the facility's contracted pharmacy on 02/07/25 at 5:00pm revealed:
-Resident #3 was first ordered cyanocobalamin 1000mcg/1ml, 1ml to be administered monthly by IM injection on 12/01/23.
-A single dose vial and a syringe were dispensed to the facility for each monthly injection as requested by the facility.
-A vial was dispensed on 01/22/25, 12/30/24 and 12/03/24.

Interview with the Administrator on 02/07/25 at 3:30pm revealed:
-She was a registered nurse (RN) and she taught each MA the steps on how to administer the IM injection to Resident #3.
-There was no return demonstration of the IM administration skill and she did not document the training.
-There was an order from Resident #3's PCP saying facility staff could administer the IM medication and she thought that was good.
-She did not think about the medication being IM and being administered by MAs when she trained them.
-There was a risk for infection to the resident if staff were not trained and competent to administer medications by IM injection.

Attempted telephone interview with the pharmacist for the facility's contracted pharmacy on 02/07/25 at 5:00pm was unsuccessful.

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Attempted telephone interview with Resident #3's primary care provider (PCP) on 02/07/25 at 4:00pm was unsuccessful.

The facility failed to ensure medication that ordered to be administered via intramuscular (IM) injection was administered by qualified staff, one of which documented the administration of the IM medication into Resident #3's stomach which was not an approved administration site, and placed the resident at risk for infection. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/07/25 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 24, 2025.