Amended

Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Wickshire Creeks Crossing
Address: 8398 Fayetteville Rd Raeford NC 28376
II. Date(s) of Visit(s): 11/21/24, 11/22/24, 12/20/24

County: Hoke
License Number: HAL-047-015
Purpose of Visit(s): Complaint Investigation/Monitoring
Exit/Report Date: 01/08/25

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F.0901(b)	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: Personal Care and Supervision/ Staff shall provide supervision of residents in accordance with each resident's assessed needs and current symptoms.		
Level of Non-Compliance: Type A1		
Findings: Based on record reviews and interviews the facility failed to provide supervision in accordance with each resident's assessed needs, for 2 of 5 sampled residents (Resident #1 and #2) related to a resident with known history of behaviors which resulted in an assault and a second resident who had repeated falls with injuries, the last of which resulted in death. The findings are: 1.Review of Resident #2's current F1-2 dated 07/23/24 revealed:		

-Diagnoses included: major neurocognitive disorder due to Alzheimer's, hypertension, high cholesterol and coronary artery disease.
-Resident #2 resided on the special care unit of the facility.
-Resident #2 was constantly disoriented.
-Resident #2 wandered
-Resident #2 was verbally abusive.
-Resident #2 was injurious to others.

Review of Resident #2's care plan dated 07/01/24 revealed that the resident had a history of major neurocognitive disorder due to Alzheimer's disease, with behavioral disturbance.

Review of the Licensed Health Professional Support form for Resident #2 dated 06/26/24 revealed the changes and follow up recommended to meet the resident's needs was to ensure the doors were locked and the resident was near the nurse's station.

Review of facility progress notes for Resident #2 dated 06/26/24 revealed:
-Resident #2 was admitted to the facility on 06/26/24.
-Resident #2 would be placed on increased supervision which included 1-hour checks for 72 hours.

Review of the 15- minute, 30- minute and 1-hour check logs for Resident #2 dated 06/28/24 revealed there was no documentation that Resident #2 was checked on between 8:00am – 2:00pm.

Review of the 15- minute, 30- minute- and 1-hour check logs for Resident #2 dated 06/29/24 revealed there was no documentation that Resident #2 was checked on between 8:00am – 1:00pm.

Review of facility progress note for Resident #2 dated 07/01/24 revealed that at 11:17pm:
-Resident #2 was located in another resident's room.
-When Resident #2 was being removed the resident hit the other resident's hand.

Review of the 30-minute check logs for Resident #2 dated 07/01/24 revealed the checks began at 5:00pm.

Review of the 30-minute check logs for Resident #2 dated 07/02/24 revealed:
-Resident #2 was on 30-minute checks for 24 hours.
-It was noted that Resident #2 walked the hall and was fighting

Review of facility progress notes for Resident #2 dated 07/03/24 revealed the resident was sent to the local emergency department (ED) due to the resident's aggressive behavior with the facility staff and other residents

Review of facility progress notes for Resident #2 dated 07/04/24 revealed the hospital called that morning and the resident was admitted.

Review of facility progress notes for Resident #2 dated 07/09/24 revealed:
-Resident #2 returned to the facility from the local hospital.
-Resident #2 was placed on 1-hour checks for 72 hours.

Review of facility progress note for Resident #2 dated 07/09/24 revealed the resident was seen coming out of different female residents' rooms with his pants unzipped and pulled down

Review of the 15-minute, 30 minute- and 1-hour check logs for Resident #2 revealed there were no 1-hour check logs completed for 07/09/24 stating that the resident was checked on every hour

Review of facility progress note for Resident #2 dated 07/10/24 revealed:
-Resident #2 insisted on going into the other residents' room.
-Resident # 2 tried to stop a lady resident from walking the hallway of the special care unit (SCU).

Review of the 15-minute, 30 minute- and 1-hour check logs for Resident #2 revealed there were no 1-hour check logs completed for 07/10/24 stating the resident was checked on every hour.

Review of facility progress note for Resident #2 dated 07/16/24 revealed:
-Resident #2 picked up the furniture and aimed it for the other residents in the SCU.
-Resident #2 kept taking off his clothes.

Review of facility progress note for Resident #2 dated 07/18/24 revealed the resident went into a female resident's room and got on top of her and would not get out of her bed or room.

Review of the 15-minute, 30 minute- and 1-hour check logs for Resident #2 provided by the facility dated 07/19/24 revealed:

-On the top of the log 1-hour checks was circled. -The 1-hour checks for Resident #2 began at 12:00am. -There was no documentation that Resident #2 was checked every hour from 7:00am – 3:00pm. -It was documented the 1-hour checks for Resident #2 resumed from 4:00pm – 11:00pm. Review of the facility progress notes for Resident #2 dated 07/20/24 revealed: -Resident #2 had a skin tear on the right hand -Resident #2 was placed on 1-hour checks. Review of the 15-minute, 30 minute- and 1-hour check logs for Resident #2 dated 07/20/24 revealed: -This was a new check for Resident# 2. -The1 hour checks for Resident #2 began at 11:00am. -There were no documented checks after 2:00pm for Resident #2. Review of the 15-minute, 30- minute and 1-hour check logs for Resident #2 dated 07/23/24 revealed: -1-hour check was highlighted at the top of the page for Resident #2 -There were no documented checks for Resident #2 from 12:00pm- 11:00pm. Review of an incident report dated 08/08/24 revealed: -Resident # 2 got into a verbal and physical altercation with another resident. -Resident # 2 had a good grip on the other residents' arms. Review of an incident report dated 08/17/24 revealed: -As a medication aide (MA) passed medications she heard a scream coming from a resident's room. -The door to the resident's room was locked. -The MA got the key to unlock the room door, a wheelchair blocked the entrance. -Resident #2 had dried blood on his hand. -The assaulted female resident had blood on her mouth and bed covers. -Resident #2 then became aggressive with the staff by striking and snatching from them. -Resident #2 stated he beat the other resident because she "wasn't in the field picking cotton". -Resident #2 was transported to the local emergency department (ED) by emergency medical services (EMS).		

Review of the facility 1-hour check log for Resident #2 dated 08/17/24 revealed: -There was a check mark by 1 hour check on top of the 15-minute, 30-minute and 1-hour check form for Resident #2. -The 1-hour checks for Resident #2 began at 2:00am. -There were no 1-hour checks documented after 6:30am. Review of the local EMS transport report dated 08/17/2024 revealed: -EMS received a call from the facility at 8:07pm. -Facility staff reported that Resident #2 hit a female resident tonight. -Facility staff reported Resident #2 had a history of becoming combative at night and wandered into another resident's room. -Resident #2 had dried" blood on his right hand/knuckles". -An assault with bodily force had occurred at the assisted living facility. Review of Resident #2's ED records dated 08/17/24 – 08/18/24 revealed: -Resident #2 was seen for a hand injury after he assaulted a female resident in the facility. -It was reported that Resident #2 hit the female resident in the face. -According to EMS this was a common occurrence for Resident #2 at night. -Resident #2 stated he assaulted the female resident because he "didn't like her." Review of the facility progress notes for Resident #2 dated 08/18/24 reveled: -Resident #2 stated he "was going to snatch up and punch the medication aide in the face". -The MA tried to calm Resident #2 down. -Resident #2 continued to physically threaten the staff present using expletives -Resident # 2 was left in his room due to "everybody being scared". Review of the facility progress notes dated 08/19/2024 revealed Resident # 2 was put on increased supervision which included 30-minute checks and would be monitored on all shifts due to the resident's combative behavior. Review of the facility 15-minute, 30-minute and 1-hour check log for Resident #2 dated 08/19/24 revealed: -The checks for Resident #2 began at 12:00am.		

-It was documented that Resident #2 had been checked on every hour, not every 30 minutes.

Review of the facility progress notes for Resident #2 dated 08/20/24 revealed the resident would remain on increased supervision and monitored on all shifts due to aggressive behavior and medication changes.
Review of the facility progress notes for Resident #2 dated 08/31/24 revealed the resident was found kissing a female resident in the mouth.

Review of an incident report for Resident #2 dated 09/09/24 revealed:
-Resident #2 was seen coming out of another resident's room.
-The resident stated that Resident #2 had fondled her breast.
-Resident #2 was removed from the room.
-Resident #2 shoved the PCA against the wall.
-Resident #2's family member was contacted.
-The family member stated if Resident #2 "goes missing too long she advised us to go look for him".

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #2 dated 09/09/24 revealed on the 15-minute, 30-minute, 1-hour check form it stated to "watch him closely!!".

Review of the facility progress notes for Resident #2 dated 09/17/24 revealed:
-The Memory Care Director (MCD) notified Resident #2's family member that mental health and the primary care provider (PCP) were working on medication changes to try and combat some of the behaviors.
-Mental health made medication changes on 09/16/24.
-Resident #2 was having increased behaviors and would be monitored on all shifts.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #2 dated 09/16/24 revealed:
-Resident #2 was on 30 minutes checks.
-The 30-minute checks for Resident #2 began at 12:30am.
-Between 12:00am and 7:00am it was documented that Resident #2 was checked on every 30 minutes.
-Between 8:00am and 2:00pm it was documented that Resident #2 was checked on every hour.
-After 2:00pm there were no documented 15-minute, 30 minute or 1-hour checks for Resident #2.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #2 dated 09/17/24 revealed: -Resident #2 was on 30 minutes checks. -The 30-minute checks began at 12:30am. -After 7:00pm there were no documented 30-minute checks for Resident #2. Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #2 dated 09/18/24 revealed: -Resident #2 was on 30 minutes checks. -The 30-minute checks began at 12:30am. -Between 8:00am and 3:00pm it was documented that Resident #2 was checked on every hour instead of every 30 minutes. Interview with a MA on 12/20/24 at 11:40am revealed: -Resident #2 was aggressive with other residents and staff. -Resident #2 was on increased supervision due to his behaviors. -72-hour checks were usually done when a resident returned from the hospital or had behaviors. -When Resident #2 was on checks the staff was supposed to check on him and keep an eye on him. Telephone interview with the other resident's family member on 11/25/24 at 11:22am revealed: -He went ED to see his family member after the assault on 08/17/24. -The resident had blood around her mouth and her eyes were puffy. -His family member was also assaulted by the same resident on 07/01/24. -The family member stated the assaults caused the resident to be fearful. -The MCD stated they would do their best to ensure nothing like this happened again; “however, the family has to understand there are wanderers on the SCU." -He talked with the Administrator over the phone and she never told him anything concrete they would do to protect the resident. Interview with the MCD on 12/20/24 at 12:00pm revealed: -Resident #2 was aggressive from the beginning when he was admitted to the facility. -Resident #2 was aggressive with the staff and the residents. -She had reached out to the mental health provider, the resident's family member and the residents PCP to inform them of the behavior issues and asked what they could do to help.		

-Resident #2 was put on increased supervision from the time he was admitted to the facility.
-She was not sure how Resident #2 had time to get into the female resident's room to assault her; because he was on increased supervision.
-After each aggressive behavior Resident #2 was placed on increased supervision which included 15-minute, 30 -minute or 1-hour checks.

Interview with the Administrator on 12/20/24 at 1:37pm revealed:
-Resident #2 had behaviors.
-Resident #2 had unprovoked triggers.
-Resident was sent to the ED and staff worked with mental health for his aggressive behaviors.
-One time in August Resident #2 slapped another resident in the mouth.
-Resident #2 was put on increased supervision.
-She was not sure if he was put on increased supervision before or after his altercation with the other resident.

Review of Resident #1 current Fl-2 dated 10/28/24 revealed:
-Resident #1 had a diagnosis of Subarachnoid hemorrhage
-Resident #1 was constantly disoriented.
-Resident #1 was total care.

Review of Resident #1 care plan dated 06/24/24 revealed:
-Resident #1required supervision for eating.
-Resident #1 was totally dependent for toileting, bathing, dressing and grooming/personal hygiene.
-Resident #1 required limited assistance with ambulation/locomotion and transferring.

Review of progress notes for Resident #1 dated 10/22/24 revealed:
-Resident #1 was found on the floor bleeding from the right side of the head.
-Pressure was applied to the wound and Emergency Medical Services (EMS) were called.

Review of an incident report for Resident #1 dated 10/22/24 revealed:
-At 1:20pm an aide reported that Resident #1 was found on the floor bleeding from the right side of the head.
-Emergency Medical Services(EMS) was called to transport Resident #1 to the local emergency department (ED).
-Resident #1 had a hematoma to the right scapula.
-Resident #1 was lethargic and drowsy.

Review of EMS transport notes for Resident #1 dated 10/22/24 revealed:
-When EMS arrived Resident #1 was found lying on the ground inside her bedroom.
-Resident #1 had an unwitnessed fall.
-Staffed reported that about 30 minutes earlier Resident #1 was walking around the dining room.
-Staffed had entered Resident #1's bedroom and found her crawling on the floor.
-Resident #1's primary impression was injury of the face.
-Resident #1 had a small laceration above the right eye.

Review of Resident #1's discharge summary dated 10/28/24 revealed:
-Resident #1's admit date was 10/22/24.
-Resident #1 was transferred to the surgical trauma unit from the local hospital on 10/22/24 due to the concerns of a head computerized tomography (CT) scan after a fall.
-Resident #1's known injuries were: subarachnoid hemorrhage, fracture of the right temporal bone, fracture of right lateral orbital wall facture and fracture of the T2 vertebral body
-Resident #1 was discharged back to the facility from the trauma surgery unit on 10/28/24.

Review of the trauma surgery unit discharge summary dated 10/28/24 revealed:
-Resident #1 was transferred to the trauma surgery on 10/22/24 as a transfer after a fall at the facility.
-Resident #1's known injuries were: subarachnoid hemorrhage, fracture of the zygomatic process of the right temporal bone, zygomaticomaxillary complex fracture and right lateral orbital wall facture and facture of the T2 vertebral body

Review of a facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 10/28/24 revealed:
-Resident #1 was placed on 1-hour checks.

Review of a facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 10/30/24 revealed:
-Resident #1 was placed on 1-hour checks.
-There were no documented checks for Resident #1 from 12:00am – 6:00am.

Review of a facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 10/31/24 revealed:
-Resident #1 was placed on 1-hour checks.

-There were no documented checks for Resident #1 from 12:00am – 6:00am.
-There were no documented checks for Resident #1 from 5:00pm – 6:45pm.
-The 1-hour checks for Resident #1 were to end at 6:45pm.

Review of Resident #1's facility progress notes dated 11/29/24 revealed:
-Resident #1 rolled around in her wheelchair in the common area and fell face first onto the hardwood floor.
-Resident #1 had a black eye and knots on both side of her head.

Review of the first EMS transport notes for Resident #1 dated 11/29/24 revealed:
-EMS had received the call from the facility at 06:05am
-Resident #1 primary impression was eye injury.
-Resident #1 had swelling and bruising to the left eye.
-Resident #1 had swelling to the point that her left eye was closed.
-The facility staff was unaware when and how Resident #1 fell.
-The staff found Resident #1 on the carpet area of her room.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 11/29/24 revealed:
-Resident #1 returned from the hospital at 10:45am.
-Resident #1 was placed on 1-hour checks.
-The 1-hour checks for Resident #1 began at 10:45am.
-Resident #1 was sent back to the ED at 1:30pm.

Review of the second EMS transport notes for Resident #1 dated 11/29/24 revealed:
- EMS had received the call from the facility at 1:13pm.
-When EMS arrived Resident #1 is seen lying on the floor on her right side in the hallway.
-EMS realized this was the same resident they had transported earlier for a fall.
- A staff member stated Resident #1 had fallen while at the hospital and then fell again back at the facility.
-There was swelling to the right side of Resident #1's face that was not there that morning.
-Per hospital staff the right side swelling happened when Resident #1 had fallen at the ED earlier.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 11/30/24 revealed:
-15-minute check was highlighted at the top of the page.
-The 15-minute checks began at 11:00pm

Review of the second facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 11/30/24 revealed:
-On top of the log "1-hour checks was written".
-There was no documentation that Resident #1 was checked on every hour from 12:00am – 6:00am.
-There was no documentation that Resident #1 had been checked on every hour from 12:00pm – 11:00pm.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 12/01/24 revealed:
- "1-hour checks was written" on top of the 15-minute, 30-minute and 1 hour check log.
-There was no documentation that Resident #1 was checked on every hour from 12:00am – 6:00am.
-There was no documentation that Resident #1 had been checked on every hour from 4:00pm – 11:00pm
-There was no documentation that Resident #1 had been checked on every hour from 12:00pm – 11:00pm.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 12/01/24 revealed:
-On top of the log "1-hour checks was written".
-There was no documentation that Resident #1 was checked on every hour from 12:00am – 10:00am.
-The 1-hour checks for Resident #1 was to stop at 11:00am.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 12/04/24 revealed:
-15-minute check was highlighted at the top of the page.
-Written on the form was indefinite 15-minute checks.
- There was no documentation that Resident #1 was checked on every 15 minutes from 12:00am – 04:00pm.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 12/05/24 revealed:
-15-minute check was highlighted at the top of the page.
-Written on the form was indefinite 15-minute checks.
-There was no documentation that Resident #1 was checked on every 15 minutes from 12:00pm – 2:00pm.

Review of the facility 15-minute, 30 minute and 1-hour check log for Resident #1 dated 12/06/24 revealed:
-15-minute check was highlighted at the top of the page.
-Written on the form was indefinite 15-minute checks.
-There was no documentation that Resident #1 was checked on every 15 minutes from 12:00am – 6:00am

Interview with a MA on 12/20/24 at 11:40am revealed:

-Resident #1 was on 15- or 30-minutes checks before the resident died.
-72-hour checks were usually done when a resident came back from the hospital.
-At the end Resident #1 had several falls back to back.
-Resident #1 had the last fall even though the resident was on increased supervision and had the fall mat.
-The MA was not sure when Resident #1 had gotten the fall mat.
-Resident #1 did not have a bed or chair alarm.

Telephone interview with Resident #1's family member on 11/25/24 at 11:22am revealed:
-He talked with the Administrator over the phone and she never told him anything concrete they would do to protect Resident #1.
-Resident #1 had several falls while at the facility.
-On 10/22/24, Resident #1 had a fall that resulted in several severe injuries: a "brain bleed, multiple facial fractures and a T2 spinal fracture".
-Resident #1 had been transported from the local hospital to a surgical trauma critical care unit on 10/22/24.
-On 11/29/24, Resident #1 had fallen twice at the facility.
-He had visited Resident #1 at the hospital on 11/29/24; both of the residents' eyes were swollen shut, she had severe facial bruising, a large lump on the left side of her face, swelling to her forehead and multiple black and blue areas on her body.
-On 12/06/24, Resident #1 died at the local hospital.

Review of Resident #1's certificate of death revealed:
-The final disease or condition resulting in death was multiple blunt force injury of the head.
-The manner of death was accident.

Interview with the Administrator on 12/20/24 at 1:37pm revealed:
-When Resident #1 was admitted to the facility the resident was on the assisted living side of the facility.
-Resident #1 was moved to the special care unit sometime in June 2024 to be monitored closely after having two falls.
-Resident #1 was on increased supervision and had a fall mat.
-Resident #1 was capable of walking at times.
-The facility did not have a written fall policy.

The facility failed to provide supervision to a resident who was documented as having wandering, verbally and physically abusive behaviors which resulted in the resident physically and sexually assaulting to other residents; for a resident who had 3

falls with significant injuries, the last of which ended in death. This failure resulted in serious physical harm and constitutes an A1 violation.

The facility provided a plan of protection in accordance with G.S. 131-D34 on 01/08/24

The correction ate for this Type A1 violation shall not exceed 02/08/25.

Rule/Statue Number: 10A NCAC 13F.0902(a)

Rule Statutory Reference:

Level of Non-compliance: Standard Deficiency

Review of Resident #4's Fl-2 dated 09/11/24 revealed:
-Resident #4 wandered.
-Resident #4's diagnoses included: chronic kidney disease, Type II diabetes and dementia

Review of Resident #4's 6-month physician orders dated 11/12/24 revealed:
-The orders were signed on 11/13/24 by Resident #4's primary care provider (PCP)
-There was an active order for Resident #4 to have compression stockings applied in the morning and removed at bedtime.

Observation of a sign over Resident #4's bed on 11/21/24 and on 12/20/24 revealed:
-Please put TED hose on the morning and remove TED hose at bedtime.
-The signature on the bottom of the sign was the memory care director (MCD).
Observation on 11/21/24 and on 12/20/24 at 11:15am revealed Resident #4 was lying in her bed dressed but did not have on her prescribed compression stockings.

Interview with a personal care aide (PCA) on 11/24/24 at 11:20pm:
-She was aware that Resident #4 was supposed to have on the compression stockings.
-There were no compression stockings in Resident #4's room.

Interview with a medication aide (MA) on 12/20/24 at 11:30 revealed:

-The MA was not sure if Resident #4 had any TED hose.
-She had not seen Resident #4 with the TED hose on in a while.
-The compression stockings are kept in the Resident #4's room and not on the medication cart.

Interview with the MCD on 11/21/2024 at 12:43pm revealed:
-She was not sure if Resident #4 compression stockings were in the resident's room.
-The MCD checked for compression stockings in Resident #4's room; there were none.
-She was going to ask Resident #4's primary care provider (PCP) for a discontinue order as the resident "doesn't have much swelling anymore".

Rule/Statue Number: 10A NCAC 13F.0503(E)

Rule/Statutory Reference: The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aides. The form requires the following: 1-4 .

Level of Non-compliance: Standard Deficiency

Findings: Based on interviews and record reviews the facility failed to ensure that 3 of 5 sampled staff (B, E, F) had their Medication Administration Skills Validation Form was signed and dated by the employees.

The findings are:

Review of Staff B's medication aide (MA) personnel record revealed:
-Staff B was hired on 10/03/24 as a MA.
-There was a completed Medication Administration Skills Validation (MASV) Form with the licensed personnel's name and date.

-The employee had not signed or dated the MASV form.
Review of Staff E's medication aide (MA) personnel record revealed:
-Staff E was hired on 10/24/24 as a MA
-There was a completed Medication Administration Skills Validation (MASV) Form with the licensed personnel's name and date.
-The employee had not signed or dated the MASV form.

Interview with Staff E on 11/20/24 at 4:00pm revealed:
-She worked as a MA on 2nd shift.
-At the other facility she worked at she had been checked off and trained by a nurse, but not at this facility and she had worked as a MA at the facility almost a month.

Review of Staff F's medication aide MA personnel record revealed:
-Staff F was hired on 10/03/24 as a MA.
-There was a completed Medication Administration Skills Validation (MASV) Form with the licensed personnel's name and date.
-The employee had not signed or dated the MASV form.

Rule/Statue Number: 10A NCAC 13F.0504(b)

Rule/Statutory Reference: Competency evaluation and Validated for Licensed Health Professional Support Task. The licensed health professional shall evaluate the staff person's knowledge, skills and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.

Level of Non-compliance: Standard Deficiency
Findings: Based on interviews and record reviews the facility failed to ensure that 5 of 5 sampled staff (A, B, D, E, F) had their skills validated before performing tasks on the residents.

The findings are:
Based on interviews and record reviews the facility failed to ensure that 5 of 5 sampled staff (A, B, D, E, F) had their skills validated before performing tasks on the residents.
Review of Staff A's personal care aide (PCA) personnel record revealed:
-Staff A was hired on 10/18/24 as a PCA.
-There was no completed licensed health professional support tasks form (LHPS) completed for Staff A and validated by a licensed health professional.

Review of Staff B's medication aide (MA)) personnel record revealed:
-Staff B was hired on 10/03/24 as a MA.
-There was no completed licensed health professional support tasks form (LHPS) completed for Staff B and validated by a licensed health professional.

Review of Staff D's personal care aide (PCA) personnel record revealed:
-Staff D was hired on 10/29/24 as a PCA.
-There was no completed licensed health professional support tasks form (LHPS) completed for Staff D and validated by a licensed health professional.

Review of Staff E's medication aide (MA) personnel record revealed:
-Staff E was hired on 10/24/24 as a MA
-There was no completed licensed health professional support tasks form (LHPS) completed for Staff E and validated by a licensed health professional.

Review of Staff F's medication aide MA personnel record revealed:
-Staff F was hired on 10/21/24 as a MA.
-There was no completed licensed health professional support tasks form (LHPS) completed for Staff F and validated by a licensed health professional.

Rule/Statue Number: 10A NCAC 13F.0406

Rule/Statutory Reference: (a) upon employment all staff shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A.0205 including subsequent amendments and editions.

Findings:

The findings are:
Based on interviews and record reviews the facility failed to ensure 3 of 5 sampled staff (A, D, E) had their second (tuberculosis) TB test completed.

Review of Staff A's personal care aide (PCA) personnel record revealed:
-Staff A was hired on 10/18/24.
-Staff A had a negative TB skin test reading on 10/20/2024.
-There was no documentation of any other TB skin test in Staff A's personnel record.

Review of Staff D's PCA personnel record revealed:
-Staff D was hired on 10/29/24.
-Staff D had a negative TB skin test reading on 11/10/24.

-There was no documentation of any other TB skin test in Staff D's personnel record. Review of Staff E's medication aide (MA) personnel record revealed: -Staff E was hired on 10/24/24. -Staff A had a negative TB skin test reading on 10/15/24. -There was no documentation of any other TB skin test in Staff E's personnel record. Interview with the business office manager (BOM) on 11/22/24 at 11:54am revealed: -The contracted nurse was supposed to come to the facility the day the forms was signed (11/10/24) by the contracted nurse. -Since the contracted nurse had not come she did not have the employee to sign the MASV form. -The contracted nurse pre-fills the check list then comes to the facility and checks the staff off. -It is her responsibility to ensure bath TB skin test are taken and the documentation given to her to put in the staff's file.		

IV. Delivered Via:		Date:
DSS Signature:		Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No		Date Sent to ACLS:

Facility Name: Wickshire Creeks Crossing

Comments:
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*