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
	HAL034087	A. BUILDING: _____ B. WING _____	R 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

(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 follow up survey on 09/27/21 to 9/28/21.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure therapeutic diets were served as ordered for 1 of 5 residents related to receiving the correct diet texture (Resident #4). The findings are: Review of Resident #4's current FL2 dated 01/27/21 revealed: -Diagnoses included generalized muscle weakness, vitamin B12 deficiency anemia and mild cognitive impairment. -The diet order was not included on the FL2. Review of Resident #4's Diet Order Form dated 06/22/21 revealed orders for a finger food diet. Review of the therapeutic diet list posted in the kitchen revealed:	D 310	On 9/28/21, the date of the survey, associates in dietary and in the care department were counseled and directed on the importance of following the diet as ordered for resident #4.All staff involved will be provided additional training on diet orders and the importance of following those orders. This training will be completed no later than 10/31/21.The Dining Services Director will be responsible to ensure all correct diet orders are posted correctly and followed by the cooks as ordered. The Director of Resident Care and/or her designee will ensure that all care staff follows diets as ordered.	10/31/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 10/8/21

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D 310	Continued From page 1 -It was dated 07/21/21. -Resident #4 was on a finger food diet. Observation of Resident #4 during the lunch meal service on 09/27/21 at 1:19pm revealed: -She ate lunch by herself in her room. -Her lunch consisted of baked beans, barbeque brisket, white rice and a square slice of cake. -She fed herself with a spoon and dropped rice and beans on her shirt multiple times. Observation of Resident #4 during the breakfast meal service on 09/28/21 at 9:10am revealed: -She was in bed with her eyes closed. -The bedside table was over her bed with a plate of scrambled eggs, 2 slices of bacon and a bowl of grits. -A fork stuck out of the pile of scrambled eggs. Interview with a medication aide (MA) on 09/27/21 at 1:19pm revealed: -Resident #4 had a finger food diet order. -She encouraged the dietary staff to offer her menu items from the entire regular menu since Resident #4 did not like to eat a lot of sandwiches. Interview with the Cook on 09/28/21 at 9:55am revealed: -She was responsible for plating the residents' meals in the kitchen and for knowing the residents' diet orders. -She typically served what the resident selected on the menu unless theitem was not allowed on the resident's diet. -If the resident selected something that was not allowed, the dietary aide or personal care aide (PCA) was responsible for obtaining a different menu selection from the resident. -She was not aware that Resident #4 was	D 310	In order to maintain compliance in this are the DSD and the DRC will review all diet orders for accuracy at least quarterly and will follow up to ensure all associates are following orders as written by observation of meals at least monthly.	

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D 310	Continued From page 2 ordered a finger food diet. -The lunch meal that should have been served to Resident #4 on 09/27/21 was barbeque brisket, corn nuggets and cooked cauliflower. -The breakfast meal that should have been served to Resident #4 on 09/28/21 was a sausage patty cut into 4 pieces, a hard-boiled egg and a pancake cut into 4 pieces. Interview with the Dietary Director on 09/28/21 at 10:35am revealed: -When a resident ate in their room, a MA or PCA would have taken their meal order. -The resident's menu had their diet order written on the top of their menu. -If a resident tried to order something that was not allowed on their diet then the MA or PCA should have the resident select an appropriate menu selection before the resident's meal order was brought to the kitchen. -The cook should have known what diet Resident #4 was on and followed her diet order. Based on interviews and observations it was determined that Resident #4 was not interviewable.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.	D 312	On 9/28/21, the date of the survey, associates responsible for assisting Resident #4 with eating were counseled about the importance of following orders and care planning that requires assistance with eating. All	10/31/21

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D 312	Continued From page 3 This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide assistance during meals to 1 of 5 residents who had a physician's order for assistance with eating (Resident #4). The findings are: Resident #4's current FL2 dated 01/27/21 revealed diagnoses included generalized muscle weakness, vitamin B12 deficiency anemia and mild cognitive impairment. Review of Resident #4's Diet Order Form dated 06/22/21 revealed that a physician's order for a finger food diet and assistance with eating. Observation of Resident #4 on 09/27/21 at 1:19pm during the lunch meal service revealed: -She was in her room and no staff member assisted her. -Her plate was on a bedside table and she sat parallel to the end of the table in a wheelchair. -She had a spoon in her hand and had dropped rice and beans on several areas of her shirt. Observation of Resident #4 on 09/28/21 at 9:10am revealed: -She was laying in bed with her eyes closed with the head of her bed elevated approximately 45 degrees. -The bedside table was positioned over her, bed at her waist, with a plate of scrambled eggs, bacon and a bowl of grits on top of the table. -No staff were at bedside to assist her in eating. Interview with a medication aide (MA) on 09/27/21 at 1:19pm revealed: -Resident #4 had an order for assistance with	D 312	associates involved in feeding, will be provided additional training on diet orders and assistance with feeding no later than 10/31/21.The Director of Resident Care and/or her designee will ensure continued compliance with this regulation by periodic/random observation of meals with residents who need assistance, for adherence to diets and physician orders.	

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D 312	Continued From page 4 eating but she did not need it daily. -She expected the personal care aide (PCA) to assist Resident #4 with meals, if needed. Interview with a second MA on 09/28/21 at 9:30AM revealed: -Resident #4 ate breakfast in her bed due to not being able to sit in a chair for an extended amount of time. -She did not require assistance with eating for all of her meal but the staff frequently encouraged her to eat. -Resident #4 was not able to hold a spoon or fork well and typically dropped a lot of food on her shirt. -She did not document when she provided Resident #4 assistance with eating. Interview with the Resident Care Coordinator on 09/28/21 at 10:50am revealed: -Resident #4 did not always require assistance with her meal. -If she was served a meal that did not consist of finger foods then it was expected that staff would help her eat. -She did not know why Resident #4 did not receive assistance with eating at lunch on 09/27/21 and breakfast on 09/28/21. Interview with the Administrator on 09/28/21 at 11:00am revealed: -She expected the staff to be aware of Resident #4's need for assistance with eating. -She expected staff to provide assistance with eating when Resident #4 was served grits. -Resident #4 should have received assistance when she was served a meal that did not consist of finger foods.	D 312		

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D 363	Continued From page 5 10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	D 363 D 363	On 9/27/21, the date of the survey, The Med Tech in the Memory Care program, was in-serviced on Medication Administration and the inappropriateness of pre-pouring of medications outside of regulatory guidelines. She was also in-serviced on the inappropriateness of signing for any medication prior to the actual administration. The Med Tech was also immediately required to complete additional Medication Administration Training and received a Disciplinary Action in response to pre-pouring of medications and pre-signing for a med administration. All Med Tech associates will be in-serviced in the area of pre-pouring od medication and pre-signing of medications no later than 10/31/21. The Director of Resident Care and/or her designee will ensure continued compliance with these regulations by periodic/random observations/audits of medication carts and MARs at least monthly.	10/31/21

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D 363	Continued From page 6 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration and protected from contamination and spillage for 2 of 7 sampled residents (Residents #6 and #7). The findings are: Observation of the Special Care Unit (SCU) medication cart on 09/27/21 at 4:00pm revealed: -There were two clear plastic medication cups in the top drawer of the medication cart. -One cup contained six medication tablets and "0" was handwritten on the cup. -A second cup contained three medication tablets and "1" was handwritten on the cup. -No resident names nor administration times were written on the cups. -The cups were not sealed and did not identify the name and strength of each medication. 1. Review of Resident #6's current FL2 dated 01/27/21 revealed diagnoses included dementia. Review of Resident #6's Medication Administration Record (MAR) for 09/27/21 revealed: -There was an entry for hydrocodone-acetaminophen (pain reliever) 5mg-325mg, 1 tablet four times daily with administration times of 6:00am, 12:00pm, 6:00pm, and 12:00am. -There was and entry for donepezil (treats dementia) 10mg, 1 tablet at bedtime with an administration time of 8:00pm.	D 363		

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D 363	Continued From page 7 -There was an entry for melatonin (promotes sleep) 5mg, 1 tablet at bedtime with an administration time of 8:00pm -There was an entry for Zoloft (treats depression) 50mg, 1 tablet at bedtime with an administration time of 8:00pm. -There was an entry for trazadone (promotes sleep) 150mg, ½ tablet (75mg) every night with an administration time of 8:00pm. -There was an entry for senna (treats constipation) 8.6mg, 1 tablet twice daily with administration times of 8:00am and 8:00pm. Refer to the interview with the medication aide (MA) on 09/27/21 at 4:08pm. Refer to the interview with the Director of Resident Care on 09/27/21 at 4:23pm. Refer to the interview with the Executive Director (ED) on 09/28/21 at 8:00am. Based on observation, interviews, and record review Resident #6 was not interviewable. 2. Review of Resident #7's current FL2 dated 06/24/20 revealed diagnoses included dementia. Review of Resident #7's Medication Administration Record (MAR) for 09/27/21 revealed: -There was an entry for Eliquis (blood thinner) 2.5mg, 1 tablet twice daily with an administration time of 8:00pm. -There was an entry for melatonin (promotes sleep) 5mg, 1 tablet at bedtime with an administration time of 8:00pm. -There was an entry for methanamine hippurate (prevents urinary tract infections) 1gm twice daily with administration times of 8:00am and 8:00pm.	D 363		

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D 363	Continued From page 8 Refer to the interview with the medication aide (MA) on 09/27/21 at 4:08pm. Refer to the interview with the Director of Resident Care on 09/27/21 at 4:23pm. Refer to the interview with the Executive Director (ED) on 09/28/21 at 8:00am. Based on observations, interviews, and record reviews Resident #7 was not interviewable. Interview with the medication aide (MA) on 09/27/21 at 4:08pm revealed: -The two cups with medications on the medication cart were the 6:00pm and 8:00pm scheduled medications for Resident #6 and #7. -She had written the residents' room numbers on the medication cups so she would know who was to receive the medications. -She had been trained to prepare medications immediately before administration but had wanted to ensure the residents received their medications timely as she had to administer medications on another hall in the facility as well. -She had only prepared the two cups with medications as she had not had time to prepare the other residents' medications on the unit as her shift had just started at 3:00pm. Interview with the Director of Resident Care on 09/27/21 at 4:23pm revealed: -She did not know what training the MA had received. -Generally, MAs were trained to prepare medications immediately before administration. Interview with the Executive Director (ED) on 09/28/21 at 8:00am revealed:	D 363		

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D 363	Continued From page 9 -It was not the facility's policy and procedure to prepare medications for administration in advance. -The MAs were trained to prepare the medications immediately before administration.	D 363		
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, interviews, and record reviews, the facility failed to ensure staff documented the administration of medications immediately following administration for 2 of 7 sampled residents (#6 and #7) related to scheduled 6:00pm and 8:00pm medications (#6) and scheduled 8:00pm medications (#7). The findings are: Review of the facility's Medication Administration Policy and Procedure revealed the documentation of administration of medications will occur after the administration. 1. Review of Resident #6's current FL2 dated 01/27/21 revealed diagnoses included dementia.	D 366	On 9/27/21, the date of the survey, the Med Tech in the Memory Care program, was in-serviced on Medication Administration and the inappropriateness of pre-pouring of medications outside of regulatory guidelines. She was also in-serviced on the inappropriateness of signing for any medication prior to the actual administration. The Med Tech was also immediately required to complete additional Medication Administration Training and received a Disciplinary Action in response to pre-pouring of medications and pre-signing for med administrations. All Med Tech associates will be in-serviced in the area of pre-pouring of medication and pre-signing for medications no later than 10/31/21.	10/31/21

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D 366	Continued From page 10 Review of Resident #6's Medication Administration Record (MAR) for 09/27/21 at 4:05pm revealed: -There was an entry for hydrocodone-acetaminophen (pain reliever) 5mg-325mg, 1 tablet four times daily with administration times of 6:00am, 12:00pm, 6:00pm, and 12:00am and documentation the 6:00pm dose had been administered. -There was and entry for donepezil (treats dementia) 10mg, 1 tablet at bedtime with an administration time of 8:00pm and documentation the 8:00pm dose had been administered. -There was an entry for melatonin (promotes sleep) 5mg, 1 tablet at bedtime with an administration time of 8:00pm and documentation the 8:00pm dose had been administered. -There was an entry for Zoloft (treats depression) 50mg, 1 tablet at bedtime with an administration time of 8:00pm and documentation the 8:00pm dose had been administered. -There was an entry for trazadone (promotes sleep) 150mg, ½ tablet (75mg) every night with an administration time of 8:00pm and documentation the 8:00pm dose had been administered. -There was an entry for senna (treats constipation) 8.6mg, 1 tablet twice daily with administration times of 8:00am and 8:00pm and documentation the 8:00pm dose had been administered. Refer to the interview with the medication aide (MA) on 09/27/21 at 4:08pm revealed: Refer to the interview with the Director of Resident Care on 09/27/21 at 4:23pm. Refer to the interview with the Executive Director (ED) on 09/28/21 at 8:00am.	D 366	The Director of Resident Care and/or her designee will ensure continued compliance with these regulations by periodic/random observation/audit of medication carts and medication passes at least monthly.	

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D 366	Continued From page 11 Based on observation, interviews, and record review Resident #6 was not interviewable. 2. Review of Resident #7's current FL2 dated 06/24/20 revealed diagnoses included dementia. Review of Resident #7's Medication Administration Record (MAR) for 09/27/21 at 4:05pm revealed: -There was an entry for Eliquis (blood thinner) 2.5mg, 1 tablet twice daily with an administration time of 8:00am and 8:00pm and documentation the 8:00pm dose had been administered. -There was an entry for melatonin (promotes sleep) 5mg, 1 tablet at bedtime with an administration time of 8:00pm and documentation the 8:00pm dose had been administered. -There was an entry for methanamine hippurate (prevents urinary tract infections) 1gm twice daily with administration times of 8:00am and 8:00pm and documentation the 8:00pm dose had been administered. Refer to the interview with the medication aide (MA) on 09/27/21 at 4:08pm. Refer to the interview with the Director of Resident Care on 09/27/21 at 4:23pm. Refer to the interview with the Executive Director (ED) on 09/28/21 at 8:00am. Based on observations, interviews, and record reviews Resident #7 was not interviewable. Interview with the medication aide (MA) on 09/27/21 at 4:08pm revealed: -She had not administered 6:00pm and 8:00pm medications yet to Residents #6 and #7 but had	D 366		

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D 366	Continued From page 12 documented in advance that she had administered them. -She had been trained to document the administration of medications immediately after administration but had wanted save time as she had to administer medications on another hall in the facility as well. Interview with the Director of Resident Care on 09/27/21 at 4:23pm revealed: -She did not know what training the MA had received. -MAs received medications clinical skills training. -Newly hired MAs would shadow another MA during their shift. -MAs were trained to document the administration of medications immediately after the administration. Interview with the Executive Director (ED) on 09/28/21 at 8:00am revealed it was the facility's policy and procedure for MAs to document the administration of medications immediately after the administration of the medications.	D 366		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:	D935	All training records will be reviewed for all Medication Technicians to ensure compliance with this regulation. Staff A, B and C as well as any other Medication Technician who is determined to not be in compliance will either have previous Medication	11/15/21

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
	HAL034087	A. BUILDING: _____ B. WING _____	R 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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D935	Continued From page 13 (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure 3 of 3 sampled staff (Staff A, Staff B and Staff C) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication aide training courses prior to administering medications. The findings are:	D935	technician employment verified, or will be provided with the required 15 hours of specific Medication Administration training no later than November 15' 2021.Continued compliance to this regulation will be ensured by the Executive Director, The Director of Resident Care and the Business Office Manager. Upon hire, the BOM will ensure that the prospective Medication Technician has written verification of employment as a Medication Technician within the previous 24 months. If this requirement is not met , the Director of Resident Care will ensure that, before passing medications unsupervised that they have met all guidelines for the regulation, and that they complete all training requirements of a Medication Technician within 60 days of date of hire. The Executive Director will review all new hire paperwork and training prior to the associate performing unsupervised on the	

Division of Health Service Regulation

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D935	Continued From page 14 1. Review of Staff A's personnel record revealed: -Staff A was hired on 12/07/20 as a medication aide. -There was no documentation Staff A completed the 5, 10 or 15-hour medication administration training. -There was no documentation of employment verification showing Staff A worked as a medication aide (MA)within the last 24 months. Telephone interview with Staff A on 09/28/21 at 1:33pm revealed: -She took a medication aide class at the local community college. -She had taken the medication aide test offered by the state of North Carolina -She had passed the written medication aide test on 10/10/20. -She had not been employed as a MA previously. -She trained with other MA's for two or three days when she was first hired but did not recall any other medication training. Refer to interview with the Executive Director (ED) on 09/28/21 at 10:25am. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 12/26/18 as a medication aide. -There was no documentation Staff B completed the 5, 10 or 15-hour medication administration training. -There was no documentation of employment verification showing Staff B worked as a MA within the last 24 months. Interview with Staff B on 09/28/21 at 10:30am revealed: -She had been a MA since 2015.	D935	floor. The ED or designee will audit training documentation at least quarterly to assure continued compliance.	

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D935	Continued From page 15 -She had previously worked as a MA prior to being employed with the current facility. -She did not remember any specific medication training since her employment began with the facility. -If she had it would be in her file in the office. Refer to interview with the ED on 09/28/21 at 10:25am. 3. Review of Staff C's personnel record revealed: -Staff C was hired on 07/18/09 as a medication aide. -There was no documentation Staff C completed the 5, 10 or 15-hour medication administration training. -There was no documentation of employment verification showing Staff C worked as a MA within the last 24 months. Attempted telephone interview with Staff C on 09/28/21 at 10:46 was unsuccessful. Refer to interview with the ED on 09/28/21 at 10:25am. _____ Interview with the ED on 09/28/21 at 10:25am revealed: -Staff A, Staff B and Staff C did not have the 5, 10, or 15-hour medication administration training. -Staff A, Staff B and Staff C did not have documentation of employment verification showing they worked as a MA's within the last 24 months. -The previous Director of Resident Care had not implemented the 5, 10, or 15-hour medication administration training or the employment verification.	D935		