STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE ADDISON OF INDIAN TRAIL	5306 SECREST SHORT CUT ROAD MONROE, NC 28110

(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 a follow up survey on January 27 - 28, 2022.	{D 000}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the documentation of fingerstick blood sugars before meals and daily weights for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's FL-2 revealed diagnoses included Alzheimer's disease, type 2 diabetes, congestive heart failure, and chronic kidney disease.. a. Review of a physician's order for Resident #3 dated 12/20/21 revealed an order to implement fingerstick blood sugars three times a day before meals and give 6 units of Novolin R insulin if the blood sugar was greater than 250. Review of Resident #3's December 2021 electronic medication administration record (eMAR) revealed 5 out of 33 opportunities that fingerstick blood sugar values were not documented as performed from 12/21/21 through	{D 276}		

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{D 276}	Continued From page 1 12/31/21. Review of Resident #3's January 2022 eMAR revealed 21 out of 78 opportunities that fingerstick blood sugar values were not documented as performed from 01/01/22 through 01/27/22. Interview with a MA on 01/28/22 at 11:30am revealed: -She did not know why some blood sugar values were not documented on the eMAR for Resident #3. -The blood sugar values determined if the medication needed to be given to Resident #3.. Interview with the Administrator on 01/28/22 at 11:45am revealed: -She expected blood sugar values to be documented on the eMAR as ordered for Resident #3. -It was important to perform and document blood sugars to determine if the medication needed to be given to Resident #3. b. Review of a physician's order for Resident #3 dated 12/16/21 revealed an order to weigh Resident #3 daily and give Torsemide 10 mg if weight gain was greater than 3 pounds within a 24-hour period. (Torsemide is used to treat high blood pressure and fluid retention). Review of Resident #3's December 2021 eMAR revealed there were 5 out of 11 days that weights were not documented as performed from 12/16/21 through 12/31/21. Review of Resident #3's January 2022 eMAR revealed there were 20 out of 27 days that weights were not documented as performed from	{D 276}		

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{D 276}	Continued From page 2 01/01/22 through 01/27/22. Interview with a MA on 01/28/22 at 11:30am revealed: -She did not know why some weights were not documented on the eMAR. -The weights let you know if the medication needed to be given. Interview with the Administrator on 01/28/22 at 11:45am revealed: -It was important to document weights for Resident #3 because there were parameters to determine if the medication should be given. -She expected weights to be performed and documented on the eMAR as ordered for Resident #3. Attempted telephone interview with Resident #3's primary care provider (PCP) on 01/28/22 at 2:45pm was unsuccessful.	{D 276}		
{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 administer medications as ordered for 3 of 4 residents (#2,	{D 358}		

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{D 358}	Continued From page 3	{D 358}		

#4, #6) observed during the medication passes as evidenced by errors with a medicatication used to treat high blood pressure and fluid retention (#2); medication used to treat osteoporosis (#4); medications used to treat a liver disorder and high blood pressure, chest pain, and an uneven heartbeat (#6); and 2 of 5 sampled residents (#2, #3) for record review which included a medication to control high blood pressure and fluid retention (#2), and a short acting insulin to control high blood sugar levels ((#3).

The findings are:

The medication error rate was 15% as evidenced by the observation of 4 errors out of 26 opportunities during the 8:00am and 9:00am medication passes on 01/27/22.

1. Review of Resident #6's FL-2 dated 11/03/21 revealed diagnoses included dementia, depression, heart failure, and cirrhosis of the liver.

a. Review of Resident #6's physician order report dated 11/03/21 revealed there was an order for propranolol HCl 10mg take 1 tablet by mouth twice a day at 8:00am and 8:00pm. (propranolol HCl is used to treat high blood pressure, chest pain, and uneven heartbeat).

Observation of the 8:00am medication pass on 01/27/22 revealed:
-The medication aide (MA) administered propranolol HCl 20mg (two tablets) to Resident #6 at 9:05am.
-The propranolol HCl 20mg (two 10mg tablets) was documented as administered at the 8:00am medication pass.

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{D 358}	Continued From page 4 Review of Resident #6's January 2022 electronic medication record (eMAR) revealed: -There was an entry for propranolol HCl 10mg take 1 tablet by mouth twice a day at 8:00am and 8:00pm. -The 01/26/22 8:00pm propranolol 10 mg dose was documented as administered on 01/27/22 at 9:08am. -The 01/27/22 8:00am propranolol HCl 10mg dose was documented as administered on 01/27/22 at the 8:00am medication pass. -Two doses of the propranolol HCl 20mg was administered on 01/27/22 at the 8:00am medication pass instead of propranolol HCl 10mg as ordered. Second interview with the MA on 01/27/22 at 2:15pm revealed: -She did not notice one of the entries that "popped" up on the screen for propranolol HCl (10mg) was from the 8:00pm medication pass from the night before (01/26/22) because propranolol HCl 10 mg was not documented as administered. -She did not notice propranolol HCl 10mg was ordered to be administered 8:00pm 01/26/22 (the night before) was in red and displayed the date 01/26/22 at 8:00pm on the eMAR screen. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/28/22 at 10:00am revealed the propranolol HCl can lower heart rate and blood pressure. Review of Resident #6's vital signs approximately 4 hours after the administration of propranolol 20mg revealed the resident's respirations (rate of breathing) were 12 breaths per minute and a pulse of 58 beats per minute (bpm).	{D 358}		

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{D 358}	Continued From page 5 Interview with the Area Nurse Manager on 01/27/22 at 1:00pm revealed: -The propranolol 10 mg "popped" up twice on the eMAR screen because one of the entries was not documented as administered at 8:00pm on 01/26/22 (the night before). -The 01/26/22 8:00pm dose of the medication was not documented as administered and prompted the system to display the medications with the 8:00am dose on 01/27/22. -The entry of the propranolol 10mg on 01/26/22 8:00pm was in red and should have prompted the MA to check the time and date of the medication. -The MA had to override the screen to document the second administration of the medication which also should have prompted her to stop and look at the date and time of the entry in red on the eMAR screen. Attempted telephone interview with Resident #6's primary care provider (PCP) on 01/28/22 at 2:30p was unsuccessful. Interview with the Administrator on 01/27/22 at 1:45pm revealed: -She expected MAs to administer medications according to the order. -She expected MAs to review the eMAR screen and verify the medications, date and time of medications to be administered and check it against the single dose bubble card containing the medication. b. Review of Resident #6's physician order report dated 11/03/21 revealed there was an order for Xifaxan 550 mg take 1 tablet by mouth twice daily at 8:00am and 8:00pm. (Xifaxan is used to treat cirrhosis of the liver.)	{D 358}		

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{D 358}	Continued From page 6 Observation of 8:00am medication pass on 01/27/22 revealed: -The MA administered Xifaxan 1100mg (two 550mg tablets) to Resident #6 at 9:05am. -Xifaxan 1100mg (two 550mg tablets) was documented as administered on 01/27/22 at the 8:00am medication pass. Review of Resident #6's January 2022 electronic medication record (eMAR) revealed: -There was an entry for Xifaxan 550mg take 1 tablet by mouth twice daily at 8:00am and 8:00pm. -The 01/26/22 8:00pm Xifaxan 550mg dose was documented as administered on 01/27/22 at 9:08am at the medication pass. (exceptions report). -The 01/27/22 8:00am Xifaxan 550mg dose was documented as administered on 01/27/22 at the 8:00am medication pass. -Two doses of Xifaxan 1100 mg was administered at the 8:00am medication pass instead of one dose (550mg) as ordered. -Iinterview with the MA on 01/27/22 at 2:15pm revealed: -She did not notice that one of the entries that "popped" up on the screen for Xifaxan 550mg was from the 8:00pm medication pass from the night before (01/26/22) because the Xifaxan 550mg was not documented as administered. -She did not notice the Xifaxan 550mg that was ordered to be administered 8:00pm 01/26/22 (the night before) was in red and displayed the date 01/26/22 at 8:00pm on the eMAR screen. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/28/22 at 10:00am revealed: -The Xifaxan can cause some nausea.	{D 358}		

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{D 358}	Continued From page 7 -The best practice would be to hold the 8:00pm dose on 01/27/22 for the Xifaxan medication and resume the ordered dose the next day. Interview with the Area Nurse Manager on 01/27/22 at 1:00pm revealed: -The Xifaxan 550mg "popped" up twice on the eMAR screen because one of the entries was not documented as administered at 8:00pm on 01/26/22 (the night before). -The 01/26/22 8:00pm dose of Xifaxan 550mg was not documented as administered prompted the system to display the medication with the 8:00am dose of Xifaxan 550mg on 01/27/22. -The entry of Xifaxan 550mg 01/26/22 8:00pm was in red and should have prompted the MA to check the time and date of the that medication. -The MA had to override the system to document the second administration of the medication which also should have prompted her to stop and look at the date and time of the entries in red on the eMAR screen. Attempted telephone interview with Resident #6's primary care provider (PCP) on 01/28/22 at 2:30pm was unsuccessful. Interview with the Administrator on 01/27/22 at 1:45pm revealed: -She expected MAs to administer medications according to the order. -She expected MAs to review the eMAR screen and verify the medications, date and time of medications to be administered and check it against the single dose bubble card containing the medication. 2. Review of Resident #4's FL-2 dated 03/23/21 revealed diagnoses included Alzheimer's disease, osteoarthritis, Type 2 diabetes, and depression.	{D 358}		

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{D 358}	Continued From page 8 Review of Resident #4's physician order report dated 12/03/21 revealed an order for Premarin 0.9mg take 1 tablet by mouth every day. (Premarin is used to treat postmenopausal osteoporosis). Observation of the 9:00am medication pass on 01/27/22 revealed: -The Premarin 0.9mg was not offered or administered to Resident #4 by the medication aide (MA) during the 8:00am medication pass. -The Premarin 0.9mg was not available in the medication cart for administration to Resident #4. Observation of Resident #4's medication on hand on 01/27/22 at 2:000pm revealed Premarin 0.9mg was not availabe for administration. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Premarin 0.9 mg take 1 tablet by mouth every day. -Premarin was documented as administered at the 9:00am medication pass from 01/01/22 through 01/27/22, except 01/26/22, which was blank). Interview with the MA on 01/27/22 at 9:30am revealed: -She must have made a mistake when she documented that the Premarin 0.9 was administered on 01/27/22 at the 9:00am medication pass for Resident #4.. -She did not know why a refill request for Premarin 0.9mg had not been submitted to the pharmacy. -There was a highlighted area on the last row of the single dose bubble card containing the medication that reminded the MA when it was	{D 358}		

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time to reorder the medication.
-The MAs was responsible for re-ordering medication.
-She did not know who was responsible for medication cart audits.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/28/22 at 10:00 am revealed:
-On 12/03/21, there was a medication order for Premarin 0.9mg take 1 tablet every day and 30 tablets were dispensed.
-The pharmacy had not received a refill request from the facility for Premarin 0.9mg since 12/03/21.
-Resident #4's Premarin 0.9mg was not dispensed to the facility in January 2022.

Interview with the Administrator on 01/27/22 at 10:00am revealed:
-The MAs were responsible for sending medication refill requests to the pharmacy.
-Medication cart audits were conducted by the facility's contracted pharmacy once a month.
-In-house medication cart audits were conducted by the Supervisor, the Resident Care Coordinator (RCC), the Memory Care Manager (MCM) or the Health and Wellness Director (HWD).
-She could not provide a schedule for in-house medication cart audits or date of the most recent last medication cart audit.

Interview with the Administrator on 01/27/22 at 1:45pm revealed:
-She expected MAs to administer medications according to the order.
-She expected MAs to review the eMAR screen and verify the medications, date and time of medications to be administered and check it against the single dose bubble card containing

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{D 358}	Continued From page 10 the medication. Attempted telephone interview with Resident #4's primary care provider (PCP) on 01/28/22 at 2:20pm was unsuccessful. Based on observations, interviews, and record reviews it was determined that Resident #4 was not interviewable. 3. Review of Resident #3's current FL-2 dated 12/13/21 revealed diagnoses included Alzheimer's disease, type 2 diabetes, congestive heart failure, and chronic kidney disease. Review of a physician's order dated 12/20/21 revealed an order for Novolin R insulin inject 6 units subcutaneous three times a day before meals for finger stick blood sugars (FSBS) greater than 250 for Resident #3. (Novolin R is a short acting insulin to control blood sugar levels). Review of Resident #3's December electronic medication record (eMAR) from 12/01/21 through 12/31/21 revealed: -There was an entry for Novolin R 6 units to be given for FSBS greater than 250. -There were 27 FSBS documented with a range from 139 to 249 from 12/21/21 through 12/31/21. -Novolin R insulin 6 units was documented as administered for 23 out of 27 FSBS when results were not greater than 250. Review of Resident #3 January 2022 eMAR from 01/01/22 through 01/27/22 revealed: -The was an entry for Novolin R 6 units to be given for FSBS greater than 250. -There were 49 entries for FSBS with a range from 120 to 250. -Novolin R insulin 6 units was documented as	{D 358}		

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administered for 41 out of 49 documented blood sugar entries when it was documented blood sugar levels were not greater than 250.

Review of the instructions on the eMAR for abbreviations revealed:
-Documenting with the MA's initials denoted the medication was given.
-Documenting with initials and (DNG) denoted the medication was not given.

Interview with a medication aide (MA) on 01/28/22 at 10:00am revealed:
-There was no consistent way to document on the eMAR when the Novolin R insulin was not given.
-She left the date and time blank on the eMAR when the FSBS was not greater than 250 because she did not have to give the Novolin R insulin 6 units.
-She would document with her initials when the Novolin R insulin was given on the eMAR.
-She might have made a mistake documenting the medication was given when the FSBS were not greater than 250.
-She documented the FSBS value on the eMAR.

Interview with a second MA on 01/28/22 at 10:20am revealed:
-She documented on the eMAR with her initials when Resident #3's FSBS was greater than 250 indicating she gave the Novolin R insulin 6 units as ordered noting the blood sugar value
-When the FSBS for Resident #3 was less than 250 she would document with her initials and include the notation DNG (drug not given) and enter the glucose value on the eMAR.

Interview with the Area Nurse Manager on 01/28/22 at 11:00am revealed she expected MAs

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to document accurately and follow medication orders.

Attempted telephone interview with Resident #4's primary provider (PCP) on 01/28/22 at 2:45pm was unsuccessful.

Interview with the Administrator on 01/28/22 at 11:30am revealed:
-Her expectation was for MAs to document with their initials when the Novolin R insulin 6 units was given.
-Her expectation was for MAs to document when the Novolin R insulin 6 units was not given with initials and the DNG (drug not given) notation when the blood sugar was less than 250.
-Her expectation was for MAs to document the blood sugar value on the eMAR.

4. Review of Resident #2's current FL-2 dated 01/28/21 revealed diagnoses include Parkinson's disease, tremors unspecified, dysarthria and anarthria, aphasia, major depressive disorder, and anxiety.

Review of Resident #2's physician orders dated 09/14/21 revealed:
-There was a physician's order for HCTZ (used to treat high blood pressure and fluid retention) 25 milligram (mg) tablet every day.
-There were no subsequent physician orders for the HCTZ 25mg tablet every day.

Observation of the 8:00am medication pass on 01/27/22 revealed:
-The medication aide (MA) prepared 11 medications for Resident #2.
-Hydrochlorothiazide (HCTZ) 25mg tablet was not prepared for administration to Resident #2.

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(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 358}	Continued From page 13 Interview with the MA on 01/27/22 at 9:01am revealed: -Resident #2 did not have any HCTZ 25mg tablets available for administration. -She did not know why there was no HCTZ available for administration to Resident #2. -She contacted the provider pharmacy on 01/25/22 and requested the HCTZ for Resident #2. Interview with Resident #2 on 01/27/22 at 9:48am revealed: -He did not know what medications he was administered. -He did not know what the medications were for that he was administered. -He did not know if he had missed any medications. Review of Resident #2's January 2022 electronic medication administration records (eMARs) revealed: -There was an entry for Hydrochlorothiazide 25mg tablet daily scheduled at 8:00am. -There was documentation for administration daily, and with a code of "DNA" next to staff initials on 01/15/22, 01/16/22, 01/18/22,1 01/19/22, 10/21/22 through 01/25/22, and 01/27/22. -There was a definition of "drug not available" for DNA listed on the eMAR. Review of the facility Medication Reorder Process with a last reviewed date of 06/03/21 revealed the reorder process included the following: -Medication orders were reviewed by the Health and Wellness Director (HWD) or designee. -When a refill order of medication was submitted to the pharmacy, the top layer of the pharmacy label was peeled off [the pharmacy dispensed	{D 358}		

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{D 358}	Continued From page 14	{D 358}		

medication blister pack] and attached to the refill order for.
-If the facility had an electronic health record, the label was scanned to reorder medication or the refill button was utilized.
-Medications were to be reordered when a 5 day supply of medication remained.
-If the order was needed the same day, the pharmacy was supposed to be called, and note on the order form that the order was phoned in.

Interview with the MA on 01/27/22 at 1:18pm revealed:
-Medications were reordered when the medication supply on hand was down to the last row on the medication blister pack.
-The MAs or facility nurse were responsible for reordering medications.
-She first contacted the provider pharmacy about the need for HCTZ for Resident #2 on 01/25/22 by fax.

Interview with the Resident Care Coordinator (RCC) on 01/28/22 at 9:21am revealed:
-She did not know Resident #2 did not have HCTZ on hand for administration as prescribed.
-She did not know how long Resident #2 had been without the HCTZ.

Telephone interview with a representative from the facility's contracted provider pharmacy on 01/28/22 at 12:09pm revealed:
-There was a prescription dated 01/29/21 on Resident #2's medication profile for HCTZ 25mg tablet every day.
-The facility requested a refill of Resident #2's HCTZ on 01/24/22 and 01/25/22.
-The physician that originally prescribed the HCTZ for Resident #2 was denying the refill because Resident #2 was no longer being seen

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{D 358}	Continued From page 15	{D 358}		

by that physician.
-The pharmacy needed a new prescription to refill the HCTZ for Resident #2.
-The facility was responsible to obtain the medication refill order.
-A copy of a signed physician order review for Resident #2 dated 09/14/21 was on file at the pharmacy.
-The 09/14/21 physician order review included a physician's order for HCTZ 25mg tablet every day but was missed when the pharmacy updated medications for Resident #2.
-He was not aware if anyone from the facility contacted the pharmacy to inquire about the reason Resident #2's HCTZ had not been dispensed to the facility.
-If the facility was not getting medication refilled by the pharmacy, the facility should call the pharmacy to find out about the medication refill.
-There was no record of calls from the facility to the pharmacy to ask why Resident #2's HCTZ had not been delivered to the facility.

Telephone interview with the nurse at the current Primary Care Provider office on 01/28/22 at 12:59pm revealed:
-There was a current order for HCTZ 25mg tablet every day (no date provided) for Resident #2.
-She did not see any documentation regarding communication from the facility regarding the HCTZ and any missed doses.

Interview with the Administrator on 01/28/22 at 1:10pm revealed:
-Medication could be obtained from the backup pharmacy.
-She expected the MAs to administer medication according to what was on the EMARs with regards to verifying the name, dosage, time of administration, and medication on hand.

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{D 358}	Continued From page 16 -She expected the MAs to enter proper notation regarding medication administration. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) was unsuccessful on 01/28/22 at 12:59pm.	{D 358}		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, and interviews the facility failed to ensure the medication cart in the memory care unit was locked and secure when not under the direct physical supervision of a medication aide observed during the 9:00am medication pass on 01/27/22 for 35 minutes. The findings are: Review of the facility's memory care unit (MCU) census report on 01/27/22 revealed there were 22 residents in the MCU. Observation during the 9:00am medication pass on 01/27/22 revealed: -The medication cart was unlocked and accessible to residents in the MCU during the observation of the medication passes of three (3)	D 378		

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residents from 8:53am to 9:28am.
-Residents in the MCU passed by the medication cart to access the dining room for breakfast.
-The medication aide (MA) prepared the medications and walked in the dining room to administer the medications to the first resident at 8:53am leaving the MCU medication cart unlocked and unattended.
-She came back to the medication cart and prepared the medications and walked to the dining room to administer the medications to a second resident at 9:05am leaving the MCU medication cart unlocked and unattended.
-She came back to the medication cart and prepared the medications and walked down the hall to a third resident's room to administer the medications at 9:25am leaving the MCU medication cart unlocked and unattended.
-She returned to the medication cart around 9:28 am.

Interview with the MA on 01/27/22 at 10:00am revealed:
-She was aware the medication cart should be locked and secure when not under her direct supervision.
-She was nervous and forgot to lock the medication cart after preparing each resident's medication during the 9:00am medication pass.

Interview with the Area Nurse Manager on 01/27/22 at 10:30 am revealed:
-She expected the medication cart to be locked at all times when the MA was not in direct physical supervision of the medication cart.
-Residents should not have accessed to medications in an unlocked and unattended medication cart for their safety.

Interview with the Administrator on 01/27/22 at

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D 378	Continued From page 18 10:40am revealed the medication cart should be locked and secure when not under the direct supervision of the MA for residents' safety.	D 378		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to adult care home medication aides training and competency. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure 6 of 6 sampled staff (A, B, C, D, E, and F) who administered medications completed the 5, 10, or 15-hour medication administration training course or had documentation of the medication aide verification form (staff A, B, E, and F), completion of a medication aide clinical skills evaluation (staff C, D, E, and F), and one staff with no documentation for verification of passing the medication aide test and having a medication aide clinical skills evaluation (staff D) prior to administering medications.. Refer to Tag D 935, G.S. 131D-4.5B(b) ACH Medication Aides	{D912}		

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{D912}	Continued From page 19 Training and Competency (Type B Violation)].	{D912}		
{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: (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	{D935}		

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{D935}	Continued From page 20 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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 6 of 6 sampled staff (A, B, C, D, E, and F) who administered medications completed the 5, 10, or 15-hour medication administration training course or had documentation of the medication aide verification form (staff A, B, E, and F), completion of a medication aide clinical skills evaluation (staff C, D, E, and F), and one staff with no documentation for verification of passing the medication aide test and having a medication aide clinical skills evaluation (staff D) prior to administering medications. The findings are: 1.Review of Staff D's personnel record revealed: -There was no hire date documented. -There was no documentation Staff D passed the written medication aide (MA) examination. -There was no documentation of a Medication Clinical Skills Competency Evaluation. -There was no documentation of medication aide employment verification in Staff D's personnel record. Review of an email dated 01/27/22 from a staffing agency revealed Staff D's first day of work at the facility was 01/22/22.	{D935}		

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{D935}	Continued From page 21 Interview with the Business Officer Manager (BOM) on 01/28/22 at 10:50am revealed: -Documentation of agency staff qualifications were in the agency portal. -She or the Administrator were supposed to access the agency portal to obtain documentation of agency staff qualifications once the agency staff was assigned to work at the facility. -She accessed the agency portal every day. -She reviewed agency staff documents recently and printed the documents. Interview with the BOM on 01/28/22 at 10:58am revealed: -Staffing assignments were established by the Administrator. -She did not know where the medication clinical skills evaluation for Staff D would be. -She did not know where the medication aide test results for Staff D were. -She was responsible for getting agency staff qualifications upon hire. -Staff D was hired at the facility through a staffing agency. -She did not know the date Staff D's began working at the facility. -Staff D worked as a MA on 01/27/22. Review of medication aide examination results for Staff D received from the Administrator on 01/28/22 at 2:52pm revealed Staff D passed the medication aide test on 10/26/21. Review of a resident's January 2022 electronic medication administration records (eMARs) revealed: -Staff D documented administering medications on 01/25/22 and 01/27/22 at 8:00am. -Staff D documented medication administration of Propanolol HCL and Xifaxan scheduled for	{D935}		

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{D935}	Continued From page 22 01/26/22 at 8:00pm, on 01/27/22 at 9:08am during the 8:00am medication pass. There was an exception code of "OTH (other)" documented with Staff D's initials. -Staff D documented medication administration of a second dose of Propanolol HCL on 01/27/22 at 9:08am during the 8:00am medication pass. Refer to the interview with the Business Office Manager (BOM) on 01/28/22 at 11:06am. Refer to the interview with the Regional Nurse on 01/28/22 at 12:50pm. Refer to the interview with the Administrator on 01/28/22 at 1:23pm. 2. Review of Staff E's personnel record revealed: -There was no hire date documented. -There was no documentation Staff E completed the 5, 10, and 15-hour medication administration training course. Review of a handwritten note received from the Business Officer Manager on 01/28/22 revealed Staff E's hire date was 12/07/21. Interview with Staff E on 01/27/22 at 8:23am revealed: -She was a Medication Aide/Supervisor. -She was hired by the facility through a staffing agency. -She had been working at the facility for two months. -The "nurse" came to the facility (no date provided) and reviewed assessments, MARs, vital signs, and the administration of insulin, eye drops, and nasal sprays. -A "form" was signed. -Training was completed before starting on the	{D935}		

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{D935}	Continued From page 23	{D935}		

medication cart.
-She worked on the assisted living (AL) section and the special care unit (SCU).

Observations of Staff E on 01/27/22 from 9:01am to 9:12am revealed:
-Staff E prepared and administered medication to a resident.
-Staff E omitted the administration of a medication to the resident that was scheduled for administration.

Review of a residents January 2022 eMARs revealed:
-Staff E documented administering medications on 01/04/22, 01/08/22, 01/09/22, 01/18/22, and 01/19/22 at 8:00pm, which were prior to the 01/20/22 documented date of Staff E's Medication Clinical Skills Competency Evaluation.
-Staff E documented administering medications on 01/04/22, 01/08/22, 01/09/22, 01/18/22, and 01/19/22, 01/20/22, 01/21/22, 01/22/22, and 01/23/22 at 8:00pm, which were prior to completion of a 5-hr and 10-hr, or 15-hr medication aide administration training course.
-Staff E documented administering medications on 01/21/22, 01/22/22, 01/24/22, and 01/27/22 at 8:00am, which were prior to completion of a 5-hr and 10-hr, or 15-hr medication aide administration training course.

Interview with the Business Officer Manager (BOM) on 01/28/22 at 10:50am revealed:
-Documentation of agency staff qualifications were in the agency portal.
-She or the Administrator were supposed to access the agency portal to obtain documentation of agency staff qualifications once the agency staff was assigned to work at the facility.
-She accessed the agency portal every day.

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{D935}	Continued From page 24 -She reviewed agency staff documents recently and printing the documents. Refer to the interview with the Business Office Manager (BOM) on 01/28/22 at 11:06am. Refer to the interview with the Regional Nurse on 01/28/22 at 12:50pm. Refer to the interview with the Administrator on 01/28/22 at 1:23pm. 3. Review of Staff F, Medication Aide's personnel record revealed: -There was no hire date documented. -There was no documentation Staff F completed the 5, 10, and 15-hour medication administration training course. -There was no documentation of a Medication Clinical Skills Competency Evaluation. -There was no documentation of medication aide employment verification in Staff F's personnel record. Review of an email dated 01/28/22 from a staffing agency revealed there was a handwritten note documenting Staff F's first day working at the facility was 01/27/22. Interview with Staff F on 01/27/22 at 4:40pm revealed: -She was a Medication Aide. -She was hired at the facility through a staffing agency. -She had been working at the facility since November 2021. -She worked at the facility "off and on all the time". -She was shown what to do on the medication cart.	{D935}		

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{D935}	Continued From page 25 -She thought training was completed before starting to work as a medication aide. Interview with the Business Officer Manager (BOM) on 01/28/22 at 10:50am revealed: -Documentation of agency staff qualifications were in the agency portal. -She or the Administrator were supposed to access the agency portal to obtain documentation of agency staff qualifications once the agency staff was assigned to work at the facility. -She accessed the agency portal every day. -She reviewed agency staff documents recently and printing the documents. Refer to the interview with the Business Office Manager (BOM) on 01/28/22 at 11:06am. Refer to the interview with the Regional Nurse on 01/28/22 at 12:50pm. Refer to the interview with the Administrator on 01/28/22 at 1:23pm. 4. Review of Staff A, Medication Aide (MA) personnel record revealed: -Staff A was hired 07/13/21 as a Medication Aide. -There was documentation of the 5-hour medication aide training course dated 08/05/21. -There was no documentation Staff A completed the 10-hour or 15-hour medication administration training course. -There was no documentation of medication aide employment verification in Staff A's personnel record. Review of resident electronic medication administration records (eMARs) for December 2021 revealed Staff A documented administering medications 12/01/21, 12/02/21,	{D935}		

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{D935}	Continued From page 26 12/8/21-12/10/21, 12/13/21-12/16/21, 12/18/21, 12/19/21, 12/21/21, 12/22/21, 12/24/21, 12/27/21-12/30/21 at 8:00am, and 12/10/21 at 9:00pm, which was prior to completion of the Medication Aide Clinical Skills Competency Evaluation completed on 01/07/22 and completing the 10-hour or 15-hour medication aide training course. Review of residents January 2022 eMARs revealed: -Staff A documented administering medications on 01/16/22 at 8:00pm, and 01/18/22 and 01/19/22 at 8:00am, with no documented completion of the 10-hour or 15-hour medication aide training course. Interview with the Administrator on 01/28/22 at 2:40pm revealed Staff A was no longer employed at the facility. Attempted telephone interview with Staff A on 01/28/22 at 3:17pm was unsuccessful. Refer to the interview with the Business Office Manager (BOM) on 01/28/22 at 11:06am. Refer to the interview with the Regional Nurse on 01/28/22 at 12:50pm. Refer to the interview with the Administrator on 01/28/22 at 1:23pm. 5. Review of Staff B, Medication Aide's (MA) personnel record revealed: -Staff B was hired 01/01/20. -There was no documentation Staff B completed the 5-hour/10-hour or 15-hour medication administration training course. -There was no documentation of medication aide	{D935}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL090035	A. BUILDING: _____ B. WING _____	R 01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D935}	Continued From page 27 employment verification in Staff B's personnel record. Review of resident electronic medication administration records (eMARs) for December 2021 revealed Staff B documented administering medications 12/01/21-12/03/21, 12/06/21-12/09/21, 12/11/21-12/13/21, 12/15/21-12/17/21, 12/20/21-12/23/21, 12/25/21-12/27/21, and 12/29/21-12/31/21 at 8:00pm, and 12/17/21 at 9:00am. Review of residents January 2022 eMARs revealed Staff B documented administering medications on 01/03/22, 01/04/22, 01/08/22, 01/09/22, 01/11/22-01/14/22, 01/17/22-01/20/22, 01/22/22, 01/23/22, 01/25/22, and 01/26/22 at 9:00pm. Interview with the Business Office Manager (BOM) on 01/28/22 at 11:03am revealed: -Staff B was employed by the former company owner. -The current company did not have access to the former company employee records. -She had been trying to locate Staff B's records from the former company and putting together personnel records "probably since July 2021". Refer to the interview with the Business Office Manager (BOM) on 01/28/22 at 11:06am. Refer to the interview with the Regional Nurse on 01/28/22 at 12:50pm. Refer to the interview with the Administrator on 01/28/22 at 1:23pm. 6. Review of Staff C, Medication Aide's (MA) personnel record revealed:	{D935}		

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{D935}	Continued From page 28 -Staff C was hired 01/11/22. -There was no documentation of a Medication Clinical Skills Competency Evaluation completed for Staff C. Review of a residents' January 2022 eMARs revealed Staff C documented administering a medication to the resident on 01/18/22-01/22/22 at 2:00am. Refer to the interview with the Business Office Manager (BOM) on 01/28/22 at 11:06am. Refer to the interview with the Regional Nurse on 01/28/22 at 12:50pm. Refer to the interview with the Administrator on 01/28/22 at 1:23pm. Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration. _____ Interview with the Business Office Manager (BOM) on 01/28/22 at 11:06am revealed: -She looked at her spreadsheet monthly to determine what staff needs were due for updating. -She "reached out" to the Health and Wellness Director or Regional Nurse for outstanding staff qualification documents such as the clinical skills evaluation checklist and 5-hr/10-hr or 15-hr medication aide training certification. Interview with the Regional Nurse on 01/28/22 at 12:50pm revealed: -She or the pharmacy nurse completed medication aide clinical skills evaluations which would be in the employee's personnel record. -The staffing agency was supposed to verify all	{D935}		

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{D935}	Continued From page 29 staffing information upon hire of an agency staff. -The staffing agency was supposed to provide the staffing information for agency employees to the facility. Interview with the Administrator on 01/28/22 at 1:23pm revealed: -Medication Aide clinical skills evaluations "typically" were completed by the facility. -Personnel records were audited by the BOM. -When there was a new medication aide assigned to the facility, someone was designated to orient the new medication aide. _____ The facility failed to ensure 6 of 6 (Staff A, B, C, D, E, and F) sampled medication aides, who were administering medications to residents in the facility, completed the 5, 10, or 15-hour medication administration training course or had documentation of the medication aide verification form (Staff A, B, E, and F), and medication clinical skills evaluations (Staff C, D, E, and F). The facility's failure to ensure MAs met training requirements prior to the administration of medications was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/28/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 14, 2022.	{D935}		