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C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey 04/23/19 to 04/24/19.	{D 000}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to notify the primary care provider for 2 of 3 sampled residents (Residents #1 and #2) regarding a multi-vitamin not available for a resident with a vitamin deficiency (#1) and 51 consecutive missed doses of a laxative (#2). The findings are: 1. Review of Resident #1's current FL2 dated 03/28/19 revealed: -Diagnoses included diabetes mellitus II, vitamin D deficiency, and vitamin B deficiency. -A physician's order for decubi-vite (multi-vitamin used to treat vitamin deficiency) once daily. Review of Resident #2's record revealed a previous FL2 dated 02/22/18 with a physician's order for decubi-vite once daily.	D 273		

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Review of Resident #1's March 2019 Medication Administration Record (MAR) revealed:
-There was an entry for decubi-vite once daily at 8:00am.
-There was no documentation the medication was administered from 03/01/19 through 03/31/19.

Review of Resident #1's April 2019 Medication Administration Record (MAR) revealed:
-There was an entry for decubi-vite once daily at 8:00am.
-There were six dates (04/02/19, 04/03/19, 04/04/19, 04/08/19, 04/09/19, and 04/13/19) with circled staff initials.
-The documentation on the back of the MAR reflected the medication was not available.
-There was no documentation the medication was administered from 04/14/19 to 04/23/19.

Observation of Resident #1's medications on hand at the facility on 04/23/19 at 11:35am revealed decubi-vite was not available for administration.

Review of Resident #1's record revealed there was no documentation the prescribing physician was notified the medication was not available for administration.

Interview with Resident #1 on 04/23/19 at 1:23pm revealed:
-He had resided at the facility for a few months, he was not sure exactly how long.
-He was not sure of the medications administered to him.
-He thought he was not administered a multi-vitamin because he did not have a lot of energy.
-He thought a vitamin would help increase his

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D 273	Continued From page 2 energy and endurance. Interview with a pharmacist at the facility's contracted pharmacy on 04/23/19 at 12:15pm revealed: -On 03/01/19 the pharmacy received an order for decubi-vite via FL2 dated 02/22/19. -An attempt to fill the medication was unsuccessful because it was discontinued from the manufacturer. -Because the medication was discontinued by the manufacturer they had not filled or dispensed decubi-vite for Resident #1. -There was documentation in their system why the medication was not dispensed, but there was no documentation if the facility had been notified. -It had been almost two months, therefore the facility staff should have called to find out why the medication was not dispensed. Interview with Resident #1's primary care physician (PCP) on 04/23/19 at 12:47pm revealed: -Resident #1 became a patient of the PCP on 03/28/19. -When Resident #1 came to see the PCP, the FL2 was already completed and listed medications, including decubi-vite. -The PCP signed the FL2 and did not question the medications listed. -The facility staff did not make the PCP aware they were unable to get decubi-vite to administer to Resident #1. -Decubi-vite was a multi-vitamin that was high in zinc, but the PCP did not know why the previous PCP ordered the medication. -If the facility staff had made the PCP aware the medication was not available, then the PCP would have ordered another medication of equal strength for Resident #1.	D 273		

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-Any medications ordered should be administered as ordered, and if there was problem getting the medication then the PCP should be notified.

Interview with the medication aide (MA) on 04/23/19 at 12:11pm revealed:
-Resident #1 was admitted to the facility on 03/01/19.
-She knew decubi-vite was not available for administration.
-Decubi-vite had not been administered since the resident was admitted to the facility.
-She had not called the pharmacy to find out why the medication was not dispensed.
-When she administered Resident #1's medications she circled her initials to show the medication was not available.
-She did not have a reason why she did not call pharmacy to find out why the medication was not dispensed.

Interview with the Administrator on 04/23/19 at 12:59pm revealed:
-She knew Resident #1's decubi-vite was not available for administration.
-It was the facility's policy to check with the pharmacy if a medication ordered was not dispensed.
-She thought the contract nurse had identified the missing medication and had contacted Resident #1's PCP and the pharmacy.
-She had not checked with the facility's contract nurse or the pharmacy to inquire why the medication was not dispensed.
-She was ultimately responsible to ensure medications were available for administration.
-She should have contacted the pharmacy or PCP regarding Resident #1's medication.

Interview with the facility's contract nurse on

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04/24/19 at 9:54am revealed:
-She was contracted to do a medication cart audit.
-She had only done a medication cart audit once.
-She started the audit the end of February 2019, but only worked two days per week so it took four weeks to complete the audit.
-When she did the medication cart audit she checked the medication orders for each resident and compared the orders to the medications on the cart.
-She also checked the MARs to ensure the medications were documented according to the orders.
-If there were concerns she followed-up with the residents' PCP and/or the pharmacy to correct errors.
-She was 90% sure, that Resident #1's decubi-vite was on the medication cart available for administration in March 2019.
-The resident may have come to the facility with some medications, but if the medication was not available she would not have addressed the issue in March 2019.

Attempt interview with Resident #1's previous PCP 04/24/19 at 11:43am was unsuccessful.

2. Review of Resident #2's current FL2 dated 08/23/18 revealed:
-Diagnoses included dementia, type 2 diabetes, chronic obstructive pulmonary disease, right eye blindness, and chronic schizophrenia disorder.
-There was an order for Amitzia 24 mcg two a day with food (used for constipation).

Review of Resident #2's medication administration record (MAR) for March 2019 revealed:
-There was an entry for Amitzia 24 mcg two times

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a day with food scheduled at 8:00 am and 5:00 pm.
-Amitzia was not documented as administered for 51 of 62 opportunities from 03/01/19 through 03/31/19.
-Staff documented Resident #2 refused Amitzia from 03/01/19 through 03/26/19.

Review of Resident #2's Resident Notes revealed there was no documentation Resident #2's Primary Care Physician (PCP) was notified of the 51 refusals of Amitzia.

Observation of Resident #2's medications on hand on 04/23/19 at 11:08 am revealed:
-Amitzia 24 mcg was available to be administered.
-There was 60 tablets of Amitzia dispensed on 04/15/19.
-There were 23 tablets remaining in the bubble pack.

Interview with Resident #2 on 04/23/19 at 1:20 pm revealed:
-The medication aides (MA) administered all her medications.
-She had a history of constipation.
-She was prescribed Amitzia for constipation.
-She continued to experience constipation without relief.
-She denied refusing Amitzia during March 2019.

Interview with a MA on 04/23/19 at 11:16 am revealed:
-She remembered Resident #2 refused Amitzia in March 2019.
-The MAs were supposed to notify the physician after one week of refusals.
-She did not remember notifying the physician of Resident #2's medication refusals.

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D 273	Continued From page 6 -Physician notification faxes should be in the staff communication book. -There was no documentation of physician notification in the staff communication book. Interview with the facility's contracted nurse on 04/23/19 at 2:17 pm revealed: -She conducted MAR to cart audits in March 2019. -She compared the MAR to the FL2 and orders. -She looked for holes and medication refusals. -She remembered Resident #2 was not administered her Amitzia for several days in March 2019. -She was not administered the Amitzia due to an insurance issue. -She did not know the staff documented the Amitzia was not administered because the resident refused. -Staff were expected to document the appropriate reason when a medication was not administered. Interview with the Administrator on 04/23/19 3:06 pm revealed: -She did not know Resident #2's Amitzia was not administered for 51 of 62 opportunities. -She remembered Resident #2 refused Amitzia on several occasions in March 2019. -Staff should notify the physician after a resident refused medication for three days. -Physician notification should be documented in the staff communication book with the fax confirmation. -She did not know if staff notified the physician. -She did not notify the physician regarding the Amitzia refusals. Attempted telephone interview with Resident #2's primary care physician on 04/23/19 at 12:00 pm was unsuccessful.	D 273		

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{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 residents sampled (Residents #1 and #2) who had orders for Humalog sliding scale insulin (SSI) with parameters (#1) and one who had an order to prevent bone loss (#2). The findings are: 1. Review of Resident #1 current FL2 dated 03/28/19 revealed: -Diagnoses included diabetes mellitus type II. -A physician's order for fingerstick blood sugars (FSBS) four times daily at meal times and at bedtime.	{D 358}		

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{D 358}	Continued From page 8 -A physician's order for Humalog (fast-acting insulin to reduce blood sugar) with sliding scale parameters 250-399 give 2 units, greater than 400 give 4 units. Review of Resident #1's March 2019 Medication Administration Record (MAR) revealed: -There was an entry for FSBS four times daily at 6:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Humalog sliding scale at 6:30am, 11:30am, 4:30pm and 8:00pm. -There were nine FSBS that required Humalog SSI coverage. -Four of the nine FSBS had no documentation for the units of insulin administered as follows: -On 03/09/19 at 8:00pm FSBS was 265, Humalog was not administered, 2 units were required. -On 03/10/19 at 8:00pm FSBS was 274, Humalog was not administered, 2 units were required. -On 03/16/19 at 8:00pm FSBS was 272, Humalog was not administered, 2 units were required. -On 03/24/19 at 8:00pm FSBS was 255, Humalog was not administered, 2 units were required. Review of Resident #1's April 2019 MAR revealed: -There was an entry for FSBS four times daily at 6:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Humalog sliding scale at 6:30am, 11:30am, 4:30pm and 8:00pm. -There were three FSBS that required Humalog SSI coverage. -One of the three FSBS had no documentation for the units insulin administered as follows: -On 04/05/19 at 8:00pm FSBS was 280, Humalog was not administered, 2 units were required. Interview with Resident #1 on 04/23/19 at 1:23pm revealed: -He was a diabetic and facility staff checked his	{D 358}		

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{D 358}	Continued From page 9 FSBS four times daily. -The facility staff did not tell him the results of the FSBS checked by facility staff. -He received injections, but did not know his medications. Interview with the medication aide (MA) on 04/23/19 at 12:11pm revealed: -Resident #1's FSBS were checked four times daily. -The resident had Humalog sliding scale for FSBS greater 250. -It was the facility's policy to document the units of insulin administered. -If there was no documentation it could not be determined that Resident #1 was administered Humalog as ordered. Interview with the Administrator on 04/23/19 at 12:59pm revealed: -Resident #1 was a diabetic and was ordered Humalog SSI for FSBS over 250. -Resident #1 did not have many FSBS over 250, but regardless staff were required to document any units of insulin administered. -Each MA were to check behind the previous MA to ensure the correct documentation, medications were administered as ordered and there were no omissions on the MAR. -Staff should have identified the dates with no documented units of Humalog administered. Attempt interview with the MA that checked Resident #1's FSBS on the dates identified at 8:00pm on 04/23/19 at 11:40am was unsuccessful. 2. Review of Resident #2's current FL2 dated 08/23/18 revealed: -Diagnoses included dementia, type 2 diabetes,	{D 358}		

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chronic obstructive pulmonary disease, right eye blindness, and chronic schizophrenia disorder.
-There was an order for Alendronate Sodium 70 mg half an hour before breakfast on Friday (used to treat or prevent osteoporosis).

Review of Resident #2's March 2019 medication administration record (MAR) revealed:
-There was an entry for Alendronate Sodium 70 mg, take one tablet half an hour before breakfast with a full glass of water scheduled at 8:00 am.
-The Alendronate Sodium was not documented as administered on 03/22/19 and 03/29/19.

Observation of Resident #2's medications on hand on 04/23/19 at 11:08 am revealed:
-There was four tablets of Alendronate Sodium dispensed on 04/15/19.
-The box of Alendronate Sodium dispensed on 04/15/19 contained all four tablets.

Interview with Resident #2 on 04/23/19 at 1:20 pm revealed:
-The staff administered all her medications.
-She knew she was prescribed Alendronate Sodium.
-She did not know if she was administered the Alendronate Sodium every Friday as ordered.

Telephone interview with a representative at the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed:
-Alendronate Sodium was an active order.
-There was four tablets of Alendronate Sodium dispensed on 03/22/19.
-There was four tablets of Alendronate Sodium dispensed on 04/15/19.

Interview with the medication aide (MA) on 04/23/19 at 11:16 am revealed:

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{D 358}	Continued From page 11 -She knew Resident #2 was ordered Alendronate Sodium. -She administered the Alendronate Sodium in March but did not document. Interview with the Administrator on 04/23/19 at 3:15 pm revealed: -She expected medications to be administered as ordered. -She expected MAs to document all medications after they were administered. -She did not know Resident #2 did not receive two doses of Alendronate Sodium in March 2019.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to assure the Medication Administration Records (MARs) were accurate and complete for 2 of 3 sampled residents (Residents #1 and #2), as related to documentation of fingerstick blood sugar (FSBS) results on the MARs (#1), and nine medications not documented as administered on 03/27/19 (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 03/28/19 revealed:
-Diagnoses included diabetes mellitus type II.
-There was a physician's order for FSBS three times daily with meals and at bedtime.

Review of Resident #1's Medication Administration Record (MAR) for March 2019 revealed:
-There was an entry for FSBS to be checked before meals and at bedtime at 6:30am, 11:30am, 4:30pm and 8:00pm.
-There were 124 opportunities to check and record Resident #1's FSBS results.
-Twenty-seven of the 124 opportunities had no documented FSBS on the MAR.

Review of the facility's shift note documents revealed there were no documented FSBS results for the same 27 opportunities in March

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D 367	Continued From page 13 2019. Review of Resident #1's MAR for April 2019 revealed: -There was an entry for FSBS to be checked before meals and at bedtime at 6:30am, 11:30am, 4:30pm and 8:00pm. -There were 88 opportunities to check and record Resident #1's FSBS results. -Eight of the 88 opportunities had no documented FSBS on the MAR. Review of the facility's shift note documents revealed there were no documented FSBS results for the same 8 opportunities in April 2019. Interview with Resident #1 on 04/23/19 at 1:23pm revealed: -He was a diabetic. -The facility staff checked his FSBS four times daily. -He did not know the FSBS results. Interview with the medication aide (MA) on 04/23/19 at 12:11pm revealed: -Resident #1's FSBS were checked four times daily. -The MA checking the resident's FSBS were required to record the FSBS result on the MAR. -She did not check the MARs to ensure MAs documented the FSBS. Interview with the Administrator on 04/23/19 at 12:59pm revealed: -Resident #1 was a diabetic and his FSBS were checked four times daily. -Each MA was supposed to the check the MAR to ensure the previous MA had documented medications, including FSBS as ordered. -She often worked as a MA and checked the	D 367		

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MAR behind the MAs.
-She also wrote FSBS on the facility's shift note.
-She had not realized Resident #1's FSBS results were not recorded those many times in March and April 2019.

Interview with the contract nurse on 04/24/19 at 9:54am revealed:
-She was contracted to do a medication cart audit and she checked the MARs.
-She had noticed the facility had a major problem with MARs omission and correct as needed (PRN) documentation.
-Three weeks ago she had discussed the concerns found with the MA on duty and with the Administrator.
-She had not had a meeting with all MAs to discuss the problems with lack of MAR documentation.

2. Review of Resident #2's current FL2 dated 08/23/18 revealed:
-Diagnoses included dementia, type 2 diabetes, chronic obstructive pulmonary disease (COPD), right eye blindness, and chronic schizophrenia disorder.

a. Review of Resident #2's current FL2 dated 08/23/18 revealed a physician's order for vitamin D3 (used to treat decreased vitamin D3 levels) 1000 units daily.

Review of Resident #2's March 2019 Medication Administration Records (MARs) revealed:
-There was an entry for vitamin D3 1000 units daily scheduled at 8:00 am.
-On 03/27/19 there was no documentation the vitamin D3 was administered.

Observation of Resident #2's medication on hand

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on 04/23/19 at 11:08 am revealed:
-Vitamin D3 1000 units was available for administration.
-There were 30 tablets of vitamin D3 dispensed on 03/18/19.

Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed:
-Vitamin D3 was an active order.
-There were 30 tablets dispensed on 02/15/19, 03/18/19, and 04/11/19.

Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed:
-She worked on 03/27/19 and administered all of Resident #2's medications.
-She administered the vitamin D3, but she must have forgot to document as administered.

Interview with Resident #2 on 04/23/19 at 1:20 pm revealed:
-She did not know all the medications she was prescribed.
-She did not know if staff administered vitamin D3 on 03/27/19 or not.

Interview with the Administrator on 04/23/19 at 3:15 pm revealed:
-She did not know staff did not document the vitamin D3 as administered on 03/27/19.
-She expected the staff to administer medications as ordered and document as administered on the MAR.
-Staff should be checking their documentation daily and checking for holes.

b. Review of Resident #2's current FL2 dated 08/23/18 revealed a physician's order for Loxapine (used to treat schizophrenia) 25 mg twice a day.

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D 367	Continued From page 16 Review of Resident #2's subsequent physicians orders dated 12/21/18 revealed an order for Loxapine 25 mg daily. Review of Resident #2's March 2019 Medication Administration Records (MARs) revealed: -There was an entry for Loxapine 25 mg daily scheduled at 8:00 am. -On 03/27/19 there was no documentation Loxapine was administered. Observation of Resident #2's medication on hand on 04/23/19 at 11:08 am revealed: -Loxapine 25 mg was available for administration. -There were 30 tablets of Loxapine dispensed on 03/18/19. Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed: -Loxapine was an active order. -There were 30 tablets dispensed on 02/15/19, 03/18/19, and 04/11/19. Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed: -She worked on 03/27/19 and administered all of Resident #2's medications. -She administered Loxapine, but she must have forgot to document as administered. Interview with Resident #2 on 04/23/19 at 1:20 pm revealed: -She did not know all the medications she was prescribed. -She did not know if staff administered Loxapine on 03/27/19 or not. Interview with the Administrator on 04/23/19 at 3:15 pm revealed:	D 367		

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-She did not know staff did not document the Loxapine as administered on 03/27/19.
-She expected the staff to administer medications as ordered and document as administered on the MAR.
-Staff should be checking their documentation daily and checking for holes.

c. Review of Resident #2's current FL2 dated 08/23/18 revealed a physician's order for Spiriva (used to treat COPD) 18 mcg daily.

Review of Resident #2's March 2019 Medication Administration Records (MARs) revealed:
-There was an entry for Spiriva 18 mcg daily scheduled at 8:00 am.
-On 03/27/19 there was no documentation Spiriva was administered.

Observation of Resident #2's medication on hand on 04/23/19 at 11:08 am revealed:
-Spiriva 18 mcg was available for administration.
-There were 30 capsules of Spiriva dispensed on 02/11/19.

Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed:
-Spiriva was an active order.
-There were 30 capsules dispensed on 02/15/19, 03/18/19, and 04/11/19.

Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed:
-She worked on 03/27/19 and administered all of Resident #2's medications.
-She administered Spiriva, but she must have forgot to document as administered.

Interview with Resident #2 on 04/23/19 at 1:20 pm revealed:

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D 367	Continued From page 18 -She did not know all the medications she was prescribed. -She did not know if staff administered Spiriva on 03/27/19 or not. Interview with the Administrator on 04/23/19 at 3:15 pm revealed: -She did not know staff did not document the Spiriva as administered on 03/27/19. -She expected the staff to administer medications as ordered and document as administered on the MAR. -Staff should be checking their documentation daily and checking for holes. d. Review of Resident #2's current FL2 dated 08/23/18 revealed a physician's order for docusate sodium (used to treat constipation) 100 mg daily. Review of Resident #2's March 2019 Medication Administration Records (MARs) revealed: -There was an entry for docusate sodium 100 mg daily scheduled at 8:00 am. -On 03/27/19 there was no documentation docusate sodium was administered. Observation of Resident #2's medication on hand on 04/23/19 at 11:08 am revealed: -Docusate sodium 100 mg was available for administration. -There were 30 tablets of docusate sodium dispensed on 03/18/19. Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed: -Docusate sodium was an active order. -There were 30 tablets dispensed on 02/15/19, 03/18/19, and 04/11/19.	D 367		

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D 367	Continued From page 19 Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed: -She worked on 03/27/19 and administered all of Resident #2's medications. -She administered docusate sodium, but she must have forgot to document as administered. Interview with Resident #2 on 04/23/19 at 1:20 pm revealed: -She did not know all the medications she was prescribed. -She did not know if staff administered docusate sodium on 03/27/19 or not. Interview with the Administrator on 04/23/19 at 3:15 pm revealed: -She did not know staff did not document the docusate sodium as administered on 03/27/19. -She expected the staff to administer medications as ordered and document as administered on the MAR. -Staff should be checking their documentation daily and checking for holes. e. Review of Resident #2's current FL2 dated 08/23/18 revealed a physician's order for ferrous sulfate (used to treat iron deficiency anemia) 325 mg daily with food. Review of Resident #2's March 2019 Medication Administration Records (MARs) revealed: -There was an entry for ferrous sulfate 325 mg daily with food scheduled at 8:00 am. -On 03/27/19 there was no documentation ferrous sulfate was administered. Observation of Resident #2's medication on hand on 04/23/19 at 11:08 am revealed: -Ferrous sulfate 325 mg was available for administration.	D 367		

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D 367	Continued From page 20 -There was 30 tablets of ferrous sulfate dispensed on 03/18/19. Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed: -Ferrous sulfate was an active order. -There were 30 tablets dispensed on 02/15/19, 03/18/19, and 04/11/19. Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed: -She worked on 03/27/19 and administered all of Resident #2's medications. -She administered ferrous sulfate, but she must have forgot to document as administered. Interview with Resident #2 on 04/23/19 at 1:20 pm revealed: -She did not know all the medications she was prescribed. -She did not know if staff administered ferrous sulfate on 03/27/19 or not. Interview with the Administrator on 04/23/19 at 3:15 pm revealed: -She did not know staff did not document the ferrous sulfate as administered on 03/27/19. -She expected the staff to administer medications as ordered and document as administered on the MAR. -Staff should be checking their documentation daily and checking for holes. f. Review of Resident #2's current FL2 dated 08/23/18 revealed a physician's order for Amitzia (used to treat constipation) 24 mcg twice a day with food. Review of Resident #2's March 2019 electronic Medication Administration Records (eMARs)	D 367		

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revealed:
-There was an entry for Amitzia 24 mcg twice a day with food scheduled at 8:00 am and 5:00 pm.
-On 03/27/19 there was no documentation Amitzia was administered at 8:00 am.

Observation of Resident #2's medication on hand on 04/23/19 at 11:08 am revealed:
-Amitzia 24 mcg was available for administration.
-There were 60 tablets of Amitzia dispensed on 04/15/19.

Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed:
-Amitzia was an active order.
-There was 42 tablets dispensed on 03/26/19.
-There was 60 tablets dispensed on 04/15/19.

Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed:
-She worked on 03/27/19 and administered all of Resident #2's medications.
-She administered Amitzia, but she must have forgot to document as administered.

Interview with Resident #2 on 04/23/19 at 1:20 pm revealed:
-She did not know all the medications she was prescribed.
-She did not know if staff administered Amitzia on 03/27/19 or not.

Interview with the Administrator on 04/23/19 at 3:15 pm revealed:
-She did not know staff did not document the Amitzia as administered on 03/27/19.
-She expected the staff to administer medications as ordered and document as administered on the MAR.
-Staff should be checking their documentation

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daily and checking for holes.

g. Review of Resident #2's current FL2 dated 08/23/18 revealed a physician's order for metformin (used to treat type 2 diabetes) 500 mg twice a day with food.

Review of Resident #2's March 2019 Medication Administration Records (MARs) revealed:
-There was an entry for metformin 500 mg twice a day with food scheduled at 8:00 am and 5:00 pm.
-On 03/27/19 there was no documentation metformin was administered at 8:00 am and 5:00 pm.

Observation of Resident #2's medication on hand on 04/23/19 at 11:08 am revealed:
-Metformin 500 mg was available for administration.
-There were 60 tablets of metformin dispensed on 03/18/19.

Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed:
-Metformin was an active order.
-There were 60 tablets dispensed on 02/15/19, 03/18/19, and 04/11/19.

Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed:
-She worked on 03/27/19 and administered all of Resident #2's medications.
-She administered metformin, but she must have forgot to document as administered.

Interview with Resident #2 on 04/23/19 at 1:20 pm revealed:
-She did not know all the medications she was prescribed.

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D 367	Continued From page 23 -She did not know if staff administered metformin on 03/27/19 or not. Interview with the Administrator on 04/23/19 at 3:15 pm revealed: -She did not know staff did not document the metformin as administered on 03/27/19. -She expected the staff to administer medications as ordered and document as administered on the MAR. -Staff should be checking their documentation daily and checking for holes. h. Review of Resident #2's current FL2 dated 08/23/18 revealed a physician's order for olanzapine (used to treat schizophrenia) 20 mg at bedtime. Review of Resident #2's March 2019 Medication Administration Records (MARs) revealed: -There was an entry for olanzapine 20 mg scheduled at 8:00 pm. -On 03/27/19 there was no documentation olanzapine was administered at 8:00 pm. Observation of Resident #2's medication on hand on 04/23/19 at 11:08 am revealed: -Olanzapine 20 mg was available for administration. -There were 30 tablets of olanzapine dispensed on 03/18/19. Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed: -Olanzapine was an active order. -There was 30 tablets dispensed on 02/15/19, 03/18/19, and 04/11/19. Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed:	D 367		

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D 367	Continued From page 24 -She worked on 03/27/19 and administered all of Resident #2's medications. -She administered olanzapine, but she must have forgot to document as administered. Interview with Resident #2 on 04/23/19 at 1:20 pm revealed: -She did not know all the medications she was prescribed. -She did not know if staff administered olanzapine on 03/27/19 or not. Interview with the Administrator on 04/23/19 at 3:15 pm revealed: -She did not know staff did not document the olanzapine as administered on 03/27/19. -She expected the staff to administer medications as ordered and document as administered on the MAR. -Staff should be checking their documentation daily and checking for holes. i. Review of Resident current FL2 dated 08/23/18 revealed a physician's order for divalproex sodium (used to treat mental disorders) 500 mg at bedtime. Review of Resident #2's March 2019 Medication Administration Records (MARs) revealed: -There was an entry for divalproex sodium 500 mg scheduled at 8:00 pm. -On 03/27/19 there was no documentation divalproex sodium was administered at 8:00 pm. Observation of Resident #2's medication on hand on 04/23/19 at 11:08 am revealed: -Divalproex sodium was available for administration. -There were 30 tablets of divalproex sodium dispensed on 03/18/19.	D 367		

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D 367	Continued From page 25 Interview with the facility's contracted pharmacy on 04/23/19 at 11:39 am revealed: -Divalproex sodium was an active order. -There were 30 tablets dispensed on 02/15/19, 03/18/19, and 04/11/19. Interview with a first shift medication aide (MA) on 04/23/19 at 11:16 am revealed: -She worked on 03/27/19 and administered all of Resident #2's medications. -She administered divalproex, but she must have forgot to document as administered. Interview with Resident #2 on 04/23/19 at 1:20 pm revealed: -She did not know all the medications she was prescribed. -She did not know if staff administered divalproex on 03/27/19 or not. Interview with the Administrator on 04/23/19 at 3:15 pm revealed: -She did not know staff did not document the divalproex as administered on 03/27/19. -She expected the staff to administer medications as ordered and document as administered on the MAR. -Staff should be checking their documentation daily and checking for holes.	D 367		
{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.	{D912}		

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{D912}	Continued From page 26 This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to medication aides training and competency. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 sampled staff (Staff B) who administered medications, had completed the Medication Clinical Skills Competency validation and the 5, 10, or 15 hour state approved medication training prior to administering medications. [Refer to Tag 935, G.S. 131D 4.5 B(b) ACH Medication Aides; Training and Competency (Unabated 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	{D935}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034019	A. BUILDING: _____ B. WING _____	R 04/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

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{D935}	Continued From page 27 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 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: FOLLOW-UP TO TYPE B VIOLATION	{D935}		

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{D935}	Continued From page 28 Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 sampled staff (Staff B) who administered medications, had completed the Medication Clinical Skills Competency validation and the 5, 10, or 15 hour state approved medication training prior to administering medications. The findings are: Review of Staff B, medication aide (MA)/Supervisor's personnel record revealed: -Staff C was hired 01/02/17 as a medication aide. -There was no documentation Staff B had completed the Medication Clinical Skills Competency validation. -There was documentation Staff B passed the written medication administration examination on 05/16/02. -There was no documentation of a medication aide verification. -There was documentation of the 5 hour medication training on 02/06/17 and 04/06/17. -There was no documentation of the 10 hour medication training in the personnel file. Review of a resident's March 2019 medication administration record (MAR) revealed Staff B documented administration of medications on 03/01/19, 03/05/19-03/07/19, 03/11/19, 03/12/19, 03/16/19-03/18/19, 03/22/19-03/24/19, and 03/26/19. Review of a resident's April 2019 MAR revealed Staff B documented administration of medications on 04/02/19, 04/03/19, 04/04/19, 04/09/19,	{D935}		

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{D935}	Continued From page 29 04/13/19-04/21/19, and 04/23/19. Telephone interview with Staff B on 04/23/19 at 1:00 pm revealed: -She started working at the facility on 01/02/17. -She was hired as a medication aide (MA). -She worked first shift. -She had worked at several facilities as a MA prior to coming to the current facility. -She knew she had completed the 5 hour medication training course at the current facility. -She did not know if she had completed the 10 hour medication training course at the current facility. -She did not know if she had completed the medication clinical skills competency validation at the current facility. -She thought she had completed all medication aide training required. Interview with the facility's contracted nurse on 04/23/19 at 2:17 pm revealed: -She was employed after Staff B was hired. -She was responsible for providing MA training. -She knew Staff B did not have the medication clinical skills competency validation or the 10 hour medication training course in her personnel record. -She planned to complete Staff B's medication clinical skills competency validation and the 10 hour medication training course, but then she took a leave of absence prior to it being completed. Interview with the Administrator on 04/23/19 at 3:15 pm revealed: -She did not know Staff B did not have a completed medication clinical skills competency validation in her personnel record. -The facility nurse was responsible for all	{D935}		

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{D935}	Continued From page 30 medication training. -The facility nurse was responsible for ensuring all medication aide training was completed for MAs. -She thought the facility nurse completed the medication administration clinical skills validation in January 2019. -She did not think the MA was required to have the 10 hour medication training because she had been a MA since 2002. Interview with the Business Office Manager (BOM) on 04/24/19 at 2:31 pm revealed: -The facility nurse was responsible for medication aide training and ensuring all medication aide training was completed. -He thought the facility nurse had completed the medication administration clinical skills competency validation. The facility failed to assure 1 of 2 medication aides had received medication administration training prior to performing unsupervised medication aide duties, which placed all residents at risk for medication errors. The facility's failure was detrimental to the health and safety of the residents and constitutes an Unabated Type B Violation. The facility failed to provide a plan of protection in accordance with G.S. 131D-34 for this violation.	{D935}		