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	HAL086001	A. BUILDING: _____ B. WING _____	R 08/03/2023

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CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

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{D 000}	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted a follow-up survey on August 2-3, 2023.	{D 000}	Filing the Plan of Correction does not constitute an admission that the deficiencies alleged, did, in fact, exist. This plan of correction is filed as evidence of the facilities desire to comply with the requirements and to continue to provide high quality resident care.	
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an uncluttered, clean, and orderly environment, free of obstructions and hazards related to two unsecured oxygen (O2) tanks in a resident room (B24). The findings are: Observation of a resident room (B24) on 08/02/23 at 11:05am during the initial tour revealed: -There were two approximate 16-inch unsecured O2 tanks sitting upright on the floor next to the closet in room B24. -There was no rack or crate to stabilize either O2 tanks. Interview with the resident who resided in room (B24) on 08/02/23 at 11:05am revealed: -She used O2 continuously. -She used an O2 concentrator while she was in	{D 079}	a) Administrator conducted an in-service with staff on facility policy on O2 tanks being secured and stored in the appropriate area to ensure safety of residents and staff. b) Administrator and/or RCC will conduct facility walk-throughs three times per week for three months to ensure all O2 tanks are secure and are in the appropriate storage location, then once weekly for one month and quarterly thereafter.	08-23-2023 10-23-2023, once weekly X 1 month, quarterly thereafter

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 09/05/2023

Reviewed and acknowledged
09/08/23

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{D 079}	Continued From page 1 her room. -She used the O2 tank when she went out of the room to the dining room for meals or activities. -She did not know when the O2 tanks that were unsecured were brought into the room and did not know who brought them. Observation of room B24 on 08/02/23 at 3:20 pm revealed the two unsecured oxygen tanks remained in the room. -Interview with a medication aide (MA) on 08/02/23 at 3:25pm revealed: -She did not bring the O2 tanks into the room. -She did not know the O2 tanks were in the room unsecured. -She goes into the room when she administers medications and to check on the resident during the day. -She thought maybe Hospice brought the tanks into the room. -She knew O2 tanks had to be secured. Observation of the O2 storage room on 08/02/23 at 3:25pm revealed there were six empty stands for portable O2 tanks. Interview with a personal care assistant (PCA) on 08/03/23 at 11:25am revealed: -She changed out the portable O2 tank in room B24 yesterday. -She saw the two unsecured portable O2 tanks in the room. -She did not know the portable O2 tanks had to be secured in stands. Interview with a second MA on 08/03/23 at 11:30am revealed: -She did not notice the 2 unsecured portable O2 tanks in room B24. -She did not know how they got there; she thought maybe Hospice brought them.	{D 079}		

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{D 079}	Continued From page 2 -She went into the room to administer medications. -She was aware portable O2 tanks had to be secured in a stand. Interview with the Resident Care Coordinator (RCC) on 08/03/23 at 11:35am revealed: -Was not aware there were two unsecured portable O2 tanks in room B24. -There was an O2 storage room that O2 should be stored in. -When portable O2 tanks were delivered to the facility, they should be put in the O2 storage room. -She was aware portable O2 tanks were supposed to be secured in a stand. -Residents should only have one portable O2 tank in their room and it should be secured in a stand. Interview with the Administrator on 08/03/23 at 3:40pm revealed: -Portable O2 tanks should be secured in stands. -She recently reviewed with all staff that portable O2 tanks needed to be secured in stands. -If a portable O2 tank is found in a resident room, it should be removed immediately. -The resident should not have had two portable O2 tanks in her room that were not being used, they should have been placed in the O2 storage closet. -She expected all staff to be aware that portable O2 tanks could not be left unsecured in resident's rooms and to remove them if they were found unsecured. -She had concerns if a portable O2 tank fell over, it could injure a resident or staff member. -She was responsible for the safety of the residents.	{D 079}		

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{D 083}	Continued From page 3	{D 083}		
{D 083}	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide undamaged window blinds for resident privacy in 3 of 22 sampled resident rooms (rooms A1, A2, and A7). The findings are: Review of the environmental inspection report from the local county health department dated 04/11/23 revealed: -The facility received 14 demerits. -There was an observation of no blinds. Observation of resident room A1 on 08/02/23 at 9:58am revealed: -Two residents resided in room A1. -The room had one window that faced the back parking lot on ground level with vertical blinds covering the window. -There were 9 slats missing on the window covering. -There was a large gap near the middle of the window covering with 5 consecutive slats missing. -The outside was visible from anywhere in the	{D 083}	a) Administrator will ensure all resident use areas are provided with appropriate window coverings. b) Administrator put in place a maintenance reporting log for staff to report any missing blinds or window coverings, the administrator and/or RCC will review the log weekly. c) Administrator and/or RCC will make weekly facility walk-throughs to ensure there are no missing or broken blind or curtains and that windows are covered to ensure residents privacy for three months, then monthly thereafter.	Ongoing 10-06-2023

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{D 083}	Continued From page 4 room. Interview with a resident who resided in room A1 on 08/02/23 at 9:58am revealed: -The blind slats had been missing since she was admitted to the facility in March 2023. -The facility staff told her they were going to order new blinds, but she had not seen any yet. -She preferred to have a full set of blinds or curtains for privacy. -She had to move from her bed area to the other side of the room when she was getting dressed. Observation of resident room A2 on 05/03/23 at 10:45am revealed: -Three residents resided in room A2. -The room had one window that faced the back parking lot on ground level with vertical blinds covering the window. -There were 5 slats missing on the window covering. -There was a holiday decorated bed blanket draped over each end of the curtain fixture but the center of the window, around 3 feet, was not covered. Interview with a resident who resided in room A2 on 08/02/23 at 10:45am revealed: -The window blinds had been missing slats since he moved in on 06/30/22. -The facility was aware the window blind was missing several vertical slats. -He had draped the blankets over the curtain rod for privacy and to filter out light at night. -He really wished the facility would fix his window blind for privacy. Observation of resident room A7 on 08/02/23 at 10:05am revealed: -One resident resided in room A7.	{D 083}		

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{D 083}	Continued From page 5 -The room had one window that was on ground level in the front of the facility, facing the main highway. -There were vertical blind slats covering the window. -There were 2 slats missing on the window covering. Interview with the resident who resided in room A7 on 08/02/23 at 10:45am revealed: -He did not like that the window blinds were missing slats. -He would like his window blinds to close completely with no open spaces. -He had told the Administrator and medication aides repeatedly that he wished his blinds were fixed. Interview with the maintenance staff on 08/02/23 at 11:30am revealed: -He did not work full time at the facility. -He shared his time with a sister facility. -The Administrator had informed him that replacement vertical blind slats had been very hard to find. -The Administrator was attempting to locate replacement blind slats. -He would assist or install the blind slats when the Administrator gave them to him. Interview with the Administrator on 08/02/23 at 11:50am revealed: -She was aware several rooms were missing vertical blind slats in the window coverings. -She had not been able to locate replacement vertical blind slats to fit the blinds. -A few of the residents had added curtains over their facility vertical blinds. -She would further attempt to obtain replacement vertical blind slats. (	{D 083}		

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{D 083}	Continued From page 6 Interview with the Administrator on 08/03/23 at 6:00pm revealed: -She had located a source for replacement slats for the missing vertical blind slats. -The replacement slats were not the correct length but since they were too long, she would have the maintenance staff trim them to fit. -The maintenance staff would be contacted for assistance when the replacement slats arrived.	{D 083}		
{D 091}	10A NCAC 13F .0306(b)(5)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; (6) additional chairs available, as needed, for use by visitors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a comfortable chair for each resident in 6 of 9 sampled rooms (A1, A3, A4, A10, B14 and B15) on the A and B halls. The findings are: Observation of the facility's layout during the entrance tour on 08/02/23 from 9:00am to 11:30am revealed:	{D 091}	a) Administrator will ensure that each resudent is provided a comfortable chair in their room. Staff will ensure upon each new admission that there is a chair available upon admission. b) Administrator and/or RCC will make monthly facility walk-throughs to ensure each resident has a comfortable chair available to them in their room.	10-06-2023

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{D 091}	Continued From page 7 -The facility was one story and resident rooms were located on one of two halls. -There was an A hall and B hall with the medication aide (MA) work area, a television room, and the dining hall seperating the two halls. Observation of resident room B14 on 08/02/23 at 11:40pm revealed: -One resident resided in the room. -The resident ambulated using a motorized wheelchair. -There was no chair in the room. Interview with the resident in room B 14 on 08/02/23 at 1:40pm revealed he did not want a chair in his room because it was easier to use his motorized wheelchair without a chair in his room. Observation of resident room B15 on 08/02/23 at 11:45pm revealed: -One resident resided in the room. -The resident ambulated using a wheelchair. -There was no chair in the room. Interview with the resident in room B 15 on 08/02/23 at 1:45pm revealed she did not want a chair in her room because she preferred the space. Observation of resident room A3 on 08/02/23 at 11:55pm revealed: -Two residents resided in the room. -Both residents ambulated by wheelchair. -There was no chair in the room. Interview with one of the residents in room A3 on 08/02/23 at 2:10pm revealed: -She did not want a chair in her room. -When she was in her room, she laid down on the bed or sit in her wheelchair.	{D 091}		

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{D 091}	Continued From page 8 Observation of resident room A4 on 08/02/23 at 12:10pm revealed: -One resident resided in the room. -She ambulated independently. -There was no chair in the room. Interview with one of the residents in room A4 on 08/02/23 at 2:20pm revealed: -She would like to have a chair in her room. -When she wanted to sit down, she sat on her bed. -Another resident visited her room sometimes and he did not have a chair to sit in. -When her family mamber visited, he sat on the bed. Interview with the Administrator on 08/03/2023 at 5:15pm revealed: -She was aware that most of the resident rooms did not have chairs. -She had been working on several other issues in the facility. -The county social worker had been doing online searches this week for chairs with good prices. -She intended on making chair purchases soon.	{D 091}		
{D 296}	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	{D 296}	a) Administrator will contact the food supplier to ensure there are menus available for all therapeutic diets. b) Administrator conducted an in-service with dietary staff on following all therapeutic diet menus and following those diets as ordered by the physician. c) Administrator and/or RCC will monitor weekly at random meals to ensure dietary staff is following therapeutic diet menus as ordered by the physician.	08-23-2023

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{D 296}	Continued From page 9 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 3 residents (#1 and #3) with physician's orders for a no concentrated sweets (NCS) diet. The findings are: Observation of the kitchen on 08/02/23 at 9:48am revealed: -The regular menus were placed on a kitchen counter, but there were no therapeutic menus available in the kitchen for staff guidance. -There were several notebooks aligned in the corner of the kitchen counter. -The Dietary Manager (DM) pulled a notebook from the counter and flipped through it, but she did not find the therapeutic menus. Observation of the kitchen on 08/03/23 at 2:50pm revealed: -The Administrator looked in two notebooks located on a kitchen counter for therapeutic menus. -The Administrator found the facility's therapeutic menus in one of the notebooks. 1. Review of Resident #1's current FL2 dated 06/19/23 revealed: -Diagnoses included diabetes mellitus. -There was an order for a NCS diet. Review of the facility's undated therapeutic diet list posted in the kitchen revealed Resident #1 was to be served a NCS diet.	{D 296}		

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{D 296}	Continued From page 10 Review of the facility's week-at-a-glance menu for for Wednesday, 08/02/23, for regular diets revealed turkey, corn, brussel sprouts, a dinner roll, and a chocolate eclair bar were to be served. Observation of the lunch meal service on 08/02/23 between 11:50am and 12:25pm revealed: -Resident #1 was served breaded chicken, corn, green beans, a roll, and two servings of pudding. -Resident #1 consumed 100% of the meal. Based on observation of the lunch meal service on 08/02/23, it could not be determined if Resident #1 was served the correct therapeutic diet due to no NCS diet menu available for staff guidance. Interview with Resident #1's primary care provider (PCP) on 08/03/23 at 10:33am revealed: -Resident #1 had a order for a NCS due to a diagnosis of diabetes. -He did not know the facility did not have a menu for NCS diet. -He expected Resident #1 to be served according to a NCS diet menu. Interview with Resident #1 on 08/03/23 at 2:33pm revealed: -He had high blood pressure and had to watch his salt and sugar intake. -He was served the same food items as all the other residents. Refer to the interview with the Dietary Manager (DM) on 08/02/23 at 9:42am. Refer to the interview with a dietary staff on 08/03/23 at 2:35pm.	{D 296}		

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{D 296}	Continued From page 11 Refer to the interview with the Resident Care Coordinator (RCC) on 08/03/23 at 3:01pm. Refer to the interview with the Administrator on 08/03/23 at 4:59pm. 2. Review of Resident #3's current FL2 dated 05/08/23 revealed: -Diagnoses included impaired glucose tolerance. -There was an order for a regular diet. Review of Resident #3's physician's orders dated 07/14/23 revealed a diet clarification for a NCS diet. Review of the facility's undated therapeutic diet list posted in the kitchen revealed Resident #3 was to be served a NCS diet. Review of the facility's week-at-a-glance menu for Thursday, August 3, 2023, for regular diets revealed beef stir-fry with vegetables, rice, a dinner roll, and fruit crisps were to be served. Observation of the lunch meal service on 08/03/23 between 12:00pm and 12:10pm revealed Resident #3 was served beef stir-fry with vegetables, rice, a roll, and mandarin oranges. Based on observation of the lunch meal service on 08/03/23, it could not be determined if Resident #3 was served the correct therapeutic diet due to no NCS diet menu available for staff guidance. Refer to the interview with the DM on 08/02/23 at 9:42am. Refer to the interview with a dietary staff on 08/03/23 at 2:35pm.	{D 296}		

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{D 296}	Continued From page 12 Refer to the interview with the Resident Care Coordinator (RCC) on 08/03/23 at 3:01pm. Refer to the interview with the Administrator on 08/03/23 at 4:59pm. _____ Interview with the DM on 08/02/23 at 9:42am revealed: -She did not remember seeing any therapeutic menus in the kitchen. -She used the regular menu to prepare all meals for all residents. -Residents who had orders for a NCS diet were served half portions of cake and pudding, one cookie, and they were not to be served starchy foods. Interview with a dietary staff on 08/03/23 at 2:35pm revealed: -She prepared and cooked meals for the residents. -The facility served NCS and NAS therapeutic diets. -She used the regular menu to prepare meals for residents who received NCS diets. -She did not add salt to food items, and she used no-salt seasonings. -She did not add sugar in food items and used sweeteners when needed. -She did not know residents who had orders for therapeutic diets should have had matching menus. -No therapeutic menus had been provided to her for guidance in meal preparation. Interview with the RCC on 08/03/23 at 3:01pm revealed she did not know anything about the therapeutic menus and did not know there were no therapeutic menus available for staff guidance.	{D 296}		

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{D 296}	Continued From page 13 Interview with the Administrator on 08/03/23 at 4:59pm revealed: -She and the co-Administrator were responsible for ensuring matching menus were available for all therapeutic diet orders of residents at the facility. -She knew the facility had therapeutic diet menus, but she did not know there were no matching menus available for the NCS diets.	{D 296}		
{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 by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #5) related to an inhaler. The findings are: Review of Resident #5's current FL2 dated 05/03/23 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD). -There was an order for Incruse Ellipta inhaler 62.5mcg inhale 1 puff daily.	{D 358}	a) Administrator will request the pharmacy RN to conduct a medication administration in-service with all Med Aides. b) Administrator and RCC will conduct random cart audits every month to assure all medications and treatments are administered correctly as prescribed by the physician.	10-06-2023 & ongoing

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{D 358}	Continued From page 14 Review of Resident #5's June 2023 electronic medication administration records (eMARs) for 06/04/23 through 06/30/23 revealed: -There was an entry for Incruse Ellipta inhaler 62.5mcg inhale 1 puff daily scheduled for administration at 6:00am. -There was documentation Incruse Ellipta was administered 25 of 26 opportunities between 06/04/23 and 06/30/23. -Incruse Ellipta was documented as not administered on 06/18/23 due to Resident #5 refused. Review of Resident #5's eMAR for July 2023 revealed: -There was an entry for Incruse Ellipta inhaler 62.5mcg inhale 1 puff daily scheduled for administration at 6:00am. -There was documentation Incruse Ellipta was administered 28 of 31 opportunities between 07/01/23 and 07/31/23. -Incruse Ellipta was documented as not administered on 07/18/23, 07/27/23, 07/29/23 due to Resident #5 refused. Review of Resident #5's August 2023 eMAR for 08/01/23 through 08/03/23 revealed: -There was an entry for Incruse Ellipta inhaler 62.5mcg inhale 1 puff daily scheduled for administration at 6:00am. -There was documentation Incruse Ellipta was administered 3 of 3 opportunities between 08/01/23 and 08/03/23. Observation of Resident #5's medications available for administration on 08/03/23 at 9:19am revealed: -Incruse Ellipta was available on the medication cart and had been dispensed from the pharmacy	{D 358}		

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{D 358}	Continued From page 15 on 05/18/23 with a quantity of 30 blisters. -The package of Incruse Ellipta was unopened with 30 blisters remaining. Telephone interview with the facility's contracted pharmacy on 08/03/23 at 11:42am revealed: -Resident #5 had an order for Incruse Ellipta inhaler 62.5mcg 1 puff daily. -Incruse Ellipta was last dispensed to the facility on 05/18/23 with a 30-day supply. -There had not been any subsequent requests to refill Incruse Ellipta. Interview with a medication aide (MA) on 08/03/23 at 9:44am revealed the Administrator and the Resident Care Coordinator (RCC) conducted cart audits, but she did not know how often. Interview with Resident #5's primary care provider (PCP) on 08/03/23 at 10:33am revealed: -Incruse Ellipta was used to treat her diagnosis of COPD. -He did not know Resident #5 had not been administered Incruse Ellipta. -He expected for the facility to administer Incruse Ellipta as ordered. -He had not noticed Resident #5 to have any increased breathing issues. Interview with Resident #5 on 08/03/23 at 2:26pm revealed: -Staff had not been administering her Incruse Ellipta to her. -She did not think they remembered to administer it to her. -She thought she last had a dose of Incruse Ellipta a week ago. -She had not experienced any trouble breathing or shortness of breath.	{D 358}		

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{D 358}	Continued From page 16 Interview with the RCC on 08/03/23 at 3:01pm revealed: -She worked as a MA on the morning of 08/03/23 and administered Resident #5's 6:00am medications. -Resident #5 refused Incruse Ellipta on the morning of 08/03/23, but she must have been talking and documented the medication was administered instead of refused. -Resident #5 refused Incruse Ellipta a lot. -MAs should have looked at the eMAR and compared it to the medication prior to administering. -She and the Administrator were responsible for conducting medication cart audits monthly. -During medication cart audits, she looked to see if residents had the right medication, if the dosage was correct on the prescription label, and made sure the medication was not expired. -She had not completed an audit of Resident #5's medications yet, but if she had, she would have looked at the date on the prescription label and observed how much of the medication remained. -None of the MAs told her they were not administering Incruse Ellipta to Resident #5 or that she consistently refused the medication. Interview with the Administrator on 08/03/23 at 4:59pm revealed: -She and the RCC were responsible for conducting medication cart audits and she expected the audits to be completed twice a month. -She did not know Resident #5 had an unopened container of Incruse Ellipta and the medication had not been dispensed from the pharmacy since 05/18/23. -She expected Resident #5's medications to be administered as ordered.	{D 358}		

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{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). This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#3) related to as needed (prn) pain medication and prn anti-anxiety medication. The findings are: Review of Resident #3's current FL-2 dated 05/08/23 revealed: -Diagnoses included chronic pain, osteoarthritis and anxiety.	{D 367}	a) Administrator will request the pharmacy RN to conduct an in-service on medication administration documentation for all Med Aides. b) Administrator and RCC will continue to complete monthly MAR, Controlled Substance Log and med cart audits.	10-06-2023

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{D 367}	Continued From page 18 -There was an order for oxycodone (a medication used to treat pain) 10/325 milligrams (mg) every six hours as needed (prn) for pain. -There was an order for Xanax (a medication used to treat anxiety) 0.5 mg every eight hours prn for anxiety. Interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 2:20 pm revealed: -On 06/06/23, 120 tablets of Oxycodone 10/325 mg were dispensed. -On 07/10/23, 120 tablets of Oxycodone 10/325 mg were dispensed. -On 06/6/23, 60 tablets of Xanax 0.5 mg were dispensed. -On 0710/23, 60 tablets of Xanax 0.5 mg were dispensed. -The pharmacy provided CSCS to match the quantity of controlled medications dispensed for the facility to use in accounting for medication administration. 1. Review of Resident #3's June 2023 (eMAR) from 06/19/23 to 06/30/23 compared to the CSCS for 120 oxycodone/acetaminophen 10/325 dispensed on 06/06/23 revealed: -There was an entry for oxycodone/acetaminophen 10/325 mg every six hours prn for pain on the eMAR and listed for prn administration. -There was documentation on the eMAR that oxycodone/acetaminophen 10/325 mg every six hours prn for pain was administered for 18 doses from 06/19/23 to 06/30/23. -There were 27 doses signed out on the CSCS as administered that were not documented on the eMAR for administration or the effectiveness of the medication. -Examples for doses documented as	{D 367}		

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{D 367}	Continued From page 19	{D 367}		

administered on the CSCS but not documented on the eMAR were as follows:
-On 06/26/23 at 6:00am, oxycodone/acetaminophen 10/325 was signed out as administered on the CSCS but not documented on the eMAR.
-On 06/28/23 at 12:00am, oxycodone/acetaminophen 10/325 was signed out as administered on the CSCS but not documented on the eMAR.
-On 06/30/23 at 9:00pm, oxycodone/acetaminophen 10/325 was signed out as administered on the CSCS but not documented on the eMAR.

Review of Resident #3's July 2023 (eMAR) from 07/01/23 to 07/31/23 compared to the CSCS for 120 oxycodone/acetaminophen 10/325 dispensed on 06/06/23 revealed:
-There was an entry for oxycodone/acetaminophen 10/325 mg every six hours prn for pain on the eMAR scheduled for prn administration.
-There was documentation on the eMAR that oxycodone/acetaminophen 10/325 mg every six hours prn for pain was administered for 50 doses from 07/01/23 to 07/31/23.
-There were 31 doses signed out on the CSCS as administered that were not documented on the eMAR for administration or the effectiveness of the medication.
-Examples for doses documented as administered on the CSCS but not documented on the eMAR were as follows:
-On 07/01/23 at 6:00am, oxycodone/acetaminophen 10/325 was signed out as administered on the CSCS but not documented on the eMAR.
-On 07/12/23 at 6:00am, oxycodone/acetaminophen 10/325 was signed

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{D 367}	Continued From page 20	{D 367}		

out as administered on the CSCS but not documented on the eMAR.
-On 07/26/23 at 2:00pm, oxycodone/acetaminophen 10/325 was signed out as administered on the CSCS but not documented on the eMAR.

Review of Resident #3's August 2023 (eMAR) from 08/01/23 to 08/03/23 revealed:
-There was an entry for oxycodone/acetaminophen 10/325 mg every six hours prn for pain on the eMAR scheduled for prn administration.
-There was documentation on the eMAR that oxycodone/acetaminophen 10/325 mg every six hours prn for pain was administered for 2 doses from 08/01/23 to 08/03/23.
-There were 7 doses signed out on the CSCS as administered that were not documented on the eMAR for administration or the effectiveness of the medication.
-Examples for doses documented as administered on the CSCS but not documented on the eMAR were as follows:
-On 08/01/23 at 7:00am, oxycodone/acetaminophen 10/325 was signed out as administered on the CSCS but not documented on the eMAR.
-On 08/02/23 at 6:00am, oxycodone/acetaminophen 10/325 was signed out as administered on the CSCS but not documented on the eMAR.
-On 08/03/23 at 12:00am, oxycodone/acetaminophen 10/325 was signed out as administered on the CSCS but not documented on the eMAR.

Refer to the interview with a medication aide (MA) on 08/03/23 at 2:30pm.

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{D 367}	Continued From page 21 Refer to the interview with a second MA on 08/03/23 at 2:40pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/03/23 at 3:00pm. Refer to the interview with Resident #3 on 08/03/23 at 3:05pm. Refer to the interview with the Administrator on 08/03/23 at 3:40pm. 2. Review of Resident #3's June 2023 (eMAR) from 06/19/23 to 06/30/23 revealed: -There was an entry for Xanax 0.5mg every eight hours as needed on the eMAR scheduled for prn administration. -There was documentation on the eMAR and corresponding CSCS Xanax 0.5mg every eight hours prn was administered for 10 doses from 06/19/23 to 06/30/23. -There were 15 doses signed out on the CSCS as administered that were not documented on the eMAR for administration or the effectiveness of the medication. -Examples for doses documented as administered on the CSCS but not documented on the eMAR were as follows: -On 06/19/23 at 6:00am, Xanax 0.5mg was signed out as administered on the CSCS but not documented on the eMAR. -On 06/28/23 at 6:00am, Xanax 0.5mg was signed out as administered on the CSCS but not documented on the eMAR. -On 06/30 at 6:00am, Xanax 0.5mg was signed out as administered on the CSCS but not documented on the eMAR. Review of Resident #3's July 2023 (eMAR) from 07/01/23 to 07/31/23 compared to the CSCS for	{D 367}		

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{D 367}	Continued From page 22 60 Xanax 0.5mg dispensed on 06/06/23 and 07/10/23 revealed: -There was an entry for Xanax 0.5mg every eight hours prn on the eMAR and listed for prn administration. -There was documentation on the eMAR and corresponding CSCS Xanax 0.5mg every eight hours prn was administered for 25 doses from 07/01/23 to 07/31/23. -There were 20 doses signed out on the CSCS as administered that were not documented on the eMAR for administration or the effectiveness of the medication. -Examples for doses documented as administered on the CSCS but not documented on the eMAR were as follows: -On 07/03/23 at 9:00pm, Xanax 0.5mg was signed out as administered on the CSCS but not documented on the eMAR. -On 07/14/23 at 6:00am, Xanax 0.5mg was signed out as administered on the CSCS but not documented on the eMAR. -On 07/26/23 at 6:00am, Xanax 0.5mg was signed out as administered on the CSCS but not documented on the eMAR. Review of Resident #3's August 2023 eMAR from 08/01/23 to 08/03/23 revealed: -There was an entry for Xanax 0.5mg every eight hours prn on the eMAR scheduled for prn administration. -There was documentation on the eMAR that Xanax 0.5mg every eight hours prn was administered for 3 doses from 08/01/23 to 08/03/23. -There were 2 doses signed out on the CSCS as administered that were not documented on the eMAR for administration or the effectiveness of the medication. -Examples for doses documented as	{D 367}		

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{D 367}	Continued From page 23 administered on the CSCS but not documented on the eMAR were as follows: -On 08/01/23 11:55pm, Xanax 0.5mg was signed out as administered on the CSCS but not documented on the eMAR. Refer to the interview with a medication aide (MA) on 08/03/23 at 2:30pm. Refer to the interview with a second MA on 08/03/23 at 2:40pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/03/23 at 3:00pm. Refer to the interview with Resident #3 on 08/03/23 at 3:05pm. Refer to the interview with the Administrator on 08/03/23 at 3:40pm. _____ Interview with a medication aide (MA) on 08/03/23 at 2:30pm revealed: -She referred to the eMAR when Resident #3 requested a prn Oxycodone or Xanax to be sure enough time has elapsed since the last dose. -If it is time for the prn medication to be administered, she pulled the medication from the narcotic drawer, scanned it, administered it and then signed the medication out on the CSCS. -After an hour, assessed Resident #3 to determine if the medication was effective and documented the result on the eMAR. -Sometimes the medication card did not scan and had to be manually entered on the eMAR. Interview with a second MA on 08/03/23 at 2:40pm revealed: -Sometimes the scanner did not work, and the medication administered had to be manually	{D 367}		

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{D 367}	Continued From page 24 entered onto the eMAR. -Resident #3 requested prn Oxycodone and Xanax frequently. -Sometimes she forgot to manually enter the prn medications she administered on the eMAR. -She did go back and ask the resident if the medication helped, but did not always document it on the eMAR. Interview with the Resident Care Coordinator (RCC) on 08/03/23 at 3:00pm revealed: -Some medication cards did not scan with the computer automated eMAR documentation used to scan medication bubble cards and document electronically on the eMAR. -It was a simple task to manually enter the medication if the card did not scan. -The MAs were responsible for manually entering the medications if the card did not scan. -The MAs were responsible for asking the resident an hour after administering the prn medications if the medication was effective and documenting the result, even if the card did not scan. -She and the Administrator were in the process of conducting audits of the charts to include the MAR and the CSCS. -She may not have audited Resident #3's chart yet. Interview with Resident #3 on 08/03/23 at 3:05pm revealed: -Her pain and anxiety are managed. -She thinks she has been taking less of her prn medications than she was before. -She understood her medication was ordered prn and she had to ask for it. -She had no concerns that she was not receiving the medications as ordered. -She was sleeping well and had not had any	{D 367}		

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{D 367}	Continued From page 25 acute pain episodes recently. -She did not think staff always came back and asked her if her pain or anxiety were improved. Interview with the Administrator on 08/03/23 at 3:40pm revealed: -Medications were to be scanned prior to being administered. -If a medication did not scan, it was to be manually entered. -Medications administered PRN were to be manually entered and effectiveness documented. -It was important to enter the effect of the prn medications to ensure the medications were appropriately prescribed. -She and the RCD were responsible for auditing the MARs and CSCS for accuracy and completeness. -They had been in the process of doing so many other things, they had not completed the audit of all the charts yet.	{D 367}		
{D 613}	10A NCAC 13F .1801 (d) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule.	{D 613}	a) Administrator will audit all personnel files immediately to ensure all staff have completed the appropriate state approved infection control training and upon any new hires will schedule upon hiring the infection control training.	10-06-2023 & ongoing

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CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

(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 613}	Continued From page 26 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the mandatory annual state approved infection control training was completed within 30 days of hire for 1 of 1 sampled staff (Resident Care Coordinator) and annually for 2 of 2 sampled staff (Staff A and Staff B) . The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A previously worked at the facility in 2018. -She was rehired on 01/22/21. -There was an on-line infection control training completed on 05/15/23. -The infection control training was not the mandatory state approved annual training. Attempted interview with Staff A on 08/03/23 at 3:30pm was unsuccessful. Refer to the interview with Administrator on 08/03/23 at 4:45pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired on 12/05/19. -There was an infection control training completed on 07/20/21. -There was no documentation of infection control training since 07/20/21. -The infection control training was not the mandatory state approved annual training. Interview with Staff B on 08/03/23 at 4:25pm revealed: -She had been doing the infection control training	{D 613}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 613}	Continued From page 27	{D 613}		

online this week.
-She completed the on-line training on 08/02/23.
-She had completed a previous infection control training online as well.

Refer to the interview with Administrator on 08/03/23 at 4:45pm.

3. Review of Staff C's, Resident Care Coordinator (RCC)., personnel record revealed:
-Staff C was hired on 06/06/23.
-There was an on-line infection control training completed on 06/04/23.
-The infection control training was not the mandatory state approved annual training.

Interview with the RCC on 08/03/23 at 4:15pm revealed:
-She completed the infection control training online.
-After she completed the online training, the pharmacy's registered nurse (RN) came to the facility and signed the certificate.
-The RN did not teach the training in-person.
-She did not know the infection control training she completed was not state approved.
-She thought she completed the mandatory state approved annual infection control training at a previous facility within the past year, but she did not have a copy.

Refer to the interview with Administrator on 08/03/23 at 4:45pm.

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Interview with the Administrator on 08/03/23 at 4:45pm revealed:
-She was responsible for making sure staff qualifications including infection control training were completed.
-The pharmacy's RN did not teach the mandatory

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{D 613}	Continued From page 28 state approved infection control training in-person. -The pharmacy's RN told her to have staff complete the infection control training online and then the RN would come to the facility and sign the certificates. -The staff had completed the infection control training online. -There were 2 different trainings online: a one Continuing Education Unit (CEU) course and a 3 hours CEU course. -She had not noticed staff completed the wrong course with the 1 hour CEU course.	{D 613}		