Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010013	A. BUILDING: _____ B. WING _____	R 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF OAK ISLAND	2910 PINE PLANTATION PARKWAY OAK ISLAND, NC 28461

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D 000	Initial Comments The Adult Care Licensure Section and Brunswick County Department of Social Services conducted a follow-up and annual survey on August 23, 2023 and August 24, 2023.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (MA) (Staff A) passed the written MA exam within 60 days of completion of the 15 hour MA training class and the MA skills checklist. The findings are: Review of Staff A's, medication aide (MA) personnel record revealed: - Staff A was hired on 01/31/22 as a resident	D 125	Landings of Oak Island shall ensure that staff who administer medications and their direct supervisors shall complete training, clinical skills validation, and pass the written exam within 60 days of completion of the 15 hour MA training class and the MA skills checklist. Business Office Coordinator (BOC) will create a tickler system to note compliance/completion dates for required items for staff files, i.e. Med Tech State exam within 60 days. Executive Director (ED) will sign off on all new hires once required documents are received, to approve that their file is complete.	10/8/23 10/8/23

Received via email 09/25/2023. Reviewed and Acknowledged 10/19/23. HF

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D 125	Continued From page 1 transporter. - Staff A completed the 15-hour MA training course on 02/28/23. -Staff A completed the MA clinical skills checklist on 02/28/23. -Staff A completed a second 15-hour MA training course on 07/31/23. -Staff A completed a second MA clinical skills checklist on 08/01/23. -There was no documentation Staff A had taken and passed the written MA exam within 60-days of taking the 15-hour MA training or completing the MA skills checklist. -There was no documentation of Diabetic Care training. Interview with Staff A on 08/24/23 at 7:15am: -He had been an MA for 5 months. -He was scheduled to take the MA test previously and could not due to having a laminated Social Security card. -He said other things came up and he never rescheduled. -He planned to schedule and take the test next week. Observation of Staff A on 08/24/23 between 7:55am and 8:28am revealed he administered medications to three residents without supervision. Review of a resident's June 2023 electronic medication administration record (eMAR) revealed there was documentation Staff A administered medication on 06/13/23 that included a fingerstick blood sugar and an insulin injection. Review of a resident's July 2023 eMAR revealed Staff A administered medication on 07/04/23,	D 125		

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D 125	Continued From page 2 07/06/23 and 07/24/23 that included fingerstick blood sugars and an insulin injections. Review of a resident's August 2023 eMAR revealed Staff A administered medication on 08/15/23, 08/16/23, 08/17/23, 08/22/23 and 08/23/23 that included fingerstick blood sugars and an insulin injection. Interview with the Resident Care Coordinator on 08/24/23 at 12:14pm revealed: -She thought the MAs were to take the MA test within 60 or 90 days of competing the 15- hour training and MA skills checklist. -She started working at the facility in April 2023 and Staff A had been administering medication since she had been there without supervision. -The Business Office Manager was responsible to keep up with staff records and training. -She was not aware that Staff A had not taken the MA test. -Staff A should have been removed from the medication cart since he had not taken the MA test. Interview with the Business Office Manager (BOM) on 08/24/23 at 12:19pm revealed: -She started work at the facility in February 2023. -She kept with the training requirements and documents for new hires. -She kept a spread sheet for the new employees and would give this information to the facility's nurse. -She thought all the current MAs had passed the MA test but there was one MA that still needed to take the MA test, but she was not sure who that was. Interview with the Administrator on 08/24/23 at 5:00pm revealed:	D 125		

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D 125	Continued From page 3 -The BOM kept a spread sheet of training and in-services requirements for the facility staff. -All MAs were required to have the 5 and 10 or 15-hour MA training class. -All MAs were required to have the MA clinical skills checklist. -All MAs were required to take and pass the MA test within 60 days of the MA training class and MA clinical skills checklist. -Staff A should not have been administering medications. -Staff A had recently retaken the 15-hour MA training course. -Staff A had recently completed the clinical skills checklist. -Staff A was scheduled to take the MA test in the next week. -Staff A will be scheduled for the diabetic training course.	D 125		
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 observations, interviews, and record review, the facility failed to ensure physician orders were implemented in a timely manner for 1 of 5 sampled residents who had an order for diabetic shoes (Resident #4).	D 276	Landing of Oak Island shall ensure documentation of written procedures, treatments, or orders from a Provider; and the implementation of procedures, treatments, or orders are in the Resident's record. ED/ Care Manager/ Designee will ensure the Order Processing System is implemented appropriately and is in compliance with its use. The Order Processing System is instrumental in ensuring appropriate approval, processing, and follow-up on Provider's orders and referrals. 10/8/23 ED/ Care Manager/ Designee will ensure implemented orders are documented appropriately in the Resident's record. 10/8/23	

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D 276	Continued From page 4 The findings are: Review of Resident #4's current FL2 dated 01/19/23 revealed diagnoses included type 2 diabetes and dementia. Review of Resident #4's Resident Register dated 02/07/23 revealed Resident #4 was admitted to the facility on 02/07/23. Review of Resident #4's Primary Care Provider (PCP) progress note dated 07/18/23 revealed: - There was a Durable Medical Equipment (DME) order for this visit, Diabetic Shoe order -This was a Face-to-Face encounter for ordering DME. Review of a PCP provider note for Resident #4 dated 08/01/23 revealed: -Orders for this visit included "please check on order for diabetic shoes. This was placed at last chronic visit and has not been done". -Review of Resident #4's resident progress notes revealed: -There was an entry dated 08/02/23 at 5:29 diabetic shoes to be ordered. -There was no entry for pertaining to diabetic shoes to be ordered prior to 08/02/23. -There was an entry dated 08/17/23 at 9:53am that the writer called to follow up on order sent last week for diabetic shoes, DME provider was contacted via phone and received voice mail and message was left requesting return phone call. -There was an entry dated 08/23/23 at 11:23am that the writer left another message with the DME provider to discuss the status of the diabetic shoes that were ordered, requesting phone call back.	D 276	Care Manager will review the electronic facility documentation daily for any needed follow-up. This documentation will be reviewed daily during management meeting with the ED to ensure follow-up and interventions are appropriate. Care Manager will complete a minimum of 2 chart audits weekly to ensure orders are accurate and have been processed and implemented. Completed chart audits will be verified by the ED.	10/8/23 10/8/23

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D 276	Continued From page 5 Interview with Resident #4 on 08/24/23 at 3:42pm revealed: -She had been told by her family member that she was to receive diabetic shoes. -She was not sure why she needed diabetic shoes. -She had not received the diabetic shoes or been contacted by anyone except a family member about diabetic shoes being ordered. Interview with the Resident Care Coordinator (RCC) on 08/24/23 at 11:58am revealed: -The RCC was responsible for new provider orders. -The PCP either wrote a paper prescription or emailed the residents' progress notes containing new orders to the facility the following their visit. -The PCP's progress notes for Resident #4 were emailed to the RCC. -The RCC was responsible to review the PCP's progress notes for new orders. -She was on vacation the week of Resident #4's 07/18/23 PCP visit and did not know who covered for her. -The acting RCC should have reviewed Resident #4's 07/18/23 PCP progress note for new orders. -She received the PCP's 08/01/23 progress note for Resident #4 on 08/02/23. -She contacted Resident #4's family member on 08/02/23 and obtained the contact information for the DME provider. -She contacted the DME provider and was told to fax the PCP's progress note and a face sheet for Resident #4 on 08/02/23. -She faxed Resident #4's PCP progress note and a face sheet to the requested DME company on 08/02/23. -She was sure she had a fax confirmation but could not locate it.	D 276		

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D 276	Continued From page 6 -She contacted the DME provider on 08/17/23 to inquire about the status of Resident #4's diabetic and had to leave a voice mail. -She never received a return call from the DME provider and called a second time on 08/23/23 and had had to leave a voice mail and has not received a return phone call. -She planned to call Resident #4's family member to update. -She planned to call the DME provider again next week. Interview with the Administrator on 08/24/23 at 5:04pm revealed: -The RCC was responsible for new provider orders. -The PCP was encouraged to write a paper prescription for DME orders but usually included these orders in the residents' PCP progress notes. -The PCP emailed the residents' progress notes to the RCC. -The RCC was responsible for reviewing the PCP's progress notes for new orders. -The current RCC was on vacation the week on 07/18/23 and the acting RCC should have reviewed Resident #4's 07/18/23 PCP progress note for all new orders. -The RCC was expected to review all PCP progress notes for new orders and to follow-up on new orders. Interview with Resident #4's PCP on 08/24/23 at 4:18pm revealed: -She treated Resident #4 for type 2 diabetes. -Resident #4 had poorly controlled type 2 diabetes and edema (swelling) in her feet and that is why she ordered diabetic shoes for her. -She was not concerned about the delay in Resident #4 getting the diabetic shoes but	D 276		

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D 276	Continued From page 7 planned to inquire again about the status of the diabetic shoes at Resident #4's upcoming visit. -She expected orders to be carried out as written by the facility. .	D 276		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 2 medication aides (MA), Staff A, observed during the 8:00am medication pass on 08/24/23, who did not sanitize his hands between the preparation and administration of medications to each resident to prevent the transmission of disease and infection, to prevent cross-contamination, and provide a safe and sanitary environment for residents. The findings are: Review of the facility's Medication Administration General Guidelines Procedures dated November 2018 revealed Handwashing and Hand Sanitization: The person administering medications adheres to good hand	D 371	Landings of Oak Island shall ensure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and Residents. Area Clinical Director (ACD) will in-service Med Techs on Medication administration, including the 6 Rights of medication administration, proper procedure for giving meds on the med cart, the importance of proper Infection control, hand hygiene, and wearing gloves appropriately. 10/8/23 ED/Care Manager will make random rounds and observations during med passes to ensure proper procedures are being followed by staff when administering medications to Residents. Any noted concerns will be addressed promptly. 10/8/23 ACD will complete random Med Tech observations during med passes to ensure at least 2 observations per month are completed. This will check 10/8/23	

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D 371	Continued From page 8 hygiene, before beginning a medication pass,prior to handling any medication,after coming into direct contact with a resident, before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations,before and after administration of medications via enteral tubes. -Examination gloves are worn when necessary. -Hand sanitization is done with an approved sanitizer between handwashing, when returning to the medication cart or preparation area, at regular intervals during the medication pass such as after each room. -Sanitization is not a substitute for proper handwashing, and washing should be done if there is any question. Review of the facility's Infectious Disease Control and Infection Control policy dated September 2021 included: -Staff will perform hand hygiene when arriving at work, when hands are visibly dirty, before, between and after each and every time you provide resident care, before putting on gloves and after taking off gloves Observation of the medication aide (MA), Staff A, during the medication pass on 08/24/23 between 7:48am and 8:33am revealed: -There was hand sanitizer on the medication cart. -He did not sanitize his hands with the sanitizer. -He reviewed the resident's electronic medication administration record (eMAR) using the computer keyboard on the medication cart. -He knocked on a resident's door and she was indisposed. -He moved the medication cart to another resident's door. -He did not sanitize his hands or wash his hands.	D 371	compliance with following proper procedures during med administration.	

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D 371	Continued From page 9 -He reviewed the next resident's eMAR using the computer keyboard on the medication cart. -He used keys to unlock the medication cart. -He prepared medications for the resident. -He used keys to lock the medication cart. -He went into the resident's room and administered medications and took the resident's blood pressure. -He returned to the medication cart and entered the administered medication into the eMAR using the computer keyboard. -He did not sanitize his hands or wash his hands. -He used keys to unlock the medication cart. -He reviewed the next resident's eMAR using the computer keyboard on the medication cart -He prepared medications for the next resident. -He used keys to lock the medication cart. -He went into the resident's room and administered the medications. -He returned to the medication cart. -He did sanitize his hands. Interview with the Staff A on 08/24/23 at 10:44am revealed: -He washed his hands at the start of the medication pass. -He used hand sanitizer after every 3rd resident. -He used gloves for insulin injections, eyedrops, topicals, ear drops and nasal sprays. -He was taught hand hygiene by the nurse that came to check everyone off. -He had completed a checklist with the nurse yesterday. Interview with the facility's regional skills nurse/area clinical director on 08/24/23 at 10:53am revealed: -The MAs were to wash their hands at the start of the medication pass and after 3rd resident. -The MAs were to sanitize their hands between	D 371		

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D 371	Continued From page 10 each resident and before and after using gloves. -She had recently completed a MA skills checklist with Staff A. -Staff A must have misunderstood about only using sanitizer after every 3rd resident. -She expected the MA to sanitize his hands between the preparation and administration of medications to each resident to prevent the spread of infection. -The MA would receive additional training. Interview with the Resident Care Coordinator on 08/24/23 at 11:02am revealed: -The MAs were to wash their hand at the start of the medication pass. -The MAs were to use hand sanitizer between each resident. -The MAs were to wash their hands if they were visibly soiled, after toileting, and before and after using gloves. -She expected the MAs to use proper hand hygiene for all resident care to prevent the spread of infection. Interview with the Administrator on 08/24/23 at 5:22pm revealed: -The MAs were expected to wash their hands at the beginning of the medication pass and between every 3rd resident or if visibly soiled and before and after using gloves. -The MAs were to use hand sanitizer between each resident. -She expected Staff A to follow infection control guidelines and to sanitize his hands between the preparation and administration of medications to each resident to prevent the spread of infection. .	D 371		