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
	HAL051064	A. BUILDING: _____ B. WING _____	R-C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 000	Initial Comments The Adult Care Licensure Section conducted a Follow Up Survey and Complaint Investigation on 09/21/23 to 09/22/23.	D 000		
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: TYPE B VIOLATION Based on interviews, record reviews, and observations the facility failed to ensure 2 of 2 sampled medication aides (Staff B and Staff C) who were administering medications had completed the medication clinical skills competency validation checklist or had a medication aide (MA) employment verification. The findings are: Review of the facility's undated medication administration policies and procedures revealed: -In bold letters, Medication shall be administered and ordered only by personnel who have passed the North Carolina Medication Administration examination, satisfactorily completed the clinical skills evaluation by a certified registered nurse	D 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Peaslee — TITLE: Administrator — (X6) DATE: 11-01-23

Reviewed and Acknowledged - Nola Y. Dixon 11/13/23

Emailed 11-01-23 AP
Re Emailed 11-06-23 AP

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D 125	Continued From page 1 and have been signed off by the Administrator. -A Medication Aide (MA) is an individual who has successfully completed the required 15-hour MA course approved by the N.C. Department of Health and Human Services, passed the state written medication exam for unlicensed staff in adult care homes, has competency skills validation by a consulting registered nurse (RN) and has been signed off by the Administrator. -All MAs for the facility must competency validation at the facility and maintain 6 hours of continuing education requirements annually. -Validation of the requirements will be maintained in the Employee's file. 1. Review of Staff B's, medication aide (MA) personnel record revealed: -Staff B hire date was 09/18/23. -There was no documentation of a medication clinical skills competency validation checklist. -There was no documentation of employment verification for the previous 24 months. -There was no documentation of medication training of 5 hours, 10 hours, or 15 hours medication training. Interview with Staff B on 09/22/23 at 2:42pm revealed: -He started the 15-hour medication training on 09/22/23 at 11:00am to 1:00pm -He had not completed the 5-hour, 10-hour or 15-hour medication training. -He had not completed the medication clinical skills validation checklist. -He had administered medication to the residents when scheduled to work. -He first began administering medication to residents on 09/18/23. -He did not have previous experience in administering medication.	D 125	Staff had finish 15 hrs. training And going forward the Business Office mgt And Administrator will monitor monthly to ensure that all requirement Are meet.	completed by: 11-06-23

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D 125	Continued From page 2 -He worked 24-hours every other two weeks as the live in staff. -The Administrator and Owner were aware he did not have previous MA experience. -He shadowed the Administrator and another MA on Monday 09/18/23 and he administered medications on 09/19/23. -He was told to study the on-line medication administration manual. -He observed the Administrator administer insulin to a resident and he administered insulin to a resident on his own on 09/20/23. -He had not had a diabetic care training class and had not had an infection control class since being hired at the facility. Observations of Staff B on 09/22/23 from 7:05am to 7:50am revealed he administered medications to 4 residents that included finger stick blood sugar (FSBS) and insulin. Review of residents' September 2023 medication administration records (MARs) revealed Staff B documented the administration of medications to residents on 09/19/23 at 9:00pm and on 09/20/23, 09/21/23 at 8:00am, 2:00pm, 5:00pm and 8:00pm and on 09/22/23 at 8:00am. Interview with the Administrator on 09/22/23 at 3:02pm revealed: -Staff B began completing the medication clinical skills validation checklist on 09/22/23. -Staff B had not completed the 5 hour, 10 hour or 15-hour medication training. -Staff B had not completed the medication aide exam. -Staff B had at least 4 hours of training in medication administration on 09/22/23. -Staff B had administered medication to the residents.	D 125		

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D 125	Continued From page 3 -She could not remember if she asked if Staff B had previous experience in administering medication. -Staff B had worked independently in administering medication to residents on 09/19/23. Interview with the Owner on 09/22/23 at 1:20pm revealed: -She hired Staff B to work as a MA. -She knew Staff B did not have previous experience in medication administration. Telephone interview with the previous Owner on 09/22/23 at 1:36pm was unsuccessful. Refer to the interview with the Administrator on 09/22/23 at 3:02pm. Refer to the interview with the Owner on 09/22/23 at 1:20pm. 2. Review of Staff C's, medication aide (MA), personnel record revealed: -There was no documentation of Staff C's hire date. -Staff C completed the 15-hour medication training on 09/12/23. -There was no documentation of a medication clinical skills competency validation checklist. -There was no documentation of employment verification for the previous 24 months. Telephone interview with Staff C on 09/22/23 at 1:30pm revealed: -She was hired in March 2023 as a MA. -She completed the 15-hour medication training. -She had completed the medication clinical skills checklist. -She could not remember when she had	D 125		

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D 125	Continued From page 4 completed the medication clinical skills checklist. -She had not taken the medication aide exam. -The previous Office Business Manager (BOM) was given copies of her certification of completion for the medication clinical skills validation checklist. -She had administered medication to residents. -She assisted in training Staff B in medication administration. -She had observed Staff B administering medication. Interview with the Administrator on 09/22/23 at 3:02pm revealed: -Staff C was hired as a MA in March 2023. -Staff C had completed the 15-hour medication training. -She thought Staff had completed the medication clinical skills checklist. -She had Staff C to assist with training Staff B in medication administration. -Staff C had worked independently in administering medication to residents. -Staff C was scheduled to complete the medication clinical skill validation checklist on 09/27/23. Telephone interview with the current Licensee on 09/22/23 at 1:36pm was unsuccessful. Refer to the interview with the Administrator on 09/22/23 at 3:02pm. Refer to the interview with the Owner on 09/22/23 at 1:20pm. _____ Interview with the Administrator on 09/22/23 at 3:02pm revealed: -The newly hired MAs provided were to provide a copy of their 15-hour medication training	D 125		

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D 125	Continued From page 5 certificate and medication aide exam. -The newly hired MAs would complete the medication clinical skills checklist with the Licensed Health Professional Support Nurse (LHPS). -Staff who were newly hired as MAs completed a hands-on training with her or another trained MA. -She had MAs to work if they had only completed the medication clinical skills checklist. -MAs who did not have previous medication administration work experience had to work alongside of an experienced MA. -The LHPS Nurse was responsible for completing the 5-hour, 10-hour or 15-hour medication training and the medication clinical skills checklist. -The previous BOM was responsible for making sure all the staff qualifications and requirements were on file. -The BOM had left in August. -She was the person responsible for the MAs having the required medication administration training. -She completed staff record audits monthly. -The last staff record audit were completed in August 2023. Interview with the Owner on 09/22/23 at 1:20pm revealed: -The Administrator was responsible for ensuring all staff training were completed. -Some of the documentation for the MAs had been removed by the previous staff. -The MAs were required to have the 5-hour, 10-hour or 15-hour state approved MA training course. -The MAs were required to complete the medication competency skills checklist with the facility's LHPS nurse. -MAs were required to take and pass the MA test	D 125		

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D 125	Continued From page 6 within 60 days of completing the 5-hour, 10-hour or 15-hour MA course and the medication skill checklist. -The Administrator was responsible for making sure all the staff qualifications and requirements were on file. _____ The failure of the facility to ensure 2 of 2 sampled medication aides (MA) who were administering medications had taken and completed the medication clinical skills competency validation checklist, completed medication aide training or had the MA employment verification was detrimental to the health and welfare to all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/22/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 6, 2023.	D 125		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes;	D 164	Going forward All Medication Aide will have All training that is required and monitor monthly by Bussiness Office and Administrator	Completed by 11/6/23

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D 164	Continued From page 7 (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff B) had completed training on the care of diabetic residents prior to administering insulin. The findings are: Review of facility's medication administration policies and procedures revealed the medication aides at the facility will be trained and the training documented and signed off by the administrator in the care of our diabetic residents in the areas of 1. Training: the facility shall ensure training on the care of residents with diabetes is provided by unlicensed staff prior to the administration of insulin by a registered nurse, registered pharmacist, or prescribing practitioner. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired on 09/18/23 as an MA. -There was no documentation of training for the	D 164		

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D 164	Continued From page 8 care of diabetic residents. Review of a resident's September 2023 medication administration record (MAR) revealed there was documentation Staff B checked the resident's FSBS 4 times and administered insulin 5 times from 09/20/23 through 009/22/23. Interview with Staff B on 09/22/23 at 11:00am revealed: -He had been an MA at the facility since September 18, 2023. -Since he started working at the facility, he had not received a training course related to the care of diabetic residents. -He observed the Administrator administer insulin injections a few times and then he administered insulin. Interview with the Administrator on 09/22/23 at 3:00pm revealed: -She was responsible for ensuring diabetic training was completed. -Staff B did not have the diabetic training course. -She instructed Staff B how to administer insulin. Interview with the current owner on 09/22/23 at 3:00pm revealed the Administrator was responsible for making sure the MAs had the required qualifications and training. Attempted interview with the current licensee on 09/22/23 at 1:36pm was unsuccessful.	D 164		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the	D 315		

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D 315	Continued From page 9 residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on interviews, record reviews and observations, the facility failed to ensure residents were offered activities designed to promote the residents' active involvement. The findings are: Review of the activities calendar in the main hallway area on 09/21/23 at 8:22am revealed: -The activities calendar for September 2023 was posted in large print on the bulletin board in the main hallway. -The September 2023 activities calendar had daily activities listed. -The activities scheduled for 09/21/22 were Bible Study from 3:30pm to 4:30pm and Movie Popcorn from 6:00pm to 8:00pm. -The activites scheduled for 09/22/23 were outting/shopping 9:00am to 11:30am and sight seeing from 1:00pm to 3:30pm. Observation of the living room area on 09/21/23 at 3:36pm to 4:30pm revealed: -There were two residents watching television (TV). -The bible study activity had not been announced to the residents. -There were two board games and several books under the TV stand.	D 315	Going forward Activities will be announced to all resident and encourge them of the Social Activities that is taken Place At the time, Administrator will monitor ON A monthly basic. Completed By: 11/06/23	

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D 315	Continued From page 10 Observation of the facility on 09/22/23 at 1:17pm revealed: -There was 3 resident seated in the living room area. -There were 2 residents seated in the smoking area of the building. -There was 1 resident in his room. -The outing/sight seeing activity was not announced. Interview with a resident on 09/21/23 at 9:30am revealed: -The residents only did a group activity which was an outing to the store about once a week. -The last activity was offered to the residents was about three months ago. -He liked to do activities but had not asked staff if activities would be offered. Interview with a second a resident on 09/22/23 at 10:39am revealed: -Residents did not have movie night and eat popcorn on 09/21/23. -Residents would go shopping but he would not always go. -Residents were not offered activities in the past two months in the facility. Interview with a medication aide (MA) on 09/22/23 at 10:46am revealed: -He had not completed activities with the residents. -He had not been trained to facilitate activities with the residents. Interview with the Transportation Coordinator on 09/22/23 at 11:05am revealed: -She took the residents shopping weekly. -She would shop for the residents who were not	D 315		

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D 315	Continued From page 11 able to go out shopping. -She would take the residents to restaurants when they would ask but it was not a scheduled activity. Interview with the Administrator on 09/22/23 at 11:00am revealed: -There were times when the bible study activity would be held at a sister facility. -She had not confirmed if the bible study activity scheduled for 09/21/23 was offered to the residents. -Not all of the residents had participated in the activities. -The current Owner was the Activites Director. -There was another MA who was responsilbe for facilitating the activities with the residents.	D 315		
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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to administer	D 358		

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D 358	Continued From page 12 medications as ordered to 1 of 3 sampled residents (#1) to include a medication to treat diabetes and an inhaled medication to treat chronic obstructive pulmonary disease (COPD). The findings are: Review of the facility's Medication Administration Policies and Procedures (undated) revealed: -The facility's contracted pharmacy's standard hours of operation are 9:00am to 5:00pm, Monday through Friday. -In the case of an emergency, the contracted pharmacy may be contacted to fill and deliver medications at any time. -Normal delivery would be between 6:00pm and 7:00pm, Monday through Friday. -Medications shall be administered per physician orders and shall be documented on the medication administration record (MAR) immediately after administration. -Medications shall be ordered when the medication card showed there was only an 8-day supply on hand. -The medication aide (MA) was responsible for filling out the refill/reorder request form. -The request form should be given to the Resident Care Coordinator (RCC) or Administrator before noon so it could be faxed to the pharmacy. -The medication would be delivered to the facility within __ business days (the number of days was left blank). -When a new medication was ordered, most physician's offices would electronically prescribe (e-scribe) the prescription. -If not escribed, the Administrator or RCC should fax the prescription to the pharmacy. Review of Resident #1's current FL-2 dated	D 358		

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D 358	Continued From page 13 01/12/23 revealed diagnoses included diabetes type 2 and COPD. Review of Resident #1's Resident Register dated 08/04/19 revealed an admission date of 04/01/19. a. Review of a physician's order sheet for Resident #1 dated 07/26/23 revealed a physician's order for Jardiance 10 mg tablet, take one tablet by mouth once daily in the morning for diabetes (a medication used to regulate blood sugar). Interview with Resident #1 on 09/21/23 at 8:56am revealed: -Staff administered the resident's medications. -He took injections and pills for diabetes. -The facility ran out his medication and it has taken several days to get medications in. Review of Resident #1's August 2023 medication administration records (MARs) revealed: -There was a printed entry for Jardiance 10mg tablet, take one tablet by mouth once daily in the morning for diabetes scheduled at 8:00am. -Jardiance 10mg was documented as administered 08/01/23 through 08/10/23 at 8:00am. -Initials were circled for Jardiance at 8:00am on 08/11/23 through 08/15/23. -There was documentation with circled initials on the MAR for 08/11/23, 08/12/23 and 08/14/23 and Jardiance was not administered due to medication being on order. -There was no documentation with circled initials on the MAR for 08/13/23 for the Jardiance 10mg at 8:00am -Jardiance 10mg was documented as administered 08/16/23 through 08/31/23 at 8:00am.	D 358	Going forward All new med Aide has had training on documentication of MAR's, Cart Audit in Place to be done on A weekly basic to ensure all medication is here, Facility will change Pharmacy as 11-01-2023 And on going train will be Provided for All med Aide, this will be monitor by All med Aide untill New Rec come on board And Administrator will monitor on A weekly basic Completed by: 11-06-23	

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D 358	Continued From page 14 Review of Resident #1's August 2023 Blood Sugar Monitoring Sheet revealed: -Finger stick blood sugar (FSBS) of 208 before breakfast on 08/11/23. -FSBS of 318 before dinner on 08/12/23. -FSBS of 208 before breakfast, 285 before dinner on 08/13/23. -FSBS of 200 before breakfast, and 199 before dinner on 08/14/23. -FSBS of 200 before breakfast, and 175 before dinner on 08/15/23. Observations of Resident #1's medications on hand on 09/22/23 at 12:00pm revealed there was a bubble card of Jardiance 10mg #30 dispensed on 09-08-23 with 24 tablets remaining. Interview with a medication aide (MA) on 09/21/23 at 9:33am revealed: -He had been employed at the facility for 1 week. -Medications were received in 30-day bubble packs. -The MAs re-ordered medications when they got to the blue line on the bubble pack, this meant the resident had 7 days of medication remaining. -The MAs completed a medication re-order sheet and gave it to the administrator. -The Administrator faxed the medication re-order sheets to the facility's contracted pharmacy. -He was not employed at the facility in August. -Medications usually arrived the same day or the following day. Interview with the facility's contracted pharmacy provider on 09/22/23 at 10:13am revealed: -90 tablets of Jardiance 10mg were dispensed to the facility on 03/24/23. -Jardiance 10mg #30 tablets were requested and delivered to the facility on 08/14/23.	D 358		

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D 358	Continued From page 15 -Jardiance 10mg #30 tablets were requested and delivered to the facility on 09/08/23. Interview with the Administrator on 09/21/23 at 9:38am revealed: -Medications were to be re-ordered 7 days prior to running out. -The MAs, Resident Care Coordinator (RCC) or the Administrator completed the medication re-order form with the resident's name and medication and faxed to the facility's contracted pharmacy and a fax confirmation was kept. -The contracted pharmacy delivered medications the same day in the evening or the next day if the re-order form was faxed late in the day -The RCC was responsible for ensuring the resident's medications were on the medication cart. -The RCC should have reviewed Resident #1's August MAR for gaps and omissions. -The RCC resigned 09/01/23. -There had been on-going issues with getting medications from the facility's contracted pharmacy in a timely manner. -She expected medications to be re-ordered and available for the residents. -She expected medications to be administered as ordered. -The facility could not use their backup pharmacy to order medications without a prescription. Interview with Resident #1's Primary Care Provider on 09/22/23 at 1:05pm revealed: -She treated Resident #1 with Jardiance for diabetes. -She was not notified that Resident #1 was out of Jardiance for 5 days in August. -She knew at times there were shortages of Jardiance and had she known Resident #1 was out of the Jardiance or if they were having trouble	D 358		

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D 358	Continued From page 16 getting Jardiance, she could have changed Resident #1's medication. -She would be concerned about possible elevated blood sugar with 5 consecutive missed days of Jardiance. -She expected the residents to receive their medications as ordered. b. Review of a physician's order sheet for Resident #1 dated 07/26/23 revealed a physician's order for budesonide 0.5mg/2ml suspension, inhale contents of 1 vial by mouth via nebulizer every 12 hours, morning, and bedtime, scheduled at 8:00am and 8:00pm (budesonide is used to treat COPD and asthma by reducing swelling or inflammation the airways). Interview with Resident #1 on 09/21/23 at 8:56am revealed -He used his nebulizer twice daily. -The facility ran out of his nebulizer medication. -The facility had been out of the nebulizer medication for the past week. -He used his albuterol inhaler more often when he was unable to receive his nebulizer treatment. -He had an albuterol inhaler in his room. -He denied shortness of breath. Review of Resident #1's July 2023 MAR revealed: -There was an entry for budesonide 0.5mg/2ml, inhale contents of 1 vial by mouth via nebulizer every 12 hours morning and night, scheduled at 8:00am and 8:00pm. -There was documentation budesonide was administered 07/01/23 to 07/21/23 at 8am and 8:00pm. -Initials were circled for budesonide on 07/23/23 at 8:00am and 8:00pm, and on 07/24/23 through 07/26/23 at 8:00am. -There was documentation that budesonide	D 358		

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D 358	Continued From page 17 0.5mg/2ml was not administered on 07/22/23 at 8:00am, on 07/24/23 at 8:00am and 8:00pm, and on 07/25/23 at 8:00am due to medication being on order. -There was documentation budesonide was administered on 07/27/23 through 07/31/23 at 8:00am and 8:00pm. Review of Resident #1's September 2023 MAR revealed: -There was a handwritten entry for budesonide inhalation suspension 0.5mg/2ml, use 1 vial via nebulizer every 12 hours scheduled for 8am and 8pm. -There was no documentation for the administration of budesonide on 09/01/23 through 09/04/23 at 8:00am and 8:00pm. -There was documentation of the administration of budesonide on 09/05/23 through 09/18/23 at 8:00am and 8:00pm and on 09/19/23 at 8:00am. -There was no documentation for the administration of budesonide on 09/19/23 at 8:00pm and 09/20/23 at 8:00am and 8:00pm and 09/21/23 at 8:00am. Observation of Resident #1's medication on hand on 09/21/23 at 9:33am revealed there was no budesonide on the medication cart. Interview with the MA on 09/21/23 at 9:33am revealed: -He had worked at the facility for 1 week. -When residents were getting low on medications, he completed a medication order sheet and notified the Administrator. -The budesonide had been ordered. Interview with a 2nd MA on 09/21/23 at 9:34am revealed she last administered budesonide to Resident #1 at 8:00pm on 09/19/23 and Resident	D 358		

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D 358	Continued From page 18 #1 had been out of budesonide since. Interview with a pharmacist with the facility's contracted pharmacy on 09/22/23 at 10:13am revealed: -Budesonide #120 vials for a 30-day supply was last dispensed on 06/22/23. -There was a shortage of budesonide in July, August and September 2023 and the budesonide prescription was transferred to a local retail pharmacy. Interview with a pharmacist at the local retail pharmacy on 09/22/23 at 10:29am revealed: -The original prescription was written on 02/10/23 and was transferred to them on 07/25/23. -Budesonide was dispensed on 07/25/23 for #120 vials for 30-day supply. -Budesonide was last dispensed and delivered on 09/21/23 for #120 vials for a 30-day supply. -The facility was not on automatic refill. -She was not sure who contacted the pharmacy for the refill. Observation of Resident #1's medication on hand on 09/21/23 at 3:29pm revealed there were 2 boxes of budesonide inhalation suspension containing #30 vials each labeled from the local retail pharmacy. Interview with the Administrator on 09/21/23 at 9:38am revealed: -The MAs, Resident Care Coordinator (RCC) or the Administrator completed the medication re-order form with the resident's name and medication and faxed to the facility's contracted pharmacy and a fax confirmation was kept. -The contracted pharmacy delivered medications the same day in the evening or the next day if the re-order form was faxed late in the day	D 358		

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D 358	Continued From page 19 -The RCC was responsible for ensuring the resident's medications were on the medication cart. -The RCC resigned 09/01/23. -There had been on-going issues with getting medications from the facility's contracted pharmacy in a timely manner. -She ordered budesonide on 09/11/23. -She had been calling the facility's contracted pharmacy and was told the budesonide had been sent. -She faxed the request for budesonide every other day to the contracted pharmacy but did not receive fax confirmation and called the contracted pharmacy twice per week. -Resident #1's primary care provider (PCP) was in the facility on 09/20/23 and she requested a new prescription for budesonide be sent to a local retail pharmacy. -She texted the contracted pharmacy again this and was told the budesonide would be sent today. -Medications were to be re-ordered 7 days prior to running out. -She expected medications to be re-ordered and available for the residents. Interview with Resident #1's PCP on 09/22/23 at 1:05pm revealed: -She treated Resident #1 with budesonide for COPD. -She was not notified that Resident #1 had been out of budesonide in July 2023 and September 2023. -Resident #1 continued to smoke and it was important for him to receive nebulizer treatments due to the potential for wheezing. -She expected to be contacted if there was a supply issue and she would have changed to medication to something more readily available.	D 358		

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D 358	Continued From page 20 Refer to TAG 125 .0403(a) Qualifications of Medication Staff.	D 358		
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 1 medication aide (MA), observed during the 8:00am medication pass on 09/22/23, who did not sanitize his hands or change gloves 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 undated Personal Protective Equipment (PPE) Policy and Procedures revealed: -Wearing gloves and changing them between patient contact does not replace the need for hand washing. Failure to change gloves between patient contact is an infection control hazard. -Hand hygiene is the cornerstone of preventing	D 371	Going forward All staff will continue training on Infection Control along with hand washing, this will be monitor by Reg med aide on a weekly basic and Administrator will monitor on a weekly basic while doing WALK through of the facility. Completed by: 11-06-23	

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D 371	Continued From page 21 infection transmission. -You should perform hand hygiene immediately after removing PPE. -If your hands become visibly contaminated during the PPE removal, wash hands before continuing to remove PPE. -Wash your hands thoroughly with soap and warm water or, if soap and water are not immediately available, use an alcohol-based hand sanitizer until hands can be washed with soap and warm water. Observation of the medication aide (MA) on 09/22/23 between 7:05am and 7:50am revealed: -The MA was gloved and at the medication cart in the facility hallway. -There was a bottle of alcohol-based hand sanitizer on the top of the medication cart. -The MA prepared medications for a resident by punching the medication from the bubble cards into his hand and placed the medication in a medication cup. -He used his key to lock the medication cart. -He administered the prepared medications to a resident and returned to the medication cart. -He documented on the paper Medication Administration Record (MAR) using an ink pen. -He used his key to unlock the medication cart. -He did not remove the gloves, wash his hands, or use hand sanitizer. -He pulled medication cards for a second resident. -He prepared the medications for the second resident by punching the medications from the bubble cards into his hand and placed the medications in a medication cup. -He locked the medication cart with his key. -He administered the prepared medications to the second resident and returned to the medication cart.	D 371		

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D 371	Continued From page 22 -He documented on the paper MAR using an ink pen. -He did not remove the gloves, wash his hands, or use hand sanitizer. -He used his key to unlock the medication cart. -He pulled medication cards for a third resident -He prepared the medications for the third resident by punching the medications from the bubble pack into his hand and placed in a medication cup. -He used his key to lock the medication cart. -He administered the prepared medications to the third resident and returned to the medication cart. -He documented on the paper MAR using an ink pen. -He did not remove the gloves, wash his hands, or use hand sanitizer. Interview with the MA on 09/22/23 at 10:49am revealed: -He was hired as an MA on 09/18/23. -He was trained by the Administrator and another MA. -He knew he was to change gloves and/or use hand sanitizer or wash his hands when is gloves became contaminated. -He was nervous and forgot to change his gloves this morning. -He had not had an infection control course at the facility. -He was told to study the on-line medication aide course. -A nurse was supposed to be here later today to do training with him. Interview with the Administrator on 09/22/23 at 8:58am: -The MAs may use gloves or hand sanitizer. -If the MA elected to wear gloves, they were to change gloves between each resident.	D 371		

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D 371	Continued From page 23 -If not using gloves, MAs were to use hand sanitizer or wash hands between each resident. -The Licensed Health Professional Support (LHPS) nurse trained new employees on hand hygiene and was scheduled to come soon. -She thought the LHPS nurse did infection control training every 6 months. -The current MA started about one week ago. -She trained him and instructed him to change gloves between each resident or to hand sanitizer or to wash his hands between each resident. -MAs should wash their hands before and after using gloves. -She expected all staff to use proper hand hygiene. Refer to TAG 125 .0403(a) Qualifications of Medication Staff.	D 371		