STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	R 11/29/2023

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FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on November 28, 2023 and November 29, 2023.	{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: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled medication aides (MA) (Staff B) had validation of a Medication Aide Clinical Skills Competency Validation Checklist prior to administering medications. The findings are: Observation of the morning medication pass on 11/29/23 at 8:25am revealed Staff B administered 5 oral medications, a topical creme, a nasal spray, and an eye drop to a resident. Review of Staff B's personnel record revealed: -Staff B was hired through a contracted staffing agency as a medication aide (MA). -Staff B did not have a hire date.	{D 125}		

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{D 125}	Continued From page 1 -Staff B was listed on the State's Medication Aide Registry for 12/07/2019 till 11/30/2025. -Staff B had taken and passed the State written MA examination on 09/25/14. -There was no documentation Staff B completed a Medication Aide Clinical Skills Competency Validation checklist. Interview with Staff B on 11/29//23 at 3:00pm revealed: -She was employed by a staffing agency and working at the facility through the agency. -She had administered medication to residents on 12/29/23 at 8:00am and 12:00pm noon. -She had been a MA at various facilities since 2014. -The employment agency had her complete an agency medication aide competency questionnaire on-line that identified areas of medication administration she had been trained to perform. -She had not completed a Medication Aide Clinical Skills Competency Validation checklist at the facility prior to administering medications. -She was not aware she needed a Medication Aide Clinical Skills Competency Validation checklist specific to the facility. -She thought the staffing agency completed all required training and competencies prior to sending her to work at the facility. Review of a resident's November 2023 electronic medication administration record (eMAR) revealed there was documentation Staff B administered medication on 11/29/23. Interview with the Business Office Manager (BOM) on 011/29/23 at 3:25pm revealed: -She started work as the BOM at the facility a 4 years ago.	{D 125}		

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{D 125}	Continued From page 2 -She kept the training requirements and documents for facility staff in her office. -The Director of Resident Care (DRC) was responsible for ensuring MA staff qualifications, including Medication Aide Clinical Skills Validation checklist, were completed and providing documentation for the BOM to file in personnel records. -The facility used a staffing agency contracted by the Corporate Office to provide MA staffing services. -The BOM was informed by corporate representatives that the staffing agency was responsible to ensuring all MA qualifications were completed prior to sending MA staff to work at the facility. -She had not checked if Staff B had a Medication Aide Clinical Skills Competency Validation checklist completed prior to administering medications at the facility. Interview with a corporate Nurse on 11/29/23 at 4:00pm revealed: -The corporate procedure was the DRC was responsible to ensure all MAs had completed competencies, including the 5, 10 or 15-hour MA training if there was no documentation for previous completion prior to administering medications to residents. -The facility had experienced staff turnover with the DRC position with 2 different DRC nurses since January 2023. -The facility had a DRC on site, but she had been hired one week ago and was in training/orientation. -The facility had no documentation the staffing agency had a Medication Aide Clinical Skills Competency Validation checklist completed for Staff B.	{D 125}		

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{D 125}	Continued From page 3 Interview with the DRC on 11/29/23 at 4:00pm revealed: -She had been working at the facility one week. -She had not audited any staff qualifications as of yet, but would create a system for ensuring all medication aides, including staff from the contracted staffing agency, had the required qualifications prior to administering medications. Interview with the Interim Executive Director (ED) on 11/29/23 at 4:20pm revealed: -All MAs were required to have the required competencies and training before administering medications. -She was serving as the Interim ED and did not have a system in place to routinely audit MA staff records for completeness. -The DRC was responsible for verifying MA staff qualification or completing necessary training. -She was instructed by corporate staff that the contracted staffing agency was responsible to only send qualified staff to administered medications.	{D 125}		
{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 CONTINUING TYPE B	{D 358}		

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{D 358}	Continued From page 4 VIOLATION Based on these findings, the previously Unabated Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#2) related to mealtime insulin not administered as ordered. The findings are: Review of Resident #2's current FL-2 dated 07/30/22 revealed diagnoses included dementia and Type II diabetes. Review of Resident #2's signed physician's orders dated 11/14/23 revealed: -There was an order for fingerstick blood sugar (FSBS) checks before meals and at bedtime. -There was an order for Humalog insulin (a rapid acting insulin) 100 units/ml inject 5 units subcutaneously (SQ) before meals. Review of Resident #2's subsequent physician's order dated 11/17/23 revealed an order to hold Humalog if FSBS is less than 150 before a meal. Review of Resident #2's November 2023 medication administration record (MAR) from 11/18/23 to 11/28/2395 revealed: -There was a pre-printed entry for check FSBS before meals and at bedtime. -There was a pre-printed entry to administer Humalog 5 units before meals. -There was a handwritten entry for hold Humalog if FSBS less than 150 before meal on a separate page of the MAR.	{D 358}		

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{D 358}	Continued From page 5 -There were 27 opportunities for FSBS values obtained before meals documented from 11/18/23 to 11/28/23. -The FSBS value documented before meals ranged from 95 to 194. -There were 23 FSBS values documented less than 150 before meals from 11/18/23 to 11/28/23 at 7:30am -There were 8 of 23 opportunities when Humalog 5 units before a meal was documented as administered but should have been held for a FSBS value less than 150. -Examples of FSBS values obtained before meals less than 150 included: -On 11/18/23 at 6:35am, FSBS was 101 and Humalog 5 units was documented as administered but should have been held. -On 11/18/23 at 11:30am, FSBS was 123 and Humalog 5 units was documented as administered but should have been held. -On 11/18/23 at 4:30pm, FSBS was 141 and Humalog 5 units was documented as administered but should have been held. -On 11/22/23 at 6:30am, FSBS was 122 and Humalog 5 units was documented as administered but should have been held. -There were no FSBS values documented less than 95 before meals and at bedtime from 11/18/23 to 11/28/23. Interview with Resident #2's primary care provider (PCP) on 11/28/23 at 3:30pm revealed: -She had been adjusting Resident #2's insulin due to decreasing FSBS values. -On 11/17/23, she had ordered for Humalog 5 units before meals to be held if the FSBS was less than 150 and decreased the residents nightly long-acting insulin dose. -Resident #2's FSBS values, when taken after Humalog doses were not held were low enough	{D 358}		

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{D 358}	Continued From page 6	{D 358}		

to cause her concern for potential hypoglycemia (sweating, shaking/trembling, loss of consciousness) symptoms.
-She expected medication aides (MA) to administer medications as ordered and to be holding Humalog 5 units before meals if FSBS values were less than 150.
-She was not aware until she came today that Resident #2 was administered Humalog 5 units with a meal when the dose should have been held.

Interview with the Director of Resident Care (DRC) on 11/29/23 at 3:50pm revealed:
-She had been working at the facility for one week.
-MAs should be reading the MARs completely and administering medications as ordered.
-She did not know Resident #2's Humalog 5 units before meals, hold for FSBS less than 150, was not administered correctly for 8 doses.
-She had not audited any resident records yet but would create a system for ensuring residents' medications were administered as ordered including medications with administration parameters like Resident #2's Humalog insulin.

Attempted telephone interview on 11/29/23 at 4:10pm with the medication aide who documented administration of Humalog insulin before breakfast and lunch on 11/18/23 for FSBS values less than 150 was unsuccessful.

Interview with the Interim Executive Director (ED) on 11/29/23 at 4:30pm revealed:
-She had not monitored residents' medications for accurate administration in a couple of months.
-The DRC was responsible for ensuring that medications were administered as ordered.
-The current DRC had been in the position for

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{D 358}	Continued From page 7 one week. Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable.	{D 358}		