STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSS ROAD RETIREMENT COMMUNITY	1302 OLD COX ROAD ASHEBORO, NC 27203

(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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 12/05/23 to 12/07/23.	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: Based on interviews and record reviews, the facility failed to ensure 3 of 6 sampled staff (D, E, F) who administered medications had completed the state approved 5-hour and 10-hour or 15-hour medication aide (MA) training courses as required. The findings are: 1. Review of Staff D's personnel record revealed: -Staff D was hired as a medication aide (MA) on 09/14/21. -There was documentation Staff D completed the medication administration clinical skills validation checklist on 07/06/21. -There was documentation Staff D passed the MA written exam on 03/28/18. -There was no documentation Staff D completed the state-approved 5 and 10, or 15-hour MA	D 125		

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	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

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D 125	Continued From page 1 training course. Interview with Staff D on 12/07/23 at 2:31pm revealed: -The previous Human Resources Director (HRD) gave him a book to study to take the medication aide test. -He was checked off on his skills by the Registered Nurse (RN). -He thought the previous HRD provided the certificate for the MA training. Refer to the interview with the Human Resources Director (HRD) on 12/07/23 at 2:00pm. Refer to the interview with the current Registered Nurse (RN) on 12/07/23 at 2:42pm. Refer to the interview with the previous RN on 12/07/23 at 2:53pm. Refer to the interview with the Administrator on 12/07/23 at 3:45pm. 2. Review of Staff E's personnel record revealed: -Staff E was hired as a medication aide (MA) on 12/05/22. -There was documentation Staff E completed the medication administration clinical skills validation checklist on 04/20/23. -There was documentation Staff E passed the MA written exam on 03/28/18. -There was no documentation Staff E completed the state-approved 5 and 10, or 15-hour MA training course. Interview with Staff E on 12/07/23 at 2:35pm revealed: -She took the MA training course at another facility in 2014.	D 125		

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	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

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D 125	Continued From page 2	D 125		

-She did not recall who taught the MA training course in 2014.
-She thought she had a certificate at her house, but she did not recall giving a copy to the facility when she was hired.
-She remembered taking a refresher course when she was hired in December 2022, but she did not recall receiving a certificate.

Refer to the interview with the Human Resources Director (HRD) on 12/07/23 at 2:00pm.

Refer to the interview with the current Registered Nurse (RN) on 12/07/23 at 2:42pm.

Refer to the interview with the previous RN on 12/07/23 at 2:53pm.

Refer to the interview with the Administrator on 12/07/23 at 3:45pm.

3. Review of Staff F's personnel record revealed:
-There was documentation Staff F completed the medication administration clinical skills validation checklist on 11/12/19.
-There was documentation Staff F passed the MA written exam on 09/25/19.
-There was no documentation Staff F completed the state-approved 5 and 10, or 15-hour MA training course.

Attempted telephone interview with Staff F on 12/07/23 at 3:07pm was unsuccessful.

Refer to the interview with the Human Resources Director (HRD) on 12/07/23 at 2:00pm.

Refer to the interview with the current Registered Nurse (RN) on 12/07/23 at 2:42pm.

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	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

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D 125	Continued From page 3 Refer to the interview with the previous RN on 12/07/23 at 2:53pm. Refer to the interview with the Administrator on 12/07/23 at 3:45pm. _____ Interview with the Human Resources Director (HRD) on 12/07/23 at 2:00pm revealed: -She was responsible for the personnel records for all employees of the facility. -She did not realize each MA needed a certificate for completing the medication aide training course filed in their personnel file. Interview with the current Registered Nurse (RN) on 12/07/23 at 2:42pm revealed: -She did not teach the medication aide training course for the facility. -She did not complete or sign certificates for completion of the medication aide training course. Interview with the previous RN on 12/07/23 at 2:53pm revealed: -She taught the medication aide training course for the facility but had not done so in several months. -She taught the 15-hour course and provided a certificate to the MAs once the class was completed. -The MAs were responsible for providing the certificate of completion to the facility. Interview with the Administrator on 12/07/23 at 3:45pm revealed: -The HRD was responsible for maintaining the personnel records. -He did not know if the MAs brought the 15-hour certificate that verified completion on the medication training course and gave it to the HRD.	D 125		

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	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

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D 125	Continued From page 4 -He expected the personnel records to be complete, including the medication aide training course certificate of completion.	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: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 7 sampled residents (#1) who had two supplemental medications for fiber. The findings are: 1. Review of Resident #1's FL-2 dated 01/19/23 revealed diagnoses included acute respiratory failure with hypokalemia, pneumonia due to Covid, hypertension, diabetes, dementia, and chronic pain. a. Review of Resident #1's signed physician orders dated 09/01/23 revealed there was an order for fiber 1 tablespoon daily. Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

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D 358	Continued From page 5	D 358		

-There was an entry for fiber 1 tablespoon mixed in beverage of choice every evening with a scheduled administration time of 8:00pm.
-There was documentation fiber was administered each evening from 10/01/23 to 10/31/23.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for fiber 1 tablespoon mixed in beverage of choice every evening with a scheduled administration time of 8:00pm.
-There was documentation fiber was administered each evening from 11/01/23 to 11/24/23 and on 11/30/23.
-There was an exception documented from 11/25/23 to 11/29/23; the exception was resident was in the hospital.

Review of Resident #1's December 2023 eMAR from 12/01/23 to 12/04/23 revealed:
-There was an entry for fiber 1 tablespoon mixed in beverage of choice every evening with a scheduled administration time of 8:00pm.
-There was documentation fiber was administered each evening from 12/01/23 to 12/04/23.

Observation of Resident #1's medication on hand on 12/06/23 @ 11:43am revealed:
-There was one bottle of 236 grams of fiber dispensed on 10/10/23.
-There was a date handwritten on the bottle top of 10/15/23.
-The bottle of fiber was ¾ empty.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/07/23 at 8:45am revealed:
-There was one 236-gram bottle of fiber on the

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 358	Continued From page 6	D 358		

medication cart that was ¾ empty.
-The dispensed date on the bottle of fiber was 10/10/23.
-There was a handwritten date on the top of the bottle of fiber dated 10/15/23.
-The pharmacy dispensed one 236-gram bottle of fiber on 2/27/23, 03/16/23, and 10/10/23.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 12/07/23 at 3:03pm revealed one 236-gram bottle of fiber would last 41 days if Resident #1 was receiving a tablespoon daily.

Interview with the Supervisor on 12/07/23 at 10:32am revealed:
-It appeared that the medication was not being administered as ordered.
-The date on the top of the bottle (10-15-23) was the date the bottle of medication was opened.

Attempted interview with Resident #1 on 12/07/23 at 10:30am unsuccessful.

Refer to the interview with the Resident Care Director (RCD) on 12/07/23 at 10:03am.

Refer to the interview with the Administrator on 12/07/23 at 11:00am.

b. Review of Resident #1's signed physician orders dated 09/01/23 revealed there was an order for one Metamucil one pack daily.

Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for one packet of Metamucil as directed every morning with a scheduled administration time of 8:00am.

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 358	Continued From page 7	D 358		

-There was documentation Metamucil was administered each morning from 10/01/23 to 10/13/23, 10/15/23 to 10/23/23, and from 10/25/23 to 10/31/23.
-There were exceptions documented on 10/14/23 and 10/24/23; the exception was the resident was out of the facility and the resident refused.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for one packet of Metamucil as directed every morning with a scheduled administration time of 8:00am.
-There was documentation Metamucil was administered each morning on 11/01/23, and from 11/03/23 to 11/24/23.
-There were exceptions documented on 11/02/23 and from 11/24/23 to 11/30/23; the exception was the resident refused and the resident was hospitalized.

Review of Resident #1's December 2023 eMAR from 12/01/24 to 12/04/23 revealed:
-There was an entry for one packet of Metamucil as directed every morning with a scheduled administration time of 8:00am.
-There was documentation Metamucil was administered each morning from 12/01/23 to 12/05/23.

Observation of Resident #1's medication on hand on 12/06/23 at 11:43am revealed:
-There were two boxes of Metamucil on the medication cart.
-The first box contained 9 of 30 individual packs of Metamucil with a dispensed date of 09/19/23.
-There was a handwritten date of 09/23/23 written on the box of Metamucil.
-The second box contained 28 of 30 individual packs of Metamucil with a dispensed date of

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D 358	Continued From page 8 11/07/23. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 12/07/23 at 8:45am revealed: -The pharmacy had an order for Metamucil one pack daily. -The pharmacy dispensed 30 packs on 07/16/23, 10/17/23, and 11/07/23. Interview with a medication aide on 12/07/23 at 9:36am revealed: -Resident #1 did not refuse her Metamucil when she administered Resident #1 her medications. -She did not know why Metamucil was not dispensed every month. -She did not know why there were extra Metamucil packs remaining based on dispensed dates. Interview with the Supervisor on 12/07/23 at 10:32am revealed: -It appeared the medication was not administered as ordered. -The MAs should administer the medications as ordered. Attempted interview with Resident #1 on 12/07/23 at 10:30am unsuccessful. Refer to the interview with the Resident Care Director (RCD) on 12/07/23 at 10:03am. Refer to the interview with the Administrator on 12/07/23 at 11:00am. _____ Interview with the Resident Care Director (RCD) on 12/07/23 at 10:03am revealed: -She did not know why there was extra medication on hand.	D 358		

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	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

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D 358	Continued From page 9 -Medication should be administered as ordered. -Medication carts were audited quarterly by the pharmacy and by the MA's if there was time. -Medication cart audits consisted of removing expired and discontinued medications and ensuring all the medications on the eMAR were in the medication cart. -Sometimes the Supervisor would do medication cart audits. Interview with the Administrator on 12/07/23 at 11:00am revealed: -The MAs should administer medications as ordered. -The MAs need to slow down and pay attention to what they are doing.	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 and interviews, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA) who administered eye drops, checked a fingerstick blood sugar (FSBS), and administered insulin and failed to wash her hands with soap and water before and after donning and doffing gloves. The findings are:	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 371	Continued From page 10 Review of the facility's Medication Administration policy revealed: -Gloves were to be worn during blood glucose monitoring. -Gloves that had touched potentially blood-contaminated objects or finger stick wounds were to be changed before touching clean surfaces. -An alcohol-based hand rub should be used between each resident finger stick. -When administering eye drops, the MA should remove gloves and clean their hands. -When administering insulin, the MA should remove gloves and clean their hands. Observation of the MA administering medications during the 9:00am medication pass on 12/06/23 between 8:13am and 8:45am revealed: -The MA prepared 11.5 pills for administration. -The MA was observed handling several of the pills with her bare hands. -The MA donned gloves and administered an eye drop to a resident. -The MA doffed the gloves and prepared medications for a second resident without washing or sanitizing her hands. -The MA donned gloves to administer eye drops to a second resident. -The MA administered eye drops to the second resident, doffed her gloves, and continued to administer medications without washing or sanitizing her hands. Observation of the MA during the 12:00pm medication pass on 12/06/23 at 11:29am revealed: -The MA prepared a resident's glucometer for a FSBS check. -The MA donned gloves and checked a resident's	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 371	Continued From page 11	D 371		

FSBS.
-The MA returned to the medication cart and prepared the resident's insulin pen for administration.
-The MA administered insulin to the resident.
-The MA did not change gloves or wash her hands between the FSBS check and the insulin administration.

Interview with the MA on 12/06/23 at 2:16pm revealed:
-She should have removed her gloves, sanitized her hands, and donned another set of gloves before she administered insulin.
-She should have washed her hands before and after donning gloves when checking FSBS, administering insulin and eye drops.
-She should have put on gloves instead of touching the pills with her bare hands.
-Hand washing should be done immediately after removing gloves.
-Hands were sanitized to decrease the chance of spreading infection.

Interview with the Resident Care Director (RCD) on 12/06/23 at 2:40pm revealed:
-The MAs should wash their hands with soap and water after every 3 residents.
-The MAs should wash or sanitize their hands before and after administration of eye drops, FSBS checks, and administration of insulin.
-The MAs should wash their hands before and after donning and doffing gloves.
-Hands washing decreases the spread of infection from resident to resident.

Interview with the Administrator on 12/06/23 at 3:30pm revealed:
-He was concerned about the spread of infection throughout the facility.

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	HAL076003	A. BUILDING: _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 371	Continued From page 12 -He expected the staff to wash and sanitize their hands per the policy.	D 371		