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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey April 16-18, 2024.	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 2 of 3 sampled staff (Staff A and Staff C) who were administering medications had completed the state approved medication administration training courses (Staff C) or the medication aide skills checklist (Staff A) as required. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired as a medication aide (MA) on 01/01/23. -There was no documentation of a medication administration clinical skills competency validation checklist completed for Staff A. Review of residents' February 2024 electronic medication administration records (eMARs)	D 125	Pertaining to 10A NCAC 13F .0403(a) Qualificationsof Medication Staff Measures we have put into place to correct the deficient practice is that we have completed a Medication Administration clinical skills competency validation checklist for staff A and we have removed staff C from the Med Cart until we can put her through our Med Tech class and have her complete the 5/10/15 hour training course at our community. Measures that are in place To prevent this happening going forward, we have implemented that every Med Tech hired, regardless of training and documentation, that we will put them through our Med Tech training to have our documentation in place before they are allowed to pass meds in the community. We will also ensure that all skills are are verified by our RN/HWD with a Med Admin clinical skills competency checklist as well before going on the Med Cart. We will also ensure that each staff member that goes through the Med Tech class schedules their exam within the first week of completing the class.This will be monitored by the HWD and BOM which will audit employee files, specifically Med Techs, every 3 months to ensure all documentation is in place.This plan was implemented 4/19/24.	4/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bobby E. Dillard AA, CD | TITLE: Executive Director | (X6) DATE: 5/13/24

Reviewed and acknowledged on 05/13/24 by JL

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revealed Staff A documented the administration of medications to residents on 02/02/24, 02/03/24, 02/06/24, 02/09/24, 02/12/24, 02/16/24, 02/27/24, 02/20/24, 02/22/24, 02/23/24, 02/25/24, and 02/03/26 at 6:00am.

Review of residents' March 2024 eMARs revealed:
-Staff A documented the administration of medications to residents on 03/06/24, 03/10/24, 03/13/24, 03/20/24, 03/22/24, 03/23/24 and 03/29/24 at 5:00pm.
-Staff A documented the administration of medications to residents on 03/08/24 and 03/25/24 at 9:00pm.

Review of residents' April 2024 eMARs revealed:
-Staff A documented the administration of medications to residents on 04/02/24 - 04/13/24, 04/16/24, 04/17/24, and 04/18/24 at 6:00am.
-Staff A documented the administration of medications to residents on 04/17/24 at 5:00pm.
-Staff A documented the administration of medications to residents on 04/05/24, 04/08/24, 04/14/24, and 04/15/24 at 7:00pm.
-Staff A documented the administration of medications to residents on 04/05/24, 04/08/24, 04/12/24, 04/14/24, and 04/15/24 at 8:00pm.

Interview with the Executive Director on 04/18/24 at 11:00am revealed:
-The Business Office Manager (BOM) was responsible for checking personnel files to make sure all staff qualifications were completed and on file.
-Staff A completed the medication administration clinical skills competency validation checklist when the previous Health and Wellness Director was employed at the facility.
-He was not sure why that documentation was not

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in Staff A's personnel record.

Attempted telephone interview with Staff A on 04/18/24 at 11:10am was unsuccessful.

Attempted telephone interview with the BOM on 04/18/24 at 11:05am was unsuccessful.

2. Review of Staff C's personnel record revealed:
-Staff C was hired as a medication aide (MA) on 10/18/23.
-There was documentation that Staff C passed the MA written exam on 06/27/18.
-There was no certificate documenting Staff C successfully completed the 5-hour, 10-hour, or 15-hour state approved medication administration training courses at this facility

Review of residents' February 2024 electronic medication administration records (eMARs) revealed Staff C documented the administration of medications to residents on 02/10/24, 02/11/24, 02/21/24, 02/24/24, 02/25/24, and 02/28/24 at 7:00pm and 9:00pm.

Review of residents' March 2024 eMARs revealed Staff C documented the administration of medications to residents on 03/06/24, 03/10/24, 03/13/24, 03/20/24, 03/22/24, 03/23/24, 03/24/24, and 03/25/24 at 9:00pm.

Review of residents' April 2024 eMARs revealed Staff C documented the administration of medications to residents on 04/02/24, 04/06/24, and 04/07/24 at 5:00pm, 7:00pm, 8:00pm, and 9:00pm.

Interview with the Executive Director on 04/18/24 at 11:00am revealed:
-The Business Office Manager (BOM) was

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D 125	Continued From page 3 responsible for checking personnel files to make sure all staff qualifications were completed and on file. -The facility did not hire personnel directly into a MA position without the paperwork documenting the completion of the state approved medication administration training course. -He was not sure why that documentation was overlooked before hiring Staff C. -He thought Staff C had completed the 15-hour state approved medication administration training course at another facility, but he could not find a certificate. -Staff C had not completed the 5-hour, 10-hour, or 15-hour state approved medication administration training courses at this facility because she had already completed it at another facility. Attempted telephone interview with the BOM on 04/18/24 at 11:05am was unsuccessful	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 interviews and record reviews, the facility failed to ensure timely implementation of physician's orders for 1 of 5 sampled residents (#4) related to an order for collection of a stool	D 276	Pertaining to 10A NCAC 13F .0902(c)(3-4) Health Care Measures we have put in place to correct the deficient practice are to put the collection of a specimen as an order into our med administration system that will not dropoff until it is collected. The measures put into place to avoid this happening again is to have the order monitored daily by HWD/HWC to ensure it is collected. If unable to collect the specimen, the MD will be notified up to sending the resident out to get the specimen. We will also instruct all staff to document every attempt at collecting a specimen. This plan is effective 5/1/24.	

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specimen.

The findings are:

Review of Resident #4's current FL2 dated 01/24/24 revealed diagnoses included Alzheimer's dementia with agitation, osteoarthritis, blindness, hypertension, and carotid artery stenosis.

Review of Resident #4's primary care provider (PCP) triage note dated 03/12/24 revealed a diagnosis of diarrhea and an order for a gastrointestinal (GI) specialist referral.

Review of Resident #4's facility progress note dated 03/13/24 revealed Resident #4 had an appointment with a GI specialist on 03/25/24.

Review of Resident #4's physician/healthcare provider visit form dated 03/25/24 revealed there was an order to check stool for clostridium difficile and culture (Clostridium difficile is a bacteria which causes diarrhea and inflammation in the colon).

Review of Resident #4's facility progress notes dated 03/25/24 to 04/15/24 revealed:
-On 03/25/24, Resident #4 returned from an appointment with an order to collect a stool sample.
-On 03/31/24, the Resident Care Coordinator (RCC) was unable to collect the stool specimen due to the sample being watery.
-On 04/12/24, the Health and Wellness Coordinator (HWC) documented the GI specialist's office contacted the facility and inquired if the facility could do a rectal swab to collect the specimen.
-On 04/12/24, the HWC documented the GI

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specialist's office was informed the facility could not do the rectal swab.
-On 04/15/24, Resident #4's family member arranged transportation to a medical appointment.
-There was no other documentation related to attempts to collect the stool specimen.
-There was no documentation of the facility contacting the GI specialist regarding attempts to collect the stool specimen.

Review of Resident #4's record on 04/16/24 revealed there were no stool culture results available for review.

Review of Resident #4's laboratory report dated 04/17/24 revealed that Resident #4's stool culture was negative for clostridium difficile and other pathogens.

Interview with Resident #4's family member on 04/17/24 at 3:20pm revealed:
-Resident #4 was admitted to the facility in January 2024.
-Resident #4 started having an increase in loose stools around the time she moved into the facility.
-The GI specialist ordered a stool specimen to determine what was causing Resident #4's loose stools and stomach pain.
-When Resident #4's family members inquired about the stool specimen and the results with different staff members at the facility, there seemed to be confusion about who was responsible for collecting the specimen.
-The facility did not collect the stool specimen, so the family arranged transportation to the GI specialist's office on 04/15/24, and the stool specimen was collected at the appointment.

Interview with a personal care aide (PCA) on

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D 276	Continued From page 6 04/17/24 at 11:36am revealed: -Resident #4 always had loose, watery stools. -Resident #4 required assistance of 2 staff members for toileting. -She assisted a medication aide (MA) 2 times with attempting to collect Resident #4's stool specimen. -She and the MA placed a specimen collection hat on the toilet and attempted to collect Resident #4's stool specimen one morning after breakfast but were not able to get a good specimen. -The HWC informed her and the MA to attempt to collect another specimen because the first specimen was not enough to send to the lab. -Later the same day, she and the MA attempted to collect the specimen again from Resident #4's soiled brief, but the stool was too watery and absorbed into the brief. -She was unsure of the date she and the MA attempted to collect Resident #4's stool specimen but was sure it was at the end March 2024. -She did not assist with collecting a stool specimen for Resident #4 on any other dates. Interview with a MA on 04/17/24 at 1:58pm revealed: -When the facility received an order for specimen collection, this information was written on a communication board. -MAs were responsible for collecting urine and stool specimens when ordered. -She tried to collect Resident #4's stool specimen twice on the same day but was unable to collect a specimen. -She was unsure of the date that she attempted to collect Resident #4's stool specimen and thought it was either 03/28/24 or 03/29/24. -She and the PCA placed a specimen collection hat on Resident #4's toilet, but Resident #4 urinated in the stool specimen.	D 276		

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-She and the PCA attempted to collect the stool specimen from Resident #4's brief later that afternoon, but the stool was too loose and watery.
-The two attempts were the only times she attempted to collect Resident #4's stool specimen.
-She notified the RCC and HWC when she was unable to collect Resident #4's stool specimen.

Interview with RCC on 04/17/24 at 2:19pm revealed:
-The facility used a communication board in the medication room to communicate information between each shift.
-Any specimens that needed to be collected were written on the communication board.
-MAs were responsible for specimen collection.
-If a specimen was not collected in 24-48 hours, the facility should contact the provider that ordered the specimen.
-The staff attempted to collect Resident #4's stool specimen multiple times.
-The staff collected one stool specimen, but the specimen could not be used because it was watery.
-She was unsure if the GI specialist was notified that the facility was unable to collect the stool specimen.
-She did not notify Resident #4's GI specialist or attempt to collect the specimen.
-Each attempt to collect the specimen should have been documented.
-She was unsure why the attempts to collect the specimen were not documented.

Interview with the HWC on 04/17/24 at 2:05pm revealed:
-The facility used a communication board in the medication room to communicate new orders.
-MAs were responsible for specimen collection.

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D 276	Continued From page 8 -She was unsure how many times staff members tried to collect a stool specimen for Resident #4. -There was one specimen collected for Resident #4, but the specimen did not cover the bottom of the cup so it could not be used. -MAs should notify the RCC, HWC, or the Health and Wellness Director (HWD) if they were unable to collect a specimen. -She was notified one day that the staff could not collect the specimen, but she was unsure of the date. -She did not work for a few days, and when she returned to work on 04/08/24, she was not notified that the specimen had not been collected. -Resident #4's family member contacted her on 04/12/24 and informed her that the specimen had not been collected. -The GI specialist's office contacted her on 04/12/24 and asked if the facility could do a rectal swab, -She informed the GI specialist's office on 04/12/24 the facility could not do a rectal swab for stool collection. -Resident #4 went to the GI specialist on 04/15/24 and the stool specimen was collected via rectal swab. -She was unsure why the attempts to collect the specimen were not documented in Resident #4's record. -Three weeks was too long to wait for the specimen to be collected and the GI specialist should have been notified about the facility being unable to collect the stool specimen. Interview with the HWD on 04/17/24 at 2:33pm revealed: -Any orders for specimen collection were written on the communication board in the medication room to alert staff members on each shift. -Any specimens that needed to be collected	D 276		

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remained on the board until the specimen was collected.
-MAs were responsible for collecting specimens.
-MAs attempted to collect Resident #4's stool specimen, but the stool was too loose each time.
-She was unsure how many times staff attempted to collect Resident #4's stool specimen, but thought it was several times.
-If the staff were unable to collect a specimen, they should notify the HWC.
-The HWC was responsible for notifying the residents' family and medical provider if a specimen could not be collected.
-Any attempts to collect Resident #4's stool specimen should have been documented in the progress notes.
-She was unsure if Resident #4's GI specialist was notified.
-The GI specialist should have been notified sooner that the staff was unable to collect the stool specimen.
-She was unsure if she received a report about the staff being unable to collect Resident #4's stool specimen.
-Three weeks was not an acceptable amount of time for specimen collection.

Interview with the Administrator on 04/17/24 at 2:47pm revealed:
-The care staff used a communication board and a new order tracking system for all orders.
-He was made aware by Resident #4's family member on 03/31/24 that Resident #4 had an order for a stool specimen.
-He followed up with the care staff that day, 03/31/24, and instructed them to collect the specimen.
-He was informed by the facility's health and wellness team that the lab they usually used did not pick up stool specimens for analysis.

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-He was informed by the facility's health and wellness team that another lab would not take Resident #4's stool specimen because it was not an acceptable specimen.
-If the staff was unable to collect a specimen, they should notify the RCC, HWC, or HWD.
-The RCC, HWC, and HWD should notify the provider if the staff was unable to collect a sample.
-Three weeks was not an acceptable amount of time to collect a stool specimen.
-The facility should have contacted the GI specialist about being unable to collect the stool specimen because Resident #4 could be at risk for dehydration and weakness from having loose stools.

Interview with a medical assistant at Resident #4's GI specialist's office on 04/17/24 at 11:49am revealed:
-The office did not receive any phone calls or faxes from the facility indicating they were unable to collect Resident #4's stool specimen.
-On 04/12/24, Resident #4's family member contacted the office and notified her that Resident #4 was still having diarrhea and the facility had not collected the stool specimen.
-She contacted the facility's HWC and inquired about the facility performing a rectal swab and was informed the facility could not do a rectal swab.
-Resident #4 was seen in the office on 04/15/24 and a stool specimen was collected by rectal swab.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.