STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092144	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKE ASSISTED LIVING	2800 KIDD ROAD RALEIGH, NC 27610

(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 and a complaint investigation on May 29, 2024, through May 30, 2024. The complaint investigation was initiated by the Wake County Department of Social Services on April 15, 2024.	D 000		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 14 hours of activities planned each week were provided for the residents. The findings are: Observation of a resident's room on 05/29/24 at 10:02am revealed an April 2024 activities calendar posted on the wall. Observation near and around the activity room on 05/29/2024 at 2:30pm revealed: -The activity room door was locked. -There were no monthly activities calendar posted in the common area for the resident's review. Observation on 05/29/24 at 4:05pm revealed: -There were 17 residents sitting in the day room, some watching TV, and some staring off into space.	D 317	A new Activity Director has been put in place. Activities of at least 14 hours per week are being conducted by the new Activity Director. The Administrator and Activity Director will educate staff on daily activities for the residents. Staff will be trained to conduct activities in the absence of the Activity Director. The Administrator will routinely monitor activities for compliance in this rule area.	6/4/24 6/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/2/2024

Reviewed and Acknowledged SC 7/15/2024

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D 317	Continued From page 1 -One staff member was sitting in the day room with the residents. Observation on 05/30/24 at 8:40am revealed: -There were 8 residents eating breakfast in the activity room who required assistance with feeding. -After breakfast the door was closed and locked, and no other activities occurred the remainder of the day Observation on 05/30/24 at 10:10am revealed: -There were 14 residents sitting in the day room, some watching TV, and some staring off into space. -The staff provided snacks to the residents. Interview with a resident on 05/29/24 at 9:50am revealed: -The facility did not provide activities. -There were no staff to do activities with the residents. -She would participate in activities if the facility offered them. Interview with a second resident on 05/29/24 at 10:02am revealed: -There had not been activities at the facility for the last two months because the person quit. -There had not been activity outings. -She would participate in activities if the facility provided them. Interview with a personal care aide (PCA) on 05/30/24 at 8:40am revealed: -The activities director (AD) was let go and there had been little to no activities since 05/01/24. -Last week, three people came to the facility and played their banjo and sang songs. -She was not asked to help with residents' activities.	D 317		

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D 317	Continued From page 2 Interview with a second PCA on 05/30/24 at 8:55am revealed: -There had been little to no activities for the residents. -She chose to do activities with the residents because she did not like seeing everyone staying inside when it was nice outside. -She played music and the resident threw the beach ball. -She was not asked to provide activities to the residents. Interview with an Administrator on 05/30/24 at 4:45pm revealed: -She has not had an AD for two weeks. -The staff took turns providing activities to the residents. -She was aware that the facility should have at least 14 hours of activities weekly. -The purpose of activities was to give the residents something to do to stimulate their minds, and it helped with less agitation because it kept their minds busy.	D 317		
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:	D 358	The Administrator and the RN conducted a meeting with the Medication Aide staff on medication administration and medication errors.	5/31/24

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D 358	Continued From page 3 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents observed during the medication pass including a medication used to treat anemia (#6). The findings are: The medication error rate was 2% as evidenced by 1 error out of 35 opportunities during the 8:00am medication pass on 05/29/24. Review of the facility's undated medication administration policy revealed the facility will ensure medications and treatments will be administered in accordance with the prescribing primary care provider's orders. Review of Resident #6's current FL2 dated 12/27/24 revealed diagnoses included dementia, bipolar disorder, seizure disorder, hypothyroidism, chronic pain syndrome, vitamin D deficiency, and sickle cell disease without crisis. Review of Resident #6's physician's order dated 02/23/24 revealed an order for Procrit 40,000 unit/milliliter, inject 0.75 milliliters (30,000 units total) under the skin 3 times a week. Please discard rest of the vial. (Procrit is a medication used to treat anemia). Observation of the medication pass on 05/29/24 from 9:05am to 10:15am revealed: -The medication aide (MA) went to the medication room and returned to the medication cart with an insulin syringe and vial of Procrit 40,000 unit/milliliter -The MA entered Resident #6's room and started drawing Procrit from the vial into the insulin syringe.	D 358	The RN provided additional education to the Medication Aide staff on proper [redacted] injection administration and identifying the proper syringes. The RN will provide training on proper administration of injections during skills validation. The Medication Aide staff must be able to demonstrate competency of injections prior to completion of skills validation. The RN will randomly and routinely conduct medication pass observations by the Medication Aide staff to maintain compliance in this rule area. The Administrator will routinely review skills validations and medication pass observations with the RN for continued compliance.	5/31/24

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D 358	Continued From page 4 -The MA drew the entire contents (1 milliliter) of the vial into the insulin syringe (1 milliliter equals 40,000 units of Procrit). -The MA started walking toward Resident #6 with the medication in the syringe. -The surveyor stopped the MA and suggested that she review Resident #6's Procrit order again. -The MA returned to the medication cart and reviewed Resident #6's electronic medication administration record (eMAR). -The MA requested assistance from the Resident Care Coordinator (RCC). -The RCC took the syringe from the MA and wasted half of the medication in the syringe in the trash receptacle on the medication cart and handed the syringe back to the MA. -The syringe contained 50 units of Procrit at that time (50 units is equivalent to 0.5 milliliters or 20,000 units of Procrit). -The MA returned to Resident #6's room, cleaned an area on the left side of Resident #6's abdomen with an alcohol swab, and administered the medication in the syringe. Observation of the medication cart on 05/29/24 at 2:50pm revealed: -There was one syringe with measurements in milliliters with a grey cap. -There were several insulin syringes with measurements in units with orange caps. Observation of the medication room on 05/29/24 at 2:51pm revealed: -There were 2 boxes of insulin syringes with measurements in units stored in a cart. -There were no syringes with measurements in milliliters. Review of Resident #6's May 2024 eMAR revealed:	D 358		

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D 358	Continued From page 5 -There was an entry for Procrit injection 40,000/ml inject 0.75ml (30,000 units) subcutaneously 3 times a week (Subcutaneous is a term meaning under the skin). -Procrit injection 30,000 units was documented as administered at 8:00am on 05/29/24. Interview with Resident #6 on 05/29/24 at 9:45am revealed: -Resident #6 had sickle cell anemia. -Resident #6 received injections a few times a week. -Resident #6 usually received the injections in her abdomen. -She was not currently experiencing any weakness or fatigue. Interview with a medication aide on 05/29/24 at 2:47pm revealed: -She administered medications according to the directions on the eMAR. -She was not currently working on the medication cart on the hall where Resident #6's room was. -She occasionally worked on the medication cart on the hall where Resident #6's room was and had administered Resident #6's Procrit injection previously. -When she prepared Resident #6's Procrit injection, she drew up 50 units in the syringe and discarded the rest of the vial. -She prepared the medication that way because that was how she was trained to prepare the medication. -She thought at one point there were syringes that were marked with milliliters instead of insulin units the staff used to prepare Resident #6's Procrit injection. Interview with the RCC on 05/29/24 at 2:57pm revealed:	D 358		

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D 358	Continued From page 6 -She previously worked as a MA and started training for the RCC position in April 2024. -MAs should follow the direction on the eMAR when giving medications. -She had given Resident #6 her Procrit injection before when she worked as a MA. -The MA should have used the syringe marked in milliliters to administer Resident #6's Procrit injection. -The facility's contracted pharmacy had sent insulin syringes to administer Resident #6's Procrit injection. -She thought there were more syringes marked in milliliters in her office. -She was concerned Resident #6 may not get the correct dose of Procrit. -Resident #6 was taking Procrit for sickle cell disease and needed to have the correct dose of the medication. Second interview with the RCC on 05/30/24 at 9:55am revealed: -The facility had a registered nurse (RN) that worked at the facility 2 days per week. -The RN was responsible for skills validations for the MAs. -She did not recall having any specific training for Procrit injections. -The facility did not have a supply of syringes marked in milliliters, so she ordered some for Resident #6 from the pharmacy today, 05/30/24. -When she assisted the MA with Resident #6's Procrit injection on 05/29/24, her finger slipped, and she accidentally pushed too much of the medication out of the syringe. -She should have pushed out 0.25 milliliters and there should have been 75 units or 0.75 milliliters for the correct dose of Resident #6's Procrit injection.	D 358		

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D 358	Continued From page 7 Interview with the RN on 05/30/24 at 10:02am revealed: -She did medication training and skills validations with MAs at the facility. -She trained MAs on how to administer Procrit injections. -The training on Procrit included what the medication is used for, how to prepare the medication, and how to administer the medication correctly. -MAs were trained to give medications as ordered by the provider. -MAs should be using syringes marked in milliliters to ensure they were preparing the correct dose of Procrit for Resident #6. -At one time, Resident #6's Procrit injection involved drawing up 0.5 milliliters of medication in the syringe, but Resident #6's Procrit dosage must have changed. Interview with the Administrator on 05/30/24 at 4:32pm revealed: -MAs should administer medication as ordered on the eMAR. -If MAs had questions about medications, they should ask the RCC or Administrator. -MAs could also contact a resident's provider for questions about medications. -The RN was responsible for completing clinical skills validations with MAs. -The RN reviewed the proper technique for preparing Procrit injections and administering the injections with MAs. -She was aware Resident #6 had sickle cell disease but was unsure what side effects Resident #6 could have by not receiving the correct dose of Procrit. Interview with a pharmacist at the facility's contracted pharmacy on 05/30/24 at 9:22am	D 358		

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D 358	Continued From page 8	D 358		

revealed:
-The pharmacy had not filled insulin syringes for Resident #6 since August 2023.
-She was unsure where the order for insulin syringes for Resident #6 originated.
-An insulin syringe was not the best syringe to use for Procrit injections since the syringe was marked in units and not in milliliters.
-The pharmacy last filled 1 milliliter syringes for Resident #6 on 03/06/24 and 10 syringes were sent to the facility at that time.
-If Resident #6 received a dose of Procrit that was too much, she could experience hypertension or weakness.
-If Resident #6 received a dose of Procrit that was not enough, she could experience anemia, swelling, or vision problems because her red blood cells would not receive enough oxygen for proper organ function.

Interview with Resident #6's primary care provider (PCP) on 05/30/24 at 10:27am revealed:
-She did not prescribe Resident #6's Procrit but Resident #6 was taking Procrit due to her diagnosis of sickle cell disease.
-Resident #6's hematologist adjusted the Procrit dose based on her lab work, so it was important for Resident #6 to get the correct dose (A hematologist is a specialist that treats blood disorders).
-Resident #6 was at risk for weakness, anemia, or could need a blood transfusion if she did not receive the correct dose of Procrit.

Attempted telephone interview with the MA who performed the 05/29/24 8:00am medication pass on 05/30/24 at 10:42am was unsuccessful.

Attempted telephone interview with Resident #6's hematologist on 05/30/24 at 9:08am was

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D 358	Continued From page 9 unsuccessful.	D 358		5/31/24
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were stored securely when a medication aide left a medication cart unlocked and unattended in a secured special care facility. The findings are: Review of the facility's undated medication storage policy revealed all medications, prescription and non-prescriptions will be kept locked except when the staff responsible for medication administration are in close proximity and can see the medications. Observation of the medication pass on 05/29/24 from 9:05am to 10:15am revealed: -The medication aide (MA) walked away from the medication cart, leaving the cart unlocked at 9:31am. -The MA entered a medication storage room, and the unlocked medication cart was out of her view. -There were 2 residents standing approximately 4 feet from the unlocked medication cart.	D 378	The Administrator and the RN conducted a meeting with Medication Aide staff on the importance and safety of maintaining medications under locked storage, while not under direct supervision. The RN will provide training on proper medication storage to Medication Aide staff prior to completion of skills validation. The RN will randomly and routinely conduct medication pass observations to maintain compliance in this rule area. The Administrator will routinely review skills validations and medication pass observations with the RN for continued compliance.	

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D 378	Continued From page 10 -The MA returned to the medication cart at 9:32am. Interview with the MA on 05/29/24 at 10:19am revealed: -She normally locked the medication cart when she walked away from the cart. -She did not lock the medication cart today, 05/29/24, because she was not feeling well. -Residents could open the medication cart and take medications if the medication cart was left unlocked. Interview with the Resident Care Coordinator (RCC) on 05/29/24 at 3:01pm revealed: -The medication cart should be locked when unattended. -The residents could be harmed if they opened an unlocked medication cart and took something from the cart. Interview with the registered nurse (RN) on 05/30/24 at 10:02am revealed: -MAs should lock the medication cart when unattended and take the keys with them. -Residents or other staff members could access medications on the cart if it was unlocked. -Residents could be harmed if they took medications that were not prescribed to them. Interview with the Administrator on 05/30/24 at 4:32pm revealed: -MAs should lock the medication cart when not in use. -The MA should have ensured the medication cart was locked. -The medication cart should be locked so residents or other staff could not access medications in the medication cart. -Residents could be harmed if they took	D 378		

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D 378	Continued From page 11 something out of the unlocked medication cart.	D 378		