

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL085008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/03/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROSE TARA SENIOR LIVING

**125 PLANTATION DRIVE
KING, NC 27021**

(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 07/02/24 to 07/03/24.	D 000	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of compliance with state law	
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 infection control measures were implemented as evidenced by a medication aide (MA) who dropped a medication on the floor then placed it in the medication cup for administration. The findings are: Review of the facility's undated Medication Administration policy revealed that facility staff were to administer medications in accordance with infection control measures. Observation of a MA administering medications during the 8:00am medication pass on 07/03/24 at 8:05am revealed: -The MA prepared and placed 6 and a half tablets in a plastic souffle cup. -The MA took one medication bubble pack card containing a controlled substance medication from the medication cart's locked drawer and punched the tablet through the foil backing on the medication card.	D 371	10A NCAC 13F .1004(n) Medication Administration Community will assure that medications are administered in accordance with infection control measures. Community Executive Director (ED) and Resident Care Coordinator (RCC) provided in-service with medication aide on infection control and proper procedures surrounding any dropped/misused medications. Community ED and/or RCC will conduct random medication pass observation with different medication aides to assure infection control measures are followed. Clinical Nurse Consultant (RN) will conduct random medication pass observations with different medication aides. Community has upcoming scheduled Medication training, to include but not limited to: 1. Infection Control 2. Process should Medication be dropped during medication pass Training will be conducted by Clinical Nurse Consultant (RN)	08/05/24 07/08/24 08/05/24 08/05/24 08/05/24

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

WFJZ11

7/16/2024

If continuation sheet 1 of 4

RECEIVED

JUL 19 2024

ADULT CARE LICENSURE SECTION
RALEIGH

Reviewed and Acknowledged by S.A. on 07/19/2024

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D 371	Continued From page 1 -The controlled substance medication tablet became stuck in the foil backing and then fell onto the floor. -The MA picked the tablet up from the floor and placed it on the top surface of the medication cart. -The MA poured a cup of water, placed the controlled substance medication tablet in the souffle cup, locked the computer screen displaying the electronic medication administration record (eMAR), locked the medication cart, and walked towards the resident to administer her medications. -The MA was asked to pause the medication pass to allow for the tablets in the souffle cup to be counted, and to obtain a new controlled substance medication tablet to replace the one that had fallen onto the floor. -At 8:07am, the MA separated the tablet that had fallen onto the floor from the souffle cup and brought it to the Resident Care Coordinator (RCC) to be destroyed. -At 8:09am, the MA took the resident's record from the medication room and went into the office to call the on-call doctor. -At 8:11am, the MA obtained a verbal order from the on-call doctor to waste the tablet that had fallen onto the floor and to administer a new tablet from the medication card. -At 8:14am, the MA popped another tablet of the controlled substance medication into the souffle cup and administered 7 and a half tablets to the resident. Interview with the MA on 07/03/24 at 8:20am revealed: -The MAs were supposed to waste any tablet that fell on the floor. -She always wasted any medication that became contaminated, but was "frazzled" being watched	D 371		

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D 371	Continued From page 2 during her medication pass. -She put the tablet of controlled substance medication that had been on the floor into the resident's medication cup to administer to her. -Any time a medication became contaminated, the MA was supposed to take the contaminated medication to the RCC to be disposed of, notify the doctor, and administer another dose of the medication to the resident. Interview with a second MA on 07/03/24 at 10:32am revealed: -If a medication fell onto the floor, the MAs were supposed to take that medication to the supervisor or RCC to waste it. -The MA was expected to obtain a new tablet or capsule to replace the contaminated dose that had been wasted. -The MA was supposed to document that the contaminated dose of medication had been wasted and another tablet was administered. Interview with the RCC on 07/03/24 at 11:04am revealed: -The MAs were all trained that the facility's protocol for replacing a contaminated medication, such as one that fell onto the floor, was to remove the contaminated medication and bring it to her to be properly disposed of. -The MA was expected to notify the primary care provider (PCP) or the on-call doctor that the medication fell on the floor and another tablet was used to replace the contaminated dose. -The MA would then obtain another dose of the medication and administer it as ordered. -The facility's contracted nurse trained all of the MAs on what to do if a medication became contaminated during the medication pass during the new hire MA and Licensed Health	D 371		

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D 371	Continued From page 3 Professional Support (LHPS) training. Interview with the Administrator on 07/03/24 at 10:25am revealed: -She and the facility's contracted nurse completed all the staff training on infection control. -The nurse no longer worked for the facility, so the facility had an interim nurse until their new nurse started in a couple of weeks. -Part of the training the nurse was responsible for completing was the annual infection control training which included what to do if a medication became contaminated during a medication pass. -The process the MA was expected to follow if a medication fell onto the floor was to notify the RCC, contact the PCP to obtain a verbal order to dispose of the medication and to administer another dose of the medication, dispose of the medication with a second MA or supervisor as a witness, administer another tablet or capsule as ordered, document the administration and the tablet was wasted.	D 371		