Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 000	Initial Comments The Adult Care Licensure Section and Moore County Department of Social Services conducted a follow-up survey July 30-31, 2024.	D 000	Responsible to cited deficiencies do not Constitute an admission or agreement by the facility of the truth of the facts in the Statement of deficiencies of Corrective Action Report, the Plan of Correction is prepared solely as a matter of compliance with State Laws.	9/3/24
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 3 of 6 sampled medication aides (MA) who administered medications to residents had a medication aide employment verification or the required documentation of the state approved 5-hour and 10-hour or 15-hour medication administration training for adult care homes (Staff C, D, and F) and 1 of 6 sampled MAs had the required documentation of the state approved 5-hour and 10-hour or 15-hour medication administration training for adult care homes (Staff A). The findings are: 1. Review of Staff A's personnel record on 07/31/24 revealed:	D 125	CNC will provide in house training to all medication aides that does the state approved 5-hour and 10-hour or 15 hour medication administration training.	9/3/24

Reviewed and acknowledged on 09/06/24 by JL

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D 125	Continued From page 1 -Staff A was hired on 12/04/15. -Staff A passed the medication aide examination on 05/20/20. -There was a medication administration clinical skills checklist dated 03/20/23. -There was a continuing education certificate dated 04/07/24 for 15 continuing education hours for a medication training course. -There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes. Interview with Staff A on 07/31/24 at 3:25pm revealed: -She recalled taking a 15-hour medication administration training course online. -She thought the medication training course consisted of watching videos and answering questions. -She did not recall any portion of the training being completed in person with an instructor. Refer to interview with the Administrator on 07/31/24 at 3:45pm. Refer to interview with the Regional Director of Operations on 07/31/24 at 2:42pm. Refer to interview with the Vice President of Clinical Services on 07/31/24 at 2:45pm. 2. Review of Staff C's personnel record on 07/31/24 revealed: -Staff C was hired on 06/17/22. -Staff C passed the medication aide examination on 06/22/11. -There was a medication administration clinical skills checklist dated 07/14/23. -There was no medication aide employment	D 125	ED and BOM will ensure that new medication aides that are hired is provided a state approved 5-hour 10-hour or 15-hour in house medication aide training from a CNC BOM and ED will audit all medication aides personal files weekly to ensure all medication aides have their state approved Certificate of completion for the 5-hour and 10-hour or 15-hour medication administration training BOM and ED will then continue to audit medication aides personal files audits monthly and will immediately correct any findings during their audits	9/3/24 9/3/24 9/3/24

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D 125	Continued From page 2 verification. -There was a continuing education certificate dated 08/15/23 for 15 continuing education hours for a medication training course. -There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes. Refer to interview with the Administrator on 07/31/24 at 3:45pm. Refer to interview with the Regional Director of Operations on 07/31/24 at 2:42pm. Refer to interview with the Vice President of Clinical Services on 07/31/24 at 2:45pm. 3. Review of Staff D's personnel record on 07/31/24 revealed: -Staff D was hired on 05/26/22. -Staff D passed the medication aide examination on 11/09/09. -There was a medication administration clinical skills checklist dated 06/05/24. -There was no medication aide employment verification. -There was a continuing education certificate dated 12/19/22 for 15 continuing education hours for a medication training course. -There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes. Refer to interview with the Administrator on 07/31/24 at 3:45pm. Refer to interview with the Regional Director of Operations on 07/31/24 at 2:42pm.	D 125		

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D 125	Continued From page 3 Refer to interview with the Vice President of Clinical Services on 07/31/24 at 2:45pm. 4. Review of Staff F's personnel record on 07/31/24 revealed: -Staff F was hired on 10/19/23. -Staff F passed the medication aide examination on 01/03/23. -There was a medication administration clinical skills checklist dated 11/30/23. -There was no medication aide employment verification. -There was a continuing education certificate dated 11/10/23 for 15 continuing education hours for a medication training course. -There was no state approved certificate of completion for the 5-hour, 10-hour, or 15-hour medication administration training for adult care homes. Refer to interview with the Administrator on 07/31/24 at 3:45pm. Refer to interview with the Regional Director of Operations on 07/31/24 at 2:42pm. Refer to interview with the Vice President of Clinical Services on 07/31/24 at 2:45pm. Interview with the Administrator on 07/31/24 at 3:45pm revealed: -The Business Office Coordinator (BOC) completed weekly personnel file audits. -She had seen the 15-hour medication administration training certificates in some of the employee files. -She was told by the facility's corporate office that the state approved certificate of completion was replaced by the new certificate and was proof of	D 125		

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D 125	Continued From page 4 the medication aides (MA) having the required training. Interview with the Regional Director of Operations on 07/31/24 at 2:42pm revealed: -The facility had started completing weekly audits on the personnel files. -The BOC and Administrator were responsible for the personnel file audits. -The MAs should have the required 15-hours of medication administration training prior to completion of their medication administration clinical skills checklist. -She thought the 15-hour training certificate currently used by the facility met the state requirements because the certificate and training program were implemented by the facility's corporate office. -The Clinical Nurse Consultant (CNC) was a registered nurse (RN) responsible for completing the 5-hour, 10-hour, and 15-hour medication administration training. -The facility did not currently have a CNC. -There were other CNCs employed by the company that could assist with medication administration training until the position was filled. Interview with the Vice President of Clinical Services on 07/31/24 at 2:45pm revealed: -The 5-hour, 10-hour, and 15-hour medication administration training courses should be taught in person by a registered nurse (RN). -The facility should stop using the current 15-hour medication training online course as the required 15-hour medication administration training and return to in-person instruction with the medication aides (MA). -The facility should use the state approved certificates for the 5-hour, 10-hour, and 15-hour medication administration training courses to	D 125		

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D 125	Continued From page 5 show proof that the MAs had completed the required training.	D 125		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#5) for medications to treat shortness of breath (dyspnea), relief of chest congestion, and a rash. The findings are: Review of Resident #5's current FL-2 dated 05/14/24 revealed diagnoses included chronic pulmonary disease, prediabetes, hyperlipemia, malignant neoplasm of upper right, right bronchus or lung, atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs, secondary malignant neoplasm of brain and solitary pulmonary nodule.	D 344	Med Techs will complete cart audits daily per facility Schedule to ensure that all residents medications and treatments orders that are prescribed by the residents' provider is verified and Compared to the residents MAR ED and Care Managers will review cart audits daily during stand-up of all cart audits and meds and treatments orders to ensure that med techs has verified and clarified residents medications and treatments orders as prescribed by the residents provider ED and care managers will review all new orders for medications and treatments Changes daily and ensure appropriate follow-up with the residents prescribing provider.	9/3/24 9/3/24 9/3/24

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D 344	Continued From page 6 a. Review of Resident #5's physician orders dated 05/14/24 revealed there was an order for Guaifenesin 100mg/5mL give 60mL (1200mg) twice daily. (Guaifenesin is used to treat relief of chest congestion). Review of Resident #5's physician order dated 07/18/24 revealed an order for Guaifenesin ER 600mg 1 tablet every 12 hours for mucus. (Guaifenesin ER is an extended release tablet used to treat thick mucus secretion.) Review of Resident #5's physician orders revealed no documentation the primary care provider (PCP) was contacted for clarification of orders. Review of Resident #5's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Guaifenesin (chest congestion relief) 100mg/5ml give 60 mL twice daily at 8:00am or 9:00am and 8:00pm or 9:00pm. -Guaifenesin 100mg/5 mL was documented as administered on 06/01/24 to 06/21/24 at 8:00am. -Guaifenesin 100mg/5 mL was documented as administered on 06/22/24 to 06/30/24 at 9:00am. -Guaifenesin 100mg/5 mL was documented as administered on 06/01/24 to 06/21/24 at 9:00pm. -Guaifenesin 100mg/5 mL was documented as administered on 06/22/24 to 06/30/24 at 9:00pm. Review of Resident #5's July 2024 eMAR revealed: -There was an entry for Guaifenesin (chest congestion relief) 100mg/5ml give 60 mL twice daily at 9:00am and 9:00pm. -Guaifenesin 100mg/5 mL was documented as administered on 07/01/24 to 07/30/24 at 9:00am.	D 344		

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D 344	Continued From page 7 -Guaifenesin 100 mg/5 mL was documented as administered on 07/01/24 to 07/29/24 at 9:00pm. -There was an entry for Mucus DM (Dextromethorphan-Guaifenesin) ER 30-600mg 1 tablet every 12 hours. (Mucus DM contains Dextromethorphan and Guaifenesin. Mucus DM is not the same Guaifenesin ER.) -Mucus DM 30-600mg ER was documented as administered on 07/25/24 to 07/30/24 at 9:00am. -Mucus DM 30-600mg ER was documented as administered on 07/24/24 to 07/29/24 at 9:00pm. Observation of Resident #5's medications on hand on 07/31/24 at 5:39pm revealed: -There was a supply of Mucus DM 30-600mg ER dispensed on 07/23/24. -The instructions were to take 1 tablet every 12 hours for cough or thick bronchial secretions. -There were 8 of 22 tablets remaining. -There was a 16 ounce bottle of Guaifenesin 100mg/5mL liquid dispensed on 07/25/24. -The instructions were to give 30mL twice daily. Interview with Resident #5 on 07/31/24 at 6:06pm revealed: -He got dizzy once in a while but not daily or on a weekly basis. -He took a pill for his chest congestion. -He did not remember if he had taken liquid medication for chest congestion. Telephone interview with Resident #5's hospice nurse on 07/31/24 at 5:47pm revealed: -The Guaifenesin was prescribed for chest congestion. -Resident #5 should not take both the pill and liquid form of the Guaifenesin at the same time. -Resident #5 should be given a choice of which form of the Guaifenesin he would like to take.	D 344		

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D 344	Continued From page 8 Interview with a medication aide (MA) on 07/31/24 at 9:18am revealed: -Resident #5 had an order for Guaifenesin in the liquid and pill form. -She administered the liquid form of Guaifenesin to Resident #5 in the morning and administered the liquid and pill form at night. -Resident #5 had not complained of dizziness. Interview with the Resident Care Coordinator (RCC) on 07/31/24 at 6:03pm revealed the Guaifenesin DM tablet was prescribed for Resident #5 because he was out of the Guaifenesin liquid. b. Review of Resident #5's physician orders dated 05/14/24 revealed there was an order for Prednisone 5mg 1 tablet daily to treat dyspnea (difficulty breathing). (Prednisone is used to treat inflammation associated with breathing problems.) Review of a physician order dated 06/27/24 revealed an order for Prednisone 10mg 1 tablet twice daily for 7 days to treat a rash. Review of Resident #5's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisone 10mg 1 tablet twice daily for itching for 7 days. -Prednisone 10mg 1 tablet twice daily for 7 days was documented as administered on 06/28/24 to 06/30/24 at 9:00am. -Prednisone 10mg 1 tablet twice daily for 7 days was documented as administered on 06/28/24 to 06/30/24 at 9:00pm. -There was an entry for Prednisone 5mg 1 tablet daily for dyspnea. -Prednisone 5mg 1 tablet daily was documented	D 344		

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D 344	Continued From page 9 as administered on 06/01/24 to 06/30/24 at 9:00am. Review of Resident #5's July 2024 eMAR revealed: -There was an entry for Prednisone 10mg 1 tablet twice daily for itching for 7 days. -Prednisone 10mg 1 tablet twice daily for 7 days was documented as administered on 07/01/24 to 07/03/24 at 9:00am. -Prednisone 10mg 1 tablet twice daily for 7 days was documented as administered on 07/03/24 to 07/07/24 at 9:00pm. -There was an entry for Prednisone 5mg 1 tablet daily for dyspnea. -Prednisone 5mg 1 tablet daily was documented as administered on 07/01/24 to 07/30/24 at 9:00am. Review of Resident #5's physician orders revealed no documentation on how the Prednisone was to be administered. Telephone interview with Resident #5 on 07/31/24 at 6:06pm revealed: -He used O2 to help with his breathing. -He did not know which medications he took at night. Observation of Resident #5's medications on hand on 07/31/24 at 5:39pm revealed: -There was a multi-dose pack (MDP) dated 07/22/24 with Prednisone 5mg take 1 tablet once daily for dyspnea. -The Prednisone 5mg tablet was packaged in the MDP for morning medications. -There were no Prednisone 10mg tablets on hand. Interview with Resident #5's hospice nurse on	D 344		

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D 344	Continued From page 10 07/31/24 at 5:47pm revealed the order for Prednisone 10mg was increased to treat a rash on the trunk for 7 days only.	D 344		
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, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#1) observed during the medication pass including errors with a rapid-acting insulin and an inhaler for breathing problems; and for 1 of 5 residents (#5) sampled for record review including an error with a medication used to treat symptoms of an enlarged prostate. The findings are: 1. The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 7:30am, 8:00am, and 9:00am medication passes on 07/31/24. a. Review of Resident #1's current FL-2 dated 05/21/24 revealed: -Diagnoses included type 2 diabetes mellitus, chronic obstructive pulmonary disease,	D 358	Clinical Nurse Consultant will re-educate Med Techs on the importance of notifying the provider when medications are not given as ordered. 9/3/24 Clinical Nurse Consultant will re-educate Med Techs to ensure there is focus on; 6 rights of med Administration, High Risk Meds, and ensuring all medications and treatments are being administered per physicam orders and given in a timely manner as prescribed by the residents provider. 9/3/24 Care managers will notify resident's prescribing provider of any missed doses of medications or treatments and follow any orders received by the prescribing provider. 9/3/24	

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D 358	Continued From page 11 unspecified dementia with behavioral disturbances, essential hypertension, hyperlipidemia, and Vitamin D deficiency. -There was an order for Novolog Flexpen, inject 4 units 3 times a day with meals, hold if fingerstick blood sugar (FSBS) less than (<) 150. (Novolog is rapid-acting insulin used to lower blood sugar that starts working 10 - 15 minutes after injection. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection.) Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog Flexpen inject 4 units 3 times a day with meals, hold if FSBS < 150. -Novolog Flexpen was scheduled to be administered at 7:30am, 12:30pm, and 5:30pm. -There was an entry for the resident's blood sugar to be checked at 7:00am, 12:00pm, and 5:00pm. -The resident's blood sugar ranged from 84 - 260 from 07/01/24 - 07/31/24. -The resident's blood sugar was documented as 144 on 07/31/24 at 7:00am. Observation on the special care unit (SCU) on 07/31/21 at 8:00am revealed: -Resident #1 came out of the dining room from eating breakfast and went to his room at 8:00am. -At 8:02am, the medication aide (MA) went to Resident #1's room to prepare and administer morning medications. -The MA did not check Resident #1's blood sugar. -The MA did not administer any Novolog insulin to the resident. Interview with the MA on 07/31/24 at 8:02am revealed: -The breakfast meal was usually served around	D 358		

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D 358	Continued From page 12 7:30am. -She held Resident #1's Novolog insulin because the resident's blood sugar was documented as 144 at 6:00am on the eMAR when third shift checked it. -She did not check the resident's blood sugar in the morning because the third shift MA checked the resident's blood sugar at 6:00am. -She used the blood sugar reading from the third shift blood sugar check (at 6:00am) to determine whether to administer or hold the Novolog insulin at breakfast. Interview with the Resident Care Coordinator (RCC) on 07/31/24 at 10:58am revealed: -The third shift MAs usually checked morning blood sugars to help save time for first shift staff. -She was not aware of Resident #1 having any symptoms of high or low blood sugars. -She would check with the resident's primary care provider (PCP) about the timing of the blood sugar checks and administering or holding the insulin. Interview with the Administrator on 07/31/24 at 11:13am revealed: -Resident #1's blood sugar would not be the same at 8:00am as it was at 6:00am. -Administering or holding the Novolog insulin based on a blood sugar taken 2 hours prior to breakfast could cause the resident's blood sugar to be too high or too low. Telephone interview with Resident #1's PCP on 07/31/24 at 6:07pm revealed: -Checking the resident's blood sugar at 6:00am was too early to determine if the resident's Novolog insulin should be held or administered with breakfast. -The resident's blood sugar should be checked	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 13 just before the breakfast meal. -Holding or administering insulin based on a blood sugar taken 2 or 3 hours before a meal could cause the resident to have high or low blood sugars. Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable. b. Review of Resident #1's current FL-2 dated 05/21/24 revealed an order for Breo Ellipta 100-25mcg dose inhaler, inhale 1 puff by mouth once daily, rinse mouth after use, do not swallow. (Breo Ellipta is used to treat chronic obstructive pulmonary disease. Breo Ellipta contains an inhaled steroid used to treat inflammation and breathing problems. According to the manufacturer, the mouth should be rinsed after using Breo Ellipta to prevent irritation and infections of the mouth.) Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Breo Ellipta 100-25mcg inhale 1 puff once daily, rinse mouth with water after use, do not swallow. -Breo Ellipta was scheduled for administration at 8:00am. Observation of the 8:00am medication pass on 07/31/24 revealed: -The medication aide (MA) prepared and administered 1 inhalation of Breo Ellipta to Resident #1 at 8:09am. -The MA told the resident to drink some more water after he used the inhaler. -The resident drank the rest of the water in the water cup provided with his oral morning	D 358		

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D 358	Continued From page 14 medications. -The resident did not rinse and spit out the water after using the inhaler as ordered. -The MA did not instruct the resident to rinse his mouth after using the Breo Ellipta inhaler. -The MA did not instruct the resident not to swallow the water after using the Breo Ellipta inhaler. Observation of Resident #1's medications on hand on 07/31/24 at 10:41am revealed: -There was a Breo Ellipta inhaler dispensed on 07/08/24 with an open date of 07/18/24. -The instructions were to inhale 1 puff by mouth once daily, rinse mouth with water after use, do not swallow. Interview with the MA on 07/31/24 at 10:40am revealed: -She usually had Resident #1 to swish and spit out water after the resident used the Breo Ellipta inhaler. -She forgot to have the resident rinse and spit out the water after using the inhaler that morning, 07/31/24. -Resident #1 had not complained of any mouth soreness or infections. Interview with the Resident Care Coordinator (RCC) on 07/31/24 at 10:58am revealed: The MAs had been trained to read the instructions on the eMAR and administer medications as ordered. -The MA should have instructed Resident #1 to rinse his mouth with water and spit it out after the use of the Breo Ellipta inhaler. Interview with the Administrator on 07/31/24 at 11:13am revealed: -The MAs should follow the medication orders	D 358		

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D 358	Continued From page 15 and instructions. -She was not aware of Resident #1 having any issues with mouth soreness or infections. Telephone interview with Resident #1's primary care provider (PCP) on 07/31/24 at 6:07pm revealed: -The MAs should have Resident #1 rinse his mouth with water after using the Breo Ellipta inhaler to prevent mouth irritation. -She was not aware of Resident #1 having any issues with mouth soreness or irritation. Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable.	D 358		
	2. Review of Resident #5's FL2 dated 05/14/24 revealed diagnoses included chronic pulmonary disease, prediabetes, hyperlipemia, malignant neoplasm of upper right, right bronchus or lung, atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs, secondary malignant neoplasm of brain and solitary pulmonary nodule. Review of a physician order dated 06/12/24 revealed there was an order for Tamsulosin 0.4mg 1 tablet daily. (Tamsulosin is used to treat symptoms of enlarged prostate such as urinary retention.) Review of a telephone order dated 07/09/24 revealed: -There was an order for Tamsulosin "to bedside". -The dosage was not documented. -The order was not signed by the primary care provider (PCP). Review of Resident #5's June 2024 electronic			

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D 358	Continued From page 16 medication administration record (eMAR) revealed: -There was an entry for Tamsulosin 0.4mg 1 capsule daily at 9:00am. -The Tamsulosin 0.4mg was documented as administered on 06/15/24 to 06/30/24 at 9:00am. Review of Resident #5's July 2024 eMAR revealed: -There was an entry for Tamsulosin 0.4mg 1 capsule daily at 9:00am. -The tamsulosin 0.4mg was documented as administered on 07/03/24 at 9:00am and at 9:00pm. Observation of Resident #5's medications on hand on 07/31/24 at 5:39pm revealed: -There was a multi-dose pack (MDP) dated 07/22/24 with Tamsulosin 0.4mg 1 capsule at bedtime for urinary flow. -The Tamsulosin capsule was packaged in the MDP for bedtime medications. Interview with Resident #5's hospice nurse on 07/31/24 at 6:06pm revealed he did not know which medications he took at night. Telephone interview with Resident #5's hospice nurse on 07/31/24 at 5:47pm revealed: -The Tamsulosin 0.4mg was prescribed to treat urinary issues for Resident #5. -The order for "bedside" on 07/09/24 was to be administered at bedtime instead of the morning.	D 358		