Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Landings of Oak Island
Address: 2910 Pine Plantation Parkway Bolivia, N.C. 28422
County: Brunswick
License Number: HAL-010-013

II. Date(s) of Visit(s): 03/08/23, 03/27/23, 04/05/23, 04/11/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 05/05/23

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c)**, indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .1004 Rule/Statutory Reference: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. Level of Non-Compliance: Type A2 Violation Findings: This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the administration of medication in accordance with physician's orders and the facility's policies and procedures for 1 of 5 sampled residents (#3), who did not receive pre-operative eye medications to prepare the residents eyes for surgery or post-operative eye medications to treat surgical eye trauma caused by cataract removal of her right and left eyes. The findings are:	☑ POC Accepted OTR *DSS Initials* Response to cited Deficiencies does not constitute an admission or agreement by the facility of the truth of facts alleged or the conclusion set forth in the corrective action. The plan of correction is prepared soley as a matter of compliance by State law.	

Review of the facility's medication administration policies and procedures dated November 2018 revealed: -Medications were to be administered in accordance with written orders of the prescriber. -If a medication with a current, active order could not be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility were to be searched. If the medication could not be located after further investigation, the pharmacy was to be contacted. Review of Resident #3's current FL-2 dated 11/15/22 revealed: -Diagnoses included Parkinson's disease, essential hypertension, hyperlipidemia, anxiety disorder, and vitamin D deficiency. -Resident #3 recommended level of care was assisted living. Review of Resident #3's eye specialist after visit summaries dated August 2023 and February 2023 revealed: -On 08/25/23 there was an entry that documented Resident #3 had cataracts in both eyes and was experiencing sensitivity to light, eye discomfort, and double vision. -Surgery for right eye cataract removal was scheduled for 02/23/23 and left eye cataract removal was scheduled for 03/08/23. -Typed pre-operative and post-operative orders were given with detailed instructions. Review of Resident #3's ophthalmologist pre-operative and post-operative orders revealed: -The physicians typed orders (not dated but read "two weeks before surgery) and gave specific details regarding Resident #3's pre-operative and post-operative treatment and medications. -There was an order (not dated) for Tropicamide/Phenylephrine (used to dilate pupils before eye surgery) "red top" eye drops 1 drop to be administered in the surgical eye the night before surgery, one drop when the resident awoke on the morning of eye surgery, and one drop before leaving the facility for surgery for the right eye (02/23/23) and the left eye (03/08/23). -There was an order for Prednisolone/Moxifloxacin/Bromfenac (used as a post-operative treatment of inflammation, pain, and the chance of infection) "yellow top" eye drops one drop to be administered in the surgical eye four times daily beginning the day before surgery and continuing for two weeks, then decreased to two	ED/RCC will re-educate Med Techs on the importance of ordering medication that is not available on the med cart, 6 rights of med administration, PCP and RCC notification when medication is not available and following up with pharmacy. Med Techs will complete MAR to Cart audits per facility schedule to ensure medications are available and order accuracy. The RCC/ED will review electronic medication compliance daily during management meeting to ensure medication administration is accurate with PCP orders. The RCC will complete 2 chart audits weekly to verify order accuracy. Completed chart audits will be reviewed by the ED for compliance.	6-4-23 6-4-23 and ongoing 6-4-23 and ongoing 6-4-23 and ongoing

times daily for two weeks.
-In addition to the hard copy prescriptions sent to the facility, the order stated the pre-operative eye drop prescription had also been sent to a compounding pharmacy, with the name and contact number of the compounding pharmacy provided to the facility.
-The order recommended the facility call the compounding pharmacy to ensure receipt of the eye drops before surgery.
-There was an order for each eye to be treated the day before surgery with a warm compress to the eyelids for 5 minutes and the eyelashes gently scrubbed with baby shampoo and rinsed.

Review of Resident #3's electronic Medication Administration Record (eMAR) for February and March 2023 revealed:
-There was no entry for Tropicamide/Phenylephrine eye drops to administered pre-operatively to the right eye or to the left eye, one drop the night before surgery, one drop when the resident awoke on the day of surgery, and one drop before leaving the facility to go for surgery for each eye.
-There was no documentation of the preoperative eye drops being administered to Resident #3 for a total of three missed doses before right eye surgery and three missed doses before left eye surgery.
-There was no documentation of Resident #3 receiving a warm compress and baby shampoo treatment before surgery.
-On 02/22/23 there was an entry for Prednisolone/Moxifloxacin/Bromfenac 1-0.5-0.075mg one drop to be administered in the right eye four times daily at 8:00am, 12:00pm, 4:00pm and 8:00pm with an end date of 03/07/23 and this was documented as administered with no documentation of any missed doses.
-On 03/08/23 there was an entry for Prednisolone/Moxifloxacin/Bromfenac 1-0.5-0.075mg one drop to be administered in the right eye two times daily at 8:00a and 8:00pm for fourteen days with an end date of 03/21/23.
-Prednisolone/Moxifloxacin/Bromfenac was documented as "not administered" due to reasons of "unavailable" and "awaiting delivery" 14 of 28 times, with other documentation the eye drops were administered, although the medication was documented to be unavailable from 03/10/23 to 03/21/23.
-On 03/08/23 there was an entry for Prednisolone/Moxifloxacin/Bromfenac 1-0.5-0.075mg one drop to be administered in the left eye four times daily at 8:00am, 12:00pm, 4:00pm and 8:00pm with an end date of

03/21/23.
- Prednisolone/Moxifloxacin/Bromfenac was documented as not administered due to reasons of "unavailable" and "awaiting delivery" 27 of 56 times, with other documentation of eye drops being administered, although the medication was documented to be unavailable from 03-14-23 to 03/21/23.
-On 03/22/23 there was an entry for Prednisolone/Moxifloxacin/Bromfenac 1-0.5-0.075mg one drop to be administered in the left eye two times daily at 8:00a and 8:00pm for fourteen days with an end date of 04/04/23.
- Prednisolone/Moxifloxacin/Bromfenac was documented as not administered due to reasons of "unavailable" and "awaiting delivery" 3 of 6 times from 03/22/23 to 03/24/23.

Review of Resident #3's electronic progress notes for February and March 2023 revealed:
-There was no February progress note entries.
-There was no March entry regarding Resident #3 having eye surgery.
-On 03/23/23 there was an entry by the Resident Care Manager (RCM) that she called the resident's ophthalmologist to ask for "new orders to replace orders received recently" for the resident.

Review of a handwritten fax notification (no name provided) from the facility to Resident #3's eye specialist dated 03/23/23 revealed notification from the facility the resident had not been receiving Prednisolone/Moxifloxacin/Bromfenac as order between 03/15/23 and 03/22/23 but the medication was now in the facility so she would start getting the eye drops as prescribed.

Review of Resident #3's ophthalmologist order dated 03/23/23 revealed the ophthalmologist provided another order for Prednisolone/Moxifloxacin/Bromfenac 1-0.5-0.075mg one drop to be administered in the left eye at four times daily at 8:00am, 12:00pm, 4:00pm and 8:00pm with no end date given by the physician.

Interview with the Resident Care Manager (RCM) on 03/27/23 at 1:30pm revealed:
-She was not aware of any issues with Resident #3 getting her eye drops as prescribed during the time of her eye surgeries.
-There had been a small misunderstanding with the way an order was written but she had gotten clarification from the adult's family member.
-The misunderstanding was because the order stated the

resident was to get her eye drops for two weeks but the family member reported she only needed to get the medication until the bottle was empty.
-Those small bottles of eye drops did not last long.
-She did not know exactly what the orders read, but Resident #3 had not missed any doses of eye medication in her right or left eye.
-The orders on the eMAR were just wrong, so it made it look like Resident #3 missed doses of her eye drops.

A second interview with the RCM at on 4/5/23 at 12:09pm revealed:
-She was having a difficult time finding the orders for Resident #3's eye drops.
-The only order she could locate was the order she requested from the ophthalmologist on 03/23/23 because she could not find one in the resident's record.
-The staff resumed giving the residents eye drops on 03/22/23 when the resident's family member got an order from the physician and filled the order for eye drops.
-She called the resident's eye specialist on 03/23/23 so she would have a copy of the order.
-This was the only record she had of communication with the ophthalmologist.
-She could see there were orders entered on the February and March eMAR's but she did not know where those orders were or why Resident #3 had so many missed doses of her eye drops.
-She did not know there were pre-operative eye drops the resident had not received.
-She did not remember seeing an order that stated the pre-operative eye drop prescription had been sent to a compounding pharmacy and the facility was to follow up with them before surgery to ensure the resident had them filled before her surgery.
-Upon review of the resident's records today (04/05/23), she acknowledged the detailed pre-operative and post-operative orders from the ophthalmologist were in Resident #3's chart.
-Even though the orders stated to give the post-operative eye drops 4 times daily for two weeks and 2 times daily for two weeks, she was "pretty sure" the eye drops were supposed to be administered until the eye drops ran out.
-She did not have any documentation of receipt of the eye drops from the facility pharmacy so did not know how many bottles of eye drops the facility actually received but it was "probably one bottle for each eye and maybe the family brought in both bottles."

Interview with Resident #3's pharmacy on 05/04/23 at 1:20pm revealed:
-They are a mail-order pharmacy.
-On 02/13/23 they received orders from Resident #3's eye specialist.
-The orders were for Tropicamide/Phenylephrine eye drops 1 drop to be administered in the surgical eye the night before surgery, one drop when the resident awoke on the morning of eye surgery, and one drop before leaving the facility for surgery for the right eye and the left eye before each surgery.
-One bottle of this eye drop was filled, which was enough medication for both eyes.
-There was an order for Prednisolone/Moxifloxacin/Bromfenac eye drops one drop to be administered in the surgical eye four times daily beginning the day before surgery and continuing for two weeks, then decreased to two times daily for two weeks.
-They filled two bottles of this eye drop, one for each eye.
-Any needed refills for this eye drop would have been completed upon request but they did not receive a request for any refills.
-All three bottles of eye drops were mailed to the home address of resident #3's responsible party.
-She did not "really know" when Resident #3 had her eye surgery or why the eye drops were not given.
-It was the responsibility of her and of the Medication Aides (MA) to order medications from the pharmacy.
-She had not received any notification from staff that Resident #3 was out of eye drops during the time she was supposed to be getting them 4 times daily or during the time she was supposed to be getting them 2 times daily.
-She thought Resident #3's family member was the one who notified her the eye drops were not being given.
-If staff did tell her, it must have been after she had been out of them for a while.
-She would usually know if medications were out if staff "happened to tell her verbally or if she found out during a cart audit."
-There was a report in the eMAR that would show her if a medication was out and she was trying to get better about routinely reviewing it.

Interview with a first shift MA on 4/5/23 at 12:45pm revealed:
-She did not know why Resident #3 did not receive her eye drops as ordered before or after her eye surgeries except that she remembered she could not find the medication.

-She did not think she told anyone because she talked to another MA, she could not remember who told her it had already been reported to the RCM.
-The RCM was usually the one to reorder medications.

Telephone interview with a first shift MA on 04/05/23 at 4:22pm revealed:
-She had inquired with another MA about Resident #3's eye drops being unavailable but was told they had run out of the eye drops and the order on the eMAR was incorrect.
-She continued to document the eye drops as unavailable since the order was still on the eMAR.

Confidential interview with staff revealed:
-About a week after Resident #3's left eye surgery, the resident came to her and said that she had not been getting her eye drops but was supposed to be getting them 4 times a day.
-Resident #3 told her "Look at my eye, it's all red."
-The staff observed Resident #3's eye was red and bruised but she did not know what it should look like that many days post-surgery.
-The resident had an upcoming follow-up appointment with her eye specialist and was anxious because she had not been given her eye drops as prescribed.
-The resident told her she was supposed to get a different eye drop before her surgery, but she did not receive that either.

Interview with the acting Executive Director on 04/05/23 at 12:29pm revealed:
-She was working on 03/18/23, about a week after Resident #3 had her left eye surgery, and a few days before she was supposed to go for a follow-up appointment with her ophthalmologist.
-Resident #3 came to her and said told her she had not been getting her prescribed eye drops.
-She asked one of the MA's about the eye drops and was told the pre-operative eye drops were compounded and the facility's primary pharmacy did not fill that kind of medication.
-She told the MA she was not talking about the pre-operative eye drops, she was talking about the post-operative eye drops.
-She searched the medication cart for Resident #3's eye drops, and the eye drops were not on the medication cart.
-She reviewed the February and March eMAR's and there was a total of four active orders on the MAR's, two for the right eye and two for the left eye.
-She contacted the pharmacy and asked that the eye drops be

"sent stat" and told the Administrator in Training (AIT) to be expecting them to be delivered. -She did not know when the medication came but Resident #3 was getting the eye drops now. Interview with Resident #3's Responsible Party on 03/02/23 at 10:21pm and 05/04/23 at 1:35pm revealed: -She received Resident #3's pre-operative and post-operative eye drops by mail, totaling 3 bottles. -She delivered the eye drops to the facility before Resident #3's first surgery. -She did not recall the name of the staff to whom she gave the medications, but it was a Medication Aide (MA). -She was aware Resident #3 had missed doses of her eye drops. -Resident #3 notified her that she was not getting her eye drops. -She called the facility, she thought on 03/20/23, and spoke with a MA, name unknown. -The MA told her they could not locate the medication or prescription, but they were trying to get another copy of the prescription and would update her soon. -She did not receive a follow-up call from the facility about their efforts to get the eye drops so she obtained a prescription from the physician herself, got it filled, hand-delivered the eye drops to the facility on 03/22/23 and told the MA she was to get the eye drop in her left eye four times daily. -Since Resident #3 had not been getting the eye drops as ordered, the physician wrote the order for 4 times daily with the end date to be determined by him later. -The recovery period was prolonged because of Resident #3 not getting her eye drops as prescribed. -She went to the RCM and discussed her concerns about Resident #3 not having her eye drops and asked her to do an "occurrence report" about the matter, but she did not know if anything was done. -She worked at the hospital and an occurrence report was what was done when medications were not administered as ordered to use as a learning tool for staff because it gave details about why medication doses were missed and the repercussions of not giving the medication. -Resident #3 was oriented and remembered very well when she did and did not get her medication. Interview with Resident #3 on 04/05/23 at 1:22pm revealed: -She knew all of her medications well and was able to speak about what her medications were given for.		

-She was supposed to get eye drops starting the night before each of her eye surgeries, but the staff did not administer the eye drops.
-She told the MA the night before her surgery she needed to give her what the eye specialist said she was to get, but nothing was given.
-She was supposed to get eye drops at least four times a day after each eye surgery, but she did not.
-She told the MAs she was not getting her eye drops after her surgeries but "they did not seem to care."
-She did not know if this had a negative effect on her vision, but when she first had her eye surgery, her vision "lit up light a Christmas tree" but it had gotten a little blurry since then.
-She did not think she had an infection in her eye after surgery, but her left eye was starting to get "matted" before she began to get the eye drops that her daughter brought in and gave to staff.

Attempted interview with the AIT revealed she was not available for interview.

Interview with Resident #3's Ophthalmologist on 04/21/23 at 2:07pm revealed:
-Detailed orders were provided to the facility before Resident #3's eye surgeries.
-The orders were specific right down to the color of the top on the eye drop bottles.
-His office made copies of the detailed instructions and orders and placed them in the folder that was returned to the facility on the day of Resident #3's last eye appointment before the resident's first eye surgery.
-He knew how things worked at a facility and that they could not do anything without a prescription, so he was careful to give them everything they would need for Resident #3.
-The day after he had sent the facility detailed instructions that included the prescriptions, someone called his office from the facility and said they needed orders for the eye drops.
-He thought to himself, "Did they not read the information I sent them and how many times do we need to give them orders?"
-Resident #3 was to receive 3 doses of Tropicamide/Phenylephrine eye drops three times before her eye surgery, beginning the night before her surgery and then twice on the morning of her surgery.
-His had typed instructions informing the facility the eye drop prescription was sent to a compounding pharmacy and for them to communicate with the pharmacy to ensure receipt of

the eye drops before surgery.
-This medication was to be used to dilate Resident #3's eyes in preparation for removal of her cataracts.
-It was difficult to get the level of dilation needed for cataract removal in the time period between arrival and surgery so that was why the eye drops were prescribed to start the dilation process early.
-If the pupil was not dilated large enough to remove the cataract, sometimes special tools would have to be used.
-He did not know, until now, Resident #3 did not get her pre-surgery eye drops.
-This could have led to special tools needing to be used to remove the cataracts, which would have caused more trauma to Resident #3's eye, but thankfully this did not have to be done.
-Post-surgery Resident #3 was to receive Prednisolone/Moxifloxacin/Bromfenac eye drops four times daily for two weeks and two times daily for an additional two weeks.
-He never advised anyone that the resident only had to be given the eye drops until the bottle was empty.
-Obviously, one bottle of eye drops would not last for four weeks for each eye so when more eye drops were needed, he would have provided refill prescriptions.
-Resident #3's left eye did not look good when he saw her for the first visit about a week after her surgery.
-There were a lot of white cells in the front part of her left eye and "I thought it was simply because the facility was not giving her eye drops appropriately."
-He had to prolong the use of post-surgery steroid eye drops, which prolonged the healing process and was not good because the prolonged use of steroids decreased the body's ability to fight infection.
-This eye drop was used post-surgery because cataract surgery is controlled trauma to the eye, but it was still trauma; the eye responds to trauma by releasing white cells to fight off what it thinks is infection, but since there was no infection to fight off, if not treated the white cell count would continue to escalate until the eye turned red and painful and the healing process was prolonged; the eye drops would tell the eye to calm down because its ok and the implant is fine; if the eye drops were not used, there was an inherent risk of the eye pressure continuing to go up and up; there was potential that if Resident #3's eye pressure had gone too high, it could have caused blindness.

The facility failed to ensure Resident #3's received eye medications as ordered to dilate her eyes in preparation for surgical removal of cataracts and failed to administer medications to treat post-surgical eye trauma, prolonging her healing process and increasing her chances of serious negative outcomes, including possible blindness. The facility's failure resulted in serious neglect of the resident and constitutes a Type A1 Violation.		
A Plan of Protection (POP) in accordance with G.S. 131D-34 was received on 04/05/23. THE CORRECTIVE DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 06/04/23.		
Rule/Statute Number: 10A NCAC 13F .1004 Rule/Statutory Reference:10A NCAC 13F .1004 Medication Administration (i)The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and before the administration of another resident's medication. Pre-charting is prohibited. Level of Non-Compliance: Type B Violation Findings: This rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure safe administration of medications according to their policies and procedures to residents including one Medication Aide (Staff A) who was observed to have multiple residents' medications pre-poured and pre-charted as administered before administration, and additional Medication Aides (MA) who were known to pre-pour medications, to pre-chart as administered, and to drop off medications to residents without observation of residents taking their medications. This included a MA supervisor (Staff B). The findings are:	ED/RCC re-educated Med-Techs on 6 rights of med administration with a focus on medication preparation at the time of administration, documenting only after resident was witnessed taking the medication. The Area Clinical Director re-educated med-techs on medication preparation, 6 rights of med admin and the importance of observing resident take medication. The RCC will audit medication carts to ensure no further pre-pouring of medication occurs. Any violations the med tech will be removed from the cart immediately. The RCC/ED will do random observations during med pass to ensure proper procedures are followed.	06/19/23 6-19-23 6-19-23 and ongoing

Review of the facility's Medication Administration policies and procedures dated 01/11/18 revealed:
-Medications were to be administered following the "five rights" which included the "Right resident, right drug, right dose, right route, and the right time.
-When medications are administered by mobile cart and taken to the resident's location such as their room or dining room, the medication was to be administered at the time they were prepared.
-Medications were not to be pre-poured either in advance of the medication pass or for more than one resident at a time.
-The resident was to always be observed after the administration
to ensure the dose was completely ingested.
-The individual who administered the medication was to record the administration on the resident's electronic Medication Administration Record (eMAR) directly after the medication was given.

Telephone interview with a former staff member revealed:
-It was a common practice at the facility for medications to be pre-poured, pre-charted, and "dropped off" to residents in the dining room or in their rooms without the staff seeing the residents taking their medication.
-Staff B had set a bad example when it came to medication administration because she was "one of the staff doing those things."
-MA's would go into the dining room during meal hours with dispensing cups of medications "stacked ten high", would distribute the medications to residents at their tables, and would leave the medications with the residents and leave.
-The MA's would write the initials of residents on the side of the dispensing cups in order to identify which medication went to which resident.
-Residents would often leave their medications on the dining room tables or their plates after staff dropped off the medications to them.
-The MA's would pre-chart as having administered the resident's medications when all they really did was give them to the residents and walk away.

Observation of a first shift MA (Staff A) on 03/08/23 at 7:58am and 10:00am revealed:
-At 7:58am Staff A was looking through the MC attempting to locate medications for a resident who was sitting nearby waiting, and Staff A seems to be having difficulty finding the

resident's medications.
-Another first-shift MA stated, "They are in the drawer."
-Staff A opened the top drawer of the medication cart (MC) and there were multiple clear medication dispensing cups containing pre-poured medications.
-The pre-poured medications were sitting side by side in the drawer with two letters handwritten on the side of each cup.
-At 8:00am Staff A removed one of eight of the pre-poured cups of medications from the drawer and handed it to a resident with no verification of giving the right medication to the right resident and no documentation on the eMAR.
-At 8:37 there was a count of seven dispensing cups with medications sitting in the top drawer of Staff A's MC and she provided the names of the residents to whom the medications were to go.
-At 10:00am Staff A removed one of the pre-poured cups of medications from the drawer and handed it to a resident and stated she had already documented the medication as administered to the resident.

Interview with Staff A on 03/08/23 at 7:58am and 10:00am revealed:
-She had worked as a MA at the facility for about 8 months.
-Sometimes she did pre-pour medications for the residents who ate breakfast in the dining room and would write their initials on the side of the dispensing cups.
-She would take the medications to the residents in the dining room.
-If the residents in the dining room declined to take the medications when she took the medications to the dining room, she would tell the residents to come and see her after they were finished eating so she could give them their medication and she would go and put the medications back in the MC drawer.
-She was not supposed to pre-pour medications, but in an effort to try to administer medications within the required timelines, she would pre-pour the medications all at the same time and would document the medications as administered on the eMAR, before giving the medications.
-She also pre-poured and pre-charted for residents who received their medications in their rooms, but "no one ever refused" medication on her halls so this did not create an issue for pre-charting.
-She provided the names of eight residents whose medications were observed to be pre-poured in dispensing cups in the MC drawer.

Review of eMAR's dated 03/08/23 for eight residents whose medications were observed to be in a MC drawer between 7:58am and 10:00am revealed eight of eight residents' medications were pre-charted as administered.

Interview with a first shift MA supervisor (Staff B) on 03/08/23 at 8:20am revealed:
-She had worked for an MA at the facility for a long while and was recently promoted to shift supervisor.
-She had not observed any issues, nor did she have any concerns about medication administration and no problems had been reported to her.
-Some residents received their medication before meals and some after meals, but she did not remember any residents getting their medications in the dining room during meals.
-She did not have any knowledge of any MA staff pre-pouring medications, pre-charting as administered, or leaving medications in the dining room or in residents' rooms without observation of the residents taking the medications.

A second interview with Staff B on 03/08/23 at 10:45am reviewed:
-Maybe she had one staff who had been observed leaving residents' medications on dining room tables, but she had given that staff member a verbal warning.
-Medications were delivered to the facility in prepackaged "bubble packs" and these were "popped" when it was time to administer the medication to a resident.
-She had weekly MA staff meetings and told staff "Don't stack pill cups, don't pre-pop, and administer one medication at a time."
-She had told staff they could not leave medications on tables for residents without watching them take them medications.
-She would provide a copy of the MA meeting topics to show that she met with staff regarding these concerns.
-The MA staff were "going to give me a heart attack" if they did not start administering medications correctly.
-She had a lot of new MA's that were still learning and maybe that was what was contributing to medication administration problems.

Interview with the acting Executive Director on 03/08/23 at 9:24am revealed:
-The facility ED had recently been terminated and the newly hired Administrator in Training (AIT) was operating under her Administrators License until the AIT was licensed.
-The acting ED was training and precepting the AIT.

-The facility's medication records were electronic, and the residents' medications came in bubble packs.
-The process for medication administration should be for the MA's to pull and scan a resident's medication, prepare the medication, and only click off the medication as administered after they have given the medication to the resident and observed them taking it.
-Pre-pouring and pre-charting should never be allowed and she had not received any reports of this happening.
-The staff knew better, and she was surprised to hear this may be happening.

Review of both typed and handwritten meeting agendas entitled "MA Meeting Topics" dated 02/22/23 and 03/02/23 revealed there were no documented meeting topics involving pre-charting, pre-pouring, or administration to one resident at a time while watching the resident take the medication.

Confidential interview with a staff member revealed:
-There were quite a few of the MAs that routinely left medications in the dining room or the resident's rooms for the resident to take on their own.
-The MAs had explained to her "why they do it" and she understood where they were coming from because there just was not enough time in a shift to get everything done that needed to be done.
-It was a big building and aides were running all over just trying to get everything done, so this was why the MAs administered medications this way.
-It would be difficult for the newly promoted shift supervisor (Staff B) to say anything to the other MAs about medication administration, because she was one of the main ones who was leaving medications for residents to take on their own.
-If Staff B knew something happened with a resident's medications that should not have, she would ask the staff to "basically lie and say they did not know anything."
-She was concerned that Staff B was setting a bad example for the MAs she was now supervising other MAs.

Telephone interview with former MA on 03/14/23 at 9:20am revealed:
-She "absolutely" saw pills that had been dropped off and left on dining room tables for residents.
-Staff B was the "ring leader" with pre-pouring, pre-charting, stacking medications in cups and dropping the medications off to residents in the dining room and their rooms.
-Some of the MAs started these practices because Staff B

was doing it.
-There were also times when she found pills left on plates or on tables after residents had left the dining room and other staff would come and get her to show her medications left in the dining room.
-She "was pretty sure" medications were being left for residents in their rooms because there were many times that she would find medication dispensing cups sitting beside a cup of water in the residents' rooms and she thought if the MA had administered the medications, they would have thrown away the dispensing cup.

Interview with a former MA in training on 3/22/23 revealed:
-She previously trained as a first-shift MA at the facility and had planned to take her MA test.
-She was "shocked" when she saw how careless the management allowed the staff to be regarding medication administration.
-She witnessed staff with medications in dispensing cups stacked as high as they could carry and leaving them on the dining room tables with residents.
-She decided not to become a MA because she was afraid "they are going to hurt somebody"
-She "made it known to management staff almost every day" but nothing changed.

Confidential interviews with residents revealed:
-5 of 8 residents stated MAs brought their medications in cups with their initials on them to the dining room and that the MAs sometimes watched them take their medications and sometimes left them on their table for them to take on their own.
-1 of 8 residents stated "I hate to say. They leave it for me and walk away but they are not supposed to do that are they?"
-2 of 8 residents stated sometimes MA's dropped off their medication to them in their room but did not always watch them take it.
-3 of 8 residents reported seeing MAs carrying more than one cup of medication at a time.

Interview with the AIT and the Resident Care Manager (RCM) on 03/27/23 at 1:25pm revealed:
-The AIT stated staff had "not really" reported to them that MA's were pre-pouring and pre-charting medications or that medications were being dropped off in the dining room and residents' rooms.
-The AIT was "not yet familiar" with the facility's medication administration policy.

-The RCM stated the medication administration policy indicated the MA staff were to first match the medication to the right resident, scan it, check off on the eMAR as prepping, pop the medication from the bubble pack, and then administer it to the resident with water, only doing one resident at a time.
-The RCM had noticed that some residents seemed to expect her to leave medications with them and just walk away when she brought them their medications, and when she just stood there, she could tell they were wondering why.
-They had witnessed some of the pre-pouring and pre-charting activity themselves and were actively addressing it in the MA meetings.
-They would search to see if they had any additional MA meeting minutes other than what had already been provided by Staff B.
-The AIT was told by staff that before she started working there, the pre-pouring and stacking medications was "pretty bad."
-The AIT had gone on a medication pass with Staff B as part of her AIT program and Staff B pre-poured medications in front of her.
-Staff B seemed to be the one initiating these activities with the medications, and the other MAs "followed her lead."
-There was no formal disciplinary action taken against any staff for pre-pouring, pre-charting, or for leaving medications with residents in the dining room and their rooms and not observing them taking the medication, it was just informal conversations.
-The AIT thought staff had done things that way for so long, and had previous management telling them it was ok, that her hands were "kind of tied."
-The AIT thought some of the problems had been addressed by getting rid of some of the previous management staff.
-The AIT was not familiar with the eMAR so she would need to familiarize herself with it to understand the documentation of medication administration in the system.
-It had not crossed her mind that staff was pre-charting medications before administration.
-The morning medication pass was usually over by the time the AIT came into work, but she had "kind of heard things from staff" about pre-pouring and "things of that nature."
-Staff B was terminated last week for reasons unrelated to medication administration.

The facility failed to administer medications to each resident

immediately following the preparation of the medication and before administration to another resident. In addition, staff pre-charted medications as administered without observation of the residents actually taking their medications. The failure of the facility to provide safe administration was detrimental to the safety of the residents and constitutes a Type B Violation. A Plan of Protection (POP) in accordance with G.S. 131D-34 was received on 03/08/23. THE CORRECTIVE DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 06/19/23.		
Rule/Statute Number: 10A NCAC 13F .1004 Rule/Statutory Reference: 10A NCAC 13F .1004 Medication Administration (b) The facility shall assure that only staff meeting the requirements in Rule .0403 of this Subchapter shall administer medications, including the preparation of medications for administration. Level of Non-Compliance: Deficiency Findings: This rule is not met as evidenced by: Based on interviews, the facility failed to assure that only staff meeting the requirements of a Medication Aide (MA) were administering medications to residents, including a first shift MA (Staff A) who requested the assistance of a non-MA to give medications to residents. Review of the facility's Medication Administration policies and procedures dated 01/11/18 revealed: -Medications were to be administered as prescribed and only by persons authorized to do so. -Medications were to be administered only by individuals authorized to administer medications. -The person who prepared the dose for administration was to be the person who administered the dose. Confidential telephone interview with a former staff member revealed: -There had been instances with staff that were not MA's and	The med aides will be inserviced on the 6 rights of medication administration to include the importance of ensuring that only the person that prepared the medication may administer the medication. The RCC/ED will complete random medication administration observation to assure continued compliance. This will be ongoing. The Area Clinical Director will complete random medication observations. Any concerns of non-compliance will be reported to RCC/ED. This will be ongoing.	6/4/23

were asked to "run the medications to residents" in their rooms.
-The MA who requested the assistance of a non-MA, would prepare the medications into medication dispensing cups and then would ask a non-MA to take the medication to the residents.

Confidential telephone interview with a staff member revealed:
-The staff member was not a MA.
-Staff A had asked her to conceal medications in her hand or to put a cup of medications in her pocket and to "run them to resident's rooms."
-This happened every time she worked with Staff A.
-She had done what she was asked to do because the was concerned she would lose her job if she did not.
-Sometimes the residents would ask her questions about the medications but she would tell them she did not know anything about it so they would need to ask Staff A.
-She would always watch the residents take their medication because she did not want it coming back on her if the resident did not take their medication.
-She was concerned that she was being asked to deliver medications to the residents and had reported it to a former supervisor.
-As far as she knew, there was no disciplinary action taken to correct Staff A because she continued to ask her for assistance with taking medications to residents.

Telephone interview with a former staff supervisor on 03/14/23 at 9:20am revealed:
-A non-MA staff reported to her she had been asked by Staff A to go and hand off medications to some of the residents.
-The former staff supervisor reported this to the ED but as far as she knew, nothing was done.
-The staff member was afraid she would get fired if she did not do as she was asked, so she had been taking the medications to the residents as requested.

Interview with a first shift MA on 03/08/23 at 7:58am and 10:00am revealed:
-She had not ever requested assistance from any non-MA staff to help her take medications to residents.
-She did not know why anyone would say she had asked them to do this.
-She knew MAs were the only staff approved to administer medications to residents.

Interview with a first shift MA supervisor on 03/07/23 at 8:20am revealed: -As far as she knew, only MA staff passed medications to residents and she had not received any reports of non-MA staff being asked to assist with taking medications to residents. -Non-MA staff were not allowed to touch medications. A second interview with a first shift MA Supervisor on 03/07/23 at 10:45am revealed: -She did have one MA who had asked a non-MA to go and "carry medications to a resident for her" but she was told not to do it again. -There was no official disciplinary action taken again the first-shift MA but she did receive a verbal warning. Interview with the acting Executive Director on 03/08/23 at 9:24am revealed: -Only MAs were allowed to give medications to residents. -Non-MA's should never be asked to deliver medications to a resident. -She had not received any reports of this happening. Interview with the Administrator in Training (AIT) on 03/27/23 at 1:25pm revealed: -She did not know of any situation where a MA had asked a non-MA to administer medications to a resident, but she had "just been asked today" if a PCA could administer a cream treatment. -She told the staff person who asked, "Absolutely not." THE CORRECTIVE ACTION DATE FOR THIS DEFICIENCY SHALL NOT EXCEED 06/04/23.		
Rule/Statute Number: 10A NCAC 13F .1212 Rule/Statutory Reference: 10A NCAC 13F .1004 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation,	All resident incidents are reported to the ED at the time of occurance. The RCC/ED will discuss incidents in morning management meeting to determine intervention and reporting requirements. The RCC will finalize all reportable incidents for review by the ED. Once ED reviews, reportable incidents will be sent to DSS as required.	6/4/23

hospitalization, or medical treatment other than first aid.
Level of Non-Compliance: Deficiency
Findings:
This rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to provide notification to the county Department of Social Services (DSS) for accidents and incidents that required medical evaluation for 10 of 10 sampled accident reports.

The findings are:

A review of the joint DSS and Facility Microsoft Teams folder titled Accidents/Incidents for January through March 2023 revealed there were no reported accidents or incidents by the facility.

Interview with the Resident Care Manager (RCM) and the Administrator in Training on 03/27/23 at 1:25pm revealed:
-The RCM was responsible for sending the reportable accident/incident reports to DSS.
-She had been uploading all reportable accidents and incident reports into the DSS/Facility Teams file.
-If nothing had been uploaded to the file recently, it "probably meant there were no reportable" events.

Interview with the Administrator in Training (AIT) on 03/27/23 at 1:37pm revealed:
-Both she and the RCM were responsible for sending reportable incident and accident reports to DSS.
-When she first began her position as AIT "a few weeks ago", she did not know this was a requirement.
-She was pretty sure all the reportable incident and accident reports were being sent to DSS by the RCM.

Review of the facility's records of accident and incident reports from January 2023 through March 2023 revealed:
-On 01/05/23 there was a report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital.
-On 01/13/23 there was a report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital and admitted.
-On 01/15/23 there was a report for a resident who had an accident that required referral for emergency medical

evaluation, resulting in the resident being transported to the hospital.
-On 02/04/23 there was a report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital
- On 02/04/23 there was a second report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital and admitted.
-On 02/10/23 there was a report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital
- On 02/12/23 there was a report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital.
- On 02/25/23 there was a report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital
-On 03/16/23 there was a report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital
-On 03/19/23 there was a report for a resident who had an accident that required referral for emergency medical evaluation, resulting in the resident being transported to the hospital.

Review of the accident and incident reports received at the county Department of Social Services (DSS) from January 2023 through March 2023 revealed there were no accident or incident reports received from the facility during this time period.

Interview with the acting Executive Director (ED) on 04/05/23 at 2:00pm revealed:
-She had reviewed the in-house records of accidents and incident reports and had identified ten that should have been reported to DSS.
-She provided copies of the reports.
-She would ensure all reportable accidents and incidents were

sent to DSS in the future. THE CORRECTIVE ACTION DATE FOR THIS DEFICIENCY SHALL NOT EXCEED 06/04/23.	

IV. Delivered Via:	Hand delivered	Date: 05/05/23
DSS Signature:	Tammie Robinson	Return to DSS By: **05/26/23**

V. CAR Received by:	Administrator/Designee (print name): LISA ASH	
	Signature: Lisa Ash	Date: 5/5/23
	Title: ED	

VI. Plan of Correction Submitted by:	Administrator (print name): Lisa Ash	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ ***POC Not Accepted*** | By: Lisa K. Ash, ED | Date: 5/26/23

Comments:

☑ ***POC Accepted*** | By: Tammie Robinson | Date: 5-30-23

Comments:

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:

Comments:

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*