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WEXFORD HOUSE	3900 WEXFORD LANE DENVER, NC 28037

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D 000	Initial Comments The Adult Care Licensure Section and the Lincoln County Department of Social Services conducted an annual survey on April 16-17, 2019, with an exit conference via telephone on April 18, 2019.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) was tested for tuberculosis upon hire. The findings are: Review of Staff A, Personal Care Aide (PCA)/Medication Aide's (MA) personnel record revealed: -Staff A was hired on 05/03/18. -There was documentation of a negative TB skin test dated 05/25/17. -There was documentation of a negative TB skin test dated 06/08/17. -There was no documentation of a TB skin test since being hired on 05/03/18.	D 131		

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D 131	Continued From page 1 Interview on Staff A on 04/17/19 at 1:15pm revealed: -She had not received a TB skin test since being hired at the facility on 05/03/18. -She provided the Business Office Manager (BOM) a copy of her TB skin test that she completed for her previous employer in 2017. -She did not know she needed a TB skin test upon hire. -She was not told that she needed to get another TB skin test. -She thought the TB skin tests completed in 2017 were sufficient. Interview with the Business Office Manager on 04/17/19 at 1:40pm revealed: -All staff were required to have a TB skin test upon hire. -A second TB skin test was required within 2 weeks. -She did not tell Staff A that she needed a two-step TB skin test upon hire. -She thought staff were able to bring proof of test from their previous employer. Interview on with the Administrator on 04/17/19 at 1:35pm revealed: -The BOM was responsible for maintaining the staff records. -The BOM was responsible for making sure all staff had a TB skin test completed upon hire. -"We know that a TB skin test is required upon hire". -He did not know why a TB skin test was not requested upon hire for Staff A, "it was missed".	D 131		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service	D 296		

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D 296	Continued From page 2 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for 3 of 6 sampled residents with a mechanical soft/no concentrated sweet (MS-NCS) diet (Resident #1 and #3), and a no concentrated sweets/renal diet (Resident #6). The findings are: 1. Review of Resident #1's current FL2 dated 01/10/19 revealed diagnoses chronic obstructive pulmonary disease, dementia, hypertension and gastroesophageal reflux disease. Review of a physician's order dated 03/14/19 revealed Resident #1 was ordered a mechanical soft/no concentrated sweets (MS-NCS) diet. Review of diet list posted in the kitchen on 04/16/19 at 10:15am revealed Resident #1 was to be served a MS-NCS diet with honey thickened liquids. There were no therapeutic diet menus available to guide staff in the preparation of a MS-NCS diet. Observation of the lunch meal service on 04/16/19 between 12:00pm and 1:00pm revealed: -Resident #1 was served shredded turkey and dumplings, green peas, a roll, a magic cup, honey	D 296		

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thickened water and honey thickened tea.
-Resident #1 consumed her meal without difficulty.

Observation of the breakfast meal service on 04/17/19 from 8:15am to 9:15am revealed:
-Resident #1 was served ground sausage, oatmeal, a pancake, sugar free syrup, eggs, canned fruit, honey thickened cranberry juice, and honey thickened water.
-Resident #1 consumed her meal without difficulty.

Without a therapeutic diet menu, it could not be determined if Resident #1 was served a MS-NCS diet as ordered by the physician.

Refer to the interview with the cook 04/16/19 at 1:21pm.

Refer to telephone interview with the Dietary Manager on 04/16/19 at 3:05pm.

Refer to the interview with the Administrator on 04/17/19 at 8:55am.

2. Review of Resident #3's current FL2 dated 03/08/19 revealed diagnoses dementia, gastroesphageal reflux disease, and hyperlipidemia.

Review of a signed physician's order dated 03/11/19 revealed a diet order for a MS-NCS diet.

Review of diet list posted in the kitchen on 04/16/19 at 10:15am revealed Resident #3 was to be served a MS-NCS diet.

There were no diet therapeutic diet menus available to guide staff in the preparation of a

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D 296	Continued From page 4 MS-NCS diet. Observation of the lunch meal service on 04/16/19 between 12:00pm and 1:00pm revealed: -Resident #3 was served shredded turkey and dumplings, broccoli, a roll, no sugar added ice cream, coffee, milk, sugar free tea, and water. -Resident #3 consumed her meal without difficulty. Observation of the breakfast meal service on 04/17/19 from 8:15am to 9:15am revealed: -Resident #3 was served ground sausage, oatmeal, a pancake, sugar free syrup, eggs, canned fruit, water, milk, and cranberry juice. -Resident #3 consumed her meal without difficulty. Without a therapeutic diet menu, it could not be determined if Resident #3 was served a MS-NCS diet as ordered by the physician. Refer to the interview with the cook 04/16/19 at 1:21pm. Refer to telephone interview with the Dietary Manager on 04/16/19 at 3:05pm. Refer to the interview with the Administrator on 04/17/19 at 8:55am. 3. Review of Resident #6's current FL2 dated 12/04/18 revealed diagnoses included atherosclerotic heart disease, hypertension, diabetes mellitus, and dysphagia. Review of a signed physician's order dated 01/23/19 revealed a diet order for a no concentrated sweets/renal diet.	D 296		

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D 296	Continued From page 5 Review of diet list posted in the kitchen on 04/16/19 at 10:15am revealed Resident #3 was to be served a no concentrated sweets/renal diet. There were no therapeutic diet menus available to guide staff in the preparation of a no concentrated sweet/renal diet. Observation of the lunch meal service on 04/16/19 between 12:00pm and 1:00pm revealed: -Resident #6 was served turkey and dumplings, green peas, a roll, no sugar added ice cream, water, milk, and coffee. -Resident #6 consumed his meal without difficulty. Observation of the breakfast meal service on 04/17/19 from 8:15am to 9:15am revealed: -Resident #6 was served sausage, a pancake, sugar free syrup, grits, eggs, coffee, water, and cranberry juice. -Resident #6 consumed his meal without difficulty. Without a therapeutic diet menu, it could not be determined if Resident #6 was served a NCS/renal diet as ordered by the physician. Refer to the interview with the cook 04/16/19 at 1:21pm. Refer to telephone interview with the Dietary Manager on 04/16/19 at 3:05pm. Refer to the interview with the Administrator on 04/17/19 at 8:55am. --- Interview with the cook 04/16/19 at 1:21pm revealed:	D 296		

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-If residents were ordered two diets she referred to two separate menus to prepare the meal.
-She called the Dietary Manager (DM) if she was not sure what to serve residents ordered two diets.
-Residents ordered a MS-NCS diet would receive ground meats and she would refer to the NCS menu for desserts and drinks.
-She referred to both the NCS and the renal diet menu to prepare the meal for residents ordered a no concentrated sweets/renal diet.

Interview with the Dietary Manager on 04/16/19 at 3:05pm revealed:
-She thought the mechanical soft diet only changed the texture of meats and was not considered a therapeutic diet.
-She thought the no concentrated sweets menu could be used to reference drinks and desserts for residents ordered a MS-NCS diet.
-For residents ordered a no concentrated sweets/renal diet, the renal diet was ordered and the NCS diet was only referenced for desserts.
-The contracted food service company did not provide menus for MS-NCS diet or a no concentrated sweets/renal diet.
-She did not know she needed menus to reference when two diets were ordered.

Interview with the Administrator on 04/17/19 at 8:55am revealed:
-He did not know therapeutic diets menus were needed for staff to reference when two diets were ordered.
-He thought the mechanical soft menu could be used to prepare meats for residents ordered a MS-NCS diet and the NCS menu could be used to prepare sides, desserts, and drinks.
-He did not know Resident #6 had an order for no concentrated sweets/renal diet. And he was

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D 296	Continued From page 7 working to get the diet order changed. Attempted interview with the Registered Dietician who reviewed the facility menus on 04/17/19 at 2:28pm was unsuccessful.	D 296		
D 354	10A NCAC 13F .1003 (c) Medication Labels 10A NCAC 13F .1003 Medication Labels (c) The facility shall assure the container is relabeled by a licensed pharmacist or a dispensing practitioner at the refilling of the medication when there is a change in the directions by the prescriber. The facility shall have a procedure for identifying direction changes until the container is correctly labeled. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication containers had correct labels for 1 of 5 sampled residents (Resident #9) related to lorazepam, a medication for anxiety. The findings are: Review of Resident #9's current FL2 dated 03/26/19 revealed:	D 354		

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-Diagnoses included chronic obstructive pulmonary disease (COPD), dysphagia and end stage renal disease.
-There was a physician's order for lorazepam 0.5mg, one tablet each night at bedtime and one tablet every 6 hours as needed for anxiety.

Review of a subsequent physician's order dated 04/01/19 revealed an order for lorazepam 0.5mg, take one tablet at bedtime and one tablet in the morning.

Observation of Resident #9's medications available for administration on 04/17/19 at 9:20am revealed:
-There was a medication bottle labeled lorazepam 0.5 mg tablets, take one tablet at bedtime and one tablet every 6 hours as needed for anxiety.
-Twenty tablets were dispensed on 04/16/19.
-There were 19 tablets remaining in the medication bottle.
-There was no change of direction sticker or indication the label was inaccurate based on the current order.

Review of Resident #9's April 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg to be administered every morning at 8:00am.
-There was an entry for lorazepam 0.5mg to be administered every 6 hours as needed for anxiety.
-There was an entry for lorazepam 0.5mg to be administered every evening at bedtime that had been discontinued on 04/02/19.

Interview with the first shift medication aide (MA) on 04/17/19 at 9:35am revealed:

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-She knew the lorazepam 0.5mg to be administered in the morning had been entered on the eMAR for Resident #9 in the beginning of April.
-She knew there were direction change labels for medications whose orders had changed.
-It was the responsibility of the MA on the cart to place a direction change label on medication bottles and bubble packs when needed.
-She had not remembered to place the direction change label on the lorazepam medication bottle.

Interview with a representative from the facility's contracted pharmacy on 04/17/19 at 11:05am revealed:
-A faxed order was received from the facility on 04/02/19 for lorazepam 0.5mg, take one tablet at bedtime and one tablet in the morning.
-Lorazepam 0.5mg, to be administered in the morning, was entered on the eMAR.
-She did not know why the entry for the evening dose of lorazepam was discontinued.
-The pharmacy software did not interface with the facility eMAR.
-The pharmacy medication profile for Resident #9 listed lorazepam 0.5mg, take one tablet at bedtime and one tablet in the morning.
-It was the responsibility of the facility to place a direction change label on a medication bottle or bubble pack when the order changed.

Interview with the Resident Care Coordinator (RCC) on 04/17/19 at 1:17pm revealed:
-If there was a change in directions ordered by the physician for an existing medication, the MAs were to place a direction change sticker on the bubble pack or medication bottle to refer to the eMAR for new directions.
-Direction change labels were located in the medication room and should be on each

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D 354	Continued From page 10 medication cart. -It was the policy of the facility to affix direction change stickers on the bubble packs of medications when their orders changed. -She had not completed cart audits on the medication carts since she had assumed her position last month. -She did not know the lorazepam for Resident #9 was not correctly labeled. -She expected the MAs to refer to the medication label and the order on the eMAR as part of the correct process for administering medications to the residents. Interview with the Administrator on 04/17/19 at 2:05pm revealed: -He relied on the RCC and the MAs to follow the process and procedures for correct medication administration. -It was his expectation the medications would be correctly labeled for administration to the residents. -The MAs should be referring to the directions on the medication label and the eMAR before administering medications. -He did not know Resident #9 had a medication that was incorrectly labeled.	D 354		
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	D 358		

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D 358	Continued From page 11 and procedures.	D 358		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policy for 1 of 3 residents (Resident #8) observed during the medication pass on 04/16/19, including an error with the administration of a medication for a resident in kidney failure (Resident #8), and 1 of 5 sampled residents who was not administered one of their anti-anxiety medications (Resident #3).

The findings are:

The medication error rate was 6% as evidenced by the observation of 2 errors out of 31 opportunities during the 11:00am-12:00pm medication pass on 04/16/19 and during the 8:00am through 9:30am medication pass on 04/17/19.

1. Review of Resident #8's current FL2 dated 06/21/18 revealed diagnoses included Charcot-Marie-Tooth-disease and Polycystic kidney disease.

The electronic medication administration record (eMAR) signed by the primary care physician (PCP) and dated 03/05/19 revealed an entry for

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calcium acetate 667mg, administer 2 capsules before each meal.

Observation of the medication pass on 04/16/19 at 11:20am am revealed:
-The medication aide (MA) removed one calcium acetate tablet from the bubble pack into a medication cup.
-The MA administered the calcium acetate to the resident with a 6 ounce cup of water.
-The MA sanitized her hands before and after the medication administration with gel located on the medication cart.
-The MA documented the administration of the vitamin supplement on the eMAR.

Review of Resident #8's April 2019 electronic medication administration record (eMAR), from 04/01/19-04/17/19 revealed;
-There was an entry for calcium acetate 667mg take 2 capsules by mouth before each meal for prophylaxis.
-There was documentation calcium acetate 667mg, 2 tablets to equal 1334mg, was administered three times a day at 8:00am, 12:00pm and 6:00pm.

Observation of Resident #8's medications on hand on 04/17/19 at 4:10pm revealed:
-There was a bubble pack labeled calcium acetate 667 mg to be administered 3 times a day before meals.
-The bubblepack was labeled "3 of 3" and there were 28 pills left in the bubblepack.

Interview with the MA on 04/16/19 at 12:05pm revealed:
-She had transferred from second shift to first shift 3 days ago.
-She was getting familiar with the resident's

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needs on first shift.
-Proper administration of medications included reading the eMAR orders and verifying those orders with the label on the medication bubble pack or bottle.
-She always checked both the eMAR order and the medication label.
-The pharmacy usually put 2 medications in one sealed pill enclosure if there were 2 pills to be administered.
-She had overlooked the eMAR entry for 2 tablets to be administered.
-She returned to the resident to administer the second calcium acetate pill.

Interview with Resident #8 on 04/16/19 at 4:05pm revealed:
-She received several pills throughout the day from the MAs.
-She thought she was administered 2 calcium acetate tablets before meals.
-She did not always pay attention to what the MAs administered to her through out the day.

Review of Resident #8's current laboratory blood levels reported on 04/10/19 revealed calcium and phosphorous levels were within normal range.

Interview with the Resident Care Coordinator (RCC) on 04/16/19 at 3:10pm revealed:
-The medication administration policy required the MAs to read the eMAR order for each medication and verify the label on the medication matched the order on the eMAR.
-If an order did not match, the MA was to verify the correct order by checking the resident's record for a copy of the order or calling the physician.
-The MA should report these discrepancies to the RCC so she could also follow up as needed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEXFORD HOUSE	3900 WEXFORD LANE DENVER, NC 28037

(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 358	Continued From page 14 -She did not know the MA administered the wrong dosage of calcium acetate to Resident #8 during the noon time medication pass. Interview with the Administrator on 04/17/19 at 2:05pm revealed: -He relied on the RCC and the MAs to follow the process and procedures for correct medication administration. -The MAs should be referring to the directions on the medication label and the eMAR before administering medications. -He did not know the MA had administered the incorrect dosage of calcium acetate to Resident #8 during the noon time medication pass. 2. Resident #3's current FL2 dated 03/08/19 revealed: -Diagnoses included dementia with behavior difficulties, major neuro cognitive disorder, schizoaffective. -A medication order for clonazepam (used to treat anxiety) 0.5mg one tablet at bedtime. Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for clonazepam 0.5mg one tablet at 8:00pm. -There was documentation the clonazepam was administered correctly. Review of Resident #3's eMAR for 04/01/19 to 04/16/19 revealed: -There was an entry for clonazepam 0.5mg one tablet at bedtime. -There was documentation the clonazepam was administered 04/01/19 - 04/09/19 at 8:00pm. -There was documentation the clonazepam was not administered 04/10/19 - 04/15/19 with the	D 358		

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reasons "waiting on med", "none on the cart to give", waiting to be send from pharmacy" documented.
-There was documentation clonazepam was administered on 04/16/19 at 8:00pm.

Review of progress notes for Resident #3's record and progress notes revealed there was no documentation of anxiety or agitation as a result of missed doses of clonazepam from 04/10/19-04/15/19.

Observation of Resident #3's medications on hand on 04/17/19 at 10:50am revealed 27 pills of clonazepam 0.5mg was available for administration.

Interview with the pharmacist at the contracted pharmacy on 04/17/19 at 9:04am revealed:
-There was an order received on 03/08/19 for clonazepam 0.5mg one tablet daily at 8:00pm for Resident #3.
-There were 25 tablets of clonazepam 0.5mg dispensed and delivered to the facility on 03/11/19.
-There were 28 tablets of clonazepam 0.5mg dispensed and delivered to the facility on 04/10/19.
-Medications were delivered to the facility the evening that they were dispensed.

Interview with a medication aide (MA) on 04/17/19 at 3:10pm revealed:
-She worked 2nd shift and administered evening medications to Resident #3 when she worked.
-She documented four times on the MAR that she was unable to administer clonazepam to Resident #3 in April 2019.
-Resident #3's clonazepam was delivered from the pharmacy and locked in a box that only the

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Resident Care Director (RCD) and the Administrator had a key.
-They were not allowed to keep more than a month supply of a controlled substance on the cart.
-MAs were responsible for notifying the RCD if they ran out of a controlled medication so that it could be retrieved from the locked box.
-She asked the RCD for the clonazepam for Resident #3, however it was not put on the cart.
-She could not remember the dates that she requested the clonazepam from the RCD.
-The RCD put the clonazepam on the cart on 04/16/19.
-She did not ask the Administrator to retrieve the clonazepam from the locked box.
-She did not know why she did not ask the Administrator to retrieve the clonazepam.

Interview with the RCD on 04/17/19 at 3:36pm revealed:
-Controlled medications were delivered to the facility and placed in a locked box until a resident was in need of the medication.
-Resident #3's clonazepam was received by her from the pharmacy on 04/10/19.
-Resident #3's clonazepam was not placed on the cart because she had enough medication on the cart.
-MAs were supposed to notify her when the medication was about to run out of the medication so that it could be placed on the cart.
-She was notified by the MA on 04/16/19 that the medication needed to be added to the cart.
-The MAs had access to her while in the building and she was available by phone when needed.
-She would have come back to the facility in the evening to retrieve Resident #3's clonazepam had she been notified that it was needed.

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D 358	Continued From page 17 Telephone interview with Resident #3's primary care provider (PCP) on 04/17/19 at 2:16pm revealed: -Resident #3 was administered clonazepam for agitation and anxiety. -Missing six doses of clonazepam could cause increased agitation and anxiety. Interview with Resident #3 on 04/17/19 at 2:51pm revealed: -She received her medications every night. -She had not felt anxious or agitated, and had no problems sleeping at night. Interview with the Administrator on 04/17/19 at 3:50pm revealed: -Medications on cycle fill were sent by the pharmacy and were received by the RCD and locked until a resident ran out of medication. -MAs were responsible for asking him or the RCD for medications when they running low. -Medications were locked up until needed to prevent diversion of medications. -He would expect MAs to ask the RCD or him for medications if they were not on the cart before running out. -He and the RCD were available by phone if needed and would come back to the facility to retrieve medications when needed.	D 358		
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	D 371		

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D 371	Continued From page 18 sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure proper infection control measures were implemented for 1 of 7 residents (Resident #7) observed during a morning medication pass related to not sanitizing her hands before administration of medications to a resident and administering a medication that had fallen on the floor (Resident #7). The findings are: Review of Resident #7's current FL2 dated 12/04/18 revealed: -Diagnoses included hypertension, anxiety and renal calculi. -There was an order for Allopurinol 200mg, to be administered once daily. Observation of the morning medication pass on 04/17/19 at 8:20am revealed: -The medication aide (MA) had not washed her hands with soap and water or used an alcohol based sanitizing gel immediately prior to preparing or administering medications to Resident #7. -Resident #7 received 9 tablets in a medication cup with a 6 ounce glass of water in the dining room. -The MA gave the medication cup to the resident who proceeded to remove the pills from the cup and swallow. -One of the pills fell to the floor. -The MA removed the pill from the floor and passed it to Resident #7 who swallowed it. -The MA returned to the medication cart and	D 371		

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documented the administration of the resident's medications.
-The MA sanitized her hands with gel after documentation.

Interview with the MA on 04/17/19 at 8:25am revealed:
-She knew the pill that had fallen to the floor was the Allopurinol medication.
-She should have discarded the medication, and returned with another Allopurinol pill for Resident #7.
-She had completed the Infection Control class with the regional registered nurse (RN) when she became a medication aide last October.

Interview with the Resident Care Coordinator (RCC) on 04/17/19 at 10:25am revealed:
-The MAs received yearly training in infection control policies and procedures from the regional RN.
-The MAs knew medications that had been contaminated were to be disposed of, and a new tablet was to be dispensed.
-Medications on the floor were contaminated and should be disposed.
-Handwashing was emphasized in the infection control class and with all in service training.
-The facility policy for hand sanitizing followed the infection control guidelines: MAs should sanitize with the gel located on each cart after every medication pass and wash their hands with soap and water after the third resident had received their medications.
-She did not know the MA had administered a medication that had fallen on the floor.
-She did not know the MA had not sanitized her hands after each medication pass.

Interview with the Administrator on 04/17/19 at

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D 371	Continued From page 20 2:05pm revealed: -The MAs were to follow the Infection Control policy during the administration of medications to the residents. -The regional RN had conducted infection control education for the MAs as part of their training. -The MAs attended annual infection control training. -The importance of handwashing and hand sanitizing was emphasized with all the staff as part of infection control education. -He did not know the MA had not implemented the handwashing policy of the facility in the administration of medications during the morning medication pass. -He did not know the MA had administered a medication to Resident #7 during the morning medication pass which had fallen on the floor. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.	D 371		