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
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

RECEIVED SEP - 9 2015 ADULT CARE LICENSURE SECTION RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Forsyth County Department of Social Services conducted an initial survey and complaint investigation on August 4, August 5, and August 6, 2015 with an exit conference via telephone on August 10, 2015.	D 000		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure 5 of 6 sampled staff (Staff A, C, D, E and F) were competency validated by a registered nurse (RN) by return demonstration prior to staff performing the required tasks such as Fingerstick Blood sugars (FSBS), injections of insulin, application of anti-embolic hose, Oxygen administration and administration of nebulizer medication. The findings are:	D 161	See Attachment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Cooper (6899) TITLE: Administrator (1QO911) (X6) DATE: 9/8/15

STATE FORM

If continuation sheet 1 of 85

POC Amended as Attached
Per phone conversation w/ Administration on 9-18-15 at 11:30 am
Appendix A Accepted w/ Amendments 9-18-15 YHP

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D161 – 10A NCAC 13F. 0504(a) – Competency Validation For LHPS Tasks:

- This rule was not met as evidenced by observations, interviews, and record review, the facility failed to assure referral and follow up to meet the routine and acute health care needs regarding physician notification of diabetic glucose monitoring as ordered.
- Completion date for items relative to our POC will be no later than 9/24/15.
- With Respect to the Specific Staff Members Cited:
  - All Staff including Staff A, C, D, E and F were trained on diabetic insulin administration 8/5/15 and completion of Licensed Health Professional Support (LHPS) skills validation on 8/6/15.

B. With Respect to How the Facility took Correction Action:

- The Resident Care Coordinator, DON and Human Resources Manager conducted a full 100% audit on (LHPS). LHPS will be completed for all new hires effective immediately within the first week of hire. Current working staff was completed 8/7/15 and all other employees had to complete their training prior to working their next scheduled shifts.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- On 8/07/15 the Resident Care Coordinator, DON and Human Resources Manager created a template for all employees to keep track of their competencies and licensures.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- Business Office Manager will complete an audit at the end of each New Member Orientation to ensure compliance.
- The status of all LHPS will be reviewed monthly by the Business Manager, Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

POC Accepted with (Amended) HWP pages ~~Amended~~ sent to appr by Administrator per Telephone call on 9-18-15 @ 11:30 am. JHPreiss

✓ HWP

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A. With Respect to Rule D164– 10A NCAC 13F. 0505: Training On Care Of Diabetic Resident

- This rule was not met as evidenced by observations, interviews, and record review, the facility failed to assure referral and follow up to meet the routine and acute health care needs regarding of diabetic residents training.

- Completion date for items relative to our POC will be no later than 9/24/15.

- With Respect to the Specific Staff Members Cited:
  - All affected staff was corrected immediately including Staff A, C, D, E and F were trained on diabetic insulin administration 8/5/15. All remaining staff was trained on 8/6/15.

B. With Respect to How the Facility took Correction Action:

- The Resident Care Coordinator, DON and Human Resources Manager conducted a full 100% audit on Training Records. Training on care of Diabetic Residents will be completed for all new hires effective immediately within the first week of hire. Current working staff was completed 8/7/15 and all other employees had to complete their training prior to working their next scheduled shifts.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- On 8/07/15 the Resident Care Coordinator, DON and Human Resources Manager created a template for all employees to keep track of their competencies and licensures.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- Business Office Manager will complete an audit at the end of each New Member Orientation to ensure compliance.

- The status of all LHPS will be reviewed monthly by the Business Manager, Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

✓HR

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 309 – 10A NCAC 13F. 0904 (e)(3): Nutrition and Food Service

This Rule is not met as evidenced by: D 309Based on observations, interviews, and record reviews, the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets (mechanical soft ground, mechanical soft chopped, puree, no concentrated sweets, no added salt, cut meat, and chopped meat) for guidance of food service staff.

- Completion date for items relative to our POC will be no later than 9/24/15.
- With Respect to the Specific Staff Members Cited: There was 100% audit done to compare MD orders for accuracy.

B. With Respect to How the Facility took Correction Action:

- The Resident Care Coordinator, DON and Dietary Manager conducted a full 100% audit on 8/7/15. Staff was reeducated on therapeutic diets, diets posting and a new procedure of informing the Dietary Manager of all new or changed diet orders. This in-service was completed on 8/14/15.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- Meals will be monitored on each shift for compliance with diet order each shift X 1 week. 1 meal will be monitored daily X 1 week. 1 meal will be monitored 3 X weekly for 2 weeks. 1 meal will be monitored weekly X 2 weeks.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- The status of all Skill Evaluations and In-Services will be reviewed monthly by the Dietary Manager, Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 310 – 10A NCAC 13F. 0904 (e)(4): Nutrition and Food Service
Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets (no concentrated sweets and mechanical soft) were served as ordered by the physician for2 of 5 sampled residents (Residents #10 and #11) in the Memory Care Unit (MCU).

- Completion date for items relative to our POC will be no later than 9/24/15.
- With Respect to the Specific Staff Members Cited: There was 100% audit done to compare MD orders for accuracy.

B. With Respect to How the Facility took Correction Action:

- The Resident Care Coordinator, DON and Dietary Manager conducted a full 100% audit on 8/7/15. Staff was reeducated on therapeutic diets, diets posting and a new procedure of informing the Dietary Manager of all new or changed diet orders. This in-service was completed on 8/14/15.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- Meals will be monitored on each shift for compliance with diet order each shift X 1 week. 1 meal will be monitored daily X 1 week. 1 meal will be monitored 3 X weekly for 2 weeks. 1 meal will be monitored weekly X 2 weeks.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- The status of all Skill Evaluations and In-Services will be reviewed monthly by the Dietary Manager, Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. **With Respect to Rule D 358 – 10A NCAC 13F. 1004(a): Medication Administration**
This Rule is not met as evidenced by:
TYPE A2 VIOLATION
Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed
prescribing practitioner for 2 of 6 residents (#3 and #6) observed during medication administration which included errors with administration of Novolin 70/30 insulin and Xarelto 20 mg and 2 of 5 sampled residents (#3,
and #5) which included errors with medications for blood clotting, constipation, and altered thyroid function.

- Completion date for items relative to our POC will be no later than 9/09/15. /
- With Respect to the Specific Staff Members Cited: Immediately each Staff member was educated on medication ordering/administration as ordered by the licensed prescribing practitioner.

B. **With Respect to How the Facility took Correction Action:**

- The Resident Care Coordinator, DON and RN Pharmacy Consultant conducted a in-service for all Medication Technicians on 8/7/15. Staff was reeducated on mediation administration according to licensed prescribing practitioner, glucometer usage per resident individually and the procedure for obtaining a glucometer if needed. Manager of all new or changed diet orders. This in-service was completed on 8/14/15.

C. **With Respect to What Systemic Measures have been put in place to Address the Stated Concern:**

- MARS will be compared to the physicians order and reviewed for accuracy.
- Review eMar exceptions and medication variances report daily for 6 weeks and then weekly.
- Medications orders expiring within 30 days to be run weekly and monitored by the Resident Care Coordinator

D. **With Respect to How the Plan of Corrective Measures will be Monitored:**
The status of medication administration will be reviewed monthly by the Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 466 – 10A NCAC 13F. 1308(b): Special Care Unit Staffing
This Rule is not met as evidenced by: Based on observations, interviews, and review of records, the facility failed to ensure a care coordinator was on duty in the Memory Care Unit (MCU) at least eight hours a day, five days a week.

- Completion date for items relative to our POC will be no later than 9/24/15.
- With Respect to the deficient practice we immediately assigned a RN to the Memory Care Unit 8 hours daily, 5 days per week.

B. With Respect to How the Facility took Correction Action:

- The Human Resources Manager placed an ad for a Special Care Unit Coordinator to the company's website.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- A Special Care Unit Coordinator hiring process has been implemented. We will interview potential applicants to fill this position.
- A Special Care Unit Coordinator was hired on 9/4/2015 but she will not start her employment until the week of October 8th. In the meantime, a nurse will assigned to the Memory Care Unit 8 hours daily, 5 days per week.

D. With Respect to How the Plan of Corrective Measures will be Monitored:
The status of the Special Care Unit Coordinator will be hired on an Interim basis to review their performance for 90 days and we will discuss/evaluate them monthly by the Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 482 – 10A NCAC 13F. 1501(a): Use of Physical Restraints And Alternatives

This Rule is not met as evidenced by: TYPE B VIOLATION
Based on observations, interviews, and record reviews, the facility failed to obtain a physician's order, provide assessment and care planning,
and document attempted alternatives to restraints for 1 of 1 sampled resident (Resident #1) prior to the use of restraints (furniture placed against the bed to prevent the resident from exiting the bed).

- Completion date for items relative to our POC will be no later than 9/24/15.
- With Respect to the deficient practice we immediately removed the furniture/restraint form the resident's bed.

B. With Respect to How the Facility took Correction Action:

- We reeducated the staff that our facility was restraint free, what is a restraint and how to report the use of restraints. This was completed on 8/14/15.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- Resident's room checks will be conducted to audit the use of restraints daily X 1 week, then 3 X week X 2 weeks, then weekly X 2 weeks, then monthly until resolved.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

These audits will be monitored and reviewed monthly by the Administrator, DON, RCC, SCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 912 – G.S. 131D-21(2): Declaration of Residents Rights

This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to staff qualifications, health care, nutrition and food services, Special Care Unit staffing, physical restraints, infection prevention requirements, and medication aide training and competency requirements.

- Completion date for items relative to our POC will be no later than 9/9/15.
- Please refer to Tags D0358, D0276, D0280, D0309, D0310, D0466, D0482 D0932, D0935.

B. With Respect to How the Facility took Correction Action:

- Please refer to Tags D0358, D0276, D0280, D0309, D0310, D0466, D0482 D0932, D0935.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- Please refer to Tags D0358, D0276, , D0280, D0309, D0310, D0466, D0482 D0932, D0935..

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- Please refer to Tags D0358 D0276, D0280, D0309, D0310, D0466, D0482 D0932, D0935..

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A. **With Respect to Rule D 914 – G.S. 131D-21(4): Declaration of Residents Rights**
Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed
prescribing practitioner for 2 of 6 residents (#3 and #6) observed during medication administration which included errors with
administration of Novolin 70/30 insulin and Xarelto 20 mg and 2 of 5 sampled residents (#3, and #5) which included errors with medications
for blood clotting, constipation, and altered thyroid function. [Refer to Tag D0358, 10A NCAC 13F.1004(a) Medication Administration (Type A2
Violation)].

- Completion date for items relative to our POC will be no later than 9/9/15.
- Please refer to Tag D0358.

B. **With Respect to How the Facility took Correction Action:**

- Please refer to Tag D0358.

C. **With Respect to What Systemic Measures have been put in place to Address the Stated Concern:**

- Please refer to Tag D0358.

D. **With Respect to How the Plan of Corrective Measures will be Monitored:**
Please refer to Tag D0358.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 932 – G.S. 131D-4.4A(b): ACH Infection Prevention Requirements
This Rule is not met as evidenced by: TYPE B VIOLATION
Based on observation, interview and record review, the facility failed to assure adequate and appropriate infection control measures were
implemented for blood glucose monitoring regarding the use of shared glucometers for 3 of 4 sampled residents (Residents # 6, #7, #8, and
#9) with orders for glucose monitoring.

- Completion date for items relative to our POC will be no later than 9/24/15.

B. With Respect to How the Facility took Correction Action:

- We immediately educated the staff that each resident is to use their own personal glucometer and the procedure for obtaining a glucometer if needed. T
- The facility audited that each resident had their own glucometer and labeled each one. This was completed on 8/07/15.
- NC DHSR approved Infection Control procedures have been added to our New Hire orientation and yearly refresher course for all Medication Technicians.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- Glucometer readings will be compared to the MAR daily X 2 weeks, then 3 X weekly X 2 weeks, then 2 X weekly for 2 weeks, then weekly X 4 weeks.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- The status of all Infection Control procedures related to glucometers will be reviewed monthly by the Business Manager, Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. **With Respect to Rule D 934 – G.S. 131D-4.5B(a): ACH Infection Prevention Requirements**
This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure all medication aides received annual in-service training for infection control, safe practices for injections and glucose monitoring for 3 of 5 sampled Staff (Staff B, C,and E).

- Completion date for items relative to our POC will be no later than 9/24/15.

B. **With Respect to How the Facility took Correction Action:**

- Human Resources Manager immediately audited all employee personnel files to identify any employees that required annual infection control training. This was completed on 8/7/15.
- NC DHSR approved Infection Control procedures have been added to our New Hire orientation and yearly refresher course for all Medication Technicians.

C. **With Respect to What Systemic Measures have been put in place to Address the Stated Concern:**

- An audit tool was created by the Human Resources Manager for all employees to show there competencies and annual requirements.
- A checklist has been added to New Hire Orientation and this must be completed and returned to Human Resources to track all training and annual requirements.

D. **With Respect to How the Plan of Corrective Measures will be Monitored:**
The status of all training and competencies will be monitored by Human Resources and reviewed monthly by the Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D276– 10A NCAC 13F. 0902 (c)(3-4): Health Care

- This rule was not met as evidenced by observations, interviews, and record review, the facility failed to assure referral and follow up to meet the routine and acute health care needs regarding written procedures, treatments or orders from a licensed health professional.
- Completion date for items relative to our POC will be no later than 9/24/15.
    - With Respect to the Specific Staff Members Cited: They were In-Serviced immediately by the Resident Care Director and Director of Nursing on 8/5/15 and the remaining staff members were In-Serviced by a Registered Nurse Pharmacy Consultant for written procedures, treatments or orders from a licensed health professional on 8/6/15.

B. With Respect to How the Facility took Correction Action:

- The Resident Care Coordinator, DON and Human Resources conducted an Audit. Training of written procedures, treatments or orders from a licensed health professional will be conducted for all new hires effective immediately within their first week of hire. Training for current employee's was completed 8/7/15 and all other employees not scheduled on 8/7/15 completed their training prior to the start of their next scheduled shift.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- On 8/07/15 the Resident Care Coordinator, DON and Human Resources Manager created a template for the community to track competencies and licensures of all staff.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- Business Office Manager will complete an audit at the end of each New Member Orientation to ensure compliance.
- The status of all Skill Evaluations and In-Services will be reviewed monthly by the Business Manager, Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

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Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. **With Respect to Rule D 935 – G.S. 131D-4.5B(b): ACH Medication Aides ; Training and Competency Evaluation Requirements** TYPE B VIOLATION

Based on observation, interview and record review, the facility failed to assure 3 of 5 sampled Staff (Staff A, Staff C, and Staff E), who were
hired after 10/1/13 as Medication Aides (MA), had successfully completed the 15 hour medication administration training and 1 of 5 sampled Staff
(Staff A) completed the Medication Clinical Skills Validation, prior to administering medications.

- Completion date for items relative to our POC will be no later than 9/24/15.

B. **With Respect to How the Facility took Correction Action:**

- Human Resources Manager immediately audited all employee personnel files to identify any employees that required annual competency training. This was completed on 8/7/15.
- NC DHSR approved Annual competency trainings procedures have been added to our New Hire orientation and yearly refresher course for all Medication Aides.

C. **With Respect to What Systemic Measures have been put in place to Address the Stated Concern:**

- An audit tool was created by the Human Resources Manager for all employees to show there competencies and annual requirements.
- A checklist has been added to New Hire Orientation and this must be completed and returned to Human Resources to track all training and annual requirements.

D. **With Respect to How the Plan of Corrective Measures will be Monitored:**

- The status of all training and competencies will be monitored by Human Resources and reviewed monthly by the Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Amended per telephone call on 9-18-15 @ 11:30 am
E Administrator.
Amended pages to follow.
Hu Reedin
9-18-15

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A. With Respect to Rule D280– 10A NCAC 13F. 0903 (c): Licensed Health Professional Support

- This rule was not met as evidenced by observations, interviews, and record review, the facility failed to assure that a licensed health professional participated in on-site review and completed a Licensed Health Professional Support (LHPS) assessment for 1 of 5 sampled residents task including anti-embolism stockings, and application of a brace or splint.

- Completion date for items relative to our POC will be no later than 9/24/15.

- With Respect to the Specific Staff Members Cited:

B. With Respect to How the Facility took Correction Action:

- The Resident Care Coordinator, DON and Human Resources Manager conducted a full 100% audit on (LHPS). LHPS will be completed for all new hires effective immediately within the first week of hire. Current working staff was completed 8/7/15 and all other employees had to complete their training prior to working their next scheduled shifts.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- On 8/07/15 the Resident Care Coordinator, DON and Human Resources Manager created a template for all employees to keep track of their competencies and licensures.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- Business Office Manager will complete an audit at the end of each New Member Orientation to ensure compliance.

- The status of all Skill Evaluations and In-Services will be reviewed monthly by the Business Manager, Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Amended
per telephone call on 9-18-15 @ 11:30 Am
w Administrator.
Amended pages to follow
HHReeder
9-18-15

Received email 9.18.15 HH

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A. With Respect to Rule D280– 10A NCAC 13F. 0903 (c): Licensed Health Professional Support

- This rule was not met as evidenced by observations, interviews, and record review, the facility failed to assure that a licensed health professional participated in on-site review and completed a Licensed Health Professional Support (LHPS) assessment for 1 of 5 sampled resident's task including anti-embolism stockings, and application of a brace or splint.
- Completion date for items relative to our POC will be no later than 9/24/15.
- With Respect to the Specific Staff Members Cited:

B. With Respect to How the Facility took Correction Action:

- The Resident Care Coordinator, DON and Human Resources Manager conducted a full 100% audit on resident (LHPS). LHPS will be completed for all new residents effective immediately.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- On 8/07/15 the Resident Care Coordinator and DON created a notebook to keep resident LHPS tracked.
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D. With Respect to How the Plan of Corrective Measures will be Monitored:

- Business Office Manager will complete an audit at the end of each New Member Orientation to ensure compliance.
- The status of all Skill Evaluations and In-Services will be reviewed monthly by the Business Manager, Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Approved HHS 9.18.15
Amended VIA telephone and E-Mail notification on 9.18.15 @ 11:30 AM

Received via Email 9-18-15 HAP

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 935 – G.S. 131D-4.5B(b): ACH Medication Aides ; Training and Competency Evaluation Requirements TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure 3 of 5 sampled Staff (Staff A, Staff C, and Staff E), who were hired after 10/1/13 as Medication Aides (MA), had successfully completed the 15 hour medication administration training and 1 of 5 sampled Staff (Staff A) completed the Medication Clinical Skills Validation, prior to administering medications.

- Completion date for items relative to our POC will be no later than 9/24/15.

B. With Respect to How the Facility took Correction Action:

- Human Resources Manager immediately audited all employee personnel files to identify any employees that required annual competency training. This was completed on 8/7/15.
- NC DHSR approved Annual competency trainings procedures have been added to our New Hire orientation and yearly refresher course for all Medication Aides.
- Staff that didn't have the required training was removed immediately and were properly trained. The remaining staff was trained prior to working the Medication Cart on their next scheduled shifts.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- An audit tool was created by the Human Resources Manager for all employees to show there competencies and annual requirements.
- A checklist has been added to New Hire Orientation and this must be completed and returned to Human Resources to track all training and annual requirements.

D. With Respect to How the Plan of Corrective Measures will be Monitored:
The status of all training and competencies will be monitored by Human Resources and reviewed monthly by the Administrator, DON, RCC and Executive Director. The Quality Assurance Improvement Team will review the effectiveness monthly during our Quality Assurance meetings.

Approved 9-18-15 HAP as amended by Administrator per telephone call on 9-18-15 at 11:20 AM