STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL026002	A. BUILDING: _____ B. WING _____	03/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TOUCH OF GRACE	7028 KITTRIDGE DRIVE FAYETTEVILLE, NC 28314

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 1 - 2, 2016.	C 000	C246 **Measures Put in Place to Correct Deficient Area:** • The deficiency occurred when staff was referring to order of resident's physician prior to the resident's admission into the care home. The resident's current physician did not include blood pressure readings on any order which resulted in some confusion. • On 3/1/16, Administrator [redacted] contacted physician to receive clear orders on blood pressure readings. Physician sent updated orders of blood pressure readings. • A drug review was conducted by the care home's nurse to include the revised blood pressure readings on 3/10/16. • Once corrective order was received by physician, staff was re-trained by nurse on procedures for reporting blood pressure readings and finding clarity when FL2 does not state readings according to what is performed. **Measure Put in Place to Prevent the Problem from Occurring Again:** • Care Home procedures have been updated to track changes with information on FL2s, physician orders, and at each physician's visit • A form has been developed that is completed by Administrator and submitted to the pharmacist for review to ensure compliance with new order. • Any changes noted on the form from a previous order or FL-2, administrator will review new orders and proper procedures with staff.	3/18/2016
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure physician notification of blood pressure readings according to physician parameters for 1 of 3 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 06/03/2015 revealed: -Diagnoses included Hypertension and Schizophrenia. -A physician order for blood pressure checks weekly with parameters for systolic readings less than 100 or greater than 180, and diastolic parameters less than 80. -There were no parameters documented for a greater than diastolic reading. Review of the physician orders on Resident #2's current FL-2 dated 06/03/2015 revealed: -A physicians order for Amlodipine Besylate 10mg tablet daily (used to treat high blood pressure). -A physicians order for Metoprolol Succ ER 100mg tablet two times a day (used to treat high blood pressure). -A physicians order for Micardis 80mg tablet daily (used to treat high blood pressure).	C 246		

Reviewed and accepted 3/30/2016 HF

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C 246	Continued From page 1 Review of blood pressure readings documented for 12/2015 for Resident #2 revealed: -On 12/06/2015 9:25am, diastolic blood pressure reading documented as 70. -On 12/27/2015 10:45am, diastolic blood pressure reading documented as 66. -No documentation the physician was notified regarding the diastolic blood pressure readings less than 80. Review of blood pressure readings documented for 01/2016 for Resident #2 revealed: -On 01/3/2016 7:50am, diastolic blood pressure reading documented as 79. -On 01/31/2016 7:15am, diastolic blood pressure reading documented as 72. -No documentation the physician was notified regarding the diastolic blood pressure readings less than 80. Review of notes documented in Resident #2's record for 01/11/2016 revealed: -Resident #2 complained of dizziness and headache. -Resident #2's blood pressure reading was recorded as (systolic) 156/101 (diastolic) at 10am. -Resident #2's blood pressure reading was recorded as 131/93-diastolic at 11am after resting. -No documentation the physician was notified regarding the blood pressure readings or resident's complaints. Review of notes documented in Resident #2's record for 01/12/2016 revealed: -Resident #2 complained of dizziness, headache, and pain in eyes. -Resident #2's blood pressure reading was	C 246	• For any order that is not clear, the physician will be contacted immediately the same day. • [redacted], Pharmacist Consultant with [redacted] Pharmacy, will conduct on-going quarterly reviews on doctor's orders and medications, as well as conduct in-service trainings with staff on compliance with state regulations, and following and monitoring physician orders. [redacted] will also follow through with physicians to receive clarification when orders are unclear. **Person Conducting Monitoring to Prevent Occurrence Again:** • [redacted], CEO/Administrator • [redacted] Pharmacist Consultant, [redacted] Pharmacy **Frequency of Monitoring Activities:** • Monitoring will occur anytime a new physician's order or FL-2 form is received as well as after each doctor's visit. Monitoring will also occur quarterly to review physician order's and medications.	

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C 246	Continued From page 2 134/85-diastolic at 7am. -No documentation the physician was notified regarding the blood pressure reading or resident's complaints. Review of blood pressure readings documented for 02/2016 for Resident #2 revealed: -On 02/07/2016 8:30am, systolic blood pressure reading documented as 98. -On 02/07/2016 8:30am, diastolic blood pressure reading documented as 57. -On 02/14/2016 8:45am, diastolic blood pressure reading documented as 67. -On 02/27/2016 10:44am, diastolic blood pressure reading documented as 75. -No documentation the physician was notified regarding the systolic blood pressure reading documented as less than 100. -No documentation the physician was notified regarding the diastolic blood pressure readings less than 80. Interview with a Medication Aide (MA) on 03/01/2016 at 4:15pm revealed: -The MA was supposed to notify the Administrator when Resident #2's blood pressure readings were high or low or when the resident had swelling in her feet. -The Administrator was responsible to contact the physician once the MA had contacted the Administrator. -The MA had not called the physician about any blood pressure readings for Resident #2. Interview with the Administrator on 03/01/2016 at 4:30pm revealed: -Resident #2's vital sign sheet was reviewed by the physician when the resident went to the doctor's office. -The facility staff thought the physician wanted to	C 246		

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C 246	Continued From page 3 be contacted when Resident #2's systolic blood pressure reading was 180 or greater. -The physician's office had not been contacted about Resident #2's blood pressure readings. -There was some discrepancy with the blood pressure parameter order that needed clarifying and the Administrator would ensure the order would be clarified. -Resident #2's blood pressure readings were good when Resident #2 had doctor appointments. Telephone interview with the physician's office nurse on 03/01/2016 at 4:35pm revealed: -Resident #2's blood pressure had been in good control. -Resident #2 was last seen by the physician on 02/08/2016 and the resident's blood pressure was 133/85. -Resident #2 was seen by the physician in January 2016 and the resident's blood pressure was 126/70 and the physician documented the resident's blood pressure was okay. -The physician would consider the blood pressure elevated if the blood pressure was 180/90. -The physician would consider the blood pressure low if the blood pressure was 90/60. -The physician had not been notified of any of the blood pressure readings at the facility that were outside the parameters. -The physician would have wanted the residents blood pressure readings repeated and to be monitored maybe 1-2 times a day and call back with the readings if the physician had been contacted with high or low blood pressure readings. Interview with Resident #2 on 03/01/2016 revealed the resident had no complaints.	C 246		

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C935	Continued From page 4	C935	C935	
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	C935	**Measures Put in Place to Correct Deficient Area:** • Upon date ATG, Inc. was made aware of this deficiency, ATG immediately halted staff from administering any medication to residents until verification from previous employment is received or the staff member completes the 10 hour training. • The staff member has completed the 10 hour training course in Medication Administration for adult care homes. A list of instructors was obtained from the NC DHHS website. Instructor [redacted] completed the 10 hour training with staff on Saturday, 3/19/16. The Certificate of Completion will be filed in the employee's record. • Agency specific certificates for Medication Administration will be completed and signed by the nurse. • The agency's nurse completed a training on 3/17/2016 on Core Concepts Course and Diabetic Training.	3/19/2016

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C935	Continued From page 5 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 1 staff (Staff A) who began performing medication aide duties after October 1, 2013 met the requirements to administer medications. The findings are: Review of Staff A's personnel file revealed: -Staff A was hired to work for the corporation on 12/31/2013. -Staff A began working at the facility as a Supervisor/Personal Care Aide/Medication Aide on 08/01/2015. -Staff A completed Medication Clinical Skills Checklists on 01/10/2014, 09/04/2014, 01/06/2015, 10/13/2015, and 01/05/2016. -Staff A completed the 5 hour medication training on 09/04/2014. -No documentation for medication aide employment verification. -No documentation for the 10 hour medication training being completed. -No documentation for the 15 hour medication training being completed. Observation of Staff A on 03/01/2016 from 12:20pm to 12:30pm revealed: -Staff A administered medication in a cup to Resident #3 in the dining room. -Staff A documented the administration of the	C935	**Measure Put in Place to Prevent the Problem from Occurring Again:** • On 3/3/2016, the Facility Medication Aide Verification was obtained from the NC DHSR website. The forms will be kept on file and sent to previous employers every time a prospective employer is considered for employment at the care home. • ATG, Inc. will ensure that prior to the hire of staff for the family care home, the Facility Medication Aide Verification form will be completed by prospective employee's previous employer indicating that worker was employed as a Medication Aide within the last 24 months. The verification form will be kept in the employee's record. If the prospective employee is verified from the previous employer, the prospective employee will also need to have passed the written exam and completed the competency skills validation. • If the verification form cannot be obtained, then the new employee will be required to complete the 5 hour training course and pass the written exam prior to the date of hire. The employee must then complete the 10 hour training course within 60 days of employment to administer medication. Certificates of completion will be filed in the employee record. **Person Conducting Monitoring to Prevent Occurrence Again:** • [redacted], CEO/Administrator	

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C935	Continued From page 6 medication after administering the medication. Interview with Staff A on 03/01/2016 at 9:30am revealed: -Staff A worked at the facility every day. -Staff A slept at the facility during the night. -Staff A's responsibilities included medication administration to the residents living in the facility. -There was one resident at the facility who required the staff to perform finger stick blood sugar checks but the resident did not require insulin administration. Review of the February 2016 Medication Administrations Records for Resident #1 revealed: -Staff A documented finger stick blood sugar checks on Mondays, Wednesdays, and Fridays. -Staff A documented administration of oral medications daily at 8:00am. Review of the February 2016 Medication Administrations Records for Resident #2 revealed: -Staff A documented administration of oral medications daily at 8:00am. -Staff A documented administration of nasal spray medication as needed by the resident. Interview with the Administrator on 03/01/2016 at 5:30pm revealed: -The Administrator thought the Medication Aide had to complete the 5 hour "or" 10 hour medication aide training. -Staff A had additional training on medication administration with the facility nurse but the training was not a state approved training. -The Administrator had not done any medication aide employment verification for Staff A. -The Administrator had talked with Staff A prior employer before Staff A was hired in the home	C935	**Frequency of Monitoring Activities:** • Monitoring will occur prior to the time of hire. On-going monitoring will occur within 60 days of hire for employees needing to complete the additional 10 hour training. Employee records are reviewed on a quarterly basis.	

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C935	Continued From page 7 but the conversation was only to confirm Staff A's ability to pass meds but did not verify Staff A had worked as a medication aide in the prior 24 months.	C935		