STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041027	A. BUILDING: _____ B. WING _____	01/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTDALE MANOR	303 WESTDALE PLACE GREENSBORO, NC 27403

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C 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services conducted an annual survey on 01/11/17 and 01/12/17 with an exit conference via telephone on 01/17/17.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain the hot water temperature between 110 degrees Fahrenheit (F) and 116 degrees F in 3 of 3 bathrooms accessible to the residents. The findings are: Review of the facility census revealed there were 6 residents currently residing at the facility. Observation on 01/11/17 at 9:15 am revealed the following hot water temperatures: -In bathroom #1, the hot water temperature was 124 degrees F in the shower and 123 degrees F in the sink. -In bathroom #2, the hot water temperature was 122 degrees F in the shower and 122 degrees F in the sink.	C 105	C 105 The facility readings were lower than the readings documented by the licensure consultant by 6 points. The highest reading we got was 118. Hot water temperatures were checked on a weekly basis. I agree that the facility was not in compliance with the state requirements. There was a snow storm on 01/06/17. There was snow still on the ground when this survey was conducted on 01/11/17. According to our plumber, due to the location of the hot water heater (under the house) the weather could have triggered a malfunction. The plumber had to replace a mixing valve and said that the hot water temperature could not have gotten over 120 due to the settings of the temperature and the malfunction caused the water to get colder than normal opposed to hotter than normal. The hot water heater was repaired on 01/18/17.	C 105 Repaired 01/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: This form has been Electronically Signed by Amma Allen

TITLE: Administrator

(X6) DATE: 04-07-17

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C 105	Continued From page 1 -In bathroom #3, the hot water temperature was 122 in the sink. There was no shower in bathroom #3. Observation on 01/11/17 at 4:20 pm revealed: -After calibration of the thermometer, hot water temperatures were rechecked with the Supervisor-In-Charge (SIC) and results compared between the two thermometers. -The hot water temperatures at all fixtures remained between 120 and 124 degrees F with both thermometers. Interview on 01/11/17 at 4:30 pm with the Supervisor-In-Charge (SIC) revealed: -She routinely checked the hot water temperatures every Friday and faxed the results to the Administrator. -She did not know what the temperature range for hot water should be. Review on 01/11/17 4:40 pm of the water temperature logs provided by the SIC revealed: -She had documentation of water temperatures taken in December 2016 and 03/30/16 through 04/29/16, but was unable to find any additional documentation. -The December 2016 log had documentation of water temperatures taken on 12/16/17 and 12/30/16. -There was no further documentation of hot water temperature checks in December 2016. -Documentation of water temperature on 12/16/16 at 4:30 pm was 104 degrees F in bathroom #1, 90 degrees F in bathroom #2, and 90 degrees F in bathroom #3. -Documentation of water temperature on 12/30/16 at 3:30 pm was 95 degrees F in bathroom #1, 90 degrees F in bathroom #2, and 93 degrees F in bathroom #3.	C 105	C 105 The measures put in place to correct this deficient area of practice is as follows: 1. A plumber was hired to repair the hot water heater. 2. The plumber also made adjustments to ensure the temperature ranges meet the state requirement ranges (between 100 and 116). 3. This measure corrected the problem that resulted in the water temperature ranges. The measures put in place to prevent this problem from occurring again is as follows: 1. Staff has been re-trained on what the proper temperature reading ranges are to comply with state rules. 2. The proper readings are also listed on the form that we use to document weekly readings to remind staff of the proper readings. 3. Staff have been re-trained to immediately contact facility management if the hot water range does not meet state requirement. 4. The weekly hot water temperature readings are faxed to facility management for review on a weekly basis. 5. We have added this subject to our quarterly QI Meeting Agenda to review this area routinely. This plan will allow us to follow up and review the measures put in place and make necessary adjustments if necessary. Who will monitor the situation and how often: 1. Staff has a routine to monitor the hot water temperatures every Friday morning between the hours of 8 AM and 12 Noon.. 2. Each staff has been instructed to contact management immediately if the hot water temperature is ever under 100 or over 116. 3. Effective January 18, 2017, Facility Management has also started checking the hot water temperature on Tuesday mornings to compare their readings to the reading recorded by the staff on Fridays.	

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C 105	Continued From page 2 -The documented water temperatures taken daily from 03/30/16 through 04/29/16 ranged between 90 and 110 degrees F with one temperature on 04/29/16 in bathroom #1 of 118 degrees F. Interview on 01/11/17 at 4:35 pm with the Administrator revealed: -She was not aware the hot water temperatures were outside the range of 100 and 116 degrees F. -"I dropped the ball. I thought the SIC would call me to let me know if the water temps were out of range". -The Administrator instructed the SIC to post signs at every hot water fixture to alert residents that the water was too hot. -She would contact a family member to come to the facility immediately to adjust the hot water temperatures. Observation on 01/12/17 at 9:30 am revealed the hot water temperature was 124 degrees F in all three bathroom fixtures. A second interview on 01/12/17 at 9:30 am with the SIC revealed the Administrator's family member adjusted the hot water thermostat last night and again this morning at 6:00 am. Interviews on 01/12/17 at 10:00 am with the 3 residents currently present in the facility revealed: -Two residents stated the water temperatures were "okay". -One resident stated when taking a shower, it took "forever to get the water right because it is so hot". The water was hot enough that it "hurt" the skin, but had never produced any blisters. Observation on 01/12/17 at 12:45 pm revealed the hot water temperature was 120 to 122	C 105	C 105 Completion dates: Effective January 18, 2017, Our new plan was implemented (see page 2). A plumber completed necessary repairs (01/18/17) and staff and facility management have been working together to maintain the proper temperature ranges according to state requirements on a weekly basis. the readings were within range 01/27/17, 02/03/17 and 02/13/17. However, On several occasions, (02/23/17 and 03/10/17) the bathroom faucets water temperature fell slightly below 100 ranging from 97 to 99. On 3/15/17 it fell to 95 at that same location. The plumber returned on March 18, 2017 and made a follow up visit to readjust to ensure the proper temperature. After reviewing the weekly water temperature logs, the results have been in the proper ranges. The lowest ranges 101 and the highest113. We will continue to follow the system in place to maintain the temperatures according to state rules and regulations. Adjustments will be made if necessary.	

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C 105	Continued From page 3 degrees F.	C 105	C 145 Staff A Hire Date: October 2015 Staff A Start Date: November 2015 Staff A Job Description: Relief SIC Staff A HCPR Check: November 10, 2015 (original possibly shredded in error) Staff A HCPR Re-Check: January 12, 2017 Facility Findings: Staff A had no substantiated findings listed on the HCPR. The measures put in place to correct the deficient area of practice is as follows: 1. The facility always completes a HCPR for all employees prior to start date. We will continue to complete a HCPR on employees prior to start date. To avoid the potential risk of misplacing employee records in the fuuture, we have established the following measures listed below. What measures are put in place to prevent this problem from occurring again: 1. Relief Staff records were kept in a separate location than our main facility employees records. Human error caused the misplacement of the original HCPR check. To prevent this error in the future we are keeping all employee records together and using a back up secure cloud sytem. Who will monitor the situation and how often? 3. Facility Management and nurse consultant will monitor everyquarter during our QI Quarterly Meetings to make sure that current and new employees not only meet the necessary state requirements but also properly filed to avoid misplacing. The cloud back up system has been beneficial.	C 145 Completion date: Employee record review 02/01/17. Cloud system put in place 02/10/17.
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure a Health Care Personnel Registry (HCPR) check was completed prior to hire for 1 of 3 sampled staff (Staff A). The findings are: Review of personnel records for Staff A, Personal Care Aide, revealed: -There was no clear documentation of hire date, but drug screening and tuberculosis testing was completed in November 2015. -No documentation of a HCPR check. Telephone interview on 01/11/17 at 11:00 am and 01/12/17 at 12:48 pm with Staff A revealed: -She had worked at the facility for "over a year". -She routinely worked every other weekend. -She did not know anything about a HCPR check or whether or not the Administrator checked it when she was hired. Interviews on 01/11/17 and 01/12/17 at various times with the Administrator revealed: -Staff A was hired in November 2015, but she did	C 145		

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C 145	Continued From page 4 not know the exact date of hire. -She was sure she checked the HCPR for Staff A upon hire, but was unable to locate documentation of the check. -She was careful to check the HCPR for all staff upon hire. -She would never let any staff work without having the HCPR check completed first. -She would continue to look for the documentation and provide it if found. A HCPR check completed on 01/12/17 for Staff A revealed there were no substantiated findings listed.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40. The findings are: Review of personnel records for Staff A, Personal Care Aide, revealed: -There was no clear documentation of hire date, but drug screening and tuberculosis testing was completed in November 2015.	C 147	C 147 Staff A Hire Date: October 2015 Staff A Start Date: November 2015 Staff A Job Description: Relief SIC Staff A Criminal Record Check: 11-10-15 (original possibly shredded in error - bank records confirm this date) Staff A Criminal Record Re-Check: 01-13-17 The facility always completes a criminal record check for all employees prior to start date. We will continue to complete a criminal record on employees prior to start date. Relief Staff records were kept in a separate location than our main facility employees records. Human error caused the misplacement of the original criminal record check. To prevent this error in the future we are keeping all employee records together and use a back up secure cloud sytem.	

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C 147	Continued From page 5 -No documentation of a criminal background check. Telephone interviews on 01/11/17 at 11:00 am and 01/12/17 at 12:48 pm with Staff A revealed: -She had worked at the facility for "over a year". -She routinely worked every other weekend. -She thought the facility did a criminal background check when she was hired. Interviews on 01/11/17 and 01/12/17 at various times with the Administrator revealed: -Staff A was hired in November 2015, but she did not know the exact date of hire. -She was sure she completed the criminal background check for Staff A upon hire, but was unable to locate documentation of the check. -She was careful to check complete the criminal background checks for all staff upon hire. -She would never let any staff work without having the completed the background check completed first. -She would continue to look for the documentation and provide it if found. No further information regarding the criminal background check was provided.	C 147	C 147 The measures put in place to correct the deficient area of practice is as follows: 1. The facility always completes a criminal background check for all employees prior to start date. We will continue to complete a criminal background check on employees prior to start date. To avoid the potential risk of misplacing employee records in the fuuture, we have established the following measures listed below. What measures are put in place to prevent this problem from occurring again: 1. Relief Staff records were kept in a separate location than our main facility employees records. Human error caused the misplacement of the original criminal background check. Bank statements proved the check was done on November 10, 2015. 2. To prevent this error in the future we are keeping all employee records together and using a back up secure cloud sytem. Who will monitor the situation and how often?	
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family 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	C 171	3. Facility Management and nurse consultant will monitor every quarter during our QI Quarterly Meetings to make sure that current and new employees not only meet the necessary state requirements but also properly filed to avoid misplacing. The cloud back up system has been beneficial.	C 147 Completion date: Employee record review 02/01/17. Cloud system put in place 02/10/17

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C 171	Continued From page 6 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: Based on interviews and record reviews, the facility failed to ensure 3 of 3 staff (Staff A, B, and C) performing Licensed Health Professional Support (LHPS) tasks (fingerstick blood sugar testing) were competency validated prior to performing the task and ongoing competency assured through staff oversight and supervision. The findings are: A. Review of personnel records for Staff A, Personal Care Aide, revealed: -There was no clear documentation of hire date, but drug screening and tuberculosis testing was completed in November 2015. -No documentation of LHPS validation. -A Medication Aide Clinical Skills Checklist dated and signed by a nurse on 09/01/16 was not signed by Staff A. Interviews on 01/11/17 at 11:20 am and 11:40 am with two residents requiring fingerstick blood sugar (FSBS) testing revealed Staff A performed the FSBS checks when she was on duty every other weekend. Telephone interviews on 01/11/17 at 11:00 am and 01/12/17 at 12:48 pm with Staff A revealed: -She had worked at the facility for "over a year" and routinely worked every other weekend. -She was not a Medication Aide (MA) but had been trained how to give medications by the Administrator.	C 171	C 171 Staff A was validated on the task that she performed at the facility (blood sugar). Our facility nurse consultant completed the necessary training required by the state.Staff A fingerstick validation dates:10-02-15, 12-09-15, 12-10-15, 09-01-16 Staff A did not perform any other LHPS Task Staff B completed LHPS Validation by an old nurse consultant originally on 08-11-03 for all LHPS task. Our current nurse consultant completed LHPS Validation for Staff B on 02-11-10. All of this information was in the staff record book and I showed this to the adult care home specialist on 01-11-17 (during the review of staff records during this survey). Staff B also completes annual training that also includes all LHPS task along with other continuing education classes. Staff B completed annual training with our nurse consultant on 12/09/15 and 12/10/15 that included training on all LHPS task. Staff C completed the necessary training for the LHPS task that she performs (fingerstick blood sugar) by our facility nurse on 04-02-09. This information was in our main employee record book that was provided and reviewed on 01/11/17. Staff C had annual continue education classes with our nurse consultant and all LHPS task were completed on 12/09/15 and 12/10/15 during annually CEU training with our nurse consultant.	

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C 171	Continued From page 7 -She had been checking residents' fingerstick blood sugars (FSBSs) since she was hired, even before training as a MA. -She did not recall being checked off to perform FSBS testing by a nurse, "just" the Administrator. -She used the same glucometer and lancing device to check FSBSs for two different residents. -She "just wiped off" the meter and the lancing pen with an alcohol swab every morning before using them to obtain the two FSBSs. Interview on 01/12/17 at 2:00 pm with the Administrator revealed: -Staff A was checked off by the nurse to perform FSBSs on 09/01/16 when the Clinical Skills Checklist was completed. -Staff A was trained by the "staff and the nurse" when she "first came" (to work at the facility). Refer to interview on 01/12/17 at 2:00 pm with the Administrator. Refer to telephone interview on 01/12/17 at 4:30 pm with the facility nurse. B. Review of personnel records for Staff B, Medication Aide, revealed: -There was no clear documentation of hire date. -Hire date was unable to be determined from additional documentation in the personnel file as tuberculosis testing was completed in 2000, Medication Aide Clinical Skills Checklist in 2003, Health Care Personnel Registry in 2006, and criminal background in 2007. -No documentation of LHPS validation. Interview on 01/12/17 at 12:25 pm with the Administrator revealed she did not know Staff B's hire date, but Staff B had worked "since the mid	C 171	C 171 The measures put in place to correct the deficient area of practice is as follows: 1. Our nurse consultant trains all employees on all LHPS task during our annual continuing education classes. During clinical skills, th nurse completes training for fingersticks because that is the only daily task currently needed. Residents currently don't require the need for any other LHPS task. When a resident may require another LHPS task, our facility nurse will complete a refresher review for staff to make sure they are trained properly prior to performing a task. An Infection Control Course is also provided annually by our facility nurse and it is a mandatory requirement for all of our employees. What measures are put in place to prevent this problem from occurring again: Staff were immediately retrained on Diabetic Care Training and Infection Control by our facility nurse. Staff C on January 12, 2017 Staff B on January 31, 2017 Staff A February 05, 2017 This training also included a review of our facilities Infection Control Policy & Procedures Manual. A sign was also posted on the wall for a quick review of implementing safety measures for infection prevention while monitoring glucose levels. Who will monitor the situation and how often? Facility Management and nurse consultant will monitor every quarter during our QI Quarterly Meetings to make sure that current and new employees meet the necessary state requirements.	C 171 Re-Training completion dates: Staff C 01/12/17 Staff B 01/31/17 Staff A 02/05/17

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C 171	Continued From page 8 80's as live-in staff". Interviews on 01/11/17 at 11:20 am and 11:40 am with two residents requiring fingerstick blood sugar (FSBS) testing revealed Staff B performed the FSBS checks when she was on duty every other weekend. Attempts to interview Staff B by telephone were unsuccessful. Refer to interview on 01/12/17 at 2:00 pm with the Administrator. Refer to telephone interview on 01/12/17 at 4:30 pm with the facility nurse. C. Review of personnel records for Staff C, Supervisor-In-Charge, revealed: -She was hired in March 2009, but the exact date was unclear. -A Medication Aide Clinical Skills Checklist was completed on 04/02/09. -There was no documentation of LHPS validation. Interview on 01/12/17 at 1:27 pm with Staff C revealed she had been checked off by a nurse but she did not remember when. Interviews on 01/11/17 at 11:20 am and 11:40 am with two residents requiring fingerstick blood sugar (FSBS) testing revealed Staff C performed the FSBS checks when she was on duty Monday through Friday. Refer to interview on 01/12/17 at 2:00 pm with the Administrator. Refer to telephone interview on 01/12/17 at 4:30 pm with the facility nurse.	C 171		

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C 171	Continued From page 9 Interview on 01/12/17 at 2:00 pm with the Administrator revealed: -The LHPS checkoffs for all staff were done when the clinical skills validations were completed; there just wasn't "a separate sheet" (documentation form). -The Clinical Skills Checklists were the "only sheets" she had. -The LHPS validations did not have to be completed since the FSBS testing was on the Clinical Skills Checklist. Telephone interview on 01/12/17 at 4:30 pm with the facility nurse revealed: -She had been performing the clinical skills checkoffs for the facility for "four years or so". -She did not remember specific staff's checkoffs or specific training, but the documentation of the checkoffs should be in the personnel records at the facility. -She did not know if infection prevention related to FSBS testing was discussed when the clinical skills checklists were completed and would "have to check" her documentation; she routinely covered whatever topics were listed on the form. -She "believed" she filled out the clinical skills checklist, there was an individual form for each LHPS task that she also filled out. -When she completed staff checkoffs, she gave all the completed forms to the Administrator; she did not have copies.	C 171		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	C 342		

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C 342	Continued From page 10 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the Medication Administration Records (MARs) for 3 of 3 sampled residents (Residents #1, #2, and #3) were accurate and included the name or initials of the person administering the medication. The findings are: A. Observation on 01/11/17 at 10:30 am revealed: -New, blank resident MARs for January 2017 were printing from the fax machine. -The Supervisor-In-Charge (SIC) was observed initialing one resident's MAR, documenting administration of medications from 01/01/17 through the present.	C 342		

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C 342	Continued From page 11 Interview on 01/11/17 at 10:32 am with the SIC revealed: -The new, blank MARs were being faxed to her from the Administrator. -The Administrator routinely faxed new MARs at the end of each month for the next month's documentation. -The Administrator had not previously faxed MARs for January 2017 because the Administrator's fax machine had "broke down", so she was unable to send the MARs before the end of the December 2015 as she usually did. -She had not documented the administration of any of the January 2017 medications, but did write down residents' fingerstick blood sugars (FSBSs) daily on a piece of paper and was going to transfer the documentation to the MARs when they arrived. -She planned to document all the medications administered since 12/31/16 on the MARs when they were received from the Administrator. -She was currently in the process of documenting one resident's medications administered throughout the month and would "catch up" the other 5 residents' documentation when the remainder of the MARs arrived. -She documented all the medications for the month because she had been on duty and administered all the medications since Monday, 01/02/17. -The MA scheduled to work the previous weekend, 01/07/17 and 01/08/17, was not able to come in due to the snow. -When asked about documentation for 01/01/17, the SIC clarified that she also worked and administered the medications on 01/01/17 because (named) MA scheduled to work that day "has kids" so the SIC came in for her about 9:00 am that day. -The facility's contracted pharmacy sent out	C 342	C 342 A. The facility has two sets of MAR's every month. One set of MAR's are created by the facility Administrator (which we typically use) and one set of MAR's are generated and delivered monthly by our pharmacy. 01/01/17 through the morning of 01/11/17, medications were documented on the pharmacy generated MAR's that were at the faciltiy. I did fax the new MAR's to the facility the morning of 01/11/17. I create our monthly MAR's to try to stay current with orders. The MAR's that I create are taken to the facility before the 1st of each month. The MAR's that I create are always taken to the facility because they have a front and back side. The facility has a small fax machine and it is rarely used for receiving faxes or making copies. I have a larger fax and copier that I utilize for making copies, etc. I was out of town for New Year's and I had planned on faxing the new MAR's on this particular occasion. Unfortunately, I was unable to pull up the MAR's on my pc from the SD card. Therefore, I was unable to fax them by the first of the month. I told the SIC/MA that I was currently unable to get the MAR's to her but to make sure she continues to document daily medication administration. I did not specify how but I was certain that she would use the MAR's that are generated every month and delivered by our pharmacy and that is accurate according to what she did. We don't typically use those MAR's but due to the circumstances, that is what she did.	

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C 342	Continued From page 12 pharmacy-generated MARs but the facility did not use them. -The Administrator had always created the MARs and instructed staff not to use the pharmacy-generated MARs. -The facility began using a new pharmacy in "mid 2015", but the facility used the MARs printed by the Administrator even before then. Interview on 01/11/17 at 2:17 pm with the Administrator revealed: -The facility did not use the pharmacy-generated MARs because there had been problems with accuracy when they were using the previous pharmacy. -When the facility switched to the new pharmacy, they continued to use the MARs she generated, as they had done previously. -She liked to "create" her own MARs because she kept up with orders and made sure the MARs were accurate. -She was out of town for the first part of the month (January). -She kept the MAR forms on an SD (secure digital) card, but there was a problem opening the files and she was unable to access the files when it was time to send the MARs to the facility. -When she got the SD card fixed, the fax machine was out of ink, so she could not fax the MARs. -She was in the facility yesterday, 01/10/17, but "forgot to bring them (MARs)". -She instructed staff to "document somehow", but did not instruct them how to do so. -She thought staff were documenting the administration of the medications, but did not know how they were doing so. Review of information presented by the SIC on 01/11/17 at 2:30 pm revealed:	C 342	C 342 - A The measures put in place to correct the deficient area of practice is as follows: A-1. The MAR's that we use should have been at the facility prior to the 1st of the month to avoid a discrepancy but they were sent on 01/11/17. The staff transferred signatures from pharmacy generated MAR to the MAR's that we typically use. The blood sugar readings and signatures were documented on 01/11/17 on regular MAR's and staff had documentation on pharmacy generated MAR's Jan 1st-11th. What measures are put in place to prevent this problem from occurring again: A-1. The MAR's that I create are now taken to the facility three to five days prior to the first of the month. This has allowed the medication aide to properly review the MAR's, make necessary changes and make sure they are ready to follow and document according to the physician's order by the first of every month. Who will monitor the situation and how often? A-1. The Administrator will review the MAR's on a weekly basis to make sure the staff are documenting properly according to the state rules. A-2. Facility Management and employees will monitor and review every quarter during our QI Quarterly Meetings to ensure MAR's are at the facility in a timely manner prior to the 1st of the month and to make sure employees are documenting properly according to the state rules and requirements. We have also posted MAR rule requirement on the MAR so the employees can review daily as a reminder	C 342-A 01-31-17 Completion of revised measures to ensure compliance.

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C 342	Continued From page 13 -The information was pharmacy-generated MARs for all residents for January 2017. -All the medications on the MARs were documented as administered from 01/01/17 through 01/11/17. -All the medications were documented as administered by the SIC. Interview on 01/11/17 at 2:30 pm with the SIC revealed: -She had been documenting administration of the medications daily on the pharmacy-generated MARs since 01/01/17. -She previously told surveyors she was not documenting on the pharmacy-generated MARs because the Administrator had instructed staff not to use those MARs and she did not "want to get her in trouble". -She did not respond when asked why the FSBS documentation for two residents was on a separate piece of paper and did not appear on the pharmacy-generated MARs. B. Interviews on 01/11/17 from 11:20 am 11:40 am with 5 of 6 residents present at the facility revealed: -The SIC routinely worked Monday through Friday and two additional staff alternated weekends. -The SIC worked the previous weekend because of the snow. -Two residents reported Staff B, Medication Aide, worked the weekend of 12/31/16 and 01/01/17. -Three residents reported either Staff A, Personal Care Aide, or Staff B worked the weekend of 12/31/16 and 01/01/17, but they did not remember which one. Review of the November 2016 and December 2016 MARs revealed: -Staff B documented administration of all	C 342	C 342-B B. Staff C was a medication aide and Staff A met the proper qualifications to administer medications for 60-days (Sept 2016 & Oct 2016) but did not measure or administer medications. When Staff A worked, Staff C administered medications and signed. What measures are put in place to correct the deficient area of practice: B-1. On January 12, 2017, A QI Meeting was immediately held with Staff to make sure that only certified med aides were administering medications to residents. What measures are put in place to prevent this problem from occurring again: B-2. On 01/31/17, A document for employees who are not medication aides was been created to avoid any miscommunication regarding medication administration qualifications. This document includes the state requirement so each employee knows what the rule is. Each employee must sign confirming that they understand this rule area and will comply . B-2. To avoid a discrepency, I will allow all certified employees to measure and administer medications as well as proper documentation. Medication aides in training will sign the MAR and document as long as they are certified and have the necessary training. All staff training as medication aides have the 15 hour state approved training course and are exempt from the 5/10/15 hour training. If they are outside of the 60-day window, they will not measure, administer or document medications until passing the state exam.	01-31-17

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C 342	Continued From page 14 residents' medications every other weekend. -The SIC documented administration of the medications on the alternate weekends. -Staff A did not document administration of any medications. Interview on 01/11/17 at 10:32 am with the Supervisor-In-Charge (SIC) revealed she routinely administered the medications when she worked through the week, as well as every other weekend when (Staff A) worked because Staff A was not a MA. Telephone interview on 01/11/17 at 11:00 am with Staff A revealed: -She had worked at the facility for "over a year" and routinely worked every other weekend. -"I only give the meds and someone else documents" on the Medication Administration Record (MAR), as they were instructed to do by the Administrator. A second interview on 01/11/17 at 12:00 pm with the SIC revealed: -When Staff A worked, Staff A gave the medications "but I fix" them and documented the administration on the MAR. -The SIC "fixed" the medications by putting them in the medication cups and Staff A "gives" them. -The SIC lived nearby so when Staff A worked, the SIC came to the facility at each medication pass to "fix" the medications. -The reason the residents did not see her on the weekends was because she prepared the medications in the "staff room" and the residents "don't go in there unless they're invited". Interviews on 01/11/17 at 2:17 pm, 01/12/17 at 12:15 pm and 2:00 pm with the Administrator revealed:	C 342	C 342 - B continued Who will monitor the situation and how often? B-3. Facility Management and administrator will monitor and review every quarter during our QI Quarterly Meetings staff records to ensure that only medication aides or staff who meet the proper guidelines to administer meds will do so according to state rules. Residents are not always accurate at self reporting but we will also interview residents quarterly regarding staff and their performed duties during their work shift. C 342 - C and D What measures were put in place to correct the deficient area of practice: C-1 and D-1 On 01/12/17, the staff person (Staff C) was retrained on Diabetic Care Training and Infection Control by our facility nurse. She was also retrained on how to properly document this information on the MAR. . What measures are put in place to prevent this problem from occurring again: . C-2 and D-2. Staff were immediately retrained on Diabetic Care Training and Infection Control by our facility nurse. Staff C on January 12, 2017,Staff B on January 31, 2017 and Staff A on February 5, 2017. C-3 & D-3. A QI Meeting was also held with our facility nurse to review state rules and requirements and to ensure that all of our employees have and will continue to meet the necessary requirements regarding LHPS task. Who will monitor the situation and how often?: This area has been added to our quarterly QI Meeting with Facility Management and employees.	01-31-17

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C 342	Continued From page 15 -Staff A did not sign the MAR because she was in training to become a Medication Aide. -"I like to check off all my people myself", so she thought the Supervisor-In-Charge (SIC) was pulling and administering the medications and Staff A was training by observing. -"No, I can't say I didn't know (Staff A was administering medications). I thought they were doing it together and both (staff) were right there". -The Administrator stated she thought it was okay for Staff A to administer the medications if the SIC was "right there". -The Administrator stated she thought it was okay for the SIC to document the administration of the medications on the MAR if she was "right there" when Staff A gave the medications to the residents. -The Administrator "thought" the SIC was administering all the medications for Staff A beginning in November 2016. A second telephone interview on 01/12/17 at 11:00 am with Staff A revealed: -For "about 6 months" when she began working at the facility, the Supervisor-In-Charge (SIC) was administering the medications while the Administrator was training her. -After "about 6 months", the SIC came to the facility at each medication pass and put the medications in the cups and Staff A administered the medications to the residents, "but she (SIC) was there". -When they became "more comfortable", the SIC came to the facility once each morning and prepared all the medications for the day and Staff A administered the prepared medications to the residents throughout the day. -"About a month ago", Staff A started pulling and administering the medications herself while the SIC "checked behind" her.	C 342		

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C 342	Continued From page 16 -The SIC checked behind her by going through the "pill packs" Staff A left out for her and checking to make sure the "right pills" were in the (medication) cups. -The SIC continued to sign the MAR because Staff A "only did it (administered medications) a time or two" by herself. -After being notified that she did not pass the MA exam, they "went back" to the SIC preparing the medications in the medication cups and Staff A administering to the residents. -The SIC prepared the day's medications in the morning and Staff A administered them throughout the day. C. Review of Resident #1's current FL-2 dated 11/16/16 revealed: -Diagnoses included Diabetes Mellitus Type II and Schizoaffective Disorder. -A physician's order for fingerstick blood sugars (FSBSs) daily. Review of the glucometer stored memory revealed the date and time was not accurately set; it was 3 months and 7.5 days ahead of the current date. Review of FSBSs in the glucometer stored memory and comparison with documented FSBS results revealed: -For the previous 32-day period, there were 5 occasions when a FSBS result was documented for Resident #1, but there were no readings in the glucometer for that day. -Of the 27 days when the FSBS was checked, 14 of the 27 documented results for Resident #1 did not match results in the glucometer memory. Interview on 01/11/17 at 11:40 am with Resident #1 revealed:	C 342		

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C 342	Continued From page 17 -The Supervisor checked her FSBS daily when she was working, but there were two other staff who also checked FSBSs when they were on duty. -The staff checked her FSBS at 8:00 am every morning. Interviews on 01/11/17 at 11:10 am and 01/12/17 at 11:15 am with the Supervisor revealed: -The reason the FSBS results in the glucometer's stored memory did not match the documented FSBSs was because "sometimes I forget what the fingerstick was". -When she forgot the FSBS result, she "guessed" a number between 110 and 130 because "I know that's about where they run". Telephone interviews on 01/11/17 at 11:00 am and 01/12/17 at 12:48 pm with a Personal Care Aide revealed: -She had worked at the facility for "over a year" and routinely worked every other weekend. -She was not a Medication Aide (MA) but had been trained how to give medications by the Administrator. -She had been checking residents' FSBSs since she was hired, even before training as a MA. -She administered medications and completed FSBS testing, but "someone else documents" on the Medication Administration Record (MAR), as they were instructed to do by the Administrator. D. Review of Resident #2's current FL-2 dated 09/17/16 revealed: -Diagnoses included type II diabetes, hypertension, and chronic schizophrenia. -A physician's order for fingerstick blood sugar (FSBS) checks daily. Review of the glucometer stored memory	C 342		

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C 342	Continued From page 18	C 342		

revealed the date and time was not accurately set; it was 3 months and 7.5 days ahead of the current date.

Review of FSBSs in the glucometer stored memory and comparison with documented FSBS results revealed:
-For the previous 32-day period, there were 5 occasions when a FSBS result was documented for Resident #2 but there were no readings in the glucometer for that day.
-Of the 27 days when the FSBS was checked, 15 of the 27 documented results for Resident #2 did not match results in the glucometer memory.

Interview on 01/11/17 at 11:20 am with Resident #2 revealed:
-The Supervisor checked his FSBS every day except on weekends, when one of two other staff members were working.
-Staff checked his FSBS "first thing in the morning".

Interviews on 01/11/17 at 11:10 am and 01/12/17 at 11:15 am with the Supervisor revealed:
-The reason the FSBS results in the glucometer's stored memory did not match the documented FSBSs was because "sometimes I forget what the fingerstick was".
-When she forgot the FSBS result, she "guessed" a number between 110 and 130 because "I know that's about where they run".

Telephone interviews on 01/11/17 at 11:00 am and 01/12/17 at 12:48 pm with a Personal Care Aide revealed:
-She had worked at the facility for "over a year" and routinely worked every other weekend.
-She was not a Medication Aide (MA) but had been trained how to give medications by the

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C 342	Continued From page 19 Administrator. -She had been checking residents' FSBSs since she was hired, even before training as a MA. -She administered medications and completed FSBS testing, but "someone else documents" on the Medication Administration Record (MAR), as they were instructed to do by the Administrator.	C 342	C 912 - A The measures put in place to correct the deficient area of practice is as follows: A-1. New meters and supplies were immediately purchased for each resident on 01/11/17. A-2. Our facility nurse came and trained Staff C on Diabetic Care Training and Infection Control. A-3. A review of the facilities Infection Control Policy & Procedures Book was also reviewed and as a reminder to utilize if needed. What measures are put in place to prevent this problem from occurring again: A-4. A QI Meeting was also held with our facility nurse to review state rules and requirements and to ensure that all of our employees have and will continue to meet the necessary training regarding infection control. A-5. A sign has been posted regarding the proper measures of glucose monitoring and infection prevention. This resource will be an added reminder for employees to review. Who will monitor the situation and how often?: A-6. This area has been added to our quarterly QI Meeting with Facility Management and employees.	C 912-A 01/12/17 and 01/31/1
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding infection prevention requirements and Medication Aide (MA) training and competency. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention (CDC) guidelines on infection control regarding the use of single-use equipment (glucometer and lancing device) for more than one resident. [Refer to Tag 932, G.S. 131D-4.4A(b) (Type A2 Violation).] B. Based on observations, interviews, and record	C 912		

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C 912	Continued From page 20 reviews, the facility failed to ensure 1 of 1 staff members (Staff A) hired after October 2013 and administering medications had completed the five-hour training program developed by the Department and the clinical skills evaluation prior to administering medications, or the additional 10-hour training program developed by the Department within 60 days, or successful completion of the Medication Aide examination administered by the Division within 60 days. [Refer to Tag 935, G.S. 131D-4.5B(b) (Type B Violation).]	C 912	C 912 - B What measures are put in place to correct the deficient area of practice: B-1. On January 12, 2017, A QI Meeting was immediately held with Staff to make sure that only certified med aides were administering medications to residents. What measures are put in place to prevent this problem from occurring again: B-2. On 01/31/17, A document for employees who are not medication aides was been created to avoid any miscommunication regarding medication administration qualifications. This document includes the state requirement so each employee knows what the rule is. Each employee must sign confirming that they understand this rule area and will comply . B-2. To avoid a discrepency, I will allow all certified employees to measure and administer medications as well as proper documentation. Medication aides in training will sign the MAR and document as long as they are certified and have the necessary training. All staff training as medication aides have the 15 hour state approved training course and are exempt from the 5/10/15 hour training. If they are outside of the 60-day window, they will not measure, administer or document medications until passing the state exam Who will monitor the situation and how often? B-3. Facility Management and administrator will monitor and review every quarter during our QI Quarterly Meetings staff records to ensure that only medication aides or staff who meet the proper guidelines to administer meds will do so according to state rules. Residents are not always accurate at self reporting but we will also interview residents quarterly regarding staff and their performed duties during their work shift.	C 912-B 01/12/17 and 01/31/17
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body	C 932		

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C 932	Continued From page 21 fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention (CDC) guidelines on infection control regarding the use of single-use equipment (glucometer and lancing device) for more than one resident. The findings are: Interview on 01/11/17 at 9:15 am with the Supervisor revealed there were two residents who had current orders for daily fingerstick blood sugar (FSBS) checks. Observation on 01/11/17 at 11:11 am revealed: -There was one glucometer stored inside a canvas pouch.	C 932		

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C 932	Continued From page 22 -Neither the glucometer nor the canvas pouch was labeled with a resident's name. -Multiple lancets were also stored inside the canvas pouch along with a lancing device. -The lancing device had visible blood spattered on the inside of the clear plastic tip and smeared on the outside of the plastic tip. -Two additional lancing devices were in a drawer of the medication cart. -One of the two additional lancing devices was clean and appeared to be unused. -The second additional lancing device had visible blood spattered on the inside of the clear plastic tip and smeared on the outside of the plastic tip. A. Review of Resident #1's current FL-2 dated 11/16/16 revealed: -Diagnoses included Diabetes Mellitus Type II and Schizoaffective Disorder. -A physician's order for fingerstick blood sugars (FSBSs) daily. Review of the glucometer stored memory revealed the date and time was not accurately set; it was 3 months and 7.5 days ahead of the current date. Review of FSBSs in the glucometer stored memory and comparison with documented FSBS results revealed: -For the previous 32-day period, there were 5 occasions when a FSBS result was documented for Resident #1, but there were no readings in the glucometer for that day. -Of the remaining 27 days, a FSBS was checked twice each day with an average time between results of less than 2 minutes. -Of the 27 days when the FSBS was checked, 14 of the 27 documented results for Resident #1 did not match results in the glucometer memory.	C 932	C 932 - A and B The measures put in place to correct the deficient area of practice is as follows: A-1 and B-1 New meters and supplies were immediately purchased for each resident on 01/11/17. A-2 and B-2 Our facility nurse came and trained Satff C on Diabetic Care Training and Infection Control. A-3 and B-3 A review of the facilities Infection Control Policy & Procedures Book was also reviewed and as a reminder to utilize if needed 01/12/17. A-4. and B-4 Each resdient has a seperate storage unit for their diabetic supplies labeled with their name. What measures are put in place to prevent this problem from occurring again: . A-5 and B-5 Staff were immediately retrained on Diabetic Care Training and Infection Control by our facility nurse. Staff C on January 12, 2017,Staff B on January 31, 2017 and Staff A on February 5, 2017. A-6 and B-6 A QI Meeting was also held with our facility nurse to review state rules and requirements and to ensure that all of our employees have and will continue to meet the necessary requirements regarding LHPS task. Who will monitor the situation and how often?: A-7 and B-7 This area has been added to our quarterly QI Meeting with Facility Management and employees as well as our nurse consultant.	C 932 01/12/17 New meters and supplies purchased for each resident. QI Meeting 02-05-17 With Staff, nurse and admin.

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C 932	Continued From page 23 Interview on 01/11/17 at 11:40 am with Resident #1 revealed: -The Supervisor checked her FSBS daily when she was working, but there were two other staff who also checked FSBSs when they were on duty. -The staff checked her FSBS at a work table in the kitchen at 8:00 am every morning. -Staff checked another (named) resident's FSBS at the same time they checked hers every morning. -Staff used the same glucometer and lancing pen for both residents, but put a new, "fresh" needle in for each resident. -She had not observed any staff clean or disinfect the equipment. Interview on 01/11/17 at 11:20 am with a second resident revealed: -The Supervisor checked his FSBS every day except on weekends, when one of two other staff members were working. -Staff checked his FSBS "first thing in the morning". -Staff checked his FSBS and another resident's FSBS at the same time and used the same glucometer and lancing device. -When asked how long facility staff had been using the same glucometer for both of them, the resident stated there had "never" been more than one glucometer. Refer to interviews on 01/11/17 at 11:10 am and 01/12/17 at 11:15 am with the Supervisor. Refer to telephone interviews on 01/11/17 at 11:00 am and 01/12/17 at 12:48 pm with a Personal Care Aide.	C 932		

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C 932	Continued From page 24 Refer to interviews on 01/11/17 at 2:17 pm and 01/12/17 at 12:10 pm with the Administrator. B. Review of Resident #2's current FL-2 dated 09/17/16 revealed: -Diagnoses included type II diabetes, hypertension, and chronic schizophrenia. -A physician's order for fingerstick blood sugar (FSBS) checks daily. Review of the glucometer stored memory revealed the date and time was not accurately set; it was 3 months and 7.5 days ahead of the current date. Review of FSBSs in the glucometer stored memory and comparison with documented FSBS results revealed: -For the previous 32-day period, there were 5 occasions when a FSBS result was documented for Resident #2 but there were no readings in the glucometer for that day. -Of the remaining 27 days, a FSBS was checked twice each day with an average time between results of less than 2 minutes. -Of the 27 days when the FSBS was checked, 15 of the 27 documented results for Resident #2 did not match results in the glucometer memory. Interview on 01/11/17 at 11:20 am with Resident #1 revealed: -The Supervisor checked his FSBS every day except on weekends, when one of two other staff members were working. -Staff checked his FSBS "first thing in the morning". -Staff checked his FSBS and another resident's FSBS at the same time and used the same glucometer and lancing device. -When asked how long facility staff had been	C 932		

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C 932	Continued From page 25 using the same glucometer for both of them, the resident stated there had "never" been more than one glucometer. Interview on 01/11/17 at 11:40 am with a second resident revealed: -The Supervisor checked her FSBS daily when she was working, but there were two other staff who also checked FSBSs when they were on duty. -The staff checked her FSBS at a work table in the kitchen at 8:00 am every morning. -Staff checked another (named) resident's FSBS at the same time they checked hers every morning. -Staff used the same glucometer and lancing pen for both residents, but put a new, "fresh" needle in for each resident. -She had not observed any staff clean or disinfect the equipment. Refer to interviews on 01/11/17 at 11:10 am and 01/12/17 at 11:15 am with the Supervisor. Refer to telephone interviews on 01/11/17 at 11:00 am and 01/12/17 at 12:48 pm with a Personal Care Aide. Refer to interviews on 01/11/17 at 2:17 pm and 01/12/17 at 12:10 pm with the Administrator. Interviews on 01/11/17 at 11:10 am and 01/12/17 at 11:15 am with the Supervisor revealed: -There was only one glucometer in the facility and she checked two residents' FSBSs every morning with the same glucometer. -There was more than one lancing pen, but she "mainly" used the one stored in the canvas pouch with the glucometer. -She cleaned the lancing pen with alcohol every	C 932		

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C 932	Continued From page 26 day before using it. -She used the same lancing pen to obtain both FSBSs, but used a different needle and test strip for each resident. -The reason the FSBS results in the glucometer's stored memory did not match the documented FSBSs was because "sometimes I forget what the fingerstick was". -When she forgot the FSBS result, she "guessed" a number between 110 and 130 because "I know that's about where they run". Telephone interviews on 01/11/17 at 11:00 am and 01/12/17 at 12:48 pm with a Personal Care Aide revealed: -She had worked at the facility for "over a year" and routinely worked every other weekend. -She was not a Medication Aide (MA) but had been trained how to give medications by the Administrator. -She had been checking residents' FSBSs since she was hired, even before training as a MA. -She did not recall being checked off by a nurse to perform FSBS checks. -Sometimes she checked the FSBS in the residents' rooms and sometimes at the table. -She used the same glucometer and lancing device to check both residents' FSBSs. -She "just wiped off" the meter and the lancing pen with an alcohol swab every morning before using them to obtain the two FSBSs. Interviews on 01/11/17 at 2:17 pm and 01/12/17 at 12:10 pm with the Administrator revealed: -She was not aware staff was using one glucometer and lancing device for multiple residents. -Each resident should have their own glucometer. -She would purchase two new glucometers today.	C 932		

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C 932	Continued From page 27 The facility failed to follow infection prevention guidelines established by the CDC by sharing glucometers and lancing devices between residents. The facility's failure to ensure equipment used to obtain blood samples was not shared between multiple residents placed the residents at substantial risk of harm or death due to the significant risk of transmission of bloodborne pathogens and constitutes a Type A2 Violation. On 01/11/17, the Administrator submitted a Plan of Protection as follows: -The Administrator would purchase a new glucometer and lancing device for each individual resident with orders for FSBSs. -The equipment would be purchased today, 01/11/17. -Staff would be retrained prior to their next scheduled shift regarding proper procedure for checking FSBSs. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2017.	C 932		
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	C935		

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C935	Continued From page 28 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 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 staff members (Staff A) hired after October 2013 and administering medications had completed the five-hour training program developed by the	C935	C935 What measures are put in place to correct the deficient area of practice: On January 12, 2017, A QI Meeting was immediately held with Staff to make sure that only certified med aides were administering medications to residents. What measures are put in place to prevent this problem from occurring again: On 01/31/17, A document for employees who are not medication aides was been created to avoid any miscommunication regarding medication administration qualifications. This document includes the state requirement so each employee knows what the rule is and what the qualifications are for medication aides.. Each employee must sign confirming that they understand this rule area and will comply . To avoid a discrepency, I will allow all certified employees to measure and administer medications as well as proper documentation. Medication aides in training will sign the MAR and document as long as they are certified and have the necessary training. All staff training as medication aides have the 15 hour state approved training course and are exempt from the 5/10/15 hour training. If they are outside of the 60-day window, they will not measure, administer or document medications until passing the state exam Who will monitor the situation and how often? Facility Management and administrator will monitor and review every quarter during our QI Quarterly Meetings staff records to ensure that only medication aides or staff who meet the proper guidelines to administer meds will do so according to state rules. Residents are not always accurate at self reporting but we will also interview residents quarterly regarding staff and their performed duties during their work shift.	C 935 01-31-17 New plan completed

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C935	Continued From page 29 Department and the clinical skills evaluation prior to administering medications, or the additional 10-hour training program developed by the Department within 60 days, or successful completion of the Medication Aide examination administered by the Division within 60 days. The findings are: Review of personnel records for Staff A, Personal Care Aide, revealed: -No clear documentation of hire date, but drug screening and tuberculosis testing was completed in November 2015. -A medication clinical skills checkoff dated 09/01/16. -No documentation of the 5-10-15-hour Medication Aide (MA) training. -A letter from the Division dated 12/09/15 indicating Staff A did not pass the Medication Aide written exam. -The letter did not indicate the date of the exam. Interviews on 01/11/17 at various times with 5 of 6 residents currently residing at the facility revealed: -Staff A administered their medications every other weekend. -They did not see the Supervisor-In-Charge (SIC) on the weekends unless she was working the weekend; they did not see her when other staff were working the weekend. -They routinely received their medications from all the staff on time and without any problems. Interview on 01/11/17 at 10:32 am with the Supervisor-In-Charge (SIC) revealed she routinely administered the medications when she worked through the week, as well as every other weekend when (Staff A) worked because Staff A	C935		

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C935	Continued From page 30 was not a MA. Telephone interview on 01/11/17 at 11:00 am with Staff A revealed: -She had worked at the facility for "over a year" and routinely worked every other weekend. -She was not a MA, but had "been trained by (named Administrator) how to give (medications)". -Staff A routinely performed fingerstick blood sugar (FSBS) testing when she worked. -She did not recall being checked off to administer medications or perform FSBS testing by a nurse, "just" the Administrator. -"I only give the meds and someone else documents" on the Medication Administration Record (MAR), as they were instructed to do by the Administrator. A second interview on 01/11/17 at 12:00 pm with the SIC revealed: -When Staff A worked, Staff A gave the medications "but I fix" them. -The SIC "fixed" the medications by putting them in the medication cups and Staff A "gives" them. -The SIC lived nearby so when Staff A worked, the SIC came to the facility at each medication pass to "fix" the medications. -The reason the residents did not see her on the weekends was because she prepared the medications in the "staff room" and the residents "don't go in there unless they're invited". Interviews on 01/11/17 at 2:17 pm, 01/12/17 at 12:15 pm and 2:00 pm with the Administrator revealed: -Staff A was hired in November 2015, but she did not know the exact date of hire. -Staff A was initially "only relief staff" and became "permanent staff around September 2016".	C935		

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C935	Continued From page 31 -Staff A was checked off by a nurse on 09/01/16 to administer medications, so she was able to administer medications for 60 days. -She received notification in December that Staff A did not pass the written exam and had not administered any further medications. -Staff A administered medications during the 60 days following the (09/01/16) clinical skills checkoff but did not administer medications anymore after the 60 days had passed. -Staff A did not sign the MAR because she was in training. -"I like to check off all my people myself", so she thought the Supervisor-In-Charge (SIC) was pulling and administering the medications and Staff A was training by observing. -"No, I can't say I didn't know (Staff A was administering medications). I thought they were doing it together and both (staff) were right there". -The Administrator stated she thought it was okay for Staff A to administer the medications if the SIC was "right there". -The Administrator "thought" the SIC was administering all the medications for Staff A beginning in November 2016. -Staff A received training from facility staff and the nurse "when she (Staff A) first came". -Staff A did not complete the specific 5-10-15-hour training course because the Administrator did not know there was a specific course, but the nurse provided training for all MAs. A second telephone interview on 01/12/17 at 11:00 am with Staff A revealed: -She routinely performed FSBS testing from the time she began working at the facility. -For "about 6 months" when she began working at the facility, the Supervisor-In-Charge (SIC) was administering the medications while the	C935		

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C935	Continued From page 32 Administrator was training her. -After "about 6 months", the SIC came to the facility at each medication pass and put the medications in the cups and Staff A administered the medications to the residents, "but she (SIC) was there. -When they became "more comfortable", the SIC came to the facility once each morning and prepared all the medications for the day and Staff A administered the prepared medications to the residents throughout the day. -"About a month ago", Staff A started pulling and administering the medications herself while the SIC "checked behind" her. -The SIC checked behind her by going through the "pill packs" Staff A left out for her and checking to make sure the "right pills" were in the (medication) cups. -The SIC continued to sign the MAR because Staff A "only did it (administered medications) a time or two" by herself. -After being notified that she did not pass the MA exam, they "went back" to the SIC preparing the medications in the medication cups and Staff A administering to the residents. -The SIC prepared the day's medications in the morning and Staff A administered them throughout the day. -She did not complete a 5-10-15-hour MA training course. Telephone interview on 01/12/17 at 4:30 pm with the facility nurse revealed: -She had been performing the clinical skills checkoffs for the facility for "four years or so". -Once a year, she gave "big classes" for the MAs during which she reviewed medications, ADL (Activities of Daily Living) tasks, "specialized tasks", etc. -She had not provided the "big class yet for the	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041027	A. BUILDING: _____ B. WING _____	01/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTDALE MANOR	303 WESTDALE PLACE GREENSBORO, NC 27403

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C935	Continued From page 33 year" and did not know exactly when the last one was provided. -She did not specifically remember Staff A's checkoff or specific training, but the documentation of the checkoffs should be in her personnel record at the facility. -She did not know anything about a specific 5-10-15-hour training course for MAs. -The course she taught MAs was one the Administrator gave her when she began doing the facility's training. -She assumed the training course given to her by the Administrator was a "state-approved course". A Plan of Protection for the Type B Violation was requested on 01/12/17 prior to exit, 01/13/17, and 01/17/17, but was not provided. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2017.	C935		