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	FCL041027	A. BUILDING: _____ B. WING _____	01/17/2017

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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	Reviewed and accepted 04/20/17 Bonnie Moore	
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	Weekly monitoring was already established and followed. As part of our QI Program, facility management will work closer with staff to ensure proper temperature ranges continue to meet state requirements. The facility questions the accuracy of the readings provided by NC DHHS Licensure Consultant Ms. Bonnie Moore. During 01/11/17and 01/12/17, according to this report, her highest reading was 124 and our highest reading was 118. Two facility employees can confirm the accuracy of our hot water temperature results which did not reach over118. She verbally told me that their highest reading was 122. I discovered while reading this report that it was listed 2 degrees higher. We used to different tools to measure. 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 hot water heater was repaired on 01/18/17 and maintains proper temperature according to state requirements.	Repaired on 01/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed by Amma Allen, Westdale Manor Administrator 02/16/17

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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	The highest temperature reported to me by NC DHHS Licensure Consultant Ms.Bonnie Moore and our county adult care home specialist was 122. That reading was inaccurate with our readings. The readings were never over 118. Even though I have a discrepancy with accuracy of the readings listed by NC DHHS Licensure Consultant Ms. Bonnie Moore, I agree that the readings were slightly above state regulations. The state requirement ranges have always been listed on the bottom of the form that the SIC/MA uses to document the water temperature readings but failed to see it. As part of our Quality Improvement Program,on 01/11/17 our facility SIC/MA was trained on the water temperature approval ranges. C 105 Weekly monitoring was already established and followed. As part of our QI Program, facility management will work closer with staff to ensure proper temperature ranges continue to meet state requirements. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary. We will continue to follow this procedure.	Repaired 01/18/17

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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	The protocol is for our employees to contact us if the ranges are below or above state requirement ranges and it states that on the form that we use for documenting the hot water temperatures. This is the same sheet that NC DHHS Licensure Consultant, Bonnie Moore used to document the water temperatures taken by the facility staff on 12/16/16 and 12/30/16. I showed that documentation to NC DHHS Licensure Consultant, Bonnie Moore on 01/11/17. I never stated that "I dropped the ball". I have never used that phrase. As part of our Quality Improvement Program,I spoke with all 6 residents at the facility on 01/11/17 and again on 01/12/17 regarding the hot water temperature. 5 of 6 residents said the hot water temperature was okay and had no complaints or concerns regarding the hot water temperature. 1 of 6 residents stated that the hot water was sometimes too hot but then said that it had never been too hot. The inaccuracy of 1 of 6 residents is most likely caused by their mental health diagnosis. A plumber came to the facility on 01/18/17 to perform a maintenance , check. **Repairs were made and the hot water heater maintains the proper ranges between 100 and116.** The plumber said that the weather may have caused a malfunction due to the location of the unit which is under the house.There was a snow storm several days before this survey was conducted which could have created issues with the hot water heater unit.	01/18/17 Repairs completed

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C 105	Continued From page 3 degrees F.	C 105		
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	Our findings are that Staff A had no substantiated findings on the North Carolina Health Care Personnel Registry. NC DHHS Licensure Consultant Bonnie Moore states this on Page 5 of this report. **The facility was in compliance with state rules and regulations.** A Health Care Personnel Registry check was completed prior to hire on Staff A at the same time I completed the criminal record check. I explained to NC DHHS Licensure Consultant Bonnie Moore that Staff A was originally hired as "Relief Staff". Relief staff information is not kept with our Main Facility Employee Book. Unfortunately, I misplaced some info for Staff A. I told Ms.Moore that we have records of all of our educational classes and I could call while she was there and have the other information verified from our local hospital's occupational health center for TB Test and Drug Screening info. I can provide the above documentation. Many things that NC DHHS Licensure Consultant reported on this survey report were inaccurate according to Staff A. Staff A also disagrees with some of the information provided. As I mentioned to NC DHHS Licensure Consultant Bonnie Moore, Staff A was originally hired as a relief staff person. She did work some weekends when needed. I can confirm that I did check the HCPR and criminal record check in November 2015. The info may have been shredded due to human error. Surveyor, Ms. Bonnie Moore also pulled up the HCPR on her cell phone to confirm **that the facility was incompliance with rule 10A NCAC 13G .0406 Other Staff Qualifications.on 01/12/17.**	

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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	**The facility did comply with the state rules andrequirements** for Staff A and her HCPR. Staff A had no substantiated finding and NC DHHS Licensure Consultant Bonnie Moore acknowledges this to the left. C 145 As part of our Quality Improvement Program, Management has implemented a more effective form of record keeping for our Relief SIC Employees. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary. We will continue to follow this procedure.	
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	According to our bank records, A criminal background check was completed November 2015. As I mentioned before, some information was misplaced but after reviewing our records we were able to confirm Staff A 's information. On 01/12/17, I informed NC DHHS Licensure Consultant Ms. Bonnie Moore that we could confirm all necessary information for Staff A prior to closing the survey. I was never given the opportunity to provide. **The facility was in compliance.**	

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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	I have several different failed attempts to provide documentation to NC DHHS Licensure Consultant Ms. Bonnie Moore. An Informal Dispute Resolution has been requested on our behalf. Staff A was originally hired as a relief employee. According to our records, Staff A took a course on Infection Control in October 2015. We were trying to be proactive because we did not know when or if we would need Staff A for releif. Staff A did not physically work at the facility as relief while we were in the process of completing necessary requirements such as criminal record check, HCRS, TB test, drug screening and CPR which we can confirm all was done November 2015. NC DHHS Licensure Consultant Bonnie Moore was made aware of this prior to the survey closing date of 01/17/17. I was not given the opportunity to provide. **The facility was in compliance.** C 147 As part of our Quality Improvement Program, Management has implemented a more effective form of record keeping for our Relief SIC Employees. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary. We will continue to follow this procedure.	
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	I have several different failed attempts to provide documentation to NC DHHS Licensure Consultant Bonnie Moore. An Informal Dispute Resolution has been requested on our behalf. **The facility was in compliance with state rules and regulations.** According to our records, Staff A completed the proper training for Competency Validation For Licensed Health Professional Support Tasks for (fingerstick bloodsugar testing). Staff A completed Infection Control in October 2015. This training also provided Diabetic Care training.	

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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	All of our employees are properly trained by our nurse consultant prior to performing task listed on the Licensed Health Professional Support Tasks Sheet. According to our records, Staff A took a state approved course on infection control in October 2015, which also included Diabetic CareTraining. LHPS Validation for Staff A was completed originally in October 2015. Additional training was performed on 12/09/15 and 12/10/15 which included state approved courses on Medication Administration, Infection Control, Diabetic Care Training, Personal Care Services, Pharmacy and other educational information. She also had other training. This is according to our records Staff A performed fingerstick blood sugar testing when on duty and had been qualified to do so since October 2015.	

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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	A. Staff A was originally hired as a relief employee. According to our records, Staff A took a course on Infection Control October 2015, which included Diabetic Care Training provided by our nurse consultant based on the state approved course. Staff A may not recall all of the events that took place in 2015. Neither can I. Fortunately, we have records to indicate the facts. Each resident originally had separate glucose meters and supplies. Something happened to one of the meters and lancing pens. The same meter and lancing pens were used to test two different residents but properly sanitized before and after using. Staff A sanitized the blood sugar meter and lancing pen before and after use. The CDC recommends single use and at one point in time, each resident had their own meter and necessary supplies. For Quality Improvement, I immediately purchased 2 new machines on 01/11/17. This has been addressed with our Quality Improvement Program but we do not feel that we violated a rule or regulation. The interview on 01/12/17 with me was based on the information that was inside the main employee records on Staff A which included clinical skills. When Staff A started training as a medication aide, staff records were stored in the main employee file. We tried to provide the employee records for Staff A prior to closing the survey but consultant Ms. Moore did not allow. B. Staff B has been an employee for over 20 years. Original records are not stored in the main employee file. Many, many years ago, the state had different TB test requirements. A 2-step TB test was performed in 2000. Clinical Skills did not exist when Staff B was hired. Through the years, our facility has complied with each rule and regulation when they were originated or taught to us. We have always tried to comply with state rules and regulations.	

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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	Health Care Personnel Registry did not exist when Staff B was hired but it was obtained when it became a requirement. I think that clinical skills originated in 2003 and that's when Staff B completed the training. Staff B performed fingerstick checks and was qualified. According to our records, LHPS validation was completed April 2009. Our records provide accurate completion dates. Staff C performed fingerstick testing and was qualified to do do according to the state rules and regulations prior to performing task. **The facility was in compliance.** C 171 As part of our Quality Improvement Program, Management has implemented a more effective form of record keeping for our Relief SIC Employees. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary. We will continue to follow this procedure.	

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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	NC DHHS Licensure Consultant Bonnie Moore is inaccurate to state that I said: The LHPS validations did not have to be completed since the FSBS testing was on the Clinical Skills Checklist. I never said nor suggested that. I did confirm that LHPS task for fingerstick testing is done during Clinical Skills Checklist. I did state that I was unaware of a "seperate sheet" other than the LHPS Sheet completed quarterly during Drug Reviews. I asked NC DHHS Licensure Consultant Bonnie Moore was there a separate sheet? I was never given an answer. I also asked her, what was the proper way to document LHPS Task? I was never given an answer. Our annual classes also provide this training. I met with our nurse consultant and reviewed employee records to confirm proper completion dates. I informed NC DHHS Licensure Consultant Bonnie Moore that I could confirm staff records/dates but was not given the opportunity after many request to do so. As a facility, we value the advice of state consultants, social workers, etc. After being an administrator for nearly 20 years, I still learn something new daily and I'm always eager to learn. It is important for us to work together for the same common goal which is to provide quality care and meet the needs of individuals who need assistance with living. I went to the facility during the survey to provide staff records. Due to the nature of the content and confidential information, employee records are kept in my possession. I always provide employee records during surveys or at the request of our adult care home specialist in my presence. That is a policy of our facility.	
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes:	C 272		

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C 272	Continued From page 10 (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve snacks between each meal for a total of three snacks per day for the 6 residents currently residing at the facility. The findings are: Interviews on 01/11/17 at various times from 9:22 am to 9:45 am with 5 residents revealed: -Four of five residents stated they got enough to eat. -One resident stated if you were hungry before lunch, you "just had to wait". -One snack was served daily in the afternoon. -No morning or evening snacks were served or available. -The residents had not asked staff for any additional snacks. -One resident purchased his own snacks to have available if he got hungry. "I'd eat them if they brought them. That would be nice". -5 of 5 residents indicated they would eat the snacks if they were served. Interview on 01/11/17 at 3:15 pm with the Supervisor-In-Charge (SIC) revealed: -She routinely served the residents a snack once daily in the afternoon. -She "didn't know" to serve snacks three times daily. Interview on 01/11/17 at 2:17 pm with the	C 272	Staff Records were reviewed and to my knowledge, we were in compliance with everything on all employees except for Staff A's criminal record and NC DHHS Licensure Consultant told me that I could provide the information prior to the survey closing (which took place on 01/17/17). I made several attempts to provide the documentation for the criminal record for Staff A but the NC DHHS Licensure Consultant failed to give me the opportunity. I did not learn of any questions or concerns with Staff B and Staff C employee records until I read this report when it was provided on 01/31/17. I could have answered any questions regarding Staff B and Staff C but not made aware of any concerns until I read this report. Staff B and Staff C have been facility employees since the creation of NC DHHS Annual Surveys and no other licensure consultant has ever had an issue or cited a deficiency on Staff B and Staff C employee records, nor has our adult care home specialist who review employee records on an annual basis. Each survey prior to this has always been conducted fairly. An Informal Dispute Resolution has been requested by our facility. C 272 Snacks are and have always been made available in between each meal on a daily basis. I interviewed 6 out of 6 residents on 01/11/17and all confirmed that snacks are and havealways been made available. Residents saidthey get snacks out of the snack bowl whenthey are not offered and they have never beendenied a snack. All residents have the right topurchase additional snacks based on theirpreference. On 01/11/17, I interviewed the SIC/MA on duty, and she stated that she did not know that snacks had to be "offered" three times a day. She said that she always serves a snack in the afternoon and makes snacks available in a snack bowl between every meal. **That is in compliance with the state rules andregulations**	

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C 272	Continued From page 11 Administrator revealed: -Residents were "supposed" to be given snacks three times daily, "preferably" at 10:00 am, 2:00 pm, and "usually around bedtime". -She was not aware snacks were being served only once daily. Observation on 01/11/17 from 9:00 am to 12:45 pm revealed no morning snack was served or offered to the residents.	C 272	I also interviewed both weekend staff and they both confirmed that snacks are and have always been made available in between each meal. I also interviewed the person who does the grocery shopping on a weekly basis and they also confirmed that snacks are being purchased on a weekly basis. NC DHHS Licensure Consultant Bonnie Moore did not observe morning snacks being served because she was outside smoking a cigarette according to the SIC/MA. The staff person on duty said that several of the residents were sleeping and several residents enjoyed their morning snack that the facility provides between each meal.	
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 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	C 342	C 272 **The facility was in compliance with state rules and regulations.** As part of our Quality Improvement Program, Management has implemented a more effective form for employees to offer and provide snacks in between each meal. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary.	

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C 342	Continued From page 12 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. 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	C 342	C 342 A. 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. On 01/01/17 (New Year's Day), 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 typically don't use those MAR's however due to the circumstances, that is what the SIC/MA used to temporarily document the medication administration to meet state requirements. When I returned from out of town, there was a snow storm (01/06/17) that further prevented me from delivering the regular MAR's that I create. Pharmacy MAR's were temporarily used but we were always in compliance with the state rules and regulations according to medication administration.	

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C 342	Continued From page 13 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 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	C 342	C 342 **The facility was in compliance with state laws and regulations. Medications were documented properly on the pharmacy generated MAR's.** 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. On 01/01/17 (New Year's Day), 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 typically don't use those MAR's however due to the circumstances, that is what the SIC/MA used to temporarily document the medication administration to meet state requirements. When I returned from out of town, there was a snow storm (01/06/17) that further prevented me from delivering the regular MAR's that Icreate. Pharmacy MAR's were temporarily used but we were always in compliance with the state rules and regulations according to medication administration .	

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C 342	Continued From page 14 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: -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.	C 342	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. On 01/01/17 (New Year's Day), 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 generated every month and delivered by our pharmacy and that is accurate according to what she did. We typically don't use those MAR's however due to the circumstances, that is what the SIC/MA used to temporarily document the medication administration to meet state requirements. When I returned from out of town, there was a snow storm (01/06/17) that further prevented me from delivering the regular MAR's that I create. Pharmacy MAR's were temporarily used but **we were always in compliance with the state rules and regulations according to medication administration** I was at the facility when the SIC/MA showed the NC DHHS Licensure Consultant Bonnie Moore the medication administration documentation on the pharmacy generated MAR's. Bonnie Moore insulted the integrity of our facilities SIC/MA stating "did you just do this". The SIC/MA said "No maam, I asked you this morning if you wanted to see it and you said no." The fingerstick testing was done and documented as well as medication administration. **Our findings are that the facility was in compliance with state rules and regulations.**	

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C 342	Continued From page 15 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 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.	C 342	B. The diagnosis of our facility residents may lead to inaccurate information. The resident clearly stated that they could not remember. An interview with residents may not provide accurate information. I told NC DHHS Licensure Consultant Bonnie Moore Staff A was hired as a relief staff worker. Staff B and Staff C were the main employees at the facility. When Staff A worked at the facility, Staff C would measure and administer medications. In September 2016, Staff A was in training as a medication aide. Within that 60 day time period, she was learning the process of how to administer medications. Staff A has worked at the facility for over a year hired as a relief staff worker. She has full-employment elsewhere. When Staff A worked, Staff C would measure and administer medications. During my interview with Staff A, she said that she told NC DHHS Licensure Consultant Bonnie Moore that she did not give medications and Staff C gives medications and documents. Staff A told me that when the state surveyor called, she was at her other job and sometimes it was hard to hear. She said that she told the state surveyor that she could not hear her and that she was at her other job. She said that it wasn't a good time to talk and if she had questions to please contact her after 5 PM during her non working hours so that she could provide accurate information. She said that the NC DHHS Licensure Consultant Bonnie Moore continued to ask her questions and due to the circumstances, she wasn't sure if the info Bonnie Moore was able to gather was accurate information. She said that Bonnie called her several times at her regular job asking questions and failed to contact her after 5 PM per Staff A's request to better assist.	

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C 342	Continued From page 16 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: -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	C 342	In September of 2016, I wanted to prepare Staff A to become a medication aide. Clinical Skills was completed in September 2016. The SIC/MA measured and administered medications but started training Staff A. Staff A also completed State Approved medication administration classes and courses prior to this. The information that NC DHHS Licensure Consultant Bonnie Moore provided in this report based on my interview is inaccurate. I told her that Staff A did not sign the MAR because she was not measuring and administering the medications. She was in training. The SIC/MA was measuring and administering. The state surveyor kept trying to put inaccurate words in my mouth to confirm something that I did not say. NC State Licensure Consultant Bonnie Moore, asked me If I knew that Staff A was administering medications? I told Bonnie that Staff A could measure and administer medications within that 60 day window after taking Clinical Skills however, the SIC/MA was still measuring and administering. After the 60 day window, Staff A was waiting to take the State Medication Exam and medication training ended. The SIC/MA started measuring and administering without staff A in training.	

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C 342	Continued From page 17 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. -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.	C 342	Staff A has worked at the facility for over a year hired a relief staff worker. She has full-employment elsewhere. When Staff A worked, Staff C would measure and administer medications. During my interview with Staff A, she said that she told NC DHHS Licensure Consultant Bonnie Moore that she did not give medications and Staff C gives medications and documents. Staff A told me that when the state surveyor called, she was at her other job and it was hard to hear. Staff A said that she told the state surveyor that she could not hear her and that she was at her other job. She said that it wasn't a good time to talk and if she had questions to please contact her after 5 PM during her non working hours so that she could provide accurate information. Staff A said the NC DHHS Licensure Consultant Bonnie Moore continued to ask her questions and due to the circumstances, she wasn't sure if Ms. Bonnie Moore was able to gather accurate information. She said that Ms. Moore called her several times at her regular job asking questions and failed to contact her after 5 PM per Staff A's request to better assist. Ms. Moore never contacted her after 5 PM. Staff A was in training to become a med aide September of 2016. Staff A and the SIC/MA confirm they were together during training. However, the SIC/MA was measuring and administering. Staff A could measure and administer medications within that 60 day window after taking Clinical Skills but the SIC/MA was still measuring, administering, and documenting. After the 60 day window, Staff A was waiting to take the State Medication Exam and medication aide training ended. The SIC/MA started measuring and administering without Staff A in training. The SIC/MA was in compliance according to 10A NCAC 13G .1004 Medication Administration, (c) Only oral solid medications that are ordered for routine administration may be prepared in advance and must be prepared within the 24 hours of the prescribed time for administration. I conducted interviews with Staff A, the SIC/MA and residents. **The facility maintained compliance according to state rules and regulations**.	

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C 342	Continued From page 18 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: -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.	C 342	C 342 C. NC DHHS Licensure Consultant BonnieMoore stated that the meter had inaccuracies. In all fairness, The stored meter may have also had inaccuracies as well. The resident said that the SIC/MA and other staff provided daily FSBS. I interviewed the SIC/MA and she stated that she was accurate when writing down the fingerstick blood sugar reading results. She said that NC DHHS Licensure Consultant Bonnie Moore implied that she could not have been performing the task due to the inaccuracy of the glucose meters memory. and her documentation The SIC/MA told me that on a few occasions, she may have been providing necessary needs for a resident and immediate documentation of the reading was not done but she said that she would look in the memory to confirm reading and document. Please note that the average ALC levels for both residents requiring daily FSBS was accurate with the daily MAR results that all employees documented. NC DHHS Licensure Consultant Bonnie Moore did not inform me of the meter readings and MAR documentation discrepancies until 01/12/17 after I had already purchased 2 new meters and supplies on 01/11/17. On 01/12/17 when I checked the meters memory and MAR documentation for accuracy,the meter memory was empty. NC DHHSLicensure Consultant Bonnie Moore was the last person to utilize the glucose meter. The SIC/MA said that the last time she utilized the old glucose meter was the morning of 01/11/17 prior to the surveyor coming to the facility.The SIC/MA told me that she did say that she knows what they usually run but never said she guessed. She used the memory to confirm.	

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C 342	Continued From page 19 -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 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".	C 342	Staff A has worked at the facility for over a year hired as a relief staff worker. She has full-employment elsewhere. When Staff A worked, Staff C would measure and administer medications. During my interview with Staff A, she said that she told NC DHHS Licensure Consultant Bonnie Moore that she did not give medications and Staff C gives medications and documents. Staff A told me that when the state surveyor called, she was at her other job and it was hard to hear. Staff A said that she told the state surveyor that she could not hear her and that she was at her other job. She said that it wasn't a good time to talk and if she had questions to please contact her after 5 PM during her non working hours so that she could provide accurate information. Staff A said the NC DHHS Licensure Consultant Bonnie Moore continued to ask her questions and due to the circumstances, she wasn't sure if the Bonnie Moore was able to gather accurate information. She said that Ms. Moore called her several times at her regular job asking questions and failed to contact her after 5 PM per Staff A's request to better assist. Ms. Moore never contacted her after 5 PM. C 342 As part of our Quality Improvement Program, Management has implemented a more effective form of record keeping for our Relief SIC Employees. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary. We will continue to follow this procedure.	

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C 342	Continued From page 20 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.	C 342	**The facility was in compliance with the state rules and regulations.** The interview conducted by NC State Licensure Consultant regarding 01/11/17 @ 11:10 am and 01/12/17 @ 11:15 am are inaccurate according to the SIC/MA. I interviewed the SIC/MA and she said that she did not say this. She stated that the state surveyor Bonnie Moore was very manipulative and tried to put words in her mouth that she did not say. The SIC/MA confirms the following: 1. She took the FSBS every morning before breakfast. Both residents also confirm. 2. The SIC/MA said, Ms Moore asked her, Why didn't the MAR documentation match the stored memory, did you just guess?" In response, the SIC/MA said the readings are usually between 110 and 130. The SIC/MA said she told her that a few times, when she finished taken the FSBS, the resident may need something and she may not be able to document immediately but shortly thereafter. She said she usually remembers but checks the memory to be sure then documents.	
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	C 912	**Staff A had the proper training according to the state rules and regulations. The facility was in compliance.** **An Informal Dispute Resolution has been requested.**	

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C 912	Continued From page 21 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 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	**A. The facility did not fail to implement infection control procedures consistent with the CDC guidelines regarding single use equipment (glucometer and lancing pen) for more than one resident. An Informal Dispute Resolution has been requested.** **B. Staff A had the proper training according to the state rules and regulations. The facility was in compliance. An Informal Dispute Resolution has been requested.** C 912 We are truly what you call a Family Care Home. Each resident at our facility is part of our extended family and to some residents, we are their only family. We are advocates for resident rights and would never intentionally violate those rights. As part of our Quality Improvement Program, Management addressed the CDC recommendations and had an immediate refresher staff training course on Diabetic Care and Infection Control. Management will work closer with staff to ensure CDC recommendations are being followed. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary. We will continue to follow this procedure.	
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	C 932		

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C 932	Continued From page 22 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 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	C 932	**The facility does have an Infection Prevention Plan. The NC DHHS Licensure Consultant Bonnie Moore did not ask me to see the plan. It is kept at the facility. I did not learn of this deficiency until I read this report sent by Ms.Moore via email on 01/31/17. The facility is in compliance**.	

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C 932	Continued From page 23 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. -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.	C 932	The facility did not fail to implement infection control procedures consistent with the CDC guidelines regarding the use of (glucometer and lancing device) for more than one resident. There was one meter. The clean lancing device is the one that the staff used. The meter and lancing pen were cleaned before after each use. Each resident did have their own meters at one time. There was a second lancing device that was broken and not usable. Which has been disposed of. The glucose meter and lancing pen that were used daily were clean. I saw this on 01/12/17 when I tried to check the glucose meter memory which is when I discovered it had been erased. The NC DHHS Licensure Consultant was the last person to utilize the machine.	

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C 932	Continued From page 24 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. 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	C 932	The glucose meter and memory should not be reliable if it has been confirmed that the date and time was not accurate according to the NC State Licensure Consultant Ms. Bonnie Moore. The facts are that each facility employee checked the FSBS every morning and documented. The 2 residents also confirmed this. Therefore, the facility was in compliance with the state rules and regulations. I tried to check the glucose meter readings on 01/12/17 to confirm the accuracy of the daily readings and the MAR documentation. The glucose meter storage was empty. Apparently it had been erased. The NC DHHS Licensure Consultant Ms. Bonnie Moore was the last person to utilize the glucose meter. The SIC/MA said that she had not used it since the morning of 01/11/17 prior to the arrival of Ms. Moore. I purchased 2 new machines on 01/11/17. The facility used the new machines and supplies on 01/12/17. . The lancing pen and glucose meter were cleaned before and after each use. Residents are not very observant and may not give accurate information due to their diagnosis and mental health conditions.	

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C 932	Continued From page 25 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. 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.	C 932	Residents are not very observant and may not give accurate information due to their diagnosis and mental health conditions. There were two meters and lancing pens. Each resident did have their own meters at one time. Neither resident had a diagnosis of a bloodborne pathogen. The glucose meter and memory should not be reliable if it has been confirmed that the date and time was not accurate according to the NC State Licensure Consultant Ms. Bonnie Moore. I should have been given the opportunity to see the inaccuracies of the stored memory. When I checked the meter it was erased and the NC DHHS Licensure Consultant was the last person to utilize the meter. New meters were purchased immediately on 01/11/17 and used on 01/12/17.	

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C 932	Continued From page 26 -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 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	C 932	Residents are not very observant and may not give accurate information due to their diagnosis and mental health conditions. There were two meters and 2 lancing pens. Each resident did have their own meters and supplies at one time. **The facility was in compliance with the state rules and regulations.**	

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C 932	Continued From page 27 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 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.	C 932	**The facility was in compliance with the state rules and regulations.** The interview conducted by NC State Licensure Consultant regarding 01/11/17 @ 11:10 am and 01/12/17 @ 11:15 am are inaccurate according to the SIC/MA. I interviewed the SIC/MA and she said that she did not say this. She stated that the state surveyor Ms. Bonnie Moore was very manipulative and tried to put words in her mouth that she did not say. The SIC/MA confirms the following: 1. She took the FSBS every morning before breakfast. Both residents also confirm. 2. The SIC/MA said, Ms Moore asked her, Why didn't the MAR documentation match the stored memory, did you just guess?" In response, the SIC/MA said the readings are usually between 110 and 130. The SIC/MA said she told her that a few times, when she finished taken the FSBS, the resident may need something and she may not be able to document immediately but shortly thereafter. She said she usually remembers but checks the memory to be sure then documents. **An Informal Dispute Resolution has been requested.**	

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C 932	Continued From page 28 -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. 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.	C 932	2 New meter and supplies were purchased immediately on 01/11/17. **The facility did not fail to implement infection control procedures consistent with the CDC guidelines rearding the use of (glucometer and lancing device) for more than one resident.Our procedures are consistent with the CDC.** C 932 As part of our Quality Improvement Program, Management, we addressed the CDC recommendations and had an immediate refresher staff training course on Diabetic Care and Infection Control. Management will work closer with staff to ensure CDC recommendations are being followed. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary. We will continue to follow this procedure.	

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	FCL041027	A. BUILDING: _____ B. WING _____	01/17/2017

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C 932	Continued From page 29 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 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	C935	**Based on documentation, our facility Medication aides have the proper training according to the state rules and regulations. I tried to present the employee file for Staff A to NC DHHS Licensure Consultant Ms. Bonnie Moore prior to 01/17/17 but was not given the opportuity. The facility was in compliance. An Informal Dispute Resolution has been requested**. Staff A had the proper training according to the state rules and regulations. The facility was in compliance. An Informal Dispute Resolution has been requested.	

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C935	Continued From page 30 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 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.	C935	**The facility did not fail to implement infection control procedures consistent with the CDC guidelines rearding the use of (glucometer and lancing device) for more than one resident.** **Staff A had the proper training according to the state rules and regulations. I tried to present the employee file to NC DHHS Licensure Ms. Bonnie Moore prior to 01/17/17but was not given the opportuity. The facility was in compliance. An Informal Dispute Resolution has been requested.** I showed Ms. Moore the letter for Staff A stating she did not pass the medication exam. Unfortunately she missed it by 1 point.	

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C935	Continued From page 31 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 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	C935	**Staff A did not work every other weekend. Residents information may not always be accurate due to their diagnosis and mental health condition.** **The facility was in compliance with the state rules and regulations.** Staff A has worked at the facility for over a year hired as a relief staff worker. She has full-employment elsewhere. When Staff A worked, Staff C would measure and administer medications. During my interview with Staff A, she said that she told NC DHHS Licensure Consultant Ms. Bonnie Moore that she did not give medications and Staff C gives medications and documents. Staff A told me that when the state surveyor called, she was at her other job and it was hard to hear. Staff A said that she told the state surveyor that she could not hear her and that she was at her other job. She said that it wasn't a good time to talk and if she had questions to please contact her after 5 PM during her non working hours so that she could provide accurate information. Staff A said the NC DHHS Licensure Consultant Ms. Bonnie Moore continued to ask her questions and due to the circumstances, she wasn't sure if the Bonnie Moore was able to gather accurate information. She said that Ms. Moore called her several times at her regular job asking questions and failed to contact her after 5 PM per Staff A's request to better assist. Ms. Moore never contacted her after 5 PM	

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C935	Continued From page 32 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". -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".	C935	Staff A was in training to become a med aide September 2016. Staff A and the SIC/MA confirm they were together during training. However, the SIC/MA was measuring and administering. Staff A could measure and administer medications within that 60 day window after taking Clinical Skills but the SIC/MA was still measuring, administering, and documenting. After the 60 day window, Staff A was waiting to take the State Medication Exam and medication aide training ended. The SIC/MA measured and administered without training Saff A. I conducted interviews with Staff A, the SIC/MA and residents. **The facility maintained compliance according to state rules and regulations** The information that NC DHHS Licensure Consultant Bonnie Moore provided in this report based on my interview is inaccurate. I told her that Staff A did not sign the MAR because she was not measuring and administering the medications. She was in training. The SIC/MA was measuring and administering. The state surveyor kept trying to put inaccurate words in my mouth to confirm something that I did not say. NC State Licensure Consultant Bonnie Moore, asked me If I knew that Staff A was administering medications? I told Bonnie that Staff A could measure and administer medications within that 60 day window after taking Clinical Skills however, the SIC/MA was still measuring and administering. After the 60 day window, Staff A was waiting to take the State Medication Exam and medication training ended. The SIC/MA started measuring and administering without staff A in training.	

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C935	Continued From page 33 -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 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	C935	The information that NC DHHS Licensure Consultant Bonnie Moore provided in this report based on my interview is inaccurate. I told her that Staff A did not sign the MAR because she was not measuring and administering the medications. She was in training. The SIC/MA was measuring and administering. T he state surveyor kept trying to put inaccurate words in my mouth to confirm something that I did not say. NC State Licensure Consultant Bonnie Moore, asked me If I knew that Staff A was administering medications? I told Bonnie that Staff A could measure and administer medications within that 60 day window after taking Clinical Skills however, the SIC/MA was still measuring and administering. After the 60 day window, Staff A was waiting to t ake the State Medication Exam and medication training ended. The SIC/MA started measuring and administering without staff A in training. **Staff A had the proper training according to the state rules and rugulations. The facility was in compliance.** **An Informal Dispute has been requested.**	

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C935	Continued From page 34 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 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	C 935 As part of our Quality Improvement Program, Management has implemented a more effective form of record keeping for our Relief SIC Employees. Quarterly monitoring has always been established at our facility and often times more often to meet necessary immediate actions we find necessary. We will continue to follow this procedure. **NC DHHS Licensure Consultant Ms. Bonnie Moore faxed a blank form to me. Ms. Moore told me to complete it, sign and return to her. She did not have the top portion completed to explain what the Type B Violation was. This was the second time I was asked by Ms. Moore to complete a blank form. I am also disputing the first one that I signed per her request. I should not have to complete a blank form with no merit nor should I be asked to complete a blank form with no merit. The facility was in compliance with state rules and regulations.** **An Informal Dispute Resolution has been requested.**	