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YANCEY HOUSE	4 COOPER LANE BURNSVILLE, NC 28714

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a follow-up survey on October 4-5, 2017.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 3 of 6 sampled staff (Staff A, Staff C and Staff D) were tested for tuberculosis using a two-step skin test method in compliance with control measures adopted by the Commission for Health Services. The findings are: A. Review of Staff A's personnel record revealed: -She had been hired as a Personal Care Aide (PCA) on 2/16/15. -A one-step TB skin test had been administered 17 months after employment and documented as negative on 7/14/16. -The district health nurse, who had performed the test and documented the result, had written "No further TB f/u (follow up) needed" on the form. -There was no documentation a second-step TB	D 131		

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D 131	Continued From page 1	D 131		

skin test had been done.

Interview on 10/5/17 at 2:30pm with Staff A revealed:
-She had one TB skin test last year and was told by the district health nurse she did not need to have a second one.
-The facility had not done a second TB skin test.

Refer to interview on 10/5/17 at 4:10pm with the Executive Director.

B. Review of Staff C's personnel record revealed:
-He had been hired as a "Certified Aide" on 7/31/17.
-There was documentation a one-step TB skin test had been given on 7/24/17.
-There was no documentation of the TB skin test results.
-There was no documentation a second-step TB skin test had been done.

Interview on 10/5/17 at 3:20pm with Staff C, revealed:
-He did not remember if the TB skin test had been checked for results.
-He had not had a second TB skin test.

Refer to interview on 10/5/17 at 4:10pm with the Executive Director.

C. Review of Staff D's personnel record revealed:
- She had been hired as a Personal Care Aide on 5/25/17.
- A one-step TB skin test had been done on 5/22/17 and read as negative.
-The district health nurse who had performed the test and documented the result had written "No further TB f/u (follow up) needed" on the form.
-There was no documentation a second-step TB

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D 131	Continued From page 2 skin test had been done. Interview on 10/6/17 at 3:55pm with Staff D revealed: -She had one TB skin test when she was hired. -She had been told at that time by the district health nurse she did not need to have a second one. -The facility had not done a second TB skin test. Refer to interview on 10/5/17 at 4:10pm with the Executive Director. Review of the facility's TB testing policy dated October 2015 revealed: -If staff could not show proof of a TB skin test in the past 12 months prior to employment, they would need the first TB skin test administered upon employment. -They would need a second TB skin test administered approximately two weeks after the first TB skin test is read. Interview on 10/5/17 at 4:10pm with the Executive Director (ED) revealed: -She had been the ED for about six months. -She was not aware Staff A, Staff C and Staff D had not had the required TB skin testing. -The Business Office Manager was responsible for making sure staff personnel records were complete. -She would have the staff personnel records reviewed to assure all staff had the required TB skin testing.	D 131		
D 133	10A NCAC 13F .0407(a)(1) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications	D 133		

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D 133	Continued From page 3 (a) Each staff person at an adult care home shall: (1) have a job description that reflects actual duties and responsibilities and is signed by the administrator and the employee; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure a job description that reflected actual duties and responsibilities was signed by the Executive Director and the employee for 3 of 6 sampled staff (Staff B, Staff C and Staff F). The findings are: A. Review of Staff B's personnel record revealed: -There was no documentation of a date of hire in the personnel record but a date of 2/16/15 was provided on a list by the Business Office Manager. -A job description electronically signed by Staff A but not signed by the Executive Director. Interview on 10/5/17 at 4:20pm with Staff B, Personal Care Aide (PCA), revealed: -She had reviewed her job description during her initial interview with the Business Office Manager. -She had worked as a PCA at another facility and she was aware of what she needed to do. Refer to interview on 10/5/17 at 4:30pm with the Executive Director. B. Review of Staff C's personnel record revealed: -There was no documentation of a date of hire in the personnel record but a date of 8/1/17 was provided on a list by the Business Office Manager. -A job description electronically signed by Staff C but not signed by the Executive Director.	D 133		

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D 133	Continued From page 4 Interview on 10/5/17 at 4:10pm with Staff C, PCA, revealed he had signed some paperwork when hired but wasn't sure what it was. Refer to interview on 10/5/17 at 4:30pm with the Executive Director. C. Review of Staff F's personnel file revealed: -There was no documentation of a date of hire in the personnel record but a date of 4/18/16 was provided on a list by the Business Office Manager. -A job description electronically signed by Staff F but not signed by the Executive Director. Interview on 10/5/17 at 3:55pm with Staff F, Medication Aide/Supervisor, revealed: -She had worked as a medication aide prior to her employment at the facility and knew what she needed to do. -She felt sure she had reviewed a job description upon hire but could not remember for sure. Refer to interview on 10/5/17 at 4:30pm with the Executive Director. Interview on 10/5/17 at 4:30pm with the Executive Director revealed: -She was unaware she was supposed to sign the job description. -New employees electronically sign all their paperwork. -They could improve upon this by as she would review and sign the job description with the new employee.	D 133		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	Continued From page 5 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult 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 assure 1 of 6 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry prior to hiring. The findings are: Review of Staff A's personnel record revealed: -She had been hired as a Personal Care Aide (PCA) on 2/16/15. -There was no documentation a North Carolina Health Care Personnel Registry (HCPR) check had been completed for this staff person. Interview on 10/5/17 at 4:10pm with the Executive Director (ED) revealed: -She had been the ED for about six months. -She was not aware Staff A did not have a HCPR check in her personnel record. -The Business Office Manager was responsible for making sure staff personnel records were complete. -She would have the staff personnel records reviewed to assure all staff had the required HCPR checks. Review of a verification completed 10/5/17 for Staff A revealed she was not listed on the	D 137		

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D 137	Continued From page 6 HCPR.	D 137		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 4 of 6 sampled staff (Staff B, Staff C, Staff D and Staff E) were competency validated by a registered nurse (RN) by return demonstration prior to performing Licensed Health Professional Support tasks. The findings are: A. Review of Staff B's personnel record revealed: -She had been hired as a Personal Care Aide (PCA) on 7/11/17. -She had completed Personal Care Training on 8/25/17. -There was no documentation Licensed Health Professional Support (LHPS) tasks competency validation had been completed.	D 161		

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D 161	Continued From page 7 Observation of Staff B on 10/4/17 during the noon meal on the Special Care Unit revealed she was feeding a resident a pureed diet. Record review revealed the resident had a diagnosis of dementia and an LHPS task of "feeding technique" due to her inability to chew effectively and swallow safely without total assistance from the staff. Interview on 10/4/17 at 2:pm with Staff B revealed she had not done a LHPS skills validation with the LHPS nurse. Refer to interview on 10/5/17 at 4:10pm with the Executive Director. B. Review of Staff C's personnel record revealed: -He had been hired as a "Certified Aide" on 7/31/17. -There was no documentation of his nurse aide training and/or certification. -There was no documentation he had completed Personal Care Training. -There was no documentation LHPS tasks competency validation had been completed. Observation of Staff C on 10/4/17 during the noon meal on the Special Care Unit revealed he was feeding a resident a pureed diet. Record review revealed the resident had a diagnosis of dementia and an LHPS task of "feeding technique" due to her inability to chew effectively and swallow safely without total assistance from the staff. Interview on 10/4/17 at 1:00pm with Staff C revealed:	D 161		

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D 161	Continued From page 8 -He had transferred residents who were non-ambulatory to/from their beds to geri-chairs. -He had physically assisted several resident who required the use of walkers when ambulating. -He had not done a LHPS skills validation with the LHPS nurse. Refer to interview on 10/5/17 at 4:10pm with the Executive Director. C. Review of Staff D's personnel record revealed: -She had been hired as a Personal Care Aide (PCA) on 5/25/17. -There was no documentation LHPS tasks competency validation had been completed. Interview on 10/6/17 at 3:55pm with Staff D revealed: -She transferred ambulatory and semi-ambulatory residents from their beds to chairs in their rooms, wheelchairs and to/from the toilet. -She removed TED (thrombo-embolic deterrent) hose before one resident went to bed. -She monitored the residents who used oxygen. Refer to interview on 10/5/17 at 4:10pm with the Executive Director. D. Review of Staff E's personnel record revealed: -She had been hired as a Personal Care Aide (PCA) on 7/19/11. -She had not been required to have Personal Care Training because she had been trained and certified as a nurses aide. -There was no documentation LHPS tasks competency validation had been completed. Refer to interview on 10/5/17 at 4:10pm with the Executive Director.	D 161		

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D 161	Continued From page 9 Interview on 10/5/17 at 4:10pm with the Executive Director (ED) revealed: -She had been the ED for about six months. -She was not aware Staff B, Staff C, Staff D and Staff E had not been LHPS competency validated. -The Business Office Manager was responsible for making sure staff personnel records were complete. -She would have the staff personnel records reviewed to assure the care staff had LHPS competency validation.	D 161		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 5 residents sampled residents (Resident #1) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:	D 234		

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Review of Resident #1's current FL2 dated 8/8/17 revealed diagnoses included dementia, Alzheimer's type, hyperlipidemia, lower back pain and macular degeneration.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 11/25/16.

Review of Resident #1's record revealed:
-There was one computer generated TB skin test from a local hospital that documented a TB skin test had been placed on 11/22/16 but was not documented as read.
-There was no electronic or written signature on the form.
-There was no documentation on the form to indicate who placed or read the TB skin test or when it was read.
-There was a facility TB skin test form in Resident #1's record with a date of 12/20/16 documenting a TB skin test was given and read on 12/22/16 with no results documented.
-There was no documentation of any other TB skin tests in the record.

Interview on 10/5/17 at 1:25pm with the Special Care Unit Coordinator revealed:
-Resident #1 should have had a 2-step TB skin test completed and documented as read with the results upon admission to the facility.
-She was not sure why the previous Licensed Health Professional Support (LHPS) nurse had not checked off the results.

Interview with the Corporate Nursing Consultant on 10/5/17 at 5:30pm and 09/15/17 at 12:37pm revealed:
-The facility had a new LHPS nurse who would be responsible for the TB skin test.

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D 234	Continued From page 11 -She would make sure that Resident #1 received a TB skin test on 10/5/17 and assure it would be documented as read with the results noted. -She was not sure why the previous LHPS nurse had not documented the results of the TB skin test but should have.	D 234		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure table service included a non-disposable place setting consisting of at least a knife, fork, and spoon. The findings are: Interview with the Executive Director on 10/4/17 at 9:45am revealed the current census was 56. Observations of the lunch meal in the Special Care Unit (SCU) dining room on 10/4/17 at 11:55am revealed: -There were 27 residents seated in the dining area. -The meal served to residents included baked	D 287		

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fish, mixed vegetables with peas, rice and butterscotch pudding for dessert.
-The place setting for all residents did not include a knife.

Observation on 10/5/17 at 11:31am of the noon meal in the SCU revealed:
-The regular meal served to residents included a pork chop, mashed potatoes with gravy, mixed vegetables and pumpkin pie.
-The place setting consisted of a fork, spoon and napkin for 21out of 27 residents.
-There were 6 residents who received a spoon and napkin for a place setting.
-Six residents were attempting to pick up the pork chop and eat it with their hands.
-Other residents were using their forks and fingers to tear apart the pork chop and then eat it.
-No staff member offered to cut up the resident's pork chops for them.
-A male resident told the SIC/MA he had "no teeth to eat the pork chop" and she brought him a bowl of pot roast back from the kitchen that he was able to eat.

Interview with a resident on 10/5/17 at 11:40pm revealed:
-The resident was not able to eat the pork chop without it being cut into smaller pieces.
-The resident did not have teeth to be able to bite the pork chop.
-He had tried to pull some of the pork chop apart but it was too tough.

Interview with the Dietary Manager on 10/5/17 at 12:05pm revealed:
-She had been the Dietary Manager for the past year.
-The meals were sent out from the kitchen to the SCU.

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D 287	Continued From page 13 -The place setting consisted of a fork, spoon, and a napkin. -No knives were given to the residents on the SCU so the silverware could not be used to hurt anyone and some of the residents would "not know how to use it anymore". -"It was like that prior to when I had started as Dietary Manager". -She was unaware all residents were to have a full place setting with each meal. -"There was one knife sent on the SCU dietary cart for the staff to cut up the residents food." Interview on 10/5/17 at 12:00pm with a day shift SIC/MA revealed: -She had assumed "they (the residents) are not supposed to have knives on the SCU." -All the silverware came from the kitchen. -"We have had residents take the silverware to their rooms." -There were no assessments as to the residents ability to use silverware. Observation on 10/5/17 at 12:25pm of the dietary cart in the SCU dining room revealed a knife in a silver container of clear pink tinted liquid. -Staff thought the pink liquid was soap. Interview on 10/5/17 at 12:27pm with the SCU Coordinator revealed: -She had been at the facility for nine years -She had just recently become the SCU Coordinator. -There were no assessments as to the SCU residents ability to use silverware. -Staff on the SCU set the place setting from the cart that the dietary department sends out. -There was no silverware or napkins kept on the unit, "everything comes from the kitchen". -She thought the residents had knives.	D 287		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 287	Continued From page 14 -She was unaware of the residents eating with their fingers. -She expected the kitchen to send out knives, forks and spoons for the resident's place setting. -"Usually they send all three." Interview on 10/5/17 at 4:10pm with Staff C, personal care aide (PCA), revealed: -He had only been employed about a months with the facility. -No one had explained to him why the residents did not have a knife and he had not asked. -Normally he had observed the kitchen cut up the food. -He did not remember ever seeing a knife on the unit. Interview on 10/5/17 at 4:20pm with Staff B, PCA, revealed: -She had employed with the facility for 2 months. -"These people are not supposed to have a knife," as they would not know how to use it. -She did not think they would know how to use a knife. -No one had ever told her why the residents on the SCU were not allowed to have a knife. -"I don't know why we didn't think to help them cut up their pork chop." Interview with the Executive Director on 10/5/17 at 4:20pm revealed: -She had been the Executive Director for approximately eight months. -She was unaware the SCU residents were not receiving a fork, spoon, knife and napkin. -She was not aware of any safety issues with the SCU residents and their silverware. -She would make sure all SCU residents received the correct place setting. -It was her expectation the Dietary department	D 287		

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	HAL100005	A. BUILDING: _____ B. WING _____	R 10/05/2017

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D 287	Continued From page 15 would send out the correct place setting. -The staff of the SCU were to make sure the correct place setting was set for each resident.	D 287		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 2 of 5 sampled residents related to the administration of valproic acid (Resident #6) and risperidone (Resident #1). The findings are: A. Review of Resident #6's current FL2 dated 9/20/17 revealed: -Diagnoses including unspecified encephalopathy, undifferentiated schizophrenia and anxiety disorder. -Medication orders including valproic acid (Depakote Solution) 250mg/5ml syrup, give 250mg at 6am, give 500mg at 12pm and 6pm and 750mg at 10pm.	D 358		

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D 358	Continued From page 16	D 358		

Review of Resident #6's Record revealed:
-A physician's order written 9/22/17 for valproic acid 250mg/5ml syrup, give 5ml by mouth, twice a day with lunch and supper and valproic acid 250mg/5ml syrup, give 10ml at bedtime.
-A physician's order written 9/28/17 for a depakote level.
-The result of the depakote level was 56.5 (Reference range 50.0-100.0)

Observation during the 10/5/17 morning medication pass revealed:
-The Medication Aide (MA) looked at Resident #6's eMAR and removed a white plastic bottle labeled with Resident #6's name from a drawer in the medication cart.
-She compared the bottle label to the eMAR and stated the resident was to be given 45cc of valproic acid and poured 45cc into a medication cup.
-She then compared it again to the eMAR.
-The state surveyor read the order on the eMAR and the label on the bottle.
-The label indicated the bottle contained valproic acid, 250mg/5ml syrup.
-The directions on the label were, "Give 5ml by mouth twice daily with lunch and supper and give 10ml by mouth at bedtime".

Interview on 10/5/17 at 8:30am with the MA revealed:
-The MA stated Resident #6 had an order for 45cc of valproic acid in the morning but she could not locate the order.
-Before the order could be verified, the MA had given Resident #6 the 45cc of valproic acid.
-When the order had been verified as no valproic acid in the morning, valproic acid 250mg/5ml syrup, give 5ml with lunch and supper and valproic acid 250mg/5ml syrup, give 10ml at

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bedtime, the MA stated she had been nervous and should not have given Resident #6 the valproic acid.

Interview on 10/5/17 at 8:35am with the Administrator and the Special Care Unit (SCU) Coordinator revealed:
-They were notified of the medication error and the SCU Coordinator stated she would immediately notify the prescribing practitioner.
-She would speak with the MA to ensure the error would not happen again.

Review of Resident #6's September 2017 electronic Medication Administration Records (eMAR) revealed:
-An entry for valproic acid 250mg/5ml syrup, give 5ml with lunch and supper.
-An entry for valproic acid 250mg/5ml syrup, give 10ml at bedtime.

Review of Resident #6's October 2017 eMAR revealed:
-An entry for valproic acid 250mg/5ml syrup, give 5ml with lunch and supper.
-An entry for valproic acid 250mg/5ml syrup, give 10ml at bedtime.

Interview on 10/5/17 at 5:00pm with the prescribing practitioner for Resident #6 revealed:
-The facility had called and notified her that morning of the medication error.
-She had instructed the facility not to give Resident #6 any more valproic acid today.
-She did not expect the resident to experience any negative effects.

B. Review of Resident #1's current FL-2 dated 8/18/17 revealed:
-Diagnoses included Alzheimer's type dementia,

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hyperlipidemia, lower back pain, macular degeneration and hypertension.
-A medication order for risperidone 0.5mg, ½ tab by mouth twice daily, as needed for agitation.

Interview on 10/05/17 at 10:43 am with Resident #1 revealed:
-She was unaware she had medication for agitation.
-She did not know the names of any of her medications.

Observation on 10/05/17 at 3:21pm of Resident #1's medication on hand revealed there was no risperidone available.

Review of Resident #1's electronic Medication Administration Records (eMARs) for August 2017 and September 2017 revealed:
-An entry for risperidone 0.5mg ½ tab by mouth twice a day as needed.
-There was no documentation of Risperidone having been administered.

Interview with a Medication Aide (MA) on 10/05/17 at 10:43am revealed she did not remember Resident #1 ever receiving risperidone 0.25mg.

Interview with the Special Care Unit Coordinator 10/05/17 at 4:35pm revealed:
-The process was for the medication to be ordered from the pharmacy if it was on the FL2 and/or the physician's order sheet.
-She was unaware of why the medication had not come from the pharmacy and was not on the cart.

Interview on 10/5/17 at 5:05pm with the pharmacy revealed:
-The pharmacy had not received a copy of the

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D 358	Continued From page 19 FL2 for Resident #1 on 8/18/17. -They had not received an order for the risperidone. -The pharmacy did not have a current order for risperidone and therefore would not have sent the medication. -The facility printed out the physician's orders and should be checking them for accuracy.	D 358		